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Legislative Budget Committee
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Madam Chairwoman and members of the Committee

My name is Cindy Luxem, Executive Director of the Kansas Health Care Association and Kansas Center for Assisted Living, a trade association with a membership of over 200 providing care in nursing homes, assisted living, residential health care, home plus, nursing facilities for mental health and HCBS services. Thank you for the opportunity to testify.

Today I would like to address some issues around the implementation of KanCare. We have been willing participants as move towards January 2013 start up, but we have concerns.

1. Global issues
   a. Savings- where can anyone show savings in any other insurance driven system. How much has been saved in New Mexico? Or Tennessee? And KanCare has been modeled after TennCare. Based on a recently published article, none of the States that have implemented these programs have saved ANY money. (Commonwealth)

   b. Transparency- Do you think the process has been transparent? Yes, there has been a plethora of meetings but very few questions have been answered.

   c. How are of the different segments of our system affected? Especially on the acute side? Probably aware over 40 hospitals have the potential of having reimbursements affected because of high re-hospitalization numbers.

2. Practical issues
   a. Implementation- The pace has been staggering and deadlines have not been met. In what other area of business would you see an old system completely disregarded for an entirely new system without sufficient time to develop infrastructure or at least examine it to see whether what is being planned will even work?
   Authenticare system was put in place approximately one year ago for the purpose of pre-billing documentation of services provided to individuals with developmental disabilities. Some of our members have yet to be paid for services rendered months ago due to system implementation problems. This is an example of a good program that would have benefited from taking another 6 months to plan and implement properly.

   b. Billing issues- What are the plans when providers do not get paid? We have been promised there will be testing of claims and billing systems before start up. In our many cases, providers will be starting over with new systems. Several issues already identified; shorter time to file claims. And currently the state has been paying clean claims in 10 days but the contracts now reflect a 20 day window. We need assurances our providers will get paid. The current statute provides for 365 days to submit a claim for services. The insurance companies contract provide for 90 to 180 days. This may seem like a fair amount of time, but in cases of individuals applying for Medicaid (so-called Medicaid pending) it takes more than 180 days to get qualified by the state. Currently the state has been paying clean claims in 10 days but the contracts now reflect a 20 day window. We need assurances our providers will get paid.

   c. Sign up of beneficiaries- Again we are not comfortable in how this will be executed. It was suggested at a recent KanCare public forum, "The state might group insurance company clients together…" That would not be a reasonable approach.

   d. Contracts- Pressure, pressure, pressure. Our members are struggling to understand everything in the contracts. The insurance companies have gone above and beyond with the provider meetings but it gets down to individual decisions about the contracts and we cannot assist with that.

      We are talking about their financial livelihood and they are being asked to sign contracts on blind faith. Within the contracts, provider manuals and protocols are referenced and just this week have we seen draft copies of the provider manuals. Grateful for this but they come from other states and they are not specific to provider type, meaning the rules for skilled nursing, hospitals, and physicians are all jumbled up in the same document. This is a complete disservice to providers, not very transparent.

   e. Lack of systems and how they work- again we believe this is why the implementation is slowed down. How can providers make informed decisions about their interest in participation?

Over many years, laws have been passed to protect beneficiaries and to keep the state in compliance of federal law. If we are not representing those safeguards then Kansas might have problems in the future. And because of the lack of time to inspect provider manuals, protocols and contracts we cannot adequately identify.

There is quite a lot hitting health care providers at this time. Medicaid Audits, Medicare Audits, Obamacare....

From our initial review, our fear is this will significantly affect the smaller providers at a particularly difficult time. We can only suspect as this moves forward the savings will come from providers so this will mean loss of jobs and the closing of homes...and probably in areas where we can least support losing more jobs. In its' rush to get KanCare implemented, the State is leaving the providers at the side of the road, with many assurances of protections to our facilities and residents, being forgotten.

So in conclusion, we will continue to work with the insurance companies on behalf of the care givers across the state of Kansas.

Are only request is that we SLOW the implementation down and allow everyone the time to get all of these systems in place so it can be productive for everyone involved...especially the beneficiaries.

Thank you.

The New York Times

September 6, 2012

With Medicaid, Long-Term Care of Elderly Looms as a Rising Cost

By NINA BERNSTEIN

Medicaid has long conjured up images of inner-city clinics jammed with poor families. Its far less-visible role is as the only safety net for millions of middle-class people whose needs for long-term care, at home or in a nursing home, outlast their resources.

With baby boomers and their parents living longer than ever, few families can count on their own money to go the distance. So while Medicare has drawn more attention in the election campaign, seniors and their families may have even more at stake in the future of Medicaid changes — those proposed, and others already under way.

Though former President Bill Clinton overstated in his convention speech on Wednesday how much Medicaid spends on the elderly in nursing homes — they account for well under a third, not nearly two-thirds, of spending — Medicaid spends more than five times as much on each senior in long-term care as it does on each poor child, and even more per person on the disabled in long-term care.

Seniors like Rena Lull, 92, who spent the last of her life savings on $250-a-day nursing home care near Cooperstown, N.Y., last year, will face uncharted territory if Republicans carry out their plan to replace Medicaid with block grants that cut spending by a third over a decade.

The move would let states change minimum eligibility, standards of care, and federal rules that now protect adult children from being billed for their parents' Medicaid care.

Now, like a vast majority of the nation's 1.8 million nursing home residents, Mrs. Lull, a retired schoolteacher with dementia, counts on Medicaid to cover most of her bill. But her daughter Rena, 66, also a retired schoolteacher with a lifetime of savings, no longer knows what she can count on in her own old age.

"I get choked up thinking about this," she said, recalling how her widowed mother had depleted $300,000 on five years of care in the community and one year in the Otsego Manor nursing home, before qualifying for Medicaid. "I'm so scared about what's going to happen to me."

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The presidential election may decide Medicaid's future. But many states faced with rising Medicaid costs and budget deficits are already trying to cut the cost of long-term care by profoundly changing Medicaid coverage, through the use of federal waivers.

Waivers sought or obtained by 26 states, including New York, California, Illinois and Texas, would affect some three million people, most of them eligible for both Medicaid and Medicare. Plans vary, but typically they try to cut costs by giving private managed-care organizations a fixed sum for a lifetime of care, from doctor and hospital visits to help at home to nursing home placement, expecting that more care will take place in less expensive settings.

Over all, 31.5 percent of Medicaid's $400 billion in shared federal and state spending goes to long-term care for the elderly and the disabled. That ranges from less than 8 percent in Hawaii, where nursing home use is low, to more than 60 percent in North Dakota.

Many people assume that Medicare will cover long-term care, but at most it covers 100 days of rehabilitation, not so-called custodial care — the help with activities of daily life, like eating and bathing, that the aged can need for years.

To be eligible for Medicaid, however, a person typically can have no more than $14,800 in assets, and though some lawyers specialize in setting up trusts that shelter certain assets, the federal government has periodically closed loopholes that allowed it.

Mrs. Lull, who married her Ithaca College sweetheart, also a teacher, when he was in the Air Force in 1944, and carried their twin girls home in a laundry basket, is required to pay all but $50 a month of her $969 income from Social Security and a pension toward the Medicaid cost of her shared room. Her case is typical, in that she cared for her husband before his death at home at 83.

Few Americans buy private long-term care insurance, and such insurance was dropped from the Affordable Care Act last year as actuarially unsound or unaffordable.

"More than $80,000 a year on average for a nursing home — who can sustain that?" said Robyn Grant, director of public policy and advocacy for the National Consumer Voice for Quality Long Term Care. "We're forced, most of us, to go onto Medicaid. People don't realize this."

No state has a more ambitious plan to overhaul Medicaid than New York, which has the biggest Medicaid budget in the country — $54 billion — and spends about 41 percent of it for long-term care, almost half on nursing homes. Jason A. Helgerson, the state's Medicaid chief, calls the redesign "a multiyear march away from fee-for-service" that he says will flatten the spending rate even as the population ages.

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By 2015, New York will start requiring some 78,000 nursing home residents to choose one of several managed care plans or be enrolled randomly. The plans are already enrolling tens of thousands of elderly and disabled New York City residents who now receive more than 120 hours a week of government-paid help at home, with those in other downstate counties next.

"We in New York are committed to using this as a force for good," Mr. Helgerson said, noting that such services, including the largest home care program in the country, have long been exempted from managed care. "By keeping people healthy, by keeping them out of unnecessarily restrictive, institutional settings, we can keep the program sustainable in the long run."

Around the country, however, some health policy analysts doubt that managed care will save money, and advocates for the aging and disabled worry that the sickest and most vulnerable people may be hurt in the process.

"Managed care isn't going to help — it's just more money going off the top," said Toby Edelman, senior policy attorney in the Washington office of the Center for Medicare Advocacy, who has written on the importance of Medicaid to Medicare beneficiaries and their middle class relatives. "The managed care company has to take its cut."

There is too little evidence available to evaluate whether managed care itself really saves money in long-term care, said H. Stephen Kaye, a professor at the Institute on Health and Aging at the University of California, San Francisco.

"One of the problems with the rush to do this is there isn't a lot of knowledge about what measures should be used or how to track this," Dr. Kaye said, noting that his analysis of 15 years of data from many states concluded that the gradual expansion of home and community services saves modest amounts, but that a rapid expansion can actually cost a state more.

While home care is generally much cheaper than nursing homes, Dr. Kaye said, states may wind up unleashing a pent-up demand for home care from eligible people who would never have entered a nursing home anyway. And, he added, the financial incentives for home care do not guarantee quality.

"It needs to be monitored with a lot of oversight," he said.

In July, John D. Rockefeller IV, the Democratic senator from West Virginia who came up with the language allowing some of the most ambitious waivers, wrote Kathleen Sebelius, the secretary of health and human services, asking her to "take immediate steps to halt this initiative." He complained that instead of rigorous demonstrations aimed at improving care, some states were shifting whole populations into untried programs.

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A spokeswoman for the federal Center for Medicare and Medicaid Services said it was "working carefully to develop new ideas to better coordinate care with appropriate safeguards to protect beneficiaries."

Under the block grant vision of Medicaid, that federal role in oversight would end. Richard J. Herrick, president of the New York State Health Facilities Association, a trade group, says that since Medicaid rates have been cut well below cost, he would welcome a change in rules that would let nursing homes bill families for their elders' care, in addition to what Medicaid pays.

Advocates for the elderly say that such a change would increase the burden of care already carried by many families.

Wendy James spent nine years and thousands of dollars struggling to keep her mother safe at home with her in Yonkers, in Westchester County. Her big mistake, she says now, was not filing a Medicaid application sooner.

Her mother, Elaine, 76, formerly a secretary in a doctor's office in Manhattan, had to quit work when she developed symptoms of Alzheimer's disease. As the illness worsened, Ms. James's father, now 80, retired from his job in a department store to help care for his wife. When she needed an adult day program in a nursing home, which rose to $2,400 a month, the family paid out of pocket. And Ms. James, 37, who works for a medical billing company, paid up to $1,000 a month for her mother's medications when she hit her Medicare prescription "doughnut hole."

A 2009 analysis by the Kaiser Family Foundation found that direct, out-of-pocket spending by individuals and families accounts for 22 percent of the $178 billion spent on nursing homes.

Mrs. James is now in a New Rochelle nursing home, where Medicaid pays the bill. Her husband travels daily to spoon-feed lunch to her in the nursing home's chaotic day room. Ms. James feeds her mother every evening after work, rubbing her cheek to remind her to swallow.

"I did what I had to do for her," said Ms. James, the youngest of three siblings. "She was the best mom before she got sick."

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