
# Association of Community Mental Health Centers of Kansas, Inc.

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**Testimony to the Senate Public Health and Welfare Committee on Medicaid Reform**

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Madame Chair and members of the Committee, my name is Mike Hammond and I serve as the Executive Director of the Association of Community Mental Health Centers of Kansas, Inc. The Association appreciates the opportunity to appear today to share our thoughts on Medicaid Reform in Kansas and the proposed KanCare program.

The Association represents the 27 licensed Community Mental Health Centers (CMHCs) in Kansas who provide home and community-based, as well as outpatient mental health services in all 105 counties in Kansas, 24-hours a day, seven days a week. In Kansas, CMHCs are the local Mental Health Authorities coordinating the delivery of publicly funded community-based mental health services. The CMHC system is state and county funded and locally administered. Consequently, service delivery decisions are made at the community level, closest to the residents that require mental health treatment. Each CMHC has a defined and discrete geographical service area. With a collective staff of over 4,500 professionals, the CMHCs provide services to Kansans of all ages with a diverse range of presenting problems. Together, this system of 27 licensed CMHCs form an integral part of the total mental health system in Kansas. As part of licensing regulations, CMHCs are required to provide services to all Kansans needing them, regardless of their ability to pay. This makes the community mental health system the "safety net" for Kansans with mental health needs, collectively serving 123,000 Kansans with mental illness.

The Administration has proposed an ambitious approach through improved care coordination and reduced fragmentation across programs to improve overall health outcomes for Medicaid beneficiaries and to slow the growth of Medicaid expenditures. All while preserving Medicaid rates, eligibility and benefits. We agree that path we are on today is not sustainable and we are appreciative of the opportunity the Administration has given us for dialogue and input on their proposal. This is an important policy direction for the State of Kansas that has received and should continue to receive meaningful attention. The Medicaid program provides much needed access to mental health services in the State of Kansas and we in the mental health provider and advocacy community view these changes as positive for persons with mental illness. Among the positive changes include improved care coordination across multiple systems, thus improving overall health outcomes and quality of care. We see opportunities for the mental health system in Kansas and those we serve. Among those opportunities include:

- Integrated person centered care
- Financial incentives tied to outcomes

- Health homes with a focus on mental health
- Disability preference for State employment
- Cash incentives for hiring of persons with disabilities
- Health and wellness initiatives
- Continued access to mental health medications

In 2007, the public mental health system transitioned to managed care for Medicaid reimbursed services. It was implemented as a carve-out where benefits are managed separately and independently from physical health and substance abuse. For our system, we are familiar with managed care and it has been successful in holding steady the average dollars paid per member while improving access to care.

While carve-out systems exist where mental health and substance abuse services are managed separately from physical health care, the Administration is choosing to integrate all populations in their Medicaid Reform approach. We don't disagree that integration of care can also be achieved in an integrated plan, particularly where those we serve also have substance use issues and poor physical health. We also don't disagree that the sustainability of the current path of Medicaid in Kansas is concerning. Since 2007, the public mental health system has been hit disproportionately with cuts in SGF since 2007 - $38 million SGF; $60 million AF. If we as a State do not address sustainability, we fear cuts to our system might continue.

We certainly are appreciative of the value placed on the use of established community partners such as the CMHCs, CDDOs, CILs and AAAs, that is required in the RFP. The State has made significant investments in these systems historically and those systems will be key partners to the MCOs.

The RFP encourages the development of shared savings for providers participating in the health home model; substantially improve health outcomes; or otherwise demonstrate specific value added service. The CMHCs hope to be able to benefit from these opportunities for shared savings.

The MCOs will need to develop a plan to conduct initial health risk assessments. This includes the beneficiary's behavioral health status. For our system, we see an opportunity to rethink how our medical staff are used within the CMHC - to conduct those health risk assessments and to further improve our efforts to focus on the whole health of beneficiaries we serve.

Of course the devil is in the detail and that detail will be in the contract between the State and each MCO, as well as in how each contract is implemented. Not knowing that level of detail yet, the concern my members have include the following:

- The RFP calls for a particular focus on overutilization in frequency and amount that is not medically necessary. For behavioral health overutilization, the contractor will work with providers to help the member change behavior. How will this work? How will the MCO determine "overutilization?"

- The RFP calls for a particular focus on utilization management that reviews services for medical necessity and monitors and evaluates on an ongoing basis the appropriateness of care and services. How will the MCO approach utilization management?

- With three contracts comes implementation by three different MCOs. The administrative costs will most definitely increase having to navigate the necessary system requirements for each of the three MCOs. What can the State do to minimize administrative variance of each contract? There is a need for uniformity of policies and procedures as best possible across all three MCOs.

- The system has been financed on fee-for-service basis historically. The reimbursement model to be used by each MCO is unknown to us. How do you sustain a provider or system infrastructure with potentially three different payment methods?

- Changing claims engines always brings challenges in transition. Ensuring that prompt cash flow continues for services delivered by providers is critical. What are the back up plans should problems arise?

- We support implementing opportunities for pharmacy savings without restricting access to mental health medications in Medicaid. We will need to be diligent to ensure the MCOs are diligent in their communications with prescribers to ensure they understand the pharmacy benefits as they relate to mental health prescription drugs.

- Much of the success will lie with the selection of the three MCOs. Due diligence needs to occur on robust evaluation of all bidders to identify who has had the greatest success; who has struggled the most; what has been their performance in other States, especially on issues similar to Kansas' programs.

- The creation of off ramps for people leaving Medicaid is promising. Those need to be affordable and last long enough to allow people to successfully and durably transition to private insurance.

- We believe that any interest earned on KanCare funds paid to the MCOs should be recouped by the State and reinvested in programs. Will the contract with MCOs address interest earned?

- I strongly believe that systems know best how to reform their respective system. The Administration as well as Legislators are receiving input about the impact of the Medicaid Reform proposal on Medicaid beneficiaries or Medicaid providers. Certain assumptions have been made with the roll out of the Medicaid Reform proposal that impact projected savings as well as State General Fund (SGF) expenditures. If there are any changes made to the Medicaid Reform proposal, what are the ramifications of those changes? What is the impact on the projected savings? What is the impact on SGF if projected Medicaid savings are not met? What would change in the Administration's proposal based on any modifications made by the Legislature?

- No matter how well you plan for systems transformation, there inevitably will be struggles, challenges and problems along the way. Ensuring there is adequate and effective oversight in the Executive Branch as well as the Legislative Branch will be critical. What will that oversight look like and when will it be put in place?

In the end, access to care when it is needed and at the right amount is paramount and we will remain strong in our advocacy to ensure that continues to occur in the new world of managed care.

Madame Chair, I thank you for the opportunity to share my system's views on Medicaid Reform in Kansas. I would be happy to stand for questions.