Senate Public Health and Welfare
Thursday, January 19, 2012
Medicaid Transformation

Good afternoon Madam Chairperson and members of the committee, my name is Tim Wood. I am the Campaign Manager for the End the Wait Campaign. Thank you for the opportunity to appear before you today.

I'm here today to focus on the DD waiting list. We view the discussion around Medicaid transformation through managed care as an opportunity to consider how we make significant and meaningful progress towards reducing and ultimately ending waiting lists.

There are currently over 4,800 adults and children on the DD Waiting List. These are over 4,800 people who have no access to the "on ramp" of the KanCare highway. Therefore any "off ramp" discussion does absolutely nothing to address their immediate needs.

A shift to Medicaid managed care for Intellectual and Developmental Disabilities - Home and Community Based Services (I/DD-HCBS), on its face, is at the same time threatening and promising. The KanCare proposal is promising in that any idea that may have potential to improve outcomes for people with developmental disabilities and therefore enhance community integration, individualization, self-direction, independence, and reduce or eliminate waiting lists, I would say is promising. However, this is not the direction of the discussion of right now.

The promise of Managed Care is built on the "hat trick" style assurance of lower costs, better access, and improved outcomes.

Let me share with the committee a statement submitted to the US House Ways and Means Health Subcommittee by the Health Care Task Force of the National Consortium for Citizens with Disabilities back in May of 1995. This statement still holds true today nearly 17 years later and will continue to hold true due to the nature of developmental disabilities:

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"A sound managed care plan can offer several advantages to people with disabilities: well coordinated care or case management, comprehensive services, the convenience of one-stop shopping which minimizes physical and other obstacles to obtaining care, and an emphasis on primary care. Unfortunately, these potential positive impacts of managed care are usually undermined by the economic incentives in managed care and capitated health plans. Many of these incentives run counter to the interests of all beneficiaries, particularly people with disabilities and chronic health conditions. People with disabilities often have extensive, special, and complex health care needs and are often underserved in these types of plans."

Although states' interest in moving in the direction of managed care has been prevalent for over 20 years in the DD Sector, only 4 states have actually included LTCS for the I/DD population in their Medicaid managed care plans. Kansas implemented principles of managed care for DD in 1995 and it has worked.

What where the motivating factors for these 4 states? Each state has its own unique set of circumstances, but the prevailing factor among states was that their current system was thought to be "fiscally unsustainable". Kansas is NOT unique in this regard. In fact, we have heard a number of times that this is exactly why this administration has chosen to transform our state's Medicaid system.

What is NOT so clear, however, is why there has been a decision to gamble with the lives and care of Kansans with developmental disabilities. There is a serious lack of empirical data that indicates that this type of shift in care delivery actually works for states and beneficiaries. Furthermore, we have heard that it is unclear if there would be ANY savings on the LTCS side of the system if DD were to be included in KanCare, but it is the "hope" of the administration that there would be savings on the medical care and mental health side of the system.

Again, I ask why we are gambling with the lives and care of Kansans with developmental disabilities? Healthcare and long-term supports interact in complex ways for people with developmental disabilities. Therefore, changes or disruption in healthcare delivery for this population could have

disastrous irreparable consequences for the DD system in Kansas and the people it serves. This is precisely why states such as Texas, New Mexico, Rhode Island, Connecticut, and many others chose, after careful consideration, NOT to include this population in their respective Medicaid managed care plans.

Let's face it; the costs of Medicaid programs are rapidly becoming more and more challenging to contain both in terms of growth and costs. I am here today to express that the DD community is very concerned with the carve-in approach of DD within the KanCare plan. In a recent meeting of the Kansas Coalition on Developmental Disabilities there were several concerned raised which include:

- No other state has attempted an "all-inclusive" shift such as this
- There is absolutely no provision to reduce or eliminate waiting lists within the KanCare RFP, in fact it is maintained separately from the KanCare program – ***We think any Medicaid transformation plan should include a road map to address this issue which has plagued our state for decades***
- The Managed Care companies admit they have no experience with this population
- There is no evidence that this type of shift would actually produce the outcomes sought by the administration and promised by the managed care industry

The Long-term care provision for the DD population should be carved-out of the KanCare plan at this time.

I honestly believe this administration has the best intentions in their effort to reform Medicaid, and that is why I hope and pray that they will take the advice we are sharing with this committee and the advice we have shared with them throughout the stakeholder process. The very lives of Kansans' depend on it.

States that have had some success with the attempt to include the I/DD population in their Medicaid managed care plans reported several benefits in doing so:

- Elimination of waiting lists/creation of an entitlement to long-term care[1]; this is not reflected in the current KanCare plan.
- Flexibility in designing supports around the needs and preferences of individuals[2], we have been doing this in Kansas for nearly 20 years.
- Efficient use of limited fiscal resources; I believe Tom Laing presented some facts to this committee that demonstrate this is already being done.
- Better coordination with acute health care services; we believe the administration can capture this within the current system structure without any disruption to the delivery system and the consumers. Care Coordination links patients and families with complex medical and non-medical needs to services that optimize the desired outcomes expressed within a person centered plan. This is best accomplished by knowledgeable care coordinators who are familiar with the available local services, and also have the patient's and families' best interest at heart not profits of share holders.

Carving LTCS for I/DD does not preclude Kansas from being at the leading edge for this population. In fact, the DD community would argue that Kansas has been at the leading edge for a long time now thanks to the collaborative effort between the DD community and public officials.

[1] Wisconsin has implemented MC in 57 of 72 counties. In many of these counties the waiting lists have been significantly reduced or eliminated altogether. HCBS became an entitlement in Arizona, Michigan, and Wisconsin by legislative action. The state of Arizona reports no DD waiting list.

[2] Kansas adopted "person centered planning" in its service provision in 1995, which was the collaborative work of the advocacy community and state officials. KSA 39-1801-1810.

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