DEVELOPMENTAL SERVICES of NORTHWEST KANSAS, INC.
A non-profit organization serving individuals with differing abilities since 1967.

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TO: Senator Vicki Schmidt (Chair, Public Health and Welfare Committee)
FROM: Jerry Michaud, President/CEO, Developmental Services of Northwest Kansas, Inc. (DSNWK)

RE: Hearing on SB 332

Good morning Chairman Schmidt and members of the Public Health and Welfare Committee,

My name is Jerry Michaud and I am the President of Developmental Services of Northwest Kansas (DSNWK), a non-profit organization serving approximately 500 individuals with intellectual and developmental disabilities (IDD) in the eighteen counties of northwest Kansas for over 50 years. I am grateful for the opportunity to share my support of SB 332, a bill which reestablishes local control and strengthens the community IDD system. The services we provide are lifelong or long term services and supports here in Kansas -- for brevity I'll reference them both as IDD/LTSS. It is vitally important to share the current status of our system. This system has been hampered by nearly a decade of static rates and force-fitted to function under the KanCare managed care model, beginning in 2013. The IDD/LTSS system had been serving people and the state through a partnership for decades before KanCare. Prior to KanCare, the IDD/LTSS system operated under managed care principles, under state contract with oversight and operated within a capitated rate system. With the coming of KanCare, there were clear concerns then about the illfit of the IDD/LTSS system into this medical model of managed care. Those concerns, echoed back in 2012, are unfortunately still resounding today. Operating within this model has resulted in further restriction of the flow of needed resources into the system, much like a diverter valve shifts the flow of the resource. The diverted resources, now flow through and supply the Managed Care Organization (MCO) system under the KanCare model and are subject to other relevant policies and practices which have reduced them further. The net effect, the IDD/LTSS services system has experienced limited or reduced resources in Kansas.

The promises of KanCare were many and the stated impact upon the IDD/LTSS system was one of protection with promises for people to retain their case managers and assurances that they would see no loss of their services. Another promise of KanCare, savings would result in resolution of the long standing Waiting List of those who need services.

KanCare - An General Perspective: Kansas, when entering into KanCare, did so under the philosophical belief that because of promised better health outcomes, better coordinated care and saving money, it was better to hand over the entire IDD community service system to the MCO model (LTSS and the medical for those same persons). The promised deliverables of KanCare that services would not be reduced, waiting list would be addressed and better coordinated care would take place simply have not proven so in the IDD/LTSS area. There appears little defendable debate on the merits of IDD/LTSS remaining in KanCare. From the simple to the complex, the results of the KanCare model upon the

community IDD/LTSS system spans from the regular irritations and frustrations to more significant concerns, some ridiculous and even incomprehensible.

KanCare - a Billing Perspective: Looking back, in 2013 KanCare took effect on the IDD LTSS system with complications experienced in the payment process for services and providers experienced long delays in receiving payment, some taking months to correct. Before KanCare, our system had a single payer, KMAP. This system worked well with minimal need to correct claims. Payments were timely, correct and the process was predictably consistent. Today, under the three Managed Care Organizations, each one has different requirements for correcting a claim and for the majority, it is especially tedious to adjust a claim. I share an example to demonstrate the ridiculousness experienced at the provider level. In this provider experience, the MCO billing portal doesn't recognize the correction or adjustment and the claim is reprocessed as a new claim causing yet another problem - now there's a duplication error. This would be followed by the provider sending screenshots to the MCO proving they had the correct code so the claim can be adjusted and reprocessed. If not challenging enough, most every adjustment sent contains a minimum of two reconsiderations like this to get the claim reprocessed by the MCO. This wrangling takes valuable time, is frustrating, and many times the provider does not see any result or correspondence for these reworked claims for 60 days or more. Startling as it may be, most claims under reconsideration take 3-6 months to get payment. Some providers might give up and write this frustrating exercise off as a loss. We do not. Amazingly enough, DSNWK has a number of outstanding claims for 2017 and a couple still pending from 2016. Billing/payment challenges unfortunately do not stop there. Continuous problems remain getting the MCOs to appropriately subtract out monthly client obligations from claims. With a desire to have clean and correct billings, when we have returned over-payments like these, the end result is the MCO recoups that value (again) from a future remittance, which causes an underpayment to the provider in their next billing cycle.

Under KanCare, we have no predictable way to know when the money for services rendered will come. It is usually at least two weeks before any payment is received. Even though we bill claims in one batch, the payment on these claims comes at varied times including a few claims at a time (instead of for all claims billed). We might experience three separate remittance on the same day from one MCO with only a couple claims on each remittance. We have one dedicated employee who just focuses on claim reprocessing. In Summary: Five years under the KanCare model and the payment process is always sporadic and remains challenged.

KanCare - a Case Management/ Person Served Perspective:

MCO Care Coordination, sounds an appealing title, however, the result has been different for IDD/LTSS. The Care Coordination provided by MCOs generally has been added duplication upon the existing case management services in the IDD/LTSS system. Care coordination has made the community work not only redundant but more difficult in many ways. Under KanCare, it is especially difficult when the trouble plays out in the lives of the individuals we serve. MCO Care Coordinators carry massive caseloads (150+) and they have been inserted into the picture. Troubling to share, in our experience, Care Coordinators have been known to meet with the individual who is developmentally unable to express their needs and then have the MCO make drastic reductions to that person's services because the individual expressed they didn't need help with certain tasks (when in reality, they do), done so without the involvement of the individual's team, and the people who know and understand the person and their support needs. The MCO response when concerns are raised, these hours can be added back. In reality, this is only after fighting back with much effort and jumping through many hoops before getting back to center. So unnecessary. Pre KanCare we rarely had problems getting individuals renewed for Medicaid. Now problems and delays are common place. Before KanCare Targeted Case Management units were

approved when needed, beyond the 240 units, when there were extenuating circumstances. Today, additional units are approved at a much lower rate by the MCOs. Extraordinary funding have become more difficult to get approved, when the hard reality is, some people we serve require extraordinary levels of support. Even in obvious situations, these are the ones which cause the most frustration. Decisions which should be swift, sometimes take months. Care Coordinators offer little in the way of assistance for the individual served or the people who serve them. The focus appears their interest is more about finding ways to seize current resources than address the needs of people with IDD. Care Coordinators often require the IDD case manager to provide them with information; copies of documents written by the case manager. The Care Coordinators ask Case Managers for updates on the individuals. They ask for the case manager to set up meetings with the individual. When a new care coordinator gets assigned, the MCO asks the IDD case manager for the same things previously provided to the former care coordinator, no matter if it was provided before. The three MCOs do things differently and care coordinators within the same MCO do things differently.

KanCare - Change in State Interest and Policy - Perspective: Several policy changes have emerged which give insight about State intent and motives. It is apparent there is a desire on the part of the administration to fundamentally change the community system (ie. recently the Person Centered Support Plan policy and in 2016 the Residential Pay Policy). These policies, as put forth by the administration, with encouraged enforcement in the KanCare 2.0 RFP (for the Res. Pay policy) demonstrate the interest and intent to move forward while disregarding the needs in the community system. Rate adjustments to sustain the community system over the last ten years have been neglected by the administration. Instead, such policy changes have placed even greater demands on the community system. It wasn't until last session, through a legislative process, when families, providers and advocates came before the legislature to demonstrate the erosion taking place in the community IDD system. **The Legislature responded with a necessary course-correction. Neither the Administration nor the MCO system with its resources, recognized any such need nor have they during any of the years of operation under KanCare. Their collective focus takes a much different approach...reducing resources in the system.** The residential pay policy alone was slated to save $1.32 million SGF, compounded by the loss of the associated federal match dollars. <u>This bill, SB 332, is another necessary course-correction to return common sense back to the functioning of the community IDD service system, a community system which is strong and a model to make Kansas proud again.</u>

The most recent announcement by the administration to hold KanCare 2.0, serves to open the door to SB 332. Core functions, like case management, remain intact. The CDDO system and networks, remain intact. Now is the time to reaffirm the value of local control and management of our Community IDD system, partnering with the State through law to carry out vital community services. Resources identified in SB 332 are practical, common sense and responsible, built upon the action started last legislative session. The community IDD/LTSS service system currently plugged into KanCare can be unplugged from KanCare. The community IDD/ LTSS can be connected to the existing infrastructure that has maintained a payment pathway for other services which have remained outside of KanCare from the very beginning.

In closing with this bill:

- **The community DD/LTSS system will continue to be managed locally by Community Developmental Disability Organizations ("CDDOs") who will manage all aspects of LTSS system.**
- **The State and MCOs will continue to serve as gatekeepers for medical and behavioral health services.**

- **Providers will apply to a single agency (designated by the State) for reimbursement of services rendered.**
- **Case managers will provide all coordination of services for persons with I/DD.**
- **CDDOs, in partnership with the State, would track and measure system performance using the National Core Indicators.**
- **HCBS I/DD reimbursement rate increases will be automatic and tied to a Consumer Price Index.**