Kansas Department of Aging and Disability Services (KDADS)
Public Hearing on Senate Bill No. 332
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Committee on Public Health and Welfare

Chairwoman Schmidt, I would like to thank you and the members of the Committee on Public Health and Welfare for the opportunity to provide you my expert testimony on the national Home and Community Based Service delivery system. My name is Dr. James Bulot and I am an Associate Director with Navigant Consulting. For more than 20 years, I've worked in the field of long term care. However, my lived experience goes back much further. Before working professionally in long term services and supports (LTSS), I spent my formative years, before and after school, at an adult day developmental program in south Louisiana operated by the Plaquemines ARC, where my mom developed one of the first real wage employment programs for adults with developmental disabilities. As a young adult and college student, I helped my parents navigate the state funded developmental disabilities (DD) system for my step sister, who has Down Syndrome. These early experiences led me to pursue a career in LTSS, where I subsequently earned my PhD in Aging and Long-Term Care with an emphasis in Public Policy, Research Methods and Statistics.

As an assistant professor at the University of Louisiana, I developed the first accredited graduate program in Long-Term Care Administration in the US. Working closely with the state agency on developmental disabilities, I created the first consumer library on DD services and resources as well as conducted sponsored research on aging with Down Syndrome. While in higher education, I earned tenure as an Associate Professor, served as Department Chair, Research Institute Director and an associate Dean in the College of Arts and Sciences. At Governor Jindal's request, I took a leave of absence to be the Executive Director of the Governor's Office of Elderly Affairs – among other responsibilities, I was largely responsible for the protection of vulnerable adults, setting statewide policy for home and community based services and administering the state's Aging and Disability Resource Center. I also served as a member of the DD Council as well as an ex-officio member of the Statewide Independent Living Council.

I later transitioned to a similar position in Georgia working with Governors Purdue and Deal, where I was responsible for most of the state and federally funded HCBS services, adult protective services and the Aging and Disability Resource Center. During my tenure in Georgia as state director for adult and aging service, I was recognized jointly by the Administration on Community Living (ACL), Administration on Aging (AoA), the Centers for Medicare and Medicaid Services (CMS) and the Veterans Administration with the Award for Outstanding Systems Change by a State. During my time as a state director, I served as Treasurer, Secretary, Vice President and President of the National Association of States United for Aging and Disability. In this role, I worked closely with several other national organizations in partnership with CMS on policy issues related to HCBS service delivery, health and welfare of vulnerable adults and early development of the managed care and conflict of interest rules. In my current role, I work with state Medicaid and LTSS agencies across the US on compliance and HCBS service delivery in both managed and Fee for Service delivery systems. I've outlined below a few key items related to managed long term services and supports (MLTSS) and its impact on people with disabilities.

The Importance of MLTSS in the Kansas Intellectual and Developmental Disabilities (I/DD) Population

Since 1981, states have had the option to provide community alternatives for people needing institutional level of care. These optional services were provided as waivers to nursing home care; however, due to limited funding, access to these services had long waiting lists. This was especially true for people with intellectual and developmental disabilities. I've worked with several states where people in need of these services had to wait years before a "slot" opened up. As a result, many people went into nursing homes while waiting for services.

In 1999, the Supreme Court ruled in **Olmstead** v. L.C. that unjustified segregation of persons with disabilities constitutes discrimination in violation of Title II of the Americans with Disabilities Act, thus setting the stage for one of the largest shifts in how and where LTSS services were delivered. Heralded as a turning point by advocates and policy makers alike, states have had varying levels of success in rebalancing the LTSS systems. While progress has been steady, it's also been extremely slow. One of the most successful initiatives by far, from a national perspective, has been the advent and expansion of Medicaid MLTSS. These programs have continuously grown since their first implementation in 1989. **As of January 2018, 23 states use capitated MCOs to deliver at least some LTSS benefits. All but a handful of states have an integrated service delivery approach where the MCO is at risk to deliver both acute and LTSS services under one contract.** While the I/DD populations are traditionally the last groups to be include in MLTSS, there are numerous benefits for people living with I/DD in the managed care delivery system. To better understand the impact of managed care, one must consider first the FFS delivery model. States tend to administer these services reactively; that is, they either need to increase or decrease service based on the volume of services already delivered. These services have rarely been subject to the intense scrutiny we see in MLTSS programs today. The assumption was always that traditional HCBS were good, and quality has been assumed – just because consumers and advocates believed that the HCBS services were better than the alternative. The fallacy is, historically, we never really measured the impact or quality of the FFS HCBS systems. Because of the "fear" of managed care, we put in place stringent quality and reporting systems, which are still lacking in FFS. Some other observations include:

1. **KanCare, MLTSS and Fee for Service Systems**

As president of NASUAD, I saw firsthand the impact MLTSS has had on the lives of people with disabilities. As more and more states began pursuing MLTSS, what CMS expected when Kansas first implemented KanCare and what is expected today is significantly different. There was relatively no guidance provided to states on Conflict of Interest, no regulations on what managed care or MLTSS should look like, and no consumer protections outside of that which already existed under a FFS system. Since the initial implementation of MLTSS, CMS has provided rules and regulations regarding both MLTSS and Conflict of Interest. Given this evolution, even if Kansas were considering going back to the "old" fee for service system, it would be difficult to be compliant with CMS rules in place. For example, prior to MLTSS in Kansas, the Community Developmental Disability Organization (CDDO) often, if not exclusively, provided both case management and direct service. Repeatedly, CMS has made it clear that entities providing HCBS case management CANNOT also provide direct services – unless there is no other available provider. MLTSS has partially solved this issue in Kansas, which has allowed the CDDOs to retain a similar role as they had in the past, while the MCOs perform the case management.

Aside from Conflict of Interest, there are few incentives in place for FFS providers to achieve the level of accountability or quality and rebalancing as there is under a risk-based model. The capitation provided for MLTSS largely favors the community-based setting. MCOs essentially "lose money" each time they are not able to successfully keep a member in the community. Additionally, as a result of the managed care rules, MCOs are required to have external review of their programs for quality, outcomes and effectiveness, and can be held financially accountable in the event they are not able to meet state performance measures. As we have seen across the country, states with only FFS systems are struggling to balance their LTSS systems; they struggle with quality initiatives, and holding providers and case management accountable. In FFS systems, I've seen personally, instances in which high need consumers are placed into an institutional setting simply because the types of services the person needs are not allowed to be provided under the FFS system. Other times, case management agencies don't understand or have the expertise to work with the person to develop a plan of care, or they don't have the capacity to develop provider networks. As a result, the person declines and ultimately winds up institutionalized. To date, MLTSS programs are still the most effective vehicle available to states to help with meeting the needs of the consumer, rebalancing LTSS expenditures, and demonstrating wholesale improvement and quality of life for consumers.

2. **MLTSS programs can improve member health outcomes and quality of life.**

One of the main issues with the traditional FFS program is the focus on volume of services and lack of care coordination. MLTSS is an opportunity for states to allow increased care coordination by requiring the MCOs to bridge multiple service disciplines and therefore, focus on improving health outcomes. States have the flexibility to design programs and payment models in MLTSS where they can set a series of specific quality targets for the MCOs, while incentivizing providers to focus on the quality of life or health outcomes. FFS systems are often difficult because of this critical payment system design. MLTSS programs have benefited from states' efforts to drive quality and health outcomes. For example, Florida reported that nearly 60% of their quality survey respondents saw their overall health improved since their enrollment. [1] Also, 77% of the respondents in Florida's survey reported an improved quality of life since joining an MLTSS plan.[2]

3. **MLTSS Programs can reduce waiting lists.**

In 2015, there were over 600,000 individuals on Home and Community-Based Services (HCBS) waiver waiting lists in 35 states.[3] Continuing with the MLTSS programs for the Kansas I/DD waiver populations can limit growth or prevent the potential creation of waiting lists while still expanding members' access to services. Several states have either eliminated waiting lists or significantly reduced their waitlists. In Tennessee, the TennCare CHOICES programs have eliminated waiting lists completely.[4]

4. **MLTSS Programs can allow increased access to services.**

In HCBS programs, states must consider the federal funding match and state budget constraints. This puts a strain on the type of services states can provide, or the case management of the higher-need

[1] http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf page 11
[2] http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf page 12
[3] http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf page 13

populations. The case management under FFS often includes a limitation of services by requiring a cap on the number of units or face-to-face visits that the case management agencies can bill. This often incents the providers to avoid individuals that require more intensive case management needs. However, MCOs can offer a more comprehensive array of services and supports because the payments are a capitated, per member per month (PMPM) format. Plans are encouraged to increase health outcomes for the individuals and therefore, are more interested in filling the gaps in services to improve the individuals' health quality. For example, New Jersey's Project ECHO (Extension for Community Healthcare Outcomes) encourages providers to work with underserved areas by providing financial incentives. In Massachusetts, the Senior Care Options program allowed MLTSS programs to offer dental services, which under the FFS system was a struggle to provide as a comprehensive program. Also, the same program now offers expanded transportation services, which the members saw as a burden to manage under the FFS system. [4]

5. MLTSS Programs help more individuals to remain in the community.

As discussed previously, PMPM payment systems will allow states to manage their budget predictably because the payment does not depend on volume or changes in individuals' utilization of services. Also, many states include a specific rebalancing target for the MCOs, where states pay a blended rate – encouraging a specific mix of consumers in long-term care facilities as well as HCBS transition population targets. MCOs' blended rates include financial incentives to meet these targets. Under an FFS system, individuals on a waiting list or those who cannot receive services because of gaps in the states' funding, could cause their conditions to deteriorate faster, thus resulting in institutionalization at a greater rate. Several states' MLTSS programs, such as New Mexico and Florida, have demonstrated that they have reduced the percentage of Medicaid recipients in nursing facilities. For New Mexico, in 2015, this rate reduced from 19 percent to 14 percent while for Florida, there was a 12 percent decrease.[5]

6. MLTSS Programs can help control costs.

The growing number of the I/DD population and rising cost of care is an increasing focus on states. Kansas is no exception. MLTSS programs allow states to predict budgets efficiently using PMPM methods. Also, the state can reduce costs further by reducing potential institutionalization or inpatient hospital visits because states can design their programs to encourage health outcomes, therefore encouraging MCOs to implement new or expanded programs. While states can incentivize the MCOs to meet these quality targets, there are no additional utilization estimates required to allow MCOs to offer expanded programs. Improved health outcomes can lead to a reduction in institutionalization and emergency room visits, which will further enable the State to save costs. For example, Florida reported that its MLTSS program met five percent savings targets established by the legislature during the first three-month period of statewide implementation in 2013 and 2014.[6] Also, to control the costs, traditional HCBS programs will require the state to take over all of the administrative and care coordination responsibilities that were left to MCOs previously. Three states with MLTSS programs

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[4] http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf Page 13 - 14
[5] http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf Page 9
[6] http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf Page 15

(Florida, Massachusetts, and Texas) all reported that implementing MLTSS decreased administrative burden in their Medicaid programs.[7]

Many provider agencies and those traditionally offering case management or service coordination would like to see a return to the old FFS system. However, real state experience suggests that MLTSS is still the best option for helping to achieve the aim of better services, higher quality, better outcomes and budget predictability.

Thank you for the opportunity to provide this written testimony.

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[7] http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf Page 15