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Continued Implementation Issues Faced by ABA Providers Working with Kansas Medicaid

The implementation and management of Medicaid by three, for-profit managed care organizations in Kansas has led to policies and procedures that negatively impact Kansas families, children, and service providers. Specifically, families and children are faced with reduced access to care and lower quality care when access is obtained. Service providers are faced challenges related to reimbursement of services rendered. This testimony is an update on the difficulties we continue to face since my testimony in August, 2017.

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Introduction

My name is Dr. Katrina Ostmeyer. I am the Associate Executive Director of Integrated Behavioral Technologies, Inc. (IBT), a not-for-profit agency that works to provide equal access to evidence-based interventions for children and youth with an emphasis on those with developmental disabilities in rural and low-come areas. I am a Board Certified Behavior Analysts (BCBA), Licensed Masters Level Psychologist, and temporary Licensed Psychologist. In my position, I am responsible for overseeing all day-to-day operations of the organization including administrative, clinical, and research tasks. My research interests and activities focus on how to increase access to evidence-based services for children with behavioral needs through the identification of barriers and solutions to overcome these barriers. I have worked in the mental health and applied behavior analysis fields for 13 years and spent most of my childhood growing up in the small northwestern town of Grinnell, KS. My work, research, and personal experiences have led me to continue to advocate for change in the implementation of the KanCare system to ensure all Kansans affected by autism have access to *quality, evidence-based* ABA services. Given the complexity of the issues we face, I have chosen to keep the text (minus appendices) from my testimony in August at the end of this document for the readers reference and have included updates at the beginning of the document.

November 2017 Updates

Credentialing Issues

Poor Communication

We continue to face significant issues related to credentialing and starting providers. Our direct service providers who turn over every 18-36 months on average each have to go through a long credentialing process. After testimony in August, I did have representatives from Sunflower/Cenpatico contact me to address our issues. It came to light that Cenpatico was sending us credentialing emails indicating providers were eligible to provide care; however, we have no record of these in spam, junk, or our agency inbox. Additionally, we had requested a list of credentialed providers several times before this and Cenpatico had been unable to procure such a list. Delays in knowing when providers are credentialed and being unable to get such information

has been detrimental to our agency and the children we work with. I do thank Sunflower/Cenpatico for remedying this situation this fall.

Credentialing Timelines

The following table shows our current credentialing timelines. Again, these are providers with high school diplomas who, while a specialty provider, turn over every 18-36 months on average.

			Time to Completion	
			August	November
1.	Application, interview, and job offer		1-2 weeks	1-2 weeks
2.	Background checks (APS, CPS, Nurse's Aide)		2-3 weeks	2-3 weeks
3.	Wait for KMAP to be approved		2-3 weeks	1-2 weeks
4.	Additional wait for KMAP letter with number *after* KMAP application is approved. Required for credentialing with the MCOs.		3-8 weeks	2-4 weeks
5.	Credentialing with each MCO.	Cenpatico: UHC: Amerigroup:	12+ months 30-60 days unclear	90+ days* 30-60 days unclear
	Total Time from initial application to ability to bill for services:	**Cenpatico:** **UHC:** **Amerigroup:**	**Over 1 year** **12-24 weeks** **8 weeks****	**12-24 weeks** **12-24 weeks** **3 weeks****

*Due to frequent changes in credentialing paperwork and additional credentialing requirements, Cenpatico often takes an additional 60 days to correct and resubmit paperwork

**Amerigroup takes less time due to ability to bill as a group and start providers as soon as KMAP has been submitted.

Our current attrition rates for 2017 are as follows:

Kansas City area:	5
Lawrence area:	7
Topeka area:	4
Manhattan area:	11
South East Kansas:	10
Total Providers Lost:	**37**

As in August 2017, these numbers to not include the providers who choose not to accept the job due to the lower rate of pay we offer due to the reasons listed below.

Failure of the Standard Credentialing Form

Since January, the state has indicated that the standard credentialing form was a solution to all of the credentialing issues we faced. Unfortunately, this is not the case as the MCOs are still able to request *any and all* additional paperwork that they desire. We began using the standard credentialing form in July, only to have our credentialing applications turned away in October by Cenpatico stating they were incomplete. When alerting the state to this issue, I was informed that the MCO was in the right and was able to request additional paperwork. ***This has resulted in the exact same credentialing paperwork with the addition for the standard credentialing form.*** The implementation of this policy has in effect, made the credentialing process *more* difficult than before.

Solution

Require all MCOs to either

a. Allow agencies to bill under the agency and monitor compliance with KMAP requirements – this solution allows for independent IIS providers to remain independent
b. Bill all services under the Autism Specialist or BCBA – this solution no longer allows for independent IIS providers
c. Have KMAP work with MCOs directly to credential providers AND ensure the credentialing start date is effective the day the provider is approved through KMAP

All of these solutions will allow agencies to start providers within weeks of the hire date rather than months leading to lower rates of attrition and improved network adequacy.

Reimbursement Rates

The reimbursement rates for Medicaid services continue to be far below industry standards in the state of Kansas. This continues to punish agencies and providers who contract with Medicaid and interfere with our ability to recruit and retain a high quality work force. Many of our providers continue to leave and work with other agencies who can offer high rates of pay.

Since we provide our services in the home and community, our providers are expected to travel to meet with children and families. For those of us who serve rural areas, the costs in personnel time and mileage can become extremely high – this is especially true as our shifts tend to range from 3-5 hours requiring travel between multiple clients. When serving rural and remote areas, providers may be required to travel in excess of an hour to reach a client. In many cases, serving clients in rural and remote areas costs our agency money even when using telehealth for the consultation and supervision portion of our services.

Solution

1. IBT along with several other agencies in the state are working together to conduct a cost analysis to determine what the true cost is to provide services in several areas of the state. We would ask the state to work with providers to help determine what rates would be agreeable and affordable to providers. This will result in increased capacity and our ability to retain quality talent.
2. This cost analysis should include additional percentage increases for rural and remote areas where the costs of travel must be incorporated into the service cost. While many of our services can be completed via telehealth, the direct services provided by IIS staff cannot.

Timely Reimbursement for Services Rendered

Over the last four months, our staff and teams from the MCOs have been working together to work through thousands of dollars of problematic claims. I am happy to report that we have had really nice cooperation between the MCOs, our contract billers, and IBT staff. At the same time, the main impetus for this increased attention and cooperation came only after we took drastic measures and reported issues to CMS, CEOs on the MCOs, and the state. The cost to our company to work through problematic claims has been immense and has moved my attention from overseeing the quality of clinical services to ensuring payment. We are looking for ways to hire another

administrative staff member who can function solely as our Clinical Director – leading to higher overhead costs and administrative bloat.

Communication has greatly improved in terms of collecting on outstanding billing since August. We are still plagued by inappropriate denials due to errors within the MCO systems and a lack of understanding and consistency in billing ABA codes. We frequently receive denials for PBS due to outdated caps on services (there is no longer any cap on PBS) and when 2 providers work with a child in a day. The costs of tracking and working through these problems lead to increased administrative time and cost.

The category 3 codes for ABA services are very cumbersome and there is hope that many issues will be improved when moving to the category 1 codes. At this time, many of the services we provide are billed with different codes for the first 30 minutes of therapy and all subsequent 30 minute blocks. At this time, MCOs are authorizing these codes separately from each other (i.e. 25 units of 0364T and 150 unites 0365T which are billed for the same service). ABA services in home and community settings often require flexibility in scheduling as we provide intensive services in the home. Due to the hours we work, we build sessions around family and provider schedules. Authorization and tracking of companion codes when authorized separately increases administrative overhead, increased time on both the MCOs and providers to adjust authorizations when a the frequency of sessions changes, and leads to increased denials when mistakes in tracking are made.

Solutions

1. Collapse the companion codes 0364T/0365T, 0360T/0361T, and 0368T/0369T rather than authorizing separately.
2. Institute penalties to MCOs for inappropriate denials.
3. Currently, the penalty for delayed approval and payment of claims is waived for Medicaid and not for private insurers. This penalty should be instituted for all 3 MCOS should they fail to make timely approval and payment of claims.

Caps on Hours and Locations

Hours cap

Currently, the "soft caps" on services for ABA services are inappropriate and out-of-line with industry standards and best practices. These "soft caps" were kept when the state moved ABA coverage from the HCBS Autism Waiver to the general Medicaid benefit under EPSDT despite the clear message from stakeholders, professionals, and national organizations that they were inappropriate. We continue to receive denials when we ask for the intensity of services and supervision of direct service providers that are in line with best practices and that we are ***legally and ethically required to uphold as licensed behavior analysts (LBAs) in the state of Kansas.*** While we can appeal these denials, this leads to increased administrative costs and burdens. In the end, we often fail to appeal because our budget and personnel are simply stretched too thin to effectively do so.

Location and Time

ABA is an intervention that is provided at high intensity (average of 10-20 hours direct service/week for targeted intervention and 30-40 hours direct service/week for comprehensive models) and focused on producing socially significant change in real world settings. To effectively manage the intensity of services, we need to provide hours during the day (i.e. during times children would tend to be in school) and to produce change in real-world settings, we need to provide services in those settings (i.e. school, home, and community). Since moving back to Kansas in 2013, I have been informed that Medicaid services could not be provided in the school setting. Recently, some MCOs have taken this another step and we have been informed that we also cannot provide services during the school day *even if the child leaves school for a medical appointment.* The latter is a direct violation of mental health parity law; however, we lack the resources to deal with non-payment while appealing this decision. When attending a KanCare 2.0 meeting last week, I was also informed that services ***can be provided in the school setting and that this was erroneous information.*** If this is indeed the case, several children have lost out on effective and intensive intervention services and this has caused irreparable harm.

Solutions

1. Eliminate soft caps
2. Educate state Medicaid staff and MCOs on appropriate service locations and hours
3. Educate state Medicaid staff and MCOs on industry standards for ABA services and approve authorizations that fall within these recommendations

Training and Provider Authorization

As mentioned in August, the state opted to change the training requirements for both IIS and AS providers in the state effective July 31, 2017. In addition to reducing the qualifications for Autism Specialists, they also canceled the state training program. This has shifted the cost of training providers from the state and MCOs to agencies and individual providers. Our budgets have already been stretched as thin as they can go. Now we have to find additional money and resources to cover training costs for providers. This has been very stressful on our agency over the last few months as our providers who are already maxed out and working high levels of non-billable time are now trying to provide training to our direct services staff. These types of conditions lead to decreased quality of initial training and higher levels of attrition of direct service providers and consultant staff. At this time, our provider network is already insufficient to meet the needs of children and families affected by autism in the state of Kansas. Rather than seeing an increase in the workforce, I am guessing that the workforce is actually dwindling.

While training qualifications have been decreased, the state decided to continue to require the 1000 hour requirement for IIS staff. This requirement has no basis in research, literature, or applied practice in helping staff prepare to work with children with autism. Ironically, we had a staff member diagnosed with autism and he was told that having autism (which would put him in excess of the 1000 hour requirement) would not meet the 1000 hour requirement. The 1000 hour requirement further truncates our available provider workforce and is unnecessary and unrelated to a provider's ability to be trained to provide ABA services with children with autism.

Solutions:

1. Remove the 1000 hour requirement for the IIS level provider
2. Reinstitute the state-level training for AS and IIS providers and cover the costs either through reimbursements to providers or offering the training for free as was once done

In Summary

ABA service providers continue to face significant barriers to effectively working with Medicaid programs to provide services. This continues to affect network adequacy and quality. Several service providers, even with agencies that are built on Medicaid funding, choose not to work with the Medicaid program for ABA services due to the significant barriers and fundamental problems with the structure of this program. While feedback has been provided to state officials and MCOs, provider concerns and recommendations have historically been ignored. The problem remains and network adequacy continues to degrade rather than improve.

August 2017 Testimony

Access to Care

Several of the policies implemented over the last few years have adversely affected access to care. Among them are low reimbursement rates for services rendered by professional staff who require a high level of training and continuing education or supervision, difficulties obtaining reimbursement, and the inordinate length of time required to move from hiring to fully billable, credentialed provider.

Credentialing

When implementing ABA services, a tiered service model is utilized. An Autism Specialist (AS) or Board Certified Behavior Analyst (BCBA) oversees a treatment team consisting of direct service providers including Intensive Individual Support (IIS) providers and, in some cases, respite providers. The AS/BCBA is a professional level (masters or higher) practitioner who designs the treatment plan and oversees the other staff. IIS and respite providers are entry level providers (requiring a high school diploma). The IIS provider is responsible for implementing treatment plans, taking data, and providing feedback to the AS/BCBA to ensure the treatment plan components match the environment they are working in. Respite level providers are required to, at minimum, implement the behavioral intervention plan (BIP) while providing quality respite care for the consumer. All of these providers are required to go through the same lengthy and highly complicated credentialing process which is as follows:

		Current Time to Completion	
1.	Application, interview, and job offer	1-2 weeks	
2.	Background checks (APS, CPS, Nurse's Aide)	2-3 weeks	
3.	Wait for KMAP to be approved	2-3 weeks	
4.	Additional wait for KMAP letter with number *after* KMAP application is approved. Required for credentialing with the MCOs.	3-8 weeks	
5.	Credentialing with each MCO.	Cenpatico:	12+ months
		UHC:	30-60 days

Total Time from initial application to ability to bill for services:	Amerigroup: unclear **Cenpatico: Over 1 year** **UHC: 12-24 weeks** **Amerigroup: 8 weeks***

*Amerigroup is 8 weeks due to the ability to bill under the agency rather than provider. We have sent a test batch of credentialing over a month ago and have not received anything back yet.

When ABA services were operated under the HCBS Autism Waiver, agencies were allowed to start providers before they were fully credentialed (i.e. the date the KMAP was sent in); however, they would only be reimbursed at 90% the contracted rate (see Table 1 for rates of codes our agency commonly utilizes). This single case exception was removed according to a representative from UHC when services were moved over to general Medicaid under EPSDT. While the 90% rate was problematic, IBT chose to utilize this method to get services to families as quickly as possible and reduce attrition during the application process due to the long wait before employees can work. We are no longer able to do this, which has led to high levels of attrition in the application process in areas where all of our clients are on Medicaid. In 2017 alone, our attrition rates due to the length of time it takes before providers can work are as follows:

Kansas City area:	5
Lawrence area:	7
Topeka area:	4
Manhattan area:	8
South East Kansas:	10
Total Providers Lost:	**34**

These numbers do not include the applicants who stopped chose not to accept the position due to the lower rate of pay that IBT offers. Both state and MCOs have been notified by this issue (Appendix A); however, a feasible solution has yet to be identified or formally discussed. While standardizing the credentialing paperwork has been implemented and will hopefully reduce some of the issues we've identified going back to 2015 (i.e. frequent form changes; lack of notification of form changes), it is insufficient to address the long timeline required for credentialing direct service providers and will unlikely lead to meaningful changes in capacity.

Reimbursement Rates

Agencies in many areas across Kansas has opted to no longer work with Medicaid and have much higher reimbursement rates. When accounting for overhead and our need to provide merit-based raises based on performance, IBT's starting rate is about $2.00/hour lower at the IIS level than the industry standard in most areas of Kansas.

While the Medicaid reimbursement rate is outside the hands of the MCOs; the additional 10% reduction in reimbursement related to the need to use non-credentialed providers as a result of the credentialing delays has been an issue. The concern that the power to control the credentialing time line was largely in the hands of the payor was directly stated by myself to both the MCO in question (Cenpatico) and the state (Appendix A).

Finally, all of the MCOs chose to implement the coverage of ABA services for non-waiver members while this was being discussed at the state. While admirable, the rates for services were

not consistent across MCOs. Cenpatico opted to apply the 4% rate reduction to all exempt codes for members who were non-Autism Waiver clients (Appendix B) while the other 2 MCOs did not. These reductions were taken on the T1005 and T1027 codes which were listed as exempt in the KMAP Bulletin number 16098 (Appendix C). Furthermore, they deemed the correct reimbursement rate for the H2015 billing code for non-HCBS was only $26.12/hour (Appendix D); a far cry from the $70/hour that was standard for the services provided. This rate is prohibitive for any professional level provider to provide services. Neither of the other 2 MCOs implemented these policies and paid out for the H2015, T1005, and T1027 codes at the same rate for clients with and without HCBS services.

Timely Reimbursement for Services Rendered

Once we have completed the arduous task of credentialing with the state as well as *each* MCO, the payment structure has changed significantly from the time when Medicaid was managed by the State. When the State was responsible for payment, billing by noon on Friday each week resulted in payment the following week. With the switch to the MCOs, payment for services has increased to more than 30 days. IBT has struggled to collect timely payment in full from the MCOs since the transition in 2012. Unfortunately, we lacked the resources to adequately track and follow-up on issues with reimbursement internally. For this reason, IBT chose to contract our billing with an outside billing provider. While the costs are higher, it has led to the ability to better track issues with reimbursement and the follow-up required to recoup payment. I would like to highlight several examples in regards to issues with reimbursement and payment. Please note that this is not a comprehensive list of non and partial payments from the MCOs; however, they highlight some of the common themes we have encountered.

Lack of Timely Resolution & Communication

Appendix E outlines a case of non-reimbursement for a member who was transitioned off the Autism Waiver who is served by Cenpatico. This document outlines the communication attempts and the outcome made by our contract billers and does not include the time and effort required by IBT staff to follow-up and reach out to the MCO to ensure payment. At this time, this client still has $3,890.54 in outstanding claims that are greater than 90 days old despite communications starting in August 2016.

Appendix F outlines the actions taken to try and resolve the issue of the 4% discount being inappropriately applied to codes T1005 and T1027. The first attempt to remedy the lack of payment was in July 2016. No clarification about this reduction was provided until we started working directly with Sunflower and Cenpatico in August 2017 due to high levels of outstanding claims (more information below).

Appendix G outlines a case with UHC about issues with collecting reimbursement for Positive Behavior Support (PBS) services. While communication was good to begin with, it tapered off over time with not only no resolution of the concerns, but a worsening of the situation when UHC took back payment on clean claims due to their system issues.

Appendix H outlines issues related to claim denials due to internal errors and erroneous communication from Amerigroup. In January 2016, Amerigroup communicated that effective

January 1, 2017, all ABA services should be billed utilizing T rather than H codes as the state would be moving services from the HCBS Autism Waiver to Medicaid under EPSDT (Appendix I). IBT received several NOAs in February 2017 reversing this decision due to delays in implementing changes at the state with directions to continue billing the H codes (See Appendix J for a redacted sample). Despite following these changing directions, all codes were denied for "not a covered service" when we billed the H codes. Our contract biller had to submit all of the billing we did in this way three times. On the first attempt, we billed H codes as directed with the most recent communication (Appendix J). On the second attempt, all billing was lost by Amerigroup (Note tracking of certified mail in Appendix H). Finally, the third attempt was accepted in June 2017. Some clients needed additional information which was provided within 1 week of request with IBT. We are still working with Amerigroup to obtain payment on these claims.

Coding and System Errors

All three MCOs blame coding and system errors leading to erroneous claim denials or partial payments. While several of these system errors have been identified as far back as Summer of 2016, there fails to be resolution. Please see Appendices F, G, and H for information and timelines.

Time, Effort, and Cost to Collect Reimbursement

As outlined in these examples, there continue to be difficulties in the ability for providers to collect reimbursement. Additionally, the time, effort, and cost required is prohibitive for many service providers. At this time, our internal staff at IBT spends an average of 20 hours/week coordinating with our contract billers, following up the individual MCOs, and following up with the state in an effort to collect reimbursement on clean claims. Due to a significant backlog of reimbursements, I have had to devote 30+ hours/week for the last 3 weeks working with the MCOs and our contract billers to collect on outstanding balances.

The increased time and cooperation with the MCOs was due to the fact that our agency was faced with a very real dilemma. Due to backlogs in reimbursement, we knew we would not be able to make another payroll. We had maxed out our lines of credit to make the last two payrolls and there was insufficient progress in working through issues related to billing with the MCOs. We notified CMS, the State, and the two MCOs with the largest balances, Cenpatico and Amerigroup, that we were at a point that we needed to furlough our staff and stop services with their members until we were able to collect payment. Our agency was able to work through these issues through escalation of concerns and did not have to stop services for any child; however, had this not resolved, we would no longer be able to provide services with Medicaid clients. IBT is the one of the three largest ABA providers for Medicaid recipients in the state and the only service provider in many rural and remote areas.

The onus is on the provider to track and report issues to the MCOs and state; however, so much time is spent identifying and attempting to work through issues, that many times, we are unable to report these adequately. Providers are also encouraged to work with each individual MCO to resolve issues, and only when that is insufficient, to make a report to the State. This adds additional delays in reporting and a lack of clarity on when to report issues. Representatives at the MCOs may be showing that they are working on the issues, but as evidenced by these case examples, the resolution is not met in a timely or adequate manner.

Lack of Consistency in Filing Periods

Prior to moving Medicaid management to the MCOs, timely filing was one year from the date of service. With the move, it became variable ranging from 90 days (Amerigroup) to 180 days (Cenpatico and UHC). Only recently (July 1) is there a standard timely filing window of 180 days across all three MCOs.

We've been battling the timely filing issue with many of the problematic claims outlined in the H to T code transition originally being denied for timely filing. While Amerigroup has agreed to pay on these claims, they must be reprocessed individually, by hand, leading to further delays in reimbursement.

In Summary

Issues related to credentialing and timely, full payment of services rendered affects provider capacity. Lack of payment leads to higher overhead costs (administrative staff to work claims and/or contracting billing out) and reduced cash flow. This in turn, further decreases the agency's ability to offer a competitive wage for direct service providers so they are less likely to accept a position with agencies that serve children with Medicaid coverage or, once they obtain the experience requirements to work with this population, move onto better paying opportunities. The exorbitant length of time between hiring and being able to work with families also leads to significant attrition of providers who accept the position. These issues greatly reduce provider capacity leading to limited access to care for children and families receiving benefits through the Medicaid program.

Quality of Care

Evidence based practice includes both research and clinical practices. Specifically, an intervention much have sufficient, quality *research* to indicate effectiveness for a population of interest and the defined standards must be followed in the *practice* of that treatment. ABA is considered an evidence-based intervention to improved, or in some cases amorilate, the behaviors and symptoms of autism spectrum disorder (Appendix K). Much of this evidence was presented to the State in previous testimony related to the formation of the Autism Waiver in 2008 and in insurance reform initiatives. Since that time, additional guidance has been provided regarding industry standards for intensity and supervision of treatment teams (Appendix L). Unfortunately, there are several barriers to implementation of *quality, evidence-based practice* while working with Kansas Medicaid.

Soft Caps on Services

When the State was discussing the movement of ABA services from the Autism Waiver to the general Medicaid benefit, professional and advocates in the field emphasized issues with the "soft caps" for CCTS (i.e. AS/BCBA) and IIS services outlined via stakeholder meetings and calls. I provided additional literature and references indicating the caps as contradictory to current evidence-based practice guidelines (Appendix M) as did Autism Speaks (Appendix N). The State opted to maintain these "soft caps" on services despite the guidance and recommendations of professionals and advocates in the field and the evidence cited and provided from the research and practice literature. Providers were assured that as long as long as higher intensity of services was

required and they could show medical necessity, these higher intensity services would be approved. In practice, providers have to show that a child's case is "more severe" than other children with autism (a diagnosis often defined by severe behavioral excesses and deficits). At this time, our agency has been unable to adequately show this despite a goal to implement best practices.

The issues most frequently encountered are when asking for CCTS codes in line with evidence-based, industry standards (an average of 3.5-5 hours/week, a far cry from the 50 hours/year set by the State's "soft cap") and when asking for greater than 25 hours/week of IIS for comprehensive behavioral programming (industry standards are 30+ hours/week) (Appendix L).

While we have successfully been able to request additional IIS billing codes with Cenpatico, we have struggled to obtain a sufficient number of CCTS codes to provide evidence-based treatment. We have had two responses from the MCOs when requesting higher levels of hours. With Cenpatico, we have been told that only the hours up to the soft cap will be authorized. If we need to provide additional intensity, we need to request more hours after we have used the authorized units. We will need to show "medical necessity" for the increased units and they are not guaranteed (Appendix O). Amerigroup has sent all of our cases where we requested increased units to Medical Review. While some cases have had hours authorized over the limits set by the "soft cap" they are still not sufficient to provide the level of supervision, training, and programming necessary to ensure evidence-based programming. (See Appendix P for a redacted sample).

This has placed our providers who are BCBAs and Registered Behavior Technicians (RBT)s in a very difficult predicament. We must either provide supervision and oversight of the program without billing for services to meet the ethical guidelines outlined by the profession or choose not to. The consequences of providing free services (2-4 hours/week/Medicaid client for our BCBAs) are outlined in the issues with a lack of reimbursement (i.e. reduced capacity due to higher overhead and ability to pay providers competitive wages). The consequences for BCBS of failing to provide adequate supervision and training for RBT staff include disciplinary action by the Behavior Analyst Certification Board including revocation of certification, and by default, Kansas licensure (LBA). RBT staff are also faced with disciplinary action and possible revocation of certification. These consequences would also lead to reduced capacity not only for children and families served by Medicaid, but also those with insurance coverage for ABA services for autism where the BCBA or RBT certification are often required.

Authorization Delays

There are cases where authorizations are taking well above the standard one week authorization period set by Kansas law. In the summer of 2016, UHC notified IBT that due to an influx of authorization requests, they were backlogged and unable to authorize services in a timely manner. This concern was reported to the state with instructions that it should only affect PBS services and not ABA services; therefore, we should wait until it is a problem (Appendix Q). Over the last several months, initial and reauthorizations for services with UHC have been taking an average of 3-4 weeks. This has led to a risk of gaps in coverage where IBT has had to determine whether to stop services until a current authorization is in place or risk non-payment of services. A decision to stop services would adversely affect the children in question; therefore, IBT chose to take the

risk of non-payment. While authorizations do eventually come in, we have already experienced some delays in payment due to not having a current authorization on file when our billed services reach the MCO.

Lack of Adequate Training

As of July 31, 2017, the state opted to change the training requirements for both IIS and AS providers in the state. In an ideal world, all providers would have the BCBA, Board Certified assistant Behavior Analyst (BCaBA), or RBT credential when implementing ABA services. The rural and remote nature of Kansas is prohibitive to the access of well-trained service providers with no BCBAs currently practicing in the Northwest corner of the state and only 2 BCBAs practicing in the Southwest corner. The State has opted to continue to include the AS and IIS designation through Medicaid to promote access to services across the state. Unfortunately, the State opted to reduce the training requirements for these service providers and no longer provide them free-of-charge to potential providers (Appendix R). These concerns have been brought up on multiple occasions to the State by myself and others (Appendix S); however, the State indicated that training that included both an evidence-based knowledge and experiential component were cost-prohibitive. At this time, none of the MCOs nor the State have accepted the responsibility of picking up the training even as indicated and it falls on the individual provider or agency, further ballooning indirect costs, reducing capacity, and leading to a decrease in quality of training.

Pressuring Providers to Increase Capacity

There is definitely a need for increased capacity, and our agency and others have felt the pressure from MCO representatives to increase the number of children we serve. I have personally received several emails from families and MCOs desperate for services. At this time, IBT has had to stop accepting new Medicaid clients due to the high overhead costs as outlined above, lack of timely reimbursement, and relatively full caseloads for our providers. When an exception was made due to an extenuating circumstance, the family indicated that the case manager at the MCO questioned our intake practices. We serve another family with multiple children on the spectrum. This family utilizes both IBT services and those from another service provider since we were unable to take all of their children on our caseload. Last week, the family received notice that they had a choice, move to a center-based program or be dropped from the caseload. The other service provider, pressured to serve more children, realized that home and community based services require more resources for implementation. In order to increase the number of clients served, they decided to move to a center-based only model. This can be prohibitive for families who lack access to transportation as Medicaid transport can only be used if an adult accompanies the child to and from appointments. This undue pressure actually reduces access for many families in low income settings.

In Summary

The structure of the state ABA benefit for children with Autism was structured to control costs while allowing for flexibility to ensure accessibility to *quality, evidence-based services*. Even though provided information regarding the inappropriateness of this structure, the state decided to continue implementation with "soft caps." MCOs have rigidly adhered to these "soft caps" on services leading to a lack of quality. Authorization delays lead to payment delays and the threat of stopped services. Neither the State nor the MCOs are willing to accept the responsibility of

increasing capacity through training a qualified workforce which disproportionately affects children and families in rural areas. Finally, providers are being pressured to increase capacity with few resources and little support.

Final Points

It is clear to me that the system for ABA services currently falls short for Kansas Medicaid Beneficiaries prohibiting them from accessing *fair and equal access* to ABA services. The system fails at both the policy level and implementation by the MCOs. I ask the State to do the following:

1. Ensure that the policies are implemented in the spirit in which they were first adopted
2. Ensure providers are paid at adequate rates and within a timely period
3. Incorporate recommendations from experts and providers in the field when implementing new policies remembering that only through adequate implementation will the state be able to see long-term cost savings
4. Work with MCOs to ensure access to an *adequate and well-trained* work force
5. Immediately look for a solution related to the timeline in provider credentialing to reduce attrition of service providers