PUBLIC COMMENTS RECEIVED AT
KanCare@kdheks.gov

From April 26, 2012 through July 17, 2012

Received July 15, 2012

Dear Division of Health Care Finance:

As a constituent, I am writing on behalf of people living with multiple sclerosis (MS) throughout the state of Kansas regarding the development and implantation of KanCare. I wanted to share a few key areas that are vital to people living with MS. I strongly urge you to consider the needs of those living with MS in the following ways:

1.) Home and Community Based Services (HCBS)-I urge you to prioritize and sustain funding for HCBS for those living with MS in Kansas. These services maximize individual choice and independence for those with MS and others with disabilities.
2.) MS therapies (biochemical medications, Specialty Drugs and/or Tier III medications)-I urge you to mandate the coverage of these medications which help slow the progression of MS and help to prevent permanent disability.
3.) Disparities in Care: I urge you to ensure that KanCare address the needs of people with physical disabilities to have access to health care, including accessible equipment, accessible exam tables and assistive technology, along with specialty care regardless of where the individual lives. I urge you to promote access to care in both urban or rural setting, including the use of telemedicine to bridge gaps.
4.) Provider reimbursements: I urge you to increase reimbursement rates to reflect the complex care required to threat those with chronic illnesses like MS, to help ensure an adequate number of providers are available.

Please feel free to contact me directly with any questions.

Sincerely,

Deanna Markley P.T.

Received July 14, 2012

Many of the concerns I have have been voiced over and over by other caregivers and service providers. Solely as a citizen of Kansas we are outsourcing $3 billion that should be kept in Kansas.

Saving money and spending $3 billion in administrative costs doesn't add up.

My personalized concerns about the Kancare plan is the speed it is being implemented. The complexities of this plan will impact peoples lives.

The most vulnerable people whose care is in our hands.

This population requires careful coordination of the many people, services, and medications. When these services are interrupted people can be harmed irreparably. Medications must be balanced carefully and while one medication works for one person it does not necessarily work the same way for another person. Please consider the consequences to the people that Kancare will serve.

My adopted son requires 24/7 supervision and medications. Interruptions in his care and/or medications could cause harm to him or those around him. There is no question that providing services within the community is a more cost effective method of long term care but that care is carefully managed by a local group of people who know him. It would be difficult to convince me that someone hundreds of miles away and who doesn't know my son could manage his care better.

Thank you for your consideration of the concerns many of my fellow Kansans have expressed about the KanCare program.

Respectfully,

Deb Peterson

Received July 14, 2012

This group of technology-dependent children is much too fragile to be included in an experiment.

I believe the State's data used to establish PMPM for these kids substantially underestimates the combined costs of direct care AND hospitalization. Once MCO actuaries have a few month's claims experience they will advise against growing this segment of beneficiaries. Long story short, MCOs will intentionally move to be unattractive to TA families and thus avoid an immigration and the resultant adverse selection and negative impact to their bottom line.

Please do not include TA kids in KanCare. At least wait until you have a couple years' experience with less fragile populations and can better protect these kids.

Richard Giblin

Richard C. Giblin | CEO, Craig HomeCare

C 316.393.7000
CraigHomeCare.com | richardg@craighomecare.com
1100 E. 1st St, P.O. Box 2241
Wichita, Kansas 67201-2241

Received July 14, 2012

Dear Division of Health Care Finance:

As a constituent, I am writing on behalf of people living with multiple sclerosis (MS) throughout the State of Kansas regarding the development and implementation of KanCare. I wanted to share a few key areas that are vital to people living with MS, including myself. I strongly urge you to consider the needs of those living with MS in the following ways:

1.) Home and Community Based Services (HCBS)-I urge you to prioritize and sustain funding for HCBS for those living with MS in Kansas. These services maximize individual choice and independence for those with MS and others with disabilities.

2.) MS therapies (biochemical medications, Specialty Drugs and/or Tier III medications)-I urge you to mandate the coverage of these medications which help slow the progression of MS and help to prevent permanent disability, thereby helping people with MS to remain productive.

3.) Disparities in Care: I urge you to ensure that KanCare address the needs of people with physical disabilities to have access to health care, including accessible equipment, accessible exam tables and assistive technology, along with specialty care regardless of where the individual lives. I urge you to promote access to care in both urban or rural settings, including the use of telemedicine to bridge gaps.

4.) Provider reimbursements: I urge you to increase reimbursement rates to reflect the complex care required to treat those with chronic illnesses like MS, to help ensure an adequate number of providers are available. I can assure you that my neurologist is very important to my continuing care, as is my primary care physician.

Please feel free to contact me directly with any questions.

Sincerely
Nita Mark
Derby, KS 67037

Received July 14, 2012

From: jobalesha@hotmail.com
To: kancare@kdhek.gov
Subject: Disabled Kansans
Date: Fri, 13 Jul 2012 16:49:09 -0500

Please take time to consider that Disabled people in the state of Kansas may not be best served by bundling the Medicaid for Medical and HCBS services together. We are the parents of a 25 year old young lady with a Disability, and must advocate for our daughter as she is non-verbal. She is, however, a registered voter in the State of Kansas.....we do want the monies

for services that she deserves to be handled inappropriately. Big business has no place in the day to day lives of our Disabled Citizens who must struggle to remain active, well, and out of the Medical offices and Hospitals. By supporting their lives as Well individuals you will contribute widely to the betterment of our Community. We further support the financial allocation of monies to take families off the waiting list for services vs hiring a Private Companys to do this job.

Barb, John and Leah Kenton

Received July 13, 2012

Please see comments from the Big Tent Coalition of Kansas (attached).

(The comments are attached in an individual PDF document at the end of this document).

You can find contact information for Big Tent at our website:

http://www.bigtentcoalition.org/

Received July 13, 2012

Please see attached.

(The comments are attached in an individual PDF document at the end of this document).

Nick Wood
Systems Change Coordinator and Lead Investigator
Disability Rights Center
635 Harrison Street, Suite 100
Topeka Ks 66603
Voice: 785-273-9661
Toll free Voice: 1-877-776-1541
Toll free TDD: 1-877-335-3725
Fax: 785-273-9414

Received July 13, 2012

Dear Division of Health Care Finance:

As the President of the Mid America Chapter of the National MS Society and on behalf of the 4,000 people living with multiple sclerosis (MS) throughout our state, I offer these remarks in regard to the development of KanCare:

Please consider:

1.) Home and Community Based Services (HCBS) - I urge you to prioritize and sustain funding for HCBS for those living with MS in Kansas. These services maximize individual choice and independence for those with MS and others with disabilities.
2.) MS therapies (biochemical medications, Specialty Drugs and/or Tier III medications) - I urge you to provide coverage of these medications which help slow the progression of MS and help to prevent permanent disability.
3.) Disparities in Care - I urge you to ensure that KanCare addresses the needs of people with physical disabilities for access to health care, including accessible equipment, accessible exam tables and assistive technology, along with specialty care regardless of where the individual lives. Please promote access to care in both urban or rural setting, including the use of telemedicine to bridge gaps.
4.) Provider reimbursements: I urge you to provide reimbursement rates that reflect the complex care required to threat those with chronic illnesses like MS, to help ensure an adequate number of providers are available.

Please feel free to contact me directly with any questions.

Sincerely,

Kay Julian

Kay Julian
President

National Multiple Sclerosis Society
Mid America Chapter
7611 State Line Road, Suite 100
Kansas City, MO 64114
Tel: +913.432.3927
Fax: +1 816 361 2369

Received July 13, 2012

Dear Secretary Moser:

As the formal comment period for the state's KanCare proposal has started, I wanted to provide you with an updated review of Kansas hospitals' thoughts and concerns regarding a number of unresolved implementation issues.

Let me begin by expressing our gratitude to you and your office for the efforts that have been made to work with us on this large and complicated project. Your staff has had many, many meetings with KHA staff and members to discuss a wide variety of issues. I know we have been very aggressive in placing these hospital issues before your agency, but the people in your office have always been extremely professional in the way they have handled our questions and concerns.

Early on in this process, the KHA Board identified a number of principles we would use to analyze the KanCare proposal and its implementation. As you might remember, those principles included five specific domains that impact hospitals: access to care; delivery system reform; care management; provider reimbursement; and issues related to the hospital provider assessment program. Through those principles we made the following points:

- Community hospitals are the ultimate safety net for the uninsured and Medicaid enrollees.
- Better utilization of primary care providers across the state should be encouraged, incentivized, and supported.
- The State's Medicaid program should move toward rewarding clinical outcomes that improve quality and reduce costs in an organized and agreed upon process that involves key stakeholder participation.
- Care delivery infrastructures should be organized in such a way that encourages beneficiaries to seek care in the most appropriate setting, at the appropriate time and discourages the over utilization of unnecessary and inappropriate services.
- Delivery system models that focus on population groups that consume a disproportionate share of the state's Medicaid resources should be a priority.
- Programs such as patient-centered medical homes, chronic disease management, and personal wellness should be encouraged, designed and developed.
- Expansion of the State's Medicaid Managed Care programs into populations that previously were not included should be approached in a very transparent and thorough manner.
- Hospitals and physicians that care for Medicaid enrollees should be paid fairly and adequately to ensure access to care is available in the right setting at the right time.
- Medicaid rules and regulations governing billing, payment, coding and audits should be examined and evaluated on how costly they are to administer and how effective they are at controlling costs.
- The State must take care to protect the Hospital Provider Assessment Program passed by the Legislature in 2004.

As the discussion regarding KanCare has moved into more specific implementation areas, we also provided numerous suggestions about several implementation issues we felt were important to consider prior to the beginning of the program. We included specific recommendations in the following areas (along with suggested language to accomplish these recommendations):

- The need for clear guidelines that detail how MCOs will provide Authorizations to providers for patient care services to be rendered dealing with such issues as delay and emergency treatment, including suggested language.
- Clear guidelines on Utilization Management practices by the MCO that ensure payment for medically necessary care and deference to physicians' orders, including suggested language.
- Clearly defined claims processing and payment guidelines covering such things as timely filing requirements, clean claims, prompt payment and electronic billing, including specific language suggestions.

- Clear guidelines for out-of-network (OON) payments that do not unfairly disadvantage providers.
- The need for uniformity among the final three MCOs regarding administrative procedures.

As we move closer to the launch of KanCare, we feel that these implementation issues take on a new urgency. Indeed, some of the questions being raised in Kentucky serve to emphasize the importance of the need for adherence to the principles we mentioned, as well as the clear guidelines summarized above.

Hospitals are significant stakeholders and providers of care for the State's Medicaid enrollees. As such, we recognize the tremendous task in front of all us in reforming and redesigning the program to match the vision "To serve Kansans in need with a transformed, fiscally sustainable Medicaid program that provides high-quality holistic care and promotes personal responsibility." As we have mentioned before, we stand willing to be partners in helping the State achieve that vision. But we must also emphasize that the success of that transformed system depends significantly on the confidence of those who are actually delivering care to patients every hour of every day.

Over the years, Kansas hospitals have worked in partnership with the state to insure that our most vulnerable and needy citizens have access to quality health care. Our commitment to that relationship and our willingness to be a partner with the state in the construction of a reformed Medicaid program remains strong. We look forward to working with you and your staff to help create a reformed Medicaid program that works.

Thank you for your consideration of our comments.

Best Regards,

Tom Bell

President and CEO

Received July 13, 2012

The waiver does not Attached, please find comments from Kansas Advocates for Better Care regarding the State of Kansas Section 1115 Waiver for KanCare. Hard copies were also sent to Lt. Gov. Jeff Colyer, Secretary Shawn Sullivan, Kansas Department of Aging & Disability Services and Kari Bruffet, Kansas Director of Health Care Finance. Thank you for your consideration.

Barb Conant
Ks Advocates for Better Care
785 383-4272
baconant@hotmail.com

KanCare Comments

ATTN: Rita Haverkamp
KDHE-DHCF
900 SW Jackson, Rm 900
Topeka, KS 66612

Dear Secretary Mosier:

Kansas Advocates for Better Care (KABC) is a consumer-driven group that for nearly 40 years has advocated for improved quality in long term care, for adults in nursing homes, assisted living facilities and at home. KABC has members and volunteers throughout the state. KABC is beholden to no commercial interests and is supported almost entirely by individual donations. It was one of several state organizations that won passage of the Nursing Home Reform Act of 1987 after it highlighted the abuse and neglect of elderly residents of nursing facilities. KABC supports a Medicaid program that cost-efficiently provides consumer access to services.

KABC appreciates the opportunity to express our concerns regarding the State's readiness to implement a change of the magnitude of KanCare. We don't believe that the State has adequately solicited and genuinely considered public input about the unique needs senior consumers and their families, as demonstrated by the lack of denture coverage among the value-added services under KanCare. We are concerned about the lack of verifiable data provided to stakeholders. We would expect that a project of this magnitude would have a detailed long-range plan for staff training, consumer education and implementation. As we research other states' experiences with managed care, we also have become concerned about weaknesses in the grievance and appeal mechanisms. Last, but certainly not least, we ask that the State craft meaningful measures that track health outcomes for recipients. We urge the State to delay the inclusion of frail elders residing in nursing homes from the initial roll out of KanCare. Frail elders are the least equipped to rebound from the missteps that will happen with a change of this magnitude.

Kansas is the first state to propose shifting its responsibility for <u>all</u> long-term care Medicaid programs to an untried and unproven model. Collectively, the contracted managed care organizations (MCOs) have little to no experience serving long term support services (LTSS) for seniors and all populations. We are concerned about the capacity of the State to provide consumer education, enrollment and data collection infrastructure, and oversight and moreover within the short time frame proposed. Further we are concerned that the MCOs do not have the knowledge and provider networks to implement LTSS within the first phase of the Medicaid statewide mandatory managed care expansion.

The RFP and waiver seek to reduce the number of nursing home residents by "restricting access," but there is no credible evidence that Kansans are flocking to nursing homes *if they have any real access to any other long-term care services and supports short of nursing home care.* Everyone agrees that moving to a nursing home is the option of last resort. A higher than average percentage of persons in institutions logically presumes that the community supports needed to keep seniors safely at home is not available. KanCare does not address the lack of community access, particularly in rural areas. Nor does it restrict the possible geographic dislocation of adults from support networks should their provider not be "in-network".

Health outcomes KanCare does not measure meaningful health outcomes, with the one exception which measures resident falls (see Attachment J, KanCare RFP). Otherwise, KanCare lacks measures that significantly promote or track health care outcomes, such as improved nurse staffing levels in nursing homes and Medicaid coverage of routine dental care for frail adults.

- We urge the State to include person-centered health outcomes that measure the emotional, social, psychosocial, and physical wellbeing of KanCare participants, such as prevention and appropriate treatment of decubitus ulcers, malnutrition, unexplained injuries, loss of bowel/bladder control, falls, preventable hospitalizations, rate of decline in functionality--mental, physical or emotional. Consumers should be assured that provider networks will restrict geographic displacement of elders to no more than 50 miles in rural areas.
- The administration has asserted KanCare will prevent premature institutionalization. But seniors who are financially ineligible for Medicaid will not access the KanCare system until their private resources are exhausted when the opportunity to prevent premature institutionalization is long past.
- KABC does not reject managed care per se, and we approve the successful Kansas model for managed care – program of All Inclusive Care of the Elderly (PACE) program. But KanCare is NOT a PACE managed care program. The elements of PACE which contribute to its success are missing from KanCare. PACE is a voluntary program. Central to PACE's success is consumer choice and individualized care plan management. PACE participates in the private long-term care market and uses its superior outcomes to attract enrollees based on choice. PACE prevents premature institutionalization because the program is directly accountable to the consumer on all quality measures. PACE has not been proven to be viable in rural areas. KanCare should at least explain to consumers how it will prevent the institutionalization of frail, elderly Kansans in our rural areas.
- Rather than focusing on quality of care to the elderly, KanCare's outcome measures are almost exclusively on quality of the MCO contractors' services to providers, timeliness of payment to providers, and cost savings. (Attachment J, KanCare RFP)

Public Input and Transparency Kansas consumers have no meaningful ability to measure the impact of KanCare, mostly because its outcome measures relating to quality of care and access are non-existent. State facilitated forums in 2011 did not address the proposal of wholesale managed care. Rather, the State convened forums gathered much input, unveiled its plan at the start of 2012 with no explanation of how stakeholder input had been incorporated, and has not addressed the many, significant concerns raised by consumers. An "experiment" of this magnitude, impacting the State's policies and budget, requires an open and transparent public discussion, inclusive planning, and flexibility.

Evidence of the State's disregard of meaningful public input includes:

- The RFP and the waiver application were drafted without input from all stakeholders, and implementation timelines have been drafted without adequate consideration of the CMS approval process.
- The implementation timeline submitted under the first 1115 waiver application does not call for consumer town hall meetings until July. That leaves no time for adjustment to consumer concerns.

- KABC strongly opposes the administration's efforts to gag providers (whether it's all of them or only the Centers for Independent Living) through a new contract provision that threatens organizational advocacy in the public legislative and administrative arenas on behalf of their constituents at both the state and federal level. Those who agree to this provision can't participate in public policy debates and the State runs the risk of losing service providers. Consumers lose access to services. This is poor timing again as the State prepares to implement a managed care system with a possible substantial decrease in providers. This does not reflect in action what the State has said it desires – a robust of engagement of stakeholders.

Consumer Choice Home-and Community-Based Services (HCBS) should help elderly Kansans stay in their homes rather than enrich entities which build facilities that are functionally indistinguishable institutions, whether nursing facilities or assisted living types. The waiver application states the "State intends to help nursing facilities build alternative HCBS capacity." It is disingenuous to propose an "expansion" of HCBS which merely permits more (and less carefully regulated) institutions to benefit from Medicaid reimbursement without the consumer protections afforded by the Nursing Home Reform Act of 1987.

The KanCare waiver calls for a "tiered functional eligibility system" for the frail and elderly that restricts access to the highest cost institutional settings only to those with the highest level of need in order to utilize appropriate alternative home and community based settings. At this time the functionality assessments have not yet been designed. An RFP to contract for the design of an assessment tool is currently in process. Because of the complexity of designing effective assessments, we believe that process should be open and transparent. However, the advocacy community nor the public has been included in the process. As is the case with many aspects of this waiver application, there are too many details missing. If eligibility for services is to be restricted based on functionality assessments, the design of those assessments should be available to the public as well as CMS for review.

The most ominous element of the KanCare waiver is the necessity for waiver of Section 1902 (a)(23) of the Medicaid Act. Freedom of choice is a core value to Americans, more especially frail, elderly Americans who have exhausted their savings and whose income does not cover the high cost of long-term care. This element, read in tandem with the stated goal in Track 2, to suspend Medicaid's status as an entitlement, will gut the only protection frail, elderly Kansans have. Nothing in the KanCare proposal sets out how managed care will "promise a healthier outcome" to elderly Kansans in long-term care. It is a program without public or legislative accountability or federal oversight.

Budget/Cost Savings & Sustainability There has been no transparency regarding the calculations. The State estimates an $850 million-$1 billion savings from KanCare. To date, the public does not know how that estimate was calculated, how soon the savings will be realized or how savings will be distributed, if at all, among Medicaid programs. All we know is that initial savings will incentivize the MCOs, rather than to improve health care, access, or outcomes for Kansans. And that the state did not include a medical loss ratio or administrative cost cap in the MCO contracts. KABC believes maximum resources should be devoted to patient care, rather than to company overhead and profits. Incentive payments should be based on objectively verifiable health outcomes and improved care management.

Infrastructure Kansas agencies charged with the responsibility for implementing the 1115 Waiver are not adequately staffed to successfully accomplish implementation within the proposed timeframe. The responsibility of the new Kansas Department of Aging & Disability Services (KDADS) stretches from children to elders and includes gambling and addictions services, mental health hospitals, and many more services. To presume that programs, changes or consumers will receive adequate preparation, planning, education, or implementation is unrealistic under the current timeline and with current staffing. KanCare does not allow for the development of transition plans for beneficiaries guaranteeing that they are not abruptly cut off from care of their long-standing provider relationships. It is a "perfect storm" in which systems will fail and consumers already challenged by frailty, disability, and poverty will undoubtedly be harmed.

Health disparities address health disparities in outcomes, access, public education, evaluation, consumer choice and input among racial, ethnic, cultural or social considerations. The waiver request fails to address health disparities in general, and specifically, for those who may need long term care based on Kansas demographic changes. KanCare fails to address health disparities among racial and ethnic populations. From 2000-2009, the rate of long-stay nursing home residents experiencing a decline in their ability to perform daily activities and requiring increasing assistance escalated among Blacks. At end of life, among high-risk long-stay residents, Blacks and Hispanics were more likely than Whites to have pressure sores. http://www.ahrq.gov/qual/nhdr11/nhdr11.pdf

The monitoring and accountability processes regarding cultural competence and diversity are not explicitly included, and thus provides no basis for assuring cultural competence and diversity.

Grievance and Appeals It is critical that there be mechanisms within KanCare to protect the rights of individuals who rely on long-term care services due to chronic conditions that are stable and not improving. The need for continuity of stable long-term services for chronic conditions is very different than for short-term acute care. Appeal rights guaranteed in the fee-for-service Medicaid, including the right to aid paid pending a hearing on a proposed reduction or termination of services should apply in the managed care context for personal care, behavioral health and other long-term services (42 C.F.R. 431.230)

Protecting consumers' rights should be a core KanCare's tenet. However, given the haste that KanCare is being implemented, the State's rush to restrict nursing home admissions, the adoption of a functional accessibility tool that has not been vetted through stakeholders and consumers and all of the concerns expressed, we do not believe consumers are well protected under the current proposal.

The federal regulations governing general Medicaid managed care do not provide for "aid paid pending," also known as "aid continuing" pending an administrative hearing to contest a reduction or termination of services authorized by an MCO, if the reduction or termination coincides with the end of an "authorized period for the service. (42 C.F.R. 438.420) Only if the MCO reduces services *during* an authorized period do appeal rights include the right to continue receiving the contested services pending the outcome of the hearing. Advocates from across the United States are appealing to the CMS to rectify this omission since so many states are moving

toward managed care. Kansas should lead by example and include this provision within its Section 1115 waiver application.

Conclusion KanCare is not a demonstration with controls and measures; it poses unnecessary risks to consumers. It does not set out a methodology to gather information for improvement; rather, it imposes an untried business model on the most vulnerable, least empowered citizens of our state. This critical policy discussion appears to be driven by financial considerations alone. Without transparency, notice and input, consumers are being asked to cross our fingers and hope. Finally, the State's new budget projects a deficit of *at least* $2.5 billion over 6 years. The budget pressures on all state services will be punishing. KanCare appears to be a vehicle for shifting more of the burden to the federal government.

We request that the State provide for proper legislative and public oversight, full transparency, a methodology for measuring improvement in outcomes for consumers and criteria for evaluating the success of the demonstration specific to access, care and services to consumers.

Sincerely,

Margaret Farley, Board President
Molly Wood, Board Member
Mitzi E. McFatrich, Executive Director
On Behalf of KABC board, members, & volunteers

Copy: Lt. Gov. Jeff Colyer
Secretary Shawn Sullivan, Kansas Department of Aging & Disability Services
Kari Bruffet, Kansas Director of Health Care Finance

Received July 13, 2012

I am worried that once KanCare takes place the people receiving long term care services will have problems receiving the needed services to keep them in the community. With the Care Coordinators in other states that do not know the people and are not familiar with the situations that they are living in, how are they going to be able to directly determine what supports are needed and what supports can be cut?

Sincerely, JS

Jaci Schrag
Case Manager for STAIRS, LLC
PO Box 1056
Newton, Ks 67114-1056

Phone:(316)253-4558
Fax: (316)768-4497
www.stairscms.biz

Received July 13, 2012

I am a board member for an organization that serves folks with developmental disabilities. I have been a clinical social worker for 16 years. I have also earned an MBA with a concentration in health care financing.

I am definitely interested in exploring ways to reduce high health care costs yet provide decent health care coverage to **all** folks. So I was pleased to see that Kansas was taking steps towards trying to lower costs for its Medicaid program while providing optimum care. However, there are several things that concern me about the current KanCare.

- Some of the organizations awarded contracts under KanCare have a documented history of committing Medicaid fraud
- Providers in other states that have moved to a managed care format have suffered because of delayed payments by managed care organizations to providers who have provided services
- Trying to successfully implement a major overhaul of the Medicaid program requires far more time than has been allotted to ensure that all the bugs have been addressed and that the best approach, through careful study and analysis based on other implemented programs, has been carefully applied to KanCare
- Managed care has not been proven to be an effective model for providing health care to the developmentally disabled. These folks require a whole host of supportive services their whole lives that are different from other folks with strictly medical issues. The organizations chosen to handle KanCare have not demonstrated their understanding of the differences of managing health care for the general population vs. managing all the needs of the developmentally disabled.

I urge Kansas to:

- Allow more time for study and analysis before implementing KanCare
- Ensure that proper safeguards are written into contracts with the managing organizations responsible for delivering this care so that the clients and the state are not defrauded and that contractors are required to make payments to all providers within 30 days or interest penalties will be imposed.
- Keep the developmentally disabled population out of KanCare until there is credible evidence that managed care does work for this population and the contractors charged with caring for this population can effectively manage their care and needs.

Thank you

--

Anne Lauer
P.O. Box 2500
Hutchinson, Kansas 67504-2500
Mobile: 620-931-6008
Home: 620-259-6801

Fax: 620-259-6802
E-mail: lauer.anne@gmail.com

Received July 13, 2012

Dear Division of Health Care Finance:

As a constituent, I am writing on behalf of people living with multiple sclerosis (MS) throughout the state of Kansas regarding the development and implantation of KanCare. I wanted to share a few key areas that are vital to people living with MS. I strongly urge you to consider the needs of those living with MS in the following ways:

1.) Home and Community Based Services (HCBS)-I urge you to prioritize and sustain funding for HCBS for those living with MS in Kansas. These services maximize individual choice and independence for those with MS and others with disabilities.

2.) MS therapies (biochemical medications, Specialty Drugs and/or Tier III medications)-I urge you to mandate the coverage of these medications which help slow the progression of MS and help to prevent permanent disability.

3.) Disparities in Care: I urge you to ensure that KanCare address the needs of people with physical disabilities to have access to health care, including accessible equipment, accessible exam tables and assistive technology, along with specialty care regardless of where the individual lives. I urge you to promote access to care in both urban or rural setting, including the use of telemedicine to bridge gaps.

4.) Provider reimbursements: I urge you to increase reimbursement rates to reflect the complex care required to threat those with chronic illnesses like MS, to help ensure an adequate number of providers are available.

Please feel free to contact me directly with any questions.

Sincerely,

Ann T. Reed
316/684-9248

Received July 13, 2012

KanCare is a terrible idea.

I started this online petition. It has 1,455 signatures. I will deliver it to Kathleen Sebelius, secretary of Health and Human Services.

I have not found one parent, one direct-care provider, one case manager, one vocational support person, one special education teacher or one agency that supports KanCare. NOT ONE.

And I do not support fixing something that isn't broken, moving support services to a for-profit, out-of-state insurance company and removing our ability as Kansans and as families and friends of individuals with intellectual disabilities to have a say in their care and support and how it is delivered.

http://signon.org/sign/stop-kancare-keep-3-billion
--
Madeline McCullough

Received July 12, 2012

My name is Shirley Mendoza and I am a home health nurse. I am very concerned about KanCare and how it will affect those who need care. I don't think that privatizing this is a good idea. I know that there is a money problem, but don't feel that this is the right thing to do. I believe that if we care for God's people then God will care for us. We need to get back to the basics and trusting God. Nothing will ever get better until that happens. Please reconsider this issue. Listen to the people Thank you. Shirley Mendoza RN BSN Phillipsburg, KS

Received July 12, 2012

Comments on Kancare

1. The fact that the State of Kansas failed to coordinate with the Indian Health Services does not bode well for the management of Kancare; i.e., that was a major oversight.
2. The fact that the State of Kansas submitted the waiver application to CMS the day BEFORE changes to the 1115 waiver process became effective also indicates poor time management.
3. The Kansas Budget Director made the statement that “small Medicaid providers shouldn’t be in business” because we are concerned about being paid for the services we provide in a manner that will allow us to remain in business.
4. 67% of people with MR/DD in day programs in Johnson County are served by other than Johnson County Developmental Supports; small providers are doing the bulk of this work.
5. County Commissioners and governing bodies should be concerned that they may be asked for funding to provide services that we will no longer be able to provide once we are overwhelmed and bogged down by administrative requirements levied by three different insurance companies.

6. Secretary Shawn Sullivan, on numerous occasions, assured Medicaid recipients that they would not be changing their providers. Exactly how can he make that assurance when there has been NO coordination with current providers?

7. When asked if there were any plans to conduct workshops or information sessions with providers, Secretary Sullivan's answer was NO.

8. Gov Brownback announced on Push Day that the DD population would be delayed one year going into Kancare. We are savvy enough to know that the reason he made that announcement was not because he really gives a fig about the DD population but because the insurance companies vying for Kancare asked for a delay so that they could figure out how to include long term care for the DD population.

9. We were also assured that we would be able to keep our current case manager. It is on the record that the insurance companies stated that would not be the case.

10. The largest insurer in the State declines to bid? If the Brownback administration were not so single minded and suffering from tunnel vision, it might ask the question why Blue Cross/Blue Shield declined to bid? And actually listen to the answer instead of twisting words to fit their sole goal, privatizing Medicaid come hell or high water?

11. Once it was determined that the 1115 waiver had to be revised and resubmitted, the Administration held two public hearings (the minimum to meet the CMS requirements) and chose to stay out of Johnson County with those hearings? Doing the "minimum" is not a way to instill confidence in the people you are forcing into this massive change.

12. The bottom line is WHY SHOULD KANSAS TAXPAYERS HAND A $2.9 BILLION SAFETY NET TO OUT OF STATE INSURANCE COMPANIES THAT HAVE DEPLORABLE HISTORIES?

KanCare is a MISTAKE.

Susan Jarsulic
Shawnee, KS

Received July 12, 2012

To whom it may concern:

I am amazed that after so much outpouring of opinion regarding KanCare, and the devastating effects it would have on our loved ones with developmental disabilities, that the plan continues to go forward!

We understand the need to work on keeping costs down, but having people with developmental disabilities participate in KanCare for long term needs is not the way.

Yes, you have had meetings, and will continue to do so. But we want to be heard at the meetings, not just responded to. There is a difference between hearing us and responding to us.

Thank you.
Respectfully,
Sarah Munday for Christopher Zerr
Overland Park, KS

Received July 12, 2012

I continue to advocate that services for individuals with developmental and intellectual disabilities should **not** be placed in managed care.

I don't believe that the state has done the homework. I requested the math before and still have not received anything. As a taxpayer, the state has yet to prove to me how moving these services to managed care will save money. The state is saying no services will be reduced, no provider rates will be reduced, no one will be cut from services AND a for-profit insurance company will be placed in the middle making money. That makes no sense at all.

This needs to stop. Thank you for giving me an opportunity to state my opinion.

Pattie Knauff

Received July 11, 2012

I have been listening and hoping that the current administration would understand that people with disabilities need long term support that cannot be provided by insurance companies that base their services on the medical model. That doesn't work for school districts either. Please don't disappoint the MRDD population and their families. Thank you, Kathryn H. Otto

---

Received July 11, 2012

My name is David P. Rundle. I am disabled and on Medicaid. I have a BA. I went to a meeting on KanCare. Two state officials spoke and I still don't understand KanCare. I do not know how it will save money while not cutting services but earn money for three companies. It does not add up.

Deny the waiver.

Stop KanCare!

Received July 11, 2012

Dear Dr. Colyer,

Thank you for this opportunity to provide comments on KanCare.

In June, we submitted the attached comments to the Centers for Medicare and Medicaid Services (CMS) on the original Section 1115 waiver application submitted by the State of Kansas on April 26, 2012. I hope that you will take these comments into consideration as you prepare the state's final waiver application.

We developed these comments in partnership with diverse advocacy organizations representing vulnerable Kansans, including Kansans with disabilities, children, seniors, and Kansans with mental illness.

Organizations that contributed to the drafting of this document include, but are not limited to:

Association of Community Mental Health Centers of Kansas, Inc.
Kansas Action for Children
Kansas Advocates for Better Care
Kansas Area Agencies on Aging Association
Kansas Chapter, National Association of Social Workers
Kansas Health Consumer Coalition
Kansas Mental Health Coalition
Health Reform Resource Project
National Alliance on Mental Illness-Kansas
Oral Health Kansas
Statewide Independent Living Council of Kansas

(The comments are attached in an individual PDF document at the end of this document).

Sincerely,

Anna Lambertson

Received July 10, 2012

(the comments are attached in an individual PDF document at the end of this document)

Bill and Mary Dondlinger
210 Cochise Trail
Hutchinson, KS 67502

Received July 9, 2012

Kan Care Concerns following the June 18, 2012 Wichita Public Meeting

Dear Sirs,
Thank you for the opportunity to comment regarding the proposed Kan Care plan that would bring managed care to our state's Medicade population. I do have several areas of concern that I hope you will address in your plans. I have presented my thoughts as bullet points to make it easier for you to read and consider them.

- I am concerned that the educational slides that were covered at the public meeting contained a number of terms such as "health home" that I and I feel many of the audience did not understand. I felt like the information and the presentation were too rushed and not geared for a "public meeting". How can the state expect us to be informed on a change of this magnitude with a 30 minute presentation? I feel that all the stakeholders should be informed and have an opportunity to comment before the final plans are written.
- I have a concern that the State of Kansas should study the concept of self insurance for Kan Care. I believe that many of the largest corporations are self insured as a way to save money while hiring Insurance Companies to administer their insurance programs. If this is a good business plan for private companies, I believe the state should address this question.
- I am concerned that Kansas does not have a legislative oversight committee prior to the executive branch implementing Kan Care. I feel that changes that are so sweeping and that will affect so many people should be subject to legislative review to insure that the voice of the people will be heard.
- I am concerned that Kansas does not have a plan to address the "waiting list" issue as a part of their waiver request. The waiting list has been an issue for too long here in Kansas and should be addressed.
- I am concerned that the delay in payments experienced in Kentucky might ocurre here in Kansas. I know that a ninety day payment cycle would be a financial disaster for many service providers. I understand that there is an expectation that a high percentage of "clean" claims will be processed within 30 days. I would like to see the agreement on the meaning of the term "clean" claim and have an understanding of what the state will do if these expectations are not met.
- I am concerned that Kan Care does not seem to address dental care.
- I am concerned that the state indicated that one of the reasons for bringing in the outside insurance companies was that "several of our service providers have only five clients and are not large enough to have needed resources. I believe that it was a policy set by the state that opened the door to the increase in the number of these smaller service providers.

Ronald Kelley
Training and Evaluation Center of Hutchinson, Inc. Board Member
4301 Winesap Drive
Hutchinson, KS 67502

Received June 28, 2012

I have the following concerns with the captioned program relative to my disabled son:

1.It does not appear to allow for the opportunity for family concerns to be expressed.

2.I am not in agreement that locally-managed facilities will be assumed by insurance companies.

3.I am concerned that medical services may changed from current services which my son is familiar.

4. Most important is the possible change of current case managers and care givers under a new program.

(not signed)

Received June 26, 2012

Kansas Action for Children Good Morning,

Kansas Action for Children advocates on behalf of the 230,000 Kansas children insured through Medicaid or CHIP. We have reviewed the KanCare proposal and provided public comments in our attachment. Thank you for the opportunity to submit comments. For further clarification or discussion, please contact the Kansas Action for Children office at 785-232-0550.

(The comments are attached in an individual PDF document at the end of this document).

Thank you,
Suzanne Wikle

Suzanne Wikle
Director of Policy and Research
Cell 785.554.1830 | suzanne@kac.org
720 SW Jackson, Suite 201 | Topeka , KS 66603
Office 785.232.0550 ext. 102 | Fax 785.232.0699

Received June 24, 2012

First of all, whose "bright idea" was it to even come up with these changes? If it isn't broke then don't fix it! I have 2 sons with Autism.

Neither one of them asked to be born, let alone have the disorder and I sure didn't know I would have 2 special needs kids. You people act as if they don't have the right to good insurance coverage!

All your concern is about is that damn bottom line!! Money matters more than the people? Really?

Well, I guess as long as you all have your insurance coverage and it isn't messed with then its just fine, right?

If you were to meet a child or adult with special needs or have a family member with special needs what would your thoughts and feelings be then? Or would your hearts still be the icy hole they are now?

None of you think about anyone else but yourselves. It's obvious. Why else make changes that affect those that clearly need good quality health insurance with NO changes that negatively impact their healthcare?

Damn your so-called "ideas" and garbage changes! My sons and everyone else's kids/loved ones DESERVE good healthcare and coverage! Stop with the changes and "waivers".

I don't know how you people sleep at night. Forget about the "bottom line" and the bonuses of those up on the hill….do whats RIGHT not what gets you favors with those that are higher up!!!!

Autumn Wilson

Received June 22, 2012

Hello—attached are comments on the 1115 waiver for KanCare. Please confirm you have received the pdf. Thank you.

(The comments are attached in an individual PDF document at the end of this document).

Sky Westerlund, LMSW
Executive Director
Kansas Chapter, NASW
700 SW Jackson, Ste. 801
Topeka, Kansas 66603
785-354-4804
fax) 785-354-1456
www.knasw.com

Received June 21, 2012

(The comments are attached in an individual PDF document at the end of this document).

Debra Harmon Zehr, President/CEO
217 SE 8th Av., Topeka, KS 66603
Ph 785-233-7443 Fax 785-233-9471
Toll free 1-800-264-5242
Email: debra@leadingagekansas.org
Website: www.leadingagekansas.org

Received June 20, 2012

To: Kari Bruffett, Director of KDHE Division of Health Care Finance

From: Tanya Dorf Brunner, Executive Director of Oral Health Kansas, Inc.

RE: KanCare 1115 Waiver Application Comments

(Written comments were received from Oral Health Kansas, Inc. The comments are attached in an individual PDF document at the end of this document).

Received June 20, 2012

I have attached testimony from Tonganoxie Nursing Center.

(*the Nursing Center's comments are attached in an individual PDF document at the end of this document)*

Miranda Metcalf
Kansas Health Care Association
(785) 267-6003

Received June 20, 2012

I was unable to send my comment through your web-site, so I am sending it through my own e-mail.

I am very much opposed to KanCare. It is a terrible idea. Why, when it is so clear that Medicare, a single payer system, works far better - is more efficient and cheaper and provides good health care - than our hodge-podge of private insurance companies, would anyone want to privatize Medicaid and make what is working into something that doesn't? We don't need this experiment. It's already been tried (is being used nationwide for those of us who have health insurance and are too young or able-bodied to be on Medicare) and it is breaking the back of this country.

That said, the idea of imposing this "experiment" on the oldest, frailest, and most vulnerable citizens of our state is outrageous. On top of that, it is unconscionable to turn the management of long-term care for people with developmental disabilities and other groups on the HCBS waivers over to private insurance companies. What do insurance companies know about long-term care? day programs? sheltered workshops? transportation needs? case managers who manage every aspect of a life, not just the medical side? group homes? church programs? recreational needs? KanCare will turn the total running of thousands of lives over to insurance companies, who, first of all, will not have a clue what they are doing, and secondly, when they finally do catch on, will inevitably put their need for profit over the needs of the people whose lives they control.
In addition, KanCare may run providers out of business. In Kansas, most of the providers working with people with developmental disabilities (the group I am most familiar with) are

small, local (or state-wide) non-proftis. Many of them have been in the business for decades; they are experienced, know their clients needs, provide services efficiently, and operate with a small overhead. If the insurance companies don't pay them in a timely fashion, (which, experience has shown, in other states where Medicaid has been partially privatized, happens with alarming frequency) some will go out of business. At the very least, they will be forced to reallocate their own resources, directing them away from client services and towards administrative tasks. It is impossible that billing three insurance companies for services is going to be easier, cheaper, and more efficient than billing one entity, the State, as under the current system. Hence, at the very least, client care is going to worsen under KanCare.

It is clear that KanCare puts the interests of the clients as the lowest priorities. KanCare will cause confusion and instability in the lives of the very people who are least able to handle those conditions - the poor, the aged, the disabled. These are the people who of the whole population (except for children) are the least able to understand what each insurance company is offering, and figure out which would be the best one for them, making trade-offs between drugs, doctors, group homes and day programs, if needed. These are the people who have trouble making connections with other people, and yet may be uprooted from their group homes and living arrangements, possibly on a yearly basis, as insurance companies change or change the providers they contract with. Under KanCare, clients even may have to change doctors regularly, or perhaps they will find mid-year that their insurance company does not pay for a new but needed medication. Even one change, is one too many, if it isn't essential to the well being of the client. These upcoming changes have nothing to do with client well being, are not essential, and aren't even necessary. They won't happen if KanCare is not implemented.

Leave the system as it is. The HCBS waivers are underfunded, yes, but for those they serve, they do a good job, especially in the DD community. KanCare will make change and chaos a way of life until it is finally jettisoned as unworkable. Please, let's avoid making a mistake that will cause the unraveling of so many lives - of clients first and their families, but also of providers who close or cut back, laying off capable and needed workers.

Allison K. Lemons
6713 E 10th St.
Wichita, KS 67206

Received June 20, 2012

Please do not implement Kancare for non-medical services, specifically day and residential services for individuals with developmental disabilities. The current system works well for our folks and at an administration cost that is much less than for-profit insurance companies can administer. Thank you.

Karen Lowder
1734 Ohio #24
Lawrence, KS 66044
kklowder@yahoo.com

Received June 20, 2012

FROM: Community Living Opportunities, Inc.

RE: Public Comment on KanCare

Community Living Opportunities, Inc. (CLO) is a non-profit organization that has provided supports to persons with developmental disabilities for 35 years. We currently serve over 400 persons in northeast, southeast, and south central Kansas.

CLO has participated in many discussion that the Administration and advocacy groups have provided about the implementation of KanCare. Although we do have concerns about the implementation of KanCare, CLO believes that there are flaws within the current system, including lack of coordination of physical, behavioral health, and personal care attendant services. As indicated by the Administration, there are current silos within the system which prevent persons with developmental disabilities from being able to access the services which will help them to be successful living and working within their own communities. This is a product of the way in which the system was designed.

Although we do have concerns about enrollment of physicians, clinics and other health services, we have had at least one Managed Care bidder request a list of all health care providers which the persons we support utilize. And, although we have concerns about billing, approval and payment timelines, we understand that the Administration has placed requirements and penalties within the MCO requirements which will hopefully mitigate any issues. And, again, one MCO bidder has indicated that their electronic payment system will be able to handle claims and pay within current timeframes.

CLO has already begun working with one Federally Qualified Safety Net Clinic in Wichita to arrange for health care services for persons we plan to support within that area. During discussions with the clinic administrator, we learned that the clinic is willing to assign a physician to the persons we serve, have that person trained about the individuals, what their difficulties are with doctor's appointments, what positive reinforcement may work, and trained on each individual's Person Centered Support Plan. The clinic is also willing to allow the persons we serve to come and visit on days when they don't have appointments, so that they can become desensitized to the environment, and not relate the clinic to a negative outcome. This is the kind of service that will reduce the likelihood of the need for persons to be sedated for minor check-ups and procedures, and which will increase the likelihood that persons will attend their preventative exams, and cooperate, on a more regular basis. If KanCare can promote relationships between health care professionals and professionals who work with persons with developmental disabilities, for the purpose of education, we believe very positive outcomes can be achieved.

In addition, CLO has received five intake calls within the past nine months regarding children under the age of 18 who have been screened in as eligible to go to Parsons State Hospital. As we have visited with families, we have found that they aren't aware of all of the options that may help to keep their child placed successfully within their local community and public school. These include behavioral services, co-parenting with a professionally trained couple, and health care supports. We believe there are two primary reasons that these supports have not been readily offered. One, is that they haven't been available, or even known by each of the CDDOs

within the State. The second is that CDDOs don't always have the flexibility with the current waiver to create creative options for families to be well supported in keeping their children at home. If MCO Organizations are better able to direct their enrolled providers to support other areas of the state either directly, or through creating new services, this may help keep more children and adults from being referred to institutional care. And, if MCO providers have more flexibility in purchasing, they can be more creative in the supports they approve.

CLO believes that the pilot program being initiated by the Administration is a very responsible way of working out any issues regarding how KanCare will work for persons with developmental disabilities, how the payment system will work, how the CDDO system will work in conjunction with MCOs, how case management will continue in cooperation with the MCO case coordination system, and how health homes are established for persons who need them.

We appreciate the opportunity to provide comment. If you have any questions, please contact Stephanie Wilson at (785)218-9391.

Received June 19, 2012

Attached is our Association's formal comments on the 1115 Waiver submission tied to KanCare.

(*the Association's comments are attached in an individual PDF document at the end of this document)*

Thank you.

Michael J. Hammond
Executive Director
Association of CMHCs of Kansas, Inc.
534 S. Kansas, Suite 330
Topeka, KS 66603

Received June 18, 2012

(not signed)

(the comments are attached in an individual PDF document at the end of this document)

Received June 18, 2012

(the comments are attached in an individual PDF document at the end of this document)

Pat and Larry McLain
109 West 20th
Hutchinson, KS 67502

Received June 16, 2012

Please be aware of what you are doing before you change the laws. Trying to read 52 pages of changes that talks about nothing? My son is a human being who tells me all the time. Mom I wish so bad that I could walk, Or being a single mom he says Mom I know you take care of me better than anyone else and I appreciate it so much. Or Mom thank you for a fun day. It can be as little as going to the grocery store but he,s doing something and around others. If changes are to what you have for insurance than I am for it. You see my son is almost 40 years old and I am not able to carry him on. My insurance due to he is not in college and over the age limit to insure him. Without Medicaid as it is now, my son would not be able to attend a workshop, he would have to sit at home all day and every day by himself as I would not e able afford a sitter. Being in a wheelchair and bored he might try to leave the house. Keep in mind, he can,t drive, doesn,t know directions,doesn,t know how to call for help to dial the phone,so that pretty much. Leaves me home with no job or income.
There are of course exceptions but most families with disabilities are cared for by 1 family member.Divorces are high as it is hard to cope with the every day worries and concerns. I am aware this is a rough time for everyone, however it seems the rich keep building these huge homes, etc but we probably pay more taxes than they do. The middle class has become the lower class. In. My case my bills are unmanageable and in process of loosing my house. Mostly the bills are fro maintains what little equipment I have been able to purchase, A lift (that is not in use needs repairs), a van with lift that Hans cost several thousands in maintenance for the lift, a house that is hard to move around in as it,s hard to find a house that is wheelchair accessible. Ranches are hard to find and costly.

This is my story, we each have our own with more to add. Please find the love in your heart when you make changes. To our life's as as you see it will change our life's forever.

God bless you all,
Mary Greer

Received June 16, 2012

I am the guardian for my sister who has Down Syndrome, a life long genetic condition. I am concerned about the whole KanCare plan. I don't understand why we have to add another level of administration to our existing system. Insurance companies are in the business to make money and they are going to make money out of funds that needs to be paid to providers (doctors, hospitals, etc) that are providing the services. This is one more layer of bureaucracy and paperwork that will only complicate the lives of people who are the most vulnerable. It is already a maze for families so why make it more difficult? My experience with my sister's case manager has been more than satisfactory. Because she knows her personally, she gets the kind of care and referrals based upon her needs and not upon some set of rules that are arbitrary and not reflective of individual needs.

I have asked of clarification of how the process will work and have gone to "town hall" meetings with local legislators and they obviously have not been given enough information to make informed decisions. I have watched the on line video from the Lt. Gov. and, again, the specifics were lacking but somehow adding the layer of insurance companies is supposed to maintain their

current level of services and yet decrease the cost of services to the state. There a lot of logic lacking here.

I guess to summarize my feedback would be is simply say, don't mess with a system that is working well for the disabled and add another layer of barriers to families and those persons with life long disabilities.

Thank you for considering my feedback,

Deborah Potter
1150 S. 220th
Pittsburg, Kansas 66762

Received June 12, 2012

Please impliment the 1115 KanCare waiver as Kancar will only add cost to the services for the disabled

(not signed)

Received June 9, 2012

As a public servant and as a citizen, I would like to provide the following comments:

I have stated earlier in several public forums that in order for the State of Kansas to ensure we maintain our capabilities to the population we serve with Medicaid funds and associated services under KanCare, we must be very diligent about the measures of success we use to determine both the effectiveness and efficiency of the new management program.

It is obvious that we cannot continue the current trends of health and Medicaid cost growth. But it is equally important, if not more important, that we do not cut necessary quality of life and life-sustaining support to those who are eligible for those services, particularly those most vulnerable.

Accepting these premises, we must have a solid way of measuring our effectiveness and our efficiency at the levels that most count. I have stated on record that one important way to measure that we are not curtailing services, not eroding quality of services, and not cutting eligible population served is to use credible, industry-accepted standards and metrics at the two most critical levels of assessment that can ensure we maintain effectiveness. Those levels of assessment are:

- User level
- Provider level

Of course, key to the process of measuring effectiveness of our programs is how we gather and analyze such metrics. We don't want to create more administrative or staff burden or add

significant cost to the process, so these success metrics should be current industry-accepted measures as well as local, state, and federal standard metrics which can be reasonably collected and objectively analyzed. These measures should then be provided to decision-makers and overseers in a format that facilitates validation of effectiveness and efficiency or provides the information for decision-making to correct or modify processes.

If we rely, predominately, on utilizing success metrics at the MCO or state level of evaluation and assessment, we run a great risk of not being able to respond in time to correct deficiencies or areas of failure where modifications to the programs may have occurred before our users of these services are seriously impacted. Our frail elderly and severely handicapped rely enormously on the effective and consistent delivery of services.

In summary, we must measure effectiveness of our programs where it most counts and is most reliable to preserve the quality of service to those we care for – the users. Secondly, we must ensure the deliverer/provider of those services meets the qualifications, ethical standards, and other requirements as prescribed by law and industry standard to adequately deliver those services to our users. In so doing, we have a built-in quality assurance methodology to ensure effective delivery of services to those who are eligible and in need. I welcome comments and questions.

Respectfully submitted,

Allen C. Schmidt
Senator, 36th District

Received May 24, 2012

To: State of Kansas Section 1115 Waiver for "KanCare"

From: Dennis Cooley, MD, FAAP, KAAP president

Subject: Public Comments submitted for the Kansas KanCare Waiver

The Kansas Chapter, American Academy of Pediatrics (KAAP) would like to bring forth the following observations and concerns with the Kansas KanCare program:

- KAAP supports Kansas Action for Children on the concerns of this waiver; including Auto-Assignment and the shorter time from 90 days to 45 days for consumer choice, Off-Ramp Proposal that details a one-time payment and if that amount is adequate, and making sure there is a detailed plan in place to transition from the current HealthWave to KanCare.

- KAAP feels any Advisory Board needs to have adequate pediatric representation.

Thank you.

Christie A. Steege
KAAP/KPF Executive Director

Received April 29, 2012

I believe that the ENTIRE DD long term services should be carved out - not put on hold - from KanCare.

I don't see how taking a current managed care system that is working not for profit and turning it over to a managed care FOR PROFIT is going to improve things. I can't wrap my brain around it. The Governor is trying to sell us the Emperor's New Clothes.

I understand that case management is not being put on hold - but will implemented along with the rest of KanCare. That would mean taking people who have known and advocated for individuals with DD away from them, or putting those people in a position of: you work for the insurance company now - you can't advocate for things that will cost more money if you want to keep your job. No matter what happens, folks with DD will lose.

I believe that the system that has been proposed to include long term DD services will damage or cost lives of individuals with DD. If my son is one of them - everyone will know what a disaster the Governor has created.

There have been several instances where someone in authority - but not part of the decision making process - has come in and made decisions about David's programming that has severely hurt him emotionally, physically, and once almost cost him his life. I would love the opportunity to talk about this. I believe that what David has gone through in his life is a clear cut example of what is going to happen to a lesser extent across the state to individuals with DD if the insurance companies take over.

Cindy Connellan

Questions and/or Comments can be written below and submitted today, or they can be submitted electronically via email to KanCare@kdheks.gov. If you would prefer to mail your comments in you can do so to the following addresses:

Rita Haverkamp, KDHE-DHCF
900 SW Jackson Room 900
Topeka, KS 66612

-OR-

Lt. Governor Jeff Colyer
300 SW 10th Ave. Room 252-S
Topeka, KS 66612

Will the responsibility of the waiting lists for PD & I/DD remain with the State of Kansas or be included as a component of the MCOs' role?

A portion of savings projected would be reasonable and should be considered for addressing the length of waiting time for these waivers.

109 West 20th
Hutchinson, KS 67502
June 18, 2012

Chairperson, KS Department of Health and Environment
Medicaid Section 1115
900 W. Jackson, Room 900
Topeka, KS 66612

~~Ms Chairman~~, HAVERKAMP ·

Following are some of the concerns we presented at the KanCare 1115 Waiver Public Forum in Wichita on June 18. These are items that we think should be addressed before full implementation of the KanCare program in January, 2014. We are one hundred percent for finding and eliminating fraud in Medicaid. We think, along with many others, that handing the administrative responsibility of caring for our most vulnerable citizens to an insurance company is a step in the wrong direction.

Item 1 The governmental obligation to care for society's most vulnerable will be handed to For-Profit Insurance Companies. Their main motivation will be to make money, both for their share holder and their exorbitantly overpaid executives.

Item 2 This KanCare plan was mandated from behind closed doors with no input from Community Service Providers or individuals/ families affected by the changes. This seems dictatorial plus rather myopic on the part of the State. The people most familiar with difficulties in the current system are the ones now 'in the trenches'. New administration from the outside may spoil some longstanding relationships between care givers and care recipients.

Item 3 Once our son is in the system will he be ranked in descending order of profit potential for the insurance company? Will it be easy for them to select someone 'higher functioning' for cataract surgery, thyroid problems, etc. and save money for the insurance company by passing up our son?

Item 4 Will his current service provider/case worker, who knows him personally--his strengths and his needs, be replaced by Insurance Company lawyers? Will they be seeing dollar signs as they limit their assistance? We are sure there will be more hassles and delays of treatment for each step along the way.

Item 5 Over 2 million dollars has been budgeted for a new computer system for the state, nothing for agencies. We can only expect a SNAFU similar to the recent Drivers Licensing mess

that will delay payments to providers. The Community Service Providers have been 'doing with less' for years and many will not have the resources to adapt new software for this. The doctors, pharmacists, dentists, etc. will also have to change software and methods of billing. Each of these elements will contribute to a slowdown of payment to the providers, much to the insurance company's benefit. The State of Kentucky has had huge problems with payment delays of up to ninety days, after only six months of their new Managed Care operation.

Item 6 The insurance companies can earn approximately $2000 per day at 1% interest by sitting on the $70 million per day that will pass through their hands. This diminishes their incentive to sniff out fraud. Why should they work hard at investigation when accumulated interest on the $70 million, arriving each day, can generate so much cash? Next easiest source of income would be to withhold service to the most vulnerable citizens.

Item 7 Lastly, we believe the State Oversight Committee may be powerless in its role. It could be like trying to corral a mustang horse with a fly swatter. A slight uptick in the interest rates would make fines by the Committee meaningless, only a hand slap to the insurance companies. In Kentucky, which implemented a similar program in November, 2011, one of the providers requested to drop its contract with a chain of 8 hospitals BECAUSE THEY WERE LOSING MONEY with these hospitals. The hospitals in turn had to sue the insurance companies to force payment of bills due.

We still firmly believe the folks on DD waivers should be omitted from KanCare. Long-Term Care is not at all compatible with Managed Care. It will be very difficult for insurance companies to profit from Long-Term Care. The exact operation of these companies, expected performance, and their checks and balances need further development before implementation.

Thank you for your consideration and action on these items.

Sincerely,

Pat McLain

Larry McLain

Pat and Larry McLain

TECH

Hutchinson

Association of Community Mental Health Centers of Kansas, Inc.

534 S. Kansas, Suite 330, Topeka, KS 66603
Telephone (785) 234-4773 Fax (785) 234-3189
Web Site: www.acmhck.org

Michael J. Hammond
Executive Director

Comments on State of Kansas Section 1115 Waiver Application for KanCare Implementation

June 18, 2012

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 the 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 also see additional 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 mental health 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. Our concern, however, is that Kansans with mental illness not be lost in this new system that may be difficult for them to navigate with three vendors rather than one as we have today.

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 - $31 million SGF; $52 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 CMHCs 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?

- The determination of medical necessity is where the rubber meets the road in the provision of health care in a managed care environment. It is critical that the MCOs are reasonable in that determination to allow for service provision to occur.

- 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. The MCOs should be 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.

- 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?

- We believe that a portion of the savings realized from KanCare should be reinvested back into the respective systems. For mental health, this is critical due to the disproportionate level of reductions in services which have fallen upon the public mental health system - $52 million All Funds, of which $33 million has come from Medicaid mental health since FY 2010.

- We believe reimbursement under KanCare should include a comprehensive array of best practices and evidence-based practices focused on services to adults with a severe and persistent mental illness (SPMI) and children/adolescents with a serious emotional disturbance (SED). KanCare should also pay for services that fall outside the traditional medical model. Specifically, rehabilitation services are cost effective for individuals with mental illness and a comprehensive array of those rehabilitation services need to continue to be available. For KanCare to succeed, it must ensure that individuals with mental illness have access to these services that allow them to remain in their own homes and communities, find meaningful work, stay active in their communities and have healthy relationships with their families and friends.

- Outcome measures under KanCare include lessening reliance on institutional care. For the behavioral health system, that would include psychiatric inpatient/residential services. For individuals served by the public mental health system, this can be an important component of the continuum of care. Individuals who are experiencing a behavioral health crisis and need that level of care should have access to it immediately. With our State psychiatric hospitals at or over capacity at an alarming rate, it will be important to focus on deficits in the service array

within the community to improve efforts to divert individuals from higher levels of care. It will also be important for the MCOs to build local acute care inpatient capacity which allows for individuals to access psychiatric inpatient care closest to their home.

- The three vendors need to place significant value on recovery for adults; resiliency for children and adolescents; peer supports; natural supports; and community-based services. If they do that effectively, individuals with mental illness can be serviced effectively and they will see positive outcomes.

- No matter how well you plan for systems transformation, there inevitably will be struggles, challenges and problems along the way. It is anticipated by many that the Centers for Medicare and Medicaid Services (CMS) will conduct a thorough assessment and evaluation of this 1115 Waiver submission. That process could impact the current timeline for implementation. We would urge the State to adjust their implementation timeline as challenges arise to ensure there is adequate time for MCOs to prepare for implementation. Among the important lessons learned from experiences in other States is to allow for adequate time for MCOs to prepare for implementation. In visiting with representatives in the managed care industry, there is agreement that no less than 6 months to prepare for a go-live date is crucial to successful implementation.

- We believe Medicaid beneficiaries should be educated about changes under KanCare, including specific benefits under each plan so that they are able to make an informed choice as to which plan best meets their needs. It is our understanding that outreach by the MCOs will be limited. There needs to be either a statewide approach to educating Medicaid beneficiaries; a regional approach; or an approach that is focused on each particular service system, where information and outreach can occur prior to the go-live date of January 1, 2013, followed by less aggressive information and outreach that occurs on an ongoing basis that is possibly web-based and available for use by all provider systems.

- Ensuring there is adequate and effective oversight in the Executive Branch as well as the Legislative Branch will be critical. Swift response to problems and challenges along the way is going to be crucial to successful implementation. Equally important will be stakeholder involvement and transparency in the oversight process.

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 integrated managed care.

We appreciate the opportunity to provide this input on the State's 1115 Waiver Submission.

Thank you.

Michael J. Hammond
Executive Director

Medicaid Managed Long Term Care Policy Considerations

Administration/Implementation

1. **Implementation timeline** - An implementation timeline for a managed long term care program should be established that allows for extensive policy evaluation, program design and modification of all appropriate regulations (Long Term Care State Plan, etc.).

2. **Any willing provider** –Statutory language should provide for "any willing nursing home provider" as long as the nursing home meets existing quality criteria for Medicaid participation under the current regulatory framework (see separate discussion of quality and performance standards). (Note that there is minimal risk to Plans if nursing home rates are paid at agency calculated rates and are reconciled based upon actual payment amounts.)

3. **Program design** – Statutory language should require multiple MCOs for each area, should allow provider service networks as authorized plans, and should require all qualified plans to meet capitalization requirements to ensure provider payment. Additionally, the State should develop a mechanism to ensure that providers are paid should a MCO not be able to meet its obligations. (Nursing homes in other states experienced significant financial losses recently upon the failure of a Medicare Special Needs Plan.)

4. **Re-balancing of nursing home and home and community-based care** – Incentives should be established with individual health plans as part of the procurement and contracting process (plan rates should take into consideration health plan mix and provide incentives that maximize appropriate safe community placement).

5. **Medical loss ratios** – We would recommend that any potential payback or savings due to not meeting medical care loss ratios should be utilized to improve payments to providers.

Quality/Access

1. **Quality performance measures** – Statutory language should ensure that nursing homes and other long term care providers are not subject to duplicative surveys (and adverse incident reporting) by multiple MCOs. The language should require that MCOs incorporate the agency survey process into their measures (deemed status) and additional quality performance measures may be used only as agreed to by the MCO and nursing home via contract. (Adverse incident reports and certain other documents are confidential and are protected under both Federal and State law from disclosure as part of the nursing home's quality assurance program.)

2. **Eligibility determination** –The eligibility process should not be changed (although improvement in processes is warranted and necessary in a managed care environment); however, outsourcing may be feasible if another independent coordinated entry mechanism is explored (i.e. Aging Resource Centers).

3. **Eligibility criteria (level of care)** –The statutory language should require that a state agency of jurisdiction be given the authority to develop the appropriate levels of care through rule, rather than in statute. This will allow for provider and MCO input into the definitions and verification/validation of the levels via an appropriate assessment tool (preferably one already in existence).

4. **Choice counseling** – Choice counseling should not be MCO-based.

5. **Mandatory assignment** – The language may require that if a beneficiary is enrolled in a Medicare Advantage or Special Needs Plan at the time of Medicaid eligibility determination, they will be automatically assigned to the Medicaid Plan administered by the same company, should one exist. Should the Medicare Advantage or Special Needs Plan not hold a contract as a participating Medicaid Plan, the beneficiary will be given the option of choosing from available Medicaid Plans. Should no choice be made, they will be auto-assigned based on pre-determined enrollment criteria.

6. **Consumer protections/provider appeal process** –Statutory language should establish an independent appeal process for denial of claims and/or coverage.

Rate Setting/Payment Provisions

1. **Medicaid rate pass-through** –Statutory language should require a payment equal to the nursing home facility specific payment rates calculated by the state agency of jurisdiction (floor), but should provide sufficient flexibility to allow negotiated mutually acceptable rates for patients requiring more complex medical care (bariatric, mental health, ventilator, etc.). The language should also require reconciliation of Plan payments to reimburse MCOs actual payments to nursing facilities, but should exclude any rate differential if plans pay higher rates.

2. **Prompt payment** – Prompt payment requirements are important for all providers; however, they are critical for nursing home providers where nearly 60% of their residents are Medicaid beneficiaries and nearly two-thirds of their operating costs are labor-related. Delays in Medicaid payment would have significant impacts in cash flow and a nursing home's ability to meet payroll obligations. As importantly, the current Nursing Home Quality Assessment program is designed such that Medicaid payment to providers and providers' payment of the assessment occur almost simultaneously. Delays in Medicaid payment would have a serious impact on nursing home providers' ability to pay the assessment. It is critical that managed care plans be required to pay nursing home claims promptly within 10 business days following submission with an appropriate statutory interest provision for failure to comply with the requirement**.**

3. **Uniform electronic on-line claims submission, EFT claims payment and weekly claims processing** –Uniform on-line claims submission, EFT claims payment, and weekly claims processing provisions are key elements necessary to ensure prompt payment (statute should require the state agency of jurisdiction to establish these standards as part of the MCO contracting process).

4. **Medicaid payment of Medicare coinsurance (Medicare crossover)** –A process must be established to ensure that Medicare crossover claims are processed properly and that documentation is sufficient to support federal requirements for Medicare bad debt (statute should require AHCA to evaluate and establish a process that ensures payment of Medicare coinsurance/bad debt). (Note that Arizona includes the coinsurance payment as part of the capitated rate and requires MCOs to process the payment; Tennessee Medicaid retains the coinsurance claims payment process and excludes the coinsurance from the capitated payment rate.)

5. **Medicaid pending –**A process must be established to ensure that retroactive payments are made for services provided while determination of Medicaid eligibility is pending and there is not an assigned managed care plan; otherwise, access to services will be limited (statute should require the state agency of jurisdiction to develop such a process).

6. **Nursing Home Quality Assessment Program –** Statutory language should be added which ensures that the funds provided by the Nursing Home Quality Assessment will be utilized in accordance with the statutory requirements that implemented it and may not be used for any other provider.

ORAL HEALTH KANSAS

To: Kari Bruffet, Director of KDHE Division of Health Care Finance

From: Tanya Dorf Brunner, Executive Director of Oral Health Kansas, Inc.

RE: KanCare 1115 Waiver Application Comments

Date: June 20, 2012

KanCare Offers Cautious Opportunities for Dental Services

Dental Provider Network

Arkansas City dentist Nick Rogers told Oral Health Kansas, "The system we have now, at least from a dental perspective, works very good. My past experiences with managed care plans, such as those proposed, do not work well." He went on to say, "It becomes particularly more complex for both recipients and providers when multiple vendors are involved, as I experienced in Missouri when I was working with Head Start. Their managed care program resulted in decreased usage, as it was very complex (by design) for all."

Kansas City area dentist Glenn Hemberger told us, "The three plans should have a streamlined single contact for providers. An updated, respectable fee schedule that reflects time and cost to providers is critical." He also suggested simplified Medicaid application forms to ensure dental program stability.

- There is low participation in the existing Medicaid program by Kansas dentists.
- Requiring dentists to enroll with 3 MCOs could further erode the participation rate.
- Dentists who currently take Medicaid can find it cumbersome to sign three different provider agreements and keep track of three sets of insurance company expectations.
- Requiring dental providers to contract with three MCOs serves as a deterrent to dentists and lowers the likelihood of creating a sufficient provider network.
- Dentists who've been reluctant to become Medicaid providers aren't likely to be enticed by the need to sign three provider agreements.

If not properly addressed, all of these issues could lead to instability in the dental provider network.

Consumer Choice

The Kansas Medicaid program does not offer a dental benefit for adults. At least two MCOs bidding on KanCare considered including dental benefits for adults in their

800 SW Jackson, Suite 1120
Topeka, KS 66612

785.235.6039 (phone)
785.233.5564 (fax)
info@oralhealthkansas.org

www.oralhealthkansas.org

value-added services. This is heartening, but we are concerned about Medicaid beneficiaries potentially not having meaningful access to the same or substantially similar benefits.

- Using an auto-assignment period to place beneficiaries into plans rather than giving them adequate education regarding their choices, including the option of dental benefits, takes a great deal of control out of the hands of consumers.
- Enrollment with the KanCare MCOs will coincide with open enrollment for Medicare. Consumers who are on both Medicaid and Medicare find each program confusing. Understanding how to enroll in the best plan for both programs at roughly the same time will be difficult at best for most consumers.
- 45 days for Medicaid beneficiaries to decide whether to change MCOs is a very short window for a very big decision.
- People on Medicaid move frequently, and it can be hard to keep track of their addresses. Again, the 45 day window makes this even more difficult.
- The original 1115 waiver application mentions a member educational campaign in passing, but no details are shared and no written plan is referenced. Samples of education materials would be a helpful way to understand if the plan will work for consumers.
- Maintaining a 90-day choice period would give consumers a more meaningful opportunity to understand which MCO will offer the best package for their individual needs, including a possible dental benefit in some of the packages.

Public Input

The waiver application lacks sufficient detail to provide meaningful feedback. Correspondingly, meaningful stakeholder feedback opportunities have not been available, and what has been available has been rushed. The waiver application begins with the proclamation that the administration "has determined that no short-term solutions could address the scale of the issue over time." We have no way to understand how this determination was made, but we know stakeholders were not involved in making it.

A Medicaid waiver application must further the objectives of the Medicaid program. In 1965, when President Johnson signed the Medicare/Medicaid bill into law, he said, "...there is another tradition that we share today. It calls upon us never to be indifferent toward despair. It commands us never to turn away from helplessness. It directs us never to ignore or to spurn those who suffer untended in a land that is bursting with abundance."

In keeping with the spirit of the law invoked by President Johnson in 1965, the core objectives of today's Medicaid program include:

- Provide affordable medical insurance for people whose income is insufficient to meet the costs of necessary medical and long-term care services.
- Reduce the access to care problem for uninsured people.

The original Kansas 1115 waiver application does not describe how the objectives of the Medicaid program will be met.

Kansas Chapter
National Association of Social Workers
...advocating for the practice and profession of Social Work...

June 20, 2012

Public Comments on proposed KanCare
1115 waiver application to CMS (Centers for Medicare and Medicaid Services)

The scope of this demonstration project affects at least the 380,000 persons covered by Medicaid as well as the thousands of providers who deliver the services. The lack of details and how the waiver will work in tandem with other elements such as the State Medicaid Plan, state laws and regulations, and the federal health care reform, make it difficult to fully assess the ramifications of the waiver.

Exclusion of certain licensees from providing integrated care

The waiver does focus on integrated, whole person care, combining physical care with behavioral care. This is a positive direction. There is another area of integrated care that is equally important. That is the integrated care of mental health and substance abuse treatment. It has been expressed that the majority of persons who seek care for substance abuse problems also suffer from a mental health condition. Examples include Post Traumatic Stress Disorder (PTSD) or depression or anxiety disorder along with the substance use disorder. Currently, integrated care of persons with this form of dual diagnosis has barriers. This is because, by current state policy, Medicaid will pay for substance abuse treatment performed by persons who are professionally licensed to offer only addictions treatment. This group of licensed professionals (clinical addictions counselors) is prohibited from diagnosing and treating any other mental health disorder. The individual with a dual diagnosis in mental health and substance abuse must go to another provider who can provide the mental health treatment. This is highly inefficient both in terms of expenditures for scarce public dollars, as well as the necessity for one Medicaid beneficiary needing to see two different behavioral health licensed professionals. The solution is that Medicaid must be able to pay licensed professionals, such as social workers, who by their state licensure authority, may diagnose and treat any disorder as designated in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM). Mental health and substance abuse are within this specific licensure authority. But the current policy mandates that these fully licensed professionals obtain a second and redundant license specifically in addictions in order to serve beneficiaries of Medicaid who have substance abuse problems. This is an unnecessary and burdensome mandate that results in the exclusion of providers who would be able to provide integrated mental health and substance abuse treatment.

Managed care model impact on small behavioral health practices

Though a managed care model for mental health services has been in place for several years, the managed care model generally results in a decrease of approved services, increased stress for clients fearing the loss of care, burdensome demands for paperwork, more provider time spent on administrative tasks such as payment disputes and audits, and decreased time available to provide care to clients. These can create a barrier for the small practices in the private sector to participate in the Medicaid provider network, even if they would like to.

Unknown performance measures for behavioral health

While the waiver does not specifically address issues of reimbursement, it does assert that meaningful financial incentives will be tied to outcomes and performance measures. Medicaid pay is typically below market rate already. Behavioral health intervention is complex and does not necessarily show clear progress in short timeframes. There are no indications of what the outcome or performance measures will be and if such outcomes or performance measures will make distinctions to recognize the differences in physical health intervention and behavioral health interventions. In addition, even behavioral health diagnosis that are the same can vary a great deal based on the need of the individual beneficiary. For example, the outcomes of treating an individual who suffers from depression due to childhood sexual abuse will take longer to show positive results as contrasted with another individual who has depression due to a marital conflict that is not rooted in earlier trauma. Both would benefit from psychotherapy, but the measures of performance and necessity of services would not be the same. One size fits all performance measures must be avoided.

Provider network in behavioral health

A provider network is crucial in order to provide timely access to care for the necessary services in both the public service delivery system and the private sector. Private sector behavioral health businesses are often sole proprietors without support staff. The combination of a managed care model, three different managed care organizations (MCO); unknown outcome measures for behavioral health that are tied to already low reimbursement and current provider exclusions in Medicaid policy may result in a less than sufficient behavioral health provider network, especially within the private sector. Not having enough providers results in beneficiaries not receiving the care that they need. Without care, unaddressed problems tend to escalate into severe problems and crisis which require far more intensive and expensive care.

Requests before approval is granted

1. Confirm that the waiver will require Medicaid reimbursement be extended to all behavioral health licensed providers to deliver the services that their licenses permit, without exclusion of some in favor of others and without the requirement that some professionally licensed persons must obtain a second and redundant professional license to deliver substance abuse services.

2. Assure that the tie between outcomes or performance measures and financial incentives are realistic and reflect the nature of behavioral health interventions and the individual needs of the beneficiary.

3. Assure that the managed care model does not create burdensome administrative requirements that would deter private sector clinicians from choosing to be a Medicaid provider.

For more information contact:
Sky Westerlund, LMSW, Executive Director, sky@knasw.com or 785.354.4804
Terry Humphrey, Lobbyist, terry@terryhumphrey.com 785.221.8215

LeadingAge™ Kansas
formerly KAHSA

To: Lt. Governor Colyer, Secretary Shawn Sullivan and Secretary Robert Moser
From: Debra Zehr, President/CEO, LeadingAge Kansas
Date: June 20, 2012

KanCare Public Forum Comments

Thank you for this opportunity to provide comments on KanCare.

LeadingAge Kansas is the statewide association representing not-for-profit aging services and long term care providers.

A stated goal of KanCare is to decrease utilization of high cost care settings, such as nursing homes, in cases where individuals can be successfully served with less comprehensive, lower cost services. Many of our members are already providing a range of services, and others are actively planning to do so.

I would like to publicly thank Secretary Sullivan and his team for their willingness to engage in discussion with us about KanCare over the past year. They have presented at our conferences and met with our board and staff several times. We have had opportunity to ask questions and raise concerns.

For years we have known that the trajectory of growth in Medicaid is unsustainable. The KanCare Request for Proposal has many elements and specifications that attempt to address this and to operationalize principles that we support: quality outcomes, consumer choice and increased care coordination across health care settings. In addition, KanCare, unlike most other states with Medicaid managed care, has built-in long term care-specific performance measures to which managed care contractors are to be held accountable. Also, we appreciate the fact that the state maintains control over basic rate-setting for long term care services.

Having said this, there is still a fair amount of insecurity and anxiety in our membership about what the process and outcome of KanCare will truly be. There are remaining concerns about beneficiary choice, billing and claims filing, pre-authorization, contracts, and other issues. We stand ready to work with Secretary Sullivan to address concerns and inevitable glitches, and to provide honest, principle-based input and feedback as KanCare is deployed.

I would be happy to answer questions.

217 SE 8th Avenue | Topeka, KS 66603-3906
P 785.233.7443 | F 785.233.9471 | LeadingAgeKansas.org

KANSAS ACTION FOR CHILDREN

Medicaid and CHIP, collectively known as HealthWave in Kansas, provide health insurance for 230,000 Kansas children; approximately one out of every three children in Kansas receives his or her health insurance through HealthWave. Therefore, substantial changes proposed for Medicaid in Kansas will have a significant impact on children. Kansas Action for Children has carefully reviewed all of the public material provided regarding the state's KanCare proposal and waiver application, and we have the following concerns:

Auto-assignment of Beneficiaries Limits Choice and Proposed Alternatives to Traditional Medicaid Are Not Adequate

The waiver submitted to the Centers for Medicare and Medicaid Services on April 26, 2012, states on page six that "All beneficiaries will receive an initial plan assignment and enrollment information in the fall, during the open enrollment period. They will have 45 days from the enrollment effective date to change to a plan of their choice, for any reason." Kansas Action for Children is concerned about the effect of auto-enrollment on consumer choice for Medicaid beneficiaries in Kansas.

Kansas Action for Children believes that beneficiaries should be able to choose their MCO providers upon enrollment, rather than be auto-assigned by the state. Currently, HealthWave beneficiaries self-select MCOs upon enrollment and there has been no need demonstrated by the state to change this method of operation.

Additionally, the waiver proposes allowing only 45 days, rather than the federal standard of 90 days, for beneficiaries to switch MCOs after their auto-assignment. Kansas Action for Children believes that families should have a minimum of 90 days to switch MCOs. This is especially important given that KanCare would possibly have three new MCOs, none of which is currently a HealthWave MCO, and families would not be familiar with any differences between the three benefit packages and provider networks.

As outlined on pages 13-14 of the Kansas waiver application, the state seeks to develop a pilot program to transition beneficiaries off of Medicaid. As outlined in the waiver application, a pilot project would be established that would provide Medicaid beneficiaries with a funded health account "for the purpose of purchasing health services or paying health insurance premiums for members with Medicaid eligibility for at least three years, including those eligible under transitional Medicaid, who would not reapply for traditional Medicaid for the next three years."

Although the waiver application does not specify a dollar amount for the funded health account, budget documents produced by the governor's budget office for the 2012 legislative session state an amount of $2,000 for accounts related to non-traditional Medicaid. Rather than serving as an "off-ramp," this proposal would represent a detour away from the benefit and cost-sharing protections to which children and families are entitled under Medicaid. It would lead them instead into private coverage, where costs are unpredictable and coverage often inadequate for those with low income, many health needs or both.

Kansas Action for Children does not believe this program will serve the purpose of Medicaid, nor will it successfully meet the health needs of Medicaid-eligible children and families. High-deductible health plans simply do not provide the access to care and the protections against unaffordable costs that

Medicaid-eligible children and families often require. Low-income populations are negatively and disproportionately impacted by the higher cost sharing that is characteristic of high-deductible plans. Evidence shows that cost-sharing causes low-income people to delay or reduce their use of needed care. Furthermore, given the complexity of HSAs and the health literacy needed to effectively use HSAs, Kansas Action for Children is concerned that parents of low-income children would not fully understand the potential consequences of forfeiting Medicaid coverage. For children in particular, this would eliminate the guarantee of EPSDT coverage, a central tenant of Medicaid's coverage for children. Additionally, Kansas Action for Children believes it is highly unlikely that $2,000 would be sufficient to cover premiums, deductibles and other cost-sharing for three years. Just one broken arm or tonsil-removing surgery would cause out-of-pocket costs to exceed this amount.

Transition of HealthWave to KanCare and Retention of Children

The concept paper and other public documents describing the KanCare proposal do not address how the HealthWave population will be transitioned to KanCare. Kansas Action for Children has two specific concerns about this transition: The loss of the HealthWave brand and the education of current HealthWave beneficiaries regarding the potential change.

The HealthWave name was created in Kansas when our CHIP program was established in the late 1990s. Families, providers and many social service providers are familiar with the name and recognize that it is a low-cost or no-cost health insurance options for many Kansas children. Kansas Action for Children believes the loss of the HealthWave brand could lead to children losing coverage or experiencing discontinuities in care because families will not have been adequately educated about the changes. To mitigate the loss of the HealthWave brand, Kansas Action for Children has recommended that KanCare be co-branded with HealthWave for one year. Co-branding will help alleviate the transition problems when children re-enroll at their annual renewal time.

HealthWave is currently operated as an MCO program, and little attention has been paid by the state regarding this population versus other populations currently operating in fee-for-service. However, Kansas Action for Children strongly believes that just as much scrutiny should be placed on the transition of children on HealthWave to KanCare as is placed on the transition of the disabled and elderly populations to KanCare. The lack of details in the waiver application concerning a transition plan for current HealthWave beneficiaries to move to KanCare is highly concerning, and Kansas Action for Children urges CMS to negotiate a detailed and comprehensive transition as part of the Kansas waiver negotiations.

Kansas Action for Children is concerned that many of the 230,000 children currently insured through the state's Medicaid and CHIP program, HealthWave, will experience a disruption of coverage with a transition from HealthWave to KanCare. As such, Kansas Action for Children believes that in addition to a transition plan, an important outcome measure Kansas should report to CMS is the retention rate of beneficiaries from HealthWave to KanCare. Reporting the number of children successfully transitioned from enrollment in HealthWave to enrollment in KanCare will ensure that ample consideration is given to the transitional needs of these beneficiaries.

Budget Neutrality Information Is Not Sufficient

Kansas Action for Children has two concerns regarding the budget neutrality part of Kansas' waiver application. One, there is not sufficient information for a reader of the waiver application to fully understand the budget projections and calculations. Second, the application, as best as can be

understood by Kansas Action for Children, seems overly aggressive in the cost savings that will be found for children insured through Medicaid and CHIP and for pregnant women and deliveries.

Kansas Action for Children urges the state to make public any additional documents the state provides to CMS regarding the cost calculations and budget neutrality section of the waiver. Currently, the waiver does not contain sufficient information to clearly understand and evaluate whether all assumptions are fair and does not allow for a comprehensive understanding of the cost components of KanCare. Because the state of Kansas is already including projected savings under KanCare into the budget for fiscal year 2013 and beyond, Kansas Action for Children believes it is critical that advocates and policymakers are able to have sufficient information to determine whether the projected savings will materialize.

The second concern of Kansas Action for Children's regarding the budget neutrality information relates directly to the cost savings projected for children insured through CHIP and Medicaid. According to the waiver application, it appears that the state of Kansas is assuming a lower cost for children who are currently insured through CHIP and Medicaid. Given that Kansas children enrolled in Medicaid and CHIP have been in managed care for over a decade, there is insufficient information provided to understand how the projected cost savings will be achieved.

For the CHIP MEG group, the state appears to be assuming a drop in the cost growth rate from 3.5 percent per year to 2.36 percent. The waiver does not provide specific information regarding how this cost savings will be realized, and Kansas Action for Children has reservations about whether these projected savings are realistic. Kansas Action for Children believes that in-depth information about how the cost savings will be achieved needs to be provided. In addition to the projected savings for the CHIP population, Kansas Action for Children has the same concerns regarding proposed cost savings for children and pregnant women insured by Medicaid. These two populations are included in MEG group 12. As Kansas Action for Children understands the waiver application, the state is planning for a reduction in cost growth rate for these populations from 2.5 percent to 1.73 percent. Like the CHIP population, children and pregnant women insured through Medicaid are currently in managed care. The amount of information provided in the Kansas waiver does not clearly articulate how this level of savings will be realized by switching from one managed care system to another.

Lastly, Kansas Action for Children is concerned about the stated cost savings for deliveries in MEG group 2 (deliveries). Based on the numbers provided in the waiver application, the state is assuming a savings of 9 percent to 10 percent for deliveries paid for my Medicaid. Importantly, MEG group 12 also includes deliveries, making it difficult to track exactly what total cost savings for delivery the state is calculating.

In Kansas, Medicaid is the payer for approximately 40 percent of all births, demonstrating that the strength of Medicaid is important to the health and well-being of the youngest infants in Kansas. As with the child Medicaid and CHIP populations, deliveries by pregnant women in Kansas insured through Medicaid are currently in managed care, making the case for 9 percent to 10 percent in cost savings from the current program appear overly aggressive.

Kansas Action for Children appreciates the opportunity to submit comments and is available to discuss any aspect of the comments in greater depth. Please do not hesitate to contact us at 785-232-0550.

KANSAS HEALTH CONSUMER COALITION

Kansas Health Consumer Coalition

534 South Kansas Avenue, Suite 1220
Topeka, KS 66603

Office: 785.232.9997
Fax: 785.232.9998
E-mail: info@kshealthconsumer.com
www.kshealthconsumer.com

July 11, 2012

The Honorable Jeff Colyer, M.D.
Lt. Governor of Kansas
State Capitol, 2nd Floor
300 SW 10th Ave.
Topeka, KS 66612

Dear Dr. Colyer,

Thank you for this opportunity to provide comments on KanCare.

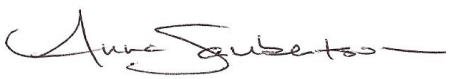
In June, we submitted the enclosed comments to the Centers for Medicare and Medicaid Services (CMS) on the original Section 1115 waiver application submitted by the State of Kansas on April 26, 2012. I hope that you will take these comments into consideration as you prepare the state's final waiver application.

We developed these comments in partnership with diverse advocacy organizations representing vulnerable Kansans, including Kansans with disabilities, children, seniors, and Kansans with mental illness.

Organizations that contributed to the drafting of this document include, but are not limited to:

Association of Community Mental Health Centers of Kansas, Inc.
Kansas Action for Children
Kansas Advocates for Better Care
Kansas Area Agencies on Aging Association
Kansas Chapter, National Association of Social Workers
Kansas Health Consumer Coalition
Kansas Mental Health Coalition
Health Reform Resource Project
National Alliance on Mental Illness-Kansas
Oral Health Kansas
Statewide Independent Living Council of Kansas

Sincerely,



Anna Lambertson
Executive Director
Kansas Health Consumer Coalition

KanCare has the stated goals of improving health outcomes for beneficiaries while also bending the cost curve of Medicaid over time. The goals of KanCare are laudable, but with more than 380,000 Kansans on Medicaid, a lot is at stake and Kansas needs to get it right.

Input and participation from stakeholders and advocates are crucial to ensure that the KanCare proposal works for Medicaid beneficiaries in Kansas. Yet to date we have not been privy to the details we need to fully evaluate the KanCare proposal and its impact on beneficiaries in our state. The enrollment data and projections in Kansas' application, as well as the related budget neutrality analysis, appear to be unsubstantiated and the State has not provided information regarding its plan to evaluate KanCare over time. In addition, we have not had the opportunity to fully engage in a meaningful way with the Governor's administration to provide substantive feedback on the proposal.

As a result, we are not convinced that KanCare, as it is laid out in Kansas' 1115 waiver application, will achieve its stated goals. We also feel that there has been insufficient preparation by the State from the outset to adequately educate Medicaid beneficiaries about the changes proposed under KanCare, or to achieve the objectives of KanCare without reducing services or benefits.

No other state has requested the level of latitude described in Kansas' proposal. We question whether KanCare is the type of "demonstration project" intended by CMS under the 1115 waiver process.

Kansas' 1115 waiver application lacks sufficient information regarding the state's plans for effective consumer education and for conserving consumer choice.

Auto-Assignment

The KanCare proposal shortens the time frame during which Medicaid beneficiaries will be able to select a MCO. Under KanCare, Medicaid beneficiaries will first be automatically enrolled in one of three MCOs, and will have only 45 days (rather than the full 90 days) to select a different plan if they prefer. We feel this shortened time frame prioritizes the interests of the MCOs over those of the affected consumers. In addition, as Kansas' waiver application lacks detail for any plan to fully educate Medicaid beneficiaries about their options, we are concerned that shortening the time frame to 45 days will significantly decrease their ability to make an informed choice.

Kansans who rely on Medicaid for their health care coverage have diverse needs and any plan to inform them about their options must take those different needs into consideration. The lack of detail in Kansas' waiver application for an effective education plan concerns us because a one-size-fits-all method will be insufficient to meet the diverse needs of beneficiaries in our state. We are also concerned that auto assignment could lead to disruptions in services for consumers if they are automatically enrolled in plans that do not contract with their existing care providers.

HealthWave Transition

KanCare does not include a plan for transitioning families currently enrolled in HealthWave, the state's children's health insurance program, to the new KanCare system. While this population is already part of a managed care system, they will still experience a significant transition to KanCare. Advocates and state agencies have spent years educating communities and families about HealthWave and trying to reduce stigma in order to encourage potentially eligible families to enroll in the program. Eliminating the well-established HealthWave brand without comprehensive, detailed transition and education plans will result in disruptions for these families.

Cost Sharing

KanCare seeks to increase personal responsibility among Medicaid beneficiaries by increasing their share of

the cost of coverage. However, cost sharing can quickly become a barrier to receiving necessary health services, and is inappropriate for low-income Kansans with chronic conditions, such as a mental illness who should not be discouraged from maintaining their prescribed treatment regimens. Medicaid serves extremely vulnerable populations near or below the poverty level. Asking them to use more of their limited resources for medical care will not improve personal responsibility. Instead it will dis-incentivize seeking necessary care and increase usage of the emergency room, and could worsen health outcomes overall.

Medicaid off-ramps under KanCare concern us considerably, particularly if these off-ramps become a condition of eligibility for Medicaid in the future.

Stakeholders and advocates have not had meaningful ways to provide substantive feedback on the KanCare proposal, and Kansas' Section 1115 waiver application lacks sufficient information to allow for a full analysis of its impact on Medicaid beneficiaries in our state.

Public forums

The general public has not had the opportunity to weigh in on KanCare or the assumptions behind this proposal. The Governor's administration has not held a single public forum or town hall meeting on KanCare and the public hasn't been provided an effective method to weigh in on the specific provisions of either the KanCare RFP, or Kansas' 1115 waiver application. The Governor's administration has touted an open door policy, but for ordinary Kansans who are unable to make the trip to Topeka to sit down with representatives of the Governor's office, this is of little consolation.

The Governor's administration held public forms prior to unveiling KanCare, but they did not seek input from stakeholders on a concrete managed care model. The administration also did not publish or make available an aggregate report of comments or feedback gathered during those meetings, and no effort was made to catalogue or organize it in a way to make it searchable or useful for the public or stakeholders. Encouraging public input is only helpful if that input is clearly used to help shape the eventual policy, and it is made clear as to how the public input was utilized.

The Governor's administration established a KanCare advisory council which to date has met twice. However, it has not been made clear how the ideas and concerns generated by the council will be incorporated into the implementation or evaluation of KanCare. We are also concerned that it does not appear that the Governor's administration will publicize future meetings. The changes proposed under KanCare are significant and public scrutiny and oversight will be crucial to ensure transparency and accountability. The Kansas Legislature failed to create a dedicated KanCare oversight committee this legislative session, leaving the Governor's advisory council as the only current avenue for public oversight of the program.

Budget Information/Cost Savings

Kansas' 1115 waiver application fails to demonstrate how KanCare will achieve the projected cost savings of more than $850 million, nor how it will be budget neutral.

The application does not include any information on how cost trends were calculated, either for the "without-waiver" or "with-waiver" projections. Similarly, assumptions about growth in each of the Medicaid populations are also not explained. For example, the "without-waiver" table on page 49 uses two trend rates for each population without describing the sources for these rates or the differences between them. The "with-waiver" table on page 50 uses different trend rates that are lower for each population, presumably reflecting lower growth due to the enrollment of beneficiaries in managed care. Other than a blanket statement that MCOs will better coordinate care, the reasons for reduced growth trends are not detailed, nor are sources provided for the figures used. Moreover, several of the populations for which savings are projected, such as CHIP, are already enrolled in managed care programs. It is not clear why further savings are projected for these beneficiaries or

how these savings will be achieved. In addition, the "rate methodology adjustment" used in this table is not explained.

Even if the growth projections were demonstrable, the waiver application remains silent on how cost savings through a change in the number of Medicaid services performed will be achieved. It is important to remember that the kind of services available and provider reimbursement rates cannot be reduced by the managed care companies that are currently competing for the contracts to service the Medicaid population in the waiver environment. That is spelled out in the request for proposals issued by the administration for those managed care companies and reiterated in public statements by the administration. Without reductions in services or reimbursement rates, savings must come from a reduction in the number of services performed. However, nowhere is it spelled out which services, where, or by how much, or the impact of these service reductions on Medicaid beneficiaries.

According to the third page of the waiver application, "Kansas Medicaid costs have grown at an annual rate of 7.4 percent over the last decade." The source of these data is not cited and it is not clear that this figure is accurate. According to statehealthfacts.org, a Kaiser Family Foundation website that uses CMS data, annual growth in Medicaid spending in Kansas from 2001-2010 ranged from 1.8 percent to 6.0 percent (http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=4&rgn=18&ind=181&sub=47). This discrepancy in growth rates raises questions as to the methods the state used in determining the financial impact of the waiver and underscores the lack of documentation in the application. It also raises questions about the data and information that have been provided to the public throughout the process.

The savings projected by the Governor's administration raise significant concerns among advocates. With the one year carve-out of services for Kansans with developmental disabilities, the projected savings are even more questionable. They do not appear to have been adjusted to reflect that temporary carve-out. In addition, the state may already be in violation of the Olmstead rules regarding access to services for people with disabilities. These potential violations stem from the state's lack of progress in eliminating long waiting lists for services. If these projected cuts in spending indicate a reduction in services, then it is difficult to imagine how this could do anything other than exacerbate the existing problem of delayed services for consumers.

Timeline

We are concerned with the ambitious timeline of KanCare, which seems to be driven by cost savings rather than by the needs of Medicaid beneficiaries and the objectives of the Medicaid program. The earliest CMS could render a decision on Kansas' waiver application is late June, which would leave only 6 months for this massive overhaul to be fully implemented. If the waiver negotiations should last longer, the implementation timeline could narrow even further. We are concerned that the 6 months time frame does not allow adequate time for all of the necessary parts of implementation to be put in place, or for a transparent process with meaningful stakeholder input to be achieved.

- Adequate provider networks must be established

The waiver application indicates that each MCO will establish adequate provider networks, however it offers no insight into how these networks will be assured. Kansas' waiver application also does not assure that both medical and behavioral health providers will be adequately represented under each plan. Given that much of our state is rural, and only a few providers serve vast areas, network adequacy is already a challenge. If a plan for network adequacy exists, that plan should be made available for timely review by the public to ensure it will meet the diverse needs of Medicaid beneficiaries across the state.

- Consumers must be educated about changes under KanCare

Kansas' waiver application lacks detail for a comprehensive public education plan, and the current state budget does not include sufficient funds for public education about KanCare.

The few details in Kansas' waiver application for how the public will be educated about KanCare are problematic. Town hall meetings for beneficiaries, for example, could potentially violate HIPAA. Additionally, for beneficiaries with mobility issues, attending public meetings can be difficult or even impossible, and no provision has been made to offer transportation. Currently there are plans to send a letter in November to Medicaid beneficiaries announcing the changes under KanCare. However, there is not a plan in place for dealing with questions and concerns that this mailing will inevitably raise among beneficiaries and their families.

We are concerned that the responsibility for educating consumers could be left to community and advocacy organizations which lack the resources to carry out the amount of intensive education necessary for a reform of such magnitude.

A "one size fits all" approach to educating the public cannot adequately reach the populations whose understanding of this complex reform is crucial for it to meet their needs.

- Agency staff must be realigned and trained in their new areas.

The KanCare proposal includes moving a large number of state employees into newly redesigned agencies and new roles. This means that in a very short time frame, the staff must be fully trained in their new positions. Yet the Governor's administration has not provided detail regarding how and when that crucial training will occur.

Kansas' 1115 waiver application lacks sufficient information regarding how health outcomes will be measured for the diverse Medicaid beneficiaries who will be affected by the changes under KanCare.

Promoting healthy outcomes for Medicaid beneficiaries is an expressed goal of KanCare, and indeed one of the goals of the Medicaid system. However, Kansas' waiver application does not include information about meaningful measures for improved health outcomes.

The waiver application indicates that the governor's administration intends to develop a plan for measuring health outcomes, and the RFP seems to indicate that the design of that plan will be left to the MCOs to establish. However, we believe that any health outcomes evaluation plan should be included with this waiver application, not just promised for future development.

We believe that in order for any managed care program to be successful, it must have real incentives for improving health outcomes, not just cutting costs.

Older adults

The KanCare proposal primarily measures processes but does not demonstrate that it will achieve substantially improved health outcomes for elders. Meaningful outcomes should assure adequate levels of nursing care, continuity of workers and care, dental care, and mental health care; and should measure substantial outcomes such as improved functional status, improved quality of life, emotional and behavioral status, preventive care, and patient safety.

The KanCare waiver calls for a "tiered functional eligibility system" for the frail and elderly that restricts access to the highest cost institutional settings only to those with the highest level of need in order to utilize appropriate alternative home and community based settings. If the functionality assessments are well designed, this can be an effective way to provide better care. However, at this time the functionality assessments have not yet been designed. A separate RFP is currently in process to create those assessments. Because of the complexity of designing effective assessments, we believe that process should be open, transparent, and subject to review by the public and stakeholders. However, neither the advocacy community nor the public has been included in the process. As is the case with many aspects of this waiver application, there are too many details missing. If eligibility for services is to be restricted based on functionality assessments, the design of those assessments should be available to the public as well as CMS for review.

Ideally, there would be a significant number of measures that would give regulators and consumers a comprehensive picture of the program's performance across a full continuum of care. A core set of measures should focus on areas of performance that have the greatest potential to improve the health outcomes and long term services and supports and increase the effectiveness and efficiency of care (e.g., areas where there is wide variation, high cost/high frequency services, and evidence of inappropriate care).

Finally, it is critical to capture data for disparities analysis; therefore performance results should be stratified by race, ethnicity, age, language, disability status, and gender. We encourage the use of direct feedback from individuals and their families through consumer experience surveys and consumer reported outcomes on functional status, compilations, pain, etc. With respect to quality, setting and assessing quality measures are only the first steps. These measures must be shared with the public at large so that the performance of plans can be understood and the process is transparent.

HCBS/FE Populations

Without a deeper examination of more detailed demographic data to determine why utilization in Kansas might be higher than the national average, it is premature to target a fixed number or percentage of nursing home residents to move to another setting. We are concerned that these targeted seniors will not actually be served at home but rather in an assisted living facility, which is often a specified wing of a nursing home. The department has discussed increased reimbursement rates for assisted living facilities. Not only does this plan put further pressure on the already reduced funds available for elder care, it encourages continued institutionalization in an out-of-home setting. An assisted living facility is essentially an institutional setting with less oversight and fewer staff available to residents than a nursing facility. Assisted living care is significantly more expensive than services delivered to elders in their homes.

Kansans with disabilities

The concept of "Managed Care" encompasses numerous models. Some of those models provide an effective way of providing medical services. However, there is very little evidence that the non-medical services used by people with developmental disabilities can also be provided effectively in this managed care system. Long-term and home-based care has never been the purview of private insurance companies, and as yet, there is very little evidence that the provision of these services could fit within the business model of a managed care organization.

In addition, as of May 1, 2012, Kansas has a significant number of persons waiting for Home and Community Based Services, and many persons have been waiting for three years or more. The number of persons waiting for Physical Disability HCBS is 3,529. The waiting list for persons with Developmental disabilities is 3,819 persons. Under the US Supreme Court's Olmstead decision, it's not enough for a state to say they don't have enough money and that they want to make more progress on the waiting list. When it comes to full integration of people with disabilities in our communities, states have to show actual, measurable progress. Kansas has lost ground in recent years. Waiting lists have gotten longer, not shorter, and wait times have increased. This waiver application does not adequately address the growing delayed services problem.

Also, advocates are unclear as to how any future savings from managed care will be reinvested. A managed care best practice is to create "reinvestment pools" which capture savings and designate them for improvements in the quality and comprehensiveness of available services. We believe a part of the funds currently designated for "uncompensated care," should be earmarked for this purpose.

Kansans with mental illness
Of the 44,000 Medicaid recipients who receive mental health services, many have severe and persistent mental illness (SPMI). These individuals rely heavily on the care management, treatment, medications and services they receive from community mental health providers. It is important that these Kansans not be lost in a new system that may make it more difficult for them to navigate their care and treatment.

We are already functioning in a managed care environment for behavioral health, including addictions treatment. We are concerned that there will be insufficient transition mechanisms for consumers who are already receiving services through specific provider networks. The current managed care system allows savings to be re-invested back into service delivery. For mental health treatment this is critical due to disproportionate level of reductions in services which have been made over the last several years. The proposed managed care system will not provide for that reinvestment. While there are references to the use of Evidence-Based Practices to improve treatment outcomes for mental illness in the RFP, the exact nature of the incentives for the expansion of EBPs needs much greater clarification. The administration has addressed the important navigator role for certain Medicaid populations to help consumers make the best choice among the MCOs; however for the behavioral health population this process has been inadequately articulated.

In Kansas, we are invested in community based treatment for those with mental illness. Services and treatment allow individuals with mental illness the opportunity to remain in their own homes and communities, find meaningful work, stay active in their communities, and have healthy relationships with their families and friends. For KanCare to succeed, it must ensure that mental health consumers have timely access to care—making it available at the right time and in the right amount.

It is imperative that, in addition to the 24 specific objectives outlined in the reform proposal, the new contracts for Medicaid services for mental health care provide:

- Statewide access to public and private mental health providers;
- Medical homes that are accessible to people of limited means;
- Access to an array of services that address the critical needs of individuals with serious mental illnesses;
- Treatment by practitioners with professional licensing or certification;
- Access to mental health medications in compliance with current Kansas law which prohibits preferred drug lists for behavioral health medications;
- Transparent utilization review and effective implementation of a medical necessity definition that recognizes the ongoing needs of persons with mental illness for services and supports;
- Sufficient preparation to prevent delays in turnaround time and backlogs in determinations of Medicaid /Healthwave eligibility; and
- Reliable information and assistance to be provided to participants and families by unbiased advocacy organizations for eligibility, information about services and treatment available, complaint processes, and dispute resolution.

Oral health needs
Kansas already suffers from a low Medicaid participation rate by dentists, which could be further eroded by requiring them to enroll with three MCOs. Dentists who currently take Medicaid, but who are skeptical about the program, can easily find it cumbersome to sign three different provider agreements and learn three different billing systems. This could make it increasingly difficult to attract dentists to participate in the Kansas Medicaid program.

Additionally, not all of the MCOs being considered are likely to offer dental benefits. We are concerned about how the statewideness-rule under KanCare would apply in a situation where not all Medicaid beneficiaries have access to the same, or substantially similar dental benefits.

Kansans who are dual eligible for Medicaid and Medicare

For Kansans who are dual eligible for Medicaid and Medicare, the success of KanCare will be directly linked to Kansas' success in securing a three-way contract between CMS, the State of Kansas, and the MCOs. To effectively improve care coordination for seniors and the disabled, there needs to be more integration between Medicaid and Medicare benefits and improved coordination between the federal government and states in order to improve access and quality of care and services. There is no information in the state's 1115 wavier application, however, on how this coordination will take place.

Bill and Mary Dondlinger
210 Cochise Trail
Hutchinson, KS 67502

July 9, 2012

Rita Haverkamp
KDHE-DHCF
900 SW Jackson, Room 900
Topeka, KS 66612

Ms. Haverkamp:

We are writing about our concerns about KanCare and community based programs for the developmentally disabled. In 1985, our son was about to leave high school and move into the work force. Community based programs had just begun and we found that there was a waiting list We and **many** others have worked over the years to help build some very good community services. However, we are sorry to say because of funding there is still a long waiting list.

We believe KanCare for the community based programs like TECH in Hutchinson would hurt rather than enhance the medical needs of the disabled. At the present time our son gets very good service from staff in seeing that his medical needs are met. It seems to us that a for profit insurance company would cost the programs more money or less service for the disabled in order to make the profit that they wanted.

The doctors and dentist that our son has along with the staff do follow up and work to keep the cost as low as possible and still have the health service that he needs. We ask that they do not receive KanCare as the program is set-up now.

Sincerely,

Bill Mary

Bill and Mary Dondlinger

DISABILITY RIGHTS CENTER of KANSAS

EQUALITY • LAW • JUSTICE

ATTN: Rita Haverkamp
KDHE-DHCF
State Capitol, 2nd Floor
Topeka, KS 66612

July 14th, 2012

The Honorable Jeff Colyer, M.D.
Lt. Governor of Kansas
900 SW Jackson, Room 900
300 SW 10th Ave.
Topeka, KS 66612

Dear Lt. Governor Colyer:

Please see the attached comments from the Disability Rights Center of Kansas (DRC) for the KanCare 1115 Demonstration Application Open Comment period.

DRC comments include comment headings that are followed by more description in the body under each heading. We have also included a document that was created by the Kentucky Auditor of Accounts that were intended fix problems with that state's managed care arrangement where to claims for reimbursement were not being paid in a timely manner and prior authorization for services, supports, and treatments that were being delayed or denied. DRC has consulted with Medicaid experts and we want to clearly state that the recommendations from the Kentucky Auditor are the minimum standard for assurances pertaining to an effective prior authorization process. Those recommendations are not meant to replace other safeguards that must be included in KanCare contracts terms and conditions such as clearly defined and mandated reporting of Medical Loss Ratio, Administrative Claiming and Profits Caps.

The Auto Assignment strategy in the KanCare 1115 goes too far to restrict Consumer Choice

The choice window—which is the amount of time consumers have to make a choice about which health plan they choose—in this application is already at the minimum of 90 days. But the Governor wants to cut the 90 days to 45 days for all populations. The application does not say, however, why this is within the goals of Medicaid. There is no way to tell how such a severe limit on choice will benefit consumers or the Medicaid program. The risks to our state, its consumers, and its taxpayers for that matter are too great to allow this kind of restriction.

HHS must reject the Auto Assignment in its entirety and force a much more reasonable approach, consistent with the goals of the Medicaid Act. We believe that HHS should force Kansas to negotiate several changes. The Big Tent and DRC have made several notations it comments of where these changes must occur (including targeting savings at dramatically reducing waiting lists, addressing Olmsted issues, ensuring independent conflict resolution, carving out HCBS Waivers, etc.). Rejecting the current Auto Assignment must be added to that list.

The part of the KanCare 1115 proposal that would provide a limited package of benefits to individuals who are not enrolled in Medicaid but who are on a waiting list for home and community-based services is not within the goals of the Medicaid Act

1115 demonstrations are supposed to be "experimental in nature" and in the past they have included a formal research methodology involving, for example, control/study group assessments. The all-encompassing nature of the application does not give the opportunity for quality analysis to prove that moving people off Medicaid coverage will help them realize better health. The application does not cite assurances for how these people would be covered, what rights they would have to appeals and conflict resolution, or how they would be able to access other services and supports that Medicaid provides. Having a separate "limited package" of benefits is dangerous and runs contrary with the goals of the Medicaid Act. This must be rejected by HHS. Instead, Kansas needs to fulfill its requirements on Olmsted and HCBS Waivers.

The KanCare 1115 application does not show how the plan to use safety net care pools will benefit consumers or result in cost-efficiency

The uncompensated care that is provided by, for example, disproportionate share hospitals, is reimbursed to them because these hospitals serve a relatively high number of people who either do not have insurance (because these people have a right to emergency room services at a minimum) or for people whose only form of insurance is Medicaid. However, we do not see that the application does anything to reduce the number of people who end up in emergency rooms. The application must show that there is a better way to serve these populations more cost-efficiently that will improve health outcomes. We want to see more people who have been relying on Emergency Rooms for their healthcare to see community doctors on a regular basis and to receive better, preventative care.

Kansas does not have the Managerial Capacity to properly oversee and ensure accountability of KanCare

State agencies in Kansas have recently incentivized early retirements and reduced personnel as part of broader budget balancing plan. As a result, the knowledge base and experience levels of state agencies have been seriously eroded and fewer administrative and technical personnel are available to develop and administer a managed long term care programs for people with disabilities.

The Performance Measures in KanCare 1115 are not appropriate for most Medicaid funded programs, especially Long-Term Services and Supports

Unfortunately, the tools the state intends to use for monitoring quality in KanCare (External quality review organizations (EQROs), Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Accreditation, and Pay for performance) are primarily focused on acute care and are not relevant to the provision of long term supports and services for people with disabilities.

KanCare does not have enough detail to ensure Health, Safety and Quality of Medicaid participants

The KanCare application states that under the 1115 the "..core features of the existing quality strategies for the 1915(c) waivers will be rolled into the KanCare program". This small passage does not have enough detail to ensure that waiver programs will be managed responsibly by the HMOs. Too much grayness around crucial management pieces like eligibility, access, provider capacity, and capability— means that Kansas won't be able to ensure the integrity of these programs and consumers and families will be poorly served or not served at all.

The KanCare 1115 is likely to incentivize cost-shifting to expensive, large-bed Institutions

While managed care offers potential for reducing the institutional bias of Medicaid policy, the LTSS proposal within KanCare is carving institutional services out of the managed care program. This action makes it impossible for Kansas to lower costs by substituting equally effective but less expensive community services for institutional care. The KanCare proposal carves-out the state's two large public ICF-MRs as well as the 11 NFsMH in Kansas. These institutions warehouse Kansans with DD and MI, and should be the target of quality improvement measures both for the sake of improving health outcomes and to improve the cost-efficiency of Kansas Medicaid. Taking the most expensive support alternative out of the cost calculation not only will decrease any savings that might otherwise occur, but also will provide the option for managed care programs to divert high cost individuals to institutional services, thus increasing the numbers serviced in the most costly support option. The net effect would be contrary to the spirit of if not a full contradiction of the Americans with Disabilities Act (ADA) as interpreted by the U.S. Supreme Court in its 1999 Olmstead decision. KanCare does carve-in regular nursing facilities, and other private institutions.

The admissions process to ICF-MRs in the 1115 is proven to be ineffective for guarding against unnecessary institutionalization of Kansans with developmental disabilities.

Decisions to admit consumers to ICF-MRs have been allowed to have been made without documented evaluations that ensure that ALL services and supports that

should be available were ever offered to the consumer/family prior to admission. Geographic scarcity in the availability of services and supports like Positive Behavior Supports, Respite, Crisis Respite, and Mobile Crisis Response undermines the confidence of families and guardians and forces them to consider a placement in an ICF-MR as the only option. Kansas segregates hundreds of individuals with disabilities in institutions that are not the most integrated setting appropriate to their needs, and fails to provide adequate community supports and services to individuals who are discharged from the institutions or who are at risk of institutionalization.

Kansas often does not meaningfully consider a resident for a more integrated setting unless the resident or their family/guardian proactively requests a more integrated setting. Most residents do not proactively request a more integrated setting because the State does not properly educate residents on what community resources are available, or the possible benefits of community placements. While confined in the institution, residents do not receive appropriate treatment to support their eventual discharge to a less restrictive setting in the community. Residents who have been confined for many years are not actively reassessed for opportunities to move to a less restrictive setting.

States who have tried to carve in HCBS have had to deal with the expense of not meeting the non-medical needs of consumers

The Texas STAR program and the SoonerCare program in Oklahoma were two examples where states tried to carve in HCBS and manage them under an HMO. Both programs had many documented failures that set those states back decades in the development of services that integrate people with disabilities to the community AND they cost Oklahoma and Texas millions more in taxpayers dollars to fix. For the most part, discussions regarding the expected benefits of Kansas' 1115 proposal have been limited to "reducing costs" and "coordinating care." For people with disabilities, coordinating care should be viewed as a means toward an end, not an end in itself. There is too little attention on the outcomes being sought for people receiving services, such as a better quality of life, control over

their services and supports, full participation in community life, protection of individual rights, employment options for working age adults, etc. Making services more cost-effective means ensuring the systemic transformations are made that will help people with disabilities live better, richer lives and gain access to the opportunities promised by the ADA.

The KanCare 1115 doesn't show evidence of planning with crucial public partners to ensure cost effectiveness of service delivery – Vocational Rehabilitation, Social Security, Education, Housing, Protection & Advocacy, etc.

To cost-efficiently meet with goals of Medicare and Medicaid, KanCare should contain a plan for how public and private management agencies will collaborate with vocational rehabilitation, public education, public housing, work force investment boards, that state Protection and Advocacy agency, and various quasi-governmental service agencies, etc. Coordination between these public systems and Medicare and Medicaid systems are critical to successful outcomes. Many times individuals are transitioning between these public systems and coordination is essential. This is particularly true for all young adults leaving public education. Collaboration between public education and adult service systems at the system level, not just the individual level, is necessary to ensure that young adults in transition do not languish, and end up losing skills learned in school and compromising their opportunities for employment as adults. Collaboration between Medicaid and Vocational Rehabilitation are important to ensure that employment goals are supported by long term supports and services.

The 1115 does not address many issues where there is clear question about State Operations and Readiness

Network Adequacy and Statewideness issues for critical Long Term Services and Supports and EPSDT that are not addressed well in the KanCare RFP, the 1115 application, or any other publically available documents related to KanCare to date and will result in more Olmstead issues for us if not well planned for. Kansas also has a lack of demonstrated State Managerial Capacity and Preparedness for such a huge shift to for-profit management. With limited knowledge, experience and staff resources, the capacity of our state agencies to not only hold managed care contractors accountable, but also to ensure the health and safety of program

participants, and evaluate quality, and make improvements in the management and delivery of services over time is likely to be severely restricted.

The KanCare 'Data Books' are not adequate after they were manipulated by the Governor's contracted consultant. They understate costs of services and supports for LTC and BH and we fear they are not Actuarially Sound based on incompleteness of data.

Without clear and accurate evaluation of the current needs of our system, how will Kansas be ready to manage KanCare?

State must maintain one website for disability and behavioral health services for the sake of transparency and to ensure quality information for consumers and families.

Managed care plan enrollees should have a mechanism for contacting the state directly when they have questions or concerns preferably via a feedback loop on the same website.

MLR, Admin, and Profit must be clearly spelled out in Terms and Conditions of contracts with HMOs and 'Care Coordination' must be included in contracts and budget information as 'medical loss' not as an administrative expense

On March 29th, a majority of the members at the newly formed KanCare Advisory Council stated that 'Health Outcomes' are the single most important determinant of success for KanCare. Yet, we fear that without clear expectations for how MLR, Profit, and Administrative Costs in KanCare will be negotiated and paid to the HMOs, we could end up with a situation where the Plans are only really incentivized to cut services and supports, not to derive profits from actual performance via improved health outcomes.

Measuring the financial performance of health plans' means we have to clearly see budget information on the **Medical Loss Ratio (MLR)**, which measures Medicaid medical expenses as a percentage of Medicaid premium revenues; the **Administrative Cost Ratio**, which measures Medicaid administrative expenses

and claims adjustment expenses as a percentage of Medicaid premium dollars; and the **Operating Margin Ratio**, which measures the percentage of Medicaid pretax operating income earned from Medicaid premium revenues.

The 1115 Application needs more content on the role the Kansas ADRC. Will ADRC provide Options Counseling or will they perform Functional Assessments?

With the lack of public involvement in the development of the 1115 proposal and the short timeframe Kansas plans to take to roll-out KanCare, any reliance on the ADRC contract to provide quality options counseling (read: information and referral) OR to conduct functional eligibility assessments is sure to be hindered by their lack of experience. The state's plans to educate managed care enrollees and ensure they receive timely and complete information about obtaining services and responses to any questions they may have is critical given the short window of opportunity they would have to exercise choice. Better content is needed on ADRC's role and the adequacy of provisions designed to safeguard the rights of program participants with disabilities, including the right to appeal plan any service related decisions.

ADAM H. EDELEN
AUDITOR OF PUBLIC ACCOUNTS

February 29, 2012

CoventryCares of Kentucky
Attention: Russell Harper and Lisa Chandler
9900 Corporate Campus Drive, Ste. 1000
Louisville, Ky. 40223

Kentucky Spirit Health Plan, Inc.
Attention: Brent Layton and Yvette Rowan
1019 Majestic Drive
Lexington, Ky. 40513

WellCare of Kentucky, Inc.
Attention: Michael Minor and Michael Ridenour
One Triton Office Place
13551 Triton Park Boulevard, Ste. 2100
Louisville, Ky. 40223

Passport Health Plan
Attention: Mark Carter
5100 Commerce Crossings Drive
Louisville, Ky. 40229

Cabinet for Health and Family Services
Attention: Neville Wise
275 E. Main St., 6W-A
Frankfort, Ky. 40621

Re: Kentucky Medicaid Managed Care Contracts

Dear Mr. Harper, Mr. Layton, Mr. Minor, Mr. Carter and Commissioner Wise:

The Auditor of Public Accounts recently made inquiries with the Cabinet for Health and Family Services, the four managed care organizations contracting with the Commonwealth on Medicaid, and the health provider community to better understand the new managed care system implemented by the Commonwealth on Nov. 1, 2011.

Based on the information received, we are making the following recommendations, which if implemented in a timely manner, should significantly reduce the problems incurred under this new system:

209 ST. CLAIR STREET
FRANKFORT, KY 40601-1817
TELEPHONE 502.564.5841
FACSIMILE 502.564.2912
WWW.AUDITOR.KY.GOV

1. The Cabinet, MCOs and provider community should develop an agreed-upon metric for measuring and reporting the timeliness of provider reimbursements, and implement action plans to resolve identified deficiencies in a timely manner.

   The Cabinet, with input from MCOs and the provider community, should specifically identify the information necessary to adequately monitor and provide trend analysis for the claims process. This information should include defined data fields, syntax of the reports, and timelines for reporting. Specific to the data field definitions, the information required from each MCO should be uniform to allow comparisons among the MCOs.

2. The Cabinet should better monitor and enforce the governing MCO contracts, specifically as relates to the timeliness of billing.

   The Cabinet should expand the monitoring process in place currently to scrutinize the reporting related to the timeliness of claim payments in order to determine whether there has been improvement since the implementation of the MCO process on November 1, 2011. Should an MCO fall below the requirements set out in the contract or the Cabinet identifies a decrease in their timeliness of claim payments, the Cabinet should use its authority granted in the contract to report this deficiency to the MCO. The MCO should then provide corrective action plans to get claims payment timeframes either within those established with the contract or back up to those timeframes seen previously.

3. MCOs and pharmacy benefit managers (PBMs) should use secure, modern technology to process pre-authorizations and reimbursement claims and transmit information to providers and pharmacists.

   For pre-authorizations, the optimal process would be an automated system available to the providers and pharmacists to provide pre-authorization responses through a real-time, encrypted transmission.

   For reimbursements, MCOs should recommend the use of direct deposit and provide information concerning how to set up this process through their communication efforts to providers and pharmacists. For direct deposit to be useful for the providers and pharmacies, however, there needs to be sufficient information provided to allow the providers and pharmacies to reconcile direct deposits, which normally provide minimal identification information, back to the reimbursement being paid. Unless this type of reconciliation information is provided, it will be difficult for the providers or pharmacists to determine what claims have been paid and are still outstanding.

4. MCOs should train providers and their billing agents to use the automated systems in place to track the submission of claims and their status in real time; providers should utilize those systems to verify claims' status, correct errors, reduce duplicate claim submissions and speed the payment process.

The automated applications to submit and query claims and any other services available to the provider/pharmacist community need to be specifically communicated to all providers and pharmacists in the MCO networks. The MCO should also provide training on what services are available and how to properly use these services. This training could be through regional live sessions or through audio-conferences, webinars, or self-study tutorials. The training should be made available to all providers and pharmacists and should be updated as changes in procedure or regulations occur.

5. Each MCO should adjust staffing as needed to clear existing backlogs in claims and pre-authorizations and ensure that processing of claims and pre-authorizations adheres to the time frames in the contracts.

   It is imperative for the MCOs to properly staff their Kentucky-based offices, in an on-going basis, to ensure processing of claims and pre-authorizations is performed efficiently and within the contractual response time-frames.

6. MCOs and PBMs should better communicate to providers and pharmacists the process for appealing denied claims and, related to specific prescription costs, the process for appealing the maximum allowable cost and dispensing fees.

   The MCOs and PBMs should provide information related to the appeal process for a denied claim or pre-authorization request and the appeal process for MAC pricing or dispensing fees in a format and location where it can be easily accessed by providers and pharmacists.

7. MCOs and PBMs should streamline and expedite the appeal process to reduce the risks to the health and safety of patients.

   The appeal process needs to be efficient for all appeals; however, it should be expedited in those instances where the health or safety of the member is at risk.

8. MCOs and PBMs should more diligently review claims to ensure relevant patient information is considered before making final decisions and provide detailed explanations when claims are denied.

   MCOs and PBMs should use all pertinent patient medical information provided within a claim to make decisions related to the claim's validity. Further, if a claim is being denied, detailed information should be provided concerning why the decision was made, what alternative(s) are available to the requested procedure or drug, and the appeal process available to the provider or pharmacist.

9. The Cabinet should study whether behavioral health patients and others who receive specialized medical services would be better served under the Medicaid fee-for-service structure administered by the Cabinet.

There is a growing concern over whether specific classes of members receiving specialized medical services, procedures, and medications are being best served by the MCO model. The Cabinet should study information from the MCOs and PBMs to determine those instances where procedures, resources, and/or drugs for members are being systematically denied or pre-authorization is being delayed. Based on this information, the Cabinet should consider whether similar classes of members, such as Behavioral Health, would be better served under the Medicaid fee-for-service architecture administered by the Cabinet.

10. MCOs and PBMs should streamline the process for a more timely execution of pre-authorizations.

    The MCOS and PBMs need to streamline the pre-authorization process to ensure members are not being placed in a life-threatening position.

    In addition, the Cabinet should review each MCO's pre-authorization requirements to ensure the procedures/resources requiring pre-authorization do not put the member at risk and, for the prescriptions being claimed as refills requiring pre-authorization, disruption in medication would not cause a life-threatening situation. Further, the Cabinet should monitor the pre-authorization processing time-frames to ensure all pre-authorizations are processed within the 48-hour timeframe. Recommended changes to pre-authorization requirements should be made in writing to the MCOs and a corrective action plan required.

As the Auditor of Public Accounts, my number one priority is to ensure that tax dollars are spent wisely and efficiently. I am hopeful, as all of us are, that managed care is the right choice for Kentucky. If executed to the level our citizens deserve, this new system has the potential to both save taxpayer dollars and improve the health and well-being of our Commonwealth's most vulnerable citizens.

Your cooperation thus far with my office has been much appreciated, and I look forward to your continued cooperation as we establish our Medicaid Accountability and Transparency Unit and step up our efforts to maximize the long-term benefits of this new system to Medicaid members throughout Kentucky.

Sincerely,

Adam Edelen
Auditor of Public Accounts

The Big Tent Coalition (BTC) is a grassroots coalition of people with disabilities, seniors, friends, family members, advocates and service providers who share a strong set of core values. We work collaboratively to empower people with disabilities, seniors and their families to speak for and represent themselves. Representation includes to influencing legislation, funding and policy, promoting consumer choice, and access and affordability of services.

- Elimination of all HCBS waiting lists and expansion of community capacity
- Funding increases for these vital services
- High-quality services, supports and staff

BTC submits the following comment as feedback to the State of Kansas for this Open Comment period for the KanCare 1115 Demonstration Application.

KanCare is an unprecedented risky gamble

48 states have some form of managed care within Medicaid, however, most are smaller initiatives, and NO other state has proposed to include all HCBS programs into managed care to the extent and in the way Kansas is seeking. State after State has thoughtfully considered whether to include all HCBS Waivers into managed care, and Legislature after Legislature overwhelmingly rejected including all Waivers.

HMOs have not shown to do a good job of managing non-medical services

Regular Medical and Home and Community Based Services (HCBS) are Different. As opposed to acute care, HCBS Waiver programs provide community-based long term-care supports (including personal care, housing, day supports, help with activities of daily living, etc.).

Overwhelming research shows Kansas must be more evaluative in its approach to Managed Care

HCBS Waivers must be "carved out" from managed care. Kansas should first focus on working with consumers and stakeholders on appropriate models to integrate the Waivers with Medicaid managed care. You can integrate the handful of HCBS Waiver codes with managed care and still carve them out. However, care and time should be taken to identify if and how other components of Medicaid are included in the future.

State officials in charge of KanCare have no plan to address the Waiting Lists for Home and Community Based Services

Make the Waiting List & Access a Top Priority of any Reform – Other states that have instituted managed care changes have made a top priority the dramatic reduction (and even the elimination!) of HCBS waiting lists. Several states have dramatically and positively impacted their waiting lists as part of Medicaid changes. Arizona basically has no waiting list for their community based waiver services. The waiting list was a priority of reform.
In Wisconsin, among the 57 counties that have managed care, many have no DD waiting list, and the others have dramatically reduced their waiting lists. *Note: managed care has been phased in over 10+ yrs in Wisconsin and 15 counties still aren't part of managed care.*

Of the four states that implemented some form of managed care within their Developmental Disability (DD) Waiver: 1) NONE have done it to the scope or extent that Kansas is proposing, 2) NONE used out-of-state, for-profit corporations as the managed care organization, 3) Three of those four states have also made community-based services an <u>entitlement, ensuring access to services</u>. This is an example of why access and waiting lists must be focused on first before Waivers are forced into managed care.

Additionally, HHS's Office of Civil Rights, the US Department of Justice and US Attorney for Kansas have expressed serious concerns about lack of Olmstead compliance in Kansas. At the same time that HHS's Office of Civil Rights was rebuffed about Olmstead compliance problems in Kansas, the State is putting

forward this application for an 1115 Waiver WITHOUT addressing the waiting list or fundamental and legitimate Olmstead problems.

The Secretary of HHS has broad authority to attach and require conditions to approval of the 1115 Waiver application. The Secretary of HHS should require, as a condition of negotiating a resolution of Kansas' 1115 Waiver application, that Kansas must address its Olmstead problems, including making significant and measurable progress on the HCBS Waiting Lists. The Secretary should make any resolution of Kansas' 1115 Waiver application contingent on a meaningful and detailed Olmstead plan that will show measurable progress on several Olmstead issues, including significant progress on the HCBS Waiting Lists.

HCBS Waivers Must be Carved Out from Managed Care – DD Waiver, PD Waiver, FE Waiver, TBI Waiver, etc.

HCBS Waiver programs and services must be "carved out" from managed care so Kansas can first focus on working with consumers and stakeholders on appropriate models to integrate the Waivers with Medicaid managed care. You can integrate the handful of HCBS Waiver codes with managed care and still carve them out. However, care and time should be taken to identify if and how other components of Medicaid are included in the future. Kansas has proposed to carve out the developmental disability (DD) HCBS Waiver for basically one year. That is clearly not enough. HHS should require, as part of its negotiation to resolve Kansas' 1115 Waiver application, that Kansas carve out ALL HCBS Waivers from the KanCare managed care arrangement.

There are very few assurances that Self Direction will be well-supported by the KanCare 1115

Before an 1115 Waiver application is approved, Kansas must first ensure compliance with the current state law governing self direction and consumer control of HCBS (which has been on the books since 1989!). Kansas should first ensure budget & decision making authority for people to hire, pay and provide benefits to their own personal care workers pursuant to state law.

The KanCare 1115 must take advantage of the Consumer Choice Option

One way for Kansas to show measurable progress on Olmstead and Waiting List issues is to apply for a Community First Choice Option, which would ensure community based personal care services are provided without waits while Kansas gets a permanent 6% increase in enhanced federal FMAP under Medicaid. This would ensure greater leveraging of federal dollars, incredible progress on most integrated setting (which is a key Olmstead issue) and provision of effective personal care services to Kansans. HHS must use the Community First Choice Option as a tool that is discussed when HHS identifies methods to ensure that Kansas addresses Olmstead and Waiting List issues as part of any resolution of the 1115 Waiver application.

Stop Taxing Kansans with Disabilities who want to use Personal Care Services services instead of a Nursing Home

Eliminate the client obligation in regards to protected income. This follows the Administration's goal of ensuring Kansans can keep more of their money. Kansas should commit to stop 'taxing' peoples social security checks because they need help to stay at home in the community. The so called "protected income level" is nothing but a huge hidden tax on our poorest citizens living on fixed incomes! This should be another consideration when examining options to ensure effective resolution of the 1115 Waiver application.

Big Tent Coalition Supports Independent Conflict Resolution for Managed Care

Kansans who receive Medicaid benefits ("members") need support and independent professional support on the back end to navigate the new systems and ensure effective access to needed Medicaid services and supports, especially in resolving conflicts and service denials.

Medicaid members are rightfully concerned about everything that can go wrong with the complicated formal and informal conflict resolution and other processes

that can prevent their access to services & supports under a new for-profit system. This is particularly a concern because they will likely have a for-profit corporation with a profit motive standing between them and the Medicaid services/supports they need to survive.

To ensure that Medicaid members are not negatively impacted by the massive changes to put almost all of Medicaid in a for-profit, managed care arrangement envisioned in the 1115 Waiver application, HHS should first require that Kansas create and fund professional, independent support for members with conflict resolution issues. This should be based on the successful Wisconsin model, and ensure that that this legally-based conflict resolution support is independent of the managed care companies, Medicaid providers and contractors and the State of Kansas. HHS should require that this be addressed as part of any resolution of Kansas' 1115 Waiver application.

Managed Care should be Phased-In Cautiously

NO other state has successfully contracted out all of Medicaid into managed care with such break-neck speed. We believe the speed and scope of the Kansas proposal are both dangerously fast and dangerously large.

Other states have phased in managed care over a series of years, starting locally or regionally at first, and being extremely cautious and selective with the services included (or "carved in") to managed care. Wisconsin started with a managed care pilot project of 5 Counties over 10 years ago, expanded it to 57 Counties, and to date still has not expanded managed care statewide (15 Counties are still not in managed care).

What's the rush? We believe Kansas should take its time in rolling out managed care. It should be phased-in. Pilot projects should be first established and monitored. Start with regular Medical with Waivers carved out. We must learn from our successes and failures of those pilot projects first and use that to plot the next phase of managed care.

HHS should require as part of any resolution of the 1115 Waiver application that managed care be phased in slowly and effectively.

Outcomes Show that the Kansas model of Managed Care will not Improve Outcomes or Decrease Spending.

Findings from two reports from the non-partisan National Bureau of Economic Research (NBER), suggest that the model of managed care proposed in Kansas will not inherently improve outcomes and will not decrease Medicaid spending.

"The empirical results demonstrate that the resulting switch from fee-for-service to managed care was associated with a **substantial increase in government spending but no observable improvement in health outcomes**, thus apparently reducing the efficiency of this large government program."

– National Bureau of Economic Research 2002 Report (Mark Duggan and Tamara Hayford, "Does Contracting Out Increase the Efficiency of Government Programs? Evidence from Medicaid HMOs.")

"Our baseline estimates suggest that the average effect on Medicaid spending of shifting recipients from FFS (fee for service) to managed care is **close to zero**. This result holds for both HMO contracting and other types of MMC (Medicaid Managed Care), and suggests that the policy-induced shift of millions of Medicaid recipients from FFS to managed care during our study period did little to reduce the strain on the typical state's budget."

– National Bureau of Economic Research 2011 Report (Mark Duggan and Tamara Hayford, "Has the Shift to Managed Care Reduced Medicaid Expenditures?")

Many Kansas advocacy groups fear that shifting all of Medicaid to managed care will not improve health outcomes, but instead will increase administrative costs, resulting in cuts to the already low rates paid to providers, and increase arbitrary denials of health-promoting, necessary and life-sustaining services and supports.

Kansas already has a high number of medically underserved areas in both rural and urban areas

Before resolving the 1115 Waiver application, HHS should carefully study the issue of sufficient provider numbers, especially in rural areas. This is yet another reason carve-out the Waivers from managed care, as people with disabilities comprise a medically underserved population in their own right.

According to the Kansas Department of Health and Environment (KDHE) Bureau of Local and Rural Health (2011), 51 of the 105 counties in Kansas are governor-designated "medically underserved" areas based on provider-to-population ratio.

KDHE also reports that Kansas has these health professional shortage areas:

- By population: 59 for primary care and 60 for dental.
- By geography: 24 for primary care, 28 for dental care, and 99 for mental health.
- For more information: http://www.kdheks.gov/olrh/download/PCUARpt.pdf

Research has shown that people with disabilities experience health and health care access disparities when compared to people without disabilities.

- These disparities result from wide-ranging social, environmental and behavioral health determinants.