Section 1115 Demonstration: Kansas KanCare

Public Comments

Title	Description	Created At
Be realistic and use common sense	• New systems are not functional as of December 24th: o Providers already can't bill for services because of the day service unit conversion o Some CDDOs cannot access the new basis system • Not only are these new system not functional, but the state administration and MCOs cannot get the issues that have been ongoing for almost a year already resolved. These issues continue to happen repeatedly because all the state has to do to indicate resolution is to have passed it on to the MCO to resolve. This is also known as 'passing the buck'. I heard many people saying over two years ago that this would happen and it is. • The MCOs are not likely to resolve the payment, pre-authorization and overwhelming administration issues the providers are facing simply because this is simply how they operate, how they do business, everywhere. Denying this is silly and not realistic. • It is saddening that after literally years of individuals with I/DD, their families, guardians, caregivers, providers, case managers, and CDDOs telling our state administration that this is not a good business model for I/DD long term services, that they can simply choose not to listen to those who know best how to provide these services, and just do as THEY choose. I haven't spoken to anyone who knows how to serve these individuals that wants this, or honestly believes it will provide better outcomes. • CMS needs to take a good look at what systems are actually working right now and judge the readiness of this program. It is being rushed, as KanCare has all along, and the consumers have and continue to suffer for it. • CMS should absolutely require that the services already managed by KanCare are managed properly BEFORE adding yet more, thus adding even more problems to, should include: o Timely payment to the providers so they can remain there to provide services and provide the consumer with as much choice as possible. o Creating a pre-authorization system that is much less cumbersome, and doesn't require providers to spend more of their time doing administrative work to get paid for their services, than they spend providing services. Admittedly, these are the tip of the iceberg, but fundamental basics that need to be resolved before anything else happens. • CMS should take a good, hard look at the recommendations outlined by the National Disability Council. This is an established council designed to advise federal policy makers. If our state will not listen to those who know how to care for these individuals – successfully – then CMS should listen to the NDC. Their outline identifies many fundamental problems that should be addressed, to their resolution, not just passed on. And as they indicate – these should be addressed before our state is allowed to put even more people and services in jeopardy. Common sense should also tell us that.	2013-12-24 12:29
State of Kansas commits to keeping IDD targeted case management through fiscal year 2015. This waiver demonstration project continues past	State of Kansas commits to continue IDD targeted case management through fiscal year 2015. This waiver demonstration period continues past fiscal year 2015. Please clarify what the future of IDD targeted case management is beyond state fiscal year 2015. Persons with IDD, families and guardians want to know!	2013-12-24 12:20

Title	Description	Created At
The IDD pilot proved the MCO's not ready	The IDD pilot didn't test the premises of KanCare, better health outcomes with cost savings created by robust care coordination by the MCO's. KanCare 1/1/14 will be capitated rates, integrated care paid for through the Managed Care Companies. The pilot wasn't capitated the state still managed the payments as a fee for service. The pilot was not integrated most participants didn't see a care coordinator or have a plan coordinated with anyone. The state continued to make payments until the test billing started in Oct. As of Dec. 20 a significant number of claims hadn't been paid with one provider owed nearly $1,000,000 in back payments. The system isn't working to move forward would only disrupt the lives of people with disabilities and further weaken the existing service system. The pilot fail to test the premise of better health care with cost savings but it did prove that the systems are not ready to move forward at this time.	2013-12-24 08:16
Please, stop the experiment!	The governor has a theory that businesses will move to Kansas if taxes are low, so he has reduced taxes and now no funding is available for community-based care for developmentally disabled Kansans. This theory of the relationship between taxes and business is unproven. In fact, a strong case could be made against it. In any case, it appears that Governor Brownback does not believe that disabled people are truly human as he is willing to conduct this experiment upon them. He is willing to sacrifice human lives for the sake of his tax theory. If Kancare's track record was better, his argument for extending it to disabled people would be more convincing. However, Kancare has been plagued in its first year by a multitude of problems – the most serious of which is that people, some of whom have life-threatening conditions, are going without needed care. Surely there are some standards that must be met? Who is going to enforce them, when the ombudsman is an employee of the administration? The long term care needs of developmentally disabled people are different from the medical needs served by the three involved insurance companies – one of which has been implicated in Medicare fraud to the tune of $225 million. Who is going to protect the rights of this vulnerable population? And how will cutting basic services save money in the long run? It will simply create crises that will require more expensive solutions later. What is being proposed is "managed cost", not "managed care". The current administration is willing to treat developmentally disabled people like guinea pigs. The long-term effects of this "experiment" will have an immense impact on our friends, families, and communities for years to come. We ask CMS - please, please delay the implementation of this ill-thought-out and destructive policy. The fact that our governor would even consider such a policy reflects a complete lack of concern for Kansas citizens. Please refer to the following link: http://www.justice.gov/opa/pr/2008/August/08-civ-723.html	2013-12-23 21:51
Too much too fast	What Kansas is planning to do is a huge system change and what was billed as an adjunct to our service system has felt more like a dismantling of the existing sophisticated and functional services system in order to force it into the infrastructure of the 3 large MCOs, who still show limited knowledge of how to favorably impact or enhance services in our non-medical world. The pilot study has generated virtually no outcomes data despite having operationalized quality of life and service system issues early in the design. There are anecdotal stories that the state and MCOs are sharing about how	2013-12-23 12:42

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	their involvement and "value adds" have made a difference in someone's life during the pilot study but no data to show how widespread or impactful or even positive their interventions have been. The state staff at the implementation level, the providers, the families, and the MCOs all have put in an honest focused effort to achieve some level of comfort with the coming changes but so many unanswered questions remain. An extended, data driven, and intentional pilot project would have better served those with I/DD poised to enter KanCare in January.	
Conflict of Interest	Having self-directed In-Home Supports apart of the KanCare system is causing so much problems. CMS needs to see that the issues have not changed nor attempted to be fixed. The State is not willing to tell the MCO's to follow the guidelines set by the State and CMS. Does CMS know that the MCO's will be writing their own Waiver Manuals? Will these be approved by CMS? If not how will we know which manual we will be held accountable to? Having the MCO's as the payer, approval of Plans of Cares and assessing the needs of the individuals is a huge CONFLICT OF INTEREST!!!	2013-12-23 10:07
I am concerned that if they take everyone off the list at once there will not be superior housing available	Available Housing	2013-12-20 12:11
Billing problems	I am a targeted case manager. I have a lot of service providers contacting me that they are not getting paid for the services. I am afraid that some providers will stop the services because they are not getting paid for. It will make a huge difference without those services for people with developmental disabilities. They might not be able to take care of themselves and things would start falling apart without the services. I have contacted KDAD about it, but no one responded.	2013-12-19 13:43
CMS must follow the recommendation of the The National Council on Disability, and not approve the 1115 waiver.	CMS should follow the recommendation of The National Council on Disability,the presidential advisory panel, and not approve the 1115 waiver. As others have pointed out, there has been no true KanCare pilot program. There is no independent ombudsman for KanCare, which CMS requested. The administration is flaunting CMS rules to fund the underserved on the waiting list. These issues must be resolved before serious consideration of another waiver is appropriate.	2013-12-19 10:47
Delay I/DD inclusion in KanCare	KanCare is still unproven for the existing services under its umbrella. It isn't ready for I/DD services to be incorporated. Furthermore, the state should be required to conduct a real test of how I/DD would work under managed care. And to address the long waiting list of disabled individuals standing by for services.	2013-12-18 15:24
We need to delay I/DD Inclusion to KanCare until the problems are resolved. Pilot Program evidence is overwhelming, it is not ready.	The billing issues speak for themselves, we all know the majority of any which have went correct have been hand-walked thru a system that has yet to perform. The ability of the MCO's to resolve issues is inadequate, they are having software challenges, employee issues, which points to system issues. The pilot is not working because they can walk these through, it would be working if the information was entered and the results came back unassisted by human hand at least 99 percent of the time. This simply is not the case. You keep speaking of improved health and improved total care as benefits from this inclusion..... health benefits were already addressed in the 2013 rollout, total care cannot improve in a system that will have MCO's focused	2013-12-18 08:25

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	on trying to resolve issues they have proven unresolvable at this point, with providers who will now be totally consumed in attempting to get issues resolved rather than focusing on care. Inclusion at this point will create less ability to focus on actual care than ever before. You have had volumes of discussions with those who are actually in the field working this, the ones who have their money and lives invested into serving this sector.....but do you actually listen.....they are the ones who are going to be affected along with the 8000 plus consumers they serve. You seem to be listening to the MCO's saying they will get this right, if they actually can, let them, but delay this until they succeed at this. Do you think the MCO's are going to ask for a delay.....of course not.....would you if millions of dollars would be in your hands until it was forced out, knowing the shrinkage rate on claims from sheer frustration will possibly be more profitable than providing service. Which brings me to a final point, these MCO's are not service providers, never have been, never will be; they are claims management, billing, and payment agents, they have not proven they can perform this service correctly on a daily basis in the pilot, or in the initial rollout, how can you with a clear conscience put them in charge of I/DD at this point. This decision will not reflect on them, it will reflect on you and our State. The evidence points heavily to this not working, wanting it to work does not make it work.....tested working proven systems do. A parting suggestion, you seem so willing to discount the feedback from all of those who are experiencing the results of this pilot, if you have proven evidence this is working correctly and smoothly please offer it to all. Currently the only proven evidence shows this is simply not ready.	
KanCare has shown its true stripes in the PRTF program: "Savings" created by cutting desparately needed services.	This past year, the MCOs through brutal measures have force the premature discharge of seriously mentally ill children and youth back to homes that are unprepared to protect these children or their syblings and without the needed level of support that might increase the likelyhood of success. This level of corporate, bottom line driven thinking must be expected to foretell the future for the IDD community if this waiver is approved. This experience has been the real "pilot" of KanCare. The evidence is clear: This is not a sound plan.	2013-12-17 14:18
As a 66 year old retiree, I am defuddled that the rates paid to providers was cut, especially factoring that there hasn't been a rate increa	I am baffled that the legislature cut rates paid to providers in the first place. Especially, when factoring that there had not been a rate increase in years. Apparently, inflation and the cost of services does not change for the DD population. The elderly, physically and developmentally disabled population of this state are the most vulnerable population and shoved into the background, when they should be the portion of the population receiving our care and attention.Not appropriately funding their needs or the timely reimbursement of those services is fundamentally wrong and needs to corrected immediately. At the very least, the law should be suspended and further examined to make the law fair, efficient, and compassionate.	2013-12-17 13:22
Do we really want to take the wait and see approach?	Being a business owner I know how important cash flow is, without providers for these services I feel that the state is going down a road that will in the long run not provide for needed individual and coast the tax payer more money. Saving a little money in the beginning and putting this in kancare compared to the long term loss is not just bad for the people who need the services it's just BAD BUSINESS.	2013-12-17 13:11
A list of concerns...	Recently I came across this list of concerns. I whole heartedly agree!	2013-12-17 11:58

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	• Billing must be tested prior to implementation to ensure small providers will be able to financially remain viable. If payments are delayed, smaller agencies will go out of business and capacity to absorb their clients may be difficult. • Rates paid to providers must not be cut. Rates haven't been increased in years, and are not sufficient as is. Cuts will be devastating. • Hours to clients being served must not be reduced through manipulation of eligibility or service need criteria. We understand that by providing fewer hours, MCO's can save money, but we urge that any cut be approved by a State agency before implementation. Saving money is not the priority, serving the client is priority. • We urge that the Legislative Oversight Committee develop a tool for MCO accountability. Including, where the dollars are spent, and changes in how the dollars are spent, as well as consider trends in spending and the outcome for the client. • Clients are able to keep their case managers and case managers are able to continue their current employment status. This is of upmost importance to clients and their families. • • CDDO's continue to perform the duties assigned to them by the Developmental Disabilities Reform Act (DDRA.)	
On site case management is extremely important. No substitute for it. EKerrigan Leawood,Ks.	Move all judgements on diagnostic activities to a designated and medically qualified individuals. Pay their salaries. do not attempt to institute off site management of these designated case mgr's.	2013-12-17 08:27
Disguised corporate welfare	I am the parent and legal guardian of a 23-year-old Kansan with severe autism. Her needs have been well served by the existing I/DD waiver system in place in Kansas. Now her well-being is threatened by the Kansas administration's drive to lower costs, not to better serve the disabled population or to reduce waiting lists, but to support huge tax cuts that primarily benefit large corporations--and, further, to funnel huge profits to MCOs who have not demonstrated competence, compassion or even understanding of the needs of the I/DD population of Kansas. Please do not approve this massive, risky experiment. The administration's own submission documents promise a program in 2014/2015 to help MCOs understand the I/DD program and needs. Shouldn't we expect the companies to fully understand this BEFORE we hand the entire program over to them? The administration's public statements to parents have consistently been unclear, confusing, internally contradictory and have shown either a lack of understanding of their own proposals, or perhaps an effort to obscure the real consequences and motivations of their proposals. My daughter greatly needs dependable, skilled, compassionate and reliable residential care, and she receives that through a small provider. We already hear stories about long payment delays and huge claims confusion on the part of the MCOs. Such delays could be detrimental for my daughter's provider, or could even drive them out of business. Yet the state shows no concern over such possibilities, but offers us patronizing letters and lectures about how "change is hard." They have repeatedly expressed resentment and frustration about parents like me expressing our concerns over this ill-conceived and ill-defined effort to experiment in lowering state tax rates on the backs of our special needs adults and children. PLEASE: serve the public interest, not the state administration. Do NOT approve this reckless experiment, which could destroy a system that has served my daughter, and thousands of others, so well.	2013-12-16 23:36
Kancare will lead to cuts in care for the	I am 26 years old and have Duchenne muscular dystrophy. I am dependent on a ventilator to breathe and a feeding tube for most of my nutrition. I also	2013-12-16 20:31

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developmental disabled community.	use a power wheelchair and have to depend on someone to help me with any task that requires physical activity. I receive 24-hour care through the I/dd Medicaid waiver, I cannot live on my own without these hours. Without these hours I will most likely end up in a group home or nursing home where I were not receive the care I need to survive. My parents are deceased and I live with my brother leaving no other family members to help take care of me if I lose my hours. if the MCOs takeover the I/dd services they will cut hours to keep their profits up no matter how much it hurts the people that can not live without their care.	
Please Do Not Take Us back To The Dark Ages	We are parents and Guardians of a daughter who is an I/DD Consumer who receives HCBS Services- Case Management, Day Services and Residential Services. We have been extremely satisfied and happy as things have been. Please DO NOT include our daughter in the KanCare when January 2014 rolls in. It would be a big mistake. Thanks	2013-12-16 18:21
KanCare will change care for Developmentally Disabled Kansans	I am writing as the guardian and sister of a developmentally disabled Kansan who is currently receiving long-term care. Below are some things that should be considered in adding long-term care to KanCare. Billing must be tested prior to implementation to ensure small providers will be able to financially remain viable. If payments are delayed, smaller agencies will go out of business and capacity to absorb their clients may be difficult. Rates paid to providers must not be cut. Rates haven't been increased in years, and are not sufficient as is. Cuts will be devastating. Hours to clients being served must not be reduced through manipulation of eligibility or service need criteria. We understand that by providing fewer hours, MCO's can save money, but we urge that any cut be approved by a State agency before implementation. Saving money is not the priority, serving the client is priority. We urge that the Legislative Oversight Committee develop a tool for MCO accountability. Including, where the dollars are spent, and changes in how the dollars are spent, as well as consider trends in spending and the outcome for the client. Clients are able to keep their case managers and case managers are able to continue their current employment status. This is of upmost importance to the client and their family. CDDO's continue to perform the duties assigned to them by the Developmental Disabilities Reform Act (DDRA.) Thank you very much for your consideration for our most vulnerable citizens. Kindly, [redacted] Sister of a Disabled Kansan	2013-12-16 15:09
Original Concerns about Kancare have all proven to have been spot on.	All the concerns expressed before the implementation of Kancare have been spot on. As consumers, caregivers and providers of service we have all seen our worst fears come to fruition. Kancare has proven to be bad for everyone in the process. Insurance companies are the only beneficiaries of this system. Please do not compound the mistake and include long term care services. As a parent and guardian of a young man with cerebral palsy and as an employee of a medical provider I see the situation on both sides. A child who can't get services he is accustomed to and a provider who can't get paid. The ombudsman appointed by Gov. Brownback may be a very	2013-12-16 03:16

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	nice person, but is ineffective and has no clue as to how the system is supposed to work. There is no recourse for beneficiaries or providers. Please do not compound the problems. Reject this application. Thank you.	
KanCare on a fast track to de-rail I/DD Services	KanCare for the I/DD Waiver is moving to fast to be successful. Not only is the I/DD Waiver being overhauled by KanCare, KDADS (Kansas Department of Aging & Disabilities Services which took over the I/DD Waiver from SRS, is also on a fast track to see the I/DD Waiver over hauled. To many system changes affecting the I/DD waiver have not been very well planned out. Secretary Sullivan stated such concern in his presentation to a the NCD panel discussion. Sullivan "said the timing of a reorganization that eliminated the former Kansas Department of Social and Rehabilitation Services and moved most of the state programs dealing with the disabled or mentally ill into his agency added complications to the KanCare transition". CMS has yet to give it's final approval on the implementation of KanCare for the I/DD Waiver or 1115 Waiver, and CMS should listen to the findings of National Council on Disability and at least allow for the process of systems change to be fully developed, because this profession is still a profession of "do no harm" and not all about the business model. KanCare is on a fast track, and is not fully ready to be implemented yet.	2013-12-15 21:32
Deny Amendmemt Request and open a Federal Investigation/inquiry into KanCare and the MCOs	I am an individual receiving SSI funds for conditions related to SPMI and chronic health issues my quality of care and out of pocket expenses for healthcare under the current KanCare plan has been nothing short of a nightmare. My MCO is Amerigroup Kansas in March of 2013 I had just obtained a full time job in hopes to become fully self sufficient and on the last day of my first week of employment I went to refill one of my prescribed medications which is a CII controlled substance and was told I no longer had insurance coverage. I then attempted to call Amerigroup, And State agencies with every place referring me to another agency or office. It was not until I lost employment due to having to take off for withdraw symptoms from the abrupt stopping of this medication I have taken as prescribed for years and receiving emergency medical care and contacted my State Representative that my problem was resolved after about 14 days. I receive 15+ letters a month from Amerigroup asking me to contact them for services received 2+ Months prior asking if the billed services were provided let me highlight the fact these letters are only in regards to MENTAL HEATH CARE not any other healthcare services. How would an individual with a psychotic disorder or an even more severe processing and language disorder understand the meanings of these letters and not think they were something very different as the words fraud and waist are used within each copy several times. My heart rate is currently at a consistent resting rate of above 120 currently and Amerigroup is telling my Physician that a Beta Blocker is not needed?!? We have been in this current battle with them for 10 days. So I just want to ask if the current MCOs can barely supply care to people that have had a stable condition until their interference with quality of care. What issues will we encounter if the MCOs and KanCare be trusted to become the decision makers for individuals that have rapidly changing and potently fatal changes to their health status that they can not survive the time to debate with the medical need of lifesaving treatment and are they truly in touch with the needs of individuals with disabilities? I personally believe the below to be supporting articles for my request for a federal inquiry and/or investigation into "Kancare" http://www.justice.gov/opa/pr/2008/August/08-civ-723.html http://kcur.org/post/kancare-means-big-medicaid-cuts-prairie-village-man	2013-12-15 13:07

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	http://www.hayspost.com/2013/11/25/many-issues-facing-kansas-nursing-homes/ http://kcur.org/post/doctors-hospitals-report-delays-kancare-companies http://www.khi.org/news/2013/nov/25/nursing-homes-feel-kancare-and-other-pressures http://www.kansascity.com/2013/12/08/4680290/kansas-managed-care-under-fire.html http://www.pratttribune.com/article/20131214/NEWS/131219551/1001/NEWS http://www.khi.org/news/2013/dec/13/national-council-disability-urges-rejection-kancar/tt http://www.khi.org/news/2012/mar/19/kancare-bidders-courting-service-providers/ http://www.pitch.com/kansascity/kancare-sam-brownback-finn-bullers/Content?oid=4031015	
Before the CMS moves forward	Although searching for ways to streamline costs and deliver quality medical services is an admirable goal, the fact that KanCare was rolled out very quickly without incorporating evidence of best practices, has led to breakdowns in service delivery, payment delays for providers, and much confusion for its recipients. It is also hard to believe that going from a single payer system to one administered by three (3) separate for profit managed care companies will generate efficiencies and streamline costs yet yield a profit for these companies without jeopardizing quality of service and medical outcomes. Maybe the state will save money, but costs for providers have expanded for health care providers in Kansas that serve the population eligible for KanCare. By the same token, including the ID/D population in KanCare without rigorously studying and developing the best and most effective ways to provide services to this population with its unique complex set of lifelong needs, demonstrates the administration's haste to save money at all costs – even on the backs of its most vulnerable citizens and their families. Most professionals tasked with the job of implementing major overhauls of delivery of services recognize that it takes a minimum of 2 – 3 years of a fully functioning pilot program to truly uncover the full impact of managed care on the ID/D population. Yet the state of Kansas hasn't devoted even three months to begin to understand this and has turned this over to three companies with virtually little prior knowledge of all the components of caring for this folks successfully in the community. In addition to rushing to transfer the care of the ID/D population under KanCare without any rational study or significant input from professionals who have worked with these folks, Kansas has made no credible effort to determine and learn how a managed care model could work for the ID/D population which has very different needs than the general Medicaid population. Before the CMS moves forward with allowing Kansas to include the ID/D folks into KanCare, the state of Kansas should be required to conduct a rigorous pilot study of at least 2 years and establish extensive collaboration with those who have been serving these folks successfully for years. Once the state has done that they will need to show clear evidence of how a managed care program can provide quality services to the ID/D folks at lower costs, efficiencies while keeping them in their communities.	2013-12-15 09:40

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Kansas has not effectively studied whether ID/D works under managed care	Although searching for ways to streamline costs and deliver quality medical services is an admirable goal, the fact that KanCare was rolled out very quickly without incorporating evidence of best practices, has led to breakdowns in service delivery, payment delays for providers, and much confusion for its recipients. It is also hard to believe that going from a single payer system to one administered by three (3) separate for profit managed care companies will generate efficiencies and streamline costs yet yield a profit for these companies without jeopardizing quality of service and medical outcomes. Maybe the state will save money, but costs for providers have expanded for health care providers in Kansas that serve the population eligible for KanCare. By the same token, including the ID/D population in KanCare without rigorously studying and developing the best and most effective ways to provide services to this population with its unique complex set of lifelong needs, demonstrates the administration's haste to save money at all costs – even on the backs of its most vulnerable citizens and their families. Most professionals tasked with the job of implementing major overhauls of delivery of services recognize that it takes a minimum of 2 – 3 years of a fully functioning pilot program to truly uncover the full impact of managed care on the ID/D population. Yet the state of Kansas hasn't devoted even three months to begin to understand this and has turned this over to three companies with virtually little prior knowledge of all the components of caring for this folks successfully in the community. In addition to rushing to transfer the care of the ID/D population under KanCare without any rational study or significant input from professionals who have worked with these folks, Kansas has made no credible effort to determine and learn how a managed care model could work for the ID/D population which has very different needs than the general Medicaid population. Before the CMS moves forward with allowing Kansas to include the ID/D folks into KanCare, the state of Kansas should be required to conduct a rigorous pilot study of at least 2 years and establish extensive collaboration with those who have been serving these folks successfully for years. Once the state has done that they will need to show clear evidence of how a managed care program can provide quality services to the ID/D folks at lower costs, efficiencies while keeping them in their communities.	2013-12-15 09:34
Previous post that had been closed due to web sight glitch. DELAY OR DISMISS KANCARE FOR THE I/DD POPULATION	As a provider in the pilot program I have to say the State of KS and MCOs are no where near being ready for this transition. There are still numerous unknowns about how things are going to work. 1) Authorizations from the MCOs that are needed for providers to bill are incorrect at times, missing, or taking as long as 30 days to obtain. 2) People in the pilot are only getting paid at around 60% of claims submitted and that's will the limited people in the pilot. 3) The code for day services is being changed from T2020 to T2021 which is going to cause yet more issues that have to be fixed in the MCO's systems before Jan 1, 2014. 4) Obtaining denials for third party insurances is of huge concern when the code is just now being changed 5) The services that were effected by KanCare on 1.1.13 are still not running smoothly and people are still not getting paid 6) There are errors showing up when claims that are submitted that the MCOs can't figure out 7) the State and MCOs are just now getting to the point of coordinating who is going to do some pieces of the puzzle 8) the pilot program for the billing component only started 10/1/13 leave very little time to work through issues - many of which are still not resolved. KanCare needs to be delayed until all the issues have been resolved and the pilot is running smoothly. Why on earth would you add thousands more people to a system that can not currently handle the hundreds in the pilot?	2013-12-13 15:14

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Old ideas are missing from this sight, CMS needs to listen to the PEOPLE who this effect.	Old ideas that were posted on this sight before the glitch are gone, there were SEVERAL important points that we can no longer see. If CMS approves the inclusion of I/DD Services for KanCare then the are not listening to the people this effects. The state is going to minimize the problems when they report to CMS to make CMS think that the system is working and that they and the insurance companies are ready for the transition. It is not going well and they are not ready. Nearly a YEAR after the implementation of KanCare there are significant payment issues that have yet to be resolved (one hospital has reported $900,000 in unpaid claims, others have reported unpaid claims in the hundreds of thousands). The systems are not in place for this transition. The MCOs do not have all the information they need in order to prepare their systems for the inclusion of the I/DD population. Providers need approvals or authorizations from the MCOs, the MCO needs Plans of Care from the state in order to enter the authorizations. The MCOs don't have all those yet and there are thousands to be completed. In addition the MCOs do not understand the terminology and processes that are in place which adds even further confusion with the preparation for the transition. At a provider meeting on 12/12/13 there were numerous questions from providers about implementation and transition processes that there were still no answers for. We still do not know all of who is going to do what in this process. Providers are still confused about what they need to do in order to bill and still can not get confirmation if they have a contract yet even though they have turned in their credentialing paperwork. The question has been asked what will happen to all the people who require 24 hour care if providers close. The answer has been that they don't plan for that to happen. That doesn't answer the question. Small providers don't have the cash reserves to endure ongoing, extensive payment delays. Hundreds of people are going to be at risk of not getting the 24 hour care they require in order to get by day to day and hundreds of other people are going to lose their jobs. Providers have already began to lay off employees in fear of KanCare. The quality of services is already being effected.	2013-12-13 13:36
KanCare concerns and recommendations	I will be brief, describing ways KanCare needs more time, planning and preparation before the inclusion of the ID/DD population goes into full effect: – the pilot program was implemented too late and was, therefore, not able to serve the true goals of a pilot program (as someone working for an organization directly involved in this so-called pilot program, I witnessed delay after delay of the implementation so there existed only a few months worth of useful data to evaluate) – a true pilot program would last a full year with time to evaluate prior to implementation of a huge scale program such as KanCare and the involvement of the ID/DD population – long-term planning for these populations needs to be completed before application of new methods. The system, as a whole, needs to be reevaluated so it is more efficient and serves the needs of all of those who need services through the ID/DD waiver. The waiting list for services needs to be substantially reduced, quickly, and then, once and for all. – Kansas needs an ombudsman program SEPARATE from the state and it needs more than one person to do the job	2013-12-13 13:16

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	– managed care contracts as they relate to the ID/DD population are not something the three contracted MCOs have a great deal of experience with. Some of them have more than others but the system in place now is already proving to be insufficient in the way it handles the needs of the clients/consumers/patients. Care is denied, insufficient, delayed, changed from actually works for the patient in favor of what is more cost effective for the MCOs. Just because a product may "seem" similar and provide similar outcomes does not mean that it can be substituted for many of these individuals who have complex needs. MCOs need to be more closely evaluated in the way they are reimbursing, covering and providing services. These clients/patients/consumers need to remain with the physicians and specialists they've known for years and have become familiar with. By auto assigning them to an MCO who may not include their doctor or specialist, you further complicate the life of an individual who has to take extreme measures to plan for their time, finances and health care. As someone without a disability, I can see the frustration this could cause for just about anyone, even with people to support them through the process of changing providers. This is an exhausting and monumental process and task ahead. It involves hundreds of thousands of people, as a whole. Without the ability to evaluate the services each group is receiving, someone is going to be neglected. This is a big industry with lots of money to be saved...and a lot more to be earned by MCOs. My recommendation is to further evaluate and prepare. Plan a TRUE pilot program, possibly in some of the larger counties, to get a full picture of what it will take to move those in the DD population into KanCare and do it in a way that does not take away services detrimental to the health, well-being and independence for these individuals who have a right to an independent life and choices, as we all wish to have. Thank you for your consideration and time.	
KanCare taking us 10 steps back	It seems the mission of this implementation is falling incredibly short of the goal line. I work for a provider and have already witnessed the shortcomings of KanCare with respect to the other Medicaid waivers already instituted. From a provider standpoint, contracting with the MCOs has been a nightmare. Services for Medicaid recipients take eons to be approved. Once they are, service plans are not written correctly, and trying to contact anyone at each MCO to resolve the issue is impossible. It has often taken several months to resolve issues. During that time, we continue to pay employees to provide support so that the Medicaid recipient is not neglected. Payment from the MCOs is delayed, as MANY providers have also experienced. In stark contrast to the mission of Kancare, what actually happens is that providers cannot continue to sustain themselves without timely payment, and therefore have to close. There is this enterprise by KanCare administrators to remove service coordination and authorization (and likely case management in the near future) from the local CDDOs in an effort to erase conflict of interest. However, this mission only creates an even larger, more concerning conflict of interest by placing the service planning, approval, and payment of into the hands of the MCO. The MCOs are conducting needs assessments, writing service plans, and receiving payment for those same services. How this glaring absence of logic has escaped so many, I don't know. Most concerning to me is the false dismissal that the MCOs will save money for the State of Kansas not by cutting services, but by "providing the right care, in the right amount, in the right setting, at the right time." This is a complete fabrication. I have personally been witness to the decrease in	2013-12-13 09:48

Title	Description	Created At
	services for nearly every single recipient on other Medicaid waivers. The case coordinators appear to have hush-hush instruction to make small, but exponential cuts in services. Service plans are run through with a fine-toothed comb, erasing any support need that is not deemed “necessary.” These are supports that allow someone with a disability to have the same quality of life as someone without a disability. KanCare is a program that abandons Kansans with disabilities and disrupts the supports they already had in place. The entire program, including the MCOs, is a medically-minded operation. It views persons with disabilities as sick, ill, and lacking medical care. Persons with disabilities are not sick. The definition of “disability” is NOT synonymous to the definition of “illness.” Now, some of them may have additional health issues, and may need more or better health care (which is quite ironic considering many of their established physicians will not contract with the MCOs because of previously discussed payment issues and low reimbursement to begin with). But a disability in its raw form is not a sickness. Long-term supports are intended to support someone whose disability, by definition, is not going to go away or be significantly reversed by medical care. The three MCOs, which are health insurance companies, clearly do not understand this concept. This has been evidenced by their management of other Medicaid waivers throughout the past year. Case management for the other waivers has been delegated to the MCOs, but my experience is that they provide no case management whatsoever. There is no advocacy or assistance coming from the MCOs. And why should there be? If the MCO cuts a person’s services, they certainly are not going to encourage their own case managers to advocate for the person and their needs. Again, this is a huge conflict of interest. The Brownback administration has barreled forward with this implementation without regard to appropriate planning and has ignored the voice of the consumers it affects. It might have worked if the State had set more regulations for the MCOs in their contracts to avoid the catastrophic fall-out that has occurred. I say all this from the perspective of both a provider and a friend of several people with disabilities. This implementation is a mistake.	
The Managed Care Model for I/DD Services is Not a Workable Solution for the Extremely Vulnerable I/DD Population.	When Kansas passed the Developmental Disabilities Reform Act (DDRA) in 1995, it was hailed as a major success for the I/DD services system in the state, even on par with the Americans with Disabilities. CDDOs and community service providers have successfully provided supports and services for thousands of Kansans with disabilities under the DDRA since its passage. This managed-care model does NOT fit with the established service structure in the state, a service structure that has worked remarkably well since its inception. The managed-care model is meant for MEDICAL services, meant for medical conditions that could reasonably be expected to be resolved over time, that is, cured. There is no 'cure' for an intellectual or other developmental disability. An intellectual or developmental disability is NOT an illness or other medical condition, and should not be treated as such. The KanCare managed care model proposes to treat I/DD as just that. Managed care through KanCare is wrong for the I/DD population, and wrong for Kansas. The state should not be playing games with the services that support the lives and abilities of so many vulnerable Kansans. This is a so-called 'grand experiment' that will fail, and when it fails, the thousands of Kansans with I/DD and their service providers and other community supports will be the ones who suffer, while the for-profit managed care organizations rake in millions in profits.	2013-12-13 09:18

Title	Description	Created At
Due to the glitch with the site, please find comments from the DD Network within comments of this post.	Recommendations from the Kansas Developmental Disability Coalition to CMS Regarding Kansas' 1115 Waiver Amendment and the DD Waiver	2013-12-13 08:26
KanCare	PART 1 - I am the parent and guardian of an I/DD Consumer who receives HCBS Services--Case Management, Day Services and Residential Services. Prior to the advent of KanCare, I have been extremely satisfied and happy with the kind and amount of care being provided my son. With the inclusion of my son in the KanCare model, effective January 1, 2014, I am neither as satisfied nor as happy. From a personal and professional perspective, I have over 35 years experience in helping organizations plan, develop, implement and evaluate the effectiveness of large-scale systems change. KanCare is a large-scale systems change project. It is an experiment. The inclusion of the I/DD Waiver in KanCare is yet a further experiment. An undertaking of this magnitude has never before been attempted in the State of Kansas, and, for that matter, only in a remarkably few places in the entire United States. The I/DD community is a highly vulnerable group of individuals who often do not understand change, particularly big change, and often have a difficult time accepting and adjusting to things that alter the established patterns in their lives. It is clearly known from vast amounts of data describing the effects of large-scale systems change that several highly predictable consequences are to be expected with any major change, even those that are well conceived, designed, planned and executed. Those who are directly impacted by the change experience an immediate and almost universal increase in uncertainty, ambiguity, and for some, outright fear. There is a broad-based decrease in trust toward those who are causing the change. And, there is a significant increase in self-preservation behavior, a clear need to "look out for #1", since the "system" is no longer doing so. In order to ensure success of large-scale systems change, senior leaders need to make certain that adequate time has been taken to inform, align and enroll those people most impacted by the change in its design and implementation. This has clearly not been the case with KanCare, overall, and with the inclusion of the I/DD community, specifically. The general feeling among parents, guardians, Consumers and service providers is that Governor Brownback and his administration are going to make these changes happen, from the top down, no matter what the consequences.	2013-12-13 07:26
CUTS?	In this proposal it states that the state will make cuts to the services. I have heard numerous times from State Program Managers and Secretary Sullivan that the intent was not to cut services. Why would we cut services to those that need these services? Be sure that after the first year people will be having their services cut. This is another reason why the I/DD waiver should be kept out of KanCare as all the other waivers Self Directed services should be taken out of KanCare.	2013-12-12 14:31
Conflict on interest	With this plan assessments, the writing of a Plan of Care, approval and coordination will be coming from the MCO companies. This is a huge conflict of interest!! We need to keep the CDDO, providers and choice for the individuls with disabilities in Kansasa.At this point individuals have been told they can keep their case managers but this will not last long. all information is being turned over to the MCO . They are already meeting with indivuduals and looking at cutting Plans of care.MCO case managers have been told to cut serivces.As a parent I have work hard over the years to see that services are provided in the community for my son. It appears all the work over the	2013-12-12 13:59

Title	Description	Created At
	last 20 some years will be gone. First the case managers then the CDDOs and next community providers who provide one on one support wil be gone. Big business will take over big business who do not understand long term supports for people with disabilities. These are not medical needs that can be fixed they are daily community supports needed to have a full life for people with disabilities. Not only is my concerned for my son but for the people on the PD and TBI waivers who have been with the MCO and are now facing cuts to services. Case management for the waivers with the MCO is not at all what it was before people are not getting the help they need and have no one to advocate for them because the case managers and services are coming form the MCOs. This whole thing is a very bad idea and a huge conflict of interest.	
We need to avoid unintended consequences.	The state has decided this is the time to change everything. KDADS has staff unfamiliar with IDD system. There seems to be no investment as to finding out how the IDD system does things or why we have the processes we do. The response is that the IDD system needs to match what the other waivers are doing. But the IDD system is a SYSTEM not just a waiver . KDADS changed day services from T2020 to T2021 and told CDDOs to get the plans in before the transition to KanCare. Oops, this put the plan in evaluation status and no one will get paid until KDADS has time to review the plan. KDADS - "gee, you should have put it in as a separate plan" not taking into consideration that we have NEVER done it that way and most CDDOs had already entered over 75% of the plans. What else have they overlooked?	2013-12-12 13:46
Lets have a real investment; instead of all this lookgood stuff.	Susan Mosier describes in her letter the importance of the Friends and Family group, but at the time of the letter, I don't believe they had met more than once. I think they could be a big help, but only if they are taking seriously! All of this: public meetings, mailings, pilot project don't seem to be valued by the KDADS staff. I know KDADS staff are busy, but if they are too busy to give these issues the attention they deserve then maybe we are to busy to incorporate IDD services into KanCare. Some pilot members have had no contact positive or negative with their MCO.	2013-12-12 13:37
Adopt a plan for reducing expensive, unconstitutional institutionalization in NFsMH and provide scattered site supported housing instead.	According to consultants from who worked on Tennessee's Creating Homes Initiative (CHI) and spoke with advocates in Topeka last year, scattered site housing is the answer to reducing growing costs associates to dehumanizing institutionalization of people with a mental health support needs. Too many young people who need help are afraid to access a system that relies so much on warehousing in substandard conditions in an old nursing home. Kansas should fully adopt a concept of Recovery and ensure everyone has an opportunity to stay in the community and get healthy.	2013-12-12 13:35
Kansas is not ready to implement this ill-conceived, risky KanCare experiment	I am the parent/guardian of an adult with Down Syndrome and for 38 years have been an informed, respectful and assertive advocate for his interests, including in the public policy arena. My son has is part of the HCBS waiver program, and I am very satisfied with his services. He needs are complex, and it has taken us a long time to fine tune his services. We've done so with a terrific case manager and a team comprised of his parents and service providers. My experience with KanCare during 2013 has been nothing but bureaucratic jargon, uninformed and abrupt MCO reps and state employees, dead-end communication, unreturned messages and conflicting information. Respectfully, these administrators don't know what they are doing. I can only conclude that Kansas is not even close to rolling out KanCare for him and others. Moving forward at this time will lead to disruption, stress and instability for persons served and families, and financial hardships for our	2013-12-12 13:26

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	community partners. In short, this is like watching the beginnings of a train wreck in slow motion, and families like mine are truly frightened, all the more so when the Brownback administration gives us nothing but vacuous assurances that can only be put in the "truthiness" category. Our system works well, is efficient in use of public funds and does not need fixing! On behalf of my son, I implore CMS to deny approval of this ill-conceived experiment or at least to delay implementation.	
Bad idea!!	I have been following the KanCare very closely as it pertains to my brothers services with the implementing of the I/DD waiver. I do not see that any of the SELF DIRECTED services should be included as they are not medical services. It seems that the MCO's view anything and everything as a medical/treatable service which they are not necessarily. There have been many issues with KanCare from people being CUT on services and providers NOT getting paid. I see that the implementing of the I/DD waiver into KanCare will just issue more troubles for the providers. I also see that there is a HUGE CONFLICT OF INTEREST with the MCO's writing and approving the Plans of Cares for people receiving services as well as being the payee of these services.	2013-12-12 13:22
Managed Care companies have been sending Notices of Action that do not meet standards for due process.	Historically a Notice of Action has only come directly from a regional or local DCF (SRS) office. The notices that are being sent out from the Managed Care companies themselves do not give correct information for appealing a decision or filing a grievance. Before KanCare was approved, KDHE/HCF staff sent written confirmation that consumers would be able to exhaust an MCO's internal Grievance process(es) before taking the issue through the state's fair hearing process. These notices do not allow time to do both. As a result, consumers are confused about the reasons for the notices and are not told under what authority the notices are presented to them. This should be an issue that CMS is familiar with and can be corrected through written, public clarification about this important protection for consumers. We would also like to see appeal and grievance info more clear in Member's Handbooks and on MCO websites. At a recent Oversight committee meeting, the KanCare Ombudsman said he has received 1600 calls since he assumed his position less than a year ago (which is several per day and is no doubt difficult for him to manage). He also said most of the calls are from consumers who need help understanding the Grievance process. Please address this issue with the appropriate agencies and review the state Fair Hearing decisions regarding Notice of Action and service reductions.	2013-12-12 13:21
KanCare creating a system overhaul	Families are being told over and over again that nothing will change, Services will not change, rates will not change and you can keep your case managers etc. But things are changing. Options for doctors and psychologists are shrinking. The availabilty for the flu shot is being limited. DD providers live in fear of non-payment or retaliation for speaking their concerns. The State is now changing how billing is done for services, tightening the scope of services restricting what is billable, expecting updates in all plans of care and changing the mechanism for uploading assessments. All this in a matter of WEEKS. What the State would have done one at a time over months, they are doing all at once in a matter of weeks; an why because it will better suit the for profit companies set to take over January 1. There are obviously a lot of people concerned about what KanCare will mean to our service system and a lot of promises have been made. While we as families are told one thing we are seeing another as our Administration and Legislators create bills that go against what is promised. The DD Reform Act is something we should be proud of as important legislation to better serve and protect those with developmental disabilities,	2013-12-12 12:46

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	but there are those who are looking to make changes. Though they won't say it publically it has been said. We need to build trust again. We want to believe our representatives represent us and they need to demonstrate that fact.	
KanCare is an example of government idea & planning at its worst. The unreasonable timelines, expectations, etc. demonstrate this.		2013-12-12 11:28
This site is not allowing for comments. It is not accepting input.	Regarding KanCare, we have been following it very carefully this past year and see no advantages or improvements over the prior systems. There is great confusion, complications to care, payments delayed, Doctors refusing to participate, limited medical services, affiliation with the MCOs is difficult, and increasing costs and more paperwork for providers. We would like definitive proof that this change is going to be for the betterment of the individuals served before charging ahead and approving KanCare.	2013-11-23 18:52
The MCO system was never set up to serve IDD services		2013-11-22 12:07
Late payments mean provider closings	With evidence pouring in from providers of other Kansas waivers, late payments will be the norm. Some providers of ILC services have not been paid in 9 months. The state of Kansas has more small providers and they will suffer from late or delayed payments; they will not be able to meet payroll, and fringe, and will eventually close. Who will serve these individuals? If not for the small providers, there will be no one to serve them. Large providers in Johnson, Wyandotte and Franklin County's are at capacity. I am concerned that our state governments want fewer providers per county. Fewer providers mean people not in services. That saves the state money. I am sure that MCO nonpayment will make sure that only clinical type settings stay open and the residential home and community based small providers will be gone. The MCO's will make money off the interest they make stalling payments to providers. What is interesting about all this is there is no reason why any provider, big or small, should not get paid, because HCBS waiver services are a state provided benefit. However, the 30 days that is mandated to pay a claim can take 90 to 120 days, by the MCO stating it's not a "clean claim". We have taken a fairly simple system, two levels, and turned it into the nightmare that is insurance. People with MRDD disabilities are NOT sick. This medical model is an insult to the ADA and the Olmstead Act. By putting HCBS MRDD waiver supports in the medical model and forcing small providers to endure long waits for payments, you reduce choice in the community and endanger the supports we have worked so hard to develop in our community. CMS needs to consider our state article 63 with regards to choice. CMS needs to mandate that all claims are paid in 30 days. CMS needs to make sure that all providers have appropriate training to submit claims. I respectfully request a review of why providers are not getting paid before CMS approves Kancare.	2013-11-22 09:57
For-profit health insurance companies have no knowledge of services for people with intellectual diabilities!	Service providers of I/DD services are currently working on contracts with the 3 MCO's chosen by Kansas politicians. The contracts refer to physician's, patients, etc. That is not what long term services for folks with I/DD are and is evidence that for-profit health insurance companies should stick to what they know instead of chasing the funds of a non-profit non-medical service system. I've been in this field since 1984 and this is the scariest time yet as we give power over people with I/DD to for-profits that know nothing about them.	2013-11-22 08:04

Title	Description	Created At
Continue to carve-out DD Services	Regardless of what the State "believes," there is little or no evidence that the MCOs have the ablity to manage LT services for the DD community. Providing "Compelling Financial Incentives" to profit motivated MCOs is more likely to result in decreased services not more or better services. We've yet to hear the results of the pilot program in 2013.	2013-11-21 11:07
Delay or get rid of KanCare for I/DD Waiver	As a provider I have to say that the State of KS and the MCO's are no where near being ready for this transition. Since the PRTF program has been going through the MCO's this year it has been a mess. We may or may not get paid and often times it's a real struggle getting paid. We cannot function as a provider if we are not being paid for the services provided.	2013-11-21 10:48
To whom it may concern: it would only be a reasobnable request to go a step further with medicaid expansion by adding a burial clause.	Expand medicaid to include a burial clause. Far too many people who illnesses need insurance however, for the greater good it would be wise to add this clause due to the fact many indigent person's don't have the money for this service, can it be added to the insurance? Thank You	2013-11-20 07:52
Extend the Pilot Program, Delay KanCare for I/DD Waiver	As a provider in the pilot program I have to say the State of KS and MCOs are no where near being ready for this transition. There are still numerous unknowns about how things are going to work. 1) Authorizations from the MCOs that are needed for providers to bill are incorrect at times, missing, or taking as long as 30 days to obtain. 2) People in the pilot are only getting paid at around 60% of claims submitted and that's will the limited people in the pilot. 3) The code for day services is being changed from T2020 to T2021 which is going to cause yet more issues that have to be fixed in the MCO's systems before Jan 1, 2014. 4) Obtaining denials for third party insurances is of huge concern when the code is just now being changed 5) The services that were effected by KanCare on 1.1.13 are still not running smoothly and people are still not getting paid 6) There are errors showing up when claims that are submitted that the MCOs can't figure out 7) the State and MCOs are just now getting to the point of coordinating who is going to do some pieces of the puzzle 8) the pilot program for the billing component only started 10/1/13 leave very little time to work through issues - many of which are still not resolved. KanCare needs to be delayed until all the issues have been resolved and the pilot is running smoothly. Why on earth would you add thousands more people to a system that can not currently handle the hundreds in the pilot?	2013-11-19 12:18
I don't see why we should pay health insurance companies to manage group homes and supervised employment.	They are in the business of paying health care claims. They don't know anything about group homes and supported employment. Paying them to pay the providers just adds another layer of complexity and siphons off money that could be used to help more disabled individuals.	2013-11-19 10:37
I am on SSDI, a Kancare recipient, and a Kansas resident for over 20 years. Since Kansas went to Kancare this year. It has been horrible.	I think Kansas should be held to the to the standard requirements of the Patient Protection and affordable care act, rather than be allowed to hide behind a "demonstration period" in order to continue stalling and obfuscating this State's requirements until our extremist "anti-Obamacare" state Governor and radical legislature and "overthrow" an established law, passed by the US House, Senate and President, then given a nod of approval by the US Supreme Court. Speaking strictly for Kansas, I think any kind of exemptions or "demonstrations" will lead us down a dangerous slippery slope.	2013-11-19 08:07

Section 1115 Demonstrations: Kansas KanCare

Public Comments

Title	Description	Created At
Monkey dance!	I am same household provider for disabled family member I take care of 24/7/365, forced to clock in and out 24/7/365, enter 38,500 phone digit presses per year, with a 20% paycut at beginning of kancare, until now forever? zero job benefits, have kept family member out of nursing home for 9 years now, then comes Kancare,..20% paycut I cant do anything about, cant get a second job or obtain more clients. money earned goes toward providing needs for family member, has had no evaluation for needs or anything for over 2 years now, all newbie insurance for kancare needed was a signature and 2 checkboxes checked! twice! (like the v.a. b.s.). its just like LOCKDOWN or under HOUSE ARREST, Cannot Care for family member if its close to clock in or clock out. cant get prescriptions or medical needs maybe 45 minutes before clock in or out, too many stipulations about clock in and out times unbelievable? the limits are too many to discuss here,.....if 15 family members visit family member guess what I still must clock in and out, or not get paid for that day, or face not enough job duty codes entered, they might get lessened in hours. can I have a holiday or better yet a vacation after 9 years?.... And I'm supposed to pay for Obamacare also?/..and give my medical records to lois lerner? 20% of hours cut, "oh still clock in and out every day @ over 120 digits pressed on phone daily? over a quarter million phone digits pressed in a ten year period?!..." cook = 4 digits, feed= 4 digits, laundry = 4 digits every day???????????????????? and 16 other double digit job duty codes on the phone every day for the rest of family members life or mine? cosnstitution says freedom to travel without having to ask for permission from anyone! workers rights? who has to clock in and out from home every day forever and enter all those job duty codes???????? caller ID TRACKING, N.S.A., suspicious employees looking for fraud who must be checking water, electricity and gas bills of suspected fraudulent care givers? so they can get a raise? instead of quotas? does anybody have any more questions, save your medical records because the state will ask you, also, for listing of symptoms, diagnosis, prescriptions, and results of medical problems and your doctors name and address, for at least a 3 year period, like they did us too!!	2014-07-28 00:58
KanCare is in its Infancy	The Kansas Medicaid Managed Care [KanCare] Program is in its infancy stage. There are numerous issues with billing, prior authorizations, coding issues, communication, etc. To include the most vulnerable group of Kansans' LTSS into this system at this phase of the programs development is not at all a wise endeavor and should be avoided at this time to give the KanCare program a bit more time to mature and be in a far better position to absorb the services that individuals with Developmental Disabilities rely	2013-12-20 10:12

Title	Description	Created At
	on all day, every day to manage tasks of daily living that the majority of us take for granted. Kansas must be required to demonstrate that each of the 3 MCOs are adequately prepared to absorb the ID/DD LTSS and CMS should require the state to develop a long-range strategic plan to guide the transition to a full-risk capitated managed care arrangement for this population, to ensure a safe transition. There may in fact be an opportunity to improve the lives of Kansans with Developmental Disabilities to achieve better outcomes through KanCare, but for the LTSS for the ID/DD population, it must be implemented in a way where the State of Kansas and its contracted MCOs can demonstrate that they are capable of doing so with minimal disruption to the lives of these individuals and the system itself. What has been conspicuously absent here and is concerning for me, as a citizen of this state and an advocate for persons with ID/DD is “Adequate Planning” to ensure the safe and effective transition of ID/DD LTSS to the KanCare System. What has happened thus far is the State of Kansas has fervently defended its half-baked attempt at a pilot project and the need the desire to carve ID/DD LTSS into KanCare, spending countless hours accomplishing absolutely nothing while stakeholders look on in utter disbelief that this is actually happening. For the state/MCOs to truly be “ready” to implement this shift of service provision for the ID/DD population there must be ample time to adequately address and ameliorate most deficiencies in the system prior to implementation. This has simply not occurred and neither the State of Kansas nor the MCOs are truly prepared for the shift in responsibility of LTSS provision for the ID/DD population. More time is needed to prepare for the shift. Furthermore the State of Kansas has never thoughtfully developed a long-term comprehensive plan to address its growing waiting list for this population, where waiting times have reached upwards of 10 years. A logical approach to this, if CMS is in fact going to approve the waiver amendment request, would be to launch the carve-in of LTSS for the ID/DD population with an opt-out provision. This would create a natural pilot, while the state, MCOs, service providers, individuals, and advocates can thoughtfully develop a long-range plan to address the many concerns that have been expressed for two years now without any meaningful attempt address them. Clearly a large portion of the 8,600 individuals served on the DD HCBS Waiver would opt-out, but there would be a sufficient number of beneficiaries who would remain in the program that the state and MCOs could truly pilot this system on a scale that would be more manageable and would not disrupt the lives of 8,600 Kansans and jeopardize the entire ID/DD LTSS system. Another reasonable approach would be to have mandatory participation in a specified number of counties or Community Developmental Disability Organization (CDDO) catchment areas of each regional type to pilot in those areas to	

Title	Description	Created At
	allow for a successful transition and an improved system when and/or if it where go live statewide. The state of Kansas, like many other states maintain waiting lists for its DD HCBS Waiver. However, what is unique about Kansas is that it operates a waiting list within its comprehensive DD waiver. Like other states, Kansas had wide discretion in developing its DD waiver, but in doing so they chose not to reserve any of the waiver capacity, nor did Kansas elect to restrict or limit access at a "point in time", yet Kansas continues to fall well short in the number of unduplicated participants. Every state, every governing body for that matter has challenges it must address in terms of how it allocates its revenues, but the state of Kansas has, for years, neglected to address the growing issues surrounding the waivers it operates that have lengthy waiting lists. This is not at all due to lack of awareness, because it is widely known around the statehouse that there are 5,000-7,000 Kansans waiting for some type of LTSS. The fact is the Kansas Legislature has made a conscientious decision to not address the issue in a strategic way that would either drastically reduce the waiting lists or eliminate them altogether. Instead, the state has turned its eye on tax cuts, reduction in programs that assist the poor, elderly, and persons with disabilities. CMS should hold Kansas accountable for its failure to uphold its obligations to serve Kansans with Developmental Disabilities at the level it assured CMS it would. Thank you for your careful consideration of all of the concerns brought to light in this comment period and those that have been voiced for over the past couple of years.	
KanCare is not needed. The current system is effective and efficient.	KanCare is a cost saving effort plain and simple. THe talking point of providing better service and improved heath outcomes is a smoke screen. Long term services, employment issues (intervention, coaching, search), transportation, interpersonal // social skills, living // housing assistance...insurance companies have zero expertise in any of these critical areas. KanCare attempts to fix a system that is not broken.	2013-12-05 06:52
Dear Director Mann: The Wisconsin Department of Health Services has proposed a section 1115 waiver that would alter Medicaid eligibility b		2013-09-20 06:16
Choices limited for certain Medicaid individuals.	Dr. Wendy Perryman 2107 Henderson Rd Garden City, KS 67846 September 27, 2012 First, Kansas Medicaid recipients had to deal with Kansas's money being outsourced to other states. Mainly Arizona and Massachusetts. This one move put many payroll corporations out of Medicaid business. This added up to hundreds of millions of dollars of Kansas's money being shifted away form Kansas. Now	2012-09-28 12:57

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	Medicaid clientele are dealing with impersonal large corporate attitude and problems in communication not only between clients but also in amongst them selves. After, listening to one and a half hour teleconference I again have noticed some serious problems associated with services being given to the most vulnerable people. Again, the State of Kansas wants to limit the choice of vulnerable people like the physically disabled and mentally disabled to choosing between only three nationwide companies, also based in Kansas, United Healthcare, Americare Healthcare, and Sunflower Healthcare. You would be surprised how many hundreds of millions of dollars the disabled bring into this Kansas economy. According to the Topeka Capitol Journal, over 150,000 Medicaid clients and their families will be affected by this change. Approximately ten to twenty companies will be put out of business and at least 50-100 employees will lose their jobs due to this change. The right to choose an independent living counselor, who knows a patient's specific needs, will be taken away. With this situation the counselors will be impersonal, large corporation people who don't care about an individual client because their focus will be rushing to meet their quota. At a public meeting held at the Clarion Inn in Garden City, Kansas to introduce these three companies, many questions were presented to the companies but could not be answered by them. An example of one question was, if they knew of the Kansas Work/Working Healthy program. None of the three were aware that this program existed. According to the individuals that ran the teleconference on August 27 the program was mentioned twice and barley mentioned at all. Many questions still remain unanswered about Kansas Work because they dropped my call. How can they help the patient if they are not aware of the individual programs within the Kansas Medicaid system? A counselor is most effective when trust exists. How can trust be established with telephone calls and different people visiting home-based clients? These counselors would be strangers. There would be no continuity or trust in their care. The counselors would not be committed to the client because the "big picture" would focus directly on effective business. This is exactly what was presented in the KanCare presentation. In our society the most impaired people on Medicaid will not receive the needed assistance for their basic care and needs with this change to counseling. If the client is completely satisfied with their counselor, these counselors should really stay in business, or be hired by one of these three companies. Some things we cannot assign a value to, because they are priceless, such as, the quality of the care given to a Medicaid patient during the last days of their lives. Please take these serious concerns into consideration. Dr. Wendy Perryman	

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Concerned over state officials changing courses "midstream" in what they are telling families and providers, and children getting overlooked	In glancing through comments, I do not see a specific mention of the issues that the KanCare transition will cause to the most medically fragile population. These are children from age 0 thru 21 who are on the Technology Assisted Waiver who without this benefit, would be institutionalized as they are on life-saving technology. With the TA Waiver, they are able to live at home and have either nursing or attendant care to meet their medical needs, as well as allowing parents to work since most daycare facilities do not accept these complicated children. RNs and APRNs are the case managers for these clients due to their medical needs. However, the state currently does not allow them to appropriately coordinate medical care as it is considered to be a "conflict of interest", even though these were independent case managers, not affilitated any agency or Medicaid provider. However, they are asking and expecting the MCOs to do this. Over the past 4 years, the TA program manager has implemented a comprehensive assessment tool to help contain costs, while determining services based on the needs of that particular client, empowering families with responsibilty for care, but yet allowing the parents to be in the work force instead of unemployed or on welfare in order to take care of their child. In the last month, case managers have been given conflicting information as to their future since they are currently Medicaid providers, unlike case managers on other waivers. However, they have now been told that they will have to be employed by the MCOs. So - what happened to the promise to families that they would keep their case managers and that the MCOs would have to keep all the current Medicaid providers? One answer case managers were given was "it only applied to those consumers on the DD waiver". Clearly at every public meeting that was given, there was never that specification or clarification that this was for DD only. TA case managers also help and educate families on navigating the process of dealing with the complicated bureaucratic system. Now that the state has implemented changes to that in the last year that were supposed to ease that burden, it has only been worse. Families were also told that services would not be decreased, but then - in this medically fragile population, where there is very little stabilization of costs. If the case manager's "job" is to save the MCOs money, who will be the ones to watch out for the safety of these clients? Will it take something tragic happening to them because the MCOs wouldn't allow the necessary services in the home due to the cost? Unfortunately, a lot of the parents of these types of children have their own medical and mental issues, and need assistance in caring for a very complicated child, and the children are caught in the middle. What concerns me most is that with the "talking out of each side of the mouth" that has been given to providers, and families. Families and providers have been given a lot of conflicting information. How much worse is this really going to be when the transition begins before January 1st? Right now, that transition process looks very shaky and destabilizing for these kids and families if this is implemented January 1st, let alone at all. If the state would assign all Medicaid beneficiaries, whether or not	2012-09-26 14:55

Title	Description	Created At
	they are on waivers, with Medicaid independent nurse case manager providers and allow them to actually case manage, I think they would find they would save the money they think they will save by giving contracts over to companies who have no investment in our state, but only in expanding their business. I suggest that you look at more of the details of the plan because those details seem to keep changing dependig on who is speaking. I agree that there needs to be a change to help reign in the rising costs of Medicaid. However, those that need the help the most are the ones that are going to suffer from this change as it seems to be more political than financial. Yes, some waivers need revamping in their administration of covered services, but to include those on the DD waiver, the FE Waiver, the TBI waiver, and the PD waiver into a change of this magnitude all at one time is socially irresponsibler. These are client's who can't always speak for themselves and when the administration has "public meetings" to get input from providers, but it is obvious that they are not respecting any of that input, until challenged "big time" and then only bows to that population because they are the biggest voice. So why is it that the smallest voices get lost? Maybe because it is one of the smallest waiver, but these children are in need of services that even private insurance will not cover. I may be a Republican, and I don't appreciate people getting services they don't deserve, or that they abuse, but with the safeguards that the TA waiver program manager has put into place, these children and their families only receive services that are needed to keep them as contributing members of society. Our TA Waiver has been looked at by many states to copy because of how it has been structured. Basically, it is a type of managed care already, so why destroy something that is already working and others want to model? Oh, I know - for political gain and the ability to say "I reigned in Medicaid costs", regardless of what happens to a small population. I thought everyone was important. Please don't make a rash decision and consider thoughtfully and complete the full ramifications of a change of this magnitude.	
The system we have is working. Putting kids above profits is always a good idea.	The problem with Kancare is that it simply doesn't. Profits will always come before Kansas kids with a system that places profits above all else. While it benefits the wealthy donors to Governor Brownback, the children of the working poor will have poor medical care, at the expense of Kansas taxpayers.	2012-09-22 10:50
Healthwave works. No change is needed.	My husband and I own a small business that has struggled during the recession. In addition to our family business, I have a full time job, but we are still reliant on Healthwave to cover our three daughters' health coverage. It provides full dental coverage for them and has saved us when they've had costly health issues that would have been too expensive for us to purchase out of pocket. It has also insured that we are able to keep up with important preventative health care and dental cleanings. Healthwave has worked beautifully for us, and I see no reason to go through the costly process of changing a system that is not broken. I am also concerned about the dubious nature of the goals of the proposed	2012-09-22 07:35

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	changes, and the risk of benefits being lost to people who need them. Please deny this waiver.	
All waiver service should be under the same Office, insted of scattered around	Currently the different kinds of waivers, are under different depatements. If all of the HCBS waivers fell under the same program, less money would be spent for the wrong thing. More people would receive the benifits they need. The HCBS waiver system is cutting corners with KanCare. Please let all services communicate together on everything? Please make each service item, a matter of record, so everyone will have services? Let the records be available to all other branches of government. If everyone would pull together, the world would be a better place.	2012-09-22 02:04
All depatmetns in Kansas Goverments should share information about each Medicaid Recepient	In the past there has been a lack of communication between the departments at SRS and in our Government Offices. It would greatly benefit each individual, if their case information could be shared, with all the different departments in our State Government. I know the privacy act limits what can be shared. However actually having every department be able to share information about all Clients, would be very helpful. The different programs for Medicaid. Please let the different programs funct enrollies wouldn't duplicate services, through another program. Or not give people all the help they need, if they reach out for help. I feel the current system is inadequate for actually helping people with Disabilities receive the care and services they need. Surely the system can be improved, so everyone can receive care and all the services they actually need. There would be a lot less confusion if all Departmetns would share what they know and who it is actualy. I pray the new Medical program will have all the information about each client on Medicaid. Then there wount be any people cheating on what their needs are and how they are being cared for. Each department could get a better quality service for all involvedl	2012-09-22 01:53
KanCare is being put together to fast, without enough reaserch on what People really need	The State of Kansas, is rushing into their KanCare Program, without really finding out what Peopel really need. They weren't thinking right, when they made the decison to have a for profit company handle our States Medicaid Program. Turning over our care to an Insurance Company, that is for profit, just lets them take another piece of the pie, as far and money alotted to each indvidiuals care by our Federal Government. I urge our Federal Government to not allow Kansas to start the Kancare Program.	2012-09-22 00:31
Transportation for People with Disabilities shoudl be a covered item for KanCare	People with Disabilities have a right to have a life, just like regular people who work do. Many can't leave their homes, due to no way to get around, no transportaion that is affordable, is available to them. KanCare should cover the cost for their trips to the store, Church and other activiities in the community, along with the rides for Medical Care. Being able to get around in our world is important to everyone, not just those who have a nice car and lots of money.	2012-09-22 00:21

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It's time our State provided decent places for People with Disabilities to live	About all a Person with Disabilities can afford to live in is Public Housing, or a very low rent apartment. An individual isn't allowed to rent a 2 bedroom house, if they are single with no children. Our Government should give people vouchers for rent and let them pick where they want to live. After all our Federal Government actually puts almost $2,000 per month into their housing programs, for each individual with Disabilities. The funds don't trickle down to those who are suppose to receive them. Most of the $2,000 gets used up in overhead and management of the Housing Programs HUD. For petes sake, just give each person the $2,000 per month and let them pick where they want to live and how large a place they want to live in. Don't restrict Poeple who are single and without kids, to a one bedroom apartment. Many of the 1 bedroom apartments are almost worse than living on the street, or under a bridge. Living in a 1 bedroom apartment, is like you are shut in a small box. As far as I'm concerend, I feel living in the restrictive tiny 1 bedroom apartment, is crule and inhuman punishment to many people. You shoud go look at some of the tiny apartments people are forced to live in here in Wichita. Also many of the local apartments are over run with rodents and bugs, with utilities that don't function correctly. Housing for Poeple with Disabilites, that is quality, instead of a Nursing Home, should be a covered cost for KanCare.	2012-09-22 00:15
People with Disabilities shouldn't be over medicated by their Dr's just to keep them quiet.	Our States Dr's, need to change their tactics, as far as prescriptions for People with Disabilities. Most People with Disabilities I know, are on 10 or more medications. This causes terrible side effects in their bodies. Also it incapacitates most of them. This is not treating a Person with Disabilities with Respect and Dignity. Many People are on pain medications and other mind altering drugs, that make it almost impossible for them to function with any quality of life. It's time People with Disabilities were given Food supplements, vitamins, nourishing foods and other natural products, instead of all the prescription drugs. They would be much healthier and it would cost our State much less for their care. For instance, vitamin B 12 is one of our bodies natural pain fighters. Instead of using Mind altering drugs for pain, I receive a 2 ML inj of Vitamin B12 per week. It's much better than not being able to think clearly. Also the mind altering pain medications and muscle relaxers, are adictive. The longer you take them, the more your body requires. Wouldn't it be better to give a person a 2ML vitamin B12 injection each week, than put them on Fentenal Trans Dermal Patches, Oxycotton or Loratab? Therr are certain basic nutrients all our bodies need to heal theirselves. It's time those kind of Products are given to people, instead of just medicating them to shut them up, because the Dr's cant' fix them and don't want to listen to their complaints, or be burdened with them. After all we aren't really broken, God made us the way we are. It's time our State recognised that each one of us has a right to a quality life. We should be given things that inhance our abilities, instead of restriciting our abilities from being over medicated.	2012-09-21 23:57

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All Poeple with Disabilities should receive HCBS Services	Please end the Wait for those who are in need of HCBS Services? People that have been on the waiting list for HCBS Services, should all receive services right away. There have been people in our State who have died, without receiving HCBS Services, while on the States Waiting Lists. There shouldn't be anyone on a waiting list for services. Our Federal Government requires that All People with Disabilities be allowed to live in the lest restrictive environment, that gives them the best quality of life their Disability allows. People shouldn't just be stuck in the Nursing Homes as it costs 3 times as much for Nursing Home care verses HCBS Services. Or be left for their families to care for them. Care for People with Disabiliities is very costly. Most families can't afford all the things that are necessary, for their Loved ones with Disabilities to have the best quality of life possible	2012-09-21 23:38
The KanCare Program should cover the cost of Dental Repair	Just doing preventive care on peoples teeth isn't enough. The State should pay for restorative services on teeth also. Fillings, crowns and dentures for those who need them. After all if a persons teeth don't work right, it's hard for them to eat. Our teeth effect our whole body and should be kept as long as possible. It isn't enough to just get your teeth cleaned. That doesn't prevent decay and help repair damage, that has already happened to peoples teeth.	2012-09-21 23:27
Wellness CAre for People on Kan-Care	I truly believe that if you would cover the cost of Food Supplements such as Protandim and Ambrotos, you would have more People with better health. People with better health, have a better quality of life and it costs less for their care. I used to be on over 24 medications, which cost the Medicaid Program over $2,000 a month for my prescriptions alone. Now that I take Food Supplements Protandim and Ambrotos, I only cost the State a few hundred dollars a month for Prescriptions. Also I have changed from being a Zombie in an electric wheelcahir, to not even needing a walker to get around. I have a much better quality of life. With fewer Dr visits and lower cost to our State.	2012-09-21 23:19
I don't believe it is right to take away our ability to choose our own Case Managers for our HCBS Waiver Care.	I suggest you allow the current Case managers to be the Care Mangers for the 3 insurance cCompanies that are included in Kan-Care. After all our current Case Managers know us better than anyone else. It has been the right of People with Disabilites to choose their Case Mangers for the HCBS services since the program started. Taking our current Case Mangers of choice away, is violating our rights.	2012-09-21 23:12
Deny the waiver	Plan and simple, privatization is a bad idea for KanCare. Please deny the waiver	2012-09-21 21:14
After reading the material I can only conclude that the most vulnerable among us will be significantly impacted by the implementation,		2012-09-21 20:24

Title	Description	Created At
Keep Medicaid Public	We should not in any way privatize a program that is there to help our citizens that do not have access to healthcare because of lack of funds. A private company is interested in one thing: money. Companies do not have the interest of people at all in mind unless those people will increase their stock prices and profit. The answer is not privatization. Our current governor and state government should stop trying to destroying public and social safety nets and find true solutions that actually help Kansas citizens. That includes the poor and lower income citizens also, not just the rich citizens and companies that dump money into the governors coffers.	2012-09-21 17:38
The person who provides care needed by the patient in my family now covered by Medicaid, will not contract with managed care.	He has been approached by managed care people who have told him that he would be reimbursed at approximately 50% more with KanCare than with Medicaid, IF: He agrees to see new patients - not if he simply continues to see the few patients he already has; if he agrees to change his pattern of treatment to "behavioral therapy" which is based on shaming patients into setting goals that don't work (goals don't work, behavior modification doesn't work and in the end patient and caregiver alike are made to feel that they have failed); if he agrees to changes in medication suggested by managed care to the extent that the in some cases the patient's well-being is threatened. Managed care is a system by which people are essentially herded to particular sites when those sites need more patient appointments. The feasibility of transport for many of the people who would be controlled by managed care is not a consideration. The appointments are made well in advance because that's when the openings exist. They appointments are so far in the future that by the time they roll around, they are missed, forgotten, no longer needed, or they occur on a day that won't work for the patient for any number of reasons. When the appointment time becomes available, people on a waiting list are offered the time (often just hours before the appointment time). When the patient is unable to take the time offered, they are out of luck because they did not take advantage of the time they could have had. Managed care makes its money hassling the providers who have signed a contract. Managed care is driven by the bottom line, making money without concern for the care of the individual patient. They do not have any incentive whatsoever to attend to the needs of the people they will control. No incentive at all. None. Managed care has people who have training in allowing only what has been determined to be cost effective. Managed care people are not in the business of providing the appropriate care, just the least costly attention. Before any action is taken on the Federal level in the process of deciding whether or not to allow the governor of Kansas to push this plan through, it is vital (literally) that the exact procedures and intentions be fully available for complete unbiased review. If there is nothing in the promises made that threatens the adequate state of the art care for those people who need it, there should be no hesitation to provide that information. For the sake of the people of Kansas who do fall into the 47% defined by the republican candidate for president, I ask that	2012-09-21 17:23

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	Health and Human Services decision makers insist on complete and unambiguous access to any and all contracts, guidelines, procedures, training courses, provider documentation, provider reimbursement tables, and all planned extras such as uncompensated care costs, alternatives to Medicaid, and actual amounts covered listed by service. This will be huge and it will be convoluted but that's how people who run such businesses make their money. They hide in plain site all the ins and outs except for the straightforward answer to how much something costs and who pays for it and who will be allowed to have it. We all know this from recent financial disasters and from the obvious lack of intent or maybe ability of those who are or will be in charge to provide the facts as they stand. Please don't let the people with personal agendas in Kansas destroy what is working now for our people who have nowhere else to turn. And please don't make people who take care of these patients for the small amount of reimbursement they already are forced to accept, please don't require them to go out of business or to adjust to the lowered income that will result causing loss of jobs that we so need.	
The private sector is far better at managing programs. Vote "YES" for the KanCare waiver	The private sector is far better at managing programs. If you do not believe it, look at the huge waste in almost every government run agency and how it is almost impossible to control it. Government manager's pay grade is based on how big a budget they manage and the number of people they supervise. If you ask what they need, the answer is always "MORE". Don't believe it? Ask any Federal bureaucrat about "mission creep". Simple stated, once a small, temporary program gets approved, it quickly grows and morphs into something huge with functions that often overlap existing programs or function that really are not the role of government. Let's approve the wavier for KanCare and take a step towards reigning in at least one bureaucracy.	2012-09-21 15:54
LeadingAge Kansas represents 160 faith-based and other not-for-profit organizations that collectively serve more than 20,000 older Kansans e	LeadingAge Kansas represents 160 faith-based and other not-for-profit organizations that collectively serve more than 20,000 older Kansans everyday through their nursing homes, retirement communities, hospital long-term care units, assisted living and residential health care residences, homes plus, low income housing, licensed home health agencies and other community based service programs. We support Medicaid policy that is focused on quality outcomes, consumer choice and increased care coordination for individuals across health care settings. KanCare is the Administration's attempt to bend the Medicaid cost curve while improving care coordination and health outcomes. If the waiver is approved and KanCare implemented, LeadingAge Kansas stands ready to assist the State to achieve those goals. Ninety eight percent of our members participate in the Medicaid program. In SFY 2011 LeadingAge Kansas members provided nearly 1.5 million days of Medicaid-funded nursing home care.	2012-09-21 15:23

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	More than 15% of the assisted living care they provided was funded by the Medicaid program. For almost two years we have closely followed the State's development of KanCare. We appreciate the numerous opportunities we have had to ask questions and provide input to State officials along the way. Legitimate concerns remain. Timeline and Readiness We are increasingly uncertain whether January 2013 will provide sufficient time for the necessary parties (i.e. state agencies, MCOs, consumers and providers) to be ready for a successful launch of KanCare. The original timeline for the launch of KanCare was very ambitious. While we appreciate that the state has contracted with an outside firm to assess whether each MCO and the state is prepared for a January launch, it is equally important to assess whether consumer education efforts underway are adequately preparing beneficiaries. The state approval of MCO contracts and provider manuals has taken significantly longer than projected, severely compressing the time available for providers to review contracts and to have their questions and concerns addressed. Providers are now being pressured by MCOs to sign contracts in an unreasonable period of time or risk being punished for missing an overly ambitious deadline. Lack of Operational Details The lack of specific answers concerning how KanCare will actually operate may make a January launch difficult and rocky. There are hundreds of unanswered questions on billing procedures, policy manuals, care managers and coordination, record keeping, quality tracking, credentialing, and community based service capacity. With less than four months until launch, we find this lack of details troublesome. Auto-Assignment and Consumer Education Concerns We believe beneficiaries should be able to choose their health plan upon enrollment, rather than being auto-assigned by the State. Short of that, beneficiaries should have at least 90 days, rather than 45 days, to change plans. KanCare providers will be serving as the state's de facto consumer educators for many beneficiaries. This must be acknowledged and the state should equip providers with appropriate tools and information to help assure beneficiaries have access to information about KanCare in real time, at the right time, in the place they call home. Medicaid Program Savings under KanCare	

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	The State has ambitiously projected an $853 million dollar savings to the Medicaid program over 5 years with KanCare. What happens to providers and consumers if those savings are not realized? If the savings do materialize, how will those funds be used? Our strong recommendation is that any savings should be reinvested to improve service access, quality and options for Medicaid beneficiaries. The Real Problem Remains Unaddressed by KanCare KanCare and the various managed care and other experiments underway in our country do not touch the real problem that is driving Medicaid spending. As long as Medicaid is the default long term care insurance program for the vast majority of Americans, and as long as hardworking middle class Americans are forced to spend themselves into poverty in order to pay for their long term care needs, Medicaid will continue to grow at an unsustainable rate.	
KanCare will Harm our most vulnerable populations.	As a provider, I am deeply concerned that the implementation of KanCare will have a negative effect on the members we serve who are mostly pediatric clients with severe medical conditions or disabilities. I fear that handing the management of these clients services over to insurance companies will decrease the overall quality of the care management. I now hear that the state of Kansas is asking for the federal government to ease regulations on how Medicaid is managed. This is alarming to me because it seems Kansas is willing to gamble with the well-being of these children and their families in order to accomplish a political agenda. This shouldn't be about politics. It should be about the people the program will affect. I plead with the government at the federal level to be very critical of this situation and not deregulate Kansas Medicaid.	2012-09-21 14:07
Focus needed on early intervention for mental health treatment	NAMI Kansas is concerned that interventions and specific services are currently being provided after many individuals experience poor outcomes – including but not limited to individuals who have ended up in jail or prison, who have had multiple hospitalizations and crisis visits to the ER. If KanCare is going to be meeting its objectives, earlier interventions with mental health services must be routinely available. Individuals with the most challenging symptoms and the most complex needs, need assurances that adequate community-based services will be available in the community if we are going to be successful in avoiding more intensive and higher cost treatment venues. We believe that KanCare should target individuals who are in the early stages of their mental illness, particularly immediately following the first episode of psychosis. Intervening effectively and intensively through coordinated and aggressive treatment during the earliest stages of mental illness could fundamentally change the trajectory of people's lives and produce the greatest outcomes – such that people would not become permanently disabled by their mental illness. Currently it takes an average of nine years	2012-09-21 13:57

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	from the first onset of symptoms to get an accurate diagnosis and effective treatment. This is unacceptable. We know that SSDI beneficiaries with psychiatric disabilities are the fastest-growing and largest disability group, that they become disabled at a young age and remain on SSDI for many years, and that they are the most costly population in the SSDI program. A 2008 GAO Report entitled "Young Adults with a Serious Mental Illness" found that young adults required multiple supports from a variety of agencies. The agencies and programs often have differing eligibility criteria – including age, income and definition of mental illness – making it even more difficult to navigate the system. According to the report, these individuals have "fewer interpersonal and emotional resources with which to do so." Families often end up being the case manager, care coordinator and advocate, at a time when they are just learning about mental illness and the various treatment systems. Connecticut, Massachusetts, Maryland and Mississippi have targeted programs for young adults with a mental illness which should be considered for inclusion in KanCare. We should take the time to investigate the type of services that were offered and the approaches utilized to meet the needs of these young adults. Early intervention, with adequate intensity, is paramount to reducing costs long term.	
1115 Waiver Comments - Recommendations - KMHC	The Coalition encourages broad transparency and oversight of the operation of the proposed KanCare program. In the immediate future, contract negotiations are crucial to the development of a program that achieves the stated goals, however, this process is not transparent and it is unclear how many of the details of the MCO contracts and practices will be public. The creation of the KanCare Advisory Council is a good start, but we do not know what processes this Committee will use to provide oversight, nor what authority it might possess to influence change. The establishment of a specific legislative oversight committee to monitor the process and the subsequent program, and focus on the potential ramifications on various populations proposed to be served under the plan is necessary. Without a designated committee, we are likely to experience multiple hearings before multiple committees on a variety of issues, which will not provide the opportunity for public comment in a focused arena. Slowing the growth of Medicaid expenditures will be a complicated challenge, and we must not assume that the dollars spent on specific treatments today are the maximum to be spent in the future. Some programs may need to grow in proportion to others in order to provide more effective and successful treatment for Kansans with serious mental illness and co-occurring diagnoses. For example, Kansas should explore new ways to address the rising numbers of individuals who are admitted to state mental health hospitals as their first contact with any form of behavioral health treatment, which may include reimbursable services outside the spectrum currently available.	2012-09-21 13:56

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	While the KanCare proposal anticipates that all Medicaid recipient populations will be included in the new programs to be operated by three managed care companies, there are those who would prefer to be carved out. The Coalition believes that current systems know best how to most effectively manage their own service delivery system. Cost containment challenges could be presented within their current systems and recommendations implemented from within. Certain assumptions have been made about the projected savings and state general fund expenditures for KanCare. These assumptions are not transparent. If there will be changes to the program as it has been outlined initially, there must be in depth review of the ramifications of those changes on the projected savings, state general fund expenditures, consumers and providers in the program. Stakeholders should be involved in any changes to the KanCare proposal. 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: 1. Statewide access to public and private mental health providers; 2. Medical homes that are accessible to people of limited means; 3. Access to an array of services that address the critical needs of individuals with serious mental illnesses; 4. Treatment by practitioners with professional licensing or certification; 5. Access to mental health medications complying with current Kansas law prohibiting preferred drug lists for behavioral health medications; 6. 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; 7. Sufficient preparation to prevent delays in turnaround time and backlogs in determinations of Medicaid /Healthwave eligibility; and 8. Reliable information and assistance to be provided to participants and families by advocacy organizations for eligibility, information about services and treatment available, complaint processes, and dispute resolution. As set out by the Consortium for Citizens with Disabilities in their May 2012 document Principles and Recommendations for Transitioning People with Disabilities into Medicaid Managed Care, "… under most state Medicaid programs, traditional health care services are augmented with a wide variety of services intended to improve functional status, assist in transportation, assist in gaining the ability to live independently and work. Traditional managed care programs and plans simply lack the experience of providing services to people with disabilities with these needs under a Medicaid benefit package. As such, there has been limited development of effective quality measures specific to individuals	

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	with disabilities to ensure that these populations are being well served." This history does not mean that KanCare will fail to appropriately care for Kansas's disabled citizens, but great care must be taken to insure that this experiment does not hurt the most vulnerable. The following CCD recommendations are excerpted from the above referenced document: 1. Before implementing managed care of long term services and supports, the state must develop and have in place a comprehensive quality management system that continuously gathers, evaluates and monitors performance data of contractors and subcontractors. Independent third party consumer and family monitoring teams should be formed and utilized as part of the quality management system to perform on-going evaluations and assessments of the effectiveness of managed care in supporting beneficiaries in living full, healthy, participatory lives in their communities. Quality management data must be transparent and readily available to the public. 2. The state must provide strong administration and oversight of the managed care system, particularly when mandatory managed care is implemented. The state must employ sufficient qualified staff with experience in addressing the needs of individuals with disabilities. The state must obtain regular input from stakeholders. The state's responsibility for day-to-day oversight of the managed care delivery system must be clearly delineated in managed care contracts. 3. The existing reservoir of disability-specific expertise, both within and outside of state government, should be fully engaged in designing service delivery and financing strategies and in performing key roles within the restructured system. 4. States should require managed care systems for people with disabilities to cover the full range of services and supports needed to address the diverse needs of people with disabilities on an individualized basis across the life span. The benefit package should build upon existing services and supports needed by beneficiaries to live in the community, including services for acquiring, restoring, maintaining and preventing deterioration of function or acquisition of secondary disabilities. Information about the benefits and any limitations imposed on the benefits should be readily available to the public. For more information, contact: Kansas Mental Health Coalition c/o Amy A. Campbell, Lobbyist P.O. Box 4103, Topeka, KS 66604 785-969-1617, fax: 785-271-8143, campbell525@sbcglobal.net c/o David Wiebe, President 5608 Cherokee Circle, Fairway, KS 66205 913-645-6175, dwiebe@kc.rr.com	
More specific focus needed for employment services	Employment Initiatives	2012-09-21 13:55

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for individuals with mental illness	People with a serious mental illness have the lowest employment rate of any disability group. Less than 15% are employed. They represent the largest group of individuals receiving federal disability payments and are more likely than other disability groups to begin receiving disability payments at an earlier age and continuing to receive disability payments for a longer period of time. People who obtain competitive employment have increased income, improved self-esteem, improved quality of life, and reduced symptoms. The Individual Placement and Support or IPS model of Supported Employment is the specific evidence-based model that should be emphasized in KanCare. While there are other employment initiatives in Kansas for individuals with disabilities, the impact of these incentive programs is untested. On the other hand, IPS Supported Employment has extensive research documenting the employment outcomes for individuals with serious mental illnesses. IPS is nearly three times more effective than other vocational approaches in helping people with mental illnesses to work competitively. Approximately half of the people who enroll in IPS become steady workers and remain competitively employed a decade later. IPS should be the default model for all mental health providers. IPS helps people in community mental health service systems to become a part of the competitive labor market. IPS is cost-effective when the costs of mental health treatment are considered. Several studies have found a reduction in community mental health treatment costs for supported employment clients, while other studies have found a reduction in psychiatric hospitalization days and emergency room usage after enrollment in supported employment. Service agencies that have replaced their day treatment programs with IPS have reduced service costs. Incentives should be in place with the MCOs to ensure that IPS Supported Employment is offered at all community mental health centers and at a scale sufficient to achieve ********** rates of at least 50 percent of the target population. Currently only half of the mental health centers operate the program and generally are not achieving the ********** threshold of 50 percent. IPS Supported Employment actually helps people get better and most consistently matches the objectives for KanCare.	
Array of mental health services needed	Medicaid recipients who live with a serious mental illness or who meet the criteria for severe and persistent mental illness (SPMI) are among the most vulnerable Medicaid populations. Accordingly, Medicaid resources should be applied to the most effective services, ideally those evidence-based practices which also have proven to be cost-effective. Medicaid should pay for services that fall outside the traditional medical model. Specifically, rehab services are cost effective for those whose illnesses are more severe.	2012-09-21 13:54

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	We are concerned that the KanCare proposal is too narrowly focused on achieving savings in the Medicaid budget and not adequately focused on positive health outcomes. The current managed care system for mental health allows savings to be re-invested back into service delivery. For mental health treatment this is critical due to disproportionate reductions in services which have been made over the last several years. KanCare will not provide for that reinvestment. It is only through making investments in a broad array of rehab services that such positive health outcomes will be achieved for individuals with serious mental illness. In addition, it is only as a result of providing the necessary array of services that individuals with serious mental illness will avoid unnecessary hospitalizations and incarcerations. The array of services should include but not be limited to the following: • Assertive Community Treatment (ACT) teams that operate with fidelity to the Dartmouth ACT model • Crisis services, including crisis stabilization programs, and short-term crisis beds in a community-based setting • Mobile teams to respond to individuals experiencing a mental health crisis • Supportive services for housing and employment for individuals with serious mental illness utilizing evidence-based models • Access to services from Certified Peer Specialists as part of all treatment teams • Models of consumer-directed care such as the Cash and Counseling program piloted by the Boston College Graduate School of Social Work with support from the Robert Wood Johnson Foundation. • Maintaining the current statutory exemption from the preferred drug list for psychiatric medications. Psychiatric medications are central to most treatment plans. An appropriate range of medications must be available to patients based on their individual needs and tolerances.	
1115 Waiver Comments - First Track - KMHC	The Kansas Mental Health Coalition is dedicated to improving the lives of Kansans living with Mental Illnesses and Severe Emotional Disorders. We are consumer and family advocates, provider associations, direct services providers, pharmaceutical companies and others who share a common mission. At monthly roundtable meetings, participants develop and track a consensus agenda that provides the basis for legislative advocacy efforts each year. This format enables many groups, that would otherwise be unable to participate in the policy making process, to have a voice in public policy matters that directly affect the lives of their constituencies. The opportunity for dialogue and the development of consensus makes all of us stronger and more effective in achieving our mission.	2012-09-21 13:48

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	The Kansas Mental Health Coalition supports those changes in Kansas Medicaid that improve access to the right treatment, at the right time, in the right place, in the right amount and for as long as necessary to ensure a timely and durable recovery for people with mental illnesses. While we appreciate the opportunity to submit comments on the 1115 Waiver and have attempted to engage in every opportunity for public input in the development of KanCare, there are few details available at this time about how mental health treatment will change Our comments raise a few of the concerns that have been discussed in the context of our Coalition. We also encourage our members to submit comments. 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 (PAHP) allows savings to be re-invested back into service delivery. For mental health treatment this is critical due to the 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 (EBP) 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. Early information addressed the important navigator role for certain Medicaid populations to help consumers make the best choice among the managed care organizations (MCOs); however for the behavioral health population this process was inadequately articulated. It is unclear how individuals will access assistance for making these choices. In fact, information provided by the central KanCare information line indicated that consumers will be expected to contact each MCO in order to find out whether or not the plans cover their chosen providers and needed medications. This is an unrealistic expectation for many Medicaid participants and contrary to prior public information which indicated that all MCOs would cover the current state formulary. The Coalition believes that there must be reliable information and assistance provided to participants and families by advocacy organizations for eligibility, information about services and treatment available, complaint processes, and dispute resolution. There has been no clear investment in this arena to date and the plans for the ADRCs are still not available.	

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	KanCare should include unbiased third party dispute resolution and an ombudsman charged to act on behalf of the consumers of Medicaid health care. Further, we are aware of no compelling reason to support limiting the enrollment period to 45 days. 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. Individual recovery depends on access to the full array of services, including rehab services and peer support. Families in particular rely on services such as respite care and wraparound for success. The current managed care system (PAHP) was charged with improving access to mental health treatment and establishing a meaningful consumer input process. The direct contractual relationship between the Department of Social and Rehabilitation Services and the managed care contractor (Kansas Health Solutions/KHS) resulted in some immediate changes to service delivery and direct oversight. We are concerned that the managed care organizations will contract with subsidiary companies to manage their behavioral health services, creating a four step separation between the state agency that manages mental health policy (Department on Aging and Disability Services) and the entity that directly makes the decisions about what services will be reimbursed for which program participants. The determination of medical necessity is where the rubber meets the road in the provision of health care in the managed care environment. According to the waiver application, the State has determined that contracting with multiple managed care organizations (MCOs) will result in the provision of efficient and effective health care services to the populations currently covered by Medicaid and CHIP in Kansas, as well as ensuring coordination of care and integration of physical and behavioral health services with each other and with HCBS. We are concerned that providing behavioral health care and addictions treatment through three separate subsidiaries will by its very nature be less accountable, less efficient and less effective than the current PAHP. It is also unclear what percentage of the predicted savings are targeted to come from future expenditures in behavioral health. Behavioral health is already under managed care. Private managed care insurance has historically achieved cost savings by limiting inpatient days or numbers of outpatient treatment visits. Will the MCOs be expected to further reduce access to inpatient care? These limitations do not lead to better mental health outcomes. Key to this issue is the interplay of care management vs. utilization review. The MCOs will certainly require the coordination of care	

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	for an individual's diabetes and a corresponding mental illness. But, for instance, will that coordination extend to recommending cognitive behavioral therapy for the person who has been prescribed an anti-psychotic medication for his bi-polar diagnosis? According to one MCO representative, it would depend on whether or not the contract requires them to do so. While such a recommendation is likely to produce better long term health, and reduce lifetime cost of treatment to the State – the MCO is only likely to make this recommendation if it is beneficial under the applicable contract. (A similar recommendation was made by an advisory committee of mental health stakeholders to the Kansas Health Policy Authority. That group has since been discontinued.) The application further states: "Including institutional and long-term care in person-centered care coordination means KanCare contractors will take on the risk and responsibility for ensuring that individuals are receiving services in the most appropriate setting. Outcome measures will include lessening reliance on institutional care." For persons with mental illness, inpatient care is sometimes the most appropriate setting. We know from experience that targeting savings by reducing the number of individuals screened for inpatient care can result in unanticipated cost increases in other state agency budgets, and result in tragic outcomes for persons with mental illness and their families. And since the state mental health hospitals can not be reimbursed by Medicaid, we are concerned how the State will incentivize the MCOs to reduce institutionalization by policies other than screening fewer people into the hospitals or other inpatient settings. This discussion also leads to questions about reimbursements for private psychiatric inpatient programs, which would be paid by the MCO contract as opposed to admissions to the state mental health hospitals. The Hospital to Home Committee as convened by the Department of Social and Rehabilitation Services recommends expanding private inpatient options, rather than reducing them. See more.	
KanCare need more work - delay implementation to protect beneficiaries	NAMI Kansas is the state organization of the National Alliance on Mental Illness, the nation's largest grassroots membership organization representing individuals living with mental illness and their family members. NAMI Kansas endorses the comments filed by the Kansas Health Consumer Coalition (KHCC) in response to the application for a section 1115 demonstration waiver for the Medicaid program filed by the state of Kansas as KanCare. We have participated in the regular meetings of the KHCC and have contributed to these collective comments. We also endorse the "Principles and Recommendations for Transitioning People with Disabilities into Medicaid Managed Care" published by the Consortium for Citizens with Disabilities and have attached this document for CMS' consideration. We	2012-09-21 13:45

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	have previously shared this document with Kansas officials although we are not aware of how these principles have been addressed in the revised KanCare waiver application or whether the KanCare work group on Specialized Healthcare is addressing these recommendations. NAMI Kansas has been closely following the development of KanCare and has been engaged in a variety of stakeholder meetings. While there was substantial public input prior to the release of the KanCare RFP, there has not been a process in place for the state to receive comments on the specific KanCare plan nor do we have an understanding how all of the comments generated in last year's public meetings were addressed. Our observation is that while there have been responses to many of the concerns raised about KanCare, for the most part there have not been substantive adjustments to the KanCare model based on input from beneficiaries, family members, and patient advocacy organizations. While it is true that there have been a number of opportunities for public input and opportunities to be heard, details of the program are substantially the same as when the concept was first introduced. NAMI Kansas supports the objectives of KanCare to improve the quality of care for Kansans receiving Medicaid and establishing reforms that improve the quality of health and wellness for Medicaid beneficiaries. We specifically support the objectives of KanCare to move toward integrated, whole-person care, the creation of health homes, the focus on creating paths to independence for individuals with disabilities by emphasizing community-based services, and support for alternative access models. When KanCare can deliver on these promises, then the waiver requests which support those specific aspects of the program should be approved. However, we are very concerned that the scale of the changes being proposed and the timeframe in which the state of Kansas is seeking to implement the changes is overwhelming the state's capacity to manage the process. We believe that the learning curve for the three MCO's, who are generally not familiar with the service delivery system in the state, adds to the burden of the implementation timeline. Barring dramatic improvements in the ability of the state and MCOs to ensure an orderly transition and guarantee continuity of care for current beneficiaries, we believe that a delay in the implementation timeline should be seriously considered and would be in the best interests of our members. We believe that the state is not adequately prepared to address issues of consumer choice once the program is set in motion. Discussions to date in the KanCare Member Involvement work group regarding concerns about the process for beneficiaries to choose among the three MCOs have not been adequately addressed. This leads us to have grave concerns for how that choice process will be managed by our members in the absence of personnel who are dedicated to walking consumers through the	

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	process. We have repeatedly asked the state to develop a contract with an impartial non-provider organization to fulfill this role. While the state's Aging & Disability Resource Center will perform this function for certain populations, it leaves many other beneficiaries to fend for themselves or to rely on patient advocacy organizations who are not equipped with the information or resources to adequately provide this service. We recognize and acknowledge the importance of controlling Medicaid program costs. However, we maintain a healthy skepticism and have genuine concerns that the proposed level of savings can be achieved without cutting services to beneficiaries which would in turn undercut the other principal objectives of the waiver application. In the last year we have asked repeatedly for the state to share its assumptions that underlie the projected savings anticipated from the implementation of KanCare. We have recently participated in briefings intended to provide a more transparent review of the underlying assumptions. However, the data which has been shared fails to demonstrate how the savings will be achieved without a reduction in services.	
As usual Kansas has found another way to dismiss its underserved. I am against the proposel.		2012-09-21 12:48
Kansas Advocates for Better Care	Kansas Advocates for Better Care has advocated for consumers with long-term care needs for 37 years. KABC is beholden to no commercial interests and is supported almost entirely by donations from people who support our mission of improving the quality of care in all long-term settings. It was among a handful of non-profit groups which worked to win passage of the Nursing Home Reform Act of 1987. KABC urges CMS to deny the Kansas waiver request until the following issues are addressed or at a minimum, delay inclusion of frail elder nursing home residents in KanCare. Meaningful Health Outcomes KanCare does not set nor measure meaningful health outcomes for older adults in nursing homes or home/community based settings. Instead of setting health care outcomes that would improve care quality, KanCare primarily sets and measures processes such as quality and timeliness of the contractor services and payments to providers, and illusory cost savings. (RFP Attachment J) We urge CMS to require health outcomes that assure and measure the emotional, social, psychosocial, and physical wellbeing of older 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. Consumers should be assured that provider networks will restrict geographic displacement of elders to no more than 50 miles in rural areas. Budget Concerns	2012-09-21 12:45

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	The State refuses to share with the public and stakeholders the assumptions that shape the budget for KanCare. There is still a scarcity of basic budget information, despite regular Medicaid stakeholder meetings and two meetings of advocates with the KDADS chief fiscal officer. The State estimates that it will "reduce the growth of Medicaid" by more than $1 billion/All Funds. The State has refused repeated requests to detail how this reduction will be achieved. As the budget neutrality section is formatted, we cannot determine even the most basic data, such as the number of nursing home residents and the number of estimated recipients to be served by the HCBS/Frail Elderly waiver. Nor, can we determine how much of the budget is estimated to be spent on these populations, or compare historical data with future projections. The public does not know how savings estimates were calculated, how soon the savings will be realized or how savings will be distributed, if at all, among Medicaid programs. Consumer and Stakeholder Communications The State's outreach plan does not take into account the needs of nursing & home- bound consumers or those with limited transportation, communications challenges, or lack of internet access. Public education and outreach has been limited to a few public meetings in urban settings and web-based information. The State has provided a teleconference option to one open hearing and one educational meeting. They have relied on traditional forms of media outreach such as press releases and stakeholder groups to notify seniors and their families. Recipients were not notified by mail of planned public meetings. The State-published phone number provided for general KanCare questions was unable to respond to questions posed by a non-DPOA advocate calling on behalf of a consumer. Disregard of Public Input Kansas consumers have no meaningful ability to measure the impact of KanCare. Its stated outcomes & measures relating to quality of care and access are meager. The Initial public forums did not propose wholesale managed care. The State has made a show of seeking input, unveiled its plan, but has not made adjustments based on consumer input or needs since. An experiment of this magnitude, impacting the State's policies and budget, requires an open and transparent public discussion, inclusive planning, and flexibility. Grievance and Appeals With changes of the magnitude proposed in KanCare, it is fair to assume there will be a high volume of beneficiary questions, concerns and complaints, along with a high number of glitches. An external entity that provides conflict resolution for and tracking of recipient problems would offer much needed consumer assistance to KanCare. An external entity could collect and use this data to inform needed KanCare revisions for MCOs and for policy makers. After being assured consumers would be able to keep their case managers, recently the State announced persons on the Frail	

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	Elderly Medicaid waiver in KanCare will have a case manager employed by the MCO. In the internal grievance and appeals process this effectively leaves frail elders on their own. Consumers have been provided with little information about how the grievance and appeals process will work and may find it daunting, if not overwhelming. Lack of Accountability and Public Oversight The State did not build in legislative authority to oversee the financial or operational aspects of KanCare. The absence of legislative oversight is one more indicator of the lack of accountability to the public that recipients and advocates raise repeatedly throughout the KanCare debate. 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. Frail elderly consumers are not receiving adequate education, preparation, or assistance to assure uninterrupted care and services in the move to KanCare. Recent Kansas budget projections are for a deficit of at least $2.5 billion over 6 years, as a result of newly passed tax reductions. All state agencies are asked to plan for a minimum of 10% annual reductions.	
KANCare is the wrong direction, under the wrong guidance	The state government of Kansas is the wrong place to go for an nonpartisan, objective oriented health care plan. The state has shown that regardless of the the worthiness of a federal program it will never be anything but "Obamacare" to them and thus is rejected in a knee jerk reaction. Looking at this road "taken alone" - it started with a rejection of Federal funds to automate the existing system in a standard and uniform way and progressed down hill from there. What of the US citizen that moves from Kansas to another state? How does this patchwork actually make sense to separate from a countrywide standard of care (lots of arguments there as to why the citizens of the country can not expect the same care as our elected officials). I can see our state government balancing the books on the backs of our seniors and we will truly understand the idea of death panels. The state of Kansas can not fund and maintain the K-12 education system - clearly a state function - yet they feel free to be confident and compelled to muck about in this area. This is an experiment that senior and currently covered Kansan's can not afford to take part in.	2012-09-21 12:42
CMS must ensure that adherence to the Americans with Disabilities Act is accomplished by the	CMS must ensure that the State of Kansas has clearly defined and described the responsibilities that the MCOs and their contractors have in meeting accommodation and accessibility requirements in all policies, practices, programs, facilities, and employment related	2012-09-21 12:23

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MCOs and their subcontractors	arenas. Oversight as to the implementation of these consistent accomplishment of these responsibilities, the training provided to ensure understanding and compliance, and ongoing assessment of physical and programmatic access across disability and age groups must be documented. As a part of quality of care assessment protocols and measurement cross disability cultural competence should be required	
KanCare is too rushed, not transparent, and has no oversight	As a person of faith and elementary school nurse, I urge CMS to deny the KanCare waiver. I worry about the families at my school. There is not enough time before 1/1/13 to replace Healthwave, get families enrolled (who frequently have computer challenges), and ensure adequate care for my students. Why is the current system needing to be scrapped when it has been working quite well, simply needs more capacity and more dental care. Finally, the governor says the change will save $1 billion. How? What profit margin for the corporations? Who will be overseeing to ensure quality of care and detect fraud? Families I work with deserve quality health care, not a rushed, "experimental", less-than-transparent process that seems driven more by corporate profit than by the health care needs of low income families (and seniors) in my community. Please deny the waiver.	2012-09-21 11:46
Data needs	Thank you for the opportunity to comment on Kansas Section 1115 “KanCare” Demonstration Application. Beginning in the mid-1990’s I have been involved in examining models of managed care including long term care for potential use in Kansas. Models that have worked well in other states often build on the existing private non-profit service infrastructure in the state and are developed collaboratively with these groups. Many previous comments have addressed issues of community collaboration and speed with which KanCare is being implemented. I want to focus my comments on the state’s need for data with which to evaluate both the costs and benefits of KanCare. I believe the state has a solid plan to have comprehensive data on customer’s health and functional status as well as supports, collected on an ongoing basis via an assessment done by staff of independent ADRCs. Careful collection and analysis of this customer specific data longitudinally will be critical to being able to determine the effect of this new initiative on people receiving services. However, information on service usage is also crucial for policy makers. The Kansas Medicaid Management Information System (MMIS) database provided a very rich and reliable source of data on service usage for fee-for-service Medicaid customers. State agencies have collaborated with university researchers and have used these data for many years to help guide policy decisions. However, under a capitated system, the monthly capitated payments may be the only data available in MMIS. Given this loss of data, the state’s requirements for data from the for-profit managed care organizations (MCOs) need to ensure state agency staff and other policy makers have sufficient information to assure program accountability and evaluate health outcomes. Such data	2012-09-21 11:34

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	need to be collected in a systematic and standardized way across all organizations administering Medicaid benefits in the state of Kansas. Careful collection and analysis of these data will make it possible to do a thorough cost benefit analysis of the impact of KanCare on the health of Kansas' most vulnerable citizens.	
Health outcomes must be appropriately measured to understand how KanCare will impact Medicaid beneficiaries over time	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 im-proving 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. Additionally, 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 func-tional 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 ********* 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	2012-09-21 11:33

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	already reduced funds available for elder care, it encourages continued institution-alization 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	

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	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. 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 ill-nesses; • 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 We were pleased to see the state asked that all three MCOs offer a preventive adult dental benefit. This is a population that has seen many years of dental neglect because they have not had access to preventive or restorative dental benefits. While a more comprehensive benefit is critical for adults in the Kansas Medicaid program, this is a step in the right direction. Still, Kansas already suffers from a low Medicaid participation rate by dentists, which could be further eroded by requiring them to	

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	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 differ-ent billing systems. This could make it increasingly difficult to attract dentists to participate in the Kansas Medicaid program. 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.	
Effective education and conflict resolution process must be in place	Public Education We continue to be concerned about public access to information about the KanCare program. The Governor's office has indeed held more public forums, however those forums have not been particularly effective at informing the public about the details of the KanCare system. Additionally, public input gathered in those forums has not been incorporated into the program in any meaningful way. The state's public forums do take place in several cities across the state; however, they are only available to individuals who are able to travel to the meeting site. Those who are homebound, or unable to attend at the particular time and date of the forum in their city have few options for obtaining the information that is offered. Additionally, no matter how well attended, it would be impossible to reach even a large percentage of Medicaid beneficiaries through public meetings alone. The format of the public forums allows little opportunity for the public to fully engage with the state regarding how KanCare will work and how to access it. Much of the information presented by the state seems much better suited to marketing and public relations than to a real discussion of the KanCare policies. Attendees are given the opportunity to submit questions in writing, but if the state's answers are inadequate or generate additional questions, they do not have the opportunity to follow up or seek clarification during the forum itself. In fact, when people attempt to be recognized to ask a follow up question, they are specifically told that the state will not take additional questions from attendees, beyond what has been submitted in writing. Additionally, the information presented at various forums, being presented by different officials and representatives, is frequently	2012-09-21 11:27

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	inconsistent between forums. The state has shown a great deal of confusion within its own ranks regarding details of the policy, and in so doing, has created greater confusion and uncertainty in the public. At forums attended by organizations contributing to this document, the state even indicated that additional information is available at the KanCare website, and offered to take questions by email, but did not ever display the website URL or email addresses. During the time beneficiaries have to select a plan, they should have access to comprehensive, accessible and detailed enough to help make an informed decision. At present no such resource exists. Even the FAQ section on the official KanCare website is difficult to search. We believe the state should be engaging in a public education process that includes mailings to beneficiaries, and public service announcements across various media. Advocates from various organizations, serving many of the affected populations have explicitly offered to assist in the crafting of educational pieces to inform the public of the coming changes, but much of our input has been ignored. One example of a specific suggestion that the state has thus far ignored, is that KanCare be co-branded during the first year with HealthWave. 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. The waiver application even refers to this suggestion specifically; During the statewide public education campaigns, education materials will emphasize that the former HealthWave program (and other programs such as Health Connect) will become KanCare on January 1, 2013. (Waiver, Pg. 27). However, to date we have still not seen a single educational piece that adequately references current Medicaid and CHIP programs, and indicates that those programs are transitioning into KanCare. Indeed, on the same page of the waiver, the state also indicates: [The state is] designing an extensive educational campaign so all Kansas Medicaid and CHIP consumers and their families, legal guardians and caregivers understand KanCare and the transition process. (Waiver, Pg. 27). If such an extensive educational campaign exists, it has not yet been initiated, nor has it been shared with the advocacy community. A series of public forums is a beginning, but it cannot be the entire educational plan.	

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	45 Day Choice Period In our comments on the original April 26th wavier, we indicated that only allowing 45 days during which to select an MCO was an inadequate amount of time, compared with the 90 days that are currently available. The state responded to this concern by indicating that because auto-enrollment will occur in the fall, prior to the January 1 effective date, beneficiaries will actually have as much as 90 days, given that they can change their plan assignment after the auto enrollment: All beneficiaries will receive an initial plan assignment and enrollment information in the fall, during the open enrollment period. They will be able to change plan assignment prior to January 1, and they will also have 45 days from the enrollment effective date of January 1 to change to a plan of their choice for any reason. (Waiver, p. 6) While this is an improvement over the language in the original waiver, we are still concerned that it does not guarantee every new KanCare beneficiary a full 90 days to review the options and choose the best MCO for their family. We see no guarantee that every beneficiary will receive their auto-enrollment notice on or before November 17, which is necessary to ensure that beneficiaries have a full 45 days prior to January 1. Additionally, this extended enrollment period, which includes as much as 45 days before the January 1 effective date, followed by 45 days after the plan becomes effective will not apply in future years to new enrollees. Future beneficiaries are to be limited to 45 days to make a selection. Our objection stated in our comments to the April 26th waiver remains; we feel this shortened time frame prioritizes the interests of the MCOs over those of the affected consumers, and will significantly decrease consumers' ability to make an informed choice. Employment Pilot Programs The August 6th waiver includes, beginning on page 15, an expanded section regarding employment, and employment-related pilot programs. Though the goal of increasing employment opportunities for Medicaid recipients is a noble one, we are concerned that too much emphasis on moving people off of Medicaid benefits and into an employment setting could result in creating unnecessary barriers to care for the state's most vulnerable populations. We are particularly concerned that participation in these programs may become a condition of eligibility for Medicaid in the future. Neither of the two pilot programs outlined in this section include adequate detail to understand how they will actually operate. The first makes reference to a "certified benefits specialist" who will be responsible for "benefits planning" for those who participate, but gives no additional information about what this will entail and how it will affect beneficiaries.	

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	Consumer Conflict Resolution Given the uncertainties surrounding KanCare, many consumers are concerned about service denials and interruptions. As services and supports will be provided by for-profit companies under KanCare, there should be an external and independent conflict resolution system. Currently conflicts and appeals of service denials are to take place within each of the three MCOs, before being appealed to the state's fair hearings board. We believe that in order for KanCare to best serve Kansas consumers, the state should create and fund professional, independent support for members with conflict resolution issues. This support system should be independent of the MCOs, Medicaid providers and contractors, as well as the state itself.	
Sufficient budgetary information is necessary to allow for a full analysis of the impact of KanCare	Budget Neutrality Kansas' 1115 waiver application fails to demonstrate how KanCare will achieve the projected cost savings of more than $1.1 billion, nor how it will be budget neutral. The advocacy community has worked tirelessly to obtain more information about the financial projections, but succeeded in uncovering only very limited answers. It is important to realize, also, that even though we have been able to access some level of detail through private meetings with government officials, much of this information continues to be inaccessible to the general public, giving them very little ability to evaluate the very optimistic claims being made by the governor regarding the cost cutting potential of the program. 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 57 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 58 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. We have pressed for more information regarding these differing trend rates. In many instances, the five year growth rate in per member per month costs differs greatly from the projected trend rates, in both the "with-waiver" and the "without-waiver" projections. We have received additional information regarding how projections were adjusted to "normalize" the data, and remove extraneous factors. However, when we have pressed for more details for each Medicaid population, we have run into	2012-09-21 11:26

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	obstacles and been told that some of the information we seek is proprietary. In addition, the "rate methodology adjustment" used in the KanCare waiver appears to be based on the average of the bids provided by the three MCOs, but there has been no transparency regarding how they will be able to provide the same services as under the current Medicaid program while operating at such vastly reduced cost. Moreover, several of the populations for which savings are projected, such as CHIP, are already enrolled in managed care programs. As of yet, no explanation has been made as to how managed care under KanCare will provide greater savings than the current managed care system. 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	

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	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.	
Transparency and Substantive Public Scrutiny are Still Lacking	Transparency In response to previously expressed concerns regarding the transparency of the process, the state convened a KanCare advisory council and four external KanCare workgroups. However, much as with the public forums, the meetings held by these groups only give the appearance of transparency, without actually opening up the process. Suggestions, concerns and offers of expertise made in the advisory council as well as in the work group meetings do not seem to translate into action by the state in any meaningful way. An example of this can be found in the state's print brochure about KanCare. Rather than seeking input from advocates at the beginning of the process of developing print materials, a completed brochure was shown to the workgroups. When advocates expressed concerns that it did not contain the most relevant or helpful information, and that the design was ineffective, the state replied that the piece had already gone to print, and there was not time or budget available to make changes. Additionally, major policy decisions are made entirely behind closed doors. Throughout most of the process of developing KanCare, the state has assured advocates and beneficiaries alike that consumers who currently have one will be able to keep their same case manager after KanCare is effective in January. That assurance was retracted late last month when the state revealed that the three MCOs will employ the case managers. This means that if a current beneficiary is auto-assigned or selects an MCO other than the one that hires his or her case manager, they will be forced to work with a new one. Additionally, there is no guarantee that any of the three MCOs will hire existing current case mangers. Neither advocates, nor the public at large, or even beneficiaries were ever asked to weigh in or comment on this change. Instead, we were merely informed after the fact that the state's policy regarding case managers had changed. Because of this lack of transparency, it is also unclear whether the organizations and individuals who currently provide case management services will be eligible to continue doing so under KanCare. One MCO's website currently has job listings posted for case managers, but limits the pool of applicants to registered nurses, which disqualifies many current case managers. Response to Public Concerns Appendix B has been expanded in the August 6th version of the waiver to include the state's responses to concerns raised during the formal public comment period. Unfortunately, many of the	2012-09-21 11:17

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	responses lack any documentation or evidence of the assertions made. On page 25, in response to the concern that the selected MCOs lack adequate experience in providing long term care services, the state asserts that, "during the bidding process, each contractor furnished information to the State that demonstrated this experience, specifically including long term care, in other Medicaid programs." If the MCOs have indeed provided information about experience in long term care services, we believe the state should make that information public, to allow advocates and beneficiaries to evaluate it. On page 27, the state responds to the question "how will the health homes program work?" by indicating that health homes will be implemented by the MCOs in 2013 for certain populations, and be expanded to all populations by the end of 2014. This answers the question of when the health homes program will be implemented, but it does not answer how it will work. We believe the state should provide additional information about how the health homes program will operate. Finally, on page 28, the state is asked how it plans to address HCBS waiting lists. The answer provided is that by reducing Medicaid costs overall, KanCare will "aid in the reduction of waiting lists." It remains to be seen whether KanCare will, indeed, reduce Medicaid costs, but even assuming that it does, the state must provide more explanation for how those saved funds will be used to reduce the HCBS waiting lists.	
KanCare Offers Cautious Opportunities for Dental Services	Oral Health Kansas is the oral health advocacy organization for the state. Our organization has over 1,100 supporters, including dentists, dental hygienists, educators, safety net clinics, charitable foundations, and advocates for children, people with disabilities and older Kansans. In June, we provided comments to CMS on the state of Kansas' first 1115 waiver application. Our comments remain largely the same in September but have been updated here. Adult Dental Benefits The state of Kansas asked all the MCOs to offer a preventive dental benefit for adults as part of their value-added services. This decision marks the most significant step forward in Medicaid dental benefits in our state's history. The Kansas Medicaid program long has guaranteed dental services will be available to children, but the same guarantee has not been available to all adults enrolled in the Medicaid program before now. Adults who are Medicaid beneficiaries generally have experienced lengthy periods of time without a way to pay for dental services they need. This population is the group typically seen at Mission of Mercy events where people have significant dental procedures up to and including full mouth extractions. A preventive benefit will not provide all that they need, but this is an important step in the	2012-09-21 11:13

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	right direction. Oral Health Kansas will promote this coverage as a major step toward ensuring quality health and wellbeing for our residents. We also will continue to advocate for a restorative dental benefit for adults to restore their mouths to full health. When people have healthy mouths, they are healthier overall, happier, and find it easier to get and keep a job. Dental Provider Network If KanCare is to continue to provide the dental services Kansas Medicaid beneficiaries have received for many years, the dental provider network must be strong. There is low participation in the existing Medicaid program by Kansas dentists. Some dentists who currently take Medicaid have reported to us that it is cumbersome to sign three different provider agreements. They also report that it is confusing to understand three sets of insurance company expectations. We have heard from several Medicaid dentists that the burden of signing three provider agreements quickly may prohibit them from remaining Medicaid providers. Many of these comments could be due to the speed with which the provider contracts are being offered in order to meet the January 1, 2013, deadline. Taking the time necessary to engage in concerted provider education can help alleviate the concerns. 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.	
Please do not allow this misguided effort to continue	Dear Secretary Sebelius, I am writing today to urge you to halt this misguided and politically motivated effort that will remove protections for portions of our population that need it the most. Please keep political game-playing separate from doing what is right. (Note: you always did this, however our current governor needs some lessons.) I have no faith in an outside organization managing this program effectively and in the best interests of the people. Signed, Mandy Stark Roeland Park, KS	2012-09-21 10:10
KanCare Places Most Vulnerable Kansans at Risk	Please deny the KanCare waiver. Moving three groups of the most vulnerable Kansans to health coverage under for-profit managed care insurance companies will result in countless additional hours of advocacy by caregivers or health care providers to get	2012-09-21 09:30

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	reimbursement. The grossly inadequate amount proposed for each child to cover out of pocket expenses will mean 1 in 3 children in the state now covered by HealthWave may not get needed care. That means all children in the state will be at greater risk as the ill children interact in school and daycare with otherwise healthier individuals . People with Intellectual and Developmental Disabilities often can not advocate for their own care. Kansans in long term care facilities may not even have access to a telephone and may be there because they are challenged to deal with daily basic needs. Moving care of these most vulnerable individuals to corporate employees who are evaluated on how well they serve the interests of shareholders by "holding down costs" is not in the best interest of providers or the state. I had health coverage through my employer and the services of professional benefits coordinators to advocate on my behalf. I still spent countless hours as did the benefits staff trying to get the for-profit provider to pay full payment according to our contract, to resubmit claims repeatedly and to fight with the provider for arbitrary denial of claims. This KanCare plan was hastily conceived and forced into a rapid deployment to meet the political aspirations of a governor who would toss his own family members under a bus if it furthered his status with his ultraconservative base. Please do not allow politics to threaten the health and care of many children, developmentally challenged and elderly in Kansas. Thank you for the opportunity to comment. Jane Hatch Kansas City, KS	
Medicaid should not be privatized.	As a clinical social worker in the field of child and family mental health, I believe having private for-profit companies as gate keepers will drastically limit benefits. Children with severe mental health diagnoses typically struggle to maintain in community-based services. The families of these children are under enormous stress. It is already difficult to obtain the services needed to keep these children, their families, and their communities safe. My fear is that as benefits become more scarce and access to the system becomes more cumbersome, children will hurt themselves and/or others.	2012-09-21 09:19
Random Assignment of Medicaid Members to one of three MCOs	Random Assignment impact on Nursing Home Residents	2012-09-21 08:24
Follow the money	Look at the contributions! Jeff Colyer, M.D. (lt. gov.) received almost 5 times the political contributions of his opponent in the last election. If you look at his list of contributors it includes the Koch Brothers, Blue Cross and Blue Shield, etc. Do you honestly believe they have not agenda in making these donations? BC/BS stands to make huge profits as you know they will be one of MCOs. Just think about it.	2012-09-21 08:20

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Dental Treatment	It is extremely important to have preventative dental care, but some who have been without such services are beyond the prevention stage and need treatment to save remaining teeth and to provide dentures that will improve not only their appearance, but their ability to eat and their access to employment. Treatment needs to be included in the benefits provided by KanCare.	2012-09-21 08:13
Treatment for tobacco addiction should include access to prescriptions and counseling.	There should be no limits on prescriptions, OTC aids or counseling for those trying to improve their help by quitting cigarettes or other tobacco products. Tobacco use is still the single most preventable cause of death in Kansas and in the United States.	2012-09-21 08:09
Medically Necessary	"Medically Necessary" is code for meanings other than: preventing the onset of ordeterioration of a medical illness and/or likely to improve/cure said condition. It can also be code for denying treatment modalities which are not parsed in the medical model of illness/diagnostics/problems. I.e. Prohealth prevention models, mental health services (as opposed "mental illness services"), services which are likely to have high recidivism rates (such as substance abuse issues or eating disorder issues (including weight loss/gain problems), health services that are not directly related to the outcomes of other identified problems (i.e. relaxation classes for hypertensive or bypass patients: example: sessions of depression treatment for bypass patients in the six months following bypass surgery results in an over $100,000 savings in E.R. sequelae expenses as compared to patients who do not get this treatment) etc. Whose monitoring the agenda of these decisions and what power do they have?	2012-09-21 08:06
The MCO's have as an agenda profits. One way to reduce profits is to deny payment for services and thereby deny services. Unethical.	The MCO's have as an agenda profits. One way to reduce profits is to deny payment for services and thereby deny services. Follow the money. Who makes money on this scheme? Which politicians get election funding from these people? Who are the shareholders of these companies and how much to they contribute? Do not mistake the public for fools.	2012-09-21 07:43
For profit providers KannotCare and will not care. Your benefits will disappear, just as they are from company plans now.	If you've been enrolled in a company insurance plan, you know how costs continue to spiral upward while benefits decline and your out-of-pocket costs increase year after year. Don't start yet another program on the same model that makes us pay through the nose and get it up the ****.	2012-09-21 07:02
KanCare must include an ombudsman program for enrollees	We appreciate the opportunity to comment on Kansas's Section 1115 Medicaid Waiver. The National Consumer Voice for Quality Long-Term Care is a nonprofit national organization that advocates for quality long-term services and supports on behalf of long-term care consumers in all settings. Our membership consists primarily of consumers of long-term care services, their families, ombudsmen, individual advocates, and citizen advocacy groups. For more than 37 years,	2012-09-21 05:56

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	the Consumer Voice has promoted quality care and consumer protection through legislative reforms, policy advocacy, and consumer and public education. As advocates for consumers, we know the critical importance of an independent ombudsman to help individuals with issues, problems and questions related to their care and service. The Consumer Voice is concerned that the Kansas proposal does not establish such an entity. Creating an independent member advocate for enrollees provides a valuable complement to oversight and monitoring provided by the authorizing state and federal agencies. The enrollee advocate's primary task would be to advocate for enrollees by collecting and reviewing complaints, assisting enrollees in appeals processes and helping enrollees understand their rights under the plan. The enrollee advocate could also assist enrollees in maintaining eligibility for services and help with advising potential members on enrollment options. In addition, the enrollee advocate can report to state and federal agencies on consumer experiences in order to assist the oversight functions of those agencies and to improve the system. We urge CMS to require Kansas to include in its waiver some type of external independent ombudsman program that is mandated to: • Provide individuals with free assistance in accessing their care, understanding and exercising their rights and responsibilities, and in appealing adverse decisions made by their plan. This assistance would include: • Understanding benefits, coverage or access rules and procedures, and participant rights and responsibilities; • Making enrollment decisions; • Exercising rights and responsibilities, including Olmstead rights around community integration; • Accessing covered benefits; • Resolving billing problems; • Appealing MCO denial, reduction or termination of service decisions; • Raising and resolving quality of care and quality of life issues; • Ensuring the right to privacy, consumer direction, and decision-making; and • Understanding and enforcing an individual's civil rights • Identify systemic problems and work with state and plan officials to raise and resolve issues. • Be accessible to all individuals through telephonic helplines and, where appropriate, in-person appointments. • Be permitted to participate in participant advisory committee meetings with MCOs and state officials. The ombudsman should prepare reports to the state, at least annually. These reports should be made public. • Be given channels of access to senior officials at the MCO and the state. A schedule of periodic meetings between the	

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	ombudsman and plans and the ombudsman and the state must be established to discuss patterns and systemic issues. • Be funded by the state. Funding must be sufficient to carry out these services. • Be housed in an independent organization with an established record of enrollee representation. The organization must have credibility with the senior and disability communities and the capacity to foster formal links with both communities. Additionally, MCOs must be required to notify individuals of the availability of the ombudsman to assist them. There are states, such as Wisconsin and Minnesota that provide consumers served by MCOs with this key protection. The citizens of Kansas deserve equal protection.	
Special Need Caregivers Should Not Be Burdened With Bureaucracy	Please deny the State of Kansas' application for KanCare. As a parent of two special needs children (with cerebral palsy and autism), caring for them with their existing network of doctors is about all their mother and I can handle. Putting another layer of bureaucracy in our lives will only negatively impact our ability to care for these children. The State of Kansas frequently ignores the stress that these additional bureaucratic maneuvers adds to parents and other caregivers. We do not want to be part of an "experimental project." The State of Kansas has failed to prove that disadvantaged children and adults will benefit from the KanCare program and that would be the only reason to waive the provisions of Section 1902.	2012-09-21 05:46
I am stongly in favor of the KanCare proposal. It will improve care and cut costs.	The use of market forces in health care delivery vice government price controls and rationing is the only way to go. Health savings accounts will help empower the the health care consumer instead of government or insurance company bureaucrats.	2012-09-21 05:16
The Similar Illusions of kanCare and the Wizard of Oz	KanCare officials believe that the bill for Medicaid can be reduced by 1.1 billion dollars over the next several years. Dorothy and Toto sought help from the magical Wizard to get them back to Kansas. When the curtain was pulled back the Wizard turned out to be an ordinary man. Substantive reductions in expenditures for Medicaid are an illusion. When the Medicaid curtain is pulled back, this is what is revealed. Kansans who use Medicaid struggle to pay for housing, food, clothing, transportation, etc. let alone health care. The local hospital loses money for each day a patient with Medicaid spends in the hospital. Reimbursement for many services under Medicaid is so low that there is a shortage of doctors and other health care professionals who will see patients with Medicaid. If anything, the Federal government and the State of Kansas need to increase the dollars spent on Medicaid. One leading health care economist who addressed several committees of the Kansas legislature several years ago reminded legislators about the idea of "gleaning" in the Old Testament. "Gleaning" is the biblical mandate that the farmer set aside 10% of his/her wheat crop each	2012-09-21 04:39

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	year to give to the widow and the orphan. Put more simply, "I am my brother's keeper." Government officials need to focus more on helping others rather than reducing the lifelines by which many Kansans live.	
I am responding on behalf of the Kansas Health Care Association (“KHCA”) to the Kansas Section 1115 “KanCare” Demonstration Application subm	I am responding on behalf of the Kansas Health Care Association (“KHCA”) to the Kansas Section 1115 “KanCare” Demonstration Application submitted on August 6, 2012 (“KanCare”). KHCA notes that this application does not comply with the requirements in 42 C.F.R. §431.412 as follows: 1. 42 C.F.R. §431.412(a)(1)(i): “A comprehensive program description of the demonstration, including the goals and objectives to be implemented under the demonstration project.” 2. 42 C.F.R. §431.412(a)(1)(ii): “A description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing (premiums, copayments, and deductibles) required of individuals who will be impacted by the demonstration to the extent such provisions would vary from the State’s current program features and requirements of the Act.” 3. 42 C.F.R. §431.412(a)(1)(iii): “An estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable.” 4. 42 C.F.R. §431.412(a)(1)(vii): “The research hypotheses that are related to the demonstration’s proposed changes, goals, and objectives, a plan for testing the hypotheses in the context of an evaluation, and, if a quantitative evaluation design is feasible, the identification of appropriate evaluation indicators.” The KanCare Application on pages 18 and 58-59 includes projected expenditures under the 1115 Waiver. However, the KanCare Application does not include any resource data to validate the projections. There are several other States currently operating their respective Medicaid programs under private managed care contracts for beneficiaries and providers using the same three managed care organizations (“MCOs”) under contract to Kansas. At the very least, Kansas should be required to provide evidence of the actual experience of the States with Medicaid managed care experience about the costs savings to their Medicaid program and the quality of care provided to the Medicaid beneficiaries under the managed care system. Without this information there is no method to determine if Kansas’ cost savings projections have any merit or support. In Kansas’ submission dated April 26, 2012, which was later withdrawn and substituted with the current August 6, 2012 application, the projected cost savings were $838,597,779.00. See Kansas April 26, 2012 Application, page 51. In the August 6, 2012 submission, the costs savings are projected to be	2012-09-20 16:20

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	$1,100,600,013.00. The August 6, 2012 submission does not explain the basis for the change in projected savings or provide any factual support for the projected savings. While the August 6th Application includes new information on co-pays, it also adds costs related to uncompensated costs. See Kansas August 6, 2012 Application, page 59. This difference in projected costs savings to Kansas of over $262 Million in less than 4 months demonstrates that Kansas cannot support the assumptions in the Application. There must be some basis to support the benefits and costs savings to support waiving Federal law. The "comprehensive program description" fails to identify how adding another layer of bureaucracy will result in cost savings. CMS should have empirical data from other States operating their Medicaid programs under managed care contracts to know whether that system is preferable in cost and quality. If not, CMS should not extend additional waivers until CMS has had an opportunity to determine if this system works. There is no harm to CMS or Kansas in maintaining the status quo when Kansas' assumptions are based on nothing more than unsubstantiated aspirations. 5. 42 C.F.R. §431.412(a)(1)(iv): This section requires the application to include "Current enrollment data, if applicable, and enrollment projections expected over the term of the demonstration for each category of beneficiary whose health care coverage is impacted by the demonstration." The KanCare Application on page 18 provides the aggregate number of enrollees with and without the Section 1115 Waiver. However, nowhere in the application are these numbers broken down into the categories of persons impacted by the Waiver. The Application on pages 32-43 lists the "Medicaid Eligibility Categories Included in KanCare" but does not include specific enrollment projections for each category. Moreover, instead of breaking down the projected enrollees into categories as required by regulation, KanCare lumps previously identifiable beneficiary groups into one. For example, under the traditional Medicaid program, there are separate beneficiary categories for long term care recipients, the frail elderly and physically disabled. KanCare lumps these three beneficiary categories together. This practice provides further doubt about the basis for the estimates. For these reasons, we believe the Application for an 1115 Waiver should be denied.	
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KNASW comments	The scope of this demonstration project affects at least the 380,000 persons covered by Medicaid as well as the hundreds of individual Social Workers who want to deliver the full range of behavioral health services. Exclusion of certain licensees from providing integrated care: The waiver focuses on integrated, whole person care, combining physical care with behavioral care. This is a positive direction. An equally important integration of care is with mental health and substance abuse. It has been expressed that the majority of persons who seek care for substance abuse problems suffer from a primary mental health condition. Examples include Post Traumatic Stress Disorder (PTSD) or depression or anxiety disorder and a substance use disorder. Currently, integrated care of persons with this form of dual diagnosis has significant barriers. This is because, by current state policy, Medicaid will pay for substance use treatment performed by persons who are professionally	2012-09-20 14:54

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	licensed to offer only addictions treatment. This group of licensed professionals is prohibited from diagnosing and treating mental health disorders except substance use. The individual who has a dual diagnosis in mental health and substance use is forced to see two different behavioral health licensed professionals instead of working with one professional (Social Workers and others) who can address both problems. This is the opposite of the waiver goal of "reducing isolated, narrowly focused care provision." Provider network in behavioral health: A provider network enables timely access to care for the necessary services in both the public service delivery system and the private sector. There has been pressure for providers to join the provider network of each of the three MCO's, but crucial information such as the Provider Manual is not made available. Providers are asked to make a business decision without knowing the administrative and service delivery expectations of the MCO's such as the approval of services, utilization review/management, paperwork, rates, payment procedures, and other in network obligations. This puts providers at a disadvantage, especially those who are sole proprieters with no support staff. Requests before approval is considered: 1. Require the state to support any willing provider, who is professionally licensed, for Medicaid reimbursement without the exclusion of some in favor of others for substance use services. 2. Assure that the three MCO's provide full information to potential providers before joining the network and do not create burdensome administrative requirements that would deter private sector clinicians from choosing to be a Medicaid provider.	
Increased administrative costs in for-profit companies a concern	I'm concerned that private insurance companies, (3) from outside our state will be more concerned with saving money than spending money on the needy. If the state's overhead is between 5-7%, with 93% to 95% going to people in need, and private insurance companies' overhead is between 15% to 20%, (80% to 85% of the money going to the needy,) how will KanCare save money? This KanCare is an "experiment" that requires a fallback position if it fails. What would that look like?	2012-09-20 14:25
Issues with data transfer-ability, success benchmarks	I am concerned that the medical records of participants will/may not transfer between the three Managed Care Organizations. How are measurements of quality recorded, collected and displayed? I am concerned that this program is an experiment with no piloted demonstration of savings. If it doesn't work, will the disabled people be the ones that suffer? I doubt that the provider CEOs will lose their pay if this goes bad. Are you going to help the disabled if this plan doesn't work out as advertised?	2012-09-20 14:20

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KanCare plan not financially feasible	It's not financially feasible. You can't provide more services with no loss to providers at a higher overhead. A similar system is being used in Kentucky and it's a disaster. Why are large payments to providers over the amount provided by DHS listed in the waiver? Where in the world do they think disabled people are going to find jobs with insurance to get them off the rolls-or find jobs for welfare moms, even? It's in the waiver! The whole plan is an unrealistic, pie in the sky mess.	2012-09-20 14:15
Outsourcing a mistake; Medicaid expansion needed	The plan has basic flaws that we know from the history of health care reform. Outsourcing health care to for profit companies is one flaw. We need to take the profit out of health care. We need to take advantage of the Medicaid Expansion to cover those above the Medicaid eligibility so those in need of coverage can get it by paying some of the premiums and getting a subsidy through a Health Insurance Exchange. The wider (more people covered) the pool, the more economical it will be for all of us taxpayers. This is what the common good is about. This is what a civilized society looks like.	2012-09-20 14:12
Branding transition, timeline coordination, oversight needed	In the transition to KanCare from Healthwave, we don't want children't coverage to get lost. We also need timeline coordination and benchmarks to be very clear, so that beneficiaries know when and how they need to act. We also need to look after our elderly population using case coordination, oversight and caseworkers.	2012-09-20 14:04
State agencies fail to provide case management or use money appropriately	I have watched the agencies that provide services get rich from my disabled daughter by extreme underpayment of employees as well as ballooned POCs and reimbursements from the state well above the services they provide or by charging for services (case management) that they do not provide. They have not been held accountable for what they do or to truly provide case management. In 6 years my daughter has seen a case manager once a year. Her case has not been managed. Yet, the agencies get paid large sums. Also, one particular agency has the only medicare provider number and is the only agency that can provide OT, speech, PT which has eliminated those services for my daughter for the past 2 years. I think the state has implemented the Brain Injury waiver for these agencies to make $ off disabled people by robbing the state!	2012-09-20 13:55
1115 waiver not a solution	The Kansas Council on Developmental Disabilities is opposed to including long-term care service for the I/DD population in the KanCare program. Any quality gains or cost saving that may or may not be realized by better medical services coordination does not require the inclusion of long-term care. Nothing in the proposed I/DD service pilot project indicate that anything other than medical care will be measured as an outcome. There is no	2012-09-20 12:17

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	indication that quality of long-term care services will be measured or improved. Adding the additional management cost of the Managed Care Organizations will only increase cost reducing resources that could better be used to address the growing waiting list.	
KanCare Needs to Provide Rigorous Oversight of MCOs Utilization Management	At a recent meeting of the KanCare Advisory Council the three MCOs described their Utilization Management processes. Two of the MCOs noted that in the Kansas City area UM staff from the MCO routinely travel to the hospitals in KC to conduct their reviews. One MCO stated that it reviews hospital stays on a daily basis and begins planning for the patient's discharge on the day of admission. Utilization management can be mild/benign; moderate; or heavy/aggressive. It seems likely that the KanCare MCOs will eventually apply these same UM processes to senior citizens in long-term nursing home care. KanCare officials will need to provide strong oversight to make sure patients at all levels of care receive the treatment prescribed by their doctors.	2012-09-20 11:03
Please do not allow the waiver for Kancare. It is simply a way to move public dollars into private dollars.	Kentucky has gone to a similar system that is not as inclusive and it is a mess. Millions of dollars have gone missing, providers are not being paid, and the managed care companies are spending more money than they take in. Please don't let this happen to Kansas.	2012-09-20 11:02
Families USA Comments: As proposed, KanCare likely to hurt people who rely on Medicaid	Families USA is pleased to provide comments on Kansas's Section 1115 Medicaid waiver for KanCare. As a national organization that focuses on access to care for low-income individuals, we have an interest in Kansas's application, as it proposes significant changes for all Kansans who rely on Medicaid. We are only commenting on Track 1. The aggressive implementation schedule proposed, particularly coupled with inadequate outreach, could result in disruptions in care. We understand that KanCare planning has begun and that the selected MCOs are planning for these additional populations and services. Nevertheless, we question the MCOs' ability to develop adequate provider networks, particularly for long-term care, in the course of a few months. The selected plans have little or no experience with long-term services. Building an adequate network takes time, particularly in a state like Kansas where many beneficiaries live in rural areas. The lack of a clear consumer education and outreach strategy is worrisome. KanCare will affect many different populations, each needing a targeted outreach plan. For example, co-branding KanCare with the well-known HealthWave brand could facilitate transition, but is not planned. A strategic outreach campaign is critical to successful transition, particularly with such a short timeframe.	2012-09-20 09:56

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	We are concerned about the magnitude of projected cost-savings presented in the proposed waiver. It is unclear how the demonstration will achieve the stated savings of $1 billion over 5 years. For example, several populations for which savings are projected are already enrolled in managed care. Even in the populations where managed care will be introduced, it is unclear how such large savings will occur so soon after implementation. Managing long-term services can potentially generate savings, but only over time. We worry that the unwritten assumptions involved in the estimates may involve anticipated cuts in or reduced access to services. Auto-assignment of beneficiaries limits choice and could compromise care. Those in Medicaid at KanCare's implementation will have the option to change plans any time between plan assignment until 45 days after KanCare begins. However, it appears that people who enroll in Medicaid after KanCare starts will have only 45 days to change plans. We believe that beneficiaries should be able to choose the plan upon enrollment, rather than being auto-assigned. Auto-assignment can disrupt care delivery for any population, but particularly for seniors and people with disabilities, who make up approximately 30 percent of Kansans in Medicaid. Many of them have chronic conditions and established relationships with care providers. Maintaining those established relationships is often essential for optimal outcomes and lower costs. Auto-assignment, particularly with such a short window for plan changes, does not support that. Current federal standards allow 90 days for beneficiaries to switch managed care plans after enrollment. The state gives no rationale for a shorter time frame. A clear description of state oversight and evaluation plans for KanCare is missing. Specifically, the proposal should include clear language around how the state plans to manage the selected MCOs and hold them accountable for providing high-quality services to beneficiaries. This waiver should not be a request to hand-off the management of Kansas Medicaid to MCOs. Furthermore, the waiver lacks critical information regarding how health outcomes will be measured across the diverse populations included in the KanCare demonstration. Particularly given the State's desire to implement the program as soon as possible, we urge the state to develop a plan for both measuring health outcomes and access, as well as to collect and incorporate feedback from key stakeholders through a public comment period. Additionally, we are concerned about the lack of consumer engagement in the development and future management of the KanCare program. While we understand that the revised waiver	

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	submitted on August 6 created a consumer advisory council, that council's role in oversight and management is unclear. Without a clear process for responding to council recommendations, we worry that council concerns may not be acted upon. To increase transparency and ensure KanCare is adequately meeting consumers' needs, creating clear plans for oversight, addressing council comments, and integrating consumer feedback are crucial. The proposed alternatives to traditional Medicaid would harm people in Medicaid. The state proposes a pilot to offer individuals a health account for at least 3 years, during which time they would be barred from applying for traditional Medicaid. This proposal is concerning. It does not specify an account dollar amount, but from the governor's FY 2013 budget, it appears to be a $2,000 payment for the 3 years. This is inadequate to purchase insurance and pay cost sharing and uncovered services for 3 years. It is unlikely that individuals in the program would actually be able to access needed care. Individuals would lose Medicaid's benefit and cost sharing protections without an option to return to Medicaid. Navigating HSAs is difficult. Low-income individuals, many with high service needs, may not understand the ramifications of giving up Medicaid. We have no indication that they will be given the in-depth counseling they would need to fully evaluate such a choice. Thank you for considering our comments. Contact Dee Mahan or Amy Traver at Families USA with any questions. Sincerely, Dee Mahan Amy Traver Director, Medicaid Advocacy Villers Fellow Families USA Families USA	
Accountability at all Levels Should be Addressed First	CMS should make sure that the KS Dept of Children and Families are actually accomplishing full, random, and mandated audits on CMHC's patient charts. Also, Legislation should address CMHC Executive Administration pay increases when services and benefits to patients are reduced, suspended or eliminated. That should be creating pause in everyone's eyes. Also, providers should not have incentive compensation programs for CMs. This promotes fraudulent activity and what is the incentive for providers to actually provide services to the patients? Why should patients get better when the revenue streams are padding personal time sheets and bank accounts. Consumers should be actively engaged in their own care and by learning to advocate for themselves and others by having the continued financial supports for Peer Support Specialists,	2012-09-20 08:50

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	Consumer Run Advocacy Groups, and Consumer Run Organizations. Also, KS Children and Families should not "grandfather" or allow providers to work outside of their own catchment area when there are waiting lists or limited resources in rural or frontier CMHCs.....Ian Boyd	
KHA Perspective on Kancare	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 KDHE Secretary Moser for the efforts that have been made to work with KHA on this large and complicated project. The KDHE 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 KDHE and the individuals within that 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. 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.	2012-09-19 14:45

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	• 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. 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 the State of Kansas to help create a reformed Medicaid program that works. Thank you for your consideration of our comments.	

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	Best Regards, Tom Bell President and CEO	
Please do not approve the 1115 demonstration waiver as currently submitted.	Today is September 19th, the end of the CMS public comment on the KanCare Proposal as a replacement for the Kansas Medicaid Program. The three proposed for-profit MCO contracts overtly reference Manuals that define how we must perform under the MCO's contracts, clinical care guidelines, billing guidelines, etc. As a provider, we are being asked to sign agreements referencing Manuals that still are not finalized or approved by the State of Kansas. The deadline for the MCOs to have 90% of their provider network contracted is October 12, 2012. The MCOs are pressuring providers to have fully executed agreements in hand by the end of September in order to assure inclusion in each MCOs "in-network" publication for beneficiaries. The contracts and manuals are non-uniform and inconsistent. Detailed provisions of all three contracts differ and will require separate negotiation. Furthermore, once implemented, this places unreasonable administrative burdens on providers to manage care under three totally different contracts and coordinate care through three different contract networks. Each network may have different hospitals, physicians, pharmacies, and other ancillary service providers. Additionally, billing processes and payment timeliness differ among the three MCOs. This timeline is being driven by Kansas Governor Brownback's desire that KanCare go live January 1, 2013. We believe it is poor public policy to rush such an important "privatization" of the entire Kansas Medicaid Program. Please do not approve the 1115 demonstration waiver as currently submitted. At a minimum, it should be tested as a pilot program before statewide implementation.	2012-09-19 14:32
Convert KanCare to a Not-for Profit Company Owned by the State of Kansas	State of Kansas officials should review what has happened to mental health services in Kansas the past twenty-five years under private managed care to gain a better understanding of what is likely to happen to KanCare under the 1115 Demonstration Waiver. Kansans would fair better under Medicaid if KanCare became a private, not-for-profit managed care company owned and managed by the State of Kansas. The prototype for such a company exists in Kansas Health Solutions.	2012-09-19 14:19
An Alternative Option - KanCare Owned and Managed by the State of Kansas	Some years ago the Community Mental Health Centers of Kansas were faced with the possibility of the Medicaid mental health dollars being managed by an out-of-state for-profit managed care company. As an alternative the CMMHCs and the State of Kansas created Kansas Health Solutions, a not-for-profit managed care company to manage the Medicaid mental health dollars.	2012-09-19 08:28

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	KanCare should consider a comparable arrangement by turning KanCare into a not-for profit managed care company owned and operated by the State of Kansas. In this way many new jobs would be created in Kansas and most dollars spent by KanCare would remain in Kansas.	
Care Co-ordination is a Medical Function, Not An insurance Function	KanCare confuses/mixes the practice of medicine with the insurance function of paying for health care. Care co-ordination is a function of the Medical Home and should be part of the doctor's office or the hospital. The three KanCare MCOs plan to hire about 700-1000 RNs, MSWs, MDs, etc. to do care co-ordination and utilization management on behalf of the MCOs. Wouldn't the KanCare patient be better served if these clinicians could be employed by the doctors' offices and hospitals themselves? The dollars paid by KanCare to the MCOs to hire these employees, should be shifted to the provider settings where they could be used to hire the same number of RNs, MSWs who would have direct daily contact with the patient and the patient's family.	2012-09-19 07:21
Although public meetings on KanCare were held, the administration did not receive input. They always come to meetings with a preset agenda a	Please deny the 1115 waiver request. Although it may appear that there was opportunity for public input, the Administration officials came to the meetings I attended with a preset agenda and took most of the time allotted telling us what they were going to do. When we did have a chance to express our concerns at one meeting, Secretary Sullivan and Dr. Mosier were in the back of the room chatting and laughing together and not listening to the public comments. This is indicative of the Administration attitude. Long term services provided for through the HCBS waiver for I/DD services are not services MCOs have any experience with and these services should be carved out. It is discriminatory that private insurance companies will be able to dictate how individuals with developmental disabilitites live and work in the community.	2012-09-19 07:19
Main Street Kansas More Reliable and Trustworthy Than Wall Street	I am a senior citizen. Most Kansans do not have long-term care insurance because of the expense. Most Kansans will spend down their private assets and then apply to Medicaid to pay for their nursing home care. It is truly worrisome that decisions about my nursing home care will be made by one of three Fortune 500 companies whose first allegiance is to profits and the price of their company's stock. I would be much more comfortable if decisions about my care were made by myself, my family, and my doctor - with assistance from employees of the State of Kansas Medicaid Division.	2012-09-19 04:04
Please Do Not Approve the "KanCare" 1115 Waiver Submission	On behalf of thousands of Kansans, InterHab asks CMS to reject the Kansas 1115 waiver proposal for long term I/DD services. We believe it is poorly designed, lacks programmatic safeguards for persons we serve, and the capacity to provide financial stewardship over the dollars at stake.	2012-09-18 14:56

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	The implication of unmanaged medical care for persons in long term services has been erroneously presented, based on studies which omitted data from Medicare. When this was called out by advocates, the State chose to continue to use the incomplete data. The current proposal has been fast-tracked and support for it is minimal. The approach has been confused and confusing. Clear and accurate information has been lacking. Information from the State has often been different from that shared by the managed care contractors. The first round of State public input opportunities were not input opportunities. No open comments were allowed, no program designs were presented, no mention was made of the radical re-design of I/DD services for Kansas. Later public input opportunities (with thousands in attendance) organized by the State and community groups showed clear opposition. (State officials took very little away from the concerns which later were responded to in any specificity) A majority of legislators in both Houses spoke out, or voted, at various times to slow down or stop this proposal, only to be told by the Administration that the legislature had no role to play. A majority of Kansas counties' governing bodies adopted official resolutions opposing KanCare's inclusion of I/DD services. The proposal is not a demonstration waiver, in which a new idea could be tested for later replication or expansion. This proposal is a radical experiment to be applied, untested, statewide, with no management system to turn to if this experiment fails. Even the "pilot" test for long term I/DD services is not emerging to be a pilot at all to evaluate the potential merits of the pilot, but instead appears to be intended to "sell" the idea of KanCare to a resistant population. The Federal government should not underwrite rash experimentation. This proposal undercuts benefits and efficiencies of the current Kansas locally managed care model for I/DD services. Administrative costs for this model will be well in excess of current administrative costs. The proposal also directs hundreds of millions of dollars into the profits of three MCOs (to replace the current single State authority) and allows the contractors to become the "owners of the Medicaid franchise" in Kansas. In order for that much money to be diverted to profits (with no new funding requested to augment the current system) will result in those dollars coming from reimbursements to providers and services to consumers. It cannot be otherwise because it is not arithmetically possible. We have been told the State will closely monitor this experiment, but we do not have confidence nor was the legislature able to secure information from the State to evaluate what resources the State has at their disposal to perform comprehensive oversight over these large corporations (each of which may actually have annual operating budgets far larger than our State's entire operating budget). There simply must be a stricter approach taken	

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	by CMS to assure that consumer protections are in place, and that financial safeguards will strictly protect our scarce financial resources. Small states like Kansas are not well equipped to monitor the national insurance industry takeover of Medicaid that we are witnessing. The Federal government should not allow this to happen. We urge CMS to evaluate the concerns we have expressed, as well as other commenters, and that you reject the State's 1115 waiver application. Thank you for the opportunity to comment.	
Cae Managemnt Services	There are many success stories across Kansas whereby an individual with a disability has transitioned from squalor, at-risk lifestyles, and major health issues to a stable, tranquil, and healthy lifestyle due DIRECTLY to upfront, intense case management. The lost of such intimate, hands-on, and face-to-face support and counsel will be detrimental to the most vulnerable citizens Kansans.	2012-09-18 14:18
Delay in Payments	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.	2012-09-18 11:34
Legislative Oversight	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 people will be heard.	2012-09-18 11:33
Thank uou	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.	2012-09-18 11:30
How will savings be achieved for children and others already in managed care?	The waiver application contains insufficient information to understand fully the budget projections and calculations. Without other program changes, moving to managed care would not generate savings among beneficiaries already covered by managed care. Nonetheless, the application forecasts savings from populations already in managed care, including children insured through Medicaid and CHIP and pregnant women. It is not clear how these will be achieved.	2012-09-18 08:17
No other state in the U.S. has three different MCOs	These three companies are for profit and will each only receive a pre-determined amount of money to function with. I see absolutely no way that all services can be funded. Many people are going to be "left out in the cold". I believe that this is an effort	2012-09-17 17:11

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	on the part of state government to eliminate a very necessary service for the disabled and the elderly.	
No clear reason to limit choice through auto-assignment	Beneficiaries should be able to choose their plan upon enrollment, rather than being auto-assigned by the state. Kansas has provided no rationale for shortening the standard 90 day choice period and we see no reason to shorten it. This is especially important given that three new MCOs will provide services under the waiver, none of which is currently serving HealthWave, and families will not be familiar with any differences between the plans and their provider networks.	2012-09-17 12:18
Health Savings Account Proposal is Harmful to Children	Kansas seeks to develop a pilot program to transition beneficiaries away from Medicaid by providing a funded health savings account with which they could purchase a private health plan. Many private plans simply do not provide the access to care and the protections against unaffordable costs that Medicaid-eligible children and families generally require.	2012-09-17 12:16
How will savings be achieved for children and others already in managed care? The waiver application contains insufficient information to u		2012-09-17 12:13
Lack of Information	I appreciate the CMS making available this feedback opportunity to express our thoughts to you. Actually, any information we have received about KanCare has not come form our State government office; but through our local leaders at the Nemaha County Training Center, tv, and...just this morning, The Topeka-Capitol Journal newspaper. We haven't received any other info about the projected changes and its implementation. More time is needed to communicate the intended changes. I have written several letters about my concerns for the projected changes. We have alread existing well designed and overseen state and county agencies and programs to supplement the funding from private organizations and individuals who support and care for persons who have intellectual and developmental handicaps. My question is: why move into an organization re-structuring that is untried and wherein it is commonly known the goals of service are for-profit to shareholders of insurance companyies? I am a considerably older person. I have been to countless meetings, conventions, and classes when the welfare of persons with intellectual and developmental disabilities have been discussed. In fact, my husband and I have been highly motivated thru these meetings to assist and support in any way our local agencies. I doubt I could ever feel the same about the proposed	2012-09-17 08:48

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	for-profit services and the persons involved in the contractual agreement with our state. Please reconsider the process and it's implications for Kansas. Sincerely, Sara Hammes	
KanCare is being foisted upon the unwilling elderly and disabled people of Kansas, their families and guardians. It was developed without o	KanCare is not in the best interest of clients, families, providers or taxpayers.	2012-09-15 13:49
Budget Neutrality Information Is Not Sufficient	Kansas Action for Children has two concerns regarding the budget neutrality part of Kansas' waiver application. First, there is not sufficient information for a reader of the waiver application to fully understand the budget projections and calculations. Second, the application appears 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 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 more than a decade, there is insufficient information provided to understand how the projected cost savings will be achieved. Moreover, the waiver does not include information regarding the "research and demonstration" required for Section 1115 Waivers. The rate methodology adjustment, demo trend rate and trend rate 2 for populations including children and pregnant women raise significant questions. The demo trend rate for the CHIP group shows a growth of 2.36%, a decrease from the trend rate 2 of 3.25%. Through conversations with state officials, Kansas Action for Children understands the demo trend rate to represent the effect of managed care on trend rate 2, which is the projected annual growth in the absence of the KanCare waiver. This represents a significant decrease in cost projections, but the	2012-09-14 13:43

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	reasons are unclear. Given that the CHIP population in Kansas has been in managed care for more than a decade (unlike other populations being moved into managed care under this wavier), Kansas Action for Children has reservations about how such aggressive cost savings can be realized without impacting children's access to health care. Furthermore, the rate methodology adjustment for the CHIP population is -4.84% - stating that the cost for children insured through CHIP will be 4.84% less than without the KanCare waiver. Again, given the history of the CHIP program historically being operated through managed care, there is not sufficient information to understand how such aggressive cost savings can be realized. Although projected cost savings for the TAF population group, which includes poverty level eligible children, are less optimistic with a trend rate 2 of 2.25% and a demo trend rate of 1.73%, the waiver application again lacks the details regarding the rationale for the savings given that this group is also currently in managed care. Kansas Action for Children has significant concerns regarding the Delivery population group projected cost savings, which show a rate methodology adjustment of -11.93%, meaning that during the first year of KanCare the cost for Medicaid deliveries will be 11.93% less than current spending levels. Additionally, the difference between trend rate 2 (1.75%) and demo trend rate (1.38%) for deliveries assumes significant cost savings. Pregnant women insured through Medicaid are currently insured through managed care, raising the same concern that Kansas Action for Children stated about children insured through Medicaid and CHIP – what differences between the current MCO program and KanCare will result in such aggressive cost savings? Lastly, it is unclear to Kansas Action for Children why there is one Medicaid Eligible Population group (MEG 2) dedicated to Deliveries, but deliveries are also included in the TAF MEG group. Because Medicaid pays for approximately 40% of the births in Kansas, it is critically important for the health of the newborn children that there exist sufficient resources to adequately pay for deliveries to poor women.	
The State Lacks a Comprehensive Plan to Transition HealthWave to KanCare and Avoid Disruptions in Coverage	Kansas Action for Children has two specific concerns about the transition of children currently enrolled in HealthWave to enrollment in KanCare: The loss of the HealthWave brand and the education of current HealthWave beneficiaries regarding this potential change. The HealthWave name was created in Kansas when our CHIP program was established in the late 1990s. Families, medical 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	2012-09-14 13:40

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	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. Kansas Action for Children presented testimony on June 20, 2012, during a KanCare public forum specifically on the issue of co-branding HealthWave and KanCare. Additionally, Kansas Action for Children submitted written comments on the initial waiver application submitted to CMS (submitted April 26, 2012) raising the issue of co-branding the KanCare materials with the HealthWave brand for one year. To date, the state has indicated, through communication with Kansas Action for Children, that it is unwilling to co-brand KanCare with HealthWave. Kansas Action for Children believes this is a simple step that can aid families through the transition. Without co-branding, many children over the course of the first year of KanCare will likely experience disruptions in coverage. HealthWave is currently operated as an MCO program, and little attention has been paid by the state to 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 from 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 disconcerting, and Kansas Action for Children urges CMS to negotiate a detailed and comprehensive transition as part of the Kansas waiver negotiations. Furthermore, the response of the state to this concern, as evidence in Appendix B, does not provide the level of detail necessary for the transition of 230,000 children. 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. Kansas Action for Children appreciates the guidelines established by CMS to establish transparency surrounding Section 1115 Waiver Applications, but believes the spirit of the law was not upheld in Kansas. The KanCare waiver application references multiple times that the development of the KanCare program in Kansas was driven and influenced regularly by consumers.	

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	Page 4 of the waiver application states, "In the summer of 2011, the State of Kansas facilitated a Medicaid public input and stakeholder consultation process, during which more than 1,700 participants engaged in discussion on how to reform the Kansas Medicaid system." While these meetings were held, discussion was limited by two factors: 1., participants in the meetings were assigned tables at which to sit; 2., there was not an opportunity for public comment beyond the comments recorded on a template designed by the state at each table. Page 11 of the waiver application states, "Consumer Voice. Because reforms must be driven by Kansans, the State has formed an advisory group of persons with disabilities, seniors, advocates, providers and other interested Kansans to provide ongoing counsel on implementation of KanCare." Despite gathering consumer feedback, Kansas Action for Children believes the feedback has not been sufficiently integrated into the program design. Pages 25-28 of the waiver application include the state's response to frequent questions voiced by advocates and consumers. Kansas Action for Children does not believe the responses provided by the state adequately show that the state has taken public concerns into account and modified its proposal. For example, in response to "How will the State transition beneficiaries from the HealthWave program and other current programs that are well known?" the answer provided does not include additional information beyond what the state has previously asserted. Kansas Action for Children continues to have significant concerns about the transition of 230,000 children from HealthWave to KanCare. KAC believes that an adequate effort by the state to incorporate consumer and advocate feedback on the KanCare proposal would have included co-branding HealthWave and KanCare for the first year.	
Auto-assignment of Beneficiaries Limits Choice; Proposed Alternatives to Traditional Medicaid Are Not Adequate	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: 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. The waiver submitted to the Centers for Medicare and Medicaid Services on August 6, 2012, offers a slightly different proposal	2012-09-14 13:31

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	regarding auto-assignment and ability to change plans than the waiver application submitted in April that was subsequently withdrawn. Although a step in the right direction, Kansas Action for Children does not believe the new proposal allows for enough consumer choice, especially for beneficiaries who enroll in Medicaid for the first time after January 1, 2013. The waiver application states that beneficiaries will be able to change plan assignment prior to January 1, 2013 (following their auto-assignment in the fall of 2012) and then for 45 days after January 2, 2013. Kansas Action for Children believes that beneficiaries should have the federal standard of 90 days post-enrollment to change MCOs. This is especially important if beneficiaries are auto-assigned – eliminating choice at enrollment and decreasing the time allowed for beneficiaries to change MCOs clearly diminishes consumer choice. Lastly, the three MCOs chosen for KanCare are not currently involved in any capacity with Kansas Medicaid. Given that families are not currently familiar with any of the MCOs, Kansas Action for Children asserts it is particularly important for families to have an adequate choice period at the beginning of KanCare. Additionally, for new beneficiaries who enroll in Medicaid after January 1, 2013, the current waiver application would only allow 45 days to change plans. Kansas Action for Children does not believe a sufficient reason exists for this shortened choice period and does not adhere to the "research and demonstration" component of Section 1115 Waivers. As outlined on pages 14-15 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. HSAs and similar "look-alike" programs simply do not provide the access to care and the protections against unaffordable costs that Medicaid-eligible	

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	children and families often require. Low-income populations are negatively and disproportionately impacted by the higher cost sharing that is characteristic of such 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. For all of the concerns listed above, Kansas Action for Children urges CMS to ensure that children will not be eligible for the "funded health account" as an alternative to traditional Medicaid.	
The KanCare proposal and subsequent Section 1115 Waiver application is an attempt by the State of Kansas, under Governor Sam Brownback's lea	The KanCare proposal and subsequent Section 1115 Waiver application is an attempt by the State of Kansas, under Governor Sam Brownback's leadership, to address the issue of growing costs and enrollment within the Kansas Medicaid program. Although Kansas is not uniquely positioned in this regard, Kansas has chosen to address this issue in a manner that is excessively aggressive and potentially disastrous for the beneficiaries and providers within the Kansas Medicaid program. Of particular note, individuals with Intellectual and Developmental Disabilities (I/DD) who receive Home and Community Based Services (HCBS) through the Kansas Medicaid program are exceptionally vulnerable to disastrous consequences from any failures that may occur if this plan runs into unexpected problems that are likely to occur. During the 2012 legislative session action was taken - through a legislative budget proviso - to delay the inclusion of long-term care I/DD population for one year from the implementation of the KanCare "demonstration". Within this proviso there is the attempt to create pilot programs to demonstrate or test how this type of managed care arrangement may work for this population prior to rolling it out state-wide. We applaud the state in this effort. HCBS or long-term care services are not necessarily "medical" in nature and they require a great deal of specialized understanding and expertise. Much of this expertise and experience comes from years of successful delivery of this highly specialized and compassionate care. Kansas has long been the envy of I/DD systems nation-wide. The Kansas I/DD system has accomplished this in the face of being woefully underfunded for many years and yet providers in this state remain committed to providing exceptional services to this population. More importantly, however, there is simply a totally lack of evidence that this type of managed care arrangement makes for a good fit for this	2012-09-14 12:24

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	population and therefore it is imperative that consideration be given to this fact. Clearly, this state and all other states face great adversity in the way of Medicaid program growth both in terms of costs and enrollment. What is also abundantly clear is that if the I/DD population is to be included in this KanCare plan, the pilot programs for this population must be meaningful, thoughtful, and engage a variety of targeted catchment areas, where the state, providers, advocates, and families can determine what works best and how implementation on a larger scale can successfully occur. What hasn't been mentioned here is the fact that there are over 5,000 Kansans with an I/DD waiting for services. The administration purposefully excluded the I/DD Waiting List from the KanCare RFP and subsequent contracts and made a conscious decision to "maintain" the list within state government, thereby not making any effort whatsoever to reduce or eliminate the waiting list for so many Kansans. Now, one can argue away perhaps 1,000 individuals by framing the way you discuss the issue in terms of age attainment or "anticipated date of service". However, having over 4,000 citizens with I/DD who wait for 5-7 years is not only unmanageable but it is utterly cruel and downright callous. It is understandable that this state and all others have faced extreme fiscal challenges over the past several years due to the economic crisis, but Kansas revenues are bouncing back. Making meaningful reduction and ultimately eliminating the I/DD HCBS waiting List should be a priority of this state and should therefore be reflected in this Section 1115 Waiver application as to how Kansas plans to reduce the risk for these individuals of being forced into institutions. We urge you to carefully consider any decision to include or not include the I/DD population and their LTSS within KanCare. In addition to the inclusion consideration, we also urge you to carefully consider how Kansas is or is not prioritizing the I/DD waiting List in this waiver application. Thank you in advance for your careful consideration of this and all other comments.	
I have attended several KanCare informational/educational sessions on KanCare, and participate on a DD pilot project advisory committee. It	I have attended several "informational/educational" sessions on KanCare, and participate on a DD pilot project advisory committee. It is very obvious that the State and the MCOs are not prepared to include the DD system in KanCare, even in a pilot. The MCOs have no idea how the HCBS system operates in Kansas, and it is becoming clear that the State officials don't either, or really are not interested in factual advice and concerns. This whole thing is headed for a trainwreck.	2012-09-14 10:19
KanCare, wrongfully named	- This program does not care about the consumers. It does not promote choice first off. Consumers are "Placed" with a MCO, they do not get to look at the differences in programs then decide which is best for themselves. One MCO for sure is not going to see over have of the consumers in person, only "over the phone" case management. Does the MCOs or the state not realize that most of	2012-09-14 08:28

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	the consumers under HCBS services don't have phone or don't have them on a majority of the time? Everyone will profit off of KanCare except for the people who really need the services. How can anything think it's okay to make a profit off of serving these people? KanCare is limited services to these people and I can see in the future these services will all together eliminated. What then? These people will be forced in living in nursing facilities and the state will have to pay 66% more than while they were under HCBS.	
I think it is a mistake for Kancare to eliminate the requirement that the 3 MCO's must use the current case maangement providers in the impl		2012-09-12 14:51
I've worked with individuals with Developmental Disabilites for over 15 years. Never before have I been so deeply worried about their future	How can a for-profit MCO better manage funds of our most vulnerable citizens than a non-profit Community Developmental Disability Organization? I am of the opinion that for a Managed Care Organization (MCO) to earn a profit from administering the same amount of Medicaid funding allocated under the current system for individuals with Developmental Disabilities, they will have to reduce those individuals benefit payments by reducing the services they receive. It appears that the only way for the MCO to make money is to save money and the only money they have to save will be taken from the already underfunded resources of our most vulnerable population. Managed Care may make sense for people with short-term acute support needs but for individuals with life-long chronic support needs funded through Medicaid, there is no doubt in my mind that Manged Care is not a viable system. I urge our administration to "Carve Out" the ID/DD population from Managed Care.	2012-09-12 13:03
MCOs, how do you coordinate with DD service recievers who are their own guardian, have no ability to coordinate with MCOs?		2012-09-10 07:50
Wrong Waiver!	The State of Kansas is applying for a 1115 waiver that is by definition a Demonstration Waiver. It is the intent of this waiver to allow for pilots to explore new programs or processes. KanCare is not a "demonstration" as it is tearing apart all current service delivery methods and infrastructure in the State to bring in Managed Care on State Wide and overall encompassing approach. This waiver does however allow for an allowance of five years versus three years for what the state should have applied. Again, this is NOT a DEMONSTRATION- It is an OVERHAUL of the system taking advantage of the system and the citizens of the State of Kansas. Please deny this application as it is not the appropriate waiver for this program.	2012-09-08 13:18

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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.	2012-09-07 15:44
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.).	2012-09-07 15:43
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.	2012-09-07 15:42
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 entitlement, ensuring access to services. 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.	2012-09-07 15:42

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	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.	2012-09-07 15:41
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.	2012-09-07 15:40
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.	2012-09-07 15:40
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	2012-09-07 15:39

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	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.	2012-09-07 15:39
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.	2012-09-07 15:38
Outcomes Show that the Kansas model of Managed Care will not Improve	Findings from two reports from the non-partisan National Bureau of Economic Research (NBER), suggest that the model of managed	2012-09-07 15:38

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Outcomes or Decrease Spending.	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: o By population: 59 for primary care and 60 for dental. o By geography: 24 for primary care, 28 for dental care, and 99 for mental health. o 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.	2012-09-07 15:37

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	o These disparities result from wide-ranging social, environmental and behavioral health determinants.	
Youth and families deserve services when and where they need it most – prevent expensive 'cost-shifting' to Juvenile Justice, Child Welfare,	We want Kansas families to be resilient and healthy especially if they have a child who has a severe emotional disorder. The costs of serving youth with severe emotional disorders after they have been separated from family are exponentially greater compared to the cost-efficiency of ensuring supports go to the people who already love and are invested in the child's success. Anyone will tell you, the 'system' does not do a good job of raising kids particularly kids with special needs. Effective coordination of services is really about working smarter, not ******. It builds on the supports that are in place and results in less fragmentation. Studies show that 'carved out' behavioral health plans provide better continuity of services and better coordination of services so that they are more able to help when families are in crisis– which is when families are tested the most. Care coordination and crisis response that wrap supports around a family– by engaging natural supports and ensuring professional services are focused on the family's goals for resiliency– will center on quality practices for engaging families, like Wraparound. Wraparound is an effective model of service delivery that will help Kansas as a national leader for its ability to support to families and ensure alternatives to expensive out-of-home residential placements. Here is the problem. Once the state takes a big chunk out of this sector for budget cuts to fund tax cuts it can't afford and the HMOs take their 16 percent and then the specialty behavioral health organizations they typically subcontract with take their cut, painful amounts of money, services, expertise and key elements of the safety net will simply disappear and we fear future innovation will be just a dream. Instead, we want to build on what has worked and show we value what we need for the future. Let's improve our care systems, but let's start in the right place at the right pace with the best plan that has the greatest chance to succeed. We don't need a large for profit HMO inserted into the administrative structure just so they can take a cut of the already limited pool of funds. Let's maintain a "managed behavioral health carve out" and build on the system that best knows and serves some of our most vulnerable Kansans. And let that system reduce costs by implementing innovations that will improve the delivery and coordination of behavioral and medical care, while greatly cutting down on costly and avoidable ER and inpatient hospital visits.	2012-09-07 15:33
The KanCare 1115 application does not ensure effective use of Peer Support or other best practices for mental health care	Peer Support Specialist services have shown to improve health and employment outcomes for adults with severe mental illness through: 1. Engagement – to ensure more preventive services and keep down unnecessary visits to psyche hospitals and ERs.	2012-09-07 15:30

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	2. Recovery – using a philosophy of Recovery supports a person's innate ability to make change in their own lives. It aims to break a costly cycle of dependence on professional supports and services. 3. Employment – training Peer Support Specialists to do supported employment for people with serious mental Illness will finally make these services cost-effective. 4. Integration with Primary Care – studies have shown that the high costs of ineffective engagement of consumers by mental health providers is a high cost for medical services for folks with severe mental illness. Recent studies show, unsurprisingly, that a large number of hospital stays each year for people with severe mental illness were for medical reasons (versus just psychiatric) and when there is active engagement with community-based mental health supports, conditions are better managed and the costs go down. Example – if people are not able to stay actively engaged with their primary care doctor, then they are less likely to receive consistent care for conditions (like renal disease or diabetes for example) that then worsen to the point they require hospitalization. This is a very costly way of managing/treating illnesses that would otherwise be better treated via regular outpatient doctor visits. This evidence lends support to a 'carve out' design because while most folks might do just fine receiving their health care through large Medicaid HMO care plans, those plans don't have any significant experience or success in properly engaging and serving a group that needs more consistent outreach, crisis assistance, rehabilitation and peer support than the typical HMO Medicaid beneficiary. Integration with primary care can be realized by ensuring these practices are built in to a 'carved out' contract with the state. That's why advocates agree that if managed care the best way to ensure that these groups are properly engaged is through a better and more closely managed behavioral health care system, with strong links to needed primary care, housing and local community supports.	
KanCare 1115 does not focus on improvements to our Behavioral Health system	Future success for Kansas' community mental health system will result from a continued focus on the strengths we possess and values that are derived from what we need. Two major needs of our state are increased access to local psychiatric acute care resources in communities across Kansas and better utilization of Peer Support Specialists to help reduce our state's dependence on costly institutional care in mental health facilities. These improvements will allow for needed acute care psychiatric crisis stabilization close to home which facilitates a speedier recovery because people then don't have to travel so far from their natural supports– i.e. friends, family, work, churches, and other members of the community who know and care about them. After 20 years	2012-09-07 15:28

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	of mental health reform policies– Kansas is in an excellent position to implement these financially and morally responsible strategies.	
HMOs do not do a good job of ensuring access to Behavioral Health Services	Kansans with disabilities have a significant concern is that, if we don't keep Behavioral Health 'carved out' and instead combine mental health services under an HMO, the result will be a significant decrease in access to services and supports while the administrative fees paid to the HMO get increased. This represents a managed care nightmare scenario, because it incentivizes cuts without any expectation that innovation will cost-efficiently improve the community mental health system.	2012-09-07 15:18
There is little existing data that demonstrates cost savings from transitioning people with disabilities from traditional Medicaid into mana	Implementing managed care would only create the potential for our state to improve access to appropriate services, better coordinated care, and ensure measured performance with regard to quality if these conditions are very carefully worded and explicitly spelled out in the terms and conditions written contract(s). Pay-for-Performance incentives must be designed and implemented to emphasize prevention and early intervention of health conditions, for example. However, managed care is literally a double-edged sword in that a poorly designed or poorly implemented Medicaid managed care program can create problems for our state that may lead to poorer health outcomes, social isolation, higher rates of institutionalization, and even death.	2012-09-07 15:17
Medicaid Managed Care Plans Owned by For-Profits Have Higher Costs, Lower Quality	In terms of clinical quality in relation to cost, national studies of states with managed care arrangements that are run by large, for-profit corporations are showing that they do not improve quality of care or lower costs to Medicaid programs for Aging and Disability populations. Managed care arrangements for this type of disability and senior services actually performed worse than non-profit managed care on quality measures and costs. Large, for-profit, multinational corporations are less likely to devote the kind of attention and innovative strategies that are needed in Kansas to produce real progress toward resolving existing gaps and barriers in our system, and in all likelihood, will create more gaps and barriers resulting in worse outcomes and inefficiently cost-shifting from the State Medicaid program to local communities-emergency rooms, shelters, jails, food pantries, and institutional facilities, etc. In short, a predictable outcome of our state choosing to contract with a large, multinational, for-profit managed care corporation is: 1) Higher average administrative costs, and 2) More arbitrary denials of important, health-promoting, life-sustaining services and supports.	2012-09-07 15:16
KanCare must ensure access to Early Periodic Screening, Diagnosis, and Treatment (EPSDT) for	We have seen numerous examples of where EPSDT services have not been effectively provided, and where the parent has to either engage an attorney or threaten to engage an attorney just to get	2012-09-07 15:15

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Kansas youth with disabilities	the mandated and entitled service provided. We fear that this problem would worsen under KanCare because of the long, nationwide track record of HMOs denying payments and delaying prior authorization of these critical supports and treatments. We would propose either a total carve-out for EPSDT under Managed Care (as it is an entitled service under federal law) and/or changes to reduce the red tape and burden faced by families accessing these critical services. The KanCare RFP and 1115 Demonstration application have very little content tha supports effective management of this legally required and critically necessary program. As part of negotiating a resolution to the 1115 Waiver application, HHS must require that EPSDT be either carved out of managed care or that extensive protections are in place to ensure that the powerful mandate of EPSDT is reflected in contracts and arranged for in Kansas.	
KanCare must increase community based access to Night Support/Sleep Cycle Support	Reduced access to essential community services like Night Support and Sleep Cycle Support has been a major cause of unnecessary institutionalization in Kansas. Cuts and threats to cut these services on the Physical Disability and Frail Elderly HCBS Waivers are reasons why Kansas is the 6th highest in the nation for per capita number of people in nursing facilities. This undermines confidence of people who want to rely on HCBS instead of being forced to live in a facility.	2012-09-07 15:14
KanCare must ensure families of youth with Autism or who have challenging behaviors have better access to Positive Behavior Support	Positive Behavior Support (PBS) is a State Plan service and is an empirically proven intensive behavioral support that families have difficulty accessing in most areas of the state. This is unfortunate, as a Medicaid service PBS must be available statewide for the sake of families and the youth themselves. As a Best Practice that helps children and youth avoid hospitals and institutionalization, any changes in Medicaid, including the 1115 Waiver Demonstration, must include a concrete plan to ensure that access to PBS is effectively available statewide.	2012-09-07 15:13
Self-Advocacy & Family Advocacy must be seen as Critical to Quality Services	Strong, educated and organized self-advocates allow for a stronger health care and long-term care system of services and supports. Kansas already has very good statewide groups of self-advocates. The Self-Advocate Coalition of Kansas (SACK), who advocates for Kansans with Intellectual Disabilites, is over 700 members strong and has chapters across the state. SACK and other consumer advocates organizations should be supported and encouraged by public and private management entitites alike. Consumer led groups like the Consumer Run Organizations (CROs) also must play a critical role in the success of Behavioral Health programs for adults with Serious Mental Illness. Parent groups like Keys for Networking, have need-to-know information on how well our Wraparound services and programs for youth with serious emotional needs are working. And likewise, local NAMI chapters across the state can help program managers provide better services if their input is encouraged and	2012-09-07 15:13

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	incorporated to improve performance. Other states that have engaged in Managed care approaches are now realizing that they should have engaged and supported self-advocacy and family advocacy in a more proactive manner, and they are playing catch-up. A strong, well funded family and self-advocacy component can and should be built in on the front end of any Medicaid changes. The state should immediately find ways to make these groups integral to the KanCare process and and continue to work with the disability community to ensure an even stronger stake for family and self-advocates in the future changes to Medicaid.	
Using the Community Choice Act makes Fiscal Sense, But its missing from the 1115	Kansas should access the enhanced 6% federal match for eliminating the bias toward nursing facilities by ensuring less expensive personal care services will always be provided. In the long run, doing this will help reduce dependence on expensive institutional levels- of-care (like nursing facilities, which are an entitlement under Medicaid) and will support less expensive, community based services for people with disabilities and seniors.	2012-09-07 15:11
JOINT RESOLUTION	JOINT RESOLUTION HARVEY COUNTY NO. 2012-8 MARION COUNTY NO. 2012-7 A JOINT RESOLUTION ENCOURAGING THE GOVERNOR OF THE STATE OF KANSAS TO CAREFULLY CONSIDER ANY CHANGE IN THE MEDICAID OR HEALTH CARE PROVISIONS FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES, TO REMOVE LONG-TERM CARE SERVICES FOR SAID PERSONS FROM THE PROPOSED PRIVATIZED MANAGED CARE PLAN, AND TO CONTINUE PRESENT STATE/COUNTY-APPOINTED CDDO ADMNISTRATION OF THIS SERVICE DELIVERY SYSTEM WHEREAS, Article 7 of the Kansas Constitution establishes that the state shall care for and support persons with intellectual and developmental disabilities, and; WHEREAS, the Developmental Disability Reform Act of 1995 and Article 64 of the Kansas Administrative Regulations establishes that services for persons with intellectual and developmental disabilities shall be provided by means of a system of contracts between state of Kansas and county-appointed Community Developmental Disability Organizations (CDDOs), who in turn contract with private service providers, and; WHEREAS, the current public-private contracting structure provides efficient, effective, and privatized, Medicaid waiver home-and community based service delivery with less than 3% administrative payment to CDDOs, and; WHEREAS, the State of Kansas plans to transform Medicaid through additional privatization by adding a another system of contracting with three managed care vendors, and;	2012-09-07 12:51

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	WHEREAS, the proposed privatization with three managed care vendors calls into question which administrative entity and appeal structure is ultimately responsible for long-term care services and supports for persons with intellectual and developmental disabilities, and; WHEREAS, the life-long need for long-term services and supports for persons with intellectual and developmental disabilities is not reduced by providing enhanced medical and behavioral health care coordination, health homes, and preventative healthcare, and; WHEREAS, persons with intellectual and developmental disabilities can benefit from plans to provide enhanced medical/behavioral healthcare coordination, health homes, and preventative healthcare to improve health outcomes, and; NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF HARVEY COUNTY COMMISSIONERS, HARVEY COUNTY, KANSAS AND THE BOARD OF MARION COUNTY COMMISSIONERS, MARION COUNTY, KANSAS THAT; The Commissioners hereby urge the Governor's administration to: 1. Remove the system of long-term care for individuals with intellectual and developmental disabilities from January 2013 implementation of Medicaid managed care, and; 2. Maintain the current state/community developmental disability contracting, administration, dispute resolution, and appeal system, and; 3. Include intellectual and developmental disabilities in proposed Medicaid managed care plans for integrated medical/behavioral healthcare coordination, health homes, and preventative healthcare to improve health outcomes, and; 4. Reconsider how proposed savings on long-term care for individuals with intellectual and developmental disabilities can be achieved with Medicaid managed care without reducing benefit levels, provider reimbursement, or eligibility, and; 5. Protect vulnerable Kansans by thorough and open vetting of potential managed care vendors for history of Medicaid fraud/ abuse of public funds, customer satisfaction/timely reimbursement for services delivered, and historical performance of improved health and financial savings outcomes. 6. This resolution shall take effect and be in force on and after its adoption. PASSED and ADOPTED by the Board of Commissioners of Harvey County, Kansas this 5th day of March, 2012. PASSED and ADOPTED by the Board of Commissioners of Marion County, Kansas this 5th day of March, 2012. BOARD OF COUNTY COMMISSIONERS OF HARVEY COUNTY, KANSAS By	

Title	Description	Created At
	Marge Roberson, Chairperson By Ron Krehbiel, Membe By George A. Westfall, Member ATTEST: Joyce Truskett, County Clerk BOARD OF COUNTY COMMISSIONERS OF MARION COUNTY, KANSAS By Dan Holub, Chairperson By Roger K Flaming, member By Randy Dallke, Member ATTEST: Carol A. Maggard, County Clerk	
Unsure	Everything has moved so fast that I am unsure how I feel about it. I also am left unsure if I will have an opinion.	2012-09-07 12:17
I am not a happy tax payer.	1) This is another layer of red tape for the DD system that already has it's own internal managed care systems in place - this just duplicates those things that are already outlined through the DD Reform act. 2) DD services is a different animal and does not fit into traditional medical services. 3) All of the companies the state is contracting with are out of state - I would rather my tax dollars stay HERE! 4) This administration has bumrushed EVERYONE on this issue - even in their own party. Very little information has been shared as to how this is going to really look; the people directly affected are confused about the entire thing.	2012-09-07 12:12
I don't understand this.	But I hope it is going to save me money using an MCO for my appointments.	2012-09-07 12:00
I am a person who uses the DD waiver.	I am confused about the whole thing.	2012-09-07 11:56
A rush to ruin.	KanCare is going faster and farther than any other State. Most States have chosen to implement Medicaid Managed Care gradually, testing it in only parts of the State first. Kansas has decided to go full steam ahead with statewide implementation in only 6 months after chosing the MCOs. California's recent pilot progam for managed care showed that 7 months of planning prior to implementation is not enough time and led to mass confusion and chaos. Also, other States that have implemented managed care, even partially, have seen dramatic rate cuts to providers, payment delays, and a decrease in the quality of care. No matter what the Brownback officials say, once the management of Medicaid services is turned over to for profit insurance companies, those companies are in charge and State's fail to provide enough oversight of those companies to prevent services, medications, and procedures from being cut or denied to people who desperately need them. The number one priority for an MCO is to	2012-09-07 08:26

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	make a profit for their shareholders. Also, MCOs have very little experience in providing long term services for people with disabilities. Long term supports are not medical model services. For the I/DD population, Kansas has been a leader in the nation. We have promoted community based services over institutional settings, passed the DD Reform Act to set up a single point of entry for eligibility, assessment, and referral for supports and passed the Employment First bill. The I/DD system already has capitated rates, fiscal oversight, utlization review, quality oversight, and a person centered approach to planning, collaboration, and coordination of comprehensive services and supports. KanCare has nothing to offer the I/DD system to improve upon it. Instead, KanCare will dismantle an effective system that consumers, families, and advocates have fought hard to build over the past 25 years. It will remove current Case Managers from the system and replace them with insurance company employees. The MCOs will write the Plans of Care and approve the Plans of Care for consumers, effectively removing any voice a consumer has in how their services will be provided and what services are needed. Instead of being able to exercise appeal rights through the State, consumers will have to argue their cause to the insurance company who will make a profit from cutting their services. This thoughtless plan will only allow the Brownback Administration to wash their hands of their responsibilities to the citizens of Kansas and destroy the progress the people here have fought for since the days of being shuttered away in a facility and forgotten.	
Converting every Medicaid program to managed care simultaneously is an impossible challenge	Speaking as one of many intellectual and developmental disability service providers throughout the state of Kansas, we urge CMS to consider the following points about the proposed Medicaid reform called KanCare: Each Medicaid program is unique. Converting nearly every Medicaid program, including long-term care services, to a managed care system simultaneously is an impossible challenge. There seems to be little understanding on the part of Gov. Brownback's administration about the real needs of individuals with intellectual disabilities. Daily support services can include appointments, assistance with personal needs and pursuing the goals of independence and inclusion. It is hard to see how these needs will be addressed by out-of-state private insurance companies; it makes as much sense as turning the public education system over to them. Gov. Brownback points to better health outcomes as the end benefit for people with intellectual disabilities; however, adding oversight of daily living supports to the mix without explaining how doing so will improve those services seems driven by cost savings without concern for the sustainability of these programs. There is no possible way to reduce Medicaid costs without reducing services, period. The "public input" process was ineffective.	2012-09-07 06:45

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	During the public meetings leading up to the announcement of KanCare – as well as in subsequent meetings trying to win support for it – one phrase seemed to resonate: "Trust us, we're the government." In fact, the listening tours were tightly scripted events that allowed for roundtable discussions on predetermined topics, and did not provide time for relevant questions to be posed by attendees. The managed care organizations are less than stellar. The three announced contractors do not have a great track record of quickly building reliable systems and ensuring that payments and services are not negatively impacted. Two have been the focus of media coverage for huge settlement agreements concerning inappropriate Medicaid billing. This type of mismanagement can threaten the existence of service providers and burden families with uncertainty about their loved ones' homes and programs. The three contractors also have little, if any, experience in applying managed care concepts to extensive and lifelong services required by people with intellectual disabilities. Information is hard to come by. We know from Gov. Brownback's administration that KanCare is coming (despite the fact that CMS is still considering the state's proposal). Other than this fact, we have vague and conflicting information. Even service providers who have been educated about KanCare still have difficulty navigating its impact. Is the person's primary care physician in the network to which they will be auto-assigned? Will he or she use a different pharmacy or be required to use a generic that has been tried previously, but is not as effective? If a person is auto-assigned to a transportation brokerage that uses a different route, how will he or she get to appointments? People need real answers about how the changes will impact them on a daily, practical basis. Meanwhile, Medicaid recipients have been told they will be auto-assigned to an insurance company next month and will begin accessing the new system in January. This brash approach, driven by a desire for cost savings, will surely result in vulnerable Kansans experiencing confusion, frustration, and worst of all, the resulting inability to access vital, life-sustaining services.	
Improving Employment section (p16)	There are two points that are listed below that the Kansas Commission on Disability Concerns (KCDC) would like to have added to KanCare. Referral and access to training in high demand occupations is very important to the success of eventual employment. The discussion for several years from the Kansas Workforce Summit has been the lack of qualified workers to hire. If workers are qualified in an area that is in high demand, the fact that they have a disability will not make a difference and they will be hired. Feedback on the employment pilot for up to 400 individuals on HCBS waiver waiting lists (p16): KCDC would suggest that you add two bullet points. 1) Access to state agency training programs (i.e.	2012-09-07 06:38

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	Vocational Rehabilitation, Workforce Investment Act intensive services, etc.) if eligible. 2)Referrals to other training programs in high demend occumpations (i.e. Cerebral Palsy Reserch Foundation Office Suite Training - Wichita, etc.) Feedback on the second pilot for targeting individuals who meet the Social Security definition of disability but are not yet receiving it and is targeted toward youth (p.16). KCDC would suggest that you add two bullet points that state: 1) Access to state agency training programs (i.e. Vocational Rehabilitation, Workforce Investment Act Intensiive Services), if eligible. 2) Access to Career Tech Education program through high school or Adult Basic Education (GED) for those who have dropped out of high school.	
A Flawed Design	I believe that the 3 KanCare MCOs will end up cutting corners at the expense of a particularly vulnerable I/DD population all in the name of unproven cost savings. All the individual complicated needs that are inherent in this population have been well served by a sophisticated, well developed, comprehensive network of service providers who have built robust and effective partnerships with an array of resources in their communities that include health care providers by the way; and who have partnered to good results with experienced Kansas state I/DD administrators. With KanCare this system is dismantled with the insertion of a for profit layer into our mostly not for profit, local community based, person centered world. I do not believe that the MCOs have the experience nor the philosophy to navigate all the details to help foster a rich quality driven life for persons on the I/DD waiver. When you are dealing with people's quality of life you don't get a learning curve. This "experiment" is a flawed design with no proven benefit other than to the MCOs' bottom line.	2012-09-06 10:51
Carve out I/DD long term care services	Kansans have overwhelmingly voiced their disapproval of including long term care (waiver) services into the Kancare proposal. The inclusion of long term supports into a tradtional medical model program is inappropriate. The MCOs have no direct experience in managing these services and have indicated that they will not save money on these services. Kansas' system (Developmental Disability Reform Act of 1995) already includes many components of managing services including access, provider enrollment, billing, choice, cost of plans of care, quality assurance, and utilization review, with an administrative cost to the state of 2.4% and at no profit.	2012-09-06 06:57
Kancare is an example of the policy of the age of contraction of services and eventual elimination of services	What I know about Kancare is that it is not going to work. Giving contracts to 3 companies to set up HMO's with the proported objective of cost cutting is not the way to go. All Kancare does is to cut services and create chaos in a population that is confused and has been denied the real truth. Reinbursement rates for rural healthcare providers have always been less than the urban providers. Kancare will simply drive a stake thru the heart of a dying healthcare system. My experience with HMO's has been that they consistently provide lower quality and eventually higher long	2012-09-05 17:44

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	range costs. As a person who has experienced three or four different state and federal systems, I can say without any hesitation that the HMO system setup does not work. Cost shifting and cost containment will lead to cuts in services and the numbers of providers will go straight down. If one wanted to destroy rural healthcare, you cound have not designed a better system to do it. One more layer of administrative and system wide barriers to services. Kancare is an example of the nationwide efforts to ration healthcare. As a student of history, I can not see how a system that does not work in the first place is then made even worse by burdening a dying medicad system with even more costs and even more red tape.	
"Everybody has to be in for this to work!"...flawed thinking	I'm not sure that the people who are saying "Everybody has to be included for this to work" realize what they are getting us into. There are two separate issues for the I/DD community. One is the medical side and I understand and agree that streamlining by coordinating the doctor's appointments, hospital visits, etc. and making sure everyone gets their preventative procedures may, in the long run, reduce overall Medicaid spending. What I don't agree with is that Managed Care Organizations know anything about how the services side of the I/DD community works. Neither do I think the for-profit MCOs can manage the services side of the system for less than the CDDOs currently do, which for one, I know, is 2.4% of the overall system's cost. The MCOs were already asking for a 5% return up front and you can convince me that rates won't be affected in some way or another. These are insurance companies, folks! I am a very healthy, well person and have had to deal minimally with insurance claims, but of the few I have, they've been nightmares....and these were for simple, preventative procedures. I can't imagine what consumers and parents are going to have to go through dealing with MCOs who are managing their non-medical, every day services. Please do whatever you can to ensure that I/DD services are carved out FOREVER of Managed Care in Kansas.	2012-09-05 14:34
KanCare is not good for individuals with ID/DD who need community services	services for individual with ID/DD should be carved out of the KANCare approach. It just doesn't fit their needs and harm will most likely be done	2012-09-05 14:02
Community based services?	As a parent of an adult son with ID/DD I believe that KanCare will become a "demonstration" of how not to reform medicaid. Put simply, the present system is flawed, but the proposal for reform shows a lack of understanding of the current system. The present proposal has not provided for the input or experiences of the ID/DD community. The process has been polluted by politics and the monetary interest of C.D.D.O's and the "affiliated" service providers. Again, in the interest of brevity, adding another layer of administrative "oversight" fails to recognize the problem. The existing system has a hand full of "power brokers" who claim to know what is best for those with ID/DD. In reality it is a fight for	2012-09-05 09:00

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	the dollars by organizations that already are driven by a profit motive. Any real reform begins with true "community based services." This does not mean C.D.D.O.'s and service providers, it means those with ID/DD and true advocates who understand what it means to support this population in the real world. How about an objective screening by a team of qualified developmental/intellectual experts as a starting point? By starting with a independent evaluation we can have a "real" starting point focusing on the "real" needs and addressing them from a consumer based starting point. This would be an appropriate demonstration. Start by a realistic look at consumer needs and do what already works best-self directed funding. Then the consumers will demand "service" by having control of what this debate is really about-MONEY.	
Please Stop Kan'tCare for MR/DD	The nature of providing care to the MR/DD population is distinctly different from the type of service that private health insurance companies normally provide. The managed "co-pays," primary care "gatekeepers," and other cost-containment devices typically employed to discourage over-use of acute care services would likely prove highly inappropriate. Agencies currently supplying care to this vulnerable, sometimes medically fragile population are stretched thin, their workers poorly compensated, and their waiting lists long. For the "house of cards" which is our current MR/DD community care funding system, even small gaps or momentary lapses in reimbursement may well prove health-endangering--if not life-threatening--for some service recipients.	2012-09-03 16:56
Eliminating the Institutional Bias is more likely to be achieved without using HMOs for the Home and Community Based Services	Money Follows the Person and State Plan services can be better utilized to move people out of expensive nursing facilities, ICFs/MR and other institutions. Using MFP to get enhanced federal dollars, and then CLOSING the bed behind the person will ensure greater savings flow to Home and Community Based Services Waivers. This could save the state considerable dollars with the provision of institutional levels of care.	2012-08-31 18:25
Current Gaps and Barriers can, and should be addressed without major administrative changes	There are current gaps and barriers in the system that must be addressed, whether managed care is implemented or not. Some Home and Community Based Services are largely underutilized. If such HCBS services were available when needed, it would decrease costs by diverting from more costly levels of services and would improve health outcomes for individuals with chronic care needs. These can be addressed without a managed care model. Or, if the administration implements managed care, these outcomes and objectives should be met through carefully worded and incentivized contracts. Outcome incentives to providers, combined with innovative capacity-building strategies and state-sponsored outreach and advocacy initiatives, can help to bring targeted systemic improvement in these areas.	2012-08-31 18:24

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HMOs don't have enough experience or proven success with Home and Community Based Services (HCBS)	If managed care is implemented, it could be done so in regular medical only, carving out all long-term care HCBS Waiver services, allowing Kansas to harness the tools and principles of managed care to achieve cost efficiency, improved access, and quality of care outcomes. If managed care is implemented for regular medical services there are still multiple barriers and pitfalls to doing so, but should not insert managed care into the already effective local-state partnership of disability services. Given the fact that almost all other states do not include HCBS Waivers in Medicaid Managed Care, HHS should require that all HCBS be carved out in the managed care program as part of any resolution of Kansas' 1115 Waiver application.	2012-08-31 18:23
Support Local Control with Direct and Ultimate State Accountability (current DD & MH systems under reform laws)	In Kansas, community-based services for individuals with developmental disabilities and mental health needs were set up years ago by policymakers as a local-state partnership. Wisely, Kansas legislators set up in law a system with local control of the gatekeepers of Home and Community Based services but with ultimate and direct state government accountability of the system. Kansas' mental health reform laws, developmental disability reform laws, and laws requiring access to personal assistance services (PAS) for people with physical disability and traumatic brain injury were passed with broad bi-partisan support and signed into law by Governors Hayden and Graves, respectively. These reform laws ensure local control over infrastructure needs for the development of social services in communities, because county commissioners designate the local authority, or gatekeeper, to form the locally provided service centers for people in their respective counties for those with support needs. The state, however, has direct and ultimate accountability over these local authorities. This system of local control and state accountability has worked for years in Kansas. The 330 partisan elected county commissioners across the state - 83% of whom are Republicans – value this local control and expect to maintain their authority to ensure that local people and providers are serving local needs. Our state does not need and would not benefit from replacing this traditional yet progressive support structure with one that inserts an unnecessary, out-of-state, for-profit corporation into the administrative structure simply so that it can take a cut of the already limited pool of public funds and stifle local innovation and flexibility. When it comes to home and community based disability services, why hire a middleman when state government already has all the tools available to manage this proven local-state partnership?	2012-08-31 18:23
Other forms of Managed Care can serve many populations better than the model in KanCare	Kansas should redesign its 1115 Waiver and KanCare proposal to keep financial and managerial responsibility with the state by requiring a simultaneous contract with a Care Coordination ASO to give choice to consumers and providers, provide competition for	2012-08-31 18:22

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	the larger MCOs, and create another way for the state to realize savings. Research we are familiar with points to using other forms of managed care— called ASO's. An ASO (short for Administrative Services Organization) that also has a strong Care Coordination component has shown to help states fix gaps and barriers that cause Olmstead problems, and help states to lower costs for serving High Risk, High Cost populations. Because they tend to be smaller and more specialized, these ASO type managed care arrangements could be promising as long as they are implemented well and build on the infrastructure Kansas already has in place. When used with a PCCM (Primary Care Case Management) model, services managed under an ASO are then integrated with primary doctors. DRC has consistently advocated for a 'carve out' of Home and Community Based Services (HCBS) because we are concerned for the State of Kansas if they move to this structure. While the state may expect savings on the 'medical side' of Medicaid due to the enhanced data systems and better integration of services with primary care physicians that are typical to traditional managed care, HCBS requires more specialization than these large HMO plans have been known to deliver. We have feared that a full 'carve in' would, at best, result in a slow degradation in the amount and quality of HCBS services, even if the state plans to take precautions to guard against it. An eventual outcome like this means the state will not realize the true savings they could if they have a vibrant and innovative HCBS system—and it also means unhappy consumers and advocates.	
Support Principles of Family-Driven Care for children and youth	Wraparound is the model and philosophy that should drive Care Coordination in Kansas' behavioral health system. An effective Medicaid redesign would include specific RFP language, projects and proposals that reflect an understanding of the model and how to operationalize it. Unfortunately, this is not the case with the 1115 Waiver application or the KanCare proposal. Intrinsic to this we are advancing philosophy is the basic rule that families and youth are given accurate, understandable, and complete information necessary to set goals and to make choices for improved planning both for individual children and the family. Kansas has historically experienced successful outcomes when children's behavioral health programs statewide fully embrace the values ensuring services and supports are 1. Family-centered, 2. Community-focused, 3. Strength's based, and 4. Culturally respectful and responsive. This must be reflected in the Care Coordination program. We have sincere doubts that a large HMO-style managed care structure will be able to get Care Coordination right. Its seems that in the long run, there is simply not enough incentive for these immense agencies to focus so much time and expertise on improving services for what is statistically a small group of their beneficiaries.	2012-08-31 18:21

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	It is not enough the the 1115 demonstration and KanCare to state that how consumer and family voice are integrated with existing and future care coordination models will be decided at some future date under the initiation of the HMOs. These principles of family and consumer driven coordination of care have been around in Kansas for several years, its not time to take a step back. KanCare must have a plan for ensuring families and consumer voice is essential and directive.	
KanCare proposal does not contain enough assurance that it will result in better state compliance with Olmstead and EPSDT	Two very strong parts of the law that protect the rights of people with disabilities are: a US Supreme Court decision which set a requirement for states to provide real community based alternatives to institutionalization (Olmstead); and existing federal laws which require states who participate in Medicaid to arrange for the Early Periodic Screening Diagnosis and Treatment for children and youth under the age of 22. We believe these two aspects of the nation's law represent a backstop against which any kind of planned redesign of Medicaid must be evaluated. As we have stated before, large 'carved in' managed care structures do not have a good history of performing well in light of Olmstead and EPSDT. Unfortunately, the State of Kansas' 1115 Waiver proposal does nothing to address the existing Olmstead problems and does not ensure that EPSDT will be effectively available. Therefore, HHS must use its power of approving or rejecting Kansas' 1115 Waiver to require that EPSDT services are carved out of KanCare and that Kansas makes significant progress on its existing Olmstead compliance issues, including but not limited to the massively long HCBS Waiting Lists. This must be a tool in HHS's toolkit when it resolves Kansas' 1115 Waiver application.	2012-08-31 18:21
Care Coordination must only enhance, not replace, community based case management for HCBS	Kansas must keep the intensive community case management services we have in place, and bolster (read: do not replace) their effectiveness with a high quality Care Coordination program that will ensure access and prevent unnecessary institutionalization. Unfortunately, the KanCare RFP, written documentation, and 1115 Waiver application are unclear how existing case management will interact with this new administrative level of "Care Coordination." If Home and Community Based Services (HCBS) are to be moved under managed care, individuals and families who need these services deserve a quality specialty Care Coordination program that strengthens and reinforces (but does not replace) quality community-based Targeted Case Management. Any proposal to implement managed care must have a well designed Care Coordination program in order to address system gaps and barriers, help determine network adequacy of providers, ensure access to needed personal support services and treatments… and comply with state and federal laws. However, Kansas does not do this in its 1115 Waiver application or KanCare RFP.	2012-08-31 18:20

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	Kansas must mitigate all potential conflicts in the coordination of services by requiring that KanCare: • Ensures that individuals can advocate for themselves or have an advocate present in planning meetings. • Ensures documentation of the choices that individual members have been offered among all qualified providers of direct services. • Establishes administrative separation between those doing assessments and service planning and those delivering direct services. • Establishes a consumer council within the each service providing organization to monitor issues of choice. • Establishes clear, well-known, and easily accessible means for consumers to make complaints and/or appeals to an independent conflict resolution program for assistance regarding concerns about choice, quality, and outcomes. • Requires all MCOs and contracting organizations to document the number and types of appeals and the decisions regarding complaints and/or appeals. • Have State quality management staff oversee providers to assure consumer choice and control are not compromised. • Document consumer experiences with measures that capture the quality of case management services.	
The 1115 and KanCare should ensure ACCESS to Peer Support Specialists	The State must ensure ACCESS to Peer Support Specialist (PSS) Rehabilitation services through a robust provider network that supports consumer choice. Unfortunately, the state does not do this, and the 1115 Waiver application does nothing to address this systemic problem. In order for the state to see the most benefit possible from PSS, it must be available statewide and in the environments where people live, work, and socialize. A combination of Medicaid funded and non-Medicaid funded PSS will provide for healthy competition and specialization of programs that ensure niche communities meet the support need of people in Recovery. Similar to our suggestion on the DD side, Peer Support should be both a readily available, statewide Medicaid service as well as services written into the Managed Care contracts. However, this 1115 Waiver application fails to do any of these things regarding PSS.	2012-08-31 18:19
Consumer Operated Services for People with Severe Mental Illness	The key to the success of promising models for expanded Consumer Operated Services has been better engagement for people with severe mental illness. Peer-Run services for people with severe mental illness are the next step forward for our behavioral health system, and the ultimate 'risk management' tool for the state in its efforts to manage spending on behavioral health. By ensuring a contractual provider network of Peer-Run supports and services, funded under the behavioral health contract, Kansas can take advantage of 20 years of Mental Health Reform and utilize an eager network of Peer Support Specialists to	2012-08-31 18:19

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	help reduce financial costs and produce higher engagement and satisfaction of services for Kansans with severe mental illnesses. Between the existing and emerging research surrounding the effectiveness of Peer-Run service models, a list of service types the state should support has developed. Although the two lists below are not meant to be comprehensive, these have been models have stood out for their ability to support a person's Recovery in the most natural and cost-effective manner possible. Unfortunately, these models are not effectively incorporated at all in the state's 1115 Waiver application. These practices include: 1. Consumer-run trainings for the MCO staff to raise their awareness regarding empowerment and recovery; 2. Consumer-run, Recovery-focused social groups to support the sometimes overlooked but nonetheless very important social and leisure time needs of people in Recovery from mental illness to prevent re-institutionalization; 3. Consumer-run satisfaction teams to provide a feedback loop to the managed care staff. 4. Below is a list of more advanced 'evidence based' Peer-Run models of support for people with severe mental illness that are more service intensive, but have also shown to produce some of the most promising cost savings and best health outcomes for Medicaid funded programs. The best programs that have been implemented in other states have services that are directly 'purchased' by state agencies and/or managed care companies: 1. Crisis Respite Programs – a supportive, empowering, and safe alternative to traditional crisis services and inpatient admissions; 2. Peer Support 'Warm Lines' – a confidential, non-crisis support line that is operated by individuals in recovery for support, information, and linkage to self-help groups; 3. Peer Supported Health Coaching services – have shown to have mastered the critical engagement piece that is so necessary for managed care plans to realize the maximum amount of savings on medical costs for people with severe mental illness; 4. Transitional Services or 'Peer Bridger' Services – Peers who have been in institutions who assist those leaving institutions to get re-established in the community. They provide a bridge to the community through critical personal supports and linkages to essential resources that enable successful transition to stable community living; 5. Peer Mentor (Long Term Care) -- individually designed service to improve participant's self-sufficiency, self-reliance, ability to access needed service, goods and opportunities in the community achieved through education, teaching, instruction, information-sharing and self-advocacy training; for seniors and those with disabilities transitioning back to community.	

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	Unfortunately, the Kansas 1115 Waiver application does not focus enough on engagement for people with severe mental illness. It does not focus on the best practices, prevailing approaches and emerging research noted above. The 1115 Waiver application focuses instead on generating cost savings to pay for massive tax cuts that the state cannot afford, which will force the systematic dismantling of our social safety net.	
Use KanCare as an opportunity to expand Consumer Operated Services by People with intellectual disabilities	When Kansans with developmental disabilities are the primary decision maker in the services planning process they are more likely to achieve preferred lifestyle outcomes. This results in more individualized services that are based on the needs of the individual, not the convenience of the service provider. Informed and well supported ID/DD self-advocates tend to be more apt to achieve independence and develop a network of natural social supports. Over and over we find that they are more likely to keep close ties with family, attend church, and to seek competitive and integrated employment. We believe that self-advocates are a great resource to the state for changing the institutional bias. Employing self-advocates to give presentations and to work with families who have a child with a developmental disability helps those families to imagine a different life for their young son or daughter—to look beyond limitations and see a life of inclusion and independence in the community. Kansas is in a great position to be a leader in the development of Consumer Operated Services for people with ID/DD. Although many of the existing models for employing self-advocates have been educational in nature and focused on outreach efforts, we believe the state should operationalize self-advocacy efforts into programming to meet state objectives like increased competitive and integrated employment, community integration, health coaching, and self determination strategies. Unfortunately, the 1115 Waiver does none of this. Self advocacy support is obviously never even considered as part of the 1115 Waiver. Neither are Consumer Operated Services for people with intellectual disabilities.	2012-08-31 18:17
Use Community Reinvestment Funds (CRF) to support Consumer Operated Services	Kansas must use Community Reinvestment Funds (CRF) to support Consumer Operated Services in combination with services that are already Medicaid funded and existing consumer run infrastructure for better cost efficiency and improved consumer engagement. Unfortunately, the state does not do this with its 1115 Waiver application. In fact, Kansas goes in the opposite direction with this 1115 Waiver application. Instead of focusing on Consumer Operated Services that are closer to the Medicaid member, Kansas focuses on bringing in managed care companies to get between the member and their benefits. Nowhere in the 1115 Waiver application or RFP are Consumer Operated Services made a	2012-08-31 18:16

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	priority through meaningful expansion of this best practice approach. The Kansas disability community was hoping that the 1115 Waiver would improve innovation in the provision of Consumer Operated Services by including goals in MCO contracts to use dedicated CRF funds to issue multiple grants that invest in new services. Unfortunately, Kansas specifically did not do this. We know that many states are requiring MCOs who do business in their states to use the flexibility of CRF to creatively develop programs that meet the needs of a particular community locale or target more specific statewide 'issue areas' such as deinstitutionalization or culturally informed health planning, for example.	
Make expansion of Consumer Operated Services a goal for KanCare and the 1115 Waiver	The 1115 Waiver and KanCare do not focus on or expand Consumer Operated Services. This is a significant problem, because these services proactively reduce the overall cost of Medicaid services and further the goals of Medicaid for inclusion and integration. Consumer Operated Services are not simply services delivered by consumers, but are independent, peer-run programs. These can also be a great way to employ people with disabilities and improve quality services in whatever reformed Medicaid system the Administration designs. Consumer Operated Services and Programs are peer-run, self-help organizations or groups that are administratively and financially controlled by persons participating in services (consumers). They are not simply services delivered by consumers however, but are independent, peer-run programs. In general, Consumer Operated Services offer mutual support, community-building, and advocacy. Medicaid redesign without consumer operated services expansion is a missed opportunity and would make the redesign less effective. Kansas must support Consumer Operated Services using Community Reinvestment Funds (CRF) funds in combination with Medicaid funded services and existing consumer run infrastructure. The value of consumer operated services cannot be understated. When it comes to efficiency in the coordination and provision of services, an informed and well-supported self-advocate is worth their weight in gold to the state of Kansas. And state-of-the-science strategies for developing Peer-Run services and supports present some of the most promising outcomes we have seen in recent years both in terms health and costs. The Medicaid redesign must support Consumer Operated Services. Below, we've separated MH self advocacy from ID/DD self-advocacy due to ongoing questions about the inclusion of Habilitative ID/DD services into managed care.	2012-08-31 18:16
Make expansion of Consumer Operated Services a goal for KanCare and the 1115 Waiver	The 1115 Waiver and KanCare do not focus on or expand Consumer Operated Services. This is a significant problem, because these services proactively reduce the overall cost of Medicaid services and further the goals of Medicaid for inclusion and integration. Consumer Operated Services are not simply	2012-08-31 18:15

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	services delivered by consumers, but are independent, peer-run programs. These can also be a great way to employ people with disabilities and improve quality services in whatever reformed Medicaid system the Administration designs. Consumer Operated Services and Programs are peer-run, self-help organizations or groups that are administratively and financially controlled by persons participating in services (consumers). They are not simply services delivered by consumers however, but are independent, peer-run programs. In general, Consumer Operated Services offer mutual support, community-building, and advocacy. Medicaid redesign without consumer operated services expansion is a missed opportunity and would make the redesign less effective. Kansas must support Consumer Operated Services using Community Reinvestment Funds (CRF) funds	
Consumer Involvement should be expanded under the 1115 Waiver and KanCare	Involving consumers in nearly every aspect of Managed Care is one of the core, basic, and minimum requirements of ensuring the future of any Managed Care system produces quality results. A vibrant, well funded network of consumer-run organizations, state-wide consumer entities, and annual consumer conferences should be expanded in Kansas regardless of the changes to other Medicaid funded programs. The advantages to the state of having a network of well informed and well organized consumers and consumer directed programs are too great to be ignored or minimized in the midst of large systemic changes. We know that in this respect, two groups like the Consumer Run Organizations (CROs) and the Self Advocate Coalition of Kansas (SACK) have been serving the interests of the state of Kansas for many years, and have only required a minimal financial investment compared to the rest of the state's budget. This infrastructure must be maintained throughout the reform efforts.	2012-08-31 18:14
The 1115 is not likely to address Kansas' Olmstead problems because it contains Institutional Service Carve-Outs	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. 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.	2012-08-31 18:13
The 1115 Application needs more content on the role the Kansas ADRC. Will ADRC provide Options	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	2012-08-31 18:12

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Counseling or will they perform Functional As	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.	
MLR, Admin, and Profit must be clearly spelled out in Terms and Conditions of contracts with HMOs and 'Care Coordination' must be included i	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.	2012-08-31 18:11
State must maintain one website for disability and behavioral health services for the sake of transparency and to ensure quality information	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.	2012-08-31 18:10
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.	2012-08-31 18:10

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	Without clear and accurate evaluation of the current needs of our system, how will Kansas be ready to manage KanCare?	
The KanCare 1115 doesn't show evidence of planning with crucial public partners to ensure cost effectiveness of service delivery – Vocationa	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.	2012-08-31 18:08
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.	2012-08-31 18:07
The admissions process to ICF-MRs in the 1115 is proven to be ineffective for guarding against unnecessary institutionalization of Kansans w	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	2012-08-31 18:06

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	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.	
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.	2012-08-31 18:06
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.	2012-08-31 18:05
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	2012-08-31 18:04

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	focused on acute care and are not relevant to the provision of long term supports and services for people with disabilities.	
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.	2012-08-31 18:04
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.	2012-08-31 18:03
The part of the KanCare 1115 proposal that would provide a limited package of benefits to individuals who are not enrolled in Medicaid but w	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.	2012-08-31 18:03
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	2012-08-31 18:00

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	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.	
Crisis Exceptions, Case Managers and overall poor planning	As a Case Manager I work closely with people of varying abilities. I also have several clients that are on the waiting list. What happens if there is a crisis and we need an emergency way for someone to get funding. There often arise cases of self neglect, abuse or criminal justice system to where a Case Manager needs to be able to help access crisis funds. What will happen to this? Additionally, what happens to the hundreds of Case Managers throughout the state that lose their jobs then may have to go on public assistance. I am fortunate to have a great husband that has a good job and I also have a nursing background that I could go back to. I prefer the hands on approach to care and helping people coordinate items they need to be successful in life to the best of their abilities. I not only help with referrals to physicians and other health care providers. I assist with finding employment, housing, activities, staffing supports and help coordinate treatment plans. I work with school teachers and advisers to assist kids in learning how to become a success. I also help develop plans for staff to assist people in managing their behaviors and possibly decrease the amount of staffing supports needed. This plan was not very well thought out and many of our most vulnerable Kansans are being put at risk. Will the Care Coordinators be able to go into the homes to check on success and visually "see" what is needed? Will they be able to attend IEP meetings and wrap around conferences to assist with continuum of care issues? Will they know the people and be able to develop bonds so the clients can trust them? Who will supervise the insurance companies to ensure that things are taken care of and needs are met? The reason I chose to do case management is that on a daily basis I have the opportunity to change someone's life for the better, not make a huge income. The standardized assessments are a good thing and going to that will alleviate some of the padding of the hours for clients that need services. I would like to see that, however, changing the whole system when it works and people rely on these services daily is not the answer.	2012-08-31 12:59
How is KAN CARE good for those with Intellectual and Developmental Disabilities?	If you look at every single thing that has to do with KAN CARE the only people who win in the end are the insurance companies and Govenor Brownback! The rich will just keep getting richer with KAN CARE! There is no positive outcome for those with Intellectual and developmental disabilities!	2012-08-31 08:26

Title	Description	Created At
We don't need Kancare.	I live on my own and can do lots of things. But some things I need help with. OCCK provides the services I need like to help me shop for groceries and to go to the doctor. I also like my case manager. I don't want to lose any of them! If Kancare means I might lose them, then please don't change what I have!	2012-08-31 08:20
Kancare is not a good idea.	OCCK provides for my needs and I'm happy with what they do. It looks like changing to Kancare will make it ****** for them to help me. I like Callie, my case manager. I don't need a new one! I know Kancare is supposed to save money, but I am worried that it means I will get less care. Please don't change things!	2012-08-31 08:12
Please don't change my services!	I live and work in Beloit, Kansas. I am a part of OCCK which is a great company. I'm afraid that I will lose my case manager who helps me a lot. I am also worried that these other companies won't want to come out to Beloit to help us. Please leave things as they are!	2012-08-31 07:59
My name is Jane Darlene Strifler. I am a 53 year old female with Spastic Quadriplegic Cerebral Palsy and I have lived in Kansas now for 19 y	My name is Jane Darlene Strifler. I am a 53 year old female with Spastic Quadriplegic Cerebral Palsy and I have lived in Kansas now for 19 years and two months. I absolutely hate it!! My birth place is Fort Riley Kansas, yes my Father Dannie Elwood Strifler gave 22 years to the United States Army he is now deceased. My father and two older sister's are also born Kansan. As a disabled person living in Kansas I think it sucks big time! My first Independent Living Center I dealt with was Three Rivers they don't even deserve the title Independent Living. All the Centers I've ever been with even my current one which is Community Works Inc. only has been able to pay my attendants, (if you can find one who actually can do the physical labor and wants to it not just sit on their ***!) no other services or programs are available! Now the state of Kansas wants to switch to KanCare it only makes the people who are supposedly running the state of Kansas look hopefully better on paper however I'm not even sure of that! Now Kansas wants to take away the best case manager I've had since living here and it hasn't been easy or fun for that matter! Accessible Housing is virtually non-existent, so is accessible transportation, education at any level; durable medical equipment availability much less a maintenance program; no activity programs through so called Independent living centers, no summer or fall programs basically nothing and no way for other disabled people to meet each other in person; just as long as we each sit or lay in our corners of where ever we may be and are out of site and out of mind!! My old home of California looks dam good to me!! Why doesn't someone from Kansas help me relocate so I won't ***** anymore at least an California you can openly ***** and they listen!!!!	2012-08-29 09:53
Individuals on the Working Healthy/WORK program are not being offered a choice.	I am an independent living counselor for participants on the Working Healthy/WORK program. The individuals I support all qualify for the HCBS I/DD waiver program, but because they have good jobs and are able to live mostly independently in the	2012-08-28 03:36

Title	Description	Created At
	community, the Working Healthy/WORK program is a better fit for their needs. However, because they do have cognitive and intellectual delays, there is extensive hands-on assistance which I currently provide. I coordinate services and supports with the state program manager, with the financial management services agency who is responsible for managing the individual's expense allocations from the state, and with the providers who provide direct care. I continuously research and coordinate other resources as needed, such as beneficial mental health resources, nutritional assistance, vocational rehabilitation, transportation assistance and medical resources. I assist individuals with finding, interviewing, hiring and training qualified direct care providers. I provide hands-on assistance with mandated paperwork and partner with individuals in creating a monthly and annual budget which they use to allocate the financial resources they are given by the state. I periodically review their expenses to ensure that resources are being utilized correctly. I ensure that individuals know about and have access to social and leisure activities which are available in their community. I work daily with providers and families to problem-solve issues that can and do occur in a community setting. I visit my individuals on a regular basis to ensure that they are happy with the services that they are receiving and to understand what other interests or needs that they may have. At a recent state-wide KanCare educational meeting, current providers were informed that the three MCO's will absorb the duties of care coordination/case management on January 1, 2013. We have not seen any detail to-date on how the individuals we currently serve will receive case management services in the future – only that they will. I am concerned that our individuals will be divided into "levels of care" and face-to-face or hands-on assistance will only be provided to those with difficult medical needs. Most of my individuals are relatively healthy, but they have other challenges which make it problematic to communicate information over the phone or through written correspondence. How will the insurance companies provide this type of hands-on assistance to all individuals on the Working Healthy/WORK program so that they can continue to be successful in the community? And why can't I continue to provide these services to the individuals I currently serve if they so choose?	
1115 waiver (KanCare) should include provisions to eliminate the Developmental Disabilities Waiting List	Currently, the list is long and something needs done to help those on the list. Some have been waiting for many years and still waiting as the list gets longer.	2012-08-27 08:46
What's the Matter with KanCare?	Persons with I/DD; family members of persons with I/DD; professionals in the I/DD field have continually expressed concerns that are continually addressed with vague answers and little detail	2012-08-27 07:38

Title	Description	Created At
	by KS. Currently more than 4,000 children and adults with I/DD are waiting for services. KanCare offers no solution. The state insists on a rushed timeline that reinforces their lack of desire to HEAR from persons with I/DD and advocates. While 'public input' meetings have been held they were 70% lecture-based and 30% Q&A. The state often portrays the outcome of these meetings in a light that befits them, but is not entirely accurate. The revised waiver request remains inadequate in addressing how a medical insurance company is a good fit for addressing long-term care support such as residential assistance and employing persons in competitive community jobs. There's so much LACKING in the KanCare proposal as it relates to serving persons with I/DD that you have to ask, what is right about KanCare? The only remaining KanCare service that may potentially benefit persons with I/DD is including them in medical services. But long-term care does not belong in the hands of out-of-state, for-profit insurance companies who have no expertise and no mission to provide supports that prioritize inclusion and independence for persons with disabilities.	
During the public comment forums that were held in June, the Administration received overwhelming negative feedback from the public regardin		2012-08-27 06:51
I believe KAN CARE is just rewarding Insurance Companies that Support Brownback and controlling republicans. Care is NO consideration.	Leave the program as is. Care will be reduced, as Insurance Company Execs will get bonuses, vacations, new office furniture. Brownback and Company don't care about people. Instead of people getting care, Execs will get bonuses, increased retirements, huge buyouts. The Insurance companies are in it to make all the money they can, and have absolutely no interest in the care and well being of the people they serve.	2012-08-27 05:18
Big Red Flags	As a case manager of one of the waivers I have heard about these proposed changes since day 1 of Gov. Brownback coming into office. This has truly been nothing but a huge snow ball effort. Ask any of the Medicaid recipients what KanCare is and don’t be surprised when no one can tell you the specifics. I have yet to hear one client comment on the upcoming change to their services and I fully believe they aren’t even aware of what is going on, as we have been told repeatedly that we aren‘t allowed to talk about it with them. The Governor hides behind the “informational meetings” that he has held, but they have been little more than a waste of time. These meetings have been held in places that involve a lot of walking and/or stairs to get to, making it impossible for most of the people affected to even get to. These are people with disabilities, both physical and mental; people who have brain injuries, who are frail and elderly. For a lot of these people the	2012-08-25 12:05

Title	Description	Created At
	only support they have in their lives is their case manager. Telling these people to come to a meeting is a joke. Most can't get out of their homes due to their limitations, and wouldn't have a way to get there if they could. And the big kicker is that the Brownback administration reports that Kansans are eager for this program to start, at least from what they are hearing at those meetings. But, if you ask anyone who was present at any of those meetings they will tell you the consensus among citizens of Kansas couldn't be more clear-people are strongly opposed and continue to voice grave concerns. Yet, Gov. Brownback continues to ramrod his KanCare plan forward and fill the media with false reports about how well things are going and how happy those affected are at this point. The administration touts that this change will be great because all services will be under one roof. The needs of the clients under each of these waivers couldn't be more different, and having them separated the way that they are now is the best fit to give them the individualized attention that they deserve and need in order to thrive. The case managers for each waiver go through continuous training in order to best serve their specific clients. It is easy to sit behind a desk and decide that you know what is best for people on Medicaid. But working with the waivers, hands on day in and day out, and working directly with the client is night and day different, in terms of knowing what changes will truly make a positive and fiscally responsible difference for the state of Kansas. Putting them all under one roof is like putting them all into a blender and watching them try to mesh together-all of their identities and their individual needs will become indistinguishable and thus the suffering begins. The proposed KanCare program will eliminate thousands of jobs across the state from the current case managers and other care providers, and the case management positions with the MCOs require a social work license. Current case manager positions, at least through some of the waivers, do not require a social work license. Where are these hundreds and hundreds of social workers at this time? What happens if there aren't enough qualified applicants to provide services for the hundreds of thousands of Kansans this affects? Please look at the infinite number of red flags that continue to be thrown up every step of the way. Millions of Kansans will be affected by KanCare when it is all said and done. From the clients, to their families, to the thousands who will lose jobs over this. People who have no other option but to be on Medicaid do not deserve to suffer no matter how much money the state of Kansas "might" make out of the deal. If KanCare is approved the immediate and long term results will be catastrophic.	
People who are disabled and their parents and guardians are not being kept informed of plans,	The State of Kansas needs to inform disabled clients and families directly, and provide response to questions and concerns.	2012-08-25 10:03

Title	Description	Created At
timetables and impact of proposed changes		
KanCare "people" cost is too high.	KanCare seems to be a vehicle to sweep vulnerable Kansans under the rug and out of sight/mind of our state government. My family trusts our case manager because we know them; face to face meetings are vital to ensure the health, safety and well-being of our son. The move to KanCare has been without thought to the short/long term "people" costs of this disasterous move.	2012-08-24 19:08
Common Sense	There is no success track record for programs of this type. If the electorate is going to be by-passed on this, I encourage those who are 'currently in power', to at least have the decency/common sense to exclude DD Long Term Care from this impending disaster.	2012-08-24 13:07
The KanCare program is a Lobbying group's canned solution to bring about an ideology of the Withering away of the State	As noted two of the selected Kansas vendors are already in Kentucky providing their "services". Medical Doctors are having to consider borrowing money to cover their expenses since the payment for services is later than promised. You know this is a sham when the official policy is to pay a "clean" invoice within 22 days and a complex invoice for services within another 15 days. It is an ALEC dream that reminds me of the Red Guards in China during the Cultural Revolution, "Red, rather than Expert" was the slogan.	2012-08-24 11:17
Outsourcing Core Jobs	KanCare as planned will outsource essential functionality of the Kansas Medicaid system to three out-of-state companies. Kansans will lose their jobs in favor of out-of-state for-profit companies. Even if, by some unimaginable chance the plan saves money, it will be because of job loss.	2012-08-23 19:39
The entire KanCare/Medicaid-for-profit scheme must be scrapped	The entire Medicaid-for-profit scheme must be scrapped and CMS should deny the 1115 waiver application of Gov. Brownback's administration. Nothing good will come of handing Medicaid over to private companies to profit off of the poor and elderly. Costs will still go up to pay high private CEO salaries, people will be denied service and benefits will be cut. Developmentally disabled individuals and their advocates and families are especially troubled by the proposed, rushed changes. Their residential care, based in the community, is managed by long-established non-profit organizations. The Medicaid privatization scheme will put their care in danger with increasing bureaucratic demands and private profits off their care, which will mean LESS CARE and lower quality care. I attended the town hall to discuss these possible changes and the analysis of the projected cost increases for Medicaid was faulty and exaggerated. The projected cost increases was put forward as the primary reason given for these extreme changes.	2012-08-23 13:52

Title	Description	Created At
	These town halls were well attended and all of the numerous speakers opposed the KanCare proposal.	
Major Concerns	There are a number of major concerns over the KanCare proposal. In recent town hall meetings the feedback from the audiences of providers, recipents, and citizens has all been negative against the plan. There is no legislative oversight in place with authority over the MCOs. Two of the selected MCOs, Amerigroup and Centene have managed Medicaid contracts in Kentucky and have had perforamnce issues resulting in failure to pay providers and law suits regarding their perfromance. This entire processed has been rushed and the timeframe for implementation is unrealistic. This is evidenced by Blue Cross of Kansas not bidding because they felt they did not have time to research the data and develope an approprate bid. The fact that only 5 companies submitted bids indicate that this was a wide held belief with many MCOs. One of the companies that lost the bid, Wellcare, then bought one of the companies awared a contract (Amerigroup). Wellcare is also involved in the Kentucky Medicaid mess.	2012-08-23 10:34
This change is happening too quickly and thoughtful planning did not happen.	Systems are not ready for this change and Medicaid participants do not have enough time to understand the timeframes for chosing an MCO. Changes in HCBS Waiver case management was not clear to providers or to Medicaid participants. We are just finding out now how "Care Coordination" is defined and it is very "medical model". This program is very concerned about saving money but where is the concern for Medicaid participants? It seems that this should be implemented slower and add groups to Managed care over time rather than shove all 390,000 Medicaid participants into the program at once. Seems like these decisions were made to please the MCO's rather than accommodate the Medicaid participants. I'm sure that CMS will be told that all is well and progressing but drill down to the details and you will find out that there are too many details that are not being considered.	2012-08-22 19:03
Disastrous	I am very concerned about Kancare as proposed by Governor Brownback. Kansas has had a excellent system in place for providing services to the elderly and disabled. Improvements and cost containments were achieved under former Governor Sebelius while restoring services that had been cut in a former administration. Now Governor Brownback wants to decimate those services and move everyone into HMOs. Originally the current administration assured beneficiaries and their families that their case managers would remain the same. Now we know the truth, hundreds of case managers will be losing their jobs and the managed care organization will provide the case	2012-08-22 14:40

Title	Description	Created At
	managers. These managers have everything to gain by reducing services to the beneficiary and enriching their employer. This conflict of interest should not be allowed to stand. The developmentally disabled population will be able to retain their case managers for another year, but will like have their level of services determined by the MCO's in 2013. State representatives say they don't know, but I suspect they do and are unwilling to admit the truth to the stakeholders. This has been a heavy handed, opaque transition. Managed care transitions in other states have been disastrous for the consumer. Before approving managed care for additional states, it would be prudent for HHA to study the cost savings, which most states are not realizing, and quality of care in the states that have already made that transition.	
It is a tragedy that Centers for Independent Living will no longer be providing case management services.	CILs should be allowed to continue doing case management which is no more a conflict of interest than allowing community mental health centers to continue providing this service. Consumers will be negatively affected the most, but many careers and agencies will be eliminated as well.	2012-08-22 10:28
Kansas ID Population is already under a managed care system, why change something that is already working	The current system is an effective managed care system that operates on only 2.4% of the DD budget versus over 5% for a managed care company. It already determines eligibility, does assessments, etc. and the actual cost to provide services per person actually dropped since 1995.	2012-08-22 09:16
Kansas County Commissions Dont Want KanCare	55 Kansas County Commisions approved resolutions asking for people with intellectual disabilities be carved out of KanCare. They agree it is a bad idea.	2012-08-22 09:06
Conflict of Interest	It appears that there is a conflict of interest with managed care companies determining eligibility for patients with their care coordinators and also determining which services are provided. Good way to reduce services for people with disabilities.	2012-08-22 09:03
Learn from Kentucky	Kentucky was rushed and look what happened. Providers not paid, people not receiving services, it was a mess!!!!	2012-08-22 08:34
Guardians Are Concerned	I have been a guardian for a person with a disability for over 15 years and Iam very concerned about how poorly KanCare has been planned. No input and only dog and pny shows for collecting our thoughts. They dont listen to concerns.	2012-08-22 08:32
KanCare Has Been Rushed	This process should have taken several years and been done incrementally by systems, not all at once. They are not prepared and will not be in three months. Learn from Kentucky, when it is rushed it is a disaster!	2012-08-22 08:30
No Oversight	There is no oversight of the managed care system. The state legislature did not approve any oversight committee during the	2012-08-22 08:19

Title	Description	Created At
	last session and it appears there is very little oversight from the Dept. of Aging and Disability Services either.	
The public has voiced their disapproval of the decision to include I/DD long term care services in managed care. There has been a	Carve DD long term care out of KanCare!	2012-08-21 20:02
Can you imagine how KanCare will work when the state of	Kansas can not even run the DMV new computer system without 6-7hour delays. This is a train wreck for the population of disabled people . Is anyone in the legislature looking out for them...the disabled population need you.	2012-08-21 18:23
As a parent and case manager I am very disturbed by the lack of information I am receiving regarding implelmentation of MCO's.	Educate the people who are hired by the insurance companies to understand what HCBS case managers do and how they differ from the medical model. They seem to have no idea of what our jobs are and continually lump us into nurse case managers.	2012-08-21 15:03
Cart Before the Horse	Kancare was created without any input from anyone other than a small group in Topeka. They created a goal and then went about trying to reach that goal when they had no idea what they were doing. Their thought process is flawed and now they are trying to dig themselves out of the hoel they created. They put the cart before the horse!!!	2012-08-21 13:35
Kancare is an Experiment	The main emphasis with Kancare is the use of health homes as the cure for the systems ills. There is no direct evidence that health homes have been successful. There is no data from anywhere supporting health homes as a successful option to the current syste. This is only an experiment and what happens when the experiment fails?	2012-08-21 13:32
Health Care will Get Worse Under Kancare	Currently, most ID/DD organizations have a nurse on staff who assists people with their medical needs. The nurse is best able to determine what the health care needs are better than a care coordinator at a call station a hundred miles away. I would argue that this will cause helath care services to get worse because in-house nursing would no longer exist under managed care.	2012-08-21 13:29
There is nothing within KanCare that addresses the waiting list that has grown to over 4,000 people with ID/DD.		2012-08-21 13:22
Worried about three plans	I am a Medicaid recipient and I am very worried about being assigned to a for profit company. I have worked with KS Health Solutions for behavioral health and I really like them. I learned that their contract will end and they will lose their jobs. I really like the nice people there. My Medicaid has paid along with my Medicare almost 100 percent for my mental health services and other health issues. I am a physically healthy individual who takes	2012-08-21 12:11

Title	Description	Created At
	care of herself every day. I don't smoke, I don't drink, and I work part time to help with my need to work. I'm concerned that my providers don't have the time or knowledge to sign up with all three plans and I'm worried about that. My prescriptions are covered and I only take one medication for my disorder. I am pretty low maintenance and I am also a published author and CJonline blogger. I care about the others on Medicaid and I worry that they may not be covered as fully as before and me too. This is a very important issue for me and my friends. I also am on a fixed income and cannot afford one more penny of health care costs. I have worked in the past even at a TV station and I dont see myself as a burden to society.	
The 1115 waiver should include provisions to end the developmental disabilities waiting list.		2012-08-21 09:21

Section 1115 Demonstrations: Kansas Kan Care - New 1115 Demonstration Request

Public Comments

Title	Description	Created At
person centered approach back peddling	There has been quite a push for years for individualized supports and services with a person centered approach to the waiver services for people with disabilities for years but now the elected officials wish to step backwards. Given the fact that almost all other states do not include HCBS Waivers in Medicaid Managed Care, HHS should require that all HCBS waiver services be carved out in the managed care program as part of any resolution of Kansas' 1115 Waiver application.	2012-06-05 12:04
Comments on the Section 1115 Demonstration Waiver Application (KanCare)	Comments on the Section 1115 Demonstration Waiver Application (KanCare) Submitted by: Mike Oxford, Exec. Dir., Topeka Independent Living Resource Center (TIlRC) There is a benefit to better coordinating and integrating Medicaid services. Besides, being economically more efficient, better coordination and integration has the potential to better serve Medicaid beneficiaries. There are problems that need to be addressed before the 1115 application is finally approved, however. Topeka Independent Living Resource Center is a civil and human rights organization whose mission is to advocate for essential services and a fully accessible and integrated society. This mission focuses our comments on the failure of KanCare to adequately address consumer control and self direction issues and the failure to address "Olmstead"compliance and waiting list management such that the wait list moves at a reasonable pace. Kansas Law gives consumers the right to direct and control their HCBS services to the maximum extent feasible including, but not limited to, selecting, dismissing, training, scheduling and managing their attendants. The Kancare proposal simply states that "All participant direction structures will be retained". This is problem since current "structures" related to the FMS Agency with Choice HCBS Waiver templates have reduced consumer control and self direction. In the past, consumers were their own employers and they were solely responsible for adequacy of training and performance of their workers and for their own emergency back-up. When "Agency with Choice" came on line, these duties fell, ultimately, into the provenance of the FMS agencies. Agencies have become responsible for duties and activities that heretofore were the responsibility of the consumer. The 1115 Waiver, KanCare should include discussion of how state law governing consumer control and self direction will be fully implemented through a "budget authority" program such as the Community First Choice Option or 1915(i). while it should be noted that there has been some discussion of this issue as part of a workgroup put together by KDADS Secretary Sullivan, there is neither a guarantee that anything concrete will result, nor any kind of timeline for full compliance. This last statement is equally true for "Olmstead" compliance and waiting list management. The proposal simply states that current practices and criteria will be maintained for wait list management. TILRC posits that there is no real management of the waiting list. Parts of the list are managed through crisis exceptions and Money Follows the Person, and while these are important, they do not really have anything to do with the "first come, first served" general wait for services that is stretching ever longer into years and years of waiting.	2012-06-05 11:44

Title	Description	Created At
	Please do not approve the 1115 Demonstration Waiver, KanCare, unless and until these critical areas have been fully addressed and there are assurances that there will be full compliance with federal (“Olmstead”) and state (self direction, consumer control) laws.	
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.	2012-06-05 10:12
"KanCare" was preconceived, designed and rolled out before meaningful input	I want to believe the overall efforts of the Governor and his administration are intended to help manage Medicaid spending in Kansas. There are, however, trouble in the details with their effort to introduce KanCare in Kansas. From my perspective, the input process and the development of "KanCare" was preconceived, designed and rolled out before meaningful input was taken. I personally attended one of the planning statewide forums conducted in Kansas, and there is little doubt that the drastic plan that emerged, called KanCare, and its intended inclusion of community long term services and supports for persons with I/DD, had little resemblance to the general discussion that took place on Medicaid at the forums. The feedback from the community service system pertaining to long term services and supports, since the unveiling of KanCare, has by and large included mostly deep concerns. This feedback has come from persons with I/DD, parents/guardians of persons with I/DD, and the community service provider network. My compliments are extended to the Secretary of Aging, on July 1st the Kansas Department of Aging and Disability Services, Shawn Sullivan, for his willingness to attend gatherings of concerned people regarding KanCare. Though present and listening, the course of KanCare continued on at its full speed, and apparently on it's original trajectory, with the expressions of concerns regarding I/DD LTSS inclusion have largely been unheard. Late during the legislative session, the Governor announced a delay in the inclusion of I/DD services from KanCare for one year. The jury remains out on just what parts of the I/DD community system will be delayed. To this end, specificity and clarification was attempted via legislative proviso language, where all the components of the current community I/DD system were noted to be 'delayed'. This made good common sense, out but this too was largely unheard. If the input and feedback didn't match the flight plan of KanCare, it was not the correct feedback or input. An example related specifically to the service, I/DD targeted case management. In the original language of the proviso, this service component was omitted - meaning it would not be delayed. When this fact was called out, there was resistance to including TCM in the legislative proviso, by the Administration. This was puzzling given the Administration's earlier and repeated assurance that there would be no changes in TCM under KanCare. After legislative push-back was made, TCM was finally included in the final proviso language. It would appear that issues and concerns from the community I/DD system, are responded to only after public upheaval. This is not a good indication of accepting and using input and feedback. The feedback is not from a select few, but rather from literally thousands of people connected to the I/DD community service system. These people would include, individuals with I/DD, providers, parents/guardians, and others including elected leaders of which include 57 County Commissions from across Kansas. When such is the rule of thumb,	2012-06-05 09:08

Title	Description	Created At
	good intentions yields to a wonderment that feedback/input is actually collected and stored nicely somewhere where it will not be in the way. In the mid-'90s, Kansas passed the Developmental Disability Reform Act (DDRA) which incorporated many managed care principles into the community I/DD service system (capitated rates, quality measurement, service access, eligibility determination and so on). Under that system, local - mostly not-for-profit organizations partnered with Kansas to administer long term services for persons with I/DD. Under the current Kansas model, this community system has effectively managed program costs for persons with I/DD and their services.	
Bottom Line for KANCARE 1115	The state hasn't done their due diligence. It's not transparent. The stated outcomes don't hold water. OLMSTEAD and EPSDTcompliance are secondary at best. All the while the DD/MR wait list grows and the state expects to pass the buck to an out of state for profit insurance company that has no clue on how to deliver services to a MR/DD waiver population. Does it pass the sniff test? Or is this a political stunt with no strategic plan other than to cut costs to balance the budget for other areas of program abuse.	2012-06-05 09:03
investors in manage care are more concern about bring down cost	When the investors be more interested in bringing down the cost ? or the quality of care our clients have been receiving ? Does this boil down to quality or a reduction in the quality of care and equipment. How much is the provider going to receive vs the quality of care?	2012-06-05 08:15
KanCare proposal rushed and lacks transparency	We oppose the waiver for the KanCare program as it is currently proposed. More than 300,000 Kansans are presently on Medicaid. Gov. Brownback's KanCare proposal seeks to make fast and sweeping changes to Medicaid putting access to care and quality of services at risk. In addition, out- of-state, private insurance companies may profit on the backs of our state's most vulnerable populations. We are most concerned about the rapid implementation without adequate consumer input, the lack of public education about the desired changes, the absence of pilot projects and the dearth of ongoing policy and cost analyses to ensure a smooth transition. Will Kansas have time to develop a website in which the three insurance companies' benefit plans can be compared apples- to- apples? Will new enrollees be given the support they need to navigate the system? Given Governor Brownback's return of the technology pilot funds for the Health Exchange (which is supposed to interface with Medicaid) and the state's recent and disastrous experience with a new state-wide Department of Motor Vehicle computer system, we have to wonder about the state's capability to implement the new health care technology by this fall in order to begin providing care on January 1, 2013. We are also concerned about the lack of legislative oversight necessary to ensure that the desired cost savings and quality of care are achieved. Connecticut, known as the "insurance capital of the world," dropped their Medicaid managed care plan this past year because these goals were not realized. Oklahoma dropped their Medicaid managed care plan in 2005. What can we learn from their experiences? We continue to be concerned about the lack of transparency and public accountability. Kansas barely avoided the federal transparency requirements by submitting its application one day early. Regardless, we feel Kansas should voluntarily comply with these requirements. It has been difficult or impossible to find out the profit margin, administrative and marketing costs as well as costs applied to clients and health care providers. We worry that there won't be enough money to assure access to care as well as quality of services. We worry that because of the lack of transparency, objective evaluation will be avoided and thus impossible.	2012-06-05 06:25

Title	Description	Created At
	As people of faith, we are concerned about the impact of this proposal on our state's most vulnerable people. Please deny the waiver. Respectfully submitted by Mike and Marta Bainum, Rev. Thom Belote, Annette Box, Alan Forker MD, Jim Geiger, Anne-Marie Hedge, Kay Heley RN, Mary Matzeder PhD, Bill Roush MBA and Lillian Shontz, members of the Health Care Action group of Shawnee Mission Unitarian Universalist Church, Overland Park, Kansas	
We oppose the waiver for the KanCare program as it is proposed. More than 300,000 Kansans are presently on Medicaid. Gov. Brown		2012-06-05 05:41
Pilot testing of managed care	The State of Kansas intends to engage in pilot testing of managed care for DD long-term care services during the one-year delay for implementation of DD long-term care within KanCare. However, the DD community has not been engaged in the development of such pilot projects. Further, serious concerns exist regarding whether the State of Kansas can adequately develop, implement and reasonably analyze outcomes from such pilot projects within the one-year delay period. There is an unsettling absence of stated outcomes for the Kansas I/DD population within the Brownback Administration's KanCare proposal that would lead to an improved quality of life for these Kansans.	2012-06-04 14:48
Budget Neutrality	The state does not adequately demonstrate how this proposal will be budget neutral in this waiver application. It does not include any information regarding how the cost trends were determined for either the with-waiver or the without-waiver projections. The "rate-methodology adjustment is similarly unexplained. Even if it is able to better demonstrate how these figures were determined, it is also silent on how cost savings will actually be achieved through the implementation of this program. Indeed, several of the populations that show cost savings are already part of managed care systems, making the administration's assertion that more savings can be achieved through KanCare dubious, at best.	2012-06-04 13:52
State's waiver raises questions due to lack of specific details.	Wyandot Inc., which oversees Wyandotte County's designated community mental health center, recognizes that the state's waiver application contains many laudable goals. It embraces broad principles— such as promoting integrated care and creating paths to independence—that we support. But the waiver is short on providing mechanisms, or processes, or prescriptions, for how to achieve these goals. It is one thing, for example, to speak of "eliminating the current silos between physical health services, behavioral health services, and long term care," but it is quite another to offer a plan for how this will be achieved. This waiver avoids such specificity on many fronts, raising numerous questions that we believe require answers. The lack of specificity is especially a concern when it comes to outcomes and measurements. Throughout the waiver, the state speaks of establishing outcomes to achieve its goals, but it does not put forth a process for establishing those outcomes. It does not say whether providers and consumers will be consulted, nor does it include the creation of measures and outcomes in its timeline. One assumes that these outcomes will be spelled out in the contracts with the MCOs, but if that's the case, the process for creating those outcomes would have circumvented the state's provider and consumer communities. The success of plans such as this depends on well-structured and clearly articulated outcomes and a process for measuring them. We would welcome the opportunity to participate in the establishment of those outcomes with the state and the MCOs.	2012-06-04 07:52

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	Finally, the waiver never acknowledges the potentially disabling nature of serious mental illness. The needs of this population are no less than those with physical disabilities, and yet the waiver does not explain how it will protect services that are designed to help them live independent and fulfilling lives. Because the MCOs vying for contracts have limited experience serving people with serious mental illness, and because this waiver does not "carve out" behavioral healthcare, we fear that their needs, which often require expensive medications and services, could get lost in the shuffle. Specifically, we fear that without specific safeguards, funds for behavioral health could be allocated to physical health services. As we said above, the lack of specifics raises several questions, especially as they relate to providing quality mental health care and treatment to some of the state's most vulnerable residents. Here are some of the questions we have: • What will the state do to ensure that the MCOs, all of them for-profit private companies, will not profit excessively and at the expense of our consumers' care? The waiver does not, for example, place caps on administrative expenses. • What will the state do to protect consumers, especially those with serious and persistent mental illness? The waiver states that rates and services will remain at current levels, and that it will achieve cost savings. But it does not specify how that will happen, raising the concern that the MCOs will have an incentive to control costs through their power to authorize, or not authorize, certain services. There is not, for example, a professional conflict resolution program independent of the state and providers for Medicaid members to help them understand their rights and access to services and supports. • How does the state plan to integrate physical and behavioral health care? The waiver lists this as one of its plans for reducing costs. We agree that it can. But the waiver does not mention, for example, whether this integration will be phased in to prevent massive disruption to existing services. Nor does it acknowledge the upfront costs, or set forth a plan for paying for those costs, associated with such an ambitious goal. We fear that costs like this will be very difficult to meet now that the Legislature has passed, and the Governor has signed, a tax cut bill that is estimated to drain $2-3 billion from the SGF over the next several years. • How will the state preserve its mental health safety net without a plan for funding facilities designed to treat people experiencing a mental health crisis? The waiver goes into great detail to explain how the new plan will create safety net care pools for hospitals, taking Medicaid dollars to pay for hospital costs. Yet it does not mention creating such pools for the state's in-patient mental health facilities, which serve a large number of people who are not eligible for Medicaid. • How can our consumers, many of them experiencing disabling psychiatric conditions, be expected to make an informed decision about which Medicaid plan to choose during a brief 45-day window? We would recommend extending that window to 90 days, with a chance to switch plans after 6 months. • What are the specific details used to support the state's intent to seek a global waiver for a block grant? Under "Looking Ahead to Track 2," the state signals its intention to seek a global waiver that would give it "flexibility in service entitlements" in exchange for "fixed federal costs (per capita), guaranteed savings and a commitment by the State to performance management and population-based outcomes." To justify this move, the state asserts that "hundreds of millions of dollars" are spent to "provide benefits to individuals who otherwise could have access to alternative, affordable insurance." When it does apply for its global waiver, we hope the state explores in much greater detail what those more affordable insurance systems are, how Medicaid	

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	beneficiaries would have access to them, and how moving to these new systems would save hundreds of millions of dollars. • Why is the state exploring new models for employment programs? Creating employment opportunities for people with disabilities is critical. For this reason, Wyandot and other mental health centers in Kansas provide an evidence-based supportive employment program. Other employment programs exist for people living with other disabilities. The waiver does not explain how the state's proposed employment programs will improve on those that are already in place.	
Proper planning prevents poor perfromance	This administration could not even roll out the FMS nor the "Kansas Authenticare" programs without mass confusion and delays for providers and consumers. Now we are asked to trust them with all things Medicaid? I don't believe it is a good idea. FMS rates were set - contracts signed - and then provider rates slashed with no explanation or input. The current FMS rate is inadequate and driving providers out of business. Kansas is not following the contract it has with the Kansas Authenticare contractor either. Yet we may be turning over the Medicaid keys to large, for-profit, out of state insurance companies? I cannot even imagine how big of a confusing cluster it will be for everyone involved. Promises of savings of milions of dollars are overblown and only good for political grandstanding - the insurance companies have even said there is no way to see that amount of savings. You cannot improve outcomes, get a better quality product, and save huge amounts of money by moving a couple silos around. Cuts will come, services will be eliminated, and both Kansas jobs and lives will be lost. KanCare as proposed is too much, too fast. It's bad for Kansas taxpayers, bad for local providers, and bad for recipeients of services.	2012-06-04 07:36
KanCare must "carve out" services for the DD.		2012-06-04 07:06
KanCare proposal does not contain enough assurance that it will result in better state compliance with Olmstead and EPSDT	Two very strong parts of the law that protect the rights of people with disabilities are: a US Supreme Court decision which set a requirement for states to provide real community based alternatives to institutionalization (Olmstead); and existing federal laws which require states who participate in Medicaid to arrange for the Early Periodic Screening Diagnosis and Treatment for children and youth under the age of 22. We believe these two aspects of the nation's law represent a backstop against which any kind of planned redesign of Medicaid must be evaluated. As we have stated before, large 'carved in' managed care structures do not have a good history of performing well in light of Olmstead and EPSDT. Unfortunately, the State of Kansas' 1115 Waiver proposal does nothing to address the existing Olmstead problems and does not ensure that EPSDT will be effectively available. Therefore, HHS must use its power of approving or rejecting Kansas' 1115 Waiver to require that EPSDT services are carved out of KanCare and that Kansas makes significant progress on its existing Olmstead compliance issues, including but not limited to the massively long HCBS Waiting Lists. This must be a tool in HHS's toolkit when it resolves Kansas' 1115 Waiver application .	2012-06-03 23:50
Care Coordination must only enhance, not replace, community based case management for HCBS	Kansas must keep the intensive community case management services we have in place, and bolster (read: do not replace) their effectiveness with a high quality Care Coordination program that will ensure access and prevent unnecessary institutionalization. Unfortunately, the KanCare RFP, written documentation, and 1115 Waiver application are unclear how existing case management will interact with this new administrative level of "Care Coordination." If Home and Community Based Services (HCBS) are to be moved under managed care, individuals and families who need these services deserve a	2012-06-03 23:43

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	quality specialty Care Coordination program that strengthens and reinforces (but does not replace) quality community-based Targeted Case Management. Any proposal to implement managed care must have a well designed Care Coordination program in order to address system gaps and barriers, help determine network adequacy of providers, ensure access to needed personal support services and treatments… and comply with state and federal laws. However, Kansas does not do this in its 1115 Waiver application or KanCare RFP. Kansas must mitigate all potential conflicts in the coordination of services by requiring that KanCare: • Ensures that individuals can advocate for themselves or have an advocate present in planning meetings. • Ensures documentation of the choices that individual members have been offered among all qualified providers of direct services. • Establishes administrative separation between those doing assessments and service planning and those delivering direct services. • Establishes a consumer council within the each service providing organization to monitor issues of choice. • Establishes clear, well-known, and easily accessible means for consumers to make complaints and/or appeals to an independent conflict resolution program for assistance regarding concerns about choice, quality, and outcomes. • Requires all MCOs and contracting organizations to document the number and types of appeals and the decisions regarding complaints and/or appeals. • Have State quality management staff oversee providers to assure consumer choice and control are not compromised. • • Document consumer experiences with measures that capture the quality of case management services.	
Ensure ACCESS to Peer Support Specialists	The State must ensure ACCESS to Peer Support Specialist (PSS) Rehabilitation services through a robust provider network that supports consumer choice. Unfortunately, the state does not do this, and the 1115 Waiver application does nothing to address this systemic problem. In order for the state to see the most benefit possible from PSS, it must be available statewide and in the environments where people live, work, and socialize. A combination of Medicaid funded and non-Medicaid funded PSS will provide for healthy competition and specialization of programs that ensure niche communities meet the support need of people in Recovery. Similar to our suggestion on the DD side, Peer Support should be both a readily available, statewide Medicaid service as well as services written into the Managed Care contracts. However, this 1115 Waiver application fails to do any of these things regarding PSS.	2012-06-03 23:41
Consumer Operated Services for People with Intellectual/Developmental Disabilities	When Kansans with developmental disabilities are the primary decision maker in the services planning process they are more likely to achieve preferred lifestyle outcomes. This results in more individualized services that are based on the needs of the individual, not the convenience of the service provider. Informed and well supported ID/DD self-advocates tend to be more apt to achieve independence and develop a network of natural social supports. Over and over we find that they are more likely to keep close ties with family, attend church, and to seek competitive and integrated employment. We believe that self-advocates are a great resource to the state for changing the institutional bias. Employing self-advocates to give presentations and to work with families who have a child with a developmental disability helps those families to imagine a different life for their young son or daughter—to look beyond limitations and see a life of inclusion and independence in the community.	2012-06-03 23:29

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	Kansas is in a great position to be a leader in the development of Consumer Operated Services for people with ID/DD. Although many of the existing models for employing self-advocates have been educational in nature and focused on outreach efforts, we believe the state should operationalize self-advocacy efforts into programming to meet state objectives like increased competitive and integrated employment, community integration, health coaching, and self determination strategies. Unfortunately, the 1115 Waiver does none of this. Self advocacy support is obviously never even considered as part of the 1115 Waiver. Neither are Consumer Operated Services for people with intellectual disabilities.	
KanCare must increase community based access to Night Support/Sleep Cycle Support	Reduced access to essential community services like Night Support and Sleep Cycle Support has been a major cause of unnecessary institutionalization in Kansas. Cuts and threats to cut these services on the Physical Disability and Frail Elderly HCBS Waivers are reasons why Kansas is the 6th highest in the nation for per capita number of people in nursing facilities. This undermines confidence of people who want to rely on HCBS instead of being forced to live in a facility.	2012-06-03 23:18
KanCare must ensure statewide access to Peer Support Specialists	Peer support is a Kansas Medicaid State Plan – Mental Health Rehabilitation Service and it is proven to be a cost effective way to eliminate dependence on institutional care for Kansans with Severe Mental Illness; however, it has only been implemented in a few CHMCs, and is not readily or effectively available statewide. Any change to Medicaid, including the proposed 1115 Waiver application must have a concrete plan to ensure that Peer Support Services are available and readily accessible statewide for people with mental illness.	2012-06-03 23:14
KanCare must ensure families of youth with Autism or who have challenging behaviors have better access to Positive Behavior Support	Positive Behavior Support (PBS) is a State Plan service and is an empirically proven intensive behavioral support that families have difficulty accessing in most areas of the state. This is unfortunate, as a Medicaid service PBS must be available statewide for the sake of families and the youth themselves. As a Best Practice that helps children and youth avoid hospitals and institutionalization, any changes in Medicaid, including the 1115 Waiver Demonstration, must include a concrete plan to ensure that access to PBS is effectively available statewide.	2012-06-03 23:12
Current Gaps and Barriers cand, and should, be addressed without major administrative changes	There are current gaps and barriers in the system that must be addressed, whether managed care is implemented or not. Some Home and Community Based Services are largely underutilized. If such HCBS services were available when needed, it would decrease costs by diverting from more costly levels of services and would improve health outcomes for individuals with chronic care needs. These can be addressed without a managed care model. Or, if the administration implements managed care, these outcomes and objectives should be met through carefully worded and incentivized contracts. Outcome incentives to providers, combined with innovative capacity-building strategies and state-sponsored outreach and advocacy initiatives, can help to bring targeted systemic improvement in these areas.	2012-06-03 23:01
HMOs don't have enough experience or proven success with Home and Community Based Services (HCBS)	If managed care is implemented, it could be done so in regular medical only, carving out all long-term care HCBS Waiver services, allowing Kansas to harness the tools and principles of managed care to achieve cost efficiency, improved access, and quality of care outcomes. If managed care is implemented for regular medical services there are still multiple barriers and pitfalls to doing so, but should not insert managed care into the already effective local-state partnership of disability services. Given the fact that almost all other states do not include HCBS Waivers in Medicaid Managed Care, HHS should require that all HCBS be carved out in the managed care program as part of any resolution of Kansas' 1115 Waiver application.	2012-06-03 23:00
Support Local Control with Direct and Ultimate State Accountability	In Kansas, community-based services for individuals with developmental disabilities and mental health needs were set up years ago by policymakers as a local-state partnership. Wisely, Kansas legislators set up in law a	2012-06-03 22:59

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(current DD & MH systems under reform laws)	system with local control of the gatekeepers of Home and Community Based services but with ultimate and direct state government accountability of the system. Kansas' mental health reform laws, developmental disability reform laws, and laws requiring access to personal assistance services (PAS) for people with physical disability and traumatic brain injury were passed with broad bi-partisan support and signed into law by Governors Hayden and Graves, respectively. These reform laws ensure local control over infrastructure needs for the development of social services in communities, because county commissioners designate the local authority, or gatekeeper, to form the locally provided service centers for people in their respective counties for those with support needs. The state, however, has direct and ultimate accountability over these local authorities. This system of local control and state accountability has worked for years in Kansas. The 330 partisan elected county commissioners across the state - 83% of whom are Republicans – value this local control and expect to maintain their authority to ensure that local people and providers are serving local needs. Our state does not need and would not benefit from replacing this traditional yet progressive support structure with one that inserts an unnecessary, out-of-state, for-profit corporation into the administrative structure simply so that it can take a cut of the already limited pool of public funds and stifle local innovation and flexibility. When it comes to home and community based disability services, why hire a middleman when state government already has all the tools available to manage this proven local-state partnership?	
Consumer Involvement should be expanded under the 1115 Waiver and KanCare	Involving consumers in nearly every aspect of Managed Care is one of the core, basic, and minimum requirements of ensuring the future of any Managed Care system produces quality results. A vibrant, well funded network of consumer-run organizations, state-wide consumer entities, and annual consumer conferences should be expanded in Kansas regardless of the changes to other Medicaid funded programs. The advantages to the state of having a network of well informed and well organized consumers and consumer directed programs are too great to be ignored or minimized in the midst of large systemic changes. We know that in this respect, two groups like the Consumer Run Organizations (CROs) and the Self Advocate Coalition of Kansas (SACK) have been serving the interests of the state of Kansas for many years, and have only required a minimal financial investment compared to the rest of the state's budget. This infrastructure must be maintained throughout the reform efforts. It would be a disaster to retreat from any existing funding for consumer capacity building at the same time that changes occur for managed care. At the same time that Kansas was finalizing its KanCare proposal and working it into an 1115 Waiver application, the Brownback Administration eliminated funding for the statewide Recovery Conference, which was the only statewide conference specifically for people with mental health needs. This is not acceptable. Kansas consumers in recovery now have no access to critical leadership, advocacy and education services to better assist their recovery. While the Medicaid Reform is ongoing, the state should keep its existing networks consistent. The state should NOT change the network of providers for these contracts at the same time it is changing Medicaid. That is a recipe for disaster because so much can potentially be lost while the state is dealing with reform in so many other areas.	2012-06-03 22:53
KanCare must ensure access to Early Periodic Screening, Diagnosis, and	We have seen numerous examples of where EPSDT services have not been effectively provided, and where the parent has to either engage an attorney or threaten to engage an attorney just to get the mandated and entitled service provided. We fear that this problem would worsen under	2012-06-03 22:50

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Treatment (EPSDT) for Kansas youth with disabilities	KanCare because of the long, nationwide track record of HMOs denying payments and delaying prior authorization of these critical supports and treatments. We would propose either a total carve-out for EPSDT under Managed Care (as it is an entitled service under federal law) and/or changes to reduce the red tape and burden faced by families accessing these critical services. The KanCare RFP and 1115 Demonstration application have very little content tha supports effective management of this legally required and critically necessary program. As part of negotiating a resolution to the 1115 Waiver application, HHS must require that EPSDT be either carved out of managed care or that extensive protections are in place to ensure that the powerful mandate of EPSDT is reflected in contracts and arranged for in Kansas.	
Self-Advocacy & Family Advocacy is Critical	Strong, educated and organized self-advocates allow for a stronger health care and long-term care system of services and supports. Kansas already has very good statewide groups of self-advocates. The Self-Advocate Coalition of Kansas (SACK), who advocates for Kansans with Intellectual Disabilites, is over 700 members strong and has chapters across the state. SACK and other consumer advocates organizations should be supported and encouraged by public and private management entitites alike. Consumer led groups like the Consumer Run Organizations (CROs) also must play a critical role in the success of Behavioral Health programs for adults with Serious Mental Illness. Parent groups like Keys for Networking, have need-to-know information on how well our Wraparound services and programs for youth with serious emotional needs are working. And likewise, local NAMI chapters across the state can help program managers provide better services if their input is encouraged and incorporated to improve performance. Other states that have engaged in Managed care approaches are now realizing that they should have engaged and supported self-advocacy and family advocacy in a more proactive manner, and they are playing catch-up. A strong, well funded family and self-advocacy component can and should be built in on the front end of any Medicaid changes. The state should immediately find ways to make these groups integral to the KanCare process and and continue to work with the disability community to ensure an even stronger stake for family and self-advocates in the future changes to Medicaid.	2012-06-03 22:06
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.	2012-05-31 12:44
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.).	2012-05-31 12:43
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.	2012-05-31 12:43
Provider Choice under KanCAre will be Greatly Limited	Since the passage of the DD Reform Act in 1995, the growth in number and quality of providers has created an environment in Kansas that favors the consumer. KanCare will weed out many small or poorly capitalized providers who are doing good work and leave consumers with "mega" providers as their only choice. This intentional result (administration officials	2012-05-31 12:28

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	have said as much) will occur as the result of cumbersome bureaucracy, payment delays, and the inevitable imposition of service limitations.	
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.	2012-05-31 12:27
HCBS Waivers Must be Carved Out from Managed Care – DD Waiver, PD Waiver, FE Waiver, TBI Waiver, etc.	HCBS Waivers 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.	2012-05-31 12:26
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 entitlement, ensuring access services. 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.	2012-05-31 12:24
The Real Public Process	After the administration rushed its perfunctory public process around the state basically announcing the foregone conclusions of KanCare, the real public process began. Town Hall meetings across the state hosted overflow crowds where real citizens expressed real opinions about Kan Care.	2012-05-31 12:23

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	Anyone who attended these meetings, including state officials, will tell you that nary a word of support for KanCare was heard.	
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 Let's first ensure budget & decision making authority for people to hire, pay and provide benefits to their own personal care workers pursuant to state law.	2012-05-31 12:21
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.	2012-05-31 12:20
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!	2012-05-31 12:19
Big Tent Coalition Supports Independent Conflict Resolution for Managed Care	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 Support for conflict resolution that this legally-based conflict resolution support is independent of the managed care companies, Medicaid providers and contractors and the Sstate of Kansas. HHS should require that this be addressed as part of any resolution of Kansas' 1115 Waiver application.	2012-05-31 12:18
Kansas already has a high number of medically underserved areas in both rural and urban areas	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.	2012-05-31 12:15

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	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: o By population: 59 for primary care and 60 for dental. o By geography: 24 for primary care, 28 for dental care, and 99 for mental health. o 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. o These disparities result from wide-ranging social, environmental and behavioral health determinants.	
Existing research shows that the Kansas model of Managed Care will not Improve Health Outcomes or Decrease Spending.	Existing research shows that the Kansas model of Managed Care will not Improve Health 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.	2012-05-31 12:13
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,	2012-05-31 12:10

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	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.	
Remember what happened when foster care was privatized!		2012-05-31 11:04
ssweeney@acmhck.org	Michael J. Hammond, Executive Director, Association of Community Mental Health Centers of Kansas, Inc. We appreciate the opportunity the Administration has given us for dialogue and input on their proposal. This is an important policy direction for Kansas that has received and should continue to receive meaningful attention. The Medicaid program provides much needed access to mental health services in Kansas and we 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. Among opportunities we see for the mental health system 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 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. Policy makers are in agreement that the path we are on today is not sustainable around Medicaid expenditures. Since 2007, the public mental health system has been hit disproportionately with cuts in SGF since 2007 - $38 million SGF; $60 million AF. If we as a State do not address sustainability, we fear cuts to our system might continue. We appreciate 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 the mental health system, we see an opportunity to rethink how medical	2012-05-31 10:12

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	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. 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, 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? • 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. The State must minimize administrative variance of each contract. • The system has been financed on fee-for-service basis historically. The reimbursement model to be used by each MCO is unknown. Therefore, it is challenging at best to plan to 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. There also needs to be a back up plan should problems arise. • We support implementing opportunities for pharmacy savings without restricting access to mental health medications in Medicaid and KanCare does that. However, efforts need to occur to ensure the MCOs are communicating with prescribers so that they understand the pharmacy benefits as they relate to mental health prescription drugs. • 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. • We believe that a portion of the savings realized from KanCare should be reinvested back into the respective systems. • 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, those ramifications need to be further examined before implementation begins. Questions to be asked include: what is the impact on the projected savings?; what is the impact on SGF if projected Medicaid savings are not met? • Ensuring there is adequate and effective oversight, with mechanisms for consumer and provider feedback will be critical. Access to care when it is needed and at the right amount is paramount in the new world of managed care.	
Purported Inevitability of a Looming Medicaid Cost Crisis Overblown	For example, per person costs for individuals on the DD waiver have actually decreased in real dollar terms in the past 15 years. The increases in overall, Medicaid medical costs have also been trending down in the past few years. This is a "crisis" created to address a political need, not a health care reality. It is now clear that KanCare was hatched to prepare the state for the gigantic revenue shortfalls that will result from the Governor's tax plan.	2012-05-31 09:44

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KanCare Proposal Lacks Oversight, Exports Profits	The conversion of the Medicaid program in Kansas to an untried managed care profit center is being rushed ahead with little explanation. There have been no public hearings on managed care and no legislative debate. I have more questions than answers. How will vulnerable populations advocate for what they need from this program? Where will people receive care? Why is it not working in other states like CT and OK? What we do know is scary. We know profits will be taken by out-of-state insurance companies, that is for sure. Why not just improve the current program that was run by Kansans for Kansans? Why can't the Federal transparency guidelines be followed? I don't trust that this change is being handled well, it is being ramrodded. Please stop the bad medical practice that both OK and CT have tried and abandoned.	2012-05-30 18:02
Caution: More Managed Care will increase the Program cost	More managed care in Kansas will increase the program cost even higher, rather than decreasing it. The current managed care plans, which have been around several years, are responsible for significant Medicaid program cost increases in Kansas. The decision to increase managed care was reached without looking at data. Adding more, to the level proposed, is like pouring gasoline on a fire. There will be a cost explosion and the state will have to dig deep to keep it going.	2012-05-30 17:14
KANCARE- let's give it a try	There is a lot og angst over the proposed KANCARE system. Change is never easy but it is necessary. Kansas, just like other states, faces a huge dilemma. If we do nothing to fix our growing medicaid costs we will not be able to sustain services for anyone, current or new that uses/needs medicaid services. Do nothing, we will get larger wait lists, people could lose services, some people could get taken off the medicaid plan that they are on. The tax payers in our state can't continue to be asked to pay more. There is a lot of fraud in the medicaid system and KANCARE will be one(and so far the only) attempt Kansas has made in the last few years to try to cap or eliminate waste. The goal for KANCARE as I have read about it, is to ensure that we have enough funds for all vulnerable populations to receive assistance under medicaid. Not just spend the majority of the medicaid budget on one or two populations while others go unserved or underserved. Most of these comments are related to the ID/DD population not wanting to participate in the system. It has left the impression then that the system that has been proposed can't work at all. Keep in mind, that one main purpose of KANCARE is to ensure that people do not get health care that is not needed. For example, we do not need to use medicaid dollars to pay for an MRI when someone has a swollen toe. There is much emphasis put on helping medicaid participants get and stay healthy so they do not require more expensive medicaid care(NF's hospitals etc.) later or at least delay it as long as possible. The more the system can know the people it serves(medically and otherwise) the more accurately the person can have their needs met. This means not giving them services they do not really need just because someone else is paying for it.	2012-05-30 15:33
Parent's View	Concerns about including ID/DD have been expressed but have being pointedly ignored. If the Administration cannot hear our concerns now, how will they hear us after it has begun and they are insulated behind insurance companies? Kentucky has been moving to managed care for Medicaid for over a decade. Given the issues that they are facing, know that two of these managed care companies have bid for Kansas. They are doing an extremely poor job in Kentucky of managing just health care, and yet they want to take on Kansas health care and ID/DD (which they are not experienced at). Reform of our Medicaid system should be made in a responsible manner, instead of driven only by dollars. 0% of community-based non-medical long-term care for adults with ID/DD in Kansas is included in any form of managed care at present. We would be	2012-05-30 15:07

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	going from 0-100% with companies that don't know how to manage these services. I don't want my daughter to be their test market! WellCare (Kansas bidder) has made their second settlement for $137.5 million for Medicaid fraud in nine states! Amerigroup (Kansas bidder) has paid well over $200 million in damages and fines. Kentucky put policies in place for prompt provider payment, but that hasn't protected their providers as policies won't be followed if laws aren't. Their track record in other states speaks for itself. While insurance companies sit on millions of tax payer dollars, provider employees get **** off, hospitals and health care providers have to open and extend lines of credit to keep their doors open. Is this really something we want to do to our Kansas community providers, their employees, and our local economy? The State wants changes to be made this quickly because of costs, not because the system we have now doesn't work. Our ID/DD long-term disability service system we have now has been carefully constructed to focus on the people it serves. It's already privatized; functioning efficiently with only 3% administrative costs, and is locally overseen by people who actually know these individuals with I/DD. Careful consideration has led 49 other states to not go this direction. No one has indicated how long we will be able to retain current case managers past initial implementation. Are they going to provide duplicate services when the insurance companies have their 'care coordinators'? How is this efficient? Will the insurance companies be able to cut case management rates down the road to where it's impossible for providers to continue to offer it? Some providers are being asked to sign 'memorandums of understanding', yet no contracts are supposed to have been awarded until summer. Have these insurance companies been given information we haven't? Like those insurance companies who had completed bids already turned in to the State BEFORE the KanCare plan was announced? The Administration says service and reimbursement rates won't be cut, but no one has indicated this will continue past initial implementation. What will these insurance companies do to make profits of our tax payer dollars when these savings don't prove to be attainable because they cannot manage these services more efficiently than they already are? They make decisions just like my insurance company who sent a letter indicating they will now only cover 1/3 of a medication they used to, out of the blue, no change in my condition, nothing from the doctor, just made a cost cutting decision and announced it. For my daughter, this would be life threatening!! The State must provide specific information on how savings will be attained. They have specific numbers on how much can be saved, but have not provided specific evidence of exactly where the savings will come from. At the statewide quality assurance meeting providers were told it isn't known how the quality assurance process will work, as each insurance company will develop and maintain their own. If the insurance companies are self reporting outcomes, how accurate will that be? Shouldn't we be telling them what we expect and measuring the outcomes ourselves? All of the benefits they indicate might be obtained through managed care are health care related rather than improving long-term ID/DD care. If health care screenings aren't being done, address this with their health care providers that can order these tests. We know how these companies create profits, by questioning the health care providers who actually examine the individuals, making it difficult to get approvals for the care/medications that is needed, and being cut-throat about limiting and cutting services/care/medications, etc.	

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	The State says they won't just turn us over to the insurance companies and walk away, yet they have already voted down the creation of a KanCare oversight committee that was to be put in place.	
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 CMS to make public any additional documents the state provides 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 policy makers 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% per year to 2.36%. 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% to 1.73%. 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 two (deliveries). Based on the numbers provided in the waiver application, the state is assuming a savings of 9-10% 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% 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	2012-05-30 09:30

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	through Medicaid are currently in managed care, making the case for 9-10% in cost savings from the current program appear overly aggressive.	
Transition of HealthWave to KanCare and Retention of Children are Critical	Medicaid and CHIP, collectively known as HealthWave in Kansas, provide health insurance for 230,000 Kansas children; approximately 1 out of every 3 children in Kansas receives their health insurance through HealthWave. Therefore, substantial changes proposed to Medicaid in Kansas will have a significant impact on 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 or no cost health insurance options for many Kansas children. Kansas Action for Children believes that 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. HealthWave is currently operated as an MCO program, and therefore 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. Holding the state responsible for 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.	2012-05-30 09:10
Auto-assignment of Beneficiaries Limits Choice; Alternatives to Medicaid Are Inadequate	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 states on page six that "All beneficiaries will receive and 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 provider upon enrollment, rather than being auto-assigned by the state. Currently, HealthWave beneficiaries self-select an	2012-05-30 09:05

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	MCO upon enrollment, and there has been no need demonstrated by the state to change this method of operation. Additionally, the state is proposing allowing only 45 days, rather than the federal standard of 90 days, for beneficiaries to switch MCOs after their auto-assignment. The state has provided no rationale for shortening this time period. 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 are currently HealthWave MCOs, 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 which 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, high 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 a child needing their tonsils removed would cause out-of-pocket costs to exceed this amount.	
People with ID/DD will not be able to use this system	People with Intellectual Disabilities will not be able to use this effectively. Nowhere in the plan does it acknowledge that this population, many of whom do not read/are non-verbal/require a great deal of assistance and advocacy with regard to managing their medical and day-to-day well-being, will need assistance in choosing a plan. Nor does it spell out how this is supposed to happen. There is almost no description of Case Management or Service Coordination that matches the current role these individuals play to both advocate and ensure quality medical and day-to-day supports. How is this most vulnerable population to be protected from exploitation? How will a person with ID/DD choose an insurance plan/provider? What happens if	2012-05-29 10:01

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	that person needs additional services or significant levels of advocacy to receive appropriate medications/treatments that the insurance provider is unwilling to cover? How will Kansans benefit by having the people on the other end of the phone out of state? What is the appeals process? Finally, what mechanisms will exist to ensure that people with ID/DD are not only healthy but also empowered to be self-advocates and make choices regarding their lifestyle and personal outcomes? I have a hard time believing any of these insurance providers have any experience with any of this. Finally, since state ICF/MR's are exempt, isn't there a danger that difficult-to-serve adults are, through political pressure from the insurance providers, shunted into the ICF/MR system? Will CMS be monitoring this?	
DD/MR Waiver program is not a medical program. There are aspects of the program that require us to access the medical system. If this prog	DD/MR/HCBS Waiver program is not a medical program. If this program is not medical in nature, why would we put it under the auspices of a medical managed care system? PLEASE do not put the DD/MR program under a medical care system. Medical managed care does not fit the needs of these individuals that require constant supervision to support their living needs. Families cannot shoulder all the burden of the children and adults in this program. We are seeing that the greater medical community wants to benefit from these individuals that do not have a voice themselves. It would be detrimental to the lives of all of our people who have disabilities for them to be under a medical system. Medical systems are for people who have illnesses that can be controlled with medically necessary planning. DD/MR individuals have a life-long disability that cannot be cured by medical means. DO not place these people in a medical system --it makes no sense. Granted,there are aspects of the program that require us to access the medical system. Even now it is nearly impossible to find a psychiatrist or a dentist who takes Medicaid. The local Mental Health facilities are overburdened and cannot take on any more individuals with needs. I know from experience with my son and his roommates in residential supports. I hope you will see the necessity of moving the MR/DD program out of managed care and placing it in its own system. We owe that to these many individuals that have care now and those who continue to wait for future resources to become available.	2012-05-29 06:31
Please Exempt Developmental Disability Services from Kancare Managed Care Plan		2012-05-28 09:16
Planning and community input have not been adequate	I have serious concerns about Kancare. Primarily, I believe that the application is too vague for Kansans to evaluate whether this will truly improve care or whether it will simply make Medicaid smaller and cheaper. One example is that while the application states that outcomes will be used to measure quality, it does not indicate how those will be developed, how they will be measured, and how they will be reported. In fact, in the timeline to submit the contract to CMS, this is not even an item on the list. For those of us who measure and use outcomes on a daily basis to improve care, we understand that outcomes are fairly complex. If you use the wrong ones or measure them incorrectly, they can actually make care worse, not improve it. The lack of attention to this area makes it appear as though the use of outcomes is not a serious endeavor. Secondly, I have concerns that the application fails to recognize in any way that there is a group of individuals receiving behavioral health services who have very severe disabilities. While there is quite a bit of discussion about individuals with developmental disabilities and how their needs might differ, there is no recognition that there is a group of individuals with severely disabling conditions who suffer from mental illness. I have serious concerns	2012-05-25 10:35

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	about simply moving these individuals into for-profit managed care without careful planning, outcomes and community input. Public policy decisions impacting this group can and have increased homelessness and incarceration among individuals with severe mental illness. To move this group into Kancare without a single area in the application addressing their needs is a mistake. In addition, the request to move the enrollment period to limit changes to 45 days is not in the best interests of Kansas healthcare consumers. The lack of information individuals will have on how the plans are managing benefits will simply not be available in 45 days. Other options should be considered, such as allowing individuals with disabilities to make that change at 90 days and 6 months if the plan is not meeting their needs. One additional concern that was shared at the public forums, but does not appear to have been heard, is that simply paying for healthcare in one plan does nothing to integrate services for individuals receiving care. Integrating care is an important goal, but I see nothing in the application that does this. Kancare simply shifts the payor to for-profit managed care companies who will and currently do, operate behavioral health services separately from physical health services. And finally, I participated in the public process on Kancare and found it lacking in integrity. The outlines at the public meetings had the groups responding to prewritten questions that were clearly slanted toward the administration views. I have not experienced this in other public processes and was disappointed. In addition, the application simply states that there was public input; nowhere have I seen what that public input included. Were there people who disagreed, had concerns, and had alternative ideas? We don't know because the summaries do not include these. Please carefully consider whether the approval of Kancare in this form is in the best interests of improving healthcare for Kansas citizens. The goals of limiting cost and improving care are worthy and in my opinion achievable. However, the scope of these changes, the lack of detail, the lack of true community involvement and the lack of outcomes should make us take a step back and ask why this must occur so quickly with so little detail and planning.	
HCBS services are not generally medical services; therefore it seems odd to have a managed care organization try to manage them.	HCBS services are not generally medical services; therefore it seems odd to have a managed care organization try to manage them. This is not about DD vs PD vs TBI vs FE -- all of the waiver populations need the ability to self-direct services that are, by their very nature, very personalized.	2012-05-25 09:10
Rushing into failure	All other states that have programs silimar to KanCare took much longer to build their program and are still not seeing the benefits. Why the rush? The idea behind KanCare does seem great, but without better planning this will never work. Kansas is not ready for this.	2012-05-25 07:54
Kancare Should Focus on the Health and Well being of its Beneficiaries	We want to commend the Governor on his efforts to make Medicaid in Kansas more efficient and effective. The goals of better quality care and lower costs are commendable. However, we believe Kansas needs to allow more time and solidify its system before it is subjected to a January 2013 start date. This proposal is dealing with the health and lives of the most vulnerable Kansans. We believe that the implementation of the KanCare Demonstration proposal cannot be done effectively in the time frame set forth in the proposal. First, we believe the focus of KanCare should be on the health and wellbeing of its beneficiaries. One way to accomplish this and the goal of better quality and lower cost is to ensure there are adequate patient protections in place. KanCare should considered protections to assure	2012-05-24 13:35

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	continuity of care for beneficiaries with chronic conditions, requiring the MCO formularies to be comprehensive-covering prescription drugs in all categories and therapeutic classes and ensuring that the formularies are no more restrictive than the coverage provided under Medicaid fee for service. In addition, the mandatory auto-enrollment of all Medicaid enrollees, including dual eligibles, as proposed, is a significant area of concern. We believe there should be an opt-in clause that ensures patient choice and informed decision-making. Mandatory auto-assignment into managed care plans that disrupts established patient regimens and expectations without adequate time for adjustment, may well undermine the program and its desired outcomes. These disruptions not only jeopardize the health and wellbeing of the enrollees, but result in additional cost to the program. If Kansas chooses to move forward with the current proposal, we would at a minimum recommend that dual eligibles not be part of the initial implementation. Kansas's proposal does not specifically address how the selected managed care organizations will provide medication management or coordinate with Medicare Part D prescription drug plans providing pharmacy coverage to dual eligible beneficiaries. Accordingly, we recommend that the State clarify how these entities will interact with Part D prescription drug plans, and how the services they provide will be coordinated. In particular, we urge Kansas to expressly confirm that dual eligible enrollees will continue to receive their prescription drug benefits through their current Medicare Part D plan, and that pharmacy management activities coordinated by participating MCOs must be carefully designed to complement Part D's existing infrastructure, patient protections, and quality assurance mechanisms.	
The 1115 waiver should not be approved without much further public & stakeholder input. So far KanCare has been crammed down our throats.		2012-05-24 13:21
The Governor chose not to offer a forum for public input...	The Governor chose not to offer a forum for public input on his 1115 request, so we offered one for self-advocates and families to share their opinions. One hundred and sixty seven concerned Kansans attended the event (w/ only 48 hours notice) and nearly 20 more shared their thoughts following the event via online surveys. Of the 88 that turned in a survey 81 stated that the 45 day time frame to make a decision on their managed care provider was not enough. 85 stated they were Horribly Concerned about KanCare taking over ID/DD services, 85 of which felt that these companies could not effectively manage DD long term care services. Here are just a few comments made following the meeting: Why son has been fortunate to have quality services. His very life depends on it. There is no way a for profit company can replace highly efficient service providers who really CARE. But, this is about eliminating help for those who just can't make it without state aid. Gov. has an agenda to turn our state into the coldest, meanest state in the union, 5/23/2012 6:55 PMView Responses I'm afraid my services will not be paid for and I will have to move, lose my staff, lose my case manager, lose my choices. 5/23/2012 4:13 PMView Responses Lack of choice, quality of care, sub quality training of personnel providing service to our daughter. Having services taken away that she already has or stating that we will have to take care of her because the state has no money and doesn't know how to do it. We are getting older, our health is	2012-05-24 11:31

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	getting worse and we have no one else that can take care of her needs. She would be left alone at the mercy of for profit insurance agency that has no clue on how to provide residential/emotional/day supports. Abuse and medical neglect by the state.The lack of services because they won't provide it due to no money. The lack of Dental coverage would impact her health. Some of her current health issues would get worse with no dental coverage which in turn will cost the state more. The parent/guardian would have limited voice in determining if she would remain eligible for services when KanCare changes the eligibility criteria. That she would die due to lack of and poor quality services because they would deem her to much of a risk and not want to cover her at all.. 5/23/2012 3:25 PMView Responses Private companies have little or no history with the disabled other than providing medical insurance after accidents. 5/23/2012 1:43 PMView Responses A lot, but this survey won't allow me to scroll through my response, so I can't get it ask down. 5/23/2012 12:06 AMView Responses Privatizing never works. Never. Historically it has not worked. It has not worked in health care, it has not worked in defense contracting, it has not worked. All accountability, all public recourse is removed from the equation when private, for-profit companies replace publicly funded government agencies. Does anyone remember DynCorp? OK, extreme example. How about Jamie Leigh Jones vs. Haliburton? By putting the care of our most fragile and needy in the hands of for-profit insurance companies we remove our say in how they are cared for moving forward. That's it. The end. They don't have to listen. They don't have to comply. I don't care what empty promises Brownback makes on this matter, he cannot ensure anything once he removes this responsibility from the people of Kansas and gives it to a for-profit, out-of-state insurance company. 5/23/2012 10:41 AMView Responses We already have one for-profit company doing business here (ResCare) and from what I have seen, it is hard for them to focus on clients when they are under pressure to cut corners and make profits. I don't want the whole system to be this way. 5/23/2012 10:34 AMView Responses I am concerned that service providers for people with ID/DD will be forced out of business due to delays getting paid and/or funding cuts. This will leave fewer options for people with ID/DD. 5/23/2012 10:25 AMView Responses	
The current administration is tromping on the	Slow customer driven customer involvment us critical. Administration showing absolute disregard for the dusabled cimmunity and its needs. Brutal changes that have already cost lives. Need to include some care concern and compassion within system.	2012-05-23 19:59
I do not support the KanCare program. I do not feel that it will work. We must care for those who can not care for themselves.		2012-05-23 19:47
KanCare will deliver 70% of your current Medicaid reimbursement rate	Word on the street: Outcomes, subjectively considered will then determine if the provider will receive the other 30%. So when they said there will not	2012-05-23 18:30

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	be a cut in current reimbursement rates... they weren't lying, they just left out the critical detail of how a provider will be able to receive the other 30%.	
The administration has assured us that there will not be any cuts to services and we know this is not true.		2012-05-23 09:08
There is very little in KanCare regarding appeals process and conflict resolution and this is very frightening.		2012-05-23 09:05
Imminent disaster	Squeezing a few extra dollars out of programs already on a shoestring budget so someone can make a profit is a terrible idea. No good will come from this.	2012-05-23 07:24
Managed Care, KanCare, will roll the ID/DD system back to the dark days of poor to limited services.	KanCare provides financial incentives to 3 private insurance companies to cut costs of services. Where do they think those savings will come from in order to cash in on that incentive? KanCare has the potential to remove case management from the level of services, as they have their own care coordinators... Don't you think the monetary savings of shaving off that level of ID/DD service would save them money? Do you think that people will get the attentive service they currently receive from a care coordinator or do you think it will be like trying to reason with an answering machine? KanCare for ID/DD population is a frightening thought when considering the impersonal private insurance companies and the lack of connectedness we all, already experience with those systems. Please do the research and check with states that have tried this system, all unsuccessfully....	2012-05-22 20:28
I have many concerns which have been adequately registered here in other comments. There are a couple things that really trouble me and sen		2012-05-22 12:00
Managed Care is not a good fit for ID/DD HCBS Services	- Although I have had opportunity to provide input to the general notion of Medicaid reform in Kansas, I have not had the opportunity to provide substantive input to the specific plan for Kancare. I have many concerns about the inclusion of the Home and Community Based Services (HCBS) for persons with intellectual and developmental disabilities (ID/DD) as a part of Kancare. It is unfortunate that there has been a lack of collaboration with the community in the development of KanCare. The plan to improve health care outcomes while reducing costs appears to be reliant upon the adoption of the person-centered health home model. I question whether adoption of such a model needs to be dependent upon contracting Medicaid services through a MCO. Many of the references throughout the Kancare proposal for improved outcomes appear to be tied to the frail elderly population in Kansas. I believe there is a lack of substantive information specific to the needs of persons with ID/DD. There has been very strong opposition to the inclusion of HCBS services for persons with ID/DD from stakeholders. Many consumers, family members and providers are concerned over 1) the apparent lack of experience of the potential MCO contractors, 2) reports of problems experienced by other States who have contracted their Medicaid programs to the same MCO contractors, and 3) the likelihood that the current level and quality of services for this vulnerable population will be disrupted. Apparently in response to the pushback from the community, on April 25, 2012, the administration agreed to delay the implementation of the inclusion	2012-05-21 06:37

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	of HCBS services for the ID/DD population until January 1, 2014. This, according to the implementation timeline put forth by the administration, would be 1 year after the implementation of Kancare for all other Medicaid services. Based upon the problems experienced by other states that have followed a similar plan of contracting Medicaid to MCO's, I believe a one year delay will not be long enough to avoid the harm of including services of this vulnerable population while still fixing the problems caused throughout the rest of the Medicaid system. The administration testified to a legislative committee in March, that implementation of Kancare would be purposefully delayed if are not ready by January 1, 2013. Slippage of the stated timeline would reduce the delay of the inclusion of ID/DD HCBS services into Kancare. Along with the announced agreement to delay entry of the ID/DD service system into Kancare, a new plan to conduct pilot projects for the management of ID/DD HCBS services via Kancare. There has not been an opportunity for input by the ID/DD community into plans for pilot-testing these services under Kancare. Within the context of implementation of Kancare, it is hard to understand how a thorough evaluation of the efficacy of inclusion of ID/DD HCBS services could be accomplished because I believe it will be a tremendous task for the state to implement Kancare as planned on a statewide basis. While CMS describes an 1115 waiver as a method to test system delivery approaches, Kansas has portrayed Kancare as a permanent restructure of the way Kansas will deliver Medicaid services in the future. It has not been portrayed as a demonstration project. I have been in conversation with each of the MCO's who have submitted responses to the Kansas RFP for KanCare. Not one has ever provided the services that are included in the Kansas HCBS-DD Waiver which are proposed to be included in KanCare. There have been varying proposals described to me by representatives of these companies. One admitted that they knew nothing about our services and described their role as facilitating status quo in the service delivery, one described a scenario of standardizing service levels according to tiered rate levels assigned by the state tool for determining funding levels. Yet another described ID/DD services under the waiver as non-evidenced based.	
Kansas Hospital Association's Perspective on KanCare	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 KanCare. Let me begin by expressing our gratitude to KDHE Secretary Moser for the efforts that have been made to work with KHA on this large and complicated project. The KDHE 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 KDHE and the individuals within that 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. 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.	2012-05-18 13:51

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	• 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. 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	

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	remains strong. We look forward to working with the State of Kansas to help create a reformed Medicaid program that works. Thank you for your consideration of our comments. Best Regards, Tom Bell President and CEO Kansas Hospital Association	
People who receive services MUST be on all decision making boards	I am a person who used to receive mental health services but has now completely recovered and exited the system. I have found full recovery from 12 diagnoses, 29 medications, up to 6 at a time, 7 shock treatments, and 6 suicide attempts. Now I have a great life, starting my own business, owning a house and car, and just got married last week. I realized that my mental health struggles were not genetic and not permanent. I have a certain level of expertise on mental health recovery that many professionals do not. I know much research than many professionals have not had time to pursue. Here is an outline of the reasons people who receive services may know more than professionals: http://wellnesswordworks.com/mental-health-outcomes/ All of your decision panels, grant review panels, and oversight boards need to be at least 1/3 staffed by people in recovery. Not just one token consumer against 10 or 15 "professionals" who often have conflicts of interest. And not an unpaid spot that is considered honorary. We are consultants. You are asking us about recovery because you do not understand it fully and our time needs to be respected.	2012-05-18 11:36
Huge cost savings that improve outcomes are already available	Mental health care is the biggest driver for the increase in Medicaid expenditures, yet is often not checked for efficient uses of funding. I've outlined 6 costs savings methods that could be implemented overnight with minimal infrastructure that would save the state a huge amount without a need to divert money into insurance company shareholders. Here's the full explanation: http://corinnawest.com/please-cut-our-budget-well-tell-you-how/ 1. Fund local peer run crisis alternatives NOT state hospitals: 1/10 the cost and better outcomes. 2. Fund community mental health NOT treatment in jails. 1/3 to 1/16th the cost. 3. Supported employment and peer support centers NOT adult day cares: 4X more people employed. 4. Peer/doctor evidence based medication reduction teams NOT preferred drug formularies: 10X lower med and hospital costs 5. Medicaid good prescribing limitations as in Texas and Missouri NOT repeated violations by out of date doctors: 3X lower medication costs 6. Peer supporters as 10% of staff in mental health centers to build wellness strategies NOT risk avoidance measures. 3X the recovery rates.	2012-05-18 11:11
Capitalism is good, but social entrepreneurship, not corporate welfare	Social entrepreneurship is the idea that companies can do well for their customers, their communities, their stakeholders, and the environment. Insurance companies like KanCare only want to do well by their stockholders. Their staff may include good people, but their corporate structure precludes consideration of anyone but their stockholders in the final decision making processes. In order to make health insurance profitable, companies need to provide the least amount of care possible. This is the single bottom line or the entire system for corporate America. Instead, we should be looking to companies with a triple bottom line that look at doing good instead of just making money.	2012-05-18 11:00

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	Capitalism is the answer to our over running health care costs, but not your grandparent's capitalism that depended on excessive regulations, defensive medicine, and denial of care that put us in this mess in the first place. We need a modern capitalistic approach. Here is my description of how this would work in mental health care: http://wellnesswordworks.com/social-entrepreneurship/	
I am against this if OCCK would partake in this initiative.	OCCK has at least one manager with severe conflicts of interests. Providing care to people with disabilities has become second to marginalizing them for having a criminal record.	2012-05-17 21:04
KanCare will only add unecessary layers & cost to a DD system that already is managed well.	According the Administration's description, the DD system will continue to use current Case Managers and health care coordinators but KanCare will add insurance company care coordinators on top of the current system in place ... to do what? Duplicate the coordination that people with DD already have. Unlike other Waiver populations, the DD population already has their care managed in the current Kansas system. Also, according to administration representatives the current contract to manage the MMIS will be in place and on top of that will be added the billing process through insurance companies. The current DD Waiver system already has capitated rates for services and statewide fiscal management of spending the Waiver allocation, including prior authorization and utlization review. It doesn't need fiscal management from an insurance company who will skim money off the top of the allocation for their corporate profit instead of spending money on services. There is no way to save money in the DD system through health care coordination since they already have that, so the only way to cut costs would be to cut needed services people already have. Every study of managed care I have read has shown that it is not effective in rural areas, which is the majority of Kansas and there is no proven successful managed care system for the DD population in the US.	2012-05-17 13:44
KanCare Slow Down	KanCare needs to be slowed down. This concept is being pushed through for approval without anyone taking the time to involve the parties involved in deciding how this system is really going to work for Kansans. The Brownback admistration has already shown how they have failed with the implentaion of FMS services and Kansas Authenticare in the state over the last year. Kansas needs to slow down and really solidify this system before it is pushed through and begins Jan 2013. We are putting the health and lives of the most vulenable Kansans on the back of three OUT of state companies to "control" or manage as they say someone's life. This is removing choice from our Medicaid system. Every individual desires to have the choice how they live their life, The state or the MCO does not have this right. Finally let's really get real about these cost saving figures. Do we really believe that Kansas can save this much money WITHOUT cutting services. This is just a policital statement to gather support in this time for need to cut spending. I urge CMS to require the state of Kansas to delay the start of KanCare. I urge CMS to require the state of Kansas to require choice in the KanCare system once it starts. I urge CMS to require a carve out of 'ALL" waiver services, not just DD. There are thousands of other individuals that desire to be carved out of KanCare.	2012-05-17 07:45
Comments on Kan-Care	I would like to commend the Lieutenant Governor and Governor for their attention to detail in reforming Medicaid in Kansas. There are issues that have existed for too long that led to inefficient, ineffective provision of services to the citizens of Kansas. Executive Reorganization Order 41 while being extensive, and by some thought to be over reaching in some	2012-05-17 06:28

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	respects, is point on in others. Removing the silos that have existed in the provision of services is a necessity whose time has come. Managing care for needy citizens is most important for quality of life as well as getting the most for our investment. The manner in which that task is undertaken is the one factor for success. To begin a revision of the process it must be well planned, well vetted and have a platform that is conducive with providing care of quality for all citizens as well user friendly for providers of that care. Delaying the implementation of Home and Community Based Services for the Developmentally Disabled is important. By the Governor's action in delaying those services it is my hope that discussions will be entered into that will lead to a well thought through plan that will serve all sectors of receiving and giving of care. I appreciate the opportunity to opine. Kansas State Representative Bob Bethell, District 113	
I support the SILCK and KACIL Comments.	I agree with Comments submitted by the Statewide Independent Living Council of Kansas and the Kansas Association of Centers for Independent Living.Posted below with permission. I would like to add a couple of points. In regard to the stakeholder input, northwest KS seems to have been forgotten. I also do not think the stakeholder input was truely utilized in the development of this proposal. Secondly, CMS is looking for demonstration projects which I think the KS proposal goes way beyond a demonstration. Thirdly, in regard to the content in the proposal discussing employment, the employment for people with disabilities must be integrated employment with wages at or above minimum wage. If the goal is to get people independent and self sufficient, sub minimum wages in a sheltered workshop will never get them off Medicaid. Here are the comments I referred to previously which I totally support. KanCare Concerns Statewide Independent Living Council of Kansas (SILCK) and the Kansas Association of Centers for Independent Living (KACIL) Access to Home and Community Based Services Waivers by all people eligible. Addressing the long waiting lists for Home and Community Based Services (HCBS) should be a priority before any systems change occurs. Florida implemented their expanded Managed Care programs without addressing the waiting lists. At that time, advocates warned costs for very expensive nursing facility placements would increase by denying access to home care services. A new study shows these fears have been realized. The waiting lists have grown 30% over the last year and the for-profit Managed Care plan was not able to contain costs. In fact, that plan cost the state of Florida significantly more, 34%-54% more, than the traditional non-profit plans.1 In the month of January 2012, 10 individuals from the HCBS PD waiting list entered a nursing facility. Based on data from the Kansas Medical Assistance Report FY 2012, the average per person cost for nursing facility admissions was $3,067/month or a total of $30,670 for those 10 persons. If those same people had been offered HCBS PD services the cost to the state would have been an average of $1,562 per person or a total of $15,620 for those 10 individuals. This would have saved the state $15,050 for just one month; this would save $180,600 in one year. Fully funding HCBS waivers makes economic sense. The existing Waiting List for the PD Waiver could be fully funded (State funds) by just 5% ($33 M) of the Governor's projected ending budget balance of approximately $700 M for FY2013. There is a system available for Medicaid recipients to receive independent conflict resolution support. Centers for Independent Living are tasked with assisting people in advocating for their individual rights, including access to	2012-05-16 13:11

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	services and adequate service provision. We believe that any move to Managed Care, must be accompanied by an independent source to assist consumers with conflict resolution and ensure that Managed Care companies are truly meeting the outcome criteria for successful care management. This is especially important due to the fact that Kansas will be using out-of-state, for-profit Managed Care Organizations. The transition to Managed Care does not occur until it can be assured that all supports for the system are in place. This includes the provider network, the billing framework, independent conflict resolution support, and the assessment and options counseling methods. The recent change to Home and Community Based Services waivers to the new Financial Management Services (FMS) system, including Kansas AuthentiCare (Electronic Visitor Verification System/ EVV), is a prime example of what can happen when systems changes are pushed through too quickly. Implementing KS AuthentiCare has been a navigational nightmare. Due to the system not being ready, the implementation date has changed from 11/1/2011 to 1/9/12 then 1/16/12 then 2/1/12 then 2/16/12 and now the suggested complete implementation is stated as 3/16/12. With each change, procedures have also changed. This means, all consumers and direct service workers (DSWs) must be notified, at the expense of the providers. Many other issues have surfaced because of the push to implement Kansas AuthentiCare, before it was ready, including; unexpected costs to consumers, confidential consumer information being available to other FMS providers, and payment delays. There are also many un-reimbursed costs to providers that were compounded due to the many changes of implementation date and procedures. One CIL, in January alone, sent out an additional 6,300 pieces of mail, many of which were large informational packets. This same CIL had to cover the cost of an additional 8,735 telephone minutes, not only the cost of the phone bill, but the greater cost of providing staff time to handle the call volume, and the research needed to solve the problems created by the ********* implementation of KS AuthentiCare. 2 It is imperative that we learn from both systems changes in our own state, as well as others, and move forward prudently to ensure the savings and health outcomes of Managed Care are realized. The state of Kentucky implemented a Managed Care system for Medicaid, and they are now discussing the issues that were unexpected and unplanned for. Some of these issues are lack of payments for medical services, difficulty in getting patient medications approved, and delays in authorizing services. Neville Wise, Kentucky's Acting Medicaid Commissioner, told the Senate Health and Welfare Committee, "We didn't expect the level of issues that we had."3 Kentucky's experience doesn't even include Home and Community Based Services. Kansas should utilize the experiences of others to develop a better system. Home and Community Based Services waivers must be the first line of service provision to those needing long term care. Kansas has a robust system of Home and Community Based Services waivers. It provides support to people to allow them to stay in their own homes, hire and manage their own workers, and allow for the optimum level of personal choice and responsibility. The CILs are the backbone of Independent Living, and must be fully funded. Access to them must not be impeded, and they must take precedence over other options that limit choice, such as PACE programs and Assisted Living Facilities. Over time, and especially with the implementation of FMS, the consumers' lawful right to self direction has been eroded. When looking at new ways of coordinating long term care services, such as the proposed "Health Homes", it is imperative that the consumer's independence, choice, and expertise are woven into service delivery. The Independent Living Philosophy acknowledges that people with disabilities are the best experts of their needs and it would be a mistake to	

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	move towards a medical model that Kansans with disabilities have fought to escape. Provider rates must be moved to sufficient levels before being “locked-in” by a Managed Care contract. In order to ensure access and choice for consumers across the state, provider rates for services like Financial Management Services (FMS), must be increased to sufficient levels to pay the costs of these services. Once approved rate of $140 per member, per month was arbitrarily reduced to $115. FMS providers, Centers for Independent Living in particular, are providing the much needed Information & Assistance service component of FMS at a level that truly supports individuals’ choices to remain in their home, and are doing so at a financial loss. Unable to sustain these massive losses, Kansas CILs are being forced to close or dramatically reduce staffing levels. This will cause increased unemployment rates in Kansas and consumers will be left without service providers. Since current provider rates are anticipated to be the “floor” rates for Managed Care, it is of the utmost importance to get these increases in place before the total implementation of KanCare. Kansas has a well-established, cost-efficient Home and Community Based Services network. The philosophy of self-directed care is not only practiced here, it is codified into state law, and Kansas boasts a higher percentage of employment of people with disabilities than the national average. Each of these points came about due to the passion, hard work, and dedication of Centers for Independent Living, policymakers, and Kansans with disabilities. The Statewide Independent Living Council of Kansas (SILCK) and the Kansas Association of Centers for Independent Living (KACIL) looks forward to working with the Administration, the Legislature, and our consumers to ensure that Medicaid Reform is successful. The success of Medicaid Reform should not only be measured in fiscal terms and health outcomes, but also in how thoroughly we honor choice, independence, and dignity of each Kansan who receives Medicaid services.	
Budget neutrality will be built on the backs of children and parents in low-income working families and all other Medicaid beneficiaries.	Kansas request for a global waiver from CMS will give Kansas the flexibility to reduce benefits, increase cost sharing, and limit enrollment or set up waiting lists for most of the “optional” and “expansion” populations in the state. For example, the state can reduce the benefits of optional and expansion populations by as much as 5 percent over the life of the waiver or impose substantial new cost sharing on them without further CMS review. In exchange for taking on the risk of operating under a capped funding arrangement, the global waiver allows Kansas to use federal Medicaid funds to create a fiscal windfall for the states three Managed care companies. Budget neutrality will be built on the backs of children and parents in low-income working families and all other Medicaid beneficiaries. I would ask CMS not to approve a global waiver that will give Kansas the flexibility to reduce benefits, increase cost sharing, and limit enrollment or set up waiting lists for waiver beneficiaries.	2012-05-16 12:44
"Managed" healthcare is not synonymous with the ideals of independent living, or making independent choices.		2012-05-16 11:32
I hope it will effect in a good way.		2012-05-16 09:23
I live in rural Kansas and get DD day and residential services. I'm afraid that Kancare won't serve rural areas.	Will private insurance companies focus on populated areas and leave us out? We need to know more! We need DD services left out of this plan until we have answers.	2012-05-16 08:49

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KanCare Delay and Carve Out	I want to commend our Governor and his staff on their effort to make Medicaid in Kansas more efficient and effective. Their goals of better quality care and lower costs are laudable. I do believe that the implementation of their proposal cannot be done effectively in the time frames they set out. This is why I, and a majority of the Senate, have signed a resolution requesting the implementation begin July 1, 2013 instead of January 1, 2013. The resolution also calls for keeping the Developmental Disability population out of the Kan-Care system. The Governor has agreed on a one year delay on including the Developmental Disability population. Both the Kansas House of Representatives and the Kansas Senate also support the delay of the inclusion of the Developmental Disability population in Kan-Care. Making changes that are as broad and complex as are set out in the Kan-Care program and this waiver request, requires so much detail work by so many people that this additional time is needed. Additionally, credentialing providers and providers learning to navigate three billing systems, because three different managed care organizations will be used, will be time consuming and will entail a steep learning curve to ensure providers can accurately submit claims to receive reimbursement. A delay will help ensure there will be no bumps in the road that will impact patient care of the ability of provider to receive reimbursement. A delay would help ensure this success. What we don't need is a plan that crashes on take-off. Sincerely, Senator **** Kelsey Session of 2012 Senate Resolution No. 1831 By Senators Brungardt, Faust-Goudeau, Francisco, Haley, Hensley, Holland, Kelly, Kelsey, Kultala, Longbine, Marshall, McGinn, Morris, Owens, Reitz, A. Schmidt, V. Schmidt, Schodorf, Teichman, Umbarger and Vratil 3-7 A RESOLUTION requesting that Governor Sam Brownback, the Secretary for Aging and Disability Services, the Department for Aging and Disability Services, the Secretary of Health and Environment and the Department of Health and Environment delay the implementation of the statewide KanCare program until July 1, 2013. WHEREAS, Delay until July 1, 2013, will allow Governor Brownback's administration to receive necessary stakeholder and public input on the implementation of the KanCare program by Managed Care Organizations; and WHEREAS, Such delay will allow the appropriate state agencies the opportunity to determine whether the state of Kansas home and community based service programs, especially the services for the developmentally disabled, and community mental health programs should be included within the KanCare program; and WHEREAS, Such delay will give more time for the members of the Kansas Legislature to study and determine, during the interim period after the 2012 regular session, the 2013 regular session and the interim period after the 2013 regular session, how medical care and long-term services and supports should be administered to low-income, the disabled and the elderly citizens of our state; and	2012-05-16 08:39

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	WHEREAS, Such delay will give more time for the members of the Kansas Legislature to study and determine, during the interim period after the 2012 regular session, the 2013 regular session and the interim period after the 2013 regular session, how the proposed KanCare program would affect the operation of hospitals, pharmacies, doctors, dentists, nursing homes and long-term care providers in rural Kansas communities; and WHEREAS, Such delay will give more time for the members of the Kansas Legislature to study and determine, during the interim period after the 2012 regular session, the 2013 regular session and the interim period after the 2013 regular session, how the proposed KanCare program would affect the operation of all hospitals and adult care facilities throughout Kansas; and WHEREAS, Such delay will allow the members of the Kansas Legislature the opportunity, during the interim period after the 2012 regular session, the 2013 regular session and the interim period after the 2013 regular session, to gather information on proposed KanCare programs, hold important committee meetings and provide oversight on the KanCare program so that appropriate case management practices are employed to ensure proper medical and long-term care decisions are made; and WHEREAS, Such delay will allow the members of the Kansas Legislature and the Kansas Commissioner of Insurance and Insurance Department sufficient time to review and assess the pending United States Supreme Court ruling on the constitutionality of the Patient Protection and Affordable Care Act, 124 Stat. 119 through 124 Stat. 1025, and to determine how the ruling will impact the implementation and operation of the KanCare program in Kansas; and WHEREAS, Such delay will allow all appropriate state agencies to obtain required federal waivers, to write appropriate implementation plans, and to communicate these implementation plans to the thousands of service providers and consumers of services in Kansas; and WHEREAS, Such delay will allow the members of the Kansas Legislature the opportunity to ensure that the thousands of medical and long-term care providers under the state Medicaid plan have been properly trained to carry out the implementation and day-to-day requirements of the KanCare program and further ensure that the Managed Care Organizations in KanCare have put in place adequate procedures to ensure proper timing in the billing of claims and that timely payments to all providers have been made and properly accounted for: Now, therefore, Be it resolved by the Senate of the State of Kansas: That we urge Governor Sam Brownback, the Secretary for Aging and Disability Services, the Department for Aging and Disability Services, the Secretary of Health and Environment and the Department of Health and Environment and all other appropriate state agencies to delay the implementation of the statewide KanCare program until July 1, 2013, in order to ensure that all participants and enrollees will continue receiving quality services under Medicaid programs and to ensure that all providers operate in a most efficient system; and Be it further resolved: That the Secretary of the Senate shall send an enrolled copy of this resolution to the Governor of the State of Kansas, the Secretary for Aging and Disability Services and the Secretary of Health and Environment.	
Payment-based FFS claims data is imperitive for credible performance outcomes measurement.	Regardless of the reform proposed by Kansas, it is imperative that complete FFS claims data continue to be collected. A peril of Managed Care arrangements is that once per Capita rates are set, these rates are trended forward year after year from the original base with no reality check. Total costs become the purview of actuaries' and analyst's convoluted	2012-05-16 08:22

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	computations, and actual FFS utilization (truth) is completely lost. Outsourced actuary vendors will have immense control over how to measure the performance of the system, and necessarily have to include many assumptions to create these outcome measures. Sufficient claims detail to allow the state to verify vendor calculations are non-existent, and final results rely heavily on the “trust me” factor. As a remedy to this situation, FFS “shadow claims” or “encounter claims” are contractually required as part of managed care arrangements. However, this is ineffectual. Because actual payments are not tied to these claims, managed care organizations do not take this reporting requirement seriously. There are no “teeth” to enforce this requirement. And even if this was enforceable, there is no guarantee that shadow claims represent true costs and utilization. Without continuing to collect payment-based detailed FFS claims information, it is impossible to evaluate program outcomes (e.g. costs, utilization, etc.) in any credible way. Sr. Analyst from a neighboring State Medicaid program	
I would like to see the Medicaid system stay the way it is in Kansas. Private insurance companies are only interested in making a profit.	I receive DD services in Kansas and I'm worried about losing what I have. I think at the very least this needs to be studied for a few years before any changes are made.	2012-05-16 07:53
Current Medicaid system is unsustainable. I support KanCare as an effort to continue to serve those in need.		2012-05-15 17:19
KanCare offers an opportunity to intergrate and coordinate services for all poeple on Medicaid in a way that has never been done previously.	For many years the system for Medicaid has been broken and the answer has typically been we don't spend enough. More was spent and the results stayed the same. Truth is Kansas hasn't coordinated systems to improve outcomes for the people on Medicaid. The state allowed much input as the developed the idea through public input using forums, websites and other ways for Kansas citizens to provide their ideas for improving system. After gathering the ideas and presenting them, they still allowed input, took feedback and addressed issues that were presented to them. In the end will KanCare be perfect ... NO .... but will it be a significant improvement over the current delivery model .... MOST DEFINITELY	2012-05-15 15:46
KanCare is an excellent plan for removing the silos that exist between the service systems, and keeping persons out of institutional care.	There are currently silos and struggles that exist between the service delivery systems, especially ID/DD and Mental Health. There are also boundaries that exist for persons who have ID/DD that are created by the system of 27 CDDOs. Individuals with ID/DD do not currently have the ability to receive information about all services available across systems, and throughout the state, that will best serve their needs. Care coordinators who are trained and work for MCOs that have access to specialized providers statewide will have better knowledge of what is available to keep persons out of institutional settings, and keep them healthy. Kansas needs change, and needs to plan for and include persons with ID/DD within KanCare.	2012-05-14 19:45
.	This is merely a political agenda, ruining the lives of the most vulnerable	2012-05-14 19:37

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Managed care providers don't understand the population they will supposedly serve.	Sending Kansas money to out-of-state companies is a pro-business tactic that seeks to dismantle the successes of the existing system and does not look far enough into the future for Kansans with disabilities.	2012-05-14 08:50
KanCare Proposal Lacks Transparency and Collaboration	For a demonstration project to be successful it takes all parties being engaged. This plan was developed well before stakeholders were involved and input has not been utilized. There is a lack of understanding from the administration on how non-medical services, particularly for the developmentally disabled, function and nothing in the application shows a willingness to examine how or if these services fit within a managed care model. Public engagement was a very broad, very restricted process about Medicaid in general. The level of detail in the KanCare proposal, specifically for the HCBS populations, was not part of the initial public engagement. Simply put, this proposal will not work if there is not a good-faith effort put forth from the administration to work with those who will be affected.	2012-05-14 08:19
Developmental Disablity and Mental Health Carve Out	If there is sufficient reason to carve out non-profit developmental disability services, then those reasons should also apply to long term mental health services and supports. Many with mental health disabilities have as many, severe and chroic need for supports as those with DD/ ID. Many with DD/ID also have serious Mental Health disabilties, and carving out DD/ID will complicate coordiantion if mental health is not also carved out.	2012-05-14 07:34
If something something isn't broke, don't fix it!	The current ID/DD service model encompases alot of the components being proposed with the Kan Care model. If something isn't broke, don't fix it; this is the mentality that should be used and carve this population out of the Managed Care proposal. For profit insurance companies do not have the expertise to "manage" the supports and services of the our most vunerable population. Kan Care is a medical model. While this makes sense for some groups (TBI and FE) this does not make sense for ID/DD-current structures look at the "whole person". Kan Care is too hevely focused on medicla needs. Focusing on one key area, by implementing Kan Care, would be devestatign to the ID/DD community which is long term. It appears as if the goal of Kan Care is to resolve medical needs, thus resulting in individuals going off of publis assistance-individuals with ID/DD will not magically become healed by focusing on medical issues. Please care out all ID/DD services!!	2012-05-13 19:03
Too much talk with typical government interference. Leave the DD citizens alone. The state of Kansas is doing fine moneyl wise.	Here's an idea, leave our DD citizens alone. As a parent, these citizens need all the help they can get. Try cutting off illegal aliens first, the drug dealers and any other group that hurts our society, not helpless citizens.	2012-05-13 13:11
Medicaid Managed Care in other states have had disastrous beginnings	Kancare was introducced to the public in November 2011 and was created behind closed doors. There are numerous questions regarding this plan and no answers. The administration claims to have sough imput from the public, but that is not true. This is being shoved down the throats of the most vulnerable Kansans. One need look no further than Kentucky to see how the needs of the disabled and elderly are not being met and care actually being denied by these managed care companies. Providers are not being reimbursed and the financial situations of the for-profit companies is concerning. Before approving KanCare, more consideration needs to be given to the failures demonstrated in other states. The savings are not materialzing and care has deteriorated.	2012-05-12 06:57
If it ain't broke don't fix it. How can a "for proffit" company provide better service		2012-05-11 14:51

Title	Description	Created At
than a "not for proffit agency"?		
I have a psychiatric disability and am very concerned about Kancare. I have had great coverage and I don't want anything to change.	I would like for things to stay the same. I have friends who work at ks health solutions and i appreciate their efforts. i don't want a change.	2012-05-11 13:31
Carve DD Services Out	Please support carving DD services out of the KanCare system. One of the most vulnerable populations should not be a test group for this new system. Those working in the Managed Care companies do not have experience in working with our population. We provide long term care, not medical care. With the current system our individuals choose their preferred lifestyle and have a say in the supports and services that they would like to recieve. They haven't been asked if they want the new KanCare system. Carve DD services out...why change what has already proven to be effective.	2012-05-11 11:22
The KanCare proposal and subsequent Section 1115 Waiver application is an attempt by the State of Kansas, under Governor Sam Brownback's lea	The KanCare proposal and subsequent Section 1115 Waiver application is an attempt by the State of Kansas, under Governor Sam Brownback's leadership, to address the issue of growing costs and enrollment within the Kansas Medicaid program. Although Kansas is not uniquely positioned in this regard, Kansas has chosen to address this issue in a manner that is somewhat aggressive and potentially disastrous manner for the beneficiaries the program serves. Of particular note, individuals with Intellectual and Developmental Disabilities (I/DD) who receive Home and Community Based Services (HCBS) through the Kansas Medicaid program are exceptionally vulnerable to disastrous consequences from any failures that may occur if this plan runs into unexpected problems that may or may not occur. HCBS or long-term care services are not necessarily "medical" in nature and they require a great deal of specialized understanding and expertise. Much of this expertise and experience comes from years of successful delivery of this highly specialized care. Kansas has long been the envy of I/DD systems nation-wide. The Kansas I/DD system has accomplished this in the face of being woefully underfunded for many years and yet providers in this state remain committed to providing exceptional services to this population. More importantly, however, there is simply a totally lack of evidence that this type of managed care arrangement makes for a good fit for this population and therefore it is imperative that consideration be given to this fact. I clearly understand the adversity that this state and every other state faces in the way of Medicaid program growth both in terms of costs and enrollment. I also understand, with great clarity, that if the I/DD population is to be included in this KanCare plan, there must be meaningful and thoughtful pilots established in targeted catchment areas, where the state, providers, and families can determine what works best and how implementation on a larger scale can successfully occur. I urge you to carefully consider any decision to include or not include the I/DD population and their LTC within KanCare. Thank you in advance for your careful consideration of mine and other's comments.	2012-05-11 10:01
KanCare looks innovative on paper but the authors aren't realistic regarding its effects on people with intellectual disabilities.	Non-profit agencies providing services to people with intellectual disabilities do not need a for-profit insurance company, that is only interested in profit, calling the shots for the services they provide. What will they know about necessary services to keep people healthy, safe, and happy with their lives. Will they seek only to cut costs? Will they put people at risk to make another dollar? The authors of KanCare have no hands on experience with	2012-05-11 09:07

Title	Description	Created At
	this population and did not seek input from them when deciding to add them to KanCare. Please don't approve this waiver. Thank You.	
This is not a good plan or idea for any disabled resident of Kansas. KanCare is not for Kansans		2012-05-11 07:46
There will be more issues than can be fixed in one year!	A one-year period of delay for the inclusion of DD long-term care services within KanCare will not be long enough for the State to adequately fix issues that will arise from the implementation of such a sweeping overhaul to the Kansas Medicaid delivery system. Long term care services for DD should be carved out all together.	2012-05-11 06:29
I believe this is a very important initiative in Kansas and happy they are leading the nation inc ID/DD svs!!	I like the pilot idea and believe this will make the KanCare program better in year two.	2012-05-10 21:15
I believe this waiver is a great idea. It will serve the undeserved well and break down the silos that have scattered the Kansas landscape.	Include DD services as soon as possible.	2012-05-10 19:27
My name is David P. Rundle. I have cerebral Palsy, epilepsy and a feeding tube. I get pneumonioa a lot. I oppose this,		2012-05-10 15:19
Medical Issues	I have a great concern regarding the vulnerabilities of persons I provide services to, and the rest of Kansas I/DD population, to the types of sweeping system changes embodied in the Brownback Administration's KanCare managed care proposal. I am particularly concerned regarding changes that may occur in the medication management of these individuals that could "de-stabilize" them and lead to costly hospitalizations for resulting behaviors. This Kansas administration also cites high incidents of cholesterol and diabetes in people with intellectual disabilities and the need to get that under control. However, a closer look reveals underlying causes that cannot be altered without jeopardizing the overall health status. The medication regimen for most individuals with intellectual disabilities include one or more atypical antipsychotics. Atypical medications raise lipid profiles leading to high cholesterol and diabetes. Since this medication is the root of the health issue, little can be done to "change" the lipid profiles of this group.	2012-05-10 13:51
KanCare RFP is Vague	The RFP that was produced by the state is very vague in regards to persons with intellectual disabilities. While there are hundreds of pages on other HCBS waivers (FE, MI, PD), there are only a few select statements regarding HCBS/MR. This has created many unknown factors and a lot of fear among family members. There have been hundreds of questions asked of the administration, but the answers have either been addressed by "we don't know" or "the managed care companies will decide that." They have also made numerous guarantees in an attempt to divert our attention away from the managed care plan, but those guarantees are not included in the RFP and are thus irrelevant.	2012-05-10 13:48
Waiting List	KanCare does not address the 4,000 person waiting list in the state of Kansas.	2012-05-10 13:44

Title	Description	Created At
Absence of Outcomes	There has been an unsettling absence of stated outcomes for the Kansas I/DD population within the Brownback Administration's KanCare proposal that would lead to an improved quality of life for these Kansan's.	2012-05-10 13:41
Lack of inclusiveness	There has been a serious lack of inclusiveness in the development of the 1115 waiver proposal, as well as the overall development of the KanCare managed care proposal.	2012-05-10 13:38
KanCare	As a parent of an adult child with a developmental/cognitive disability I oppose the implementation of KanCare. She is on the Home and Community Based Waiver, she has a wonderful case manager, she has a person centered support plan that addresses her long-term care and health needs, and we are content with the current arrangement with the state of Kansas. We do not want a for-profit insurance company, with no experience in long-term care for I/DD individuals, to take away the benefits she now has. She does not need a health care coordinator to manage her "health home" - that is already being addressed in her Person Centered Support Plan by her case manager and her Personal Assistant. Why re-invent the wheel and add costs to an already managed care program that has been successful in Kansas for many years.	2012-05-10 13:18
KanCare is not a good fit for long-term services for Kansans with developmental disabilities.	There is an unsettling absence of stated outcomes from the Kansas I/DD population within the Brownback Administration's KanCare proposal that would lead to the improved quality of life for these Kansans. While an insurance company may have experience in improving coordination of medical services, they have no proven expertise in understanding long-term care supports such as residential services, employment coordination, day services, etc. My fear is that the profit-driven models of MCOs will dismiss the value of long-term supports and therefore reduce critically important services (that promote the independence and well being of an individual) to find financial gain.	2012-05-10 12:06