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Jeff Colyer, M.D., Lieutenant Governor

Sam Brownback, Governor

December 26, 2017

Mr. Eric D. Hargan
Acting Secretary and Deputy Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Acting Secretary Hargan:

On behalf of the State of Kansas, I am pleased to submit our request for a Section 1115 demonstration waiver renewal application to implement the KanCare 2.0 program from January 1, 2019 to December 31, 2023. Building on the success of the current KanCare demonstration, the goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by providing services and supports for social determinants of health and independence in addition to traditional Medicaid benefits.

The State of Kansas appreciates your consideration of this Section 1115 demonstration waiver renewal application and looks forward to working with CMS to improve the health and independence of KanCare members.

Please let me know if you have any questions or need additional information.

Sincerely,

[redacted]

Jeffrey Colyer, M.D.
Lieutenant Governor

State of Kansas

KanCare 2.0
Section 1115 Demonstration Renewal Application

Final Submission to CMS

December 20, 2017

Table of Contents

I. Introduction

The Kansas Department of Health & Environment (KDHE), in partnership with the Kansas Department for Aging and Disability Services (KDADS) is pleased to submit this Section 1115 demonstration renewal application for the KanCare program. KanCare, Kansas' statewide mandatory Medicaid managed care program, was implemented on January 1, 2013, under authority of a waiver through Section 1115 of the Social Security Act. The initial demonstration was approved for five years, and the Centers for Medicare and Medicaid Services (CMS) approved a one-year extension on October 13, 2017.

The original goals of the KanCare demonstration focused on providing integrated and whole-person care, creating health homes, preserving or creating a path to independence, and establishing alternative access models with an emphasis on home and community-based services (HCBS). Building on the success of the current KanCare demonstration, the goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid benefits. The State of Kansas (the State) seeks a five-year Section 1115 demonstration renewal from CMS to further improve health outcomes, coordinate care and social services, address social determinants of health, facilitate achievement of member independence, and advance fiscal responsibility.

II. Historical Narrative Summary of KanCare and Requested Changes

This section provides an overview of the State's current KanCare demonstration and requested changes under KanCare 2.0.

Historical Narrative Summary of KanCare

KanCare is a Medicaid managed care program which serves the State through a coordinated approach. The State determined that partnerships with managed care organizations (MCOs) will result in more efficient and effective provision of health care services to the populations covered by the Medicaid and Children's Health Insurance Program (CHIP) in Kansas. Three MCOs currently serve the KanCare program – Amerigroup, Sunflower Health Plan, and UnitedHealthcare. The State will begin the reprocurement process for new MCO contracts in November 2017 to implement KanCare 2.0.

Prior to the implementation of KanCare, the State operated a managed care program which provided services to children, pregnant women, and parents in the State's Medicaid program, as well as carved out mental health and substance use disorder (SUD) services to separate managed care entities. On August 6, 2012, the State submitted a Medicaid Section 1115 demonstration proposal, entitled KanCare. CMS approved that proposal on December 27, 2012, effective from January 1, 2013 through December 31, 2017. On August 19, 2013, the State submitted a letter to CMS requesting approval of an amendment to the KanCare demonstration, detailing three changes to KanCare:

Figure 1. Previously Requested KanCare Demonstration Amendments Approval Status

Proposed Change	CMS Approval Date
Provide Long-Term Supports and Services (LTSS) for individuals with intellectual and developmental disabilities (I/DD) through KanCare managed care plans	CMS approved the LTSS integration of I/DD population in a letter dated January 29, 2014, and approved amendments to the HCBS I/DD waiver in a letter dated February 3, 2014
Establish a supplemental security income pilot program to support employment and alternatives to Medicaid	State withdrew this proposed change on July 24, 2017
Change the timeline for the Delivery System Reform Incentive Payment (DSRIP) Pool	CMS approved the DSRIP delay amendment on September 20, 2013

KanCare is operating concurrently with the State's section 1915(c) HCBS waivers, which together provide the authority necessary for the State to require enrollment of almost all Medicaid beneficiaries across the State into a managed care delivery system to receive State Plan and waiver services. Appendix A lists the groups included in KanCare under the current 1115 demonstration Special Terms and Conditions (STC). Although most of the populations within the demonstration renewal will remain the same, the State is considering the addition of certain MediKan enrollees who voluntarily discontinue pursuit of a disability determination in exchange for Medicaid benefits with employment support for a duration of 18 months.

The KanCare program integrates medical, behavioral, and long-term care health delivery systems and covers mandatory and optional services under the approved Medicaid State Plan. Kansas is not requesting any changes in covered benefits for this renewal.

Currently, KanCare includes a Delivery System Reform Incentive Payment (DSRIP) Pool, which aims to advance the goals of access to services and healthy living by specifically focusing on incentivizing projects that increase access to integrated delivery systems and projects that expand successful models for prevention and management of chronic and complex diseases. Participating hospitals work with community partners statewide to implement projects that have measurable milestones for improvements in infrastructure, processes, and healthcare quality.

The DSRIP program in Kansas includes two major hospitals: Children's Mercy Hospital and The University of Kansas Hospital. The two hospital systems are major medical service providers to Kansas and Missouri residents. Each hospital system is implementing two projects selected from a catalog of five projects approved by CMS and the State that target specific needs of Kansas residents who are receiving Medicaid services or are uninsured. The Kansas DSRIP projects were originally planned to be implemented as four-year projects from 2014 through 2017. In 2013, the State amended the 1115 demonstration to change the projects to begin in 2015. Then in 2017, the State received approval to extend the projects through December 21, 2018. Under KanCare 2.0, the State proposes to extend the DSRIP program for two additional years through December 31, 2020. Subsequently, the State will propose a design for an alternative payment model (APM) approach that replaces the DSRIP program beginning in January 2021. In developing the design for the DSRIP replacement, the State will work closely with CMS and will seek input from key stakeholders. The State will consider the lessons learned from the current DSRIP program, including data collection and reporting practices, and intends to align performance measures with KanCare 2.0 objectives.

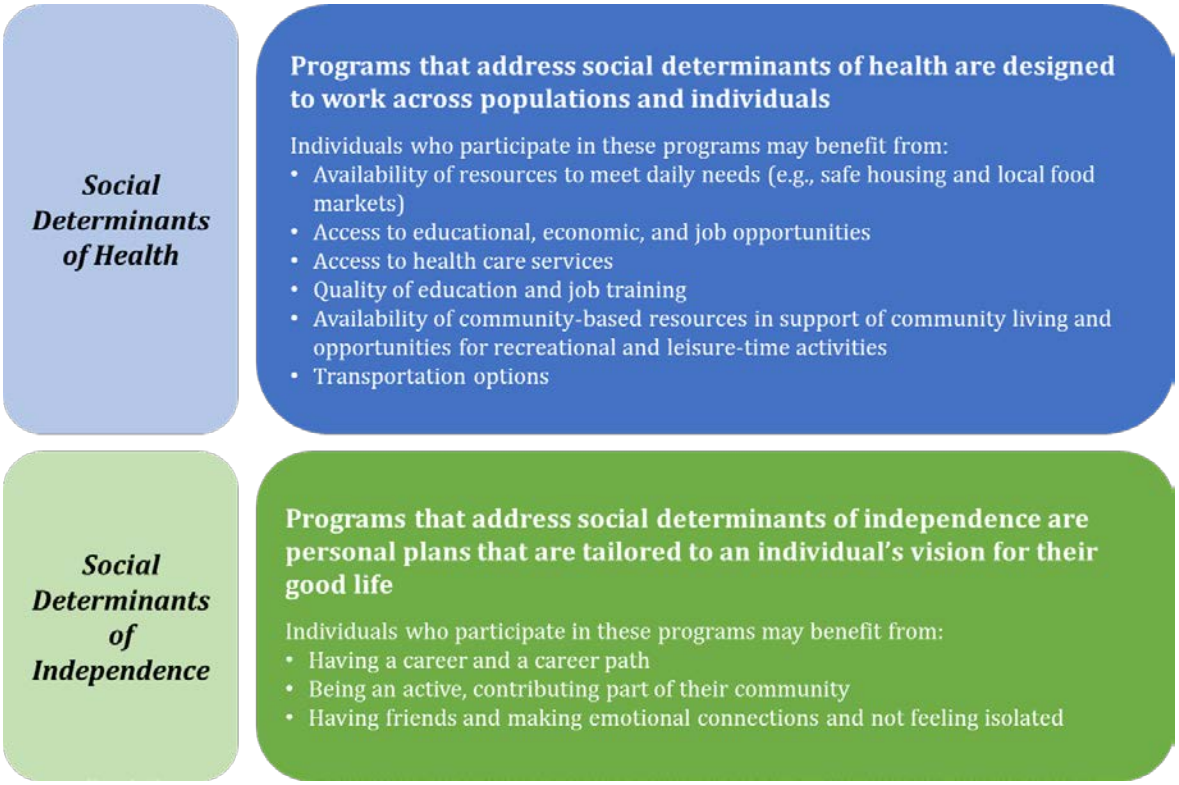
KanCare also includes an Uncompensated Care (UC) Pool (also referred to as a Safety Net Care Pool). The UC Pool provides payments to hospitals to defray hospital costs of uncompensated care provided to Medicaid-eligible or uninsured individuals. The UC Pool consists of two sub-pools, the Health Care Access Improvement Program (HCAIP) Pool and the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool. Under KanCare 2.0, the State proposes to increase the size of the UC Pool as discussed further below.

Finally, refer to Section IV, Quality Reporting and Section VI, Evaluation Design, for additional information regarding performance of the current KanCare program.

Requested Changes

Building on the success of the current KanCare program, the goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid and CHIP benefits. Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[1] Social determinants of independence are an individual's goals that help them achieve sustainable improvements and advancement in their lives. Addressing social determinants of independence in conjunction with social determinants of health accelerates an individual's path to higher levels of independence and attainment of their vision for a good life.

Figure 2. Examples of Social Determinants of Health and Independence



[1] Healthy People 2020, 2017. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Kansas will test the following hypotheses in KanCare 2.0 to accomplish the goal of helping Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid benefits:

1. Expanding service coordination to include assisting members with accessing affordable housing, food security, employment, and other social determinants of health and independence will increase independence, stability, and resilience and improve health outcomes;

2. Increasing employment and independent living supports for members with behavioral health needs, or who have intellectual, developmental or physical disabilities or traumatic brain injuries will increase independence and improve health outcomes; and

3. Providing service coordination for all youth in foster care will decrease the number of placements, reduce psychotropic medication use, and improve health outcomes for these youth.

The State will not continue to test hypotheses previously included under KanCare. The vision for KanCare 2.0 includes enhancements, advancements, and innovations focusing on areas below.

Figure 3. Key Themes and Initiatives Under KanCare 2.0

Coordinate Services to Strengthen Social Determinants of Health and Independence, and Person Centered Planning	•Service coordination •Plan of service and person centered service planning •Community service coordination •Service coordination pilot programs
Promote Highest Level of Member Independence	•Employment programs, including work requirements and voluntary work opportunities •Independence accounts
Drive Performance and Quality Improvement for Better Care	•Value-based models and purchasing strategies, including MCO and provider-level initiatives •Quality improvement •Safety net pools
Improve Effectiveness and Efficiency of State Medicaid Program	•Alignment of MCO operations •Data analytics capabilities •Member access to behavioral health services

Each of the key themes and selected initiatives is described in further detail below.

Coordinate Services to Strengthen Social Determinants of Health and Independence, and Person Centered Planning

KanCare 2.0 will expand upon care coordination to provide service coordination, which is a comprehensive, holistic, integrated approach to person centered care. Service coordination is a foundational component to improving the health and well-being of members. It allows for maximum access to supports by coordinating and monitoring all of an individual's care (acute, behavioral health, and LTSS) through direct interventions, provider referrals, and linkages to community resources. Case management, disease management, discharge planning, and transition planning are also elements of service coordination for members across all providers and settings.

Figure 4. Key Elements of the KanCare 2.0 Service Coordination Model

The State will require MCOs to provide service coordination to groups such as:

- Individuals enrolled in a 1915(c) waiver or on a waiver waiting list,
- Youth (birth up through age 21) who have intensive behavioral health needs,
- Youth who are in an out-of-home placement through the foster care system,
- Individuals who are institutionalized in a nursing facility, intermediate care facility for individuals who have intellectual disabilities or hospital, psychiatric residential treatment facility, psychiatric hospital or other institution,
- Adults who have behavioral health needs,
- Individuals who have chronic and/or complex physical and/or mental health conditions, and
- Individuals participating in the Work Opportunities Reward Kansans (WORK) program or other employment programs.

Plans of Service and Person Centered Service Plans

To support our hypotheses, KanCare 2.0 service coordination enhancements and advancements include tools for assessing initial and ongoing member needs and other systematic efforts to identify the health and social resources required to meet the member's needs and confirm coordination across settings and during transitions of care.

MCOs will complete health screenings for members using a screening tool that contains State-prescribed questions and fields. For all members whose health screen results indicate the need for a health risk assessment (HRA), MCOs will use a State-developed tool for members who have behavioral health conditions or enrolled in a HCBS waiver program to determine the type of needs assessment warranted by the member's health status and next steps in the process. MCOs will conduct health screenings and HRAs in a centralized information system that is capable of interfacing with the State's Kansas Medicaid Modular System (KMMS).

Following the assessment, MCOs will develop plans of service and person centered service plans (PCSP), based on their needs shown in the figure below.

Figure 5. Plan of Service and Person Centered Service Plan

Plan of Service

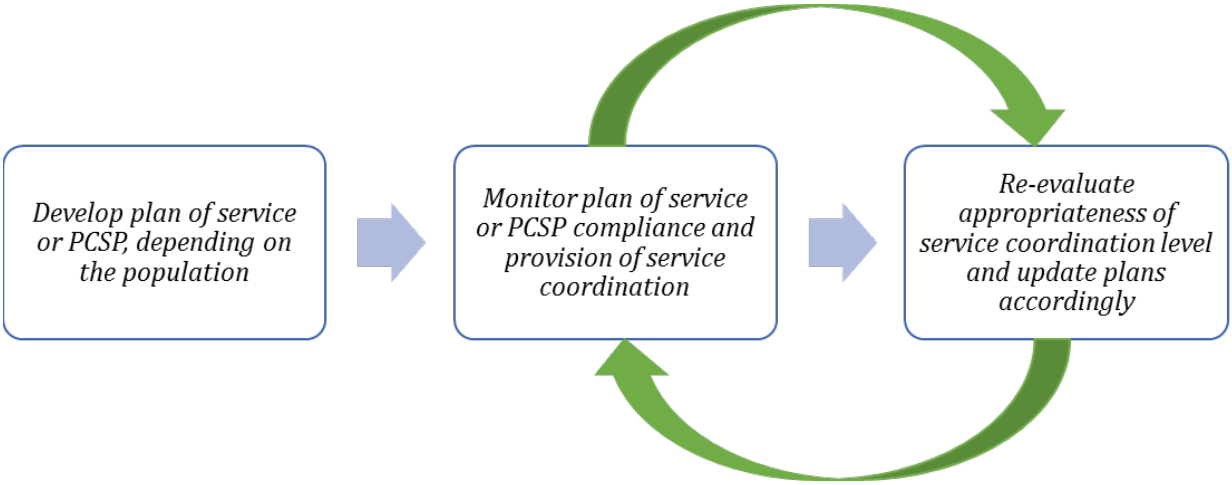
Members receiving service coordination are encouraged to participate in their individualized plan of service development process. The plan of service is a written document that describes the member's goals and service needs in accordance with State policy. The plan of service records the strategies to meet goals and interventions selected by the member and the team that will support

the member's health and well-being and address social determinants of health and independence. The plan of service will accurately document the member's strengths, needs, goals, lifestyle preferences, and other preferences, and will outline the services and supports that will be provided to meet member needs. MCOs will also consider the availability and role of unpaid supports provided by family members and other natural supports.

Person Centered Service Planning

For all members enrolled in HCBS waiver services, children in foster care, and members who have behavioral health needs, MCOs will ensure that members participate in the person centered service planning process that is compliant with federal requirements, (e.g., 42 C.F.R 441.301(c)), State law, and the State's PCSP policy. The PCSP will involve an interdisciplinary team of professionals including individuals chosen by the member. These professionals must have adequate knowledge, training and expertise around community living and person centered service delivery. The PCSP process will promote self-determination and actively engage the member and individuals of their choice.

Figure 6. KanCare 2.0 Service Planning Process



<u>Community Service Coordination</u>

KanCare 2.0's service coordination will feature:

- Person and family-centeredness,
- Timely and proactive communication,
- Promotion of self-care and independence,
- Cross continuum and system collaboration,
- Comprehensive consideration of physical, behavioral, and social determinants of health and independence, and
- Promotion of community access and participation in community activities.

KanCare 2.0 will create linkages to allow for sharing information through KMMS (discussed further below), tracking referrals, obtaining the appropriate approvals or member consent to share health and care information, and maintain ongoing coordination efforts with community agencies important to the health and well-being of members.

The State will require MCOs to work with local entities to perform community service coordination activities. These activities may include items such as:

- Development, implementation, monitoring, and approval of the plan of service or PCSP,
- Choice counseling,
- Member contacts and home visits,
- Linkage and referral to community resources and non-Medicaid supports,
- Referrals for education, employment, and housing, and
- Education to the member regarding self-direction and the WORK program and other employment programs.

Service Coordination Pilots

Finally, the State is considering the implementation of potential pilots to further improve services coordination for members. We describe the goals of these initiatives below.

Figure 7. Potential Service Coordination Pilots

Target Population	Goals
Individuals with Disabilities & Behavioral Health Condition	• Help members obtain and maintain competitive integrated employment • Help members achieve their highest level of independence
Children in Foster Care	• Increase stability at home and school • Support the child and foster family to reduce adverse childhood experiences • Ease transitions
Adults with Chronic Conditions	• Improve outcomes for people with chronic conditions through direct primary care • Lower emergency room visits and hospital admissions
Members Living in Rural & Frontier Areas	• Expand services delivered through telehealth • Increase provider capacity through tele-mentoring • Promote and expand the rural workforce

Promote Highest Level of Member Independence

The goal of Medicaid long-term supports and services (LTSS) initiatives is to "create a person-driven, long-term support system that offers people who have disabilities and chronic conditions choice, control and access to services that help them achieve independence, good health and quality of life."[2] Individuals who have disabilities comprise 14.5 percent of Kansas' Medicaid and CHIP enrollment but represent 47.5 percent of Kansas' Medicaid and CHIP spending in State Fiscal Year 2016.[3] Many KanCare members who have disabilities wish to remain within the community and complete activities of daily life on their own, to the extent possible. The State is considering the following initiatives to promote the highest level of member independence, as defined by the member. The State is also interested in promoting member-driven health care decisions by supporting health care quality and cost transparency, and will work with MCOs to help members identify high quality, high value providers who can best meet their specific needs.

Employment Programs

Stakeholders in Kansas and the rest of the nation have identified a number of barriers impacting individuals' abilities to achieve employment. Among these are low expectations for youth and adults who have disabilities, medical and service providers who discourage employment, lack of work experience for transition age youth, a Social Security system that defines disability as the inability to work, state and federal systems that incentivize unemployment, and inconsistency across systems in terms of their approach to employment.

Unemployed Americans face numerous health challenges beyond loss of income. Workers who are laid-off are "54 percent more likely than those continuously employed to have fair or poor health, and 83 percent more likely to develop a stress-related condition, such as stroke, heart attack, heart disease, or arthritis." [4] With respect to behavioral health, a 2013 Gallup Poll found that "the longer Americans are unemployed, the more likely they are to report signs of poor psychological well-being."[5] Employment plays a major role in adult life, frequently bringing with it a sense of accomplishment, personal satisfaction, self-reliance, social interaction, and integration into the community, which can ultimately impact an individual's social determinants of health and independence. Steady employment can provide the income, benefits, and stability necessary for good health.

The Temporary Assistance to Needy Families (TANF) program in Kansas has been successful in increasing the number of Kansans with new jobs: from January 2011 through June 2017, 43,975 new employments were reported for TANF clients. As the State builds on its TANF program and KanCare successes to further promote member independence, the State will institute work requirements for only some able-bodied adults and offer work opportunities for other KanCare members who wish to work.

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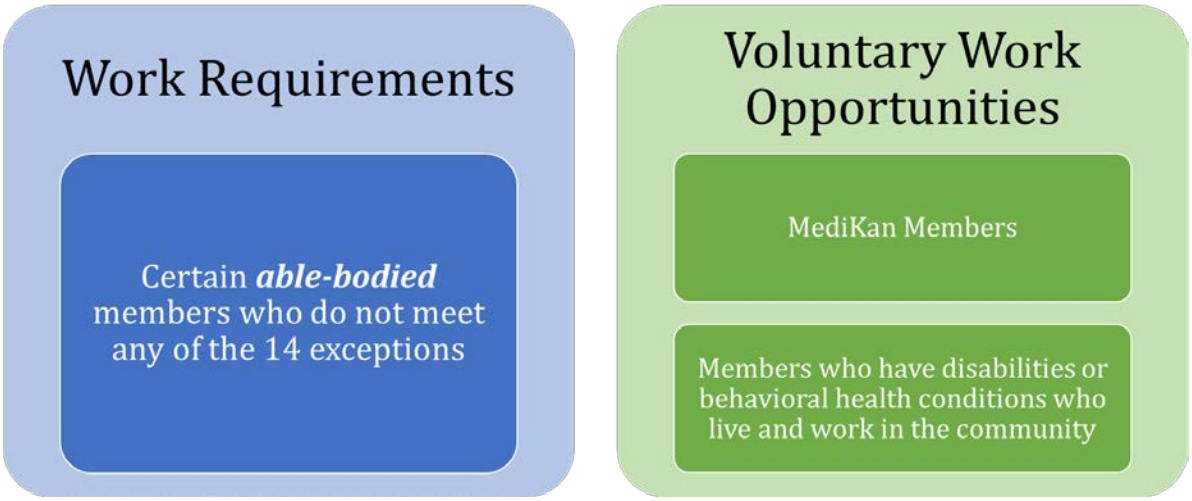
[2] Centers for Medicare & Medicaid Services, 2017. Available at: https://www.medicaid.gov/medicaid/ltss/balancing/index.html
[3] Kansas Health Institute, 2017. Available at: http://www.khi.org/assets/uploads/news/14738/kansasmedicaidprimer2017.pdf
[4] Robert Wood Johnson Foundation, 2013. Available at: https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf403360
[5] Gallup News, 2014. Available at: http://news.gallup.com/poll/171044/depression-rates-higher-among-long-term-unemployed.aspx

Figure 8. KanCare 2.0 Employment Programs



Work Requirements

As part of the State's broader effort to encourage member independence, the State will require only some able-bodied adults to meet work requirements under KanCare 2.0. Work requirements will be implemented as soon as possible on or after January 1, 2019, and no later than July 1, 2020. This policy aligns with Kansas' initiative across public programs to promote the highest level of member independence. Work requirements will build on requirements already in place for the Temporary Assistance to Needy Families (TANF) program. Therefore, if the KanCare member is receiving TANF benefits and complies with work participation requirements for TANF, he or she will also meet KanCare 2.0 work requirements. Training and employment support resources available via TANF will also be available to KanCare members required to comply with this requirement.

<u>Population</u>

Only some KanCare able-bodied adults will be required to comply with work requirements.

The following KanCare members will **not** be subject to work requirements:

1. Members receiving long-term care, including institutional care and Money Follows the Person;
2. Members enrolled in or on the waiting list for the following Home- and Community-Based Services (HCBS) waiver programs: Autism, Serious Emotional Disturbance (SED), Technology Assisted (TA), Frail Elderly (FE), Traumatic Brain Injury (TBI), Intellectual and Developmental Disabilities (I/DD), and Physical Disability (PD);
3. Children;
4. Women who are pregnant;
5. Members who have disabilities and are receiving Supplemental Security Income (SSI);
6. Caretakers for dependent children under six years or those caring for a household member who has a disability;
7. Medicaid beneficiaries who have an eligibility period that is only retroactive;
8. Members enrolled in the MediKan program;
9. Members presumptively eligible for Medicaid;
10. Persons whose only coverage is under a Medicare Savings Program;

11. Persons enrolled in Programs of All-inclusive Care for the Elderly (PACE);
12. Members with TBI, human immunodeficiency virus (HIV), or in the Breast and Cervical Cancer Program;
13. Members who are over the age of 65 years; and
14. Certain caretakers of KanCare members 65 years and older who meet criteria specified by the State.

The State may consider an exceptions process for members who have certain behavioral health conditions.

Eligibility

The State will assess Kansas Medicaid beneficiaries at the point of application or redetermination to determine if they are required to meet the KanCare work requirements. Members will be able to request exemptions throughout their eligibility. Members who must comply with these work requirements can receive a grace period of up to three months of KanCare coverage in a 36-month period. The State may authorize an additional month of eligibility for coverage beyond the three months in exceptional circumstances (e.g., natural disasters). The following table provides an overview of members' eligibility and the maximum length of KanCare coverage they may receive based on proof of meeting work requirements.

Figure 9. KanCare Member Eligibility and Maximum Coverage under Work Requirements

Eligibility	Maximum Length of KanCare Coverage
Members who are subject to work requirements but **do not meet** work requirements	3 months of KanCare coverage in a 36-month period
Members who are subject to work requirements **who meet** work requirements	36 months

Participation

The State will align KanCare work requirements with TANF program requirements. Minimum weekly requirements are 20 or 30 hours in a one-adult household, depending on whether there is a child under the age of six. Minimum weekly requirements are 35 or 55 hours in two-adult households.[6] For any given individual, the maximum requirement is 40 hours per week per individual. Applicants are required to complete a self-assessment and an orientation.

Consistent with Section 407 of the Social Security Act and the TANF program, the following

[6] Some two-adult households do not meet the two-parent definition. For instance, there may not be a mutual child or they are cohabiting partners. For TANF, effective May 1, 2017, two-adult households are required to participate 30 hours per week. If there is a child under the age of six, at least 20 of those hours are to be completed by one adult. If there is no child under the age of six, all 30 hours must be completed by one adult. http://content.dcf.ks.gov/ees/KEESM/SOC_Rev_82_05-17.html

activities will meet the State's definition of work:

- Unsubsidized Employment: This activity includes employment that is full or part-time including self-employment, apprenticeship, and internship/practicum that pays a wage or salary.
- Subsidized Public Employment: Contracted employment such as temporary staffing in the public sector, federal work study, Job Corps, or Workforce Innovation and Opportunity Act (WIOA)-paid work experience in which the wages are subsidized by TANF or other public funds.
- Subsidized Private Employment: Employment in the private sector in which the wages are subsidized by TANF or other public funds. This could include, but is not limited to, work study, WIOA work experience, temporary staffing, and other work experience opportunities.
- Work Experience: An unpaid, supervised assignment to help the member develop work history, improve work habits and increase self-confidence and esteem. Work experience may occur in the public or private sector.
- On-the-Job Training: Paid employment that provides significant and/or additional training in the knowledge and skills necessary to perform one's job. Training would be based on a well-defined plan and may be subsidized or unsubsidized, in either the public or private sector.
- Supervised Community Service: Work that is performed for the direct benefit of the community and the member in a variety of capacities while under supervision. This includes, but is not limited to AmeriCorps, Volunteers in Service to America (VISTA), faith-based organizations, probation conditions, substance abuse recovery centers, and animal shelters.
- Vocational Education: Employment training that prepares members for employment in current or emerging occupations. This includes, but is not limited to skill specific certificate programs, work towards an Associate Baccalaureate Degree, language instruction, or online distance learning.
- Job Search/Job Readiness: The following are considered job search/job readiness for those who are otherwise employable:
    - Individual or Group Job Search: Supervised individual job search or workshops designed to build job search competency and support the individual in searching and interviewing for job openings.
    - Job readiness: This includes, but is not limited to community or agency workshops and/or support groups designated to enhance life skills and remove barriers that may prevent obtaining and retaining employment including rehabilitation activities such as short-term physical therapy.
- Job Readiness Case Management: One-on-one services to help remove employment barriers and assist the participant in learning and adhering to employers' general expectations.
- Job Skills Training Directly Related to Employment: Training or education that is customized to job specific skills required by an employer to obtain employment or to adapt to the changing demands of the workplace.
- Education related to Employment: Education activities that include Adult Basic Education, English as a Second Language, and other courses designed to provide knowledge and skills for a specific job.

- Secondary School Attendance: This activity includes a member's efforts toward General Educational Development (GED) and/or completing a high school degree, particularly those under 20 years of age.

Tracking

The State will track countable months for members who are required to comply with work requirements. Members who fail to comply with the work requirements and who have exhausted their three-month grace period will be removed from KanCare until compliance is achieved. The start date of the disenrollment shall be the first of the month after normal procedures for closing or removal of the member have taken place. Should a fair hearing delay the disenrollment process, the period shall start the first of the month following the decision upholding the State's determination. The disqualification period shall continue until the disqualified member complies with all work requirements. Members will be afforded the usual grievance and appeal rights and existing Medicaid protections.

Voluntary Work Opportunities

The State will also offer two programs to support voluntary work opportunities for KanCare members who wish to or elect to work. KanCare 2.0 will include voluntary work opportunities for the following members:

- Members in the MediKan program, and
- Members who have disabilities or behavioral health conditions living and working in the community.

Work Opportunities for MediKan Members

The initiative focuses on individuals who apply for a disability determination through the Kansas Presumptive Medical Disability process who do not meet the Social Security Administration (SSA) guidelines for a disability determination. These individuals tend to have a combination of physical and behavioral conditions that do not meet SSA criteria for a disability, as well as socio-economic issues that may be a barrier to a stable lifestyle. Approximately 35 percent of individuals in this population have mental illness as one of their disabilities. The higher rate of mental illness and health problems, combined with education and socioeconomic issues, likely result in a greatly reduced capacity to obtain and/or maintain gainful employment, and highlight the need for vocational supports and other interventions in order for them to leave the general assistance rolls and become employed. As of June 2017, there were 2,101 individuals eligible to receive the MediKan benefit.

Under KanCare 2.0, beginning in 2020, the State will provide a voluntary choice to MediKan members who are under the age of 65 years to pursue a disability determination from the SSA and be eligible for 12 months of MediKan, or they may discontinue pursuit of a disability determination. Subsequently, they would receive a broader array of health care and social support services than the traditional MediKan program with employment support. These individuals will be a new population under the KanCare demonstration. MediKan members who discontinue pursuit of a disability determination will receive Medicaid benefits through a KanCare MCO and will receive employment support such as job skills training for a duration of 18 months.

The goal is to provide a comprehensive benefit package to these individuals to:

- Decrease the likelihood of a future disability determination by stabilizing their immediate health care needs and providing preventive care,
- Support their employment pursuits and assist in maintaining employment, and
- Promote greater independence and self-sufficiency.

The State will require MCOs to contract with community partners that have trained staff to provide employment supports. These partners will have strong ties with the State's vocational and rehabilitation and workforce systems. To further increase work opportunities for members who have disabilities, the State is also considering requiring MCOs to adopt recruitment strategies that establish a hiring preference for Kansans who have disabilities.

Work Opportunities for Members who have Disabilities or Behavioral Health Conditions

The State is also considering a pilot program for individuals who have disabilities or behavioral health conditions, and who are living and working in the community. The State may provide services such as:

- Employment support,
- Independent living skills training,
- Personal assistance, and
- Transportation.

KanCare members who have disabilities or behavioral health conditions and who are at risk for institutionalization would have the option to receive services under the demonstration program.

This pilot program would allow the State to test whether offering supported employment, combined with supportive housing, independent living skills training and personal assistance services, results in a significant increase in the number of members who have disabilities or behavioral health conditions who gain and maintain competitive employment. The pilot supports the goals of KanCare 2.0, and if it demonstrates positive results, the State can expand the pilot.

Independence Accounts

The TransMed program is a transitional Medicaid program which is designed to provide temporary health coverage to families moving from welfare to economic self-sufficiency. The TransMed program provides an additional 12 months of coverage for families who were previously eligible for Medicaid and lost financial eligibility due to increased earnings. The State is considering the creation of Independence Accounts, also known as health savings accounts, for adults enrolled in the TransMed program to encourage them to:

- Maintain employment, and
- Transition out of Medicaid and onto the health insurance exchange or other commercial insurance plans.

Each TransMed member will have the option to sign up for an Independence Account. The State will deposit funds into the Independence Account for the member for the 12 months of TransMed coverage, contingent upon the member's continued employment for all 12 months. At the end of the TransMed eligibility period, members will receive a debit card with which they can access funds from their Independence Account use for items specified by the State and approved by CMS. These

funds do not expire. Members who choose to participate in this initiative would be prohibited from re-enrolling in Medicaid for a period of time determined by the State.

The State will conduct a pilot of the Independence Accounts in a limited geographic area for TransMed members before determining whether to make them available on a statewide basis. The State may require MCOs to manage the Independence Accounts for enrolled members and support members in transitioning to commercial health insurance alternatives.

Drive Performance and Quality Improvement for Better Care

Demand for health care services continues to increase, and health care costs represent a large proportion of corporate and governmental budgets, with Medicaid comprising 21 percent of the State's General Fund expenditures in State Fiscal Year 2015.[7] Policymakers and payers alike recognize the need to transform the health care delivery system into one that aligns financial incentives to reward high quality services and improve outcomes, rather than a system that drives volume. Value-based models and purchasing strategies focus on those innovative programs that will drive better value for members and increase quality and outcomes with provider payment incentives, while reducing costs.

With the goal of driving performance and quality improvement for better care, KanCare 2.0 will leverage value-based models and purchasing strategies, use of data to drive quality improvement, and safety net pools.

Value-Based Models and Purchasing Strategies

KanCare 2.0 promotes two different types of value-based models and purchasing strategies:

1. Provider payment and/or innovative delivery system design strategies between MCOs and their contracted providers, and
2. A pay-for-performance (P4P) program between the State and contracted MCOs.

Value-based models incorporate performance and quality initiatives into service delivery. Such initiatives will be critical to helping Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence.

The first value-based model and purchasing strategy will incentivize providers. MCOs will implement provider payment and/or innovative delivery system design strategies that incorporate performance and quality initiatives in service delivery models. The State is considering both types of strategies so long as they support the goals and objectives of KanCare 2.0. The State will offer MCOs flexibility to design strategies to support the goals and objectives of KanCare 2.0, with the State reserving the ultimate authority for approval. MCOs will submit proposals that utilize strategic approaches, such as those outlined below.

[7] Kaiser State Health Facts, State Fiscal Year 2015.

Figure 10. Examples of Value-Based Model and Purchasing Strategies

Approach	Description
Alternative Payment Models (APM)	• Includes quality and/or outcome measures as a part of the reimbursement strategy
Social Determinants of Health and Independence	• Uses direct interventions that address social determinants that impact the overall health and well-being of members and result in decreased medical expenditures
Behavioral Health Services	• Reduces total cost of care, addresses gaps and improvement in access to services, quality of providers, incentives for transitions from institutions to community based programs and services, seamless follow-up care, diversion from institutions, and reduces inpatient admissions
Long-Term Supports and Services (LTSS)	• Addresses gaps and improvement in access to services, quality of providers, incentives for transitions from institutions to community based programs and services, reductions in reliance of institutions for treatment, ensuring choice of in-home versus residential services
Physical and Behavioral Health Integration Strategies	• Identifies, treats, and transitions members to appropriate behavioral health services and providers when presenting at the hospital with an emergent medical condition
Telehealth Projects	• Uses telemedicine, telemonitoring, and telementoring to enhance access to services for rural areas, access to behavioral health services, and support chronic pain management interventions

The State will make available the registries, tools, and resources to the MCOs to assist in the implementation of value-based purchasing models targeting providers. Some of these resources will include:

- Defined condition registries currently under consideration for inclusion by the State in its KMMS development,
- Reports available through the State enterprise data warehouse,
- Public health registries,
- Health information exchanges (HIE),
- Kansas Medical Assistance Program (KMAP) website containing updated eligibility information, and
- KMAP provider registry.

The second value-based model and purchasing strategy will continue the P4P program, rewarding MCOs that meet measures and targets under KanCare 2.0 goals. The basis behind the P4P program is a payment withhold, where the State withholds a portion of the payments due to MCOs each month. At the end of the year, the State assesses whether or not each MCO has met the required performance targets and distributes or withholds payments based on level of achievement. The State aims to improve health care quality and reduce costs by holding MCOs accountable to outcomes and performance measures and tying measures to meaningful financial incentives. Example monetary incentives and penalties include:

- A percent of total payments used as performance incentives to motivate continuous quality improvement, and
- Penalties associated with low quality and insufficient reporting.

Quality Improvement

The State will update its Quality Strategy to incorporate performance measures and reporting to support KanCare 2.0 initiatives, and will include a variety of performance measures derived from sources such as the Healthcare Effectiveness Data and Information Set® (HEDIS®), Consumer Assessment of Healthcare Providers and Systems® (CAHPS®), and a survey of KanCare members receiving mental health services. Quality assessments and performance improvement programs will continue to include performance improvement projects (PIP) that focus on clinical and non-clinical areas.

The State will require MCOs to implement at least three clinical and two non-clinical PIPs. Clinical PIPs may include, but are not limited to projects focusing on prevention and care of acute and chronic conditions, high-risk populations, high-volume services, high-risk services, and continuity and coordination of care. Non-clinical PIPs may include, but are not limited to projects focusing on availability, accessibility, and cultural competency of services, claims payment timeliness, interpersonal aspects of care, grievances and appeals, and other complaints. Each of the PIPs will have benchmarks and achievable performance goals. The State may link PIP outcome requirements to P4P indicators in efforts to hold MCOs accountable for improvement standards.

Use of Data to Drive Quality Improvement

The State will continue to require each MCO to submit reports for all KanCare populations and identify key metrics to drive program improvement, which we describe in more detail in Section IV, Quality Reporting Summary. Additionally, the State will conduct its own analysis of MCO claims data and work with each individual MCO to strengthen network adequacy and improve quality of care.

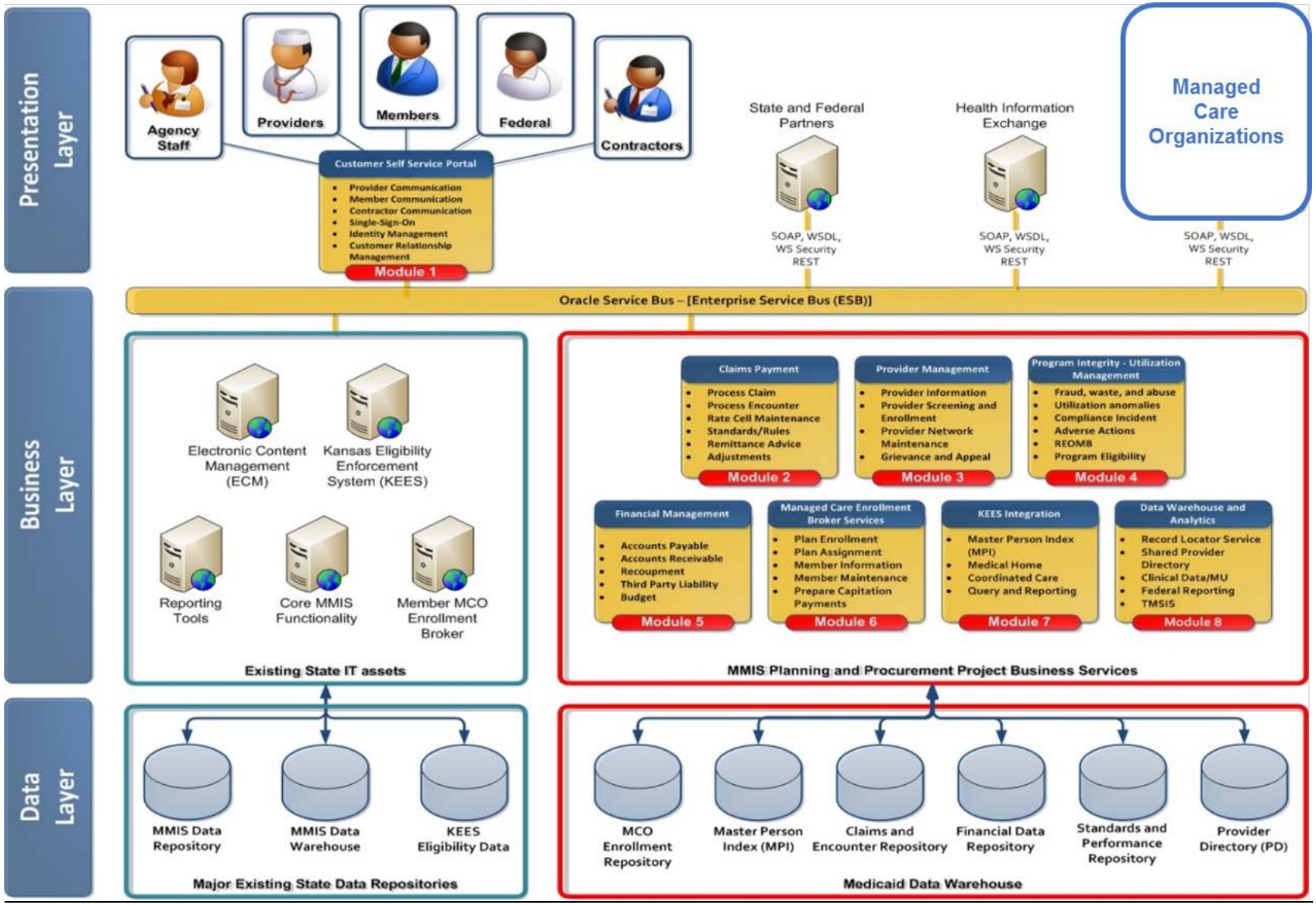
Under KanCare 2.0, the State will continue its current strategies for data collection and use of data to drive quality improvement. The State is in the process of enhancing its data analytics capabilities to streamline all data sources into one central location for a more comprehensive review of MCO performance. The new Kansas Modular Medicaid System (KMMS) will be based on Medicaid Information Technology Architecture (MITA) 3.0 standards. KMMS will allow the State to evaluate MCO performance against benchmarks and trend MCO data over time, providing a more robust analysis to all stakeholders regarding the performance of the KanCare program.

KMMS is a service-oriented architecture platform with transactions brokered through an enterprise service bus (ESB) operating in a virtual private cloud, making data more accessible to the State and MCOs. KMMS includes eight modules:

1. Customer Self Service Portal
2. Claims Payment/Encounter Processing
3. Provider Management
4. Program Integrity/Utilization Management
5. Financial Management
6. Managed Care Enrollment Broker Services
7. Kansas Eligibility Enforcement System Integration
8. Data Warehouse and Analytics

KMMS facilitates innovative collaborations by connecting modules across agencies for better monitoring and oversight. It allows individual and population needs to be assessed holistically, and not only programmatically. KMMS provides a 360-degree view of a member's care and plan of service or PCSP to identify where improved coordination and integration of services is needed. Data is collected from various sources for State, federal, health information exchange (HIE), and MCO use. KMMS will allow the State to move from a disparate set of systems to an integrated system architecture with modules linking member and provider data within the Medicaid data warehouse, as shown in the figure on the next page.

Figure 11. Medicaid Enterprise Diagram



Safety Net Pools

DSRIP History

The State operates a DSRIP Pool authorized under the current KanCare demonstration, which aims to advance the goals of access to services and healthy living by focusing on projects that increase access to integrated delivery systems and expand successful models for prevention and management of chronic and complex diseases. Two hospitals are eligible to participate in the DSRIP program: The University of Kansas Hospital and Children's Mercy Hospital.

Each hospital was required to implement at least two projects from the following list:

- Access to integrated delivery systems
    - Expansion of Patient Centered Medical Homes (PCMH) and Neighborhoods
- Prevention and management of chronic and complex diseases
    - Self-Management and Care/Resiliency
    - HeartSafe Community
    - Improving Coordinated Care for Medically Complex Patients
    - Statewide Expansion of Sepsis Early-Warning and Escalation Process

For each selected project, each hospital was required to create a Hospital DSRIP Plan, which was approved by CMS and the State.

The University of Kansas Hospital is engaged in two DSRIP projects:

- ***STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis.*** The objective of this project is to expand internal quality programs to reduce the prevalence of sepsis in rural nursing facilities and hospitals in Kansas.
- ***Supporting Personal Accountability and Resiliency for Chronic Conditions.*** The objective of this project is to improve heart failure patients' ability to self-manage their condition.

Children's Mercy Hospital is also engaged in two DSRIP projects:

- ***Expansion of PCMH and Neighborhoods.*** The objective of this project is to promote PCMH to improve pediatric primary care in Kansas, including increasing access to primary care services and the use of health information technology.
- ***Improving Coordinated Care for Medically Complex Patients.*** The objective of this project is to improve care coordination and provide primary care provider consultations for children living in rural areas.

To date, these DSRIP projects have achieved key measurable outcomes for the target populations, including a reduction in the number of septic patients transferred to a higher-level facility, reduction in the patient-reported heart failure admission rate, increased percentage of adolescent patients that receive well-care visits, and increased immunization rates for patients diagnosed with asthma.[8]

[8] 2016 Delivery System Reform Incentive Payment Pool (DSRIP) Hospitals Annual Report Prepared for KanCare (February 28, 2017).

In demonstration year (DY) 3 and DY 4, the KanCare DSRIP program paid $22,848,750 to eligible providers related to specific performance metrics associated with the DSRIP projects.[9] Providers will be eligible to receive an additional $30,000,000 in DY 5, and the State's one-year waiver extension application includes $30,000,000 in DSRIP funding for DY 6.

DSRIP Under KanCare 2.0

Under the KanCare 2.0 demonstration, the State proposes to extend the DSRIP program by two additional years, through December 31, 2020 (DY 7 and DY 8). For each additional year, the State proposes annual DSRIP funding of $30,000,000. During this two-year period, the current DSRIP providers, The University of Kansas Hospital and Children's Mercy Hospital, will continue their current DSRIP projects. The State intends to continue the momentum with these DSRIP projects, while leveraging the infrastructure and processes that have been set up by the State and the participating hospitals to maximize results.

Because a number of the population-focused metrics across the four DSRIP projects are based on HEDIS® metrics, the cycle to obtain and evaluate data follows a longer trajectory (e.g., due to data collection and validation), particularly since it can take years to realize improvements in quality and outcome metrics and achieve a return on investment. Therefore, extending the DSRIP program through December 31, 2020 will provide the State the opportunity to have a more complete picture of DSRIP program performance and accomplishments. It will also allow each hospital to build upon the successes they have achieved to date, and increase the impact of their selected projects.

For the two-year DSRIP extension period, the State will review the current DSRIP metrics used to evaluate project performance and examine whether any of the metrics should be modified to create a stronger link between payment and performance and increase the accountability of the participating providers. The State will also consider introducing additional project metrics that better reflect the more advanced implementation stage of the DSRIP projects, and incorporate lessons learned from data collection exercises to date.

The State will also use the two-year DSRIP extension period to design and implement an APM approach that will replace the DSRIP program beginning in January 2021. APMs are one of the value-based model and purchasing strategies listed in Figure 10 that the State expects MCOs to continue to employ under KanCare 2.0. The transition from the DSRIP model to the APM approach will shift reporting from DSRIP project-based metrics to APM provider-based quality and outcome metrics. Similar to the DSRIP program, the APM approach will require that providers meet or exceed pre-determined quality and outcome improvements to receive incentive payments.

The State will designate additional funding for MCO capitation payments to be used as APM incentive payments, under which MCOs will make additional payments to qualifying providers for meeting or exceeding the pre-determined quality and outcome improvement benchmarks. It is also anticipated that additional providers beyond The University of Kansas Hospital and Children's Mercy Hospital will be eligible to participate in these APMs.

The State will define in its contracts with MCOs the additional requirements necessary to execute APMs with specified groups of providers. The State will use the period through Summer 2020 to

[9] Evaluation of Uncompensated Care Pool and Delivery System Reform Incentive Payment Program Funding for Kansas Medicaid 1115 Waiver. Prepared for Kansas Department of Health and Environment. (September 2017).

develop and finalize the roadmap and approach for these additional APMs, including defining the following:

- Types of APMs that the State will require MCOs to implement with contracted providers (e.g., pay-for-performance (P4P) arrangements),
- Performance measures and related benchmarks to evaluate value and outcomes,
- Terms of performance for participation and measurement periods,
- Classes of providers eligible to participate in APMs,
- Total funds available for incentive payments to specified providers and methodology for disbursing those funds, and
- Plan for evaluating the impact of the APMs on the State's quality objectives.

In developing the design for the DSRIP replacement, the State will work closely with CMS and will seek input from key stakeholders. The State will consider the lessons learned from the current DSRIP program, including data collection and reporting practices, and intends to align performance measures with KanCare 2.0 objectives.

UC Pool

The original KanCare demonstration included a UC Pool. Historically, the UC Pool consisted of two sub-pools, the HCAIP and the LPTH/BCCH Pool. The objective of the UC Pool was to provide payments to hospitals to defray hospital costs of uncompensated care provided to Medicaid-eligible or uninsured individuals.

Under KanCare 2.0, the State will maintain the HCAIP Pool for the five-year KanCare 2.0 demonstration period. The State proposes to increase the size of the Pool by $20 million each year, for a total of $61 million annually. The increase in the Pool amount will allow both of the hospitals currently in the HCAIP Pool plus critical access hospitals to benefit from the UC Pool helping defray their uncompensated care costs. It is important that this Pool continues in order to help mitigate uncompensated care costs and support access to care among vulnerable populations, including those served by critical access hospitals.

Under KanCare 2.0, the State proposes to maintain the LPTH/BCCH Pool for the five-year KanCare 2.0 demonstration period, at $9,856,550 each year.

Improve Effectiveness and Efficiency of State Medicaid Program

The State contracts with multiple MCOs to provide services to KanCare members. Based on this program design, KanCare providers contracting with more than one MCO must understand each MCO's policies and procedures in key areas, such as prior authorizations, service coordination, and contracting and credentialing. The State understands that providers have expressed concerns with perceived administrative complexities built into the current KanCare program, most recently through KanCare public input sessions held in June 2017.

To improve administrative effectiveness and simplicity for both providers and members, KanCare 2.0 will improve the effectiveness and efficiency of the State's Medicaid program through the following methods:

- Alignment of MCO operations,
- Improved data analytics capabilities, and
- Member access to inpatient behavioral health services.

Alignment of MCO Operations

Medicaid providers spend a significant amount of time and resources understanding, complying with, and executing each MCO's individual processes for credentialing, service coordination, utilization management, and grievances and appeals, among others. Although MCOs make every effort to simplify their processes, interfacing with multiple MCOs in lieu of the single state Medicaid agency presents some additional administrative burden for providers.

With the goal of enhancing the member and provider experience, the State will establish standardized tools and processes across MCOs to reduce the challenges providers face in contracting with multiple MCOs. Some of these areas may include:

- **Health screenings:** MCOs must conduct initial health screenings for all members using a State-developed health screening and algorithm. MCOs will store health screening data within a centralized information system that will be capable of interfacing with KMMS.

- **Health risk assessment tool tailored with sections for specific populations:** Contracted MCOs will use the State-prescribed tool for the assessment of behavioral health needs and for each waiver program for the assessment of HCBS needs.

- **Prior authorizations for selected services:** MCOs will use the State's preferred drug list to authorize the use of prescription drugs. MCOs will also have the capability for providers to submit prior authorizations electronically by July 2019.

- **Grievances and appeals:** Contracted MCOs will use the same grievance and appeals process for members and providers.

- **Provider credentialing:** KanCare 2.0 will implement a standardized provider application and enrollment process for all providers applying for network status. The State will eventually automate this process to streamline credentialing activities for providers, allow for more accurate tracking of the enrollment application process, and permit monitoring of time frames for MCOs to complete provider credentialing activities.

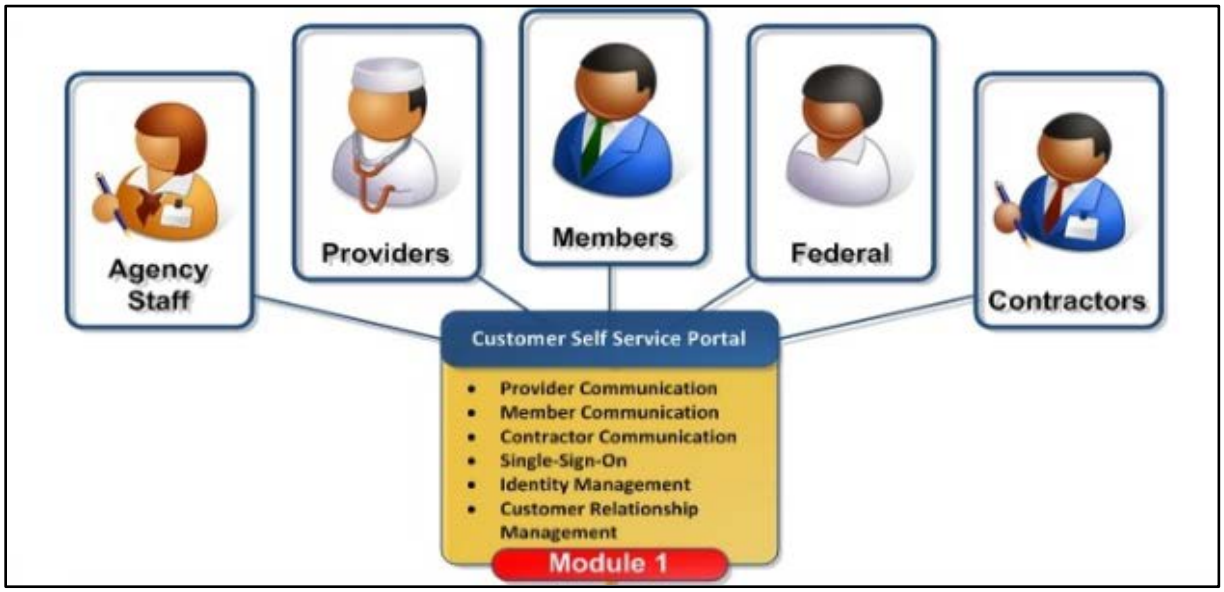
The State's intention through these efforts is to reduce member and provider administrative burden and ultimately support MCO provider network recruitment and retention efforts and allow providers to focus more on patient care.

Data Analytics Capabilities

The State is in the process of implementing the new KMMS, a new information technology infrastructure which will allow the State to better connect with each other and with other state agencies and organizations to share information, including data to support initiatives addressing social determinants of health and independence.

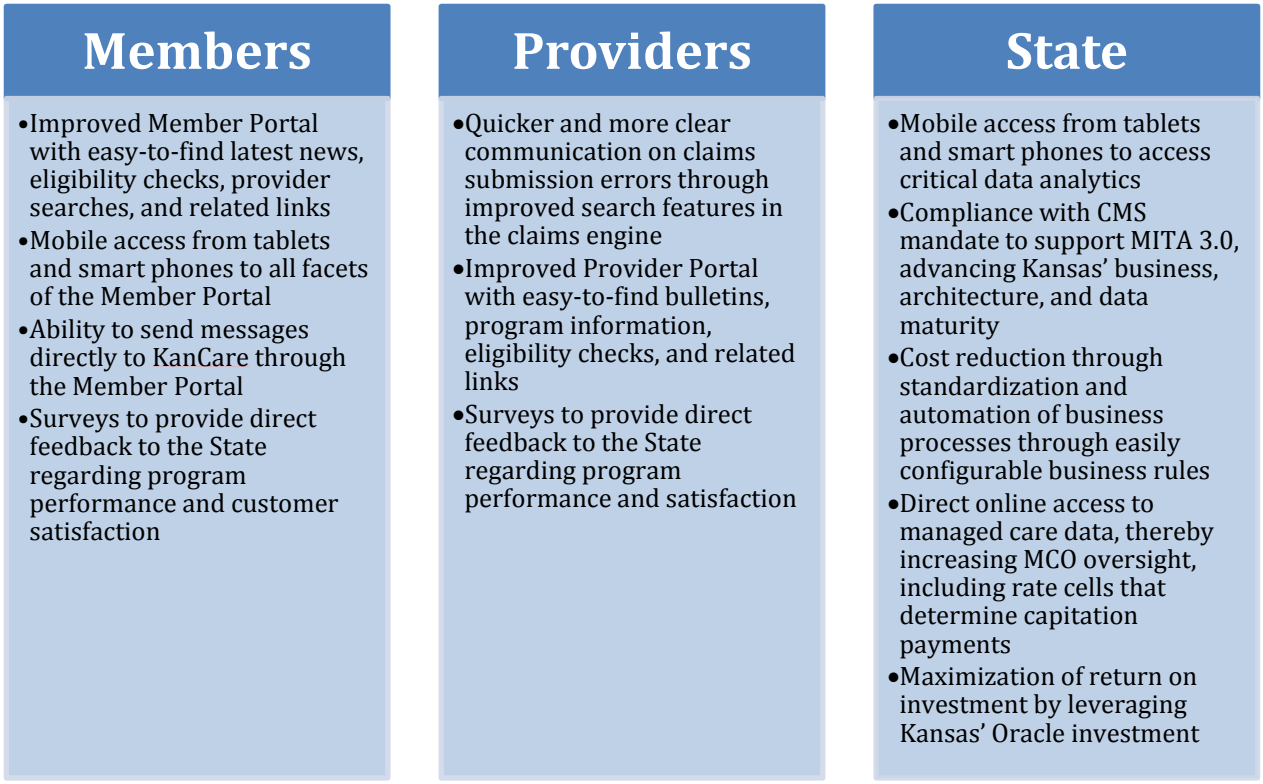
KMMS will provide a 360-degree view of a Medicaid beneficiary to meet that individual's needs holistically and address social determinants of health and independence. KMMS will collect a wide range of information not available currently, such as the results of the functional assessment for HCBS waiver programs. As a result, KMMS will facilitate increased and improved service coordination and integration of services by breaking down silos of behavioral and physical health, and agencies and organizations.

Figure 12. KMMS Customer Service Portal



KMMS will provide an enhanced user approach to members, providers, and the State, shown in the figure below.

Figure 13. Enhanced User Experience



Member Access to Inpatient Behavioral Health Services

CMS's July 2016 regulation (Federal Rule 42 C.F.R. 438.6(e) as amended) prohibits the State from claiming federal financial participation for a monthly payment made by the State to a member's MCO responsible for all care of the member when the member's stay in an Institution for Mental Disease (IMD) is longer than 15 days during any given month. This exclusion causes a loss of Medicaid coverage for members requiring inpatient psychiatric care and limits provider innovation.

The State is seeking a waiver of this authority to provide coverage under KanCare 2.0 for otherwise-covered services provided to Medicaid-eligible individuals aged 21 through 64 who are enrolled in a Medicaid MCO and who are receiving services in a publicly-owned or non-public IMD.

III. Requested Waiver and Expenditure Authorities

The State is requesting all of the same waiver and expenditure authorities as those approved in the current demonstration, which are restated below. The State is also requesting a new waiver authority related to eligibility and new waiver expenditure authority for Institutions for Mental Disease.

Waiver Authorities

1. **Amount, Duration, and Scope of Services – Section 1902(a)(10)(B)**

To the extent necessary to enable Kansas to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, by providing additional services to individuals who are enrollees in certain managed care arrangements.

2. **Freedom of Choice – Section 1902(a)(23)(A)**

To the extent necessary to enable Kansas to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services. No waiver of freedom of choice is authorized for family planning providers.

3. **Eligibility – Section 1902(a)(10)(A)**

State requests new authority to require able-bodied KanCare 2.0 adults, as a condition of eligibility, to meet work requirements.

Expenditure Authorities

Service-Related Expenditures

1. **Expenditures for Additional Services for Individuals with Behavioral Health or Substance Use Disorder Needs**

Expenditures for the following services furnished to individuals eligible under the approved State Plan and concurrent 1915(c) waivers, pursuant to the limitations and qualifications provided in STC 22 to address behavioral health and SUD needs:

- Physician Consultation (Case Conferences),
- Personal Care Services, and
- Rehabilitation Services.

2. **Expenditures for Institution for Mental Disease (IMD)**

State requests new expenditure authority for otherwise-covered services provided to Medicaid-eligible individuals aged 21 through 64 years who are enrolled in a Medicaid managed care organization and who are receiving services in a publicly-owned or non-public IMD.

Safety Net Care Pool (SNCP) Expenditures

Expenditures for the following categories of expenditures, subject to overall SNCP limits and category-specific limits set forth in the STCs.

1. **Uncompensated Care Pool**

Pursuant to STC 68, expenditures for payments to hospitals to defray hospital costs of uncompensated care furnished to Medicaid-eligible or uninsured individuals that meets the definition of "medical assistance" under section 1905(a) of the Act, to the extent that such costs exceed the amounts received by the hospital pursuant to 1923 of the Act.

2. **Delivery System Reform Incentive Payment Program**

Expenditures from Pool funds for the DSRIP Program, pursuant to STC 69, for incentive payments to hospitals for the development and implementation of approved programs that support hospital efforts to enhance access to health care and improve the quality of care. DSRIP incentive payments are not direct reimbursement for service delivery, and may not duplicate other federal funding. The State requests this expenditure authority for DY 7 and DY 8.

IV. Quality Reporting Summary

The State contracts with the Kansas Foundation for Medical Care (KFMC) to develop external quality review organization (EQRO) reports. Covered topics may include:

- Performance measure validation,
- Performance improvement project (PIP) validation,
- Balanced Budget Act (BBA) compliance review, and
- Survey validation, including the Mental Health Survey and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®).

Quality reporting topics will remain similar under KanCare 2.0. However, the State will update measures, surveys, and compliance review areas to reflect KanCare 2.0 priorities and goals.

Performance Measures

The State relies on various types of quantitative performance measure reports using medical/case record information, which include the following:

- HEDIS®,
- Mental health measures, including Serious Emotional Disturbance (SED) waiver reports and National Outcome Measures,
- Nursing facility measures,
- Substance use disorder (SUD) measures,
- HCBS waiver reports,
- Case record reviews,
- Access reports, and
- Financial reports.

Kansas evaluates MCO performance on HEDIS® measures on an annual basis, and compares MCO performance to national benchmarks. HEDIS® is a tool used by most health plans to measure performance on important dimensions of care and service. MCOs will include performance measure requirements for medical, behavioral health and LTSS in the quality assessment and performance

improvement methodology. See Appendix B for more detailed information on statewide HEDIS® performance from CY 2013 – CY 2015.

The Final Evaluation Design for the current KanCare demonstration is available at: https://www.kancare.ks.gov/docs/default-source/policies-and-reports/quality-measurement/kancare-final-evaluation-design-march-2015.pdf?sfvrsn=2.

Performance Improvement Projects

To achieve safe, effective, patient centered, timely, and equitable care, the State encourages MCOs to develop and implement PIPs that focus on assessing the impact of improvement initiatives on health outcomes or quality of care. Two of the three KanCare MCOs – Amerigroup and UnitedHealthcare - initiated PIPs in July 2013, followed by Sunflower in January 2014. The current collaborative PIP started in August 2016, focusing upon the HEDIS® measure for Human Papillomavirus vaccination.

Amerigroup, Sunflower, and UnitedHealthcare are completing the following individual PIPs:

- Amerigroup chose to improve well-child visit rates in the third, fourth, fifth and sixth years of life.
- UnitedHealthcare chose to improve follow-up after hospitalization for mental illness.
- Sunflower chose to increase the rate of initiation and engagement of alcohol and other drug dependence treatment.

The State reviews all PIP methodology and revises it to ensure clear interventions, outcomes, tracking, and measurement methods are identified. Representatives of each MCO report PIP progress at regular KanCare interagency meetings. Written updates are also provided post-implementation of each PIP. MCOs must also submit monthly PIP progress reports, including how lessons learned will be used to improve the outcomes of PIPs. Under KanCare 2.0, the State will continue to support MCOs in attaining PIP results. Each PIP will utilize principles of rapid cycle process improvement and be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and will include some of the following elements:

- Measurement of performance using objective quality indicators,
- Implementation of interventions to achieve improvement in the access and quality of care,
- Evaluation of the effectiveness of interventions based on established performance measures, and
- Planning and initiation of activities for increasing or sustaining improvement.

Balanced Budget Act Compliance Review

On an ongoing basis and as part of the State's readiness review process, the State assesses MCO compliance with managed care-related federal regulations associated with the Balanced Budget Act (BBA) including:

- Enrollee rights and protections;
- Quality assessment and performance improvement, including:
    - Access standards,
    - Structure and operation standards,
    - Measurement and improvement standards; and
- Grievance system.

Within the regulatory areas there are approximately 312 individual requirements for which the MCOs will submit supporting evidence and documentation to demonstrate compliance with the federal regulations and state contract requirements. For each MCO, the State reviews approximately 60 cases for provider credentialing (including individual, institutional, initial credentialing, recredentialing, and denied credentialing) and 300 cases for physical health records, behavioral health records, grievances, appeals, and denied claims.

KFMC conducted full reviews in 2013 and 2016. In 2014 and 2015, KFMC reviewed and reported on MCO follow-up efforts to address recommendations made in the full review. MCOs' overall compliance ratings from the 2013 full review, and follow-up improvements from 2014 and 2015 were:

- **Amerigroup:** 82% Fully Met, 15% Substantially Met, 3% Partially Met, 1% Minimally Met, and 0% Not Met. (Of 71 areas identified for improvement in the 2013 full review, Amerigroup brought 92% into full or substantial compliance.)

- **UnitedHealthcare:** 76% Fully Met, 16% Substantially Met, 5% Partially Met, 3% Minimally Met, and 0% Not Met. (Of 100 areas identified for improvement in the 2013 full review, UnitedHealthcare brought 98% into full or substantial compliance.)

- **Sunflower:** 69% Fully Met, 24% Substantially Met, 4% Partially Met, 2% Minimally Met, and 1% Not Met. (Of 151 areas identified for improvement in the 2013 full review, Sunflower brought 93% areas into full or substantial compliance.)

Section VII, Compliance with STCs, further describes the State's efforts to continue to improve its MCO oversight based on analysis of MCOs' submitted data, and to apply this information in decision making at the programmatic level.

Under KanCare 2.0, the State will continue to review compliance with the BBA on an ongoing basis and during readiness reviews.

Mental Health Survey

Since 2010, the State has administered and analyzed results of surveys of Kansas Medicaid members receiving mental health services. Survey results are reported by adults, youth (family members completing the survey, with separate questions completed by youth ages 12-17), and youth and young adults receiving SED Waiver services. The State analyzes survey results annually for statistical significance and to identify trends over time, including comparison of survey results in 2011 and 2012 (pre-KanCare) with current survey results. Members have consistently expressed high levels of satisfaction with services provided in both pre-KanCare and KanCare years. Questions are related to the perception of care coordination for members receiving mental health services. See Appendix C for detailed survey results.

KanCare 2.0 will continue its efforts to ensure high level of quality of care in mental health services. In addition to continuing administration of a survey to assess feedback from members receiving mental health services, MCOs will develop and implement a comprehensive service coordination program that emphasizes the integration of treatment for co-occurring mental health and SUDs. The State will develop time and distance standards and timeframes to receive mental health services, and ensure MCOs maintain a comprehensive behavioral health crisis response network.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey

CAHPS® is a survey tool developed to assess consumer satisfaction and member experiences with their health plan. It is a nationally standardized survey tool sponsored by the Agency for Health Care Research and Quality (AHRQ), and co-developed with National Committee for Quality Assurance (NCQA). The survey measures how well MCOs are meeting their members' expectations and goals to determine which areas of service have the greatest effect on members' overall satisfaction and to identify areas for improvement which could aid plans in increasing the quality of care provided to members. Detailed specifications are provided by NCQA to be used by health plans in conducting the survey. In order for a health plan's CAHPS® survey to be a dependable source of information, it must be administered according to the published CAHPS® technical specifications.

When administered properly, CAHPS® surveys provide information regarding the access, timeliness and/or quality of health care services provided to health care consumers. Since the launch of KanCare in January of 2013, KanCare MCOs have conducted CAHPS® surveys annually and have them validated by KFMC. KanCare members rate their experiences positively with key aspects of KanCare services, which ranked above 2016 national benchmarks. The figure below highlights select survey responses over the past three years from across all population members that rated their satisfaction with a 9 or 10, in a scale that ranged 0-10. See Appendix D for detailed CAHPS® survey quality of care results.

Figure 14. KanCare CAHPS® Results

	Adult			General Child			Children with Chronic Conditions		
Measure ***(Scale of 0-10, Responses of 9, 10)***	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**
Rating of Health Care	53%	51%	54%	69%	69%	71%	65%	65%	66%
Rating of Personal Doctor	64%	67%	68%	73%	73%	76%	72%	73%	74%
Rating of Specialist	65%	66%	67%	70%	69%	70%	69%	68%	73%
Rating of Health Plan	55%	58%	61%	71%	72%	74%	63%	67%	67%

The State will continue to use CAHPS® surveys in KanCare 2.0 as an integral instrument for assessing consumer satisfaction and KanCare member experiences.

MCO and State Quality Assurance Reporting

The State requires MCOs to submit a number of reports and facilitates monthly meetings with each MCO to discuss operational issues, data discrepancies, and areas for MCO improvement. Below, we summarize selected aspects of MCO reporting. For more information, please see KanCare quarterly and annual reports, which further highlight successes and areas for improvement in the KanCare program. These reports are available at the following webpage: http://www.kancare.ks.gov/policies-and-reports/annual-and-quarterly-reports.

Section VII, Compliance with STCs, further describes the State's efforts to continue to improve its MCO oversight based on analysis of MCOs' submitted data and to apply this information in decision making at the programmatic level.

KanCare 2.0 will continue to collect monthly, quarterly, and annual reports from MCOs to confirm compliance with State requirements and to identify areas for program improvement, lessons learned, and promising practices.

Utilization

The State measures utilization of different services, such as preventive/ambulatory health services, dental visits, and emergency department visits. KanCare places a greater emphasis on health, wellness, prevention, earlier detection, and earlier intervention with members. Under the current KanCare demonstration, the frequency of inpatient services, nursing home stays, and outpatient emergency room treatment declined. This is partly attributed to the upward movement of the community-based, local, outpatient office visits and ancillary services that KanCare provides to members. The figure below compares utilization data from KanCare DY 4 with pre-KanCare measurements.

Figure 15. KanCare Aggregate Utilization Report

Aggregate Utilization Report	Comparison of CY 2016 to CY 2012 (Pre-KanCare)
Type of Service	**% Difference**
Primary Care Physician	18%
Transportation	58%
Outpatient (Non-Emergency Room (ER))	10%
Inpatient	-30%
Emergency Room	-7%
Dental	25%
Pharmacy	2%
Vision	16%

Under KanCare 2.0, the State will continue to analyze and report utilization data for all MCOs, separately addressing physical health, behavioral health, nursing facility, and HCBS services by demonstration quarter. The State will continue to monitor and manage utilization, in effort to detect under-utilization, over-utilization, and mis-utilization and assess the quality and appropriateness of care furnished. Utilization reports are one component of the State's initiative to move toward the primary goal of controlling Medicaid costs by emphasizing health, wellness, prevention, and early detection.

Network Adequacy

The State evaluates recruitment and retention of network providers through MCOs' monthly submission of GeoAccess reports that identify gaps in coverage. MCOs also report strategies for

closing any gaps in coverage. The following table presents the average number of unique contracting providers under each MCO since 2014.

Figure 16. Average Number of Unique Providers Enrolled in KanCare by Year and MCO

KanCare MCO	Average # of Unique Providers in 2014	Average # of Unique Providers in 2015	Average # of Unique Providers in 2016
Amerigroup	14,200	14,918	16,430
Sunflower	17,007	19,912	20,790
UnitedHealthcare	19,752	19,245	22,881

Providers for the figure above were de-duplicated by National Provider Identifier; however, the table does not account for providers covering multiple specialties or areas. In addition to continuing to recruit pre-KanCare Medicaid providers and any newly identified providers, the MCOs have demonstrated their commitment to working with providers in adjacent cities and counties in adjacent states to provide services to members.

Under KanCare 2.0, MCOs will continue to develop, maintain, and monitor their network of providers. MCOs will report any gaps in network adequacy coverage (e.g., provider ratios, distance and time standards, appointment availability, timely access, etc.) each month, using Geo Access Reports and other provider network reports. Both the State and MCOs will perform analyses of network adequacy data with the goal of offering members a choice of providers to the extent possible and ensuring covered services are reasonably accessible. See Section VII, Compliance with Special Terms and Conditions for additional steps the State is taking under the current KanCare demonstration to improve network adequacy.

Dental Care

KanCare and partner agencies emphasize the importance of regular dental care for members and are committed to increasing utilization of these important services. Dental services data show significant improvement from 2014 to 2015, as illustrated in the figure below.

Figure 17. Total Eligibles Receiving Dental Services in 2014 to 2015

	SFY 2014	SFY 2015
Total eligible receiving dental treatment	125,413	129,720
Total eligible receiving preventative services	116,526	122,724

Under KanCare 2.0, the State will continue to collaborate with MCOs in increasing dental health and wellness service utilization. The State will monitor dental services through HEDIS® measures and Geo Access Reports. KanCare 2.0 aims to close gaps in access to dental primary care for members in frontier, rural, or densely-settled rural counties.

MCO Financial Performance

MCOs are responsible for monthly, quarterly, and annual financial reports, and must report any profits. As of December 31, 2016, all three MCOs are in a sound and solvent financial standing. All

three KanCare MCOs reported profits in 2016. Statutory filings for the KanCare MCOs are available on the National Association of Insurance Commissioner's (NAIC) "Company Search for Compliant and Financial Information" website: https://eapps.naic.org/cis/.

Under KanCare 2.0, the State will continue to submit financial reports and track medical loss ratio (MLR), detailing the percent of claims incurred related to activities that improve health care quality and fraud prevention. MCOs will owe remittance for the difference between the MLR for the reporting year and the minimum MLR percentage of 85 percent.

KanCare MCO Contract Annual Audit Process

In addition to routine ongoing monitoring activities, the State and KFMC conduct an MCO contract review process each year. One of the purposes of the audit process is to evaluate compliance with State contract requirements and MCO policies and procedures that the State has previously approved. The State and KFMC conduct planning meetings to prepare for the reviews and establish the desk review and on-site review tools. The MCOs submit documentation prior to the desk and on-site reviews. For the on-site review, a three-day time block is scheduled with each MCO. Examples of focus areas for the on-site review include appeals, grievances, finance, coordination of care, customer service, and provider credentialing. Following the conclusion of the desk and on-site reviews, the State works with KFMC to develop an executive report and individual reports for each MCO.

V. Financial Data

Kansas does not anticipate a significant change in enrollment or aggregated expenditure trends for the renewal period. The following table summarizes the annual enrollment and aggregated expenditures for KanCare, by demonstration year (DY). Kansas projects continued savings under the KanCare program as compared to the absence of the KanCare program.

Appendix E includes required financing and budget neutrality forms. Appendix F includes the budget neutrality workbook.

Figure 18. Projected KanCare 2.0 Enrollment and Expenditures*

	DY1 (actual)	DY2 (actual)	DY3 (actual)	DY4 (actual)	DY5 (projected)	DY6 (projected)
Total Member Months	3,954,724	4,206,474	4,240,388	4,553,224	4,373,929	4,383,052
Total Expenditures	$ 2,614,464,846	$ 2,837,185,334	$ 3,066,579,865	$ 3,212,952,243	$ 3,179,290,798	$ 3,577,978,363
	DY7 (projected)	**DY8 (projected)**	**DY9 (projected)**	**DY10 (projected)**	**DY11 (projected)**	
Total Member Months	4,469,538	4,558,290	4,649,371	4,742,845	4,838,778	
Total Expenditures	$ 3,827,708,851	$ 4,058,572,138	$ 4,282,596,858	$ 4,520,616,672	$ 4,773,562,737	

*Notes:

1. The State updated member month enrollment from prior demonstration years to reflect retroactive membership. As a result, enrollment may vary slightly from previous submissions to CMS.
2. The State updated prior total expenditure amounts submitted to CMS. Specifically:
    a. DY1 (CY13) – DY6 (CY18) include Share of Cost to be consistent with the Without Waiver per member per month (PMPM) estimates, which also include Share of Cost.
    b. The Health Insurer Provider Fee (HIPF) amounts are included for DY3 (CY15) and DY4 (CY16).
    c. Previously DY5 (CY17) and DY6 (CY18) were projected amounts. DY5 (CY17) includes the most recent actual expenditures, and DY6 (CY18) has been updated with the most recent capitation rates for that period.

VI. Evaluation Design

On April 26, 2013, Kansas submitted to CMS for approval a draft Evaluation Design for overall evaluation of the current KanCare demonstration. CMS provided comments on the draft KanCare Evaluation Design on June 25, 2013. After discussing the comments with CMS and gathering additional input from stakeholders, Kansas submitted the final KanCare Evaluation Design to CMS on August 24, 2013. CMS approved the KanCare Evaluation Design on September 11, 2013.

After submission of the Final KanCare Evaluation Design, Kansas began implementation as described in the approved document. Kansas contracted with KFMC to serve as the independent evaluator for the KanCare demonstration. Kansas has submitted updates on the progress related to the implementation design of the KanCare Evaluation Design in each of the quarterly and annual reports. Kansas also submitted to CMS a revised KanCare Evaluation Design in March 2015, and CMS did not identify any concerns with this revised KanCare Evaluation Design. The approved Final Evaluation Design for the current KanCare demonstration is available at: https://www.kancare.ks.gov/docs/default-source/policies-and-reports/quality-measurement/kancare-final-evaluation-design-march-2015.pdf?sfvrsn=2.

The original goals of the KanCare demonstration focused on providing integrated, whole-person care, creating health homes, preserving or creating a path to independence, and establishing alternative access models with an emphasis on HCBS. Building on the success of KanCare, the goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by providing services and supports for social determinants of health and independence in addition to traditional Medicaid benefits. The State will modify and strengthen evaluation activities under KanCare 2.0 to measure progress in meeting this goal. The State will also prepare a detailed KanCare 2.0 Evaluation Design after receiving approval of the demonstration renewal application from CMS.

Below we summarize previous evaluation findings and our proposed approach for evaluation activities under KanCare 2.0.

Previous Evaluation Findings

In the KanCare annual and quarterly evaluation reports, KFMC, the State's external quality review organization, reports on performance metrics related to the following categories:

- Quality of care,
- Coordination of care and integration,
- Cost of care,
- Access to care, and
- Efficiency.

The evaluation reports also include findings regarding the UC and DSRIP Pools. Below, we include selected findings from the 2016 KanCare Evaluation Annual Report. See Appendix G for the full 2016 KanCare Evaluation Annual Report.

1. **Quality of Care:** The baseline data submitted by the MCOs, including results by age group, revealed a mixed performance with areas of strength, where performance metric results were above the 50th or 75th percentile nationwide, and several measures below the 50th percentile. Many of these low-performing metrics have been persistently low for several years. Quality of care in mental health and SUD services improved over the duration of the demonstration.

2. **Coordination of Care (and Integration):** Members receiving waiver services had more primary care and annual dental visits over the course of the demonstration. These members also decreased their count of emergency department visits.

3. **Cost of Care:** KanCare placed a greater emphasis on health, wellness, prevention, earlier detection and earlier intervention with members, which helped control Medicaid costs. Furthermore, the frequency of inpatient services, nursing home stays and outpatient emergency room treatment declined. This is partly attributed to the upward movement of the community-based, local, outpatient office visits and ancillary services that KanCare provides to members. The figure below compares utilization data from KanCare DY 4 with pre-KanCare data.

Figure 19. Comparison of KanCare Utilization Data

Aggregate Utilization Report	Comparison of Pre-Care to CY 2016
Type of Service	**% Difference Between CY 2012 and 2016**
Primary Care Physician	↑ +18%
Transportation	↑ +58%
Outpatient (Non-Emergency Room (ER))	↑ +10%
Inpatient	↓ -30%
Emergency Room	↓ -7%
Dental	↑ +25%
Pharmacy	↑ +2%
Vision	↑ +16%

4. **Access to Care:** As shown in Figure 16 under Section IV, Quality Reporting Summary, the average number of unique contracting providers under each MCO since 2014 has increased under KanCare.

   In addition to continuing to recruit pre-KanCare Medicaid providers and any newly identified providers, the MCOs have demonstrated their commitment to working with providers in cities and counties in adjacent states to provide services to members. In calendar year 2016, each of the KanCare MCOs achieved 100 percent of the required State behavioral health access standards for each county type:

   - Urban/semi-urban: One provider within 30 miles,
   - Densely-settled rural: One provider within 45 miles, and
   - Rural/frontier: One provider within 60 miles.

5. **Efficiency:** Emergency department visit rates for HCBS were much lower in 2013-2015 compared to rates in 2012 pre-KanCare. However, inpatient hospitalization rates were higher in 2015 for some waiver participants, including members who have I/DD, and lower for other waiver participants than inpatient admission rates in 2012, pre-KanCare.

The successes and accomplishments of the current KanCare demonstration serve as a foundation for KanCare 2.0. The State will modify and strengthen evaluation activities under KanCare 2.0 to build on lessons learned and address challenges.

Proposed KanCare 2.0 Evaluation Approach

Under KanCare 2.0, the KanCare Evaluation Design will utilize KMMS, discussed in more detail under Section II, Historical Narrative Summary of KanCare and Requested Changes, and continue to include quantitative and qualitative sources such as:

- Administrative data (e.g., financial data, claims, encounters, Automated Information Management Systems (AIMS)),
- Medical and case records, and
- Consumer and provider feedback (e.g., surveys, grievances, Ombudsman Reports).

Building on the original KanCare Evaluation Design, Kansas will test the hypotheses listed in the figure below under KanCare 2.0 while maintaining many of current evaluation measures. The figure also includes potential measures that the State may use to test the KanCare 2.0 hypotheses. However, the State will select and finalize specific measures to test under the KanCare 2.0 Evaluation Design after receiving approval of the demonstration renewal application from CMS. The State will work with other State agencies and stakeholders in developing the KanCare 2.0 Quality Strategy which will inform the KanCare 2.0 Evaluation Design.

Figure 20. Example Measures for KanCare 2.0 Evaluation

#	Example Measures	Applicable Population(s)*	Data Source
Hypothesis 1. Expanding service coordination to include assisting members with accessing affordable housing, food security, employment and other social determinants of health and independence will increase independence, stability and resilience and improve health outcomes.			
1.1	Percentage of members receiving service coordination who move from unemployed (actively seeking employment) to employed.	All KanCare members ages 18 and older receiving service coordination	Medical and Case Records; Administrative Data
1.2	Percentage of members receiving service coordination utilizing services (e.g., inpatient, ER, preventive) compared to members who are not receiving service coordination.	All KanCare members	Administrative Data; Medical and Case Records
1.3	Percentage of members who can perform instrumental activities of daily living (IADL) (e.g., meal preparation, taking prescribed medications, home maintenance) who are receiving service coordination to those who are not receiving service coordination.	HCBS waiver populations	Consumer and Provider Survey

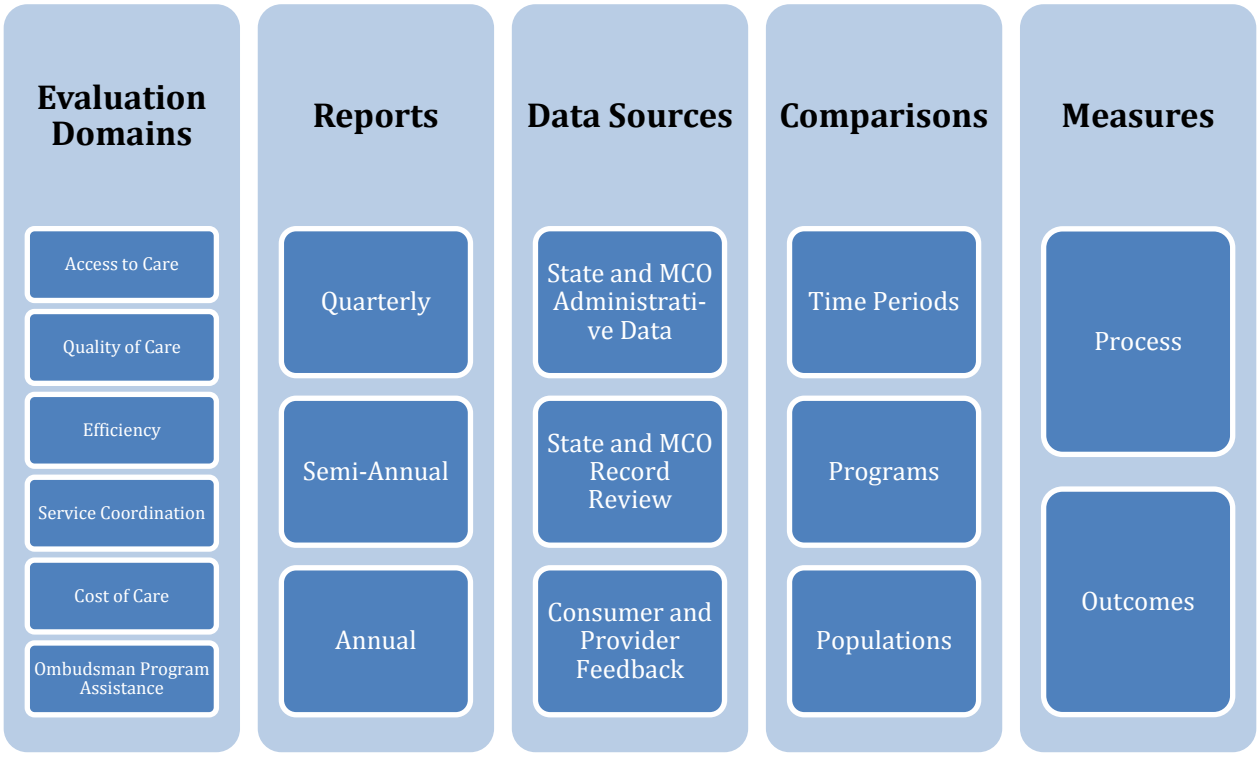
#	Example Measures	Applicable Population(s)*	Data Source
1.4	Percentage of members reporting the following: - As a direct result of services I received, I am better able to control my life. - As a direct result of services I received, I am better able to deal with crisis. - As a direct result of services I received, I am better able to do things that I want to do.	All KanCare members receiving behavioral health services	Consumer Survey
1.5	Percentage of deliveries that received a prenatal care visit in the first trimester.	Pregnant women	Administrative Data; Medical and Case Records
1.6	Percentage of members 3-6 years of age who had one or more well-child visits with a primary care provider (PCP).	Children ages 3-6	Administrative Data
Hypothesis 2. Increasing employment and independent living supports for members with behavioral health needs, or who have intellectual, developmental or physical disabilities or traumatic brain injuries will increase independence and improve health outcomes.			
2.1	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.	Members ages 12 years and older	Administrative Data; Medical and Case Records
2.2	Percentage of inpatient visits by members with behavioral health, I/DD, physical disability, SPMI, or TBI who are employed to those who are not employed.	All KanCare members who have a behavioral health diagnosis	Administrative Data; Medical and Case Records
2.3	Percentage of KanCare members, receiving HCBS PD, I/DD, or TBI waiver services eligible for the WORK program who have increased competitive employment.	HCBS waiver population	Medical and Case Records; Consumer Survey
2.4	Percentage of KanCare members who report: - Having a place to live that is comfortable for them - Having a job or volunteer opportunities - Having a job they want	All KanCare members	Consumer Survey

#	Example Measures	Applicable Population(s)*	Data Source
Hypothesis 3. Providing service coordination for all youth in foster care will decrease the number of placements, reduce psychotropic medication use, and improve health outcomes for these youths.			
3.1	Percentage of youths in foster care obtaining permanency (e.g., guardianship, adoption, kinship, etc.).	Children in foster care	Administrative Data
3.2	Percentage of foster care members receiving an antipsychotic medication *without* evidence of a psychotic disorder or related condition.	Children in foster care	Administrative Data; Medical and Case Records
3.3	Percentage of foster care members receiving an antipsychotic medication *with* evidence of a psychotic disorder or related condition.	Children in foster care	Administrative Data; Medical and Case Records
*The State will track measures by subpopulation (e.g., adults, children, pregnant women, children in foster care, HCBS waiver population) as appropriate.			

Evaluation Components

KanCare 2.0 evaluation components will continue to consider a number of evaluation designs, reports, data sources, comparisons, and measures, as shown in the figure below.

Figure 21. KanCare 2.0 Evaluation Activities



The reports and data sources also consist of elements that are quantitative and qualitative in nature, to provide the State and KFMC a wide range of information to be considered as part of the overall evaluation. These quantitative and qualitative elements include those in the figure below and will pertain to all KanCare members.

Figure 22. Quantitative and Qualitative Reports

Report Type	Elements
Quantitative	• HEDIS®; • Mental Health measures, including Serious Emotional Disturbance (SED) Waiver reports and National Outcome Measures; • Nursing Facility measures; • Substance Use Disorder (SUD) measures; • HCBS Waiver reports; • Case Record reviews; • Access reports; and • Financial reports.
Qualitative	• CAHPS®; • Mental Health Statistical Improvement Program consumer survey; • SUD consumer survey; • Provider survey; • Kansas Client Placement Criteria database, which contains member self-reported data; • Automated Information Management System database, which includes some self-reported data; • Care manager feedback and surveys; and • Grievance reports.

VII. Compliance with Special Terms and Conditions

Kansas has successfully completed, or discussed with CMS modified due dates, for the deliverables required by the current KanCare demonstration STCs. In a letter dated January 13, 2017, CMS identified needed improvements in KanCare program implementation. Kansas has developed correction action plans corresponding to CMS' findings and continues to work diligently to assure compliance with all STCs.

During the current demonstration period, Kansas implemented changes to comply with modifications in such requirements, including the *Affordable Care Act* and the *Medicaid and CHIP Managed Care Final Rule* as published in the Federal Register on April 25, 2016. Under KanCare 2.0, the State will continue compliance with these STCs and others as required by CMS.

KanCare Demonstration Benefits and Coordination

KanCare maintains benefits that were available before implementation of the current KanCare demonstration in at least the same amount, duration, and scope that services are provided in the State Plan. MCOs also offer value-added benefits at no cost to the State.

MCOs are contractually responsible for the management, coordination, and continuity of care for all members and are additionally required to maintain policies and procedures to address this responsibility. MCOs must also coordinate access to needed services excluded from KanCare and

make every effort to permit members to continue, if they so desire, with previously established providers who meet the same qualifications and financial agreements as others in the network.

Compliance with DSRIP and UC Pool Terms

The Kansas DSRIP projects were originally planned to be implemented as four-year projects from 2014 through 2017. In 2013, the State amended the 1115 demonstration to change the projects to begin in 2015. Then in 2017, the State received approval to extend the projects through December 21, 2018.

Kansas has implemented the following under the current waiver demonstration:

- The University of Kansas Hospital and Children's Mercy Hospital and Clinics are eligible to participate in the DSRIP program.
- Kansas convened the Healthy Kansas 2020 Steering Committee to receive input on the proposed DSRIP focus areas and to provide the Steering Committee with an example of how their priority strategies were being put into practice in the State. CMS approved the DSRIP projects on February 5, 2015. Each hospital participating in the DSRIP program was required to select at least two projects.
- Each DSRIP project has milestones from each of the following four categories: Category 1 (infrastructure milestones), 2 (process milestones), 3 (quality and outcome milestones), and 4 (population focused improvements).
- Kansas completes annual reports regarding the progress and outcomes associated with the DSRIP Pool.

In addition to the DSRIP Pool, CMS also authorized a UC Pool that consists of two sub-pools: the HCAIP Pool and the LPTH/BCCH Pool. Kansas has only made payments to the hospitals listed in the STC as eligible for the HCAIP sub-pool and the LPTH/BCCH sub-pool.

Please see Section II, Historical Narrative of Summary of KanCare and Requested Changes, for more information on planned changes to safety net pools.

Compliance with Quality and Reporting Requirements

Kansas has submitted progress reports to CMS following the end of each quarter and each DY since the start of the current KanCare demonstration period. Kansas posts all reports on its publicly available webpage. Each report includes details of compliance with STCs, including engaging the public through post award forums. Reports are additionally accompanied by demonstrations of network adequacy, documenting assurances that MCOs have sufficient capacity to serve the expected enrollment in their service area and offer an adequate range of preventive, primary, pharmacy, specialty, acute, and HCBS services for the anticipated number of enrollees in the service area. These reports are also publicly available on the KanCare website.

The KanCare annual reports also describe the implementation and effectiveness of the comprehensive Quality Strategy as it impacts the demonstration. The Medicaid State Quality Strategy was finalized in September 2014, and contains specific provisions for assessment of care quality and appropriateness as well as improvement following such an assessment. The State Quality Strategy is regularly reviewed and operational details continually evaluated, adjusted, and put into use. The Quality Strategy includes the KanCare Evaluation Design, approved by CMS on September 11, 2013, and updated in March 2015.

Kansas also submits quarterly expenditure reports using Form CMS-64 to separately report expenditures provided through the current KanCare demonstration.

Continuing to Ensure Compliance with KanCare Program Requirements through a Corrective Action Plan

On January 13, 2017, CMS identified needed improvements in KanCare program implementation. In response to this letter, the State developed a corrective action plan (CAP), sent to CMS on February 17, 2017. The CAP outlines the State's responses to the CMS findings, and the actions the State is taking to address those findings.

CMS approved the CAP for LTSS services on May 22, 2017 and the CAP for annual HCBS reporting (Form CMS-372) on August 24, 2017. To implement the CAP, the State is working to address key areas such as:

- Monitoring and reporting,
- Standard operating procedures (SOPs),
- Training,
- Roles and responsibilities, including interagency coordination, and
- Stakeholder engagement.

Below, we provide a sample of the State's responses contained in the CAPs:

- The State will continue to improve its MCO oversight based on analysis of MCOs' submitted data, and use this information to inform decision-making at the programmatic level. Beyond its current efforts, the State will develop and implement SOPs regarding MCO data analysis and communication, focusing on MCO data verification and performance review.
- The State has been consistent in its monitoring operations since the implementation of KanCare and continues to facilitate monthly meetings with MCOs to discuss operational issues, data discrepancies, and areas for MCO improvement. In addition to its current efforts, the State will develop and distribute internal policies and procedures and train staff responsible for the state contract review annual report development.
- In 2015, the State worked with individual MCOs to perform a provider access and network adequacy data clean up as a result of onsite audits the State conducted in 2013 and 2014. The State will continue its efforts in monitoring provider network adequacy by conducting a comprehensive review of network adequacy reporting templates as compared to the Medicaid Managed Care Final Rule. The State will also update internal policies and procedures to guide agency staff in the review and monitoring of State provider network access and adequacy reports. In addition, the State will develop internal analysis tools to begin trending and comparing MCO data with each report submission based on the newly implemented MCO reporting templates.
- As it pertains to tracking critical incidents, Kansas has rigid and effective statutes surrounding the reporting and investigation of abuse, neglect, and exploitation (ANE). Continuing this process, the State and the MCOs have collectively charged a critical incidents workgroup with overseeing the development and implementation of enhanced reporting, tracking, and trending of critical incidents. In addition, the State has made programmatic updates to data collection and reporting processes through its real-time, web-based Adverse Incident Reporting system (AIR).
- The State is updating policies regarding the integrated person centered planning processes for all three MCOs to comply with federal regulations at 42 C.F.R. *§* 441.301 and the 1915(c) HCBS waivers. In addition, the State has reviewed the audit findings and will establish

internal procedures regarding staff responsibilities in the HCBS quality review process. The State will implement effective oversight to ensure the level of care and provision of services are provided to beneficiaries as indicated in their plan of care.

- The State has an Interagency Agreement, which is an evergreen agreement that is automatically renewed every year. The latest agreement is from 2012, and the State will update this agreement with criteria for interagency evaluation. The State will also update position descriptions that describe specific roles and responsibilities of each agency and procedural documentation, such as SOPs.
- The State uses multiple methods for disseminating information and gathering stakeholder feedback including, but not limited to, website postings, memos to beneficiaries and providers, and public meetings and forums. To promote continued information sharing following standard procedures, the State will implement policies and procedures for programmatic communications to MCOs and stakeholders, as well as processes for collecting public and stakeholder feedback. The State will also train agency staff on proper procedures.
- The State will standardize requirements across 1915(c) waivers, where there were prior inconsistencies to allow for streamlined operations and monitoring efforts (e.g., reporting and documentation of critical incidents). The State will work with CMS to identify what requirement changes meet the criteria of a "substantive change", thus requiring a formal amendment to the waiver, subject to the public comment process.
- The State will identify an ongoing process for systemic remediation to issues identified through the quarterly quality monitoring process. Appropriate representatives in each agency will deliver findings to the established Long-Term Care committee to review remediation steps and identify if any CAPs are warranted.

To keep CMS apprised of the status of our CAP, the State facilitates a bi-weekly status call to review each CAP activity and respond to any CMS questions or requests for clarification. Below is a sampling of the State's accomplishments as a result of the CAPs actions to date:

- The State formalized processes and procedures for the annual MCO contract review process, detailing key steps, responsible parties, and associated timeframes. The State implemented the new processes in time for upcoming reviews on site at MCO locations in Fall 2017.
- The State developed internal analysis tools for purposes of monitoring MCO provider network adequacy. The tools allow the State to track key provider types and whether KanCare members have an appropriate provider network to meet their unique needs.
- The State updated position descriptions for staff responsible for all CAP-related activities. Updates including more accurate descriptions of task responsibilities and allows the State to hold staff accountable for monitoring for MCO compliance.
- The State formalized its processes and procedures for oversight of enrollment broker activities to monitor whether enrollees seeking to become KanCare members have adequate support through the enrollment process. Procedures also detail how the State reviews member materials and enrollment broker publications against state requirements.
- The State developed procedures governing the new Medical Care Advisory Committee and is in the process of recruiting members to join the committee. The purpose of the committee is to advise the Medicaid agency about health and medical care services through providing input on policy development and program administration, including furthering the participation of beneficiaries in Kansas Medicaid.

VIII. Public Notice Process

The State facilitates meaningful dialogue with stakeholders and collects detailed feedback. We conducted formal public input meetings on KanCare in June 2017 and asked questions such as:

- How has care coordination worked for you?
- What would you like to improve about your care coordination experience?
- Which extra services have been or would be most helpful to you?
- Do you understand information your MCO sends you?
- Is it easy to get questions answered when you call your MCO?
- How can your MCO better communicate with you?

A summary of feedback the State received is available at the following webpage: http://www.kancare.ks.gov/docs/default-source/about-kancare/kancare-renewal-forums/kancare-2-0-public-input-report.pdf?sfvrsn=2. We incorporated the feedback from these public input meetings into the KanCare 2.0 Demonstration Renewal Application.

The State facilitated a Medicaid public input and stakeholder consultation process from October 27, 2017 to November 26, 2017. Twelve public hearings were held in-person, while two public hearings took place by conference call, described in the figure below. Because it can be difficult for call-in participants to hear the presentation and comments, there were no telephonic or web conference capabilities at the in-person hearings. Instead, the State offered a dedicated public hearing for call-in participants on November 20, 2017 so that participants could better hear and provide comments. The same information and opportunity for feedback was shared at each session. The State used the following methods to notify the public of the KanCare renewal application and public hearings opportunities:

- Published an abbreviated public notice in the *Kansas Register* on October 26, 2017; please see Appendix H for the abbreviated public notice;
- Emailed a notice to tribal government officials to ensure compliance with the Tribal Consultation process; please see Appendix I for the e-mail documentation of this notice; and
- Posted a full public notice on the KanCare website; please see Appendix J for the full public notice.

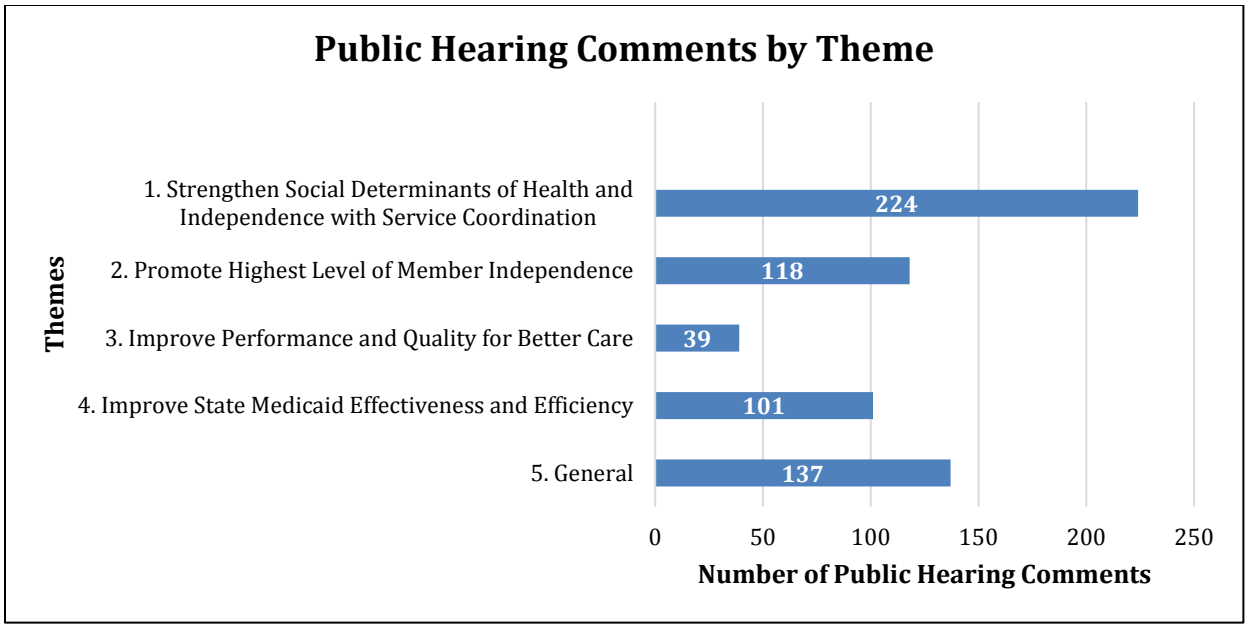
Figure 23. KanCare 2.0 Public Hearing Schedule

Day/Date	Location	Time	Audience
Tuesday, November 14, 2017	Pittsburg State University, Overman Student Center, Ballroom A, 1701 S, Broadway St, Pittsburg, KS, 66762	2:00pm to 4:00pm	Providers
		6:00pm to 8:00pm	Members
	Dodge House Hotel & Convention Center 2408 West Wyatt Earp Blvd., Dodge City, KS, 67801	2:00pm to 4:00pm	Providers
		6:00pm to 8:00pm	Members

Day/Date	Location	Time	Audience
Wednesday, November 15, 2017	Kansas State University Olathe, Great Plains A & B, 22201 W. Innovation Drive, Olathe, KS, 66061	2:00pm to 4:00pm	Providers
		6:00pm to 8:00pm	Members
	Perkins Restaurant & Bakery, Meeting Room, 2920 10th Street, Great Bend, KS, 67530	2:00pm to 4:00pm	Providers
		6:00pm to 8:00pm	Members
Thursday, November 16, 2017	Ramada Topeka Downtown, Jefferson Hall, 420 SE 6th St., Topeka, KS, 66607	2:00pm to 4:00pm	Providers
		6:00pm to 8:00pm	Members
	Wichita Marriott, Corporate Hills Ballroom, 9100 Corporate Hills Drive, Wichita, KS, 67207	2:00pm to 4:00pm	Providers
		6:00pm to 8:00pm	Members
Monday, November 20, 2017	Conference Call Option: 1-833-791-5968 and Enter Code: 871 777 85	12:00pm to 1:30pm	Providers
		6:00pm to 7:30pm	Members

The resulting comments and recommendations received, public hearing testimonies, and State responses were summarized and are included in Appendix K. The State received approximately 619 comments at the public hearings, illustrated in the figure below and grouped by theme. The State also received approximately 47 written comments through mail or email.

Figure 24. Public Hearing Comments by Theme



Appendix A. List of KanCare Populations

[See following page.]

a. **Medicaid State Plan Mandatory Populations**

State Plan Mandatory Medicaid Eligibility Groups	Description	FPL	Resource Standard	Medicaid Eligibility Group (MEG)
POVERTY LEVEL RELATED PREGNANT WOMEN	1902(a)(10)(A)(i)(IV) 1902(l)(1)(A)	150%	N/A	Adults
POVERTY LEVEL RELATED CHILDREN				
Infants Less than one year old	1902(a)(10)(A)(i)(IV) 1902(l)(1)(B)	150%	N/A	Children
Children ages 1 through 5 years	1902(a)(10)(A)(i)(VI) 1902(l)(1)(C)	133%	N/A	Children
Children ages 6 through 18 years	1902(a)(10)(A)(i)(VII) 1902(l)(1)(D)	100%	N/A	Children
Permanent custodianship subsidy	This program is for children age 14 to 18 years old that are in state custody, are not receiving SSI benefits, and have a permanent qualifying custodian. The child will receive coverage through the Foster Care Medical program.			Children
Deemed Newborns	1902(e)(4)	Children born to a Medicaid mother	N/A	Children
LOW INCOME FAMILIES WITH CHILDREN	1902(a)(10)(A)(i)(I) 1931	Approximately 30% (State's 7/16/1996 AFDC payment standards by family size)	N/A	Children Adults
TRANSMED – WORK	1902(a)(10)(A)(i)(I)	Coverage for up to 12 months is provided to	N/A	Children

State Plan Mandatory Medicaid Eligibility Groups	Description	FPL	Resource Standard	Medicaid Eligibility Group (MEG)
TRANSITION (Transitional Medical Assistance (TMA))	408(a)(11)(A)1925 1931(c)(2)	families who receive coverage on the Low Income Families with Children program and have lost financial eligibility due to an increase in earnings, increase in working hours, or loss of time-limited earned income disregard. Income must exceed guidelines for Low Income Families with Children program.		Adults
EXTENDED MEDICAL	1902(a)(10)(A)(i)(I) 408(a)(11)(B) 1931(c)(1)	Coverage for 4 months is provided to families who received coverage on the Low Income Families with Children program and lost financial eligibility due to an increase in child or spousal support. Income must exceed guidelines for Low Income Families with Children program.	N/A	Children Adults
FOSTER CARE MEDICAL (IV-E)	1902(a)(10)(A)(i)(I) 473(b)(3)	This program is for children who have been removed from a home whose family members meet the eligibility criteria for federal participation in the IV-E foster care program, taken into state custody, and placed with an individual, family or institution.	N/A	Children
ADOPTION SUPPORT MEDICAL (IV-E)	1902(a)(10)(A)(i)(I) 473(b)(3)	This program is for adopted children with special needs who were in state custody and meet the eligibility criteria for federal participation in the IV-E adoption support program.	N/A	Children
SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS	1902(a)(10)(A)(i)(II) 1619(a) 1619(b) 1905(q)	$698/month (single) $1,048/month(couple)	$2,000 (single) $3,000 (couple)	ABD/SD Dual ABD/SD Non Dual

State Plan Mandatory Medicaid Eligibility Groups	Description	FPL	Resource Standard	Medicaid Eligibility Group (MEG)
PICKLE AMENDMENT	Section 503 of P.L. 94-566		$2,000 (single) $3,000 (couple)	MN Dual MN Non Dual
ADULT DISABLED CHILD	1634(c) Section 1939		$2,000 (single) $3,000 (couple)	MN Dual MN Non Dual
EARLY OR DISABLED WIDOWS AND WIDOWERS	1634(b) 1935 (Disabled Widow/ers) 1634(d) 1935 (Early Widow/ers)		$2,000 (single) $3,000 (couple)	MN Dual MN Non Dual
CHILD IN AN INSTITUTION	This program is for children through the age of 21 years old who are residing in an institution for a long term stay. Children eligible under this program whose income exceeds the protected income level are responsible for a portion of the cost of their care in the facility. (1902(a)(10)(A)(ii)(V))	300 % $62/month Personal Need Allowance	N/A	Children

b. **Medicaid State Plan Optional Populations**

State Plan Optional Medicaid Eligibility Groups	Description	FPL	Resource Standard	MEG
FOSTER CARE MEDICAL (NON IV-E)	This program is for children under age 21 who have been removed from a home whose family members do not meet the eligibility criteria for federal participation in the IV-E foster care program, taken into state custody, and placed with an individual, family or institution.	State's 7/16/1996 AFDC payment standards by family size	n/a	Children
FOSTER CARE MEDICAL (AGED OUT)	1902(a)(10)(A)(ii)(XVII)	No income test. This program is for children transitioning to adult independent living who are being removed from the Foster Care Medical program because they are turning 18 years old. Medicaid coverage may continue through age 21.[1]	n/a	Children
ADOPTION SUPPORT MEDICAL (NON IV-E)	1902(a)(10)(A)(ii)(VIII)	This program is for adopted children with special needs receiving non-IV-E state adoption assistance who do not meet the eligibility criteria for federal participation in the IV-E adoption support program and met the Medicaid eligibility requirements at the time of adoption and are under age 21.	n/a	Children

1. The State now covers this population through the age of 26 per the Affordable Care Act.

State Plan Optional Medicaid Eligibility Groups	Description	FPL	Resource Standard	MEG
MEDICALLY NEEDY	1902(a)(10)(C)	$475/month (single and couple)	$2,000 (single) $3,000 (couple)	MN Dual MN Non Dual ABD/SD Dual ABD/SD Non Dual
BREAST AND CERVICAL CANCER	1902(a)(10)(A)(ii)(XVIII)	N/A	N/A	Adults
WORKING HEALTHY	1902(a)(10)(A)(ii)(XV)	$2,793/month (single) $3,783/month (couple)	$15,000 (single and couple)	ABD/SD Non Dual
WORKING HEALTHY MEDICALLY IMPROVED	1902(a)(10)(A)(ii)(XVI)	$2,793/month (single) $3,783/month (couple)	$15,000 (single and couple)	ABD/SD Non Dual
LONG TERM INSTITUTIONAL CARE	1902(a)(10)(A)(ii)(V) Except for individuals residing in a public ICF/ID	300%SSI $62/month Personal Needs Allowance	$2,000	LTC

c. **Section 1915(c) Waiver Populations.** Individuals enrolled in the concurrent section 1915(c) waivers listed below are eligible for this demonstration.

Waiver Eligible Groups	Description	Personal Needs Allowance	Resource Standard	MEG
Autism Waiver	1902(a)(10)(A)(ii)(VI)	$727/month	$2,000	Waiver
Intellectual Disabilities/Developmental Disabilities	1902(a)(10)(A)(ii)(VI)	$727/month	$2,000	DD Waiver
Frail Elderly	1902(a)(10)(A)(ii)(VI)	$727/month	$2,000	LTC
Physically Disabled	1902(a)(10)(A)(ii)(VI)	$727/month	$2,000	LTC
Technology Assisted	1902(a)(10)(A)(ii)(VI)	$727/month	$2,000	Waiver
Traumatic Brain Injury	1902(a)(10)(A)(ii)(VI)	$727/month	$2,000	Waiver
Serious Emotional Disturbance	1902(a)(10)(A)(ii)(VI)	$727/month	$2,000	Waiver

i. Individuals on the section 1915(c) waiver waiting lists who are not otherwise eligible for Medicaid through the approved state plan are excluded from the demonstration.

18. Exemption. The following population is exempt from mandatory enrollment in mandatory managed care and is not affected by this demonstration except to the extent that individuals elect to enroll in managed care.

a. American Indians/Alaska Natives (AI/AN): The AI/AN population will be automatically enrolled in managed care under the demonstration. This population will have the ability to opt out of managed care at the beneficiary's discretion. The state will use the definition of Indian provided at 42 CFR 447.50.

19. Eligibility Exclusions. Notwithstanding STC 17, the following populations are excluded from this demonstration.

Exclusions from KanCare	Description	FPL	Resource Standard
Aliens eligible for emergency services only	1903(v)(3)	Varies depending on eligibility category.	Varies depending on the specific underlying medical program.
QUALIFIED MEDICARE BENEFICIARY (QMB), not otherwise Medicaid eligible	1902(a)(10)(E)(i) 1905(p)(1)	100%	 $6,940 (single) $10,410 (couple)
SPECIAL LOW-INCOME MEDICARE BENEFICIARY (LMB) not otherwise Medicaid eligible	1902(a)(10)(E)(iii) 1902(a)(10)(E)(iii)	120%	$6,940 (single) $10,410 (couple)
EXPANDED SPECIAL LOW-INCOME MEDICARE BENEFICIARY (E-LMB)	1902(a)(10)(E)(iv)(I)	135%	 $6,940 (single) $10,410 (couple)
PROGRAM OF ALL-INTENSIVE CARE FOR THE ELDERLY (PACE)	1934	$62/month (institution) $727/month (HCBS)	$2,000
LONG TERM INSTITUTIONAL CARE Individuals residing in a public Intermediate Care Facility for Persons with Intellectual or Developmental Disabilities (ICF/ID)	1902(a)(10)(A)(ii)(V)	300% SSI $62/month Personal Needs Allowance	$2,000
RESIDENTS OF MENTAL	1902(a)(10)(A)(ii)(V)	$62/month	$2,000

Exclusions from KanCare	Description	FPL	Resource Standard
HEALTH NURSING FACILITIES			

Appendix B. Summary of Statewide HEDIS® Performance

HEDIS Measure Aggregated MCO Results for CY2013 - CY2015							
* ↑ indicates HEDIS aggregated results above the national Quality Compass (QC) 50th percentile; ↓ indicates HEDIS aggregated results below the QC 50th percentile. NA indicates no QC comparison available.							
^ HEDIS rates greater than 50th percentile that indicate poor performance							
Measure	Type (Hybrid/Admin)	HEDIS Aggregated Results			Quality Compass 50th Percentile*		
		CY15	CY14	CY13	CY15	CY14	CY13
Comprehensive Diabetes Care							
HbA1c Testing (P4P)	Hybrid	84.90%	84.80%	83.10%	↓	↓	↓
Eye Exam (P4P)		62.50%	58.60%	50.10%	↑	↑	↓
Medical Attention for Nephropathy (P4P)		89.20%	76.80%	75.80%	↓	↓	↓
HbA1c Control (<8.0%) (P4P)		46.60%	39.30%	39.00%	↓	↓	↓
HbA1c Poor Control (>9.0%) (lower % is goal)		45.40%	52.90%	54.40%	↓	↓	↓
Blood Pressure Control (<140/90) (P4P)		58.80%	52.60%	53.10%	↓	↓	↓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life							
	Admin	62.70%	62.10%	60.80%	↓	↓	↓
Adolescent Well Care Visits							
	Admin	43.00%	42.60%	42.30%	↓	↓	↓
Adults' Access to Preventive/Ambulatory Health Services (P4P)							
Ages 20-44	Admin	83.70%	84.30%	85.40%	↑	↑	↑
Ages 45-64		92.30%	92.40%	92.20%	↑	↑	↑
Ages 65 and older		89.70%	88.60%	89.50%	↑	↑	↑
Total - Ages 20 and older		87.10%	87.50%	88.40%	↑	↑	↑
Annual Monitoring for Patients on Persistent Medications							
	Admin	90.20%	89.70%	84.90%	↑	↑	↓
Follow-up after Hospitalization for Mental Illness, within seven days of discharge							
	Admin	62.80%	56.20%	61.00%	↑	↑	↑
Prenatal Care							
	Hybrid	67.40%	70.40%	71.40%	↓	↓	↓
Postpartum Care							
	Hybrid	57.50%	55.80%	60.30%	↓	↓	↓
Chlamydia Screening in Women							
Ages 16-20	Admin	41.30%	41.00%	42.40%	↓	↓	↓
Ages 21-24		53.50%	54.50%	55.60%	↓	↓	↓
Total – Ages 16-24		45.80%	45.40%	46.10%	↓	↓	↓
Controlling High Blood Pressure							
	Hybrid	48.20%	51.50%	47.30%	↓	↓	↓
Initiation in Treatment for Alcohol or other Drug Dependence							
Ages 13-17	Admin	46.40%	50.80%	49.00%	↑	↑	↑
Ages 18 and older		37.70%	41.30%	40.90%	↓	↑	↑
Total – Ages 13 and older		38.90%	42.60%	42.10%	↑	↑	↑
Engagement in Treatment for Alcohol or other Drug Dependence							
Ages 13-17	Admin	26.80%	31.00%	32.50%	↑	↑	↑
Ages 18 and older		10.70%	12.10%	12.20%	↑	↑	↑
Total – Ages 13 and older		12.90%	14.80%	15.20%	↑	↑	↑
Weight Assessment/BMI for Children and Adolescents							
Ages 3-11	Hybrid	48.90%	44.30%	33.70%	↓	↓	↓
Ages 12-17		48.10%	47.30%	36.60%	↓	↓	↓
Total – Ages 3-17		48.60%	45.30%	34.70%	↓	↓	↓

HEDIS Measure Aggregated MCO Results for CY2013 - CY2015							
* ↑ indicates HEDIS aggregated results above the national Quality Compass (QC) 50th percentile; ↓ indicates HEDIS aggregated results below the QC 50th percentile. NA indicates no QC comparison available.							
^ HEDIS rates greater than 50th percentile that indicate poor performance							
Measure	Type (Hybrid/Admin)	HEDIS Aggregated Results			Quality Compass 50th Percentile*		
		CY15	CY14	CY13	CY15	CY14	CY13
Counseling for Nutrition for Children and Adolescents							
Ages 3-11	Hybrid	50.60%	50.80%	47.40%	↓	↓	↓
Ages 12-17		45.70%	47.00%	46.00%	↓	↓	↓
Total – Ages 3-17		49.10%	49.50%	46.90%	↓	↓	↓
Counseling for Physical Activity for Children and Adolescents							
Ages 3-11	Hybrid	43.30%	43.50%	39.60%	↓	↓	↓
Ages 12-17		48.30%	50.60%	53.10%	↓	↓	↓
Total – Ages 3-17		44.90%	45.80%	44.00%	↓	↓	↓
Appropriate Treatment for Children with Upper Respiratory Infection (URI)							
	Admin	76.30%	73.50%	71.90%	↓	↓	↓
Appropriate Testing for Children with Pharyngitis							
	Admin	55.10%	52.20%	51.60%	↓	↓	↓
Diabetes Monitoring for People with Diabetes and Schizophrenia							
	Admin	65.30%	60.10%	62.90%	↓	↓	↓
Flu Shot or Spray, Ages 18-64 (P4P), CY2015 CAHPS Survey							
	Admin	43.70%	46.10%	47.50%	↑	↑	N/A
Annual Dental Visit							
Ages 2-3	Admin	42.80%	41.20%	40.80%	↑	↑	↑
Ages 4-6		66.20%	65.70%	66.30%	↑	↑	↑
Ages 7-10		70.40%	70.10%	70.70%	↑	↑	↑
Ages 11-14		63.20%	62.80%	62.80%	↑	↑	↑
Ages 15-18		54.10%	53.50%	53.90%	↑	↑	↑
Ages 19-21		34.70%	30.20%	31.50%	↑	↓	↓
Total - Ages 2-21		60.90%	60.00%	60.30%	↑	↑	↑
Smoking or Tobacco Use in last six months, CY2015 CAHPS Survey							
Do you smoke or use tobacco? If yes:	Admin	32.20%	33.50%	37.50%	↓	↓	↑
Often advised to quit smoking or using tobacco by a doctor or other health provider in your plan. (P4P)		79.50%	76.20%	75.70%	↑	↓	↓
Medication to assist with quitting recommended by health provider or discussed		46.10%	43.20%	48.30%	↓	↓	↑
Health provider discussed or provided methods or strategies other than medication to assist with quitting		44.40%	37.50%	38.60%	↑	↓	↓
Well-Child Visits in the First 15 Months of Life							
0 visits	Admin	3.40%	4.20%	N/A	↑^	↑^	N/A
1 visit		3.80%	4.80%	N/A	↑^	↑^	N/A
2 visits		5.20%	6.20%	N/A	↑^	↑^	N/A
3 visits		7.40%	8.30%	N/A	↑^	↑^	N/A
4 visits		10.00%	13.40%	N/A	↓	↑	N/A
5 visits		15.10%	18.40%	N/A	↓	↑	N/A
6 or more visits		55.10%	44.70%	N/A	↓	↓	N/A

HEDIS Measure Aggregated MCO Results for CY2013 - CY2015							
* ↑ indicates HEDIS aggregated results above the national Quality Compass (QC) 50th percentile; ↓ indicates HEDIS aggregated results below the QC 50th percentile. NA indicates no QC comparison available.							
^ HEDIS rates greater than 50th percentile that indicate poor performance							
Measure	Type (Hybrid/Admin)	HEDIS Aggregated Results			Quality Compass 50th Percentile*		
		CY15	CY14	CY13	CY15	CY14	CY13
Medication Management for People with Asthma							
5-11 years of age	Admin	29.10%	27.40%	N/A	↑	↑	N/A
12-18 years of age		26.60%	24.10%	N/A	↑	↑	N/A
19-50 years of age		38.80%	39.60%	N/A	↑	↑	N/A
51-64 years of age		55.10%	53.00%	N/A	↑	↑	N/A
Total - Ages 5-64		29.90%	28.10%	N/A	↓	↓	N/A
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication							
Initiation Phase	Admin	50.70%	48.00%	N/A	↑	↑	N/A
Continuation & Maintenance Phase		61.20%	54.80%	N/A	↑	↑	N/A
Adult BMI							
	Hybrid	77.60%	72.20%	N/A	↓	↓	N/A

Appendix C. Statewide Mental Health Quality Scores

Mental Health Survey - Quality-Related Questions								
Item	Year (0% – 100%)	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
If I had other choices, I would still get services from my mental health providers.	**General Adult (Age 18+)**						
	2016	**85.0%**	**246 / 289**	**80.4% – 88.7%**		.25	.94
	2015	88.4%	336 / 380	84.8% – 91.3%	.20		
	2014	89.4%	720 / 805	87.1% – 91.4%	.05		
	2013	88.3%	911/1,034	86.2% – 90.1%	.13		
	2012	84.4%	232 / 275	79.6% – 88.2%	.83		
	2011	88.3%	263 / 298	84.1% – 91.5%	.25		
I felt comfortable asking questions about my treatment and medication.	**General Adult (Age 18+)**						
	2016	**85.9%**	**245 / 285**	**81.3% – 89.5%**		.24	.29
	2015	94.5%	358 / 379	91.7% – 96.4%	**<.001 -**		
	2014	90.7%	733 / 808	88.5% – 92.5%	**.02 -**		
	2013	91.1%	959/1,052	89.2% – 92.7%	**<.01 -**		
	2012	87.5%	244 / 279	83.0% – 90.9%	.59		
	2011	93.6%	278 / 297	90.2% – 95.9%	**<.01 -**		
I have people I am comfortable talking with about my child's problems.	**General Youth (Ages 0-17), Family Responding**						
	2016	**91.5%**	**289 / 316**	**87.9% – 94.2%**		.89	.47
	2015	92.5%	300 / 324	89.0% – 94.9%	.66		
	2014	90.4%	688 / 761	88.1% – 92.3%	.57		
	2013	91.6%	871 / 954	89.7% – 93.2%	.95		
	2012	93.1%	244 / 262	89.3% – 95.7%	.47		
	2011	92.6%	301 / 325	89.2% – 95.0%	.61		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**89.9%**	**289 / 322**	**86.1% – 92.8%**		.84	.89
	2015	87.7%	288 / 328	83.7% – 90.9%	.39		
	2014	88.0%	366 / 417	84.5% – 90.8%	.43		
	2013	89.1%	423 / 475	85.9% – 91.6%	.71		
	2012	87.5%	281 / 321	83.4% – 90.7%	.34		
	2011	89.4%	254 / 284	85.3% – 92.5%	.85		
As a result of services I received, I am better able to deal with crisis.	**General Adult (Age 18+)**						
	2016	**69.2%**	**192 / 277**	**63.6% – 74.4%**		**<.01↓**	.12
	2015	79.3%	279 / 352	74.8% – 83.3%	**<.01 -**		
	2014	78.7%	602 / 765	75.7% – 81.5%	**<.01 -**		
	2013	79.1%	780 / 987	76.4% – 81.5%	**<.001 -**		
	2012	71.4%	182 / 255	65.5% – 76.6%	.59		
	2011	80.4%	221 / 275	75.2% – 84.6%	**<.01 -**		
My mental health providers helped me obtain information I needed so that I could take charge of managing my illness.	**General Adult (Age 18+)**						
	2016	**82.7%**	**230 / 278**	**77.8% – 86.7%**		.06	.20
	2015	86.3%	315 / 365	82.4% – 89.5%	.20		
	2014	86.8%	675 / 778	84.2% – 89.0%	.09		
	2013	87.6%	891/1,020	85.4% – 89.4%	**.03 -**		
	2012	81.6%	213 / 261	76.4% – 85.9%	.75		
	2011	89.3%	258 / 289	85.1% – 92.4%	**.02 -**		

Mental Health Survey - Quality-Related Questions (Continued)								
Item	Year 0% 100%	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
As a result of services I received, I am better able to control my life.	**General Adult (Age 18+)**						
	2016	**74.8%**	**213 / 284**	**69.4% – 79.5%**		**.02↓**	.11
	2015	83.8%	309 / 369	79.7% – 87.2%	**<.01 -**		
	2014	84.9%	669 / 788	82.2% – 87.2%	**<.001 -**		
	2013	83.0%	851/1,025	80.6% – 85.2%	**<.01 -**		
	2012	76.4%	204 / 267	70.9% – 81.1%	.66		
	2011	86.5%	250 / 289	82.1% – 90.0%	**<.001 -**		
As a result of services I received, I am better at handling daily life.	**General Youth (Ages 12-17), Youth Responding**						
	2016	**85.3%**	**131 / 154**	**78.8% – 90.1%**		.29	.93
	2015	87.0%	127 / 146	80.5% – 91.6%	.67		
	2014	86.0%	260 / 302	81.6% – 89.5%	.84		
	2013	88.6%	450 / 510	85.3% – 91.2%	.28		
	2012	88.8%	87 / 98	80.8% – 93.8%	.43		
	2011	83.1%	108 / 130	75.6% – 88.6%	.61		
	SED Waiver Youth (Ages 12-17), Youth Responding						
	2016	**85.9%**	**140 / 163**	**79.7% – 90.5%**		.13	.83
	2015	83.0%	124 / 149	76.1% – 88.2%	.48		
	2014	84.1%	158 / 187	78.1% – 88.7%	.63		
	2013	79.6%	176 / 221	73.8% – 84.3%	.11		
	2012	82.4%	112 / 136	75.0% – 87.9%	.40		
	2011	90.1%	109 / 121	83.3% – 94.4%	.29		
As a result of services my child and /or family received, my child is better at handling daily life.	**General Youth (Ages 0-17), Family Responding**						
	2016	**77.8%**	**252 / 324**	**72.9% – 82.0%**		.17	.54
	2015	82.0%	265 / 323	77.4% – 85.8%	.18		
	2014	79.6%	606 / 764	76.6% – 82.3%	.50		
	2013	82.1%	772 / 948	79.5% – 84.4%	.09		
	2012	81.0%	205 / 253	75.7% – 85.4%	.34		
	2011	79.4%	258 / 325	74.6% – 83.4%	.61		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**75.9%**	**243 / 323**	**70.9% – 80.2%**		.81	.14
	2015	71.5%	233 / 326	66.4% – 76.1%	.21		
	2014	72.0%	297 / 407	67.4% – 76.1%	.24		
	2013	74.4%	355 / 477	70.3% – 78.1%	.64		
	2012	75.6%	241 / 319	70.6% – 80.0%	.93		
	2011	79.2%	227 / 286	74.2% – 83.5%	.32		

Mental Health Survey - Quality-Related Questions (Continued)								
Item	Year 0% 100%	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
As a result of services I received, I am better able to do things that I want to do.	**General Adult (Age 18+)**						
	2016	**69.3%**	**195 / 280**	**63.6% – 74.4%**		**.04↓**	**.03↓**
	2015	78.9%	290 / 368	74.4% – 82.8%	**<.01 -**		
	2014	74.3%	581 / 782	71.1% – 77.3%	.10		
	2013	77.7%	786/1,012	75.0% – 80.2%	**<.01 -**		
	2012	70.1%	185 / 264	64.3% – 75.3%	.84		
	2011	82.4%	238 / 289	77.5% – 86.3%	**<.001 -**		
As a result of the services my child and/or family (I) received, my child is (I am) better able to do things he or she wants (I want) to do.	**General Youth (Ages 0-17), Family Responding**						
	2016	**80.7%**	**255 / 317**	**76.0% – 84.7%**		.26	.14
	2015	84.5%	268 / 317	80.1% – 88.1%	.20		
	2014	80.7%	606 / 751	77.8% – 83.4%	.99		
	2013	84.3%	780 / 930	81.8% – 86.5%	.14		
	2012	85.0%	215 / 253	80.0% – 88.9%	.18		
	2011	84.1%	264 / 314	79.6% – 87.7%	.27		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**73.5%**	**231 / 316**	**68.3% – 78.1%**		.79	.26
	2015	69.9%	227 / 324	64.7% – 74.7%	.32		
	2014	71.1%	290 / 405	66.6% – 75.3%	.49		
	2013	73.5%	349 / 475	69.4% – 77.3%	.98		
	2012	72.3%	229 / 317	67.1% – 76.9%	.74		
	2011	76.5%	210 / 275	71.1% – 81.1%	.40		

Mental Health Survey - Quality-Related Questions (Continued)							
Item	Year 0% 100%	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
I, not my mental health providers, decided my treatment goals.	**General Adult (Age 18+)**						
	2016	**78.6%**	**219 / 278**	**73.4% – 83.0%**		.77	.76
	2015	85.1%	303 / 356	81.1% – 88.5%	**.03 -**		
	2014	84.0%	655 / 780	81.3% – 86.5%	**.04 -**		
	2013	81.8%	809 / 989	79.3% – 84.1%	.22		
	2012	77.0%	198 / 257	71.5% – 81.8%	.67		
	2011	83.7%	237 / 283	79.0% – 87.6%	.12		
I helped to choose my treatment goals.	**General Youth (Ages 12-17), Youth Responding**						
	2016	**84.6%**	**128 / 151**	**77.9% – 89.5%**		.38	.96
	2015	91.0%	127 / 140	84.9% – 94.8%	.10		
	2014	84.1%	255 / 302	79.5% – 87.8%	.89		
	2013	88.8%	448 / 509	85.6% – 91.4%	.17		
	2012	81.6%	80 / 98	72.7% – 88.1%	.54		
	2011	86.8%	112 / 129	79.8% – 91.7%	.60		
	SED Waiver Youth (Ages 12-17), Youth Responding						
	2016	**86.8%**	**140 / 161**	**80.6% – 91.2%**		.07	**.02↑**
	2015	92.3%	135 / 146	86.7% – 95.7%	.12		
	2014	86.9%	169 / 194	81.4% – 91.0%	.97		
	2013	82.2%	183 / 222	76.7% – 86.7%	.23		
	2012	81.3%	109 / 134	73.9% – 87.1%	.20		
	2011	83.5%	101 / 121	75.8% – 89.1%	.44		
I helped to choose my child's treatment goals. (I, not my mental health providers, decided my treatment goals.)	**General Youth (Ages 0-17), Family Responding**						
	2016	**92.5%**	**288 / 311**	**89.0% – 95.0%**		.17	.21
	2015	92.7%	289 / 312	89.2% – 95.1%	.92		
	2014	92.2%	689 / 750	90.0% – 93.9%	.87		
	2013	90.5%	847 / 937	88.4% – 92.2%	.29		
	2012	91.6%	229 / 250	87.4% – 94.5%	.70		
	2011	90.7%	294 / 324	87.1% – 93.5%	.43		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**94.3%**	**301 / 318**	**91.2% – 96.4%**		.45	.78
	2015	95.0%	310 / 327	92.1% – 97.0%	.69		
	2014	95.8%	395 / 412	93.3% – 97.4%	.37		
	2013	93.1%	451 / 483	90.5% – 95.1%	.49		
	2012	96.1%	303 / 315	93.3% – 97.8%	.28		
	2011	93.8%	264 / 281	90.2% – 96.1%	.77		

Mental Health Survey - Quality-Related Questions (Continued)								
Item	Year 0% 100%	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
My (my child's) mental health providers spoke with me in a way that I understood.	**General Adult (Age 18+)**						
	2016	**90.0%**	**266 / 295**	**86.0% – 92.9%**		.07	.60
	2015	**95.3%**	368 / 386	92.7% – 97.1%	**<.01 -**		
	2014	**93.6%**	765 / 817	91.7% – 95.1%	**.04 -**		
	2013	**94.3%**	1,002/1,063	92.8% – 95.6%	**<.01 -**		
	2012	91.5%	257 / 281	87.6% – 94.2%	.54		
	2011	93.4%	282 / 302	89.9% – 95.7%	.13		
	General Youth (Ages 12-17), Youth Responding						
	2016	**94.4%**	**148 / 157**	**89.5% – 97.2%**		.18	.06
	2015	93.9%	137 / 146	88.6% – 96.9%	.86		
	2014	95.5%	290 / 303	92.5% – 97.4%	.60		
	2013	96.3%	495 / 515	94.2% – 97.7%	.29		
	2012	98.0%	97 / 99	92.5% – 99.9%	.16*		
	2011	97.0%	131 / 135	92.4% – 99.1%	.27		
	SED Waiver Youth (Ages 12-17), Youth Responding						
	2016	**95.5%**	**158 / 165**	**91.0% – 97.9%**		.31	**.02↑**
	2015	97.4%	147 / 151	93.3% – 99.2%	.36		
	2014	96.9%	183 / 189	93.2% – 98.7%	.49		
	2013	93.8%	213 / 227	89.8% – 96.3%	.46		
	2012	92.0%	126 / 137	86.1% – 95.6%	.20		
	2011	92.1%	116 / 126	85.9% – 95.8%	.22		
	General Youth (Ages 0-17), Family Responding						
	2016	**97.5%**	**323 / 331**	**95.1% – 98.8%**		.46	.30
	2015	98.8%	324 / 328	96.9% – 99.7%	.19		
	2014	97.5%	766 / 786	96.1% – 98.4%	.96		
	2013	97.3%	950 / 981	96.1% – 98.2%	.89		
	2012	97.8%	262 / 268	95.1% – 99.1%	.81		
	2011	96.7%	327 / 338	94.2% – 98.2%	.58		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**98.0%**	**324 / 331**	**95.8% – 99.1%**		.60	.43
	2015	97.9%	329 / 336	95.7% – 99.1%	.94		
	2014	98.2%	414 / 422	96.4% – 99.2%	.85		
	2013	97.4%	476 / 488	95.5% – 98.5%	.58		
	2012	97.8%	314 / 321	95.5% – 99.0%	.87		
	2011	97.2%	278 / 286	94.4% – 98.6%	.49		

Appendix D. Statewide CAHPS® Quality of Care Scores

Member Survey (CAHPS) - Quality of Care Questions, 2014 - 2016							
Question	Pop	Weighted % Positive Responses			QC 50th Percentile		
		2014	2015	2016	2014	2015	2016
Using any number from 0 to 10, where 0 is the worst score possible and 10 is the best score possible:							
What number would you use to rate all your (your child's) health care in the last 6 months? (Rating 9 or 10)	**Adult**	52.8%	50.9%	**53.9%**	↑	↓	↑
	GC	68.6%	68.9%	**70.7%**	↑	↑	↑
	CCC	65.2%	64.8%	**66.2%**	↑	↑	↑
What number would you use to rate your (your child's) personal doctor? (Rating 9 or 10)	**Adult**	64.4%	67.4%	**67.5%**	↑	↑	↑
	GC	73.4%	72.5%	**75.9%**	↓	↓	↑
	CCC	71.8%	72.9%	**74.3%**	↓	↓	↓
We want to know your rating of the specialist you (your child) saw most often in the last 6 months. What number would you use to rate that specialist? (Rating 9 or 10)	**Adult**	64.8%	66.1%	**66.5%**	↓	↑	↑
	GC	69.6%	69.3%	**70.1%**	↓	↓	↑
	CCC	68.5%	67.8%	**73.0%**	↓	↓	↑
What number would you use to rate your (your child's) health plan? (Rating 9 or 10)	**Adult**	54.6%	57.6%	**60.9%**	↓	↓	↑
	GC	71.0%	72.1%	**73.8%**	↑	↑	↑
	CCC	63.3%	66.8%	**67.4%**	↓	↑	↑
In the last 6 months, how often did your (your child's) personal doctor show respect for what you had to say?	**Adult**	91.9%	92.5%	**93.4%**	↑	↑	↑
	GC	96.7%	96.0%	**96.0%**	↑	↑	↑
	CCC	94.4%	95.8%	**95.3%**	↓	↑	↓
In the last 6 months, how often did your (your child's) personal doctor spend enough time with you (your child)?	**Adult**	89.0%	89.4%	**89.7%**	↑	↑	↑
	GC	90.4%	89.7%	**91.0%**	↑	↑	↑
	CCC	90.6%	91.3%	**91.2%**	↓	↓	↓

Appendix E. Budget Neutrality Forms

[See following page.]

Budget Neutrality Form

I. Without- and With-Waiver Projections for Historical Medicaid Populations

A. Recent Historical Actual or Estimated Data

Provide historic data, actual or estimated, for the last five years pertaining to the Medicaid Populations or sub-Populations (Populations broken out by cost categories) in the Demonstration program.

Please see Budget Neutrality (BN) workbook.

The "Historical Data" tab from the Table Shell contains a structured template for entering these data. There are slots for three Medicaid Populations; more slots should be added as needed. The year headers "HY 1," "HY 2," etc., should be replaced with the actual historical years.

Please see BN workbook.

The Medicaid Populations submitted for budget neutrality purposes should correspond to the Populations reported in Section II. If not identical, a crosswalk must be provided that relates the budget neutrality Populations to the Section II populations. Use the tables below to provide descriptions of the populations defined for budget neutrality, and the cross-walk to Section II.

Populations in BN workbook correspond to the same populations in Section II.

States that are submitting amendments or extension requests and that wish to add new Medicaid populations can use the "Historical Data" tab to provide 5 years of historical data for the new populations.

No new populations are being added for this waiver extension.

Explain the sources and methodology used for the actual and/or estimated historical data. If actual data have been provided, explain the source of the data (MMIS data, other state system Medicaid data, other program data, etc.) and the program(s) and source(s) of program funding that the data represent. Indicate if the data represent all Medicaid expenditures for the population. For example, are they inclusive of long-term care expenditures? Were the expenditures reported on the CMS-64? If the data provided are a combination of actual and estimated data, provide the dates pertaining to each type of data. If any of the data are estimated, provide a detailed explanation concerning how the estimated data were developed.

Enrollment Trends

The State has elected to continue the per capita method for budget neutrality, so membership projections will not impact the budget neutrality of the waiver and are for illustrative purposes only. The same membership has been used for both the with-waiver and without-waiver calculations.

Enrollment for CY13 – CY16 represents actual historic enrollment. CY17 enrollment is based on actual membership for the first 6 months of the year, and a projection for the last half of the year based on State caseload projections.

CY18 projected membership is based on State caseload projections, which decrease from CY17 to CY18 due to an adjustment for redetermination. There were delays in redetermination during CY16 and early CY17, which have been corrected now and resulted in a one-time drop in membership.

CY19 membership based on State caseload projections, which are flat for non-LTC and non-waiver populations. Overall membership growth is projected to increase at 2.00% per year.

Without-Waiver Trends

PMPMs for CY13-CY18 are the without-waiver PMPMs from the previously approved waivers. Membership represents the same membership outlined above, and historic without-waiver dollars by MEG have been calculated as the MEG-specific PMPM times the MEG-specific actual membership for each respective year.

CY19 – CY23 without-waiver PMPM trends are based on the most recently approved 1115 waiver (at the time; Massachusetts) without-waiver trends, since the President's Budget trends by MEG are not publicly available.

B. Bridge Period

Based on the ending date of the most recent year of historic data and the proposed Demonstration implementation date, a bridge period will apply to this proposal. Estimates of Demonstration costs must be trended across this bridge period when calculating the projected first year of PMPM costs without the waiver. In the blanks below, enter the last day of the most recent historical year, and the last day of the year immediately preceding the first Demonstration Year. The number of months between these dates is the length of the bridge period. Depending on the length of the available historical data series and data quality, each demonstration population could have its own unique bridge period.

6/30/2011 – 12/31/2012

Enter the number of months in the bridge period in the "WOW" tab of the Excel Workbook, in the grayed cell under "MONTHS OF AGING." The spreadsheet is programmed to project Demonstration Year PMPM expenditures and member month totals using historical trend rates and the length of bridge period, and assumes that the same bridge period applies to all calculations. Applicants should feel free to alter these programming features as needed.

18 months has been input for "MONTHS OF AGING" in BN workbook.

C. Without-Waiver Trend Rates, PMPM costs and Member Months with Justification

The WOW tab of the Excel Workbook is where the state displays its projections for what the cost of coverage for included Medicaid populations would be in the absence of the demonstration. A block of cells is provided to display the WOW estimates for each Medicaid population specified. Next to "Pop Type," the correct option should be selected to identify each group as a Medicaid population.

All populations have been selected as Medicaid.

The workbook is programmed to project without-waiver (WOW) PMPM expenditures and member months using the most recent historical data, historical enrollment and per capita cost trends, and the length of bridge period specified. CMS policy is to use the lower of the state's historical trends and President's Budget trends to determine the WOW baseline.

Note that the workbook includes a projected Demonstration Year 0 (DY 00), which is an estimate of the last full year immediately prior to the projected demonstration start date. DY 00 is included to provide a common "jumping off point" for both WOW and with waiver (WW) projections.

D. Risk

CMS will provide technical assistance to states to establish an appropriate budget neutrality methodology for their demonstration request. Potential methodologies include:

PER CAPITA METHOD: The state will be at risk for the per capita (PMPM) cost of individuals served by the Demonstration, to the extent these costs exceed those that would have been incurred absent the Demonstration (based on data shown and to be agreed to above). The state shall be at risk to repay CMS for the federal share of any costs in excess of the "Without Demonstration" cost, based on historical data shown above, which are the sum of the estimated PMPM costs times the number of member months by Population. The state shall not be at risk for the number of member months of participation in the Demonstration, to the extent that they may increase above initial projections.

The state will be continuing the PER CAPITA METHOD consistent with the current 1115 waiver.

AGGREGATE METHOD: The state will be at risk for both the number of member months used under the Demonstration, as well as the per capita cost for Demonstration participants; to the extent these exceed the "without waiver" costs and member months that are agreed to based on the data provided above.

The state will be continuing the PER CAPITA METHOD consistent with the current 1115 waiver.

E. Historical Medicaid Populations: With-Waiver PMPM Cost and Member Month Projections

The "WW" tab of the Excel Workbook is for use by the State to enter its projected WW PMPM cost and member month projections for historical populations. In general, these can be different from the proposed without-waiver baseline. If the State's demonstration is designed to reduce PMPM costs, the number of member months by category and year should be the same here as in the without-waiver projection. (This is the default formulation used in the Excel Workbook.)

The state will be continuing the PER CAPITA METHOD consistent with the current 1115 waiver, so the same membership has been used for both the WOW and WW tabs in the BN workbook.

F. Justification for With-Waiver Trend Rates, PMPM Costs and Member Months

The State must provide below a justification for the proposed with-waiver trend rate and the methodology used by the State to arrive at the proposed trend rate, estimates of PMPM costs, and number of member months.

With-waiver CY13 through CY16 PMPMs represent actual expenditures. CY17 PMPM is projected based on emerging expenditures for that year and the capitation rates effective for that period. CY18 PMPMs are reflective of the most recently developed capitation rates for CY18. CY19 – CY23 PMPMs are calculated based on the CY18 PMPM and trending them annually by trends developed within the CY18 capitation rate development.

II. Cost Projections for New Populations

This section is to report cost projections for new title XIX Populations. These could be Populations or sub-Populations that will be added to the state's Medicaid program under the Demonstration, including "Expansion Populations" that are not provided for in the Act but are created under the Demonstration. In the table below, list all of the New Populations and explain their relationship to the eligibility groups listed in Section II.

No new populations are being added for this waiver extension.

III. Disproportionate Share Hospital Expenditure Offset

Is the state is proposing to use a reduction in Disproportionate Share Hospital (DSH) Claims to offset Demonstration costs in the calculation of budget neutrality for the Demonstration?

The state is not proposing to use any reductions to DSH claims to offset any Demonstration costs in the calculation of budget neutrality.

If yes, the state must provide data to demonstrate that the combination of Demonstration expenditures and the remaining DSH expenditures will not exceed the lower of the state’s historical DSH spending amount or the state's DSH Allotment for each year of the Demonstration. The state may provide Adjusted DSH Claim Amounts if additional DSH claims are pending due to claims lag or other reasons.

N/A

In the DSH tab of the Excel Workbook, enter the state’s DSH allotments and actual DSH spending for the five most recent Federal fiscal years in Panel 1. All figures entered should represent the federal share of DSH allotments and spending.

Please see BN workbook.

Provide an explanation for any Adjusted DSH Claim Amounts: In Panel 2 of the Excel Workbook, enter projected DSH allotments for the federal fiscal years that will overlap the proposed Demonstration period, and in the following row, enter projections for what DSH spending would be in the absence of the demonstration. All figures entered should represent the federal share of DSH allotments and spending.

The state is not projecting any differences in DSH claim amounts between WOW and WW.

Explanation of Estimates, Methodology and Data

IV. Summary of Budget Neutrality

The Excel Workbook's Summary tab shows an initial assessment of budget neutrality for the Demonstration. Formulas are included that reference cells in the WOW, WW, and DSH tabs so that projected WOW and WW expenditures for each category of expenditure appear in tabular form and can be summarized by Demonstration Year, and for the entire proposed duration of the Demonstration. The Variance shown for the entire duration of the demonstration must be non-negative.

Please see BN workbook.

As indicated above, spending estimates for Other WOW Categories and Other WW Categories should be entered directly into the Summary tab where indicated.

Please see BN workbook.

V. Additional Information to Demonstrate Budget Neutrality

Provide any additional information the State believes is necessary for CMS to complete its analysis of the budget neutrality submission.

Demonstration Financing Form

Please complete this form to accompany Section VI of the application in order to describe the financing of the Demonstration.

The State proposes to finance the non-federal share of expenditures under the Demonstration using the following (please check all that are applicable):

☑ State General Funds

☑ Voluntary intergovernmental transfers from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).

☐ Voluntary certified public expenditures from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).

☑ Provider taxes. (Provide description the narrative section – Section VI of the application).

☑ Other (If the State is interested in other funding or financing arrangements, please describe. Some examples could include, but are not limited to, safety net care pools, designated state health programs, Accountable Care Organization-like structures, bundled payments, etc.)

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking States to confirm to CMS that providers retain 100 per cent of the payments for services rendered or coverage provided.

Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

☑ Yes ☐ No

If no, provide an explanation of the provider payment arrangement.

Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of payments are returned to the State, local governmental entity, or other intermediary organizations?

☐ Yes ☑ No

If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount of percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.). Please indicate the period that the following data is from.

Section 1902(a) (2) provides that the lack of adequate funds from other sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced payments, capitation payments, other) is funded.

Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment. Please indicate the period that the following data is from:

If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

For any payment funded by CPEs or IGTs, please provide the following, and indicate the period that the data is from:

Name of Entity Transferring/ Certifying Funds	Type of Entity (State, County, City)	Amount Transferred or Certified	Does the entity have taxing authority?	Did the entity receive appropriations?	Amount of appropriations
University of Kansas Hospital	State	$18.2 M	No		

Section 1902(a) (30)(A) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) and 2105(a)(1) provide for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type, and indicate the time period that that the data is from.

Provider Type	Supplemental or Enhance Payment Amount
Please see attached list. Timeframe is SFY 2015	

Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

See next page for response.

Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, and other) that, in the aggregate, exceed its reasonable costs of providing services?

☐ Yes ☑ No

If yes, provide an explanation.

In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

☐ Yes ☑ No ☐ Not Applicable

If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

☐ Yes ☐ No

Use of other Federal Funds

Are other federal funds, from CMS or another federal agency, being used for the Demonstration program? ☐ Yes ☑ No

If yes, provide a list below of grants the State is receiving from CMS or other federal agencies. CMS must ensure these funds are not being used as a source of the non-federal share, unless such use is permitted under federal law. In addition, this will help to identify potential areas of duplicative efforts and highlight that this demonstration is building off of an existing grant or program.

Source of Federal Funds	Amount of Federal Funds	Period of Funding

Section 1902(a)(30) response:

SFY 2015:

Critical Access Hospital (CAH) Cost Settlement	$566 thousand
GME	$1.0 million
DSH	$67.1 million
Supplemental GME for certain licensed professional services	$12.1 million
Federally Qualified Health Centers (FQHC)	$800 thousand
Rural Health Clinics	$3.3 million

Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

State Response: For Inpatient and Outpatient Hospital, we break the hospitals into their respective classes. For the UPL demonstration, we use a payment to charge ratio. We take the Medicare Payment and divide by the Medicare Charges to determine the ratio. That ratio is applied to the Medicaid charges to arrive at the Medicaid UPL. The Medicaid Payments are subtracted from the UPL to arrive at the under/overage. This amount at the aggregate for each class determines the overall UPL for the State for each class.

Appendix F. Budget Neutrality Workbook

[Attached under a separate cover.]

Appendix G. 2016 KanCare Evaluation Annual Report

[See following page.]

Kansas Foundation for Medical Care, Inc
2947 SW Wanamaker Drive
Topeka, Kansas 66614-4193
Phone 785-273-2552
kfmc.org

March 31, 2017

Becky Ross
Medicaid Initiatives Coordinator
Kansas Department of Health & Environment
Division of Health Care Finance
900 SW Jackson St.
Topeka, KS 66612

RE: **2016 KanCare Evaluation Annual Report**
Year 4, January – December 2016

Dear Ms. Ross:

Enclosed is the 2016 KanCare Evaluation annual report for Year 4, January – December 2016. If you have questions regarding this information, please contact me, jpanichello@kfmc.org.

Sincerely,

Janice D. Panichello, Ph.D., MPA
Director of Quality Review and Epidemiologist

Electronic Version: Shirley Norris, Senior Manager, MCO Operations, KDHE

Enclosures

2016 KanCare Evaluation Annual Report

Year 4, January - December 2016

KFMC Contract Number:	**11231**
Program(s) Reviewed:	**KanCare Demonstration**
Submission Date:	**March 31, 2017**
Review Team:	**Janice Panichello, Ph.D., MPA, Director of Quality Review and Epidemiologist** **Lynne Valdivia, BSN, RN, MSW, CCEP, Vice President Quality Improvement and Review**

Prepared for:

KanCare

Table of Contents

2016 KanCare Evaluation Annual Report

Year 4, January – December 2016

List of Tables

2016 KanCare Evaluation Annual Report
Year 4, January-December 2016
March 31, 2017

Background

KanCare is an integrated managed care Medicaid program that is to serve the State of Kansas through a coordinated approach. The goal of KanCare is to provide efficient and effective health care services and ensure coordination of care and integration of physical and behavioral health services with each other and with home and community-based services (HCBS).

In December 2012, the Centers for Medicare & Medicaid Services (CMS) approved the State of Kansas Medicaid section 1115 demonstration proposal, entitled KanCare. KanCare operates concurrently with the State's section 1915(c) HCBS waivers and together provide the authority necessary for the State to require enrollment of almost all Medicaid beneficiaries across Kansas into a managed care delivery system. KanCare also includes a safety net care pool to support certain hospitals that incur uncompensated care costs for Medicaid beneficiaries and the uninsured, and to provide incentives to hospitals for programs that result in delivery system reforms that enhance access to health care and improve the quality of care.

Goals

The KanCare demonstration will assist the State in its goals to:

- **Provide integration and coordination of care** across the whole spectrum of health to include physical health, behavioral health (mental health and substance use disorders) and long term services and supports (LTSS);
- **Improve the quality of care** Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes);
- **Control Medicaid costs** by emphasizing health, wellness, prevention and early detection, as well as integration and coordination of care; and
- **Establish long-lasting reforms** that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms, as well.

Hypotheses

The evaluation will test the following KanCare hypotheses:

- By holding managed care organizations (MCOs) to outcomes and performance measures, and tying measures to meaningful financial incentives, the State will improve health care quality and reduce costs;
- The KanCare model will reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired;

- The State will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health (BH), and LTSS; and
- KanCare will provide integrated care coordination to individuals with developmental disabilities, which will improve access to health services and improve the health of those individuals.

Performance Objectives

Through the extensive public input and stakeholder consultation process, when designing the comprehensive Medicaid reform plan, the State has identified a number of KanCare performance objectives and outcome goals to be reached through the comprehensive managed care contracts. These objectives include the following:

- Measurably improve health care outcomes for members in the areas including: diabetes, coronary artery disease, prenatal care, and BH;
- Improve coordination and integration of physical health care with BH care;
- Support members' desires to live successfully in their communities;
- Promote wellness and healthy lifestyles; and
- Lower the overall cost of health care.

Evaluation Plan

Evaluation is required to measure the effectiveness and usefulness of the demonstration as a model to help shape health care delivery and policy. The KanCare evaluation is being completed by the Kansas Foundation for Medical Care, Inc. (KFMC), which will subcontract as needed for targeted review. KFMC is the External Quality Review Organization (EQRO) in Kansas. Evaluation criteria are outlined in the comprehensive KanCare Program Medicaid State Quality Strategy and the CMS Special Terms and Conditions document.

In an effort to achieve safe, effective, patient-centered, timely, and equitable care, the State is assessing the quality strategy on at least an annual basis and will revise the State Quality Strategy document accordingly. The State Quality Strategy – as part of the comprehensive quality improvement strategy for the KanCare program, as well as the Quality Assurance and Performance Improvement plans of the KanCare MCOs, are dynamic and responsive tools to support strong, high quality performance of the program. As such, the State Quality Strategy is regularly reviewed and operational details will be continually evaluated, adjusted, and put into use. Revisions in the State Quality Strategy will be reviewed to determine the need for restructuring the specific measurements in the evaluation design and documented and discussed in the evaluation reports.

The KanCare Evaluation Design, approved by CMS in September 2013, updated in March 2015, includes over 100 performance measures focused on eight major categories with 27 subcategories (see Table 1):

- Quality of Care
- Coordination of Care (and Integration)
- Cost of Care
- Access to Care
- Ombudsman Program
- Efficiency
- Uncompensated Care Cost Pool (UCC)
- Delivery System Reform Incentive Program (DSRIP)

Table 1. Evaluation Design Categories and Subcategories
Quality of Care
(1) Physical Health
(2) Substance Use Disorder Services
(3) Mental Health Services
(4) Healthy Life Expectancy
(5) Home and Community Based Services (HCBS) Waiver Services
(6) Long Term Care: Nursing Facilities
(7) Member Surveys - Quality
(8) Provider Survey
(9) Grievances
(10) Other (Tentative) Studies (specific studies to be determined)
Coordination of Care (and Integration)
(11) Care Management for Members Receiving HCBS Services
(12) Other (Tentative) Study (specific study to be determined)
(13) Care Management for Members with I/DD
(14) Member Survey - CAHPS
(15) Member Survey - Mental Health (MH)
(16) Member Survey - Substance Use Disorder (SUD)
(17) Provider Survey
Cost of Care
(18) Costs
Access to Care
(19) Provider Network - GeoAccess
(20) Member Survey - CAHPS
(21) Member Survey - MH
(22) Member Survey - SUD
(23) Provider Survey
(24) Grievances
Ombudsman Program
(25) Calls and Assistance
Efficiency
(26) Systems
(27) Member Surveys
Uncompensated Care Pool
Delivery System Reform Incentive (DSRIP)

Over the five-year KanCare demonstration, performance measures are evaluated on either a quarterly basis or an annual basis. Due to revisions in reporting requirements, program updates, and changes in Healthcare Effectiveness Data and Information (HEDIS) measure specifications, a few measures were deleted, and several measures in the 2013 KanCare Evaluation Design were added or were slightly revised in 2015.

Data for the performance measures are provided by the Kansas Department of Health and Environment, Division of Healthcare Finance (KDHE-DHCF) and the Kansas Department for Aging and Disability Services (KDADS). Data sources include state tracking systems and databases, as well as

reports from the MCOs providing KanCare/Medicaid services. In calendar year (CY) 2013 through CY2017, the three MCOs are Amerigroup Kansas, Inc. (Amerigroup or AGP), Sunflower State Health Plan (Sunflower or SSHP), and UnitedHealthcare Community Plan of Kansas (UnitedHealthcare or UHC).

Wherever appropriate, and where data are available, performance measures will be analyzed by one or more of the following stratified populations:

- Program - Title XIX/Medicaid and Title XXI/CHIP (Children's Health Insurance Program)
- Age groups - particularly where stratified in HEDIS measures, waivers, and survey populations
- Waiver services
  - Intellectually/Developmentally Disabled (I/DD)
  - Physically Disabled (PD)
  - Traumatic Brain Injury (TBI)
  - Technical Assistance (TA)
  - Serious Emotional Disturbance (SED)
  - Frail Elderly (FE)
  - Money Follows the Person (MFP)
  - Autism
- Providers
- County type (Urban/Semi-Urban, Densely-Settled Rural, Rural/Frontier)
- Those receiving mental health (MH) services
  - Serious and Persistent Mental Illness (SPMI)
  - Serious Mental Illness (SMI)
  - SED (waiver and non-waiver)
- Those receiving treatment for Substance Use Disorder (SUD)
- Those receiving Nursing Facility (NF) services

Annual Evaluation 2016

In the first year of KanCare, baseline data and data criteria were established and defined. For some of the performance measures, baseline data were available pre-KanCare (CY2012 and CY2011). Where pre-KanCare data were not available, baseline data were based on CY2013 data or, for measures that require more than one year of data, CY2013/CY2014.

This fourth annual KanCare Evaluation includes analysis of performance for several measures that have pre-KanCare data, CY2013 through CY2015, and CY2016 available as of 3/10/2017. Data for CY2016 for many of the performance measures are not yet available. A major reason is that data for the entire year cannot be determined accurately until claims for the year, including fourth quarter CY2016 claims, are more complete (submitted to the MCOs and processed). Several measures are based on standardized HEDIS data analysis, and HEDIS data for 2016 will not be available until July 2017. Some of the HEDIS measures are multi-year measures; for these measures, baseline data for 2013 and 2014 are first reported in the KanCare Annual Evaluation for 2015.

In addition to the measures reviewed annually, there are several measures reviewed quarterly that are briefly summarized in this report. These quarterly measures are analyzed and summarized in detail in the KanCare Evaluation Quarterly Reports, beginning in Quarter 4 (Q4) CY2013, that are available for public review on the KanCare website.

Quality of Care

Goals, Related Objectives, and Hypotheses for Quality of Care subcategories:

- *Goal: Improve the quality of care Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes).*
- *Related Objectives: Measurably improve health care outcomes for members in areas including: diabetes; coronary artery disease; prenatal care; behavioral health.*
  - *Improve coordination and integration of physical health care with behavioral health care.*
  - *Support members successfully in their communities.*
  - *Promote wellness and healthy lifestyles.*
- *Hypotheses:*
  - *By holding MCOs to outcomes and performance measures, and tying measures to meaningful financial incentives, the State will improve health care quality and reduce costs.*
  - *The State will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health, mental health, substance use disorder, and LTSS.*

(1) Physical Health

The Physical Health performance measures include 18 HEDIS measures:

- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Adult BMI Assessment (ABA)
- Follow-Up Care for Children Prescribed ADHD Medication (ADD)
- Annual Dental Visit (ADV)
- Adolescent Well-Care Visits (AWC)
- Controlling High Blood Pressure (CBP)
- Comprehensive Diabetes Care (CDC)
- Chlamydia Screening in Women (CHL)
- Appropriate Testing for Children with Pharyngitis (CWP)
- Follow-Up after Hospitalization for Mental Illness (FUH)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
- Annual Monitoring for Patients on Persistent Medications (MPM)
- Medication Management for People with Asthma (MMA)
- Prenatal and Postpartum Care (PPC)
- Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)

Other Physical Health measures include Well-Child Visits (four or more) within the First Seven Months of Life (HEDIS-like measure) and Preterm Delivery.

The baseline data for most HEDIS and HEDIS-like measures are HEDIS 2014 (CY2013) administrative and hybrid data from claims and medical record review. (The baseline for multi-year measures is HEDIS 2015, including data from CY2013 and CY2014.) Administrative HEDIS data include all KanCare members from each MCO who met HEDIS eligibility criteria for each measure. Since these measures include all eligible members, the numerators and denominators for the three MCOs were combined to assess the aggregate baseline

percentages. Hybrid HEDIS data are based on samples of eligible members and include both administrative data and medical record review. As the hybrid HEDIS data are based on samples from each MCO, the aggregate data for hybrid measures were weighted to adjust for any differences in population and sample sizes.

The aggregated HEDIS percentages were compared to National Committee for Quality Assurance (NCQA) Quality Compass (QC) percentiles for HEDIS and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. HEDIS results, including comparison to QC national percentiles, are summarized in Table 2. Beginning with HEDIS 2015, QC percentile categories were expanded to report the 33.33rd and 66.67th percentiles. As a result, comparisons with previous years' reported percentiles may not be directly comparable; a metric reported for CY2013 as below the 50th percentile (and above the 25th percentile) may in CY2014 be reported as below the 33.33rd percentile but not represent a percentile drop.

Table 2. Physical Health HEDIS Measures, CY2013 - CY2015

Measure	HEDIS Aggregated Results			Quality Compass 50th Percentile		
	CY2015	CY2014	CY2013	CY2015	CY2014	CY2013
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
Ages 20-44	**83.7%**	84.3%	85.4%	↑	↑	↑
Ages 45-64	**92.3%**	92.4%	92.2%	↑	↑	↑
Ages 65 and older	**89.7%**	88.6%	89.5%	↑	↑	↑
Total - Ages 20 and older	**87.1%**	87.5%	88.4%	↑	↑	↑
Annual Dental Visit (ADV)						
Ages 2-3	**42.8%**	41.2%	40.8%	↑	↑	↑
Ages 4-6	**66.2%**	65.7%	66.3%	↑	↑	↑
Ages 7-10	**70.4%**	70.1%	70.7%	↑	↑	↑
Ages 11-14	**63.2%**	62.8%	62.8%	↑	↑	↑
Ages 15-18	**54.1%**	53.5%	53.9%	↑	↑	↑
Ages 19-21	**34.7%**	30.2%	31.5%	↑	↓	↓
Total - Ages 2-21	**60.9%**	60.0%	60.3%	↑	↑	↑
Adolescent Well Care Visits (AWC)						
	43.0%	42.6%	42.3%	↓	↓	↓
Controlling High Blood Pressure (CBP)						
	48.2%	51.5%	47.3%	↓	↓	↓
Comprehensive Diabetes Care (CDC)						
HbA1c Testing	**84.9%**	84.8%	83.1%	↓	↓	↓
Eye Exam (Retinal)	**62.5%**	58.6%	50.1%	↑	↑	↓
Medical Attention for Nephropathy	**89.2%**	76.8%	75.8%	↑	↓	↓
HbA1c Control (<8.0%)	**46.6%**	39.3%	39.0%	↓	↓	↓
HbA1c Poor Control (>9.0%) (lower % is goal)	**45.4%**	52.9%	54.4%	↓	↓	↓
Blood Pressure Control (<140/90)	**58.8%**	52.6%	53.1%	↓	↓	↓

Table 2. Physical Health HEDIS Measures, CY2013 - CY2015 (Continued)						
Measure	HEDIS Aggregated Results			Quality Compass 50th Percentile		
	CY2014		CY2013	CY2015	CY2014	CY2013
Chlamydia Screening in Women (CHL)						
Ages 16-20	**41.3%**	41.0%	42.4%	↓	↓	↓
Ages 21-24	**53.5%**	54.5%	55.6%	↓	↓	↓
Total – Ages 16-24	**45.8%**	45.4%	46.1%	↓	↓	↓
Appropriate Testing for Children with Pharyngitis (CWP)						
	55.1%	52.2%	51.6%	↓	↓	↓
Follow-up after Hospitalization for Mental Illness, within seven days of discharge (FUH)						
	62.8%	56.2%	61.0%	↑	↑	↑
Initiation in Treatment for Alcohol or other Drug Dependence (IET)						
Ages 13-17	**46.4%**	50.8%	49.0%	↑	↑	↑
Ages 18 and older	**37.7%**	41.3%	40.9%	↓	↑	↑
Total – Ages 13 and older	**38.9%**	42.6%	42.1%	↑	↑	↑
Engagement in Treatment for Alcohol or other Drug Dependence (IET)						
Ages 13-17	**26.8%**	31.0%	32.5%	↑	↑	↑
Ages 18 and older	**10.7%**	12.1%	12.2%	↑	↑	↑
Total – Ages 13 and older	**12.9%**	14.8%	15.2%	↑	↑	↑
Annual Monitoring for Patients on Persistent Medications (MPM)						
	90.2%	89.7%	84.9%	↑	↑	↓
Prenatal Care (PPC)						
	67.4%	70.4%	71.4%	↓	↓	↓
Postpartum Care (PPC)						
	57.5%	55.8%	60.3%	↓	↓	↓
Appropriate Treatment for Children with Upper Respiratory Infection (URI)						
	76.3%	73.5%	71.9%	↓	↓	↓
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)						
	62.8%	62.1%	60.8%	↓	↓	↓
Weight Assessment/BMI for Children and Adolescents (WCC)						
Ages 3-11	48.9%	44.3%	33.7%	↓	↓	↓
Ages 12-17	48.1%	47.3%	36.6%	↓	↓	↓
Total – Ages 3-17	48.6%	45.3%	34.7%	↓	↓	↓
Counseling for Nutrition for Children and Adolescents (WCC)						
Ages 3-11	50.6%	50.8%	47.4%	↓	↓	↓
Ages 12-17	45.7%	47.0%	46.0%	↓	↓	↓
Total – Ages 3-17	49.1%	49.5%	46.9%	↓	↓	↓
Counseling for Physical Activity for Children and Adolescents (WCC)						
Ages 3-11	43.3%	43.5%	39.6%	↓	↓	↓
Ages 12-17	48.3%	50.6%	53.1%	↓	↓	↓
Total – Ages 3-17	44.9%	45.8%	44.0%	↓	↓	↓

Table 2. Physical Health HEDIS Measures, CY2013 - CY2015 (Continued)					
Measure	HEDIS Aggregated Results			Quality Compass 50th Percentile	
Multi-Year HEDIS Measures Reported Beginning in CY2014 (HEDIS 2015)					
	CY2015	CY2014		CY2015	CY2014	CY2013
Adult BMI Assessment (ABA)					
	77.6%	72.2%		↓	↓	
Follow-Up Care for Children Prescribed ADHD Medication (ADD)					
Initiation Phase	50.7%	48.0%		↑	↑	
Continuation & Maintenance Phase	61.2%	54.8%		↑	↑	
Medication Management for People with Asthma (MMA)					
5-11 years of age	29.1%	27.4%		↑	↑	
12-18 years of age	26.6%	24.1%		↑	↑	
19-50 years of age	38.3%	39.6%		↑	↑	
51-64 years of age	55.1%	53.0%		↑	↑	
Total - Ages 5-64	29.9%	28.1%		↓	↓	
Well-Child Visits in the First 15 Months of Life (W15)					
0 visits	3.4%	4.2%		↑*	↑*	
1 visit	3.8%	4.8%		↑*	↑*	
2 visits	5.2%	6.2%		↑*	↑*	
3 visits	7.4%	8.3%		↑*	↑*	
4 visits	10.0%	13.4%		↑	↑	
5 visits	15.1%	18.4%		↓	↑	
6 or more visits	55.1%	44.7%		↓	↓	
* HEDIS rates greater than 50th percentile that indicate poor performance						

Pre-KanCare data available for some of the HEDIS measures below (CDC, W15, W34, AAP, and PPC) are based on HEDIS data for CY2012 from MCOs (Coventry and UniCare) that provided services to Kansas Medicaid members in 2012. The pre-KanCare and KanCare populations, however, are not directly comparable, as the KanCare populations include members receiving waiver services.

HEDIS measures

Adults' Access to Preventive/Ambulatory Health Services (AAP)

Population: Ages 20-44; 45-65; 65 and older; Medicaid

Analysis: Annual comparison to CY2013 baseline, trending over time

This measure tracks annual preventive/ambulatory visits. In each of the age ranges, the aggregate HEDIS results for CY2013 through CY2015 were above the QC 50th percentile; for ages 45-64 the results were again above the QC 90th percentile and for ages 20 and older continue to be above the QC 75th percentile. Pre-KanCare data were available for ages 20-44 and ages 45-64.

- **Ages 20-44 -** The KanCare aggregate rate based on administrative data for CY2015 was 83.7%, lower than in CY2014 (84.3%) and CY2013 (85.4%) but above the QC 75th percentile. SSHP was above the 75th percentile in all three years. In CY2012, the aggregate pre-KanCare percentage was slightly higher at 86.1%.

- **Ages 45-64 -** The KanCare aggregate rate based on administrative data for CY2015 (92.3%) was comparable to CY2014 (92.4%) and CY2013 (92.2%) and above the QC 90th percentile in all three years. In CY2012, the aggregate pre-KanCare percentage was lower at 87.8%.
- **Ages 65 and older -** The KanCare aggregate rate based on administrative data for CY2015 was 89.7%, higher than in CY2014 (88.6%) and comparable to CY2013 (89.5%). Rankings for all three MCOs were above the QC 66.67th percentile. (Pre-KanCare data were not reported by the MCOs for CY2012 for those ages 65 and older.)
- **Total – Ages 20 and older -** The KanCare aggregate rate based on administrative data for CY2015 was 87.1%, comparable to CY2014 (87.5%) and lower than in CY2013 (88.4%), and above the QC 75th percentile in all three years..

Annual Dental Visit (ADV) (P4P 2016)
Population: Medicaid and CHIP combined populations, Ages 2-3; Ages 4-6; Ages 7-10; Ages 11-14; Ages 15-18; Ages 19-21; Total (Ages 2-21)
Analysis: Annual comparison to CY2013 baseline and trending over time
In CY2015, aggregate administrative HEDIS rates for each age range were above the QC 50th percentile.

- **Ages 2-3** – 42.8% in CY2015 (>66.67th QC percentile), higher than 41.2% in CY2014 (>50th QC percentile) and 40.8% in CY2013 (>50th QC percentile).
- **Ages 4-6** – 66.2% in CY2015, higher than CY2014 (65.7%) and comparable to CY2013 (66.3%).
- **Ages 7-10** – 70.4% in CY2015, comparable to CY2014 (70.1%) and CY2013 (70.7%).
- **Ages 11-14** – 63.2% in CY2015, slightly above CY2014 (62.8%) and CY2013 (62.8%).
- **Ages 15-18** – 54.1% in CY2015, slightly above CY2014 (53.5%) and CY2013 (53.9%).
- **Ages 19-20** – 34.7% in CY2015 (>50th QC percentile), an increase from CY2014 (30.2%; <50th QC percentile) and 31.5% (<50th QC percentile).
- **Total - Ages 2-20** – 60.9% in CY2015 (>75th QC percentile for all three MCOs), comparable to 60.0% in CY2014 (>66.67th QC percentile for all three MCOs) and 60.3% in CY2013 (>50th QC percentile).

Adolescent Well Care Visits (AWC)
Population: Ages 12-21; Medicaid and CHIP combined populations
Analysis: Annual comparison to CY 2013 baseline and trending over time
(*AWC is a quality measure in the CMS 2017 Core Set of Child Health Care Quality Measures for Medicaid*.)
The aggregate rate based on administrative data for CY2015 was 43.0%, comparable to CY2014 (42.6%) and CY2013 (42.3%), and below the QC 50th percentile. Results for all three MCOs were below the QC 50th percentile; AGP again had the lowest result, 40.6%, which was below the QC 25th percentile.

Controlling High Blood Pressure (CBP)
Population: Medicaid
Analysis: Annual comparison to CY2013 baseline, trending over time
(*CBP is a quality measure in the CMS 2017 Core Set of Adult Health Care Quality Measures for Medicaid*.)
The aggregate rate based on weighted hybrid data for CY2015 was 48.2% (below the QC 33.33rd percentile), a decrease compared to 51.5% in CY2014 (below the QC 33.33rd percentile), and an increase compared to CY2013 (47.3%; below the QC 25th percentile).

Comprehensive Diabetes Care (CDC)

This measure is a composite HEDIS measure composed of eight metrics. Five of these metrics are Kansas pay-for-performance (P4P) measures. In CY2013 through CY2015, the three MCOs reported hybrid data for seven of the eight measures. The eighth measure, glycated hemoglobin (HbA1c) <7.0% has a more limited eligibility; only two of the three MCOs reported HEDIS results for CY2014.

Population: Ages 18-75; Medicaid

Analysis: Pre-KanCare compared to KanCare and trending over time

(*HbA1c Testing and HbA1c Poor Control [>9.0%] are quality measures in the CMS 2017 Core Set of Adult Health Care Quality Measures for Medicaid*.)

- **HbA1c Testing** (P4P 2014-2016) **-** The aggregate rate based on weighted hybrid data for CY2015 was 84.9%, comparable to CY2014 (84.8%) and higher than CY2013 (83.1%) and CY2012 pre-KanCare (76.5%). All three MCOs in CY2015 were below the QC 50th percentile.
- **Eye Exam (Retinal)** (P4P 2014-2016) - The aggregate rate based on weighted hybrid data for CY2015 was 62.5%, above the QC 75th percentile, and higher than CY2014 (58.6%; above the QC 50th percentile) and CY2013 (50.1%; below the QC 50th percentile). Rates in CY2013 to CY2015 were higher than in CY2012 (41.7%). In CY2015, SSHP and UHC rates were above the QC 75th percentile, and AGP's rate was above the QC 50th percentile.
- **Medical Attention for Nephropathy** (P4P 2014-2016) - The aggregate rate based on weighted hybrid data for CY2015 was 89.2%, which was higher than in CY2014 (76.8%), CY2013 (75.8%), and CY2012 (66.3%), but below the QC 33.33rd percentile due to high national rates for this metric. The MCO rates in CY2015 ranged from 85.9% (<25th QC percentile) to 92.5% (>75th QC percentile).
- **HbA1c Control (<8.0%)** (P4P 2014-2016) - The aggregate rate based on weighted hybrid data for CY2015 was 46.6%. Though below the QC 50th percentile, the CY2015 rates were 7.3% higher than CY2014 (39.3%) and higher than CY2013 (39.0%) and CY2012 (16.0%). Rates and QC percentile ranks for all three MCOs increased in CY2015: AGP's rate increased 5.2% (49.3%; >50th QC percentile); SSHP's rate increased 5.5% (45.6%; <50th QC percentile); and UHC's percentage increased 16.7% (43.0%; <50th QC percentile).
- **Blood Pressure Control (<140/90)** (P4P 2014-2016) - The aggregate rate based on weighted hybrid data for CY2015 was 58.8%, which was above the rates in CY2014 (52.6%) and CY2013 (53.1%). QC ranking increased from below the QC 25th percentile to above the 33.33rd percentile. AGP's rate was above the QC 50th percentile; SSHP's and UHC's rates were below the QC 50th percentile.
- **HbA1c Poor Control (>9.0%)** – For this metric, the goal is to have a lower rate and lower QC percentile. The aggregate rate based on weighted hybrid data for CY2015 was 45.4%, an improvement compared to CY2014 (52.9%), CY2013 (54.4%), and CY2012 (83.4%) and was below the QC 50th percentile (i.e., nationally less than 50% had lower percentages of eligible members with HbA1c >9.0%). SSHP's and UHC's rates were below the 50th percentile; AGP's percentage (49.3%) was higher and was above the QC 50th percentile.

Appropriate Testing for Children with Pharyngitis (CWP)

Population: Medicaid and CHIP combined populations

Analysis: Annual comparison to 2013 baseline and trending over time

The aggregate rate based on administrative data for CY2015 was 55.1% (<10th QC percentile), up from 52.2% in CY2014 and 51.6% in CY2013 (51.6%).

Chlamydia Screening in Women (CHL)
Population: Medicaid and CHIP combined populations
Analysis: Annual comparison to CY2013 baseline and trending over time
(*CHL is a quality measure in the CMS Adult and Child 2017 Core Sets of Health Care Quality Measures for Medicaid*.)
The CY2015 and CY2014 aggregate rates and by age group were comparable and slightly lower than those of CY2013. Rates in CY2015 in total and for both age groups were below the QC 25th percentile for all three MCOs.

- **Ages 16-20** – 41.3% in CY2015; 41.0% in CY2014; 42.4% in CY2013.
- **Ages 21-24** – 53.5% in CY2015; 54.5% in CY2014; 55.6% in CY2013.
- **Total – Ages 16-24** – 45.8% in CY2015; 45.4% in CY2014; 46.1% in CY2013.

Follow-up after Hospitalization for Mental Illness, within seven days of discharge (FUH) (P4P 2014-2015)
Population: Medicaid and CHIP combined populations
Analysis: Annual comparison to CY2013 baseline, trending over time
(*FUH is a quality measure in the CMS Adult, Child, and Behavioral Health 2017 Core Sets of Health Care Quality Measures for Medicaid*.)
The aggregate rate based on administrative data for CY2015 was 62.8%, higher than in CY2014 (56.2%) and CY2013 (61.0%). SSHP's rate (67.2%) and UHC's rate (67.7%) were both above the QC 90th percentile in CY2015; AGP's rate (54.3%) was above the 66.67th percentile.

Initiation and Engagement in Treatment for Alcohol or other Drug Dependence (IET)
Population: Medicaid and CHIP combined populations
Analysis: Annual comparison to CY2013 baseline, trending over time
(*IET is a quality measure in the CMS Adult and Behavioral Health 2017 Core Sets of Health Care Quality Measures for Medicaid*.)

- **Initiation in Treatment**
  The CY2015 aggregate HEDIS rates for the total eligible KanCare population and for both age strata were lower than rates in CY2014 and CY2013.
  - **Ages 13-17** - The aggregate rate based on administrative data for CY2015 was 46.4% (>50th QC percentile) and below CY2014 (50.8%) and CY2013 (49.0%). Rankings in CY2013 and CY2014 were above the 75th percentile. SSHP's rate in CY2015 (41.7%) was below the 50th percentile and was a drop of 13.6%. AGP's rate was >50th QC percentile and decreased 4.7%. UHC's rate increased 5.4% and was >75th QC percentile.
  - **Age 18 and older** - The aggregate rate based on administrative data for CY2015 was 37.7% (below the QC 50th percentile), dropping from 41.3% in CY2014 (>66.67th QC percentile) and 40.9% in CY2013 (>50th QC percentile). AGP's and UHC's rates were below the QC 50th percentile after being >75th (AGP) and >50th (UHC) QC percentiles in CY2014. SSHP's rate was >50th QC percentile, down from >75th QC percentile in CY2014.
  - **Total – Age 13 and older** - The aggregate rate based on administrative data for CY2015 was 38.9% (>50th QC percentile for all three MCOs), a decrease from 42.6% in CY2014 (>75th QC percentile) and 42.1% in CY2013.
- **Engagement in Treatment**
  The CY2015 aggregate HEDIS rate for the total population decreased from CY2014 and CY2013, but was above the QC 66.67th percentile. It should be noted, however, that the national HEDIS rates for engagement in treatment are not very high; although the total results for the KanCare population

in CY2015 were above the QC 66.67th percentile, only 12.9% of eligible members ages 13 and older were engaged in treatment.

- **Ages 13-17** - The aggregate rate based on administrative data for CY2015 was 26.8% (>90th QC percentile), a decrease from CY2014 (31.0%) and CY2013 (32.5%).
- **Age 18 and older** - The aggregate rate based on administrative data was only 10.7% in CY2015, a decrease from 12.1% in CY2014 and 12.2% in CY2013, but above the QC 50th percentile in all three years.
- **Total – Ages 13 and older** - The aggregate rate based on administrative data for CY2015 was 12.91%, a decrease from 14.8% in CY2014 (> QC 66.67th percentile in CY2014 and CY2015), and a decrease compared to 15.2% in CY2013 (>75th QC percentile).

Annual Monitoring for Patients on Persistent Medications (MPM) (P4P 2014-2016)
Population: Medicaid, Age 18 and older
Analysis: Annual comparison to CY2013 baseline, trending over time
(*MPM is a quality measure in the CMS 2017 Core Set of Adult Health Care Quality Measures for Medicaid*.)
The aggregate rate based on administrative data for CY2015 was 90.2%, comparable to CY2014 (89.7%) and above the QC 75th percentile in both years. This is an improvement compared to CY2013 (84.9%) where all three MCOs' percentages were below the QC 50th percentile.

Prenatal and Postpartum Care (PPC) (P4P – Prenatal Care 2016)
Population: Medicaid and CHIP combined populations
Analysis: Pre-KanCare compared to KanCare and trending over time
(*PPC- Prenatal Care is a quality measure in the CMS 2017 Core Set of Child Health Care Quality Measures for Medicaid*. *PPC – Postpartum Care is a quality measure in the CMS 2017 Core Set of Adult Health Care Quality Measures for Medicaid*.)

- **Prenatal Care** - The aggregate rate based on weighted hybrid data for CY2015 was 67.4%, a decrease compared to CY2014 (70.4%) and CY2013 (71.4%) and below the QC 25th percentile in all three years. SSHP had the highest rate in CY2015 (71.8%); rates for AGP (65.4%) and UHC (64.7%) were below the QC 10th percentile. This measure is a P4P measure beginning in CY2016. The CY2012 hybrid percentage available from one of the pre-KanCare MCOs was lower at 57.9%.
- **Postpartum Care** - The aggregate rate based on weighted hybrid data for CY2015 was 57.5%, above the CY2014 rate (55.8%) and below CY2013 (58.5%). The rates were below the QC 50th percentile all three years. The CY2012 hybrid percentage available from one of the pre-KanCare MCOs was lower at 54.8%.

Appropriate Treatment for Children with Upper Respiratory Infection (URI)
Population: Medicaid and CHIP combined populations
Analysis: Annual comparison to CY2013 baseline and trending over time
The aggregate rate based on administrative data for CY2015 was 76.3% (<25th QC percentile), up from 73.5% in CY2014 and 71.9% in CY2013 (71.9%).

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
Population: Ages 3-6; Medicaid and CHIP combined populations
Analysis: Pre-KanCare compared to KanCare and trending over time
(*W34 is a quality measure in the CMS 2017 Core Set of Child Health Care Quality Measures for Medicaid*.)

The aggregate rate based on administrative data for CY2015 was 62.8%, a slight increase over CY2014 (62.1%), higher than in CY2013 (60.8%), but lower than in CY2012 (65.4%). The aggregate rates in CY2013 through CY2015 were below the QC 25th percentile.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

Population: Medicaid and CHIP combined populations, ages 3-17.
Analysis: Annual comparison to CY2013 baseline and trending over time
(*WCC – Weight Assessment/BMI is a quality measure in the CMS 2017 Core Set of Child Health Care Quality Measures for Medicaid*.)

- **Weight Assessment/BMI**
  The aggregate weighted hybrid HEDIS rates for reporting BMI (Body Mass Index) have increased from CY2013 to CY2015 but have remained below the QC 25th percentile.
  - **Ages 3-11** – 48.9% in CY2015; 44.3% in CY2014; 33.7% in CY2013.
  - **Ages 12-17** – 48.1% in CY2015; 47.3% in CY2014; 36.6% in CY2013.
  - **Total – Ages 3-17** – 48.6% in CY2015; 45.3% in CY2014; 34.7% in CY2013.
- **Counseling for Nutrition**
  The CY2015 aggregate weighted hybrid HEDIS rates in total and by age group were below the QC 25th percentile.
  - **Ages 3-11** – 50.6% in CY2015, comparable to 50.8% in CY2014 and above CY2013 (47.4%).
  - **Ages 12-17** – 45.7% in CY2015, lower than CY2014 (47.0%) and comparable to CY2013 (46.0%).
  - **Total – Ages 3-17** – 49.1% in CY2015, comparable to CY2014 (49.5%) and higher than in CY2013 (46.9%).
- **Counseling for Physical Activity**
  The aggregate weighted hybrid HEDIS rate for each age strata (ages 3-11; ages 12-17; and ages 3-17) were below the QC 50th percentile in CY2013 through CY2015.
  - **Ages 3-11** – 43.3% (<25th QC percentile) in CY2015, comparable to 43.5% in CY2014 (<33.33rd QC percentile), higher than in CY2013 (39.6%; <50th QC percentile). AGP had the lowest percentage (37.4%) and UHC had the highest (48.2%).
  - **Ages 12-17** – 48.3% in CY2015, lower than in CY2014 (50.6%) and CY2013 (53.1; AGP had the lowest percentage (42.5%) and SSHP the highest (53.1%).
  - **Total – Ages 3-17** – 44.9% in CY2015, down from 45.8% in CY2014 and higher than in CY2013 (44.0%).

Multi-year HEDIS measures
The eligibility criteria for the following HEDIS measures extend beyond one year. Data reported in for CY2013 and CY2014 serve as baseline for assessing changes in subsequent years.

Adult BMI Assessment (ABA)

Data for this measure are based on aggregate weighted hybrid HEDIS data.
Population: Medicaid and CHIP combined populations age 18 and older
Analysis: Annual comparison to baseline reported in CY2014 and trending over time
(Adult BMI assessment is a quality measure in the CMS 2017 Core Set of Adult Health Care Quality Measures for Medicaid.)
The aggregate rate based on hybrid data for CY2015 was 77.6%, an increase compared to 72.2% in CY2014 was 72.2%, but below the QC 33.33rd percentile.

Follow-Up Care for Children Prescribed ADHD Medication (ADD)
Data are based on aggregate weighted administrative HEDIS data.
Population: Ages 6-12; Medicaid and CHIP combined populations; Children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD)
Analysis: Annual comparison to baselines reported in CY2014 and trending over time
(*ADD is a quality measure in the CMS Child and Behavioral Health 2017 Core Sets of Health Care Quality Measures for Medicaid*.)

- **Initiation Phase** – The aggregate weighted rate in CY2015 was 50.7% (>75th QC percentile), an increase 48.0% in CY2014 (>66.67th QC percentile). UHC had the highest rate (56.6%; >90th QC percentile); SSHP at 54.2% was above the QC 75th percentile; and AGP's 41.2% rate in CY2015 was below the QC 50th percentile.
- **Continuation & Maintenance Phase** – The aggregate weighted rate was 61.2% in CY2015 (>66.67th QC percentile), up from 54.8% in CY2014 (>50th QC percentile). Rates for continuation and maintenance increased for all three MCOs. UHC had the highest rate (67.3%; >90th QC percentile); SSHP at 66.3% was above the 75th percentile; AGP at 50.4% was below the QC 50th percentile, but was a 10% increase compared to CY2014.

Medication Management for People with Asthma (MMA)
Data are based on aggregated weighted administrative HEDIS data. QC percentiles are based on 75% compliance by age group and in total.
Population: Ages 5-11, 12-18, 19-50, 51-65; Medicaid and CHIP combined populations
Analysis: Annual comparison to baselines reported in CY2014 and trending over time
(MMA is a quality measure in the CMS 2017 Core Set of Child Health Care Quality Measures for Medicaid)

- **Ages 5-11** – 29.1% in CY2015, up from 27.4% in CY2014, above the QC 50th percentile both years. UHC's rate (31.3%; >66.67th QC percentile) was the highest of the three MCOs, increasing more than 8%. AGP (30.1%) and SSHP (26.7%) were both above the QC 50th percentile.
- **Ages 12-18** – 26.6% in CY2015, an increase compared to 24.1% in CY2014, above the QC 50th percentile both years.
- **Ages 19-50** – 38.3% in CY2015 (>50th QC percentile), an increase compared to 39.6% in CY2014 (> 66.67th QC percentile). UHC had the highest rate (45.7%; >75th QC percentile), and AGP had the lowest (32.2%; <33.33rd QC percentile). SSHP's 38.1% rate was above the QC 50th percentile.
- **Ages 51-64** – 55.1% in CY2015, an increase compared to 53.0% in CY2014, above the QC 66.67th percentile both years.
- **Total (Ages 5-64)** – 29.9% in CY2015, an increase compared to 28.1% in CY2014, below the QC 50th percentile both years. UHC's 31.9% was the highest of the three MCOs (>50th QC percentile). AGP's rate (29.4%) and SSHP's rate (28.9%) were below the QC 50th percentile.

Well-Child Visits in the First 15 Months of Life (W15)
This metric tracks the number of well-child visits after hospital discharge post-delivery. QC percentiles must be interpreted differently from those above; being above the 75th percentile for "0 visits," for example is not a positive result, whereas being above the 75th percentile for "6 or more visits" would be a positive result. Data are based on aggregated weighted administrative HEDIS data.
Population: Age through 15 months; Medicaid and CHIP combined populations
Analysis: Annual administrative rates compared to baselines reported in CY2014 and trending over time

(*W15 is a quality measure in the CMS 2017 Core Set of Child Health Care Quality Measures for Medicaid*.)

- **0 visits** – 3.4% in CY2015, an improvement compared to 4.2% in CY2014 (>75th QC percentile both years).
- **1 visit** – 3.8% in CY2015 (>75th QC percentile), an improvement compared to 4.8% in CY2014 (>95th QC percentile).
- **2 visits** – 5.2% in CY2015 (>75th QC percentile), an improvement compared to 6.2% in CY2014 (>90th QC percentile).
- **3 visits** – 7.4% in CY2015 (>75th QC percentile), an improvement compared to 8.3% in CY2014 (>90th QC percentile).
- **4 visits** – 10.0% in CY2015 (>50th QC percentile), a decrease from 13.4% in CY2014 (>75th QC percentile).
- **5 visits** – 15.1% in CY2015 (<33.33rd QC percentile), a decrease from 18.4% in CY2014 (>50th QC percentile).
- **6 or more visits** – 55.1% in CY2015 (<33.33rd QC percentile), an increase from 44.7% in CY2014 (<25th QC percentile).

Additional P4P Physical Health Measures

Well-Child Visits, Four Visits within the First Seven Months of Life (P4P 2014-2015)

For this P4P measure, the MCOs reported the percentage of children who had four or more well-child visits within the first seven months (post-discharge after birth). This measure is HEDIS-like, in that the HEDIS criteria and software for Well-Child Visits within the first 15 months of Life (W15) was adapted to include well-child visits only within the first seven months to allow annual calendar year assessment of progress. Now that multiple years of MCO data are available, progress in completing well-child visits in these first months will be assessed through the Well-Child Visits in the First 15 Months of Life (W15) HEDIS measure.

Population: Medicaid and CHIP combined populations

Analysis: Annual comparison to 2013 baseline, trending over time

In CY2015, 67.6% of 4,471 infant members born in January through May 2015 had four or more well-child visits by the time they were seven months of age. This was a 6.2% decrease compared to CY2014 (72.1% of 6,442) and comparable to CY2013 (66.9% of 5,824).

Preterm Delivery (P4P 2014-2015)

Population: Medicaid and CHIP combined populations

Analysis: Annual comparison to 2013 baseline, trending over time

Preterm delivery rates in 2013 to Medicaid and CHIP members were the baseline data. Each MCO uses unique systems for tracking preterm delivery. Because of differences in tracking methods and criteria, the preterm delivery rates should not be compared to preterm birth rates reported in vital statistics records of the State or other agencies. MCO preterm delivery rates ranged from 9.8% (SSHP) to 10.7% (AGP). SSHP had the highest improvement, with their preterm delivery rate dropping from 11.4% to 9.8%, a relative decrease of 14% from 2014 to 2015. UHC's preterm delivery rate, which had the largest improvement of the three MCOs from 2013 (10.3%) to 2014 (9.5%), increased to 10.5% in 2015. AGP's preterm delivery rate decreased 5% from 11.3% in 2014 to 10.7% in 2015.

(2) Substance Use Disorder (SUD) Services

The following performance measures are based on National Outcome Measurement System (NOMS) measures for members who are receiving SUD services, including improvement in living arrangements,

reduction in number of arrests, reduction in drug and alcohol use, attendance at self-help meetings, and employment status. Each of these measures is tracked annually and for trends over time, comparing pre-KanCare (CY2012) with each year of the KanCare demonstration project.

In the following SUD measures, members may be included in more than one quarter of data (or may be counted more than once in a quarter), as they may be discharged from SUD treatment in one month, but re-enter treatment later in the quarter or year. The denominators in the tables below represent the number of times members were discharged from SUD treatment during the quarter. The actual number of individual members who received SUD services each year is not reported.

The number and percent of members receiving SUD services whose living arrangements improved
The denominator for this performance measure is the number of KanCare members (annual quarterly average) who were discharged from SUD services during the measurement period and whose living arrangement details were collected by KDADS in the Kansas Client Placement Criteria (KCPC) state tracking system. The numerator is the number of members with stable living situations at time of discharge from SUD services (see Table 3).

Table 3. Number and Percent of Members Receiving SUD Services who were in Stable Living Situations at Discharge - Annual Quarterly Average, CY2012 - CY2016

	Pre-KanCare	KanCare			
	CY2012	CY2013	CY2014	CY2015	CY2016
Numerator: Number of KanCare members in stable living situations at discharge	199	218	189	183	190
Denominator: Number of KanCare members discharged from SUD services during the reporting period	201	220	190	185	196
Percent of KanCare members in stable living situations at discharge from SUD services	99.0%	99.1%	99.3%	98.7%	96.9%

Data for this measure are tracked and reported quarterly by KDADS. The percentages of members in stable living conditions at time of discharge from SUD services were consistently high throughout CY2012 through CY2016. The high rate, over 96% in each quarter of the four year period, is attributed by KDADS staff to the nature of treatment (active participation and attendance) in conjunction with the time of data collection (on day of discharge from treatment).

The number and percent of members receiving SUD services whose criminal justice involvement improved
The denominator for this measure is the number of members who were discharged from SUD services during the measurement period (annual quarterly average) and whose criminal justice involvements were collected in the KCPC system at both admission and discharge from SUD services (see Table 4). The numerator is the number of members who reported no arrests in the 30 days prior to discharge.

Quarterly rates of those without arrests were over 98% for each quarter of CY2012 through CY2016. This equates to about 1 to 4 arrests per quarter.

Table 4. Number and Percent of Members Receiving SUD Services Whose Criminal Justice Involvement Decreased - Annual Quarterly Average, CY2012 - CY2016					
	Pre-KanCare	KanCare			
	CY2012	CY2013	CY2014	CY2015	CY2016
Numerator: Number of members without arrests at time of discharge from SUD services	199	219	188	183	193
Denominator: Number of members discharged from SUD services during the reporting period	201	220	190	185	196
Percent of members without arrests during reporting period	99.0%	99.3%	98.9%	98.8%	98.5%

The number and percent of members receiving SUD services whose drug and/or alcohol use decreased

The denominator for this measure is the number of members (annual quarterly average) who were discharged from SUD services during the measurement period and whose substance use information was collected in the KCPC at discharge from SUD treatment (see Table 5). The numerator is the number of members who reported at discharge no use of alcohol and other drugs for the prior 30 days.

Table 5. Number and Percent of Members Receiving SUD Services with Decreased Drug and/or Alcohol Use - Annual Quarterly Average, CY2012 - CY2016					
	Pre-KanCare	KanCare			
	CY2012	CY2013	CY2014	CY2015	CY2016
Numerator: Number of members discharged from SUD services who were abstinent from alcohol and other drugs	191	207	181	173	178
Denominator: Number of KanCare members discharged from SUD services during reporting period	201	220	190	185	196
Percent of members abstinent from alcohol and other drugs at time of discharge from SUD services	95.3%	94.2%	95.5%	93.3%	90.8%

The quarterly percentages of decreased use of alcohol and other drugs were reported to be above 90% in each quarter of CY2012 through CY2016. The annual quarterly average for CY2016 (90.8%) was the lowest in the last five years.

The number and percent of members, receiving SUD services, whose attendance of self-help meetings increased

The denominator for this measure is the number of members who were discharged from SUD services during the measurement period (annual quarterly average) and whose attendance at self-help programs was collected in KCPC at both admission and discharge from SUD treatment services (see Table 6). The numerator is the number of members who reported attendance at self-help programs prior to discharge from SUD services.

The average annual quarterly percentage of attendance of self- help programs has been decreasing since CY2012. The annual quarterly average in CY2016 (39.0%) was the lowest in the five year period from CY2012 to CY2016.

Table 6. Number and Percent of Members Receiving SUD Services Attending Self-help Programs - Annual Quarterly Average, CY2012 - CY2016					
	Pre-KanCare	KanCare			
	CY2012	CY2013	CY2014	CY2015	CY2016
Numerator: Number of KanCare members attending self-help programs	121	93	85	73	71
Denominator: Number of KanCare members discharged from SUD services during quarter	201	220	190	185	182
Percent of KanCare members attending self-help programs	59.9%	42.3%	44.5%	39.5%	39.0%

The number and percent of members receiving SUD services whose employment status was improved or maintained (P4P 2014-2016)
The denominator for this measure is the number of members, ages 18 and older at admission to SUD services, (annual quarterly average) who were discharged from SUD services during the measurement period and whose employment status was collected in the KCPC database at discharge from SUD services (see Table 7). The numerator is the number of members who reported at discharge from SUD services that they were employed full-time or part-time.

Table 7. Number and Percent of Members Discharged from SUD Services who were Employed - Annual Quarterly Average, CY2012 - CY2016					
	Pre-KanCare	KanCare			
	CY2012	CY2013	CY2014	CY2015	CY2016
Numerator: Number of KanCare members employed (full-time or part-time)	60	70	80	86	75
Denominator: Number of KanCare members discharged from SUD services during reporting period	201	220	229	206	196
Percent of members employed at discharge from SUD services	29.7%	31.8%	34.7%	41.8%	38.3%

The percentage of members reporting employment at discharge in 2015 (41.8%) was 20.5% higher (7.1 percentage points) than in 2014 (34.7%) In 2016, the percentage employed decreased by 9.1% (3.5 percentage points) compared to 2015.

There are two types of SUD treatment services: outpatient/reintegration and intermediate/residential. In outpatient/reintegration, working is allowed or encouraged, while in intermediate/residential treatment employment is not permitted, which is a major factor in the low percentage employed at discharge from SUD treatment.

(3) Mental Health Services
The following performance measures are based on NOMS for members who are receiving MH services, including adults with SPMI and youth experiencing SED. Measures focus on increased access to services for SPMI adults and SED youth, improvement in housing status for homeless adults, improvement or maintenance of residential status for youth, gain or maintenance of employment status for SPMI

adults, improvement in Child Behavior Checklist (CBCL) Competence scores, and reduction in inpatient psychiatric services. Each of these measures is to be tracked annually and for trends over time, comparing pre-KanCare (CY2012) with each year of the KanCare demonstration project.

In the following measures, members may be included in more than one quarter of data, as housing and employment status may change throughout the year. Members may also have more than one inpatient admission during the year (or within a quarter).

The number and percent of adults with SPMI with access to services (P4P 2014-2015)
The denominator for this measure is the number of KanCare adult members at the beginning of each quarterly measurement period (see Table 8). The numerator is the number of KanCare adults with SPMI based on assessments and reporting by Community Mental Health Centers (CMHCs) who continue to be eligible to receive services in the measurement period.

Table 8. Number and Percent of KanCare Adults with SPMI - Annual Quarterly Average, CY2012 - CY2016

	Pre-KanCare	KanCare				
	CY2012	CY2013	CY2014	CY2014	CY2015	CY2016
Numerator: Number of KanCare adults with SPMI	8,051	5,745	5,440	7,515	7,389	6,933
Denominator: Number of KanCare adults	123,656	126,305	131,989	134,843	136,989	143,108
Percent of KanCare adults with SPMI	6.5%	4.5%	4.1%	5.6%	5.4%	4.8%
Adult access rate per 10,000	651.1	454.9	412.2	557.3	539.4	484.5

Tracking for this measure is dependent on consistent and complete reporting of data to KDADS by the CMHCs. In CY2015, KDADS implemented policies that have resulted in increased and more complete reporting of this data, which allows more accurate trend analysis. The percentage of members identified as SPMI was slightly lower in CY2015 (5.4%) than in CY2014 (5.6%). The CY2016 percentage (4.8%) was lower, but may be incomplete due to claims lag.

The number and percent of youth experiencing SED who had increased access to services (P4P 2014-2015)
The denominator for this measure is the number of KanCare youth members at the beginning of each measurement period (see Table 9). The numerator is the number of KanCare youth experiencing SED based on assessments and reporting by CMHCs for each measurement period.

Table 9. Number and Percent of KanCare Youth Experiencing SED - Annual Quarterly Average, CY2012 - CY2016

	Pre-KanCare	KanCare			
	CY2012	CY2013	CY2014	CY2015	CY2016
Numerator: Number of SED youth	14,937	11,984	14,782	14,834	15,206
Denominator: Number of KanCare youth	267,788	274,326	285,753	284,830	294,494
Percent of SED youth	5.6%	4.4%	5.2%	5.2%	5.2%
SED rate per 10,000	557.8	436.9	517.3	520.8	516.3

Tracking for this measure is dependent on consistent and complete reporting of data to KDADS by the CMHCs. In CY2015, KDADS implemented policies that have resulted in increased and more complete reporting of this data that allows more accurate trend analysis. The percentage of youth identified as SED has been stable for the last three years at 5.2% of youth members.

The number and percent of adults with SPMI who were homeless at the beginning of the reporting period that were housed by the end of the reporting period

The denominator for this measure is the number of KanCare homeless adults with SPMI at the beginning of each quarter. The numerator is the number of KanCare adults with SPMI with improvement in their housing status by the end of the quarter for CY2012 to CY2015 (see Table 10).

Table 10. Number and Percent of Members with SPMI Homeless at the Beginning of the Quarter That were Housed at the End of the Quarter - Annual Quarterly Average, CY2012 - CY2015

	Pre-KanCare	KanCare		
	CY2012	CY2013	CY2014	CY2015
Numerator: Number of KanCare adults with SPMI homeless at the beginning of quarter housed at the end of the quarter	69	58	35	46
Denominator: Number of KanCare adults with SPMI homeless at the beginning of the quarter	150	100	70	104
Percentage of adults with SPMI who were homeless at the beginning of the quarter housed by the end of the quarter	45.7%	58.0%	49.1%	44.6%

The annual quarterly average number of adults with SPMI who were homeless at the start of each quarter decreased from an average of 150 in CY2012 to 100 in CY2013 to 70 in CY2014 and then increased again to an annual quarterly average of 104 in CY2015. Compared to CY2012 (45.7%), the average annual quarterly average of those who were housed at the end of each quarter was higher in CY2013 (58.0%) and CY2014 (49.1%), but dropped in CY2015 to 44.6%. No update was available for CY2016.

The number and percent of KanCare youth receiving MH services with improvement in their Child Behavior Checklist (CBCL Competence T-scores)

The denominator is the number of youth with prior competence scores within clinical range (score of 40 or less). The numerator is the number of youth with improvement in their most recent competence score (see Table 11).

The numbers of SED/CBS (Community-Based Services) youth with prior competence scores of 40 or less have decreased each year from CY2012 to CY2014. The percentage with improvement in their most recent CBCL score has been relatively comparable in each of these testing periods. CY2015 continues this trend. No update was available for CY2016.

Table 11. Number and Percent of KanCare SED/CBS Youth with Improvement in Their Child Behavior Checklist (CBCL) Scores, CY2012 - CY2015								
	Pre-KanCare		KanCare					
	CY2012		CY2013		CY2014		CY2015	
	S1	S2	S1	S2*	S1	S2	S1	S2
Numerator: Number of KanCare SED/CBS youth with increased total competence score	1313	1170	1466		912	785	958	886
Denominator: Number of KanCare SED/CBS youth with prior competence score less than 40	2,490	2,207	2,796		1,705	1,513	1,804	1,666
Percent of KanCare SED/CBS youth with improvement in their most recent CBCL competence score	52.7%	53.0%	52.4%		53.5%	51.9%	53.1%	53.2%
* No data available								

The number and percent of youth with an SED who experienced improvement in their residential status

The denominator for this measure is the number of KanCare SED youth with unstable living arrangements at the beginning of each quarterly measurement period. The numerator for this measure is the number of KanCare SED youth with improved housing status at the end of the quarterly measurement period (see Table 12).

Table 12. Number and Percent of SED Youth who Experienced Improvement in Their Residential Status - Annual Quarterly Average, CY2012 - CY2015				
	Pre-KanCare	KanCare		
	CY2012	CY2013	CY2014	CY2015
Numerator: Number of KanCare SED youth with improved housing status at end of quarter	208	177	142	168
Denominator: Number of KanCare SED youth with unstable living arrangements at beginning of quarter	254	219	174	198
Percent of SED youth with improved housing status	81.7%	80.6%	81.3%	84.9%

The annual quarterly average percentage of SED youth with improved housing status in CY2015 (84.9%) was higher than in the CY2012 (81.7%), CY 2013 (80.6%), and CY2014 (81.3%). The quarterly rates in CY2015, however, fluctuated from 82.7% in Q1 to 88.2% in Q2 and 88.9% in Q3, then dropping to 78.8% in Q4. No data were available for CY2016.

The number and percent of youth with an SED who maintained their residential status

The denominator for this measure is the number of KanCare SED youth with stable living arrangements at the beginning of the measurement period. The numerator is the number of KanCare SED youth who maintained a stable living arrangement at the end of the measurement period (see Table 13).

Table 13. Number and Percent of SED Youth who Maintained Their Residential Status - Annual Quarterly Average, CY2012 - CY2015				
	Pre-KanCare	KanCare		
	CY2012	CY2013	CY2014	CY2015
Numerator: Number of KanCare SED youth who maintained a stable living arrangement at end of quarter	5,284	4,554	3,293	4,279
Denominator: Number of KanCare SED youth with stable living arrangements at beginning of quarter	5,568	4,612	3,316	4,328
Percent of SED youth that maintained residential status	94.9%	98.7%	99.3%	98.9%

Rates of maintaining stable living arrangements for SED youth were consistently and strongly high in CY2012 through CY2015. At the end of Q4 CY2012, 99.4% of SED youth had maintained a stable living arrangement, and this rate remained steady throughout CY2015 dropping slightly by Q4 CY2015 to 98.5%. While the percentages have remained stable each year, the reported numbers of youth with stable living arrangements at the beginning of each quarter varied greatly each year; the quarterly average dropped from 5,568 in CY2012 to 4,612 in CY2013 to 3,316 in CY2014, and then increased to a quarterly average of 4,328 in CY2015. No data were available for CY2016.

The number and percent of KanCare members, diagnosed with SPMI, who were competitively employed (P4P 2014-2016)
The denominator for this measure is the number of KanCare adults with SPMI in each measurement period, and the numerator is the number of adults with SPMI who are competitively employed during the measurement period and whose employment status is reported by the CMHC providing services to the members (see Table 14).

Table 14. Number and Percent of KanCare Adults Diagnosed with an SPMI who were Competitively Employed - Annual Quarterly Average, CY2012 - CY2016					
	Pre-KanCare	KanCare			
	CY2012	CY2013	CY2014	CY2015	CY2016
Numerator: Number of KanCare SPMI adults competitively employed	481	382	610	628	567
Denominator: Number of KanCare SPMI adults	3,596	3,100	3,900	3,854	3,562
Percent of SPMI adults competitively employed	13.4%	12.3%	15.6%	16.3%	15.9%

Tracking for this measure is dependent on consistent and complete reporting of data to KDADS by the CMHCs. In CY2015, KDADS implemented policies that have resulted in increased and more complete reporting of this data that allows more accurate trend analysis.

From CY2014 to CY2015, the percentage of SPMI members employed increased by 4.5% (0.7 percentage points) from 15.6% to 16.3%. In 2016, the percentage of SPMI members employed decreased slightly to 15.9%, but may be based on incomplete data due to claims lag.

The number and percent of members utilizing inpatient mental health services (P4P 2014-2015)
The denominator for this measure is the number of KanCare eligible members at the end of each quarter. The numerator is the number of KanCare members admitted to an inpatient MH facility during each quarter (see Table 15). Rates are reported per 10,000.

Table 15. Number and Percent of KanCare Members Utilizing Inpatient Services Annual Quarterly Average, CY2012 - CY2015

	Pre-KanCare	KanCare		
	CY2012	CY2013	CY2014	CY2015
Numerator: Number of KanCare members with an inpatient mental health admission during the quarter	1,560	1,298	1,306	1,020
Denominator: Number of KanCare members	391,444	406,731	418,610	413,145
Percent of members utilizing inpatient mental health services	0.4%	0.3%	0.3%	0.2%
Rate per 10,000	39.9	31.9	31.2	24.7

Each year the annual quarterly average rate (per 10,000) of inpatient admissions decreased from 39.9 in CY2012 to 31.9 in CY2013 to 31.2 in CY2014. The low 27.45 average rate in CY2015 is due in part to a significant drop in rates in Q4 to 10.64 per 10,000 due to a statewide change in screening policy that as of October 2015 no longer requires inpatient screens to be completed by CMHC personnel at non-CMHC at non-CMHC locations. This is no longer a P4P performance measure; no additional data are available for CY2016.

(4) Healthy Life Expectancy

Health Literacy
Survey questions for this performance measure are based on questions in CAHPS surveys.

In 2014, although all three MCOs conducted separate surveys of sample populations of adults, general child population (GC), and children with chronic conditions (CCC), two of the MCOs (Amerigroup and UnitedHealthcare) did not sample the Title XIX/Title XXI populations separately. In 2015, all three MCOs administered the CAHPS survey to separate sample populations of Title XIX and Title XXI children using the child survey with CCC module. In 2016, Sunflower did not sample the Title XIX/Title XXI populations separately. Comparisons to calendar years 2015, 2014, and pre-KanCare (2012) and aggregate weighted rates for the three MCOs' Adult, GC, and CC surveys are reported where data are available and where questions were worded the same.

The analysis below is based on the percentage of positive responses as reported in the CAHPS surveys. Table 16 shows percentages of positive responses for CAHPS questions related to physical health. (See Table 23 for questions related to quality of care, Table 30 for questions related to coordination of care, Table 41 for questions related to access to care, and Table 48 for an efficiency-related question.)

Table 16. Healthy Life Expectancy - CAHPS Survey

Question	Pop	Weighted % Positive Responses			QC 50th Percentile		
		2016	2015	2014	2016	2015	2014
Questions on Adult and Child Surveys							
In the last six months, did you and a (your child's) doctor or other health provider talk about specific things you could do to prevent illness (in your child)?	Adult	**70.1%**	68.0%	71.6%	↓	↓	↓
	GC	**67.3%**	67.1%	70.7%	↓	↓	↓
	CCC	**71.4%**	71.6%	73.3%	↓	↓	↑
In the last six months, did you and a (your child's) doctor or other health provider talk about starting or stopping a prescription medicine (for your child)?	Adult	**50.2%**	52.9%	53.5%	NA	NA	NA
	GC	**33.2%**	33.3%	31.9%	NA	NA	NA
	CCC	**53.2%**	50.7%	51.3%	NA	NA	NA
Did you and a doctor or other health provider talk about the reasons you might want (your child) to take a medicine?	Adult	**93.3%**	91.0%	93.3%	↑	↓	NA
	GC	**96.7%**	94.8%	98.3%	↑	↑	NA
	CCC	**97.8%**	96.7%	98.2%	↑	↑	NA
Did you and a doctor or other health provider talk about the reasons you might not want (your child) to take a medicine?	Adult	**68.9%**	72.3%	73.1%	↑	↑	NA
	GC	**69.4%**	68.0%	77.4%	↑	↑	NA
	CCC	**74.3%**	76.8%	81.5%	↓	↑	NA
When you talked about (your child) starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you (your child)?	Adult	**79.4%**	79.5%	75.9%	↑	↑	↓
	GC	**80.6%**	80.0%	77.7%	↑	↑	↑
	CCC	**82.3%**	86.0%	83.5%	↓	↑	↑
In the last six months, how often did your (child's) personal doctor explain things (about your child's health) in a way that was easy to understand?	Adult	**93.0%**	91.8%	91.9%	↑	↑	↑
	GC	**95.2%**	94.9%	95.5%	↑	↑	↑
	CCC	**95.0%**	95.6%	95.3%	↓	↑	↑
In the last six months, how often did your (child's) personal doctor listen carefully to you?	Adult	**91.5%**	91.2%	89.7%	↑	↑	↓
	GC	**94.5%**	95.2%	95.7%	↓	↑	↑
	CCC	**94.6%**	94.9%	94.4%	↓	↑	↑

Table 16. Healthy Life Expectancy - CAHPS Survey (Continued)							
Question	Pop	Weighted % Positive Responses			QC 50th Percentile		
		2016	2015	2014	2016	2015	2014
Questions on Child Surveys only							
In the last six months, how often did you have your questions answered by your child's doctors or other health providers?	**GC**	**90.0%**	89.3%	89.6%	NA	NA	NA
	CCC	**91.1%**	91.9%	90.9%	NA	NA	NA
In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for your child to understand?	**GC**	**92.5%**	91.4%	91.1%	NA	NA	NA
	CCC	**92.8%**	92.1%	92.4%	NA	NA	NA
Questions on Adult Survey only							
Have you had either a flu shot or flu spray in the nose since July 1, [previous year]?	**Adult**	**43.7%**	46.5%	47.5%	↑	↑	NA
Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	**Adult**	**32.2%**	33.5%	37.6%	↑	↓	↑
In the last six months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	**Adult**	**79.5%**	76.2%	75.7%	↑	↓	↓
In the last six months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.	**Adult**	**46.1%**	43.2%	48.3%	↓	↓	↑
In the last six months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco?	**Adult**	**44.4%**	37.5%	38.6%	↑	↓	↓

Questions on both adult and child surveys:

In the last 6 months:

- **Did you and a (your child's) doctor or other health provider talk about specific things you could do to prevent illness (in your child)?**
  Results for the aggregate rates for the adult and child surveys were comparable across years (Adult: CY2016 – 70.1%, CY2015 – 68.0%, CY2014 – 71.6%, CY2012 – 70.0%; GC: CY2016 – 67.3%, CY2015 - 67.1%, CY2014 – 70.7%, CY2012 – 68.90%; CCC: CY2016 – 71.4%, CY2015 – 71.6%, CY2014 – 73.3%). The CY2016 Adult rate was below the QC 33.33rd percentile; GC rate was below the QC 25th percentile; and CCC rate was below the QC 10th percentile.
- **Did you and a (your child's) doctor or other health provider talk about starting or stopping a prescription medicine (for your child)?**
  Over half of the adult survey respondents in CY2014 through CY2016 (50.2% - 53.5%) and CCC survey respondents (50.7% - 53.2%) indicated they had talked with a provider about starting or stopping a medication in the previous six months, while closer to one-third of the GC survey

respondents talked with a provider about starting or stopping a prescription medication (31.9% - 33.3%).

If yes:

When you talked about (your child) starting or stopping a prescription medicine,

- **How much did a doctor or other health provider talk about the reasons you might want (your child) to take a medicine?**
  In CY2015, the response options for this question changed from the previous years' responses of "a lot," "some," "a little," and "none" to "yes" and "no." The CY2016 and CY2015 "yes" responses were compared to CY2014's "a lot," "some," and "a little" responses. Results were generally comparable in CY2014 to CY2016 for all populations (Adult: CY2016 – 93.3%, CY2015 – 91.0%, CY2014 – 97.0%; GC: CY2016 – 96.7%, CY2015 – 94.8%, CY2014 – 98.2%; CCC: CY2016 – 97.7%, CY2015 – 96.7%, CY2014 -98.2%).
- **How much did a doctor or other health provider talk about the reasons you might <u>not</u> want (your child) to take a medicine?**
  In CY2015, the response options for this question changed from the previous years' responses of "a lot," "some," "a little," and "none" to "yes" and "no." The CY2016 and CY2015 "yes" responses were compared to CY2014's "a lot," "some," and "a little" responses. While positive response results for all populations were generally comparable between CY2016 and CY2015, they were notably lower than CY2014 results (Adult: CY2016 – 68.9%, CY2015 – 72.3%, CY2014 – 79.2%; GC: CY2016 – 69.4%, CY2015 – 68.0%, CY2014 – 78.2%; CCC: CY2016 – 74.3%, CY2015 – 76.8%, CY2014 – 81.5%). The decrease in CCC rate from 76.8% in CY2015 to 74.3% in CY2015 resulted in a decrease in the QC percentile from above the 75th to below 50th.
- **Did a doctor or other health provider ask you what you thought was best for you (your child)?**
  Results for all CY2016 weighted aggregate results decreased or were comparable to CY2015 in CY2016 (Adult: CY2016 – 79.4%, CY2015 - 79.5%, CY2014 - 75.9%; GC: CY2016 – 80.6%, CY2015 - 80.0%, CY2014 - 77.7%; CCC: CY2016 – 82.3%, CY2015 - 86.0%, CY2014 - 83.5%).

- **How often did your (child's) personal doctor explain things (about your child's health) in a way that was easy to understand?**
  The weighted aggregate rates were generally comparable for all populations in CY2014 through CY2016 (Adults: 91.8 % – 93.0%; GC: 94.9% - 95.5%; CCC: 95.0% - 95.6%).
- **How often did your (child's) personal doctor listen carefully to you?**
  The weighted aggregate rates were comparable for all populations in CY2014 through CY2016 (Adults: 89.7% - 91.5%; GC: 94.5% - 95.7%; CCC: 94.4% - 94.9%).

Questions on child surveys only:

- **In the last 6 months, how often did you have your questions answered by your child's doctors or other health providers?**
  Since CY2014, responses have remained comparable for both child survey populations (GC: 89.3% - 90.0%; CCC: 90.9% - 91.9%).
- **In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for your child to understand?**
  Results were generally comparable in CY2014 through CY2016 for both populations (GC: 91.1% – 92.5%; CCC: 92.1% - 92.8%).

Questions on adult survey only:

Flu shots for adults (P4P 2014-2015)

- **Have you had either a flu shot or flu spray in the nose since July 1, [previous year]?**
  Of those in the adult survey sample, 43.7% in CY2016, 46.5% in CY2015, and 47.5% in CY2014 indicated they received a flu shot or flu spray in the second six months of previous calendar year. All MCO percentages decreased from CY2015. The CY2014 rate serves as the baseline year since the flu shot question was a new CAHPS question in 2014.

Smoking Cessation

- **Do you now smoke cigarettes or use tobacco: every day, some days, or not at all?**
  Rates of adults who reported that they smoke or use tobacco at least some days continued to decrease in all MCO adult populations, with the aggregate weighted adult rate in CY2016 at 32.2% (CY2015 - 33.5%; CY2014 – 37.6%; CY2012 – 37.2%). Members who responded "every day" or "some days" were asked the following questions:
  In the last 6 months,
  - **How often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?** (P4P 2014-2015)
    The weighted aggregate rate continued to improve (CY2016 – 79.5%; CY2015 – 76.2%; CY2014 – 75.7%; CY2012 – 65.5%) and increased to above the QC 50th percentile. Amerigroup had the greatest increase from 73.8% in CY2015 to 83.4% in CY2016. AGP's CY2016 rate was above the QC 90th percentile; SSHP and UHC were above the QC 50th percentile.
  - **How often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.**
    The weighted aggregate rate has fluctuated each year, while remaining above the CY2012 rate (CY2016 -46.1%; CY2015 – 43.2%; CY2014 – 48.3%; CY2012 – 41.5%). The CY2016 rate is below the QC 50th percentile.
  - **How often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.**
    The CY2016 weighted aggregate adult rate of 44.4% (above the QC 50th percentile) increased from the CY2015 rate of 37.5% (less than QC 25th percentile). This was impacted by an increase in AGP's rate from 32.4% in CY2015 to 50.3% in CY2016. UHC's rate also increased from 38.7% in CY2015 to 41.3% in CY2016. SSHP's rate decreased from 42.9% in CY2015 to 40.9% in CY2016.

HEDIS – Healthy Life Expectancy

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

Population: Members diagnosed with diabetes and schizophrenia

Analysis: Annual comparison to CY2013 baseline and trending over time

The aggregate rate based on administrative data for CY2015 was 65.3%, up from 60.1% in CY2014 and 62.9% in CY2013. The aggregate rate was below the QC 33.33rd percentile in CY2015. UHC had the highest rate (70.4%), an 11.1% annual increase and moved from below the 25th QC percentile to above the QC 50th percentile. AGP had the lowest rate (61.8%) and was below the QC 25th percentile. SSHP's rate was 66.6% (<50th QC percentile), which was an 11% annual increase.

Healthy Life Expectancy for persons with SMI, I/DD, and PD

The following measures are described as "HEDIS-like" in that HEDIS criteria are used for each performance measure, but the HEDIS programming is adapted to include only those populations that meet eligibility criteria and are also I/DD, PD, or SMI (see Table 17). Each of these measures was a P4P measure for the MCOs in 2014 and 2015; though no longer P4P, the State has directed the MCOs to continue to report these rates separately for the HCBS population to allow continued tracking of progress in improving these rates.

Table 17. HEDIS-Like Measures - PD, I/DD, SMI Populations, CY2013 - CY2015

	CY2015	CY2014	CY2013
Breast cancer screening*	50.5%*	47.0%*	31.0%
Cervical cancer screening*	52.1%*	48.8%*	47.0%
Adults' access to preventive/ambulatory health services	94.9%	95.2%	95.6%
Comprehensive diabetes care			
HbA1c testing	87.6%	86.5%	84.4%
HbA1c Control (<8.0%)	46.5%	38.0%	38.1%
Eye exam (retinal) performed	66.5%	63.7%	58.7%
Medical attention for nephropathy	90.8%	75.2%	77.8%
Blood pressure control (<140/90)	60.2%	51.0%	57.0%

* Multi-year measure - CY2014, for example, includes members who were screened in CY2013 or CY2014.

- **Preventive Ambulatory Health Services** (P4P 2014-2015)
  In CY2013 through CY2015, over 94.5% of adult PD, I/DD, SMI members (ages 20-65) were reported to have had an ambulatory preventive care visit during the year. Rates for this subpopulation were higher than rates for all eligible KanCare members in CY2013 (95.6% for PD-I/DD-SMI adults, compared to 88.4% for all KanCare adult members); in CY2014 (95.2% for PD-I/DD-SMI, compared to 87.5% for all KanCare adult members); and in CY2015 (94.9% for PD-I/DD-SMI, compared to 87.1% for all KanCare adult members).
- **Breast Cancer Screening** (P4P 2014-2015) *(CMS 2017 Core Adult Health Care Quality Measure)*
  The breast cancer screening HEDIS measure has eligibility criteria that are multi-year. The numerators for CY2014 and CY2015 include two years of data for members (PD, I/DD, and SMI women ages 52-74) who had mammograms. The numerator for CY2013 includes only one year of data due to 2013 being the first year the MCOs began providing services in Kansas. Due to the multi-year HEDIS criteria, data for 2015 were the first HEDIS data reported by the three MCOs. The breast cancer screening rate reported for the CY2015 PD, I/DD, SMI population (50.5%) was higher than the aggregated CY2015 HEDIS rate for the eligible KanCare population (45.0%; <10th QC percentile).
- **Cervical Cancer Screening** (P4P 2014-2015) *(CMS 2017 Core Adult Health Care Quality Measure)*
  The cervical cancer screening measure, as with the breast cancer screening measure, is a multi-year measure. The cervical cancer screening rate reported for the CY2015 PD, I/DD, SMI population (52.1%) was higher than the aggregated CY2015 HEDIS rate for the eligible KanCare population (46.9%).
- **Comprehensive Diabetes Care** (P4P 2014-2015)
  The five HEDIS diabetes measures that are P4P for the general KanCare adult population are also P4P measures for KanCare adult members who have an SMI or are receiving I/DD or PD waiver services.

- **HbA1c testing** - *(CMS 2017 Core Adult Health Care Quality Measure)* Rates for PD-I/DD-SMI members were higher than rates for all eligible KanCare members in CY2015 (87.6% for PD-I/DD-SMI, compared to 84.9% for all KanCare adult members), in CY2014 (86.5% for PD-I/DD-SMI, compared to 84.8% for all KanCare adult members), and CY2013 (84.4% for PD-I/DD-SMI adults, compared to 83.1% for all KanCare adult members).
- **HbA1c control <8.0%** - Rates for HbA1c testing for PD, I/DD, and SMI with diabetes were higher in in CY2015 (87.6%), CY2014 (86.5%), and CY2013 (84.4%) than for all eligible KanCare members in CY2015 (84.9%, CY2014 (84.8%), and CY2013 (83.1%).
- **Eye exam (retinal)** - Rates for PD-I/DD-SMI members were higher in CY2015 (66.5%) than in CY2014 (63.7%) and CY2013 (58.7%). Rates for PD-I/DD-SMI members were also higher each year than rates for all eligible KanCare members in CY2015 (62.5%), in CY2014 (58.6%), and in CY2013 (50.1%).
- **Medical attention for nephropathy** – Rates for the PD-I/DD-SMI population and for all eligible KanCare members greatly increased in CY2015 compared to the two previous years. The CY2015 rate for the PD-I/DD-SMI population (90.8%) was 20.7% higher than in CY2014 (75.2%), and was higher than the rate for all eligible KanCare members (89.2%).
- **Blood pressure control <140/90** - The CY2015 rate for PD-I/DD-SMI members (60.2%) was 18% higher than in CY2014 (51.0%) and higher than the rate for all eligible KanCare members (58.8%). In CY2014 and CY2013, the blood pressure control rates for PD-I/DD-SMI members were lower than rates for all eligible KanCare members in CY2014 (51.0% for PD-I/DD-SMI; 52.9% for all KanCare adult members) and in CY2013 (54.0% for PD-I/DD-SMI adults; 54.4% for all KanCare adult members).

(5) Home and Community Based Services (HCBS) Waiver Services

The populations for the following performance measures are members who are receiving HCBS services (includes I/DD, PD, FE, TBI, TA, SED, Autism, and MFP).

The number and percent of KanCare members receiving PD or TBI waiver services who are eligible for the WORK program who have increased competitive employment (P4P 2014-2015)

This measure compares the number of members receiving PD or TBI waiver services who are enrolled in the Work Opportunities Reward Kansans (WORK) program. The WORK program provides personal services and other services to assist employed persons with disabilities (including PD, TBI, and I/DD). For the P4P measure, progress is measured based on enrollment as of April each year (after MCO open enrollment is completed) compared to enrollment as of December. In assessing progress, exceptions are allowed for members who have moved out of state, who age out of the program, who are hospitalized or deceased during the year, or graduated to full-time employment.

In April 2014, there were 143 PD Waiver members and 16 TBI Waiver members participating in the WORK program. During the year, 10 additional members participated (nine additional PD and one additional TBI). In April 2015, there were 72 PD Waiver members and 15 TBI Waiver members participating in the WORK program. During the year, one additional TBI member participated in the program.

Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment

The denominator for this measure is the number of waiver participants whose service plans were reviewed, and the numerator is the number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment. Percentages reported by KDADS are summarized in Table 18.

Table 18. Percent of HCBS Waiver Participants Whose Service Plans Address Their Assessed Needs and Capabilities, CY2013 - CY2015

Waiver	CY2013	CY2014	CY2015
Intellectual/Developmental Disability (I/DD)	99%	78%	48%
Physical Disability (PD)	86%	87%	59%
Frail Elderly (FE)	87%	86%	61%
Traumatic Brain Injury (TBI)	72%	73%	45%
Technical Assistance (TA)	96%	96%	59%
Serious Emotional Disturbance (SED)	92%	90%	97%
Autism	59%	68%	46%

These data are gathered through MCO record review by KDADS quality staff, and compliance percentages vary by waiver. As shown in Table 18, only the SED waiver service plans had consistently improving documentation of members' assessed needs and capabilities over the three-year period. As part of remediation efforts, KDADS is currently in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and will be developing policy by August 2017 to provide clear direction on the plan of care development process.

Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan

The denominator for this measure is the number of waiver participants whose service plans were reviewed, and the numerator is the number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan. Percentages reported by KDADS are summarized in Table 19.

Table 19. Percent of HCBS Waiver Participants who Received Services in the Type, Scope, Amount, Duration, and Frequency Specified in Their Service Plan, CY2013 - CY2015

Waiver	CY2013	CY2014	CY2015
Intellectual/Developmental Disability (I/DD)	98%	92%	68%
Physical Disability (PD)	85%	95%	72%
Frail Elderly (FE)	87%	92%	72%
Traumatic Brain Injury (FE)	70%	87%	56%
Technical Assistance (TA)	100%	98%	74%
Serious Emotional Disturbance (SED)	13%	93%	98%
Autism	50%	86%	49%

These data are gathered through MCO record review by KDADS quality staff, and compliance percentages vary by waiver. As shown in Table 19, SED waiver service plans had the most complete documentation of services received, as identified in member service plans. As part of remediation efforts in 2017, KDADS has drafted clear guidance to all three MCOs to ensure that all required service plan information and signatures/dates are clearly documented on each participant's plan of care to

render it valid for quality review in terms of type, scope, amount, duration, and frequency specified in the service plan.

(6) Long-Term Care: Nursing Facilities

Percentage of Medicaid Nursing Facility (NF) claims denied by the MCO (P4P 2014)
The denominator for this measure is the number of NF claims, and the numerator is the number of these claims that were denied in the calendar year (see Table 20). Due to claims lag, data for 2016 will be reported in the 2017 annual report.

Table 20. Nursing Facility Claims Denials, CY2012 - CY2015

	CY2012	CY2013	CY2014	CY2015
Total number of nursing facility claims	555,652	337,767	368,242	361,293
Number of nursing facility claims denied	63,976	45,475	38,339	47,645
Percent of nursing facility claims denied	11.5%	13.5%	10.4%	13.2%

The percentage of NF claims that were denied increased from 11.5% in CY2012 (pre-KanCare) to 13.5% in CY2013, and then decreased to 10.4% in CY2014. The denial rate in CY2015 (13.2%) was comparable to CY2013.

Percentage of NF members who had a fall with a major injury (P4P 2014-2015)
The denominator for this measure is the number of NF members in KanCare, and the numerator is the number of these members that had falls that resulted in a major injury during the year (see Table 21). Data for CY2016 include only the first three quarters due to the time lag for submitting and processing claims.

Table 21. Nursing Facility Major Injury Falls, CY2012 - CY2016

	CY2012	CY2013	CY2014	CY2015	CY2016 Q1-Q3
Nursing facility KanCare members	46,794	46,114	43,589	42,301	32,218
Number of nursing facility major injury falls	288	246	232	236	183
Percent of nursing facility Kancare members with major injury falls	0.62%	0.53%	0.53%	0.56%	0.57%

The percentage of NF Medicaid members who had falls with major injuries decreased from 0.62% in CY2012 (pre-KanCare) to 0.53% in CY2013 and CY2014. There were 42 fewer falls in CY2013 than in CY2012, and 46 fewer falls in CY2014 than in CY2012. In CY2015, the fall percentage increased slightly to 0.56% and during the first three quarters of CY2016, the rate was 0.57%. As many of the nursing facilities have members from more than one MCO, MCOs have been encouraged by the State to work together and with State agencies to ensure nursing facilities throughout Kansas are continuing to implement fall prevention practices.

Percentage of members discharged from a NF who had a hospital admission within 30 days (P4P 2014-2015)
The denominator for this measure is the number KanCare members discharged from a NF. The numerator is the number of these members who had hospital admissions within 30 days of being discharged from the NF (see Table 22).

The percentage of NF Medicaid members who were readmitted to a hospital after being discharged from an NF increased from 7.18% in CY2012 (pre-KanCare) to 11.98% in CY2013 and increased again in CY2014 to 12.70%. In CY2015, the percentage decreased to 12.04%, and, during the first two quarters of CY2016, the percentage increased to 13.60%. Data for CY2016 are limited to the first six months of the year due to the time lag for submitting and processing claims; the annual percentage for CY2016 will be reported in next year's KanCare Evaluation Annual Report. (Based upon the EQRO validation process, the numerator and denominator for calendar years 2013 and 2014 have been updated.)

Table 22. Hospital Admissions After Nursing Facility Discharge, CY2012 - CY2016

	CY2012	CY2013	CY2014	CY2015	CY2016 Q1-Q2
Number of nursing facility discharges	2,130	2,052	2,268	2,210	985
Number of hospital admissions after nursing facility discharge	153	250	288	266	134
Percent of hospital admissions after nursing facility discharge	7.18%	11.98%	12.70%	12.04%	13.60%

Number of Person Centered Care Homes as recognized by the PEAK program (Promoting Excellent Alternatives in Kansas) in the MCO network (P4P 2014)

PEAK program data are used to identify nursing facilities designated as Person-Centered Care Homes, along with MCO provider files to verify inclusion in the network. PEAK program data are reported on a fiscal year basis, based on the State fiscal year that begins July 1.

- By the end of FY2013 (June 2013) there were eight nursing facilities recognized as PEAK: five Level 5 homes, one Level 4 home, and two Level 3 homes.
- By the end of FY2014 (June 2014), there were nine nursing facilities recognized as PEAK: six Level 5 homes, one Level 4 home, and two Level 3 homes.
- By the end of FY2015 (June 2015), there were 10 nursing facilities recognized as PEAK: four Level 5 homes, three Level 4 homes, and three Level 3 homes.
- By the end of FY2016 (June 2016), there were 15 nursing facilities recognized as PEAK: four Level 5 homes, five Level 4 homes, and six Level 3 home.

(7) Member Survey – Quality

CAHPS Survey

CAHPS questions related to quality of care include the following questions focused on patient perceptions of provider treatment. Four of the questions are "rating" questions where survey respondents were asked to rate their (or their child's) personal doctor, health care, health plan, and the specialist seen most frequently. Rating was based on a scale from zero to 10, with 10 being the "best possible" and zero the "worst possible." Positive response for these rating questions below follow the NCQA standard of combining results for selections of "9" or "10," and then weighted by MCO population for aggregating the results. Results for the ratings questions and two additional questions are provided in Table 23.

Table 23. Member Survey (CAHPS) - Quality of Care Questions, 2014 - 2016							
Question	Pop	Weighted % Positive Responses			QC 50th Percentile		
		2016	2015	2014	2016	2015	2014
Using any number from 0 to 10, where 0 is the worst score possible and 10 is the best score possible:							
What number would you use to rate all your (your child's) health care in the last 6 months? (Rating 9 or 10)	Adult	**53.9%**	50.9%	52.8%	↑	↓	↑
	GC	**70.7%**	68.9%	68.6%	↑	↑	↑
	CCC	**66.2%**	64.8%	65.2%	↑	↑	↑
What number would you use to rate your (your child's) personal doctor? (Rating 9 or 10)	Adult	**67.5%**	67.4%	64.4%	↑	↑	↑
	GC	**75.9%**	72.5%	73.4%	↑	↓	↓
	CCC	**74.3%**	72.9%	71.8%	↓	↓	↓
We want to know your rating of the specialist you (your child) saw most often in the last 6 months. What number would you use to rate that specialist? (Rating 9 or 10)	Adult	**66.5%**	66.1%	64.8%	↑	↑	↓
	GC	**70.1%**	69.3%	69.6%	↑	↓	↓
	CCC	**73.0%**	67.8%	68.5%	↑	↓	↓
What number would you use to rate your (your child's) health plan? (Rating 9 or 10)	Adult	**60.9%**	57.6%	54.6%	↑	↓	↓
	GC	**73.8%**	72.1%	71.0%	↑	↑	↑
	CCC	**67.4%**	66.8%	63.3%	↑	↑	↓
In the last 6 months, how often did your (your child's) personal doctor show respect for what you had to say?	Adult	**93.4%**	92.5%	91.9%	↑	↑	↑
	GC	**96.0%**	96.0%	96.7%	↑	↑	↑
	CCC	**95.3%**	95.8%	94.4%	↓	↑	↓
In the last 6 months, how often did your (your child's) personal doctor spend enough time with you (your child)?	Adult	**89.7%**	89.4%	89.0%	↑	↑	↑
	GC	**91.0%**	89.7%	90.4%	↑	↑	↑
	CCC	**91.2%**	91.3%	90.6%	↓	↓	↓

- **Rating of health care**
  In CY2016, 53.9% of adult survey respondents rated their health care as 9 or 10, up from 50.9% in CY2015 and 52.8% in CY2014. The adult survey respondent ratings were below the QC 50th percentile for AGP and UHC and above the QC 50th percentile for SSHP. Child survey ratings in CY2016 (GC – 70.7%, >66.67th QC percentile; CCC – 66.2%, >50th QC percentile) were higher than CY2015 rates (GC – 68.9%; CCC – 64.8%), which were comparable to CY2014.
- **Rating of personal doctor**
  Adult ratings of members' personal doctors as a 9 or 10 were comparable in CY2016 (67.5%) and CY2015 (67.4%); the pre-KanCare CY2012 rate was 66.7%. The adult rating remained above the QC 66.67th percentile in CY2016. Child survey results had higher positive ratings than the adult population (GC: CY2016 - 75.9%, CY2015 – 72.5%, CY2014 – 73.4%; CCC: CY2016 – 74.3%, CY2015-72.9%, CY2014 – 71.8%); however, the CY2015 GC rating was above the QC 50th percentile and the CY2015 CCC rate was below the QC 50th percentile.
- **Rating of health plan**
  The weighted aggregate adult ratings of their health plan as a 9 or 10 increased from 54.6% in CY2014 to 57.6% in CY2015 to 60.9% in CY2016 (>66.67th QC percentile). The aggregate GC survey results continued to improve in CY2016 (73.8%; >66.67th QC percentile) compared to CY2015

(72.1%), CY2014 (71.0%), and CY2012 (65.9%). The CY2016 CCC positive rating of their health plan increased from 66.8% in CY2015 to 67.4% in CY2016 and was above the QC 66.67th percentile.

- **Rating of specialist seen most often**
  The weighted aggregate adult survey rating of specialists was comparable in CY2014 through CY2016 (64.8% - 66.5%). The GC positive rating was also comparable across years (68.4% - 70.1%). The CCC CY2016 positive rating (73.0%) increased from CY2015 (67.8%) and CY2014 (68.5%). All survey populations' positive ratings were above the QC 50th percentile in CY2016.
- **Doctor respected member's comments.**
  Over 93% of survey respondents in CY2016 indicated their personal doctor showed respect for what they had to say. Weighted aggregate adult results in CY2016 (93.4%) were slightly higher than in CY2015 (92.5%), CY2014 (91.9%), and CY2012 (83.7%); the CY2016 adult results remained above the QC 50th percentile. The GC results were comparable in CY2014 through CY2016 (CY2016 -96.0%; CY2015 -96.0%; CY2014 -96.7%) and remained higher than CY2012 (91.8%). The CCC results were comparable across years (CY2016 - 95.3%; CY2015 - 95.8%; CY2014 – 94.4%).
- **Doctor spent enough time with the member.**
  The weighted aggregate results for all populations were comparable across years (Adult: – 89.0% - 89.7%; GC: 89.7% -91.0%; CCC: 90.6% – 91.3%).

Mental Health Survey

Member perceptions of MH provider treatment are based on responses to MH surveys conducted in 2016 of a random sample of KanCare members who had received one or more MH services in the prior six-month period. The Mental Health Statistics Improvement Program (MHSIP) Youth Services Survey, Youth Services Survey for Families, and Adult Consumer Survey tools, as modified by KFMC over the past six years, were used for this project.

Questions were the same in 2011 through 2016, with the exception of a question added in CY2013 on whether medication was available timely and three questions added in CY2015 on smoking cessation (adults only). In 2016, at the request of the State, KFMC added three questions to the youth survey related to whether the parent/guardian feels the child's mental health provider believes the child can grow, change, and recover; talks to them in an encouraging way; and encourages the child's growth and success. Also, "mental health provider" was added to the professionals listed for asking whether the parent/guardian was informed of what side effects to watch for when the member takes medication for emotional/behavioral problems.

In CY2016, the survey was mailed to 10,196 KanCare members (not stratified by MCO) and the following were completed: 301 General Adult, 338 General Youth, 309 SED Waiver Youth, and 23 SED Waiver young adult surveys. Results were also stratified by whether the member completed the survey or whether a family member/guardian completed the survey for a child (age <18).

For most of the questions, responses were generally positive and did not change significantly from pre-KanCare (CY2011 and CY2012) to KanCare (CY2013 to CY2016).

Table 24 shows rates of positive responses for questions related to quality of care. (See Table 31 for questions related to coordination of care, Table 41 for questions related to access to care, and Table 49 for an efficiency-related question.)

Table 24. Mental Health Survey - Quality-Related Questions

Item	Year	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
If I had other choices, I would still get services from my mental health providers.	**General Adult (Age 18+)**						
	2016	**85.0%**	**246 / 289**	**80.4% – 88.7%**		.25	.94
	2015	88.4%	336 / 380	84.8% – 91.3%	.20		
	2014	89.4%	720 / 805	87.1% – 91.4%	.05		
	2013	88.3%	911/1,034	86.2% – 90.1%	.13		
	2012	84.4%	232 / 275	79.6% – 88.2%	.83		
	2011	88.3%	263 / 298	84.1% – 91.5%	.25		
I felt comfortable asking questions about my treatment and medication.	**General Adult (Age 18+)**						
	2016	**85.9%**	**245 / 285**	**81.3% – 89.5%**		.24	.29
	2015	94.5%	358 / 379	91.7% – 96.4%	**<.001 -**		
	2014	90.7%	733 / 808	88.5% – 92.5%	**.02 -**		
	2013	91.1%	959/1,052	89.2% – 92.7%	**<.01 -**		
	2012	87.5%	244 / 279	83.0% – 90.9%	.59		
	2011	93.6%	278 / 297	90.2% – 95.9%	**<.01 -**		
I have people I am comfortable talking with about my child's problems.	**General Youth (Ages 0-17), Family Responding**						
	2016	**91.5%**	**289 / 316**	**87.9% – 94.2%**		.89	.47
	2015	92.5%	300 / 324	89.0% – 94.9%	.66		
	2014	90.4%	688 / 761	88.1% – 92.3%	.57		
	2013	91.6%	871 / 954	89.7% – 93.2%	.95		
	2012	93.1%	244 / 262	89.3% – 95.7%	.47		
	2011	92.6%	301 / 325	89.2% – 95.0%	.61		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**89.9%**	**289 / 322**	**86.1% – 92.8%**		.84	.89
	2015	87.7%	288 / 328	83.7% – 90.9%	.39		
	2014	88.0%	366 / 417	84.5% – 90.8%	.43		
	2013	89.1%	423 / 475	85.9% – 91.6%	.71		
	2012	87.5%	281 / 321	83.4% – 90.7%	.34		
	2011	89.4%	254 / 284	85.3% – 92.5%	.85		
As a result of services I received, I am better able to deal with crisis.	**General Adult (Age 18+)**						
	2016	**69.2%**	**192 / 277**	**63.6% – 74.4%**		**<.01↓**	.12
	2015	79.3%	279 / 352	74.8% – 83.3%	**<.01 -**		
	2014	78.7%	602 / 765	75.7% – 81.5%	**<.01 -**		
	2013	79.1%	780 / 987	76.4% – 81.5%	**<.001 -**		
	2012	71.4%	182 / 255	65.5% – 76.6%	.59		
	2011	80.4%	221 / 275	75.2% – 84.6%	**<.01 -**		
My mental health providers helped me obtain information I needed so that I could take charge of managing my illness.	**General Adult (Age 18+)**						
	2016	**82.7%**	**230 / 278**	**77.8% – 86.7%**		.06	.20
	2015	86.3%	315 / 365	82.4% – 89.5%	.20		
	2014	86.8%	675 / 778	84.2% – 89.0%	.09		
	2013	87.6%	891/1,020	85.4% – 89.4%	**.03 -**		
	2012	81.6%	213 / 261	76.4% – 85.9%	.75		
	2011	89.3%	258 / 289	85.1% – 92.4%	**.02 -**		

Table 24. Mental Health Survey - Quality-Related Questions (Continued)

Item	Year	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
As a result of services I received, I am better able to control my life.	**General Adult (Age 18+)**						
	2016	**74.8%**	**213 / 284**	**69.4% – 79.5%**		**.02↓**	.11
	2015	83.8%	309 / 369	79.7% – 87.2%	**<.01 -**		
	2014	84.9%	669 / 788	82.2% – 87.2%	**<.001 -**		
	2013	83.0%	851/1,025	80.6% – 85.2%	**<.01 -**		
	2012	76.4%	204 / 267	70.9% – 81.1%	.66		
	2011	86.5%	250 / 289	82.1% – 90.0%	**<.001 -**		
As a result of services I received, I am better at handling daily life.	**General Youth (Ages 12-17), Youth Responding**						
	2016	**85.3%**	**131 / 154**	**78.8% – 90.1%**		.29	.93
	2015	87.0%	127 / 146	80.5% – 91.6%	.67		
	2014	86.0%	260 / 302	81.6% – 89.5%	.84		
	2013	88.6%	450 / 510	85.3% – 91.2%	.28		
	2012	88.8%	87 / 98	80.8% – 93.8%	.43		
	2011	83.1%	108 / 130	75.6% – 88.6%	.61		
	SED Waiver Youth (Ages 12-17), Youth Responding						
	2016	**85.9%**	**140 / 163**	**79.7% – 90.5%**		.13	.83
	2015	83.0%	124 / 149	76.1% – 88.2%	.48		
	2014	84.1%	158 / 187	78.1% – 88.7%	.63		
	2013	79.6%	176 / 221	73.8% – 84.3%	.11		
	2012	82.4%	112 / 136	75.0% – 87.9%	.40		
	2011	90.1%	109 / 121	83.3% – 94.4%	.29		
As a result of services my child and /or family received, my child is better at handling daily life.	**General Youth (Ages 0-17), Family Responding**						
	2016	**77.8%**	**252 / 324**	**72.9% – 82.0%**		.17	.54
	2015	82.0%	265 / 323	77.4% – 85.8%	.18		
	2014	79.6%	606 / 764	76.6% – 82.3%	.50		
	2013	82.1%	772 / 948	79.5% – 84.4%	.09		
	2012	81.0%	205 / 253	75.7% – 85.4%	.34		
	2011	79.4%	258 / 325	74.6% – 83.4%	.61		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**75.9%**	**243 / 323**	**70.9% – 80.2%**		.81	.14
	2015	71.5%	233 / 326	66.4% – 76.1%	.21		
	2014	72.0%	297 / 407	67.4% – 76.1%	.24		
	2013	74.4%	355 / 477	70.3% – 78.1%	.64		
	2012	75.6%	241 / 319	70.6% – 80.0%	.93		
	2011	79.2%	227 / 286	74.2% – 83.5%	.32		
As a result of services I received, I am better able to do things that I want to do.	**General Adult (Age 18+)**						
	2016	**69.3%**	**195 / 280**	**63.6% – 74.4%**		**.04↓**	**.03↓**
	2015	78.9%	290 / 368	74.4% – 82.8%	**<.01 -**		
	2014	74.3%	581 / 782	71.1% – 77.3%	.10		
	2013	77.7%	786/1,012	75.0% – 80.2%	**<.01 -**		
	2012	70.1%	185 / 264	64.3% – 75.3%	.84		
	2011	82.4%	238 / 289	77.5% – 86.3%	**<.001 -**		
As a result of the services my child and/or family (I) received, my child is (I am) better able to do things he or she wants (I want) to do.	**General Youth (Ages 0-17), Family Responding**						
	2016	**80.7%**	**255 / 317**	**76.0% – 84.7%**		.26	.14
	2015	84.5%	268 / 317	80.1% – 88.1%	.20		
	2014	80.7%	606 / 751	77.8% – 83.4%	.99		
	2013	84.3%	780 / 930	81.8% – 86.5%	.14		
	2012	85.0%	215 / 253	80.0% – 88.9%	.18		
	2011	84.1%	264 / 314	79.6% – 87.7%	.27		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**73.5%**	**231 / 316**	**68.3% – 78.1%**		.79	.26
	2015	69.9%	227 / 324	64.7% – 74.7%	.32		
	2014	71.1%	290 / 405	66.6% – 75.3%	.49		
	2013	73.5%	349 / 475	69.4% – 77.3%	.98		
	2012	72.3%	229 / 317	67.1% – 76.9%	.74		
	2011	76.5%	210 / 275	71.1% – 81.1%	.40		

Table 24. Mental Health Survey - Quality-Related Questions (Continued)

Item	Year	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
I, not my mental health providers, decided my treatment goals.	**General Adult (Age 18+)**						
	2016	**78.6%**	**219 / 278**	**73.4% – 83.0%**		.77	.76
	2015	85.1%	303 / 356	81.1% – 88.5%	**.03 -**		
	2014	84.0%	655 / 780	81.3% – 86.5%	**.04 -**		
	2013	81.8%	809 / 989	79.3% – 84.1%	.22		
	2012	77.0%	198 / 257	71.5% – 81.8%	.67		
	2011	83.7%	237 / 283	79.0% – 87.6%	.12		
I helped to choose my treatment goals.	**General Youth (Ages 12-17), Youth Responding**						
	2016	**84.6%**	**128 / 151**	**77.9% – 89.5%**		.38	.96
	2015	91.0%	127 / 140	84.9% – 94.8%	.10		
	2014	84.1%	255 / 302	79.5% – 87.8%	.89		
	2013	88.8%	448 / 509	85.6% – 91.4%	.17		
	2012	81.6%	80 / 98	72.7% – 88.1%	.54		
	2011	86.8%	112 / 129	79.8% – 91.7%	.60		
	SED Waiver Youth (Ages 12-17), Youth Responding						
	2016	**86.8%**	**140 / 161**	**80.6% – 91.2%**		.07	**.02↑**
	2015	92.3%	135 / 146	86.7% – 95.7%	.12		
	2014	86.9%	169 / 194	81.4% – 91.0%	.97		
	2013	82.2%	183 / 222	76.7% – 86.7%	.23		
	2012	81.3%	109 / 134	73.9% – 87.1%	.20		
	2011	83.5%	101 / 121	75.8% – 89.1%	.44		
I helped to choose my child's treatment goals. (I, not my mental health providers, decided my treatment goals.)	**General Youth (Ages 0-17), Family Responding**						
	2016	**92.5%**	**288 / 311**	**89.0% – 95.0%**		.17	.21
	2015	92.7%	289 / 312	89.2% – 95.1%	.92		
	2014	92.2%	689 / 750	90.0% – 93.9%	.87		
	2013	90.5%	847 / 937	88.4% – 92.2%	.29		
	2012	91.6%	229 / 250	87.4% – 94.5%	.70		
	2011	90.7%	294 / 324	87.1% – 93.5%	.43		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**94.3%**	**301 / 318**	**91.2% – 96.4%**		.45	.78
	2015	95.0%	310 / 327	92.1% – 97.0%	.69		
	2014	95.8%	395 / 412	93.3% – 97.4%	.37		
	2013	93.1%	451 / 483	90.5% – 95.1%	.49		
	2012	96.1%	303 / 315	93.3% – 97.8%	.28		
	2011	93.8%	264 / 281	90.2% – 96.1%	.77		

Table 24. Mental Health Survey - Quality-Related Questions (Continued)

Item	Year	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
My (my child's) mental health providers spoke with me in a way that I understood.	**General Adult (Age 18+)**						
	2016	**90.0%**	**266 / 295**	**86.0% – 92.9%**		.07	.60
	2015	**95.3%**	368 / 386	92.7% – 97.1%	**<.01 -**		
	2014	**93.6%**	765 / 817	91.7% – 95.1%	**.04 -**		
	2013	**94.3%**	1,002/1,063	92.8% – 95.6%	**<.01 -**		
	2012	91.5%	257 / 281	87.6% – 94.2%	.54		
	2011	93.4%	282 / 302	89.9% – 95.7%	.13		
	General Youth (Ages 12-17), Youth Responding						
	2016	**94.4%**	**148 / 157**	**89.5% – 97.2%**		.18	.06
	2015	93.9%	137 / 146	88.6% – 96.9%	.86		
	2014	95.5%	290 / 303	92.5% – 97.4%	.60		
	2013	96.3%	495 / 515	94.2% – 97.7%	.29		
	2012	98.0%	97 / 99	92.5% – 99.9%	.16*		
	2011	97.0%	131 / 135	92.4% – 99.1%	.27		
	SED Waiver Youth (Ages 12-17), Youth Responding						
	2016	**95.5%**	**158 / 165**	**91.0% – 97.9%**		.31	**.02↑**
	2015	97.4%	147 / 151	93.3% – 99.2%	.36		
	2014	96.9%	183 / 189	93.2% – 98.7%	.49		
	2013	93.8%	213 / 227	89.8% – 96.3%	.46		
	2012	92.0%	126 / 137	86.1% – 95.6%	.20		
	2011	92.1%	116 / 126	85.9% – 95.8%	.22		
	General Youth (Ages 0-17), Family Responding						
	2016	**97.5%**	**323 / 331**	**95.1% – 98.8%**		.46	.30
	2015	98.8%	324 / 328	96.9% – 99.7%	.19		
	2014	97.5%	766 / 786	96.1% – 98.4%	.96		
	2013	97.3%	950 / 981	96.1% – 98.2%	.89		
	2012	97.8%	262 / 268	95.1% – 99.1%	.81		
	2011	96.7%	327 / 338	94.2% – 98.2%	.58		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**98.0%**	**324 / 331**	**95.8% – 99.1%**		.60	.43
	2015	97.9%	329 / 336	95.7% – 99.1%	.94		
	2014	98.2%	414 / 422	96.4% – 99.2%	.85		
	2013	97.4%	476 / 488	95.5% – 98.5%	.58		
	2012	97.8%	314 / 321	95.5% – 99.0%	.87		
	2011	97.2%	278 / 286	94.4% – 98.6%	.49		

The quality-related questions in Table 24 focus on the following:

- **Better control of daily life due to services provided.**
  - For the General Adult population, there was a significant decrease in positive responses in 2016 (74.8%) compared to 2015 (83.8%; $p<.01$), compared to 2014 (84.9%; $p<.001$), and compared to 2013 (83.0%; $p<.01$). The 2016 rate was the lowest rate in the six-year period. There was a statistically significant negative trend from 2013 to 2016 ($p=.02$).
  - For SED Waiver youth and young adults, there was an increase from 71.5% in 2015 to 75.9% in 2016.
  - Rates for SED Waiver youth (ages 12-17, youth responding) increased from 83.0% in 2015 to 85.9% in 2016.
  - Rates for General Youth (ages 12-17, youth responding) decreased from 87.0% in 2015 to 85.3% in 2016.

  - For General Youth (family responding), rates ranged from 77.8% in 2016 to 82.1% in 2013.
- **Member choice of treatment goals.**
  - In 2016, the percentage of members who indicated they had a choice of treatment goals ranged from 78.6% (General Adult) to 94.3% (SED Waiver youth and young adults).
  - For General Youth (family responding) and SED Waiver youth and young adults (family/member responding) rates have been above 90% each year from 2011 to 2016. General Youth rates ranged from 90.5% to 92.7%; SED Waiver youth and young adult rates ranged from 93.1% to 96.1%.
  - For the General Adult population, there was a significant decrease in positive responses in 2016 (78.6%) compared to 2015 (85.1%; p=.03) and compared to 2014 (84.0%; p=.04).
  - For General Youth (ages 12-17, youth responding), there was a decrease from 91.0% in 2015 to 84.6% in 2016.
  - For SED Waiver youth (ages 12-17, youth responding), positive response percentages decreased in 2016 to 86.8% from 92.3% in 2015 and were comparable to the 2014 rate of 86.9%. From 2011 to 2016, there was a statistically significant positive trend (2011 – 83.5%; 2012 – 81.3%; 2013 – 82.2%; 2014 – 86.9%; 2015 – 92.3%; 2016 – 86.8%; [p=.02]).
- **If given other choices, the member would still get services from their most recent mental health provider.**
  This question was asked of adults (non-SED Waiver). From CY2014 to CY2016 there was a decrease in positive response from 89.4% to 85.0%. From 2011 to 2016, rates ranged from 84.4% in 2012 to 89.4% in 2014.
- **Assistance in obtaining information to assist members in managing their health.**
  The 2016 rate for the General Adult population (82.7%) was lower than four of the five previous years, decreasing each year from 2013 (87.6%; p=.03) to 86.8% in 2014 to 86.3% in 2015.
- **Comfort in asking questions about treatment, medication, and/or children's problems.**
  - For the General Adult population, there was a significant decrease in positive responses in 2016 (85.9%) compared to 2015 (94.5%; p<.001), 2014 (90.7%; p=.02), 2013 (91.1%; p<.01), and 2011 (93.6%; p<.01).
  - Rates for General Youth (family responding) were above 90% each year from 2011 to 2016.
  - Rates for SED Waiver youth and young adults (family/member responding) were generally comparable over the six-year period, ranging from 87.5% in 2012 to 89.9% in 2016.
- **Better able to do things the member wants to do, as a direct result of services provided.**
  From 2011 to 2016, there was a significant downward trend in rates for the General Adult population, dropping from 82.4% in 2011 to 69.3% in 2016 (p=.03). Rates for SED Waiver youth/young adult were also relatively low, ranging from 69.9% in 2015 to 73.5% in 2013 and 2016. General Youth rates ranged from 80.7% in 2016 and 2014 to 85.0% in 2012.
- **Better ability to deal with crisis, as a direct result of services provided.**
  The rate in 2016 (69.2%) for the General Adult population was the lowest since 2011 (80.4%). Trend analysis showed a significant decrease in positive responses from 2013 to 2016 (p<.01). The 2016 rate was significantly lower than the rate in 2015 (79.3%; p<.01), 2014 (78.7%; p<.01), 2013 (79.1%; p<.001), and 2011 (80.4%; p<.01).
- **Understandable communication from provider with member**
  - Rates for all five survey populations in the six-year period were 90% or above.
  - For the General Adult population, there was a significant decrease in positive responses in 2016 (90.0%) compared to 2015 (95.3%; p<.01), compared to 2014 (93.6%; p=.04), and compared to 2013 (94.3%; p<.01).

- For the SED Waiver youth (ages 12-17, youth responding), rates were above 90% for the six-year period. The six-year positive trend from 2011 (92.1%) to 2016 (95.5%) was statistically significant (p=0.2).
- General Youth (ages 0-17 family responding) rates ranged from 96.7% to 98.8%. SED Waiver youth and young adults (family/member responding) rates ranged from 97.2% to 98.2%. General Youth (ages 12-17, youth responding) rates ranged from 93.9% to 98.0%.

SUD Consumer Survey

In 2011 and 2012, Value Options-Kansas (VO) conducted satisfaction surveys of members who accessed SUD treatment services. The survey consisted of 30 questions administered in 2012 by mail and through face-to-face interviews at provider locations. The VO survey was administered to 629 individuals, including Medicaid members and others receiving SUD services. Amerigroup, Sunflower, and UnitedHealthcare administered the survey to 342 in 2016 KanCare members, up from 193 in 2015 and 238 in 2014. The survey was a convenience survey administered in May through August through face-to-face interviews, mail, and follow-up phone calls. The demographics differed somewhat in that 43.9% of the 2014 survey respondents, 44.8% of 2015 respondents, and 42.1% of 2016 respondents were male compared to 61.6% for the 2012 VO survey. The average age for the 2016 survey was 33.9, compared to 32 in 2015, 33.7 in 2014, and 31.8 in 2012.

The 2012 results are reported for the SUD survey questions in this report; however, due to the difference in numbers of survey respondents and the additional non-Medicaid members surveyed in 2012, comparisons cannot be directly made with survey results in 2014 to 2016. SUD survey questions related to quality of care include the following summarized in Table 25:

Table 25. SUD Survey - Quality-Related Questions, CY2014 - CY2016

	CY2016	CY2015	CY2014
Overall, how would you rate the quality of service you have received from your counselor? (Percent of "Very good" or "Good" responses)	**93.3%**	**93.2%**	**94.3%**
How well does your counselor involve you in decisions about your care? (Percent of "Very good" or "Good" responses)	**92.6%**	**88.4%**	**92.0%**
Since beginning treatment, in general are you feeling much better, better, about the same, or worse? (Percent "Much better" or "Better" responses)	**88.9%**	**92.6%**	**87.1%**

- **Overall, how would you rate the quality of service you have received from your counselor?**
  In 2016, 93.3% of 327 members rated the quality of service as very good or good, comparable to 2015 (93.2%) and 2014 (94.3%), and to pre-KanCare (2012 - 95.3%).
- **How would you rate your counselor on involving you in decisions about your care?**
  In 2016, 92.6% of 324 members rated counselor involvement of members in decisions about their care as very good or good, which was higher than in 2015 (88.4%) and comparable to 2014 (92.0%). (2012 – 93.5%; 2011 – 96.7%).
- **Since beginning treatment, in general are you feeling much better, better, about the same, or worse?**
  In 2016, 88.9% of 323 members responded they were feeling much better or better since beginning

treatment, lower than in 2015 (92.6%) and slightly higher than in 2014 (87.1%). The percentage of members reporting they were feeling much better or better was much higher in 2012 (98.8%).

(8) Provider Survey

For provider surveys in 2014 and subsequent years in KanCare, the MCOs were directed to include three questions related to quality, timeliness, and access. These three questions and response options are to be worded identically on each of the MCOs' surveys to allow comparison and ability to better assess the overall program and trends over time.

Two of the MCOs, Sunflower and UnitedHealthcare, administer separate surveys to their BH providers. The MCOs were asked to include these three questions on their BH surveys as well. The UnitedHealthcare survey (conducted by Optum) included the three questions with wording for questions and response options as directed. Sunflower's BH survey (conducted by Cenpatico) included the questions and response options in 2015.

The surveys also differed in the numbers of survey responses. For the three questions reviewed in this report, in 2016 Amerigroup had 160 to 215 provider responses; Sunflower had 261 to 311 physical health provider responses and 167 to 172 BH survey responses; and UnitedHealthcare had only 71 to 72 physical health provider responses and 145 to 146 BH survey responses.

Unlike other sections of the KanCare Evaluation Report where data for the three MCOs are aggregated, data for the provider survey responses are reported separately by MCO. This is due in part to the separate surveying of BH providers and to the possibility that the same providers may have responded to two or three of the MCO surveys. The primary reason, however, is that the three questions are MCO-specific related to provider perceptions of each MCO's unique preauthorization processes, availability of specialists, and commitment to quality of care.

In this section, results are reported for the quality-related question. The provider survey results for the timeliness-related question are in Section 17, and results for the access-related question are in Section 23.

Providers were asked, "**Please rate your satisfaction with (MCO name's) demonstration of their commitment to high quality of care for their members."** Table26 provides the available survey results by individual MCO.

Amerigroup - Amerigroup conducts one survey for both physical health providers and BH providers. In 2016, Amerigroup received 215 completed surveys, approximately half as many as in 2015 (427) and fewer than in 2014 (283). In 2016, 60.9% of providers surveyed responded they were very or somewhat satisfied related to whether Amerigroup is committed to high quality of care for their members, slightly lower than in 2015 (62.8%), but much higher than in 2014 (50.9%). The percentage of providers responding "very dissatisfied" or "somewhat dissatisfied" with that statement was higher in 2016 (16.3%) than in 2015 (13.8%) and lower than in 2014 (18.8%).

Sunflower - Sunflower conducts a general survey of physical health providers and a separate survey by Cenpatico of BH providers.

- **Sunflower general provider survey** – In 2016, 50.8% of 311 providers responded they were very or somewhat satisfied, up from 47.1% in 2015 and much higher than in 2014 (37.5%). The percentage

responding they were very or somewhat dissatisfied decreased from 17.6% in 2014 to 11.9% in 2015, decreasing again in 2016 to 10.3%.

- **Sunflower (Cenpatico) BH provider survey -** This question was not asked in the 2014 BH survey. As directed by the State, this question was added to the 2015 survey. In 2015, 51.6% of 126 BH providers responded they were very or somewhat satisfied, and 7.2% were very or somewhat dissatisfied. Rates were comparable in 2016 – 48.8% of 172 BH providers responded they were very or somewhat satisfied, and 7.0% said they were very or somewhat dissatisfied.

Table 26. Provider Satisfaction with MCO'sCommitment to High Quality of Care for Their Members, CY2014 - CY2016

MCO	Very or Somewhat Satisfied			Neither Satisfied nor Dissatisfied			Very or Somewhat Dissatisfied			Total Responses*		
General Provider Surveys												
	2016	**2015**	**2014**	**2016**	**2015**	**2014**	**2016**	**2015**	**2014**	**2016**	**2015**	**2014**
Amerigroup	**60.9%**	62.8%	50.9%	**22.8%**	23.4%	30.4%	**16.3%**	13.8%	18.8%	**215**	427	283
Sunflower	**50.8%**	47.1%	37.5%	**38.9%**	41.0%	45.0%	**10.3%**	11.9%	17.6%	**311**	293	251
UnitedHealthcare	**40.3%**	44.7%	^	**44.4%**	40.8%	^	**15.3%**	14.5%	^	**72**	76	^
Behavioral Health Provider Surveys+												
	2016	**2015**	**2014**	**2016**	**2015**	**2014**	**2016**	**2015**	**2014**	**2016**	**2015**	**2014**
Cenpatico (SSHP)	**48.8%**	51.6%	**	**44.2%**	41.3%	**	**7.0%**	7.2%	**	**172**	126	**
Optum (UHC)	**55.9%**	59.4%	54.7%	**35.2%**	34.7%	36.9%	**9.0%**	5.9%	8.4%	**145**	101	84

*Providers may have responded to more than one MCO provider survey.
^UnitedHealthcare results for 2014 cannot be determined due to a typographical error in the survey instrument that included "Somewhat satisfied" twice and excluded "Somewhat dissatisfied."
+Amerigroup includes Behavioral Health Providers in their General Provider Survey
**Question was not asked in Cenpatico survey in 2014.

UnitedHealthcare – UHC conducts an annual survey of physical health providers and a separate BH provider survey through Optum.

- **UnitedHealthcare general provider survey** – As in the two previous years, UHC's 2016 survey had fewer than one-third of the provider responses as the other MCOs. Compared to AGP and SSHP, UHC had the lowest percentage of providers responding they were very or somewhat satisfied – 40.3% in 2016 (compared to 50.8% for SSHP and 60.9% for AGP) and lower than in 2015 (44.7%). The percentage responding they were very or somewhat dissatisfied increased slightly to 15.3% in 2016, compared to 14.5% in 2015. In 2014, UHC surveyed 66 providers, but, due to a typographical error in the survey instrument, the results cannot be compared.
  - Recommendation: In the 2014 UHC provider survey validation report, KFMC recommended UHC increase the number of providers surveyed. In 2015, the number of responses increased by only ten and decreased in 2016. KFMC recommends UHC consider other methods for surveying providers, including online options such as "Survey Monkey," and/or greatly increase the sample size to increase the number of providers surveyed.
- **UHC (Optum) BH provider survey –** In 2016, 55.9% of 145 BH providers responded they were very or somewhat satisfied, fairly comparable to 2015 (59.4%) and 2014 (54.7%). The percentage responding they were very or somewhat dissatisfied increased in 2016 to 9.0%, up from 5.9% in 2015 and 8.4% in 2014.

(9) Grievances – Reported Quarterly

Compare/track number of grievances related to quality over time, by population type.

Grievances are analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KDHE KanCare website for public review.

(10) Other (Tentative) Studies (Specific studies to be determined)

The focus and topics for "other studies" will be determined based on review of the various program outcomes, planned preventive health projects, and value-added benefits provided by the MCOs. One of the studies underway that will be reported in the 2017 KanCare Evaluation Annual report is an evaluation of the impact of P4P on HEDIS measures in years when P4P is in effect and in the time period that follows.

Coordination of Care (and Integration)

Goals, Related Objectives, and Hypotheses for Coordination of Care subcategories:

- *Goal: Provide integration and coordination of care across the whole spectrum of health to include physical health, behavioral health, mental health, substance use disorders, and LTSS.*
- *Related Objectives:*
  - *Improve coordination and integration of physical healthcare with behavioral healthcare.*
  - *Support members successfully in their communities.*
- *Hypothesis:*
  - *The KanCare model will reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired.*

(11) Care Management for Members Receiving HCBS Services

The population for the following performance measures is members who are receiving HCBS waiver services, including Intellectual/Developmental Disability (I/DD), PD, TA, TBI, Autism, FE, and MFP.

The number and percent of KanCare member waiver participants with documented change in needs whose service plans were revised, as needed, to address the change

The denominator for this measure is the number of waiver participants whose service plans were reviewed, and the numerator is the number of waiver participants with documented change in needs whose service plans were revised, as needed, to address the change (see Table 27).

Table 27. Percent of HCBS Waiver Participants with Documented Change in Needs Whose Service Plans were Revised, as Needed, to Address the Change, CY2013 - CY2015

Waiver	CY2013	CY2014	CY2015
Intellectual/Developmental Disability (I/DD) Waiver	7%	23%	28%
Physical Disability (PD) Waiver	75%	39%	53%
Frail Elderly (FE) Waiver	78%	38%	54%
Traumatic Brain Injury (TBI) Waiver	53%	38%	38%
Technical Assistance (TA) Waiver	92%	42%	75%
Serious Emotional Disturbance (SED) Waiver	85%	86%	88%
Autism Waiver	45%	11%	11%

These data are gathered through MCO record review by KDADS quality staff, and compliance percentages vary by waiver. As shown in Table 27, documentation in service plans of changes in needs was highest in CY2013 to CY2015 for the SED waiver. As part of remediation efforts, KDADS is currently in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and will be developing policy by August 2017 to provide clear direction on the plan of care development process.

The number and percent of KanCare member waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs.

The denominator for this measure is the number and percent of waiver participants who had assessments, and the numerator is the number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs (see Table 28).

These data are gathered through MCO record review by KDADS quality staff, and compliance percentages vary by waiver. As part of remediation efforts, KDADS is currently in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and will be developing policy by August 2017 to provide clear direction on the plan of care development process.

Table 28. Percent of Waiver Participants who had Assessments Completed by the MCO that Included Physical, Behavioral, and Functional Components to Determine the Member's Needs, CY2014 - CY2015

Waiver	CY2014	CY2015
Intellectual/Developmental Disability (I/DD) Waiver	78%	58%
Physical Disability (PD) Waiver	87%	66%
Frail Elderly (FE) Waiver	87%	70%
Traumatic Brain Injury (TBI) Waiver	71%	65%
Technical Assistance (TA) Waiver	95%	75%
Serious Emotional Disturbance (SED) Waiver	92%	54%
Autism Waiver	68%	48%

For the following HCBS HEDIS-like performance measures, members with dual eligibility, i.e., enrolled in both Medicare and Medicaid, are excluded because Medicaid is a secondary payer to Medicare; claims paid partially or entirely by Medicare are not always available to the MCOs at the time of analysis, which complicates interpretation and reporting of rates. These measures were P4P in 2014 and 2015; though no longer P4P, the State has directed the MCOs to continue to report these rates separately for the HCBS population to allow continued tracking of progress in improving these rates.

Table 29. HEDIS-Like Measures - HCBS Populations, CY2013 - CY2015			
	CY2015	CY2014	CY2013
Adults' access to preventive/ambulatory health services	94.0%	93.1%	92.0%
Annual Dental Visits	51.6%	49.0%	49.4%
Decrease in number of Emergency Department Visits* *(Visits/1000 member months)*	79.64	78.06	77.58
* The goal for this measure is to decrease the rate.			

Increased preventive care – Increase in the number of primary care visits (P4P 2014-2015)
This measure is based on the HEDIS "AAP" measure, but includes only HCBS members who were not dual-eligible.
Population: HCBS
Analysis: Annual comparison to baseline, trending over time
The percentage of HCBS members who had an annual preventive health visit increased from 92.0% in CY2013 to 93.1% in CY2014 and to 94.0% in CY2015. The rates for the HCBS member subpopulation were 4% to 8% higher than the rates for all KanCare adult members in all three years (88.4% in CY2013, 87.5% in CY2014, and 87.1% in CY2015).

Increase in Annual Dental Visits (P4P 2014-2015)
This measure is based on the HEDIS "ADV" measure, but includes only HCBS members who were not dual-eligible.
Population: HCBS (ages 2-21)
Analysis: Annual comparison to 2013 baseline, trending over time
The percentage of HCBS members who had an annual dental visit was higher in CY2015 (51.6%) compared to CY2014 (49.0%) and CY2013 (49.4%). The annual dentist visit rates for HCBS members were 15% to 18% lower than the HEDIS rates for the overall KanCare population in each of the three years – CY2015 (60.9%), CY2014 (60.0%) and (CY2013 (60.3%).

Decrease in number of Emergency Department Visits (P4P 2014-2015)
This measure is based on the HEDIS "Ambulatory Care – Emergency Department Visits (AMB)" measure. As per HEDIS criteria, this metric is reported as a rate based on visits per 1,000 member-months.
Population: HCBS
Analysis: Annual comparison to 2013 baseline, trending over time
From CY2013 to CY2015, emergency department (ED) visit rates (per 1,000 member-months) for the HCBS population increased slightly from 77.58 in 2013 to 78.06 in 2014 to 79.64 in 2015. The rates for the HCBS population were higher than the HEDIS rates for the overall KanCare population (65.17 in CY2013, 64.19 in CY2014, and 66.31 in CY2015).

(12) Other (Tentative) Study (Specific study to be determined)
This measure will be reported when a specific study and study criteria are determined and defined, and will be based on areas of special focus on care coordination and integration of care.

(13) Care Management for members with I/DD
Measures in this section pertain to the completed I/DD pilot project conducted in CY2013 through January 2014. Data provided by KDADS for this section were described and reviewed in the 2013 and 2014 KanCare Evaluation Reports.

(14) Member Survey – CAHPS

CAHPS questions related to coordination of care (see Table 30) include the following questions focused on perception of care and treatment in the Medicaid and CHIP populations. Additional detail on the CAHPS survey In CY2016 can be found in Section 4 of this report in the Health Literacy section.

Questions on both adult and child surveys:

- **In the last 6 months, how often was it easy (for your child) to get the care, tests, or treatment you (your child) needed?**
  The weighted aggregate rates remain generally comparable for all populations in CY2014 through CY2016 (Adult: 87.2% - 88.1%; GC: 92.0% - 93.4%; CCC: 91.9% - 93.0%). All results remain above the QC 50th percentile.
- **In the last 6 months, did you (your child) get care from a doctor or other health provider besides your (child's) personal doctor?**
  The 2016 survey positive responses were comparable within each population in CY2014 through CY2016 (Adult: 60.9% - 62.0%; GC: 39.5% - 44.1%; CCC: 58.3% - 60.7%).
  - **In the last 6 months, how often did your (child's) personal doctor seem informed and up-to-date about the care you (your child) got from these doctors or other health providers?**
    Those who responded positively to receiving care from a provider other than their personal doctor were asked this question.

    The CY2016 weighted aggregate result for adults (85.0%) increased from CY2015 (82.7%) and CY2014 (83.0%). The GC rates were comparable in CY2014 through CY2016 (81.9% - 82.3%) The CCC aggregate rates were generally comparable across years (CY2016 -80.7%; CY2015 -83.3%; CY2014 – 80.5%).

Table 30. Member Survey - CAHPS Coordination of Care Questions

Question	Pop	Weighted % Positive Responses			QC 50th Percentile		
		2016	2015	2014	2016	2015	2014
Questions on Adult and Child Surveys							
In the last 6 months…							
How often was it easy to get the care, tests, or treatment you (your child) needed?	Adult	**87.2%**	88.1%	87.6%	↑	↑	↑
	GC	**92.1%**	92.0%	93.4%	↑	↑	↑
	CCC	**92.4%**	91.9%	93.0%	↑	↑	↑
Did you (your child) get care from a doctor or other health provider besides your (his or her) personal doctor?	Adult	**60.9%**	61.4%	62.0%	NA	NA	NA
	GC	**39.6%**	44.1%	39.5%	NA	NA	NA
	CCC	**58.6%**	60.7%	58.3%	NA	NA	NA
How often did your (child's) personal doctor seem informed and up-to-date about the care you (your child) got from these doctors or other health providers?	Adult	**85.0%**	82.7%	83.0%	↑	↑	↑
	GC	**81.9%**	82.3%	81.9%	↓	↑	↑
	CCC	**80.7%**	83.3%	80.5%	↓	↑	↓
Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments (for your child) to see a specialist?	Adult	**44.3%**	46.5%	43.0%	NA	NA	NA
	GC	**17.9%**	19.4%	17.9%	NA	NA	NA
	CCC	**39.8%**	39.5%	38.4%	NA	NA	NA
How often did you get an appointment (for your child) to see a specialist as soon as you needed?	Adult	**86.2%**	81.7%	84.8%	↑	↑	↑
	GC	**80.8%**	84.6%	83.2%	↓	↑	↑
	CCC	**86.2%**	83.3%	85.3%	↑	↑	↑

Table 30. Member Survey - CAHPS Coordination of Care Questions (Continued)							
Question	Pop	Weighted % Positive Responses			QC 50th Percentile		
		2016	2015	2014	2016	2015	2014
Questions on Child Surveys only							
Did your child get care from more than one kind of health care provider or use more than one kind of health care service?	**GC**	**21.9%**	24.5%	22.3%	NA	NA	NA
	CCC	**45.3%**	48.0%	46.2%	NA	NA	NA
Did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?	**GC**	**55.2%**	56.4%	56.7%	NA	NA	NA
	CCC	**57.7%**	58.2%	57.9%	↓	↓	↓
Did you need your child's doctors or other health providers to contact a school or daycare center about your child's health or health care?	**GC**	**10.2%**	11.2%	10.4%	NA	NA	NA
	CCC	**16.8%**	17.3%	16.6%	NA	NA	NA
Did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?	**GC**	**94.5%**	92.5%	91.1%	NA	NA	NA
	CCC	**94.9%**	93.1%	96.5%	NA	NA	↑
Does your child have any medical, behavioral, or other health conditions that have lasted more than 3 months?	**GC**	**26.7%**	28.6%	24.5%	NA	NA	NA
	CCC	**74.8%**	76.8%	77.2%	NA	NA	NA
Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?	**GC**	**91.4%**	92.4%	92.9%	NA	NA	NA
	CCC	**92.0%**	92.4%	92.3%	↓	↓	↓
Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your family's day-to-day life?	**GC**	**89.5%**	88.8%	92.5%	NA	NA	NA
	CCC	**88.9%**	89.1%	90.3%	↓	↓	↑
In the last 6 months, did you get or refill any prescription medicines for your child?	**GC**	**50.3%**	53.0%	50.8%	NA	NA	NA
	CCC	**84.0%**	86.0%	86.5%	NA	NA	NA
How often was it easy to get prescription medicines for your child through his or her health plan?	**GC**	**94.5%**	93.1%	95.2%	NA	NA	NA
	CCC	**94.4%**	93.2%	94.7%	NA	NA	NA
Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?	**GC**	**54.7%**	59.5%	56.7%	NA	NA	NA
	CCC	**57.0%**	59.6%	57.6%	↓	↑	↓

- **In the last 6 months, did you make any appointments (for your child) to see a specialist?**
  In CY2016, 44.3% of adults, 17.9% of the GC population, and 39.8% of the CCC population reported having one or more appointments with a specialist. The CY2016 rates were comparable to CY2015 and CY2014.
  - **In the last 6 months, how often did you get an appointment (for your child) to see a specialist as soon as you needed?**
    Of those who had appointments with a specialist in the previous six months, 86.2% of adults in CY2016 obtained an appointment as soon as they needed, compared to 81.7% in CY2015, 84.8% in CY2014, and 75.9% in CY2012. The CY2016 adult results increased from above the QC 50th percentile to above the 95th QC percentile. All three MCOs had increases in the adult populations' rates and QC percentiles. The CY2015 GC results continued to be higher than CY2012, although there were variations across years (GC: CY2016 – 80.8%, CY2015 – 84.6%, CY2014 – 83.2%, CY2012 – 79.0%). The CCC results in CY2016 increased to 86.2% from CY2015 – 83.3% and CY2014 – 85.3%, and were above the QC 75th percentile in 2016.

Questions on child surveys only (pre-KanCare results for CY2012 were not available for these questions):

- **In the last 6 months, did your child get care from more than one kind of health care provider or use more than one kind of health care service?**
  The percentage of children obtaining care from more than one kind of health care provider and/or service decreased slightly (GC: CY2016 – 21.9%, CY2015- 24.5%, CY2014 – 22.3%; CCC: CY2016 – 45.3%, CY2015 -48.0%, CY2014 – 46.2%).
  - **In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?**
    Of those receiving these additional services, 55.2% of the GC population in CY2016 responded they received help from the health plan, doctor's office, or clinic to coordinate their child's care among the different providers or services; the rate was slightly higher in CY2015 (56.4%) and CY2014 (56.7%). The CY2016 results for the CCC population (57.7%) were slightly lower than CY2015 (58.2%) and CY2014 (57.9%) and remained below the QC 25th percentile.
- **Does your child have any medical, behavioral, or other health conditions that have lasted more than 3 months?**
  This question is used to help identify children who have chronic conditions; 26.7% of the CY2016 GC survey respondents indicated their child had a condition lasting longer than 3 months (CY2015 - 28.6; CY2014 - 24.5%); 74.8% of the CY2016 CCC population (CY2015 - 76.8%; CY2014 - 77.2%) responded positively to this question.
  - **Does your child's personal doctor understand how these medical behavioral or other health conditions affect your child's day-to-day life?**
    Of those in CY2016 that indicated their child has a chronic medical, behavioral, or other health condition, 91.4% of the GC population (CY2015 - 92.4%; CY2014 - 92.9%) and 92.0% of the CCC population (CY2015 - 92.4%; CY2014 - 92.3%) responded that their personal doctor understands how these health conditions affect their child's life.
  - **Does your child's personal doctor understand how your child's medical, behavioral or other health conditions affect your family's day-to-day life?**
    Of those in CY2016 who indicated their child has a chronic medical, behavioral, or other health condition, 89.5% of the GC population (CY2015 - 88.8%; CY2014 - 92.5%) and 88.9% of the CCC population (CY2015 - 89.1%; CY2014 - 90.3%) responded that their doctor understands how their condition affects the family's day-to-day life.
- **In the last 6 months, did you get or refill any prescription medicines for your child?**
  In CY2016, 50.3% of the GC population surveyed indicated they obtained prescription medicines for

their child, compared to 53.0% in CY2015 and 50.8% in 2014. Of the CCC population surveyed, 84.0% in CY2016, 86.0% in CY2015 and 86.5% in CY2014 indicated they had prescriptions filled for their child.

- **In the last 6 months, was it easy to get prescription medicines for your child through his or her health plan?**
  Of those who indicated they had gotten or refilled a prescription for their child in the last 6 months, 94.5% of the CY2016 GC population (CY2015 - 93.1%; CY2014 - 95.2%) and 94.4% of the CCC population (CY2015 - 93.2%; CY2014 - 94.7%) indicated it was easy to get prescriptions for their child through their health plan.
- **Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?**
  Of the CY2016 respondents who indicated they had gotten or refilled a prescription for their child in the last 6 months, 54.7% of the GC population (CY2015 - 59.5%; CY2014 -56.7%) and 57.0% of the CCC population (CY2015 - 59.6%; CY2014 - 57.6%) indicated they received help from their health plan, doctor's office, or clinic to get the child's prescription.

- **In the last 6 months, did you need your child's doctors or other health providers to contact a school or daycare center about your child's health or health care?**
  The percent of child survey respondents with a positive response was comparable in CY2014 through CY2016 within each population (GC: 10.2% - 11.2%; CCC 16.6% - 17.3%).
  - **In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?**
    Of those who needed help in contacting a school or daycare, 94.5% of the CY2016 GC respondents (CY2015 - 92.5%; CY2014 - 91.1%) and 94.9% of the CY2016 CCC respondents (CY2015 - 93.1%; CY2014 -96.5%) indicated they received the help they needed.

(15) Member Survey – Mental Health

The MH Surveys conducted in CY2011 through CY2016 are described above in Section 7 "Member Survey – Quality." The questions in Table 31 are related to the perception of care coordination for members receiving MH services.

- **Encouragement to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.)**
  General Adult positive response percentages ranged from 76.7% in 2012 to 83.4% in 2013. The 78.7% rate in 2016 was the lowest since 2012.
- **Perception that the members were able to access all of the services that they thought they needed**
  - Rates in 2016 ranged from 77.6% for SED Waiver youth and young adults (family/member responding) to 83.1% (General Youth, ages 12-17, youth responding). The 2016 rates in each of the five survey populations were lower than in 2015.
  - The 2016 General Adult rate (80.7%) is the second lowest of the six year period, with only the 2012 rate (78.8%) lower.
  - For the SED Waiver youth (ages 12-17, youth responding), there was a significant increase in rates from 71.8% in 2013 to 79.3% in 2016 (p=0.03).
  - For the General Youth (family responding), the 2016 rate (82.2%) decreased from the 2015 rate (86.3%). Rates decreased each year from 2011 (84.2%) to 79.7% in 2014.
  - The rate for General Youth (ages 12-17, youth responding) decreased in 2016 (83.1%) from 2015 (87.5%); the only rate lower than the 2016 rate was 82.8% in 2013.

- The rate for the SED Waiver youth and young adults decreased in 2016 (77.6%) from 2015 (78.9%). The 2015 rate was the highest in the six-year period.

Table 31. Mental Health Survey - Questions Related to Coordination of Care

Item	Year	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	**General Adult (Age 18+)**						
	2016	**78.7%**	**207 / 264**	**73.3% – 83.2%**		.05	.52
	2015	80.4%	278 / 346	75.9% – 84.3%	.60		
	2014	82.3%	589 / 716	79.4% – 84.9%	.20		
	2013	83.4%	802 / 962	80.9% – 85.6%	.08		
	2012	76.7%	191 / 249	71.1% – 81.5%	.59		
	2011	82.3%	214 / 260	77.2% – 86.5%	.30		
I was able to get all the services I thought I needed.	**General Adult (Age 18+)**						
	2016	**80.7%**	**235 / 290**	**75.8% – 84.9%**		.05	.05
	2015	84.9%	325 / 383	81.0% – 88.2%	.15		
	2014	86.5%	704 / 814	84.0% – 88.7%	**.02 -**		
	2013	86.0%	917/1,066	83.8% – 87.9%	**.03 -**		
	2012	78.8%	219 / 278	73.6% – 83.2%	.56		
	2011	91.3%	274 / 300	87.6% – 94.1%	**<.001 -**		
	General Youth (Ages 12–17), Youth Responding						
	2016	**83.1%**	**126 / 152**	**76.3% – 88.3%**		.55	.94
	2015	87.5%	126 / 144	81.0% – 92.1%	.28		
	2014	83.8%	260 / 309	79.2% – 87.5%	.85		
	2013	82.8%	427 / 518	79.1% – 86.0%	.94		
	2012	85.0%	85 / 100	76.6% – 90.8%	.68		
	2011	85.1%	114 / 134	78.0% – 90.2%	.64		
	SED Waiver Youth (Ages 12-17), Youth Responding						
	2016	**79.3%**	**127 / 161**	**72.3% – 84.9%**		**.03↑**	.27
	2015	81.5%	123 / 151	74.6% – 86.9%	.61		
	2014	74.8%	138 / 184	68.0% – 80.5%	.33		
	2013	71.8%	165 / 229	65.7% – 77.2%	.10		
	2012	76.3%	103 / 135	68.4% – 82.7%	.54		
	2011	77.6%	97 / 125	69.5% – 84.1%	.74		
My family got as much help as we needed for my child. (I was able to get all the services I thought I needed.)	**General Youth (Ages 0-17), Family Responding**						
	2016	**82.2%**	**264 / 320**	**77.6% – 86.0%**		.87	.62
	2015	86.3%	278 / 322	82.1% – 89.6%	.15		
	2014	79.7%	609 / 766	76.7% – 82.4%	.34		
	2013	83.2%	799 / 966	80.7% – 85.4%	.67		
	2012	82.9%	213 / 257	77.8% – 87.0%	.83		
	2011	84.2%	278 / 330	79.9% – 87.8%	.48		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**77.6%**	**253 / 325**	**72.7% – 81.8%**		.29	.68
	2015	78.9%	260 / 330	74.2% – 83.0%	.67		
	2014	76.4%	318 / 413	72.0% – 80.2%	.70		
	2013	75.2%	363 / 482	71.1% – 78.8%	.43		
	2012	77.3%	248 / 321	72.4% – 81.6%	.93		
	2011	77.4%	220 / 284	72.2% – 81.9%	.97		

(16) Member Survey – SUD

Section 7 provides background on the SUD survey conducted by the three MCOs in CY2014, CY2015, and CY2016. Questions related to perceptions of care coordination include the following questions (see Table 32):

Table 32. SUD Survey - Questions Related to Coordination of Care, CY2014 - CY2016

	CY2016	CY2015	CY2014
In the last year, have you received services from any other substance use counselor in addition to your current counselor? (Percent of "Yes" responses)	**44.3%**	**34.8%**	**35.7%**
If yes to previous question: Has your current counselor asked you to sign a "release of information" form to share details about your visit(s) with the other substance use counselor who you saw? (Percent of "Yes" responses)	**82.4%**	**85.1%**	**60.3%**
Thinking about the coordination of all your health care, do you have a primary care provider or medical doctor?* (Percent of "Yes" responses)	**66.4%**	**64.4%**	**64.9%**
If yes to previous question: Has your counselor asked you to sign a "release of information" form to allow him/her to discuss your treatment with your primary care provider or medical doctor? (Percent "Yes" responses)	**70.4%**	**69.8%**	**52.5%**

*Denominator for question includes "Don't know" responses in addition to "Yes" and "No" responses.

- **Has your counselor requested a release of information for this other substance abuse counselor who you saw?**
  - In 2016, 44.3% (136) of 307 members who responded indicated they had received services in the past year from a substance abuse counselor in addition to their current counselor, from 34.8% (63 of 181 surveyed) in 2015 and 35.7% (70 of 196) surveyed in 2014.
  - Of the 136 who received services from more than on substance use counselor, 108 responded to the follow-up question asking if their counselor requested a release of information from the other counselor. Of the 108, 89 (82.4%) indicated their counselor requested a release of information, comparable to 2015 (85.1%) and higher than in 2014 (60.3%).
- **Has your counselor requested a release of information for and discussed your treatment with your medical doctor?**
  - In 2016, 4.0% (14) of 327 members responding indicated they did not know if they have a primary care provider (PCP), compared to 3.1% (6 of 191) in 2015 and 7.1% (15 of 211) in 2014. In 2016, 66.4% (217 of 327) indicated they have a PCP, comparable to 64.4% in 2015 and 64.9% in 2014.
  - Of those who indicated they have a PCP, 70.4% (107 of 152) in 2016 reported their counselor requested a release of information, comparable to 69.8% in 2015 and higher than in 2014 (52.5%).

(17) Provider Survey

Background information and comments on the 2014 Provider Survey are described in Section 8. In this section, results are reported for satisfaction with the preauthorization process. The provider survey results for the quality-related question are in Section 8, and results for the access-related question are in Section 23.

Providers were asked, "**Please rate your satisfaction with obtaining precertification and/or authorization for (MCO's) members**." Table 33 provides the available survey results by individual MCO.

Table 33. Provider Satisfaction with Obtaining Precertification and/or Authorization for Their Members, CY2014 - CY2016

MCO	Very or Somewhat Satisfied			Neither Satisfied nor Dissatisfied			Very or Somewhat Dissatisfied			Total Responses*		
General Provider Surveys												
	2016	**2015**	**2014**	**2016**	**2015**	**2014**	**2016**	**2015**	**2014**	**2016**	**2015**	**2014**
Amerigroup	**51.7%**	61.2%	53.3%	**19.7%**	18.1%	23.9%	**28.7%**	20.7%	22.8%	**178**	397	272
Sunflower	**46.1%**	39.8%	38.2%	**38.2%**	36.4%	32.8%	**15.7%**	23.8%	29.0%	**293**	269	241
UnitedHealthcare	**41.7%**	50.0%	^	**33.3%**	27.6%	^	**25.0%**	22.4%	^	**72**	76	66
Behavioral Health Provider Surveys+												
	2016	**2015**	**2014**	**2016**	**2015**	**2014**	**2016**	**2015**	**2014**	**2016**	**2015**	**2014**
Cenpatico (SSHP)	**32.3%**	42.5%	63.4%	**58.7%**	44.1%	26.9%	**9.0%**	13.4%	9.6%	**167**	127	52
Optum (UHC)	**51.4%**	58.4%	52.3%	**39.7%**	36.6%	34.5%	**8.9%**	5.0%	13.1%	**146**	101	84

*Providers may have responded to more than one MCO provider survey.
^UnitedHealthcare results for 2014 cannot be determined due to a typographical error in the survey instrument that included "Somewhat satisfied" twice and excluded "Somewhat dissatisfied."
+Amerigroup includes Behavioral Health Providers in their General Provider Survey

Amerigroup

- In 2016, 51.7% of 178 providers were very or somewhat satisfied with AGP preauthorization and precertification, down from 61.2% in 2015 and comparable to 53.3% in 2014, but higher than in 2013 (40.7%).
- In 2016, 28.7% of providers surveyed were very or somewhat dissatisfied, higher than in 2015 (20.7%) and 2014 (22.8%), but lower than in 2013 (42.6%).

Sunflower

- **Sunflower general provider survey** - No comparison can be made with the 2013 general provider survey results since Sunflower's 2013 survey questions were asked of providers only in comparison to other MCOs. In 2016, 46.1% of providers surveyed indicated they were very or somewhat satisfied, higher than In 2015 (39.8%) and 2014 (38.2%). In 2016, 15.7% of the providers were very or somewhat dissatisfied, lower than in 2015 (23.8%) and in 2014 (29.0%).
- **Sunflower (Cenpatico) BH provider survey** – In 2016 32.3% of 167 BH providers indicated they were very or somewhat satisfied with Cenpatico precertification/preauthorization, lower than in 2015 (42.5%) and 2014 (63.4%). The percentage dissatisfied or very dissatisfied was lower in 2016 (9.0%) than in 2015 (13.4%) and 2014 (9.6%). BH providers were asked, "How would you rate the authorization process (sending in a form) for your Cenpatico clients?" (i.e., worded differently from the 2015 survey question). Of 52 BH providers surveyed in 2014, 63.4% (33) replied "very good or good" and 9.6% (5) replied "very poor or poor."

UnitedHealthcare

- **UnitedHealthcare general provider survey –**In 2016, 41.7% of 72 providers surveyed were very or somewhat satisfied, lower than in 2015 (50.0%). The percentage indicating they were very or somewhat dissatisfied was higher in 2016 (25.0%) than in 2015 (22.4%).
- **UHC (Optum) BH provider survey** –In 2016, 51.4% of the 146 BH providers surveyed were very or somewhat satisfied with Optum's precertification and authorization process, down from 2015

(58.4%) and comparable to 2014 (52.3%). In 2016, 8.9% of BH providers were very or somewhat dissatisfied, up from 5.0% in 2015 and down from 13.1% in 2014.

Cost of Care

Goals, Related Objectives, and Hypotheses for Costs subcategory:

- *Goal: Control Medicaid costs by emphasizing health, wellness, prevention and early detection, as well as integration and coordination of care*
  Related Objectives:
  - *Promote wellness and healthy lifestyles*
  - *Lower the overall cost of health care.*
- *Hypothesis: By holding MCOs to outcomes and performance measures, and typing measures to meaningful financial incentives, the state will improve health care quality and reduce costs.*

(18) Costs

The data for the following measures continue to be analyzed; additional analysis (e.g., per member per year costs of HCBS, utilization of services by a specific population group) will be included in future reporting.

Population: KanCare Members by Medicaid Eligibility Group (MEG)

Analysis: Pre-KanCare compared to KanCare and trending over time beginning in DY2

Comparison of Pre-KanCare and KanCare Service Utilization

Table 34 shows a comparison of the annual number of services used by those eligible for Medicaid services pre-KanCare in CY2012 with services used by KanCare members in CY2015.

Table 34. Comparison of Pre-KanCare (2012) and KanCare (2015) Service Utilization

Type of Service	% Utilization Difference
Dental	32%
Home & Community-Based Services	23%
Primary Care Physician	24%
Inpatient	-23%
Outpatient Emergency Room	-1%
Outpatient, Non-Emergency Room	10%
Pharmacy	7%
Transportation	33%
Vision	16%

Services with increased utilization in CY2015 compared to CY2012 were Primary Care Physician (24% increase), Dental (32% increase), Home and Community-Based Services (23% increase), Vision (16% increase), Transportation (33% increase), and Non-Emergency Room (ER) Outpatient Services (10% increase).

Inpatient Hospitalization decreased 23% in CY2015 compared to CY2012, and Emergency Room Outpatient Visits decreased by 1%. Decreases in utilization of these services are a positive outcome, reflecting increased access of treatment from .the member's primary care provider instead of an ER and increased preventive care and home services to avoid lengthy hospital stays.

Per Member Per Month (PMPM) Average Annual Service Expenditures

Per member per month (PMPM) is the annual average monthly cost to provide care. "Cost to provide care" is based on encounters, i.e., payments to providers who have submitted claims for services. Table 35 shows the PMPM for CY2013, CY2014, and CY2015 in total and by comparison groups.

Table 35. Per Member Per Month (PMPM) Service Expenditures by Medicaid Eligibility Group, CY2013 - CY2015

Comparison Groups	CY2013	CY2014	CY2015
Children & Families	150	213	209
Waiver Services	3,275	3,192	3,617
Long Term Care	1,644	3,108	2,963
Persons with Disabilities	554	827	829
Pregnant Women	504	674	655
Other	502	665	680
Total	503	699	694

Due to "claims lag," i.e., the time allowed for providers to submit claims and the time allowed for the MCOs to process the claims, a certain portion of service costs in one year will be reflected in the PMPM the following year. As shown in Table 35, CY2013 would appear to have lower PMPM, when in actuality, the differences are likely due to CY2013 being the first year of KanCare, and some of the service costs in CY2013 were paid in CY2014. On the same note, some of the costs for services received in CY2014 were paid in CY2015 and are reflected in those numbers. PMPMs for CY2014 and CY2015 (and CY2016 to be reported in next year's report) are better used for comparison of service costs over time.

The five comparison population groups in the PMPM analysis above consist of:

- Children & Families: CHIP (Children's Health Insurance Program), Foster Care, TAF (Temporary Assistance for Families), and PLE (Poverty Level Eligible);
- Waiver Services: Autism, TA, SED, TBI, and I/DD waiver populations;
- Long Term Care: Child in Institution, FE Waiver, PD Waiver, Nursing Facility, and ICF/MR (intermediate care facility for persons with mental retardation);
- Persons with Disabilities: SSI (Supplemental Security Income) Aged, Blind, and Disabled and Medically Needy Aged Blind and Disabled;
- Pregnant Women
- Other: Refugees, Breast & Cervical Cancer, and members participating in the WORK and Working Disabled programs.

Access to Care

Goals, Related Objectives, and Hypotheses for Access to Care subcategories:

- *Goal: Establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms as well.*
- *Related Objectives:*
  - *Measurably improve health outcomes for members.*
  - *Support members successfully in their communities.*
  - *Promote wellness and healthy lifestyles.*
  - *Improve coordination and integration of physical health care with behavioral health care.*
  - *Lower the overall cost of health care.*
- *Hypothesis: The state will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health, mental health, substance use disorder, and LTSS.*

(19) Provider Network – GeoAccess

Percent of counties covered within access standards, by provider type (physicians, hospital, eye care, dental, ancillary [physical therapy, occupational therapy, x-ray, and lab], and pharmacy).

KFMC reviewed the GeoAccess reports, maps, and other data to identify the percent of counties where specific provider types are not available from at least one MCO. KFMC also reviewed GeoAccess maps showing provider access by provider type for CY2012-CY2016. The number of providers and number of locations by service type and MCO, as reported by the MCOs to KDHE in December 2016, are listed in Table 36. Service types include physicians by specialty, hospitals, retail pharmacies, dental primary care, and ancillary services (physical therapy, x-ray, lab, optometry, and occupational therapy). Table 36 also includes the change in the number of providers and locations for each provider type by MCO from 2015 to 2016. MCOs with the highest number of providers and locations by provider type are also highlighted in the table.

The GeoAccess reports include access to services by county and county type, number of members in each county by MCO, and percentage of each county within prescribed mileage ranges, depending on the type of service. Table 37 reports the number of counties (and whether the county is urban or non-urban) where each MCO reported that 100% of the county has no access to that particular provider type from the MCO at the time the report was submitted to the State. As shown in the table, there are some specialties, particularly in rural and frontier counties, where the number of counties without access is comparable for all three MCOs. Plastic & Reconstructive Surgery, for example, is not available in 19 to 23 counties. For other specialties, however, the number of counties without access to a specialty differs more widely, indicating opportunities for MCOs to expand their networks. Physical Medicine/Rehab providers, for example, are not available in 31 counties for UHC and only 6 counties for SSHP, and Gastroenterology providers are not available in 4 counties for UHC and 22 to 24 counties in the AGP and SSHP networks.

Of the 105 counties in Kansas, 16 are “Urban” or “Semi-Urban” and 89 are non-urban (21 “Densely-Settled Rural,” 32 “Rural,” and 36 “Frontier”).

Table 36. Number of Providers and Provider Locations by MCO and by Provider Type, CY2016						
Provider Type	Number of Providers/ Number of Locations			Difference from 2015 to 2016		
	AGP	SSHP	UHC	AGP	SSHP	UHC
Physicians						
Primary Care Provider	2,300 / 748	3,256 / 1,020	**6,639/ 2,128**	+44 / -32	+139 / +65	+1,342 / +509
Allergy	39/ 22	42 / 30	**46 / 45**	-2 / -2	+1 / +5	-1 / -1
Cardiology	345 / 152	335 / 178	**436 / 283**	+19 / -3	-9 / +6	+26 / +4
Dermatology	40 / 45	44 / 37	**79 / 80**	-3 / +8	-2 / +5	+11 / +16
Gastroenterology	111 / 57	116 / 75	**133 / 182**	-3 / -2	0 / +3	+4 / +68
General Surgery	331 / 181	346 / 224	**374 / 313**	-25 / -8	+14 / +14	-42 / -27
Hematology/Oncology	217 / 111	105 / 53	**265 / 205**	-16 / +16	-12 / -2	+1 / -6
Internal Medicine	**1,142** / 389	782 / 383	904 / **840**	-130 / -36	+12 / +17	+237 / +380
Neonatology	69 / 11	**74** / 20	72 / **33**	-4 / -1	+7 / +1	-25 / -7
Nephrology	92 / 35	71 / 50	**107 / 76**	-1 / +1	0 / +3	-8 / -11
Neurology	206 / 104	266 / 124	**306 / 225**	-11 / +4	+19 / +10	+40 / +48
Neurosurgery	73 / 37	87 / 52	**98 / 93**	+4 / -3	+6 / +5	+12 / +20
OB/GYN	382 / 185	391 / 219	**484 / 291**	-7 / 0	+9 / +17	+3 / +24
Ophthalmology	129 / **204**	136 / 168	**185** / 160	-9 / -21	-17 / +17	+32 / +1
Orthopedics	221 / 107	265 / 150	**330 / 256**	-2 / -9	+23 / +19	+33 / +39
Otolaryngology	93 / 62	**104** / 62	103 / **91**	-2 / -3	-1 / -7	+1 / -2
Physical Medicine/Rehab	55 / 41	72 / 61	**90 / 81**	-3 / 0	-3 / +2	+2 / -14
Plastic & Reconstructive Surgery	37 / 30	43 / 36	**60 / 61**	0 / 0	0 / 0	+2 / +7
Podiatry	37 / 47	38 / 41	**105 / 149**	+2 / -8	0 / -2	+26 / -2
Psychiatrist	475 / **365**	**513** / 237	335 / 296	+119 / +153	+29 / +13	-49 / -51
Pulmonary Disease	139 / 66	119 / 100	**141 / 127**	+15 / -7	+6 / +11	-9 / -10
Urology	100 / 57	100 / 72	**159 / 136**	-2 / -5	-10 / +4	+15 / +17
Hospital						
Hospitals	**247 / 233**	166 / 166	149 / 152	+126 / +111	0 / 0	-4 / -1
Eye Care - Optometry						
Eye Care - Optometry	401 / 417	450 / 445	**548 / 484**	-23 / -9	+15 / +34	+10 / +33
Dental						
Dental Primary Care	395 / **286**	**405** / 285	396 / 284	+30 / +9	-3 / -7	+26 / +4
Ancillary Services						
Physical Therapy	494 / **368**	**536** / 301	420 / 224	-46 / +31	-1 / +16	-1 / -5
Occupational Therapy	**503 / 344**	224 / 192	207 / 158	+227 / +92	+10 / +11	+7 / -4
X-ray	**277 / 263**	179 / 186	149 / 152	+70 / +26	+24 / +31	-3 / 0
Lab	**287 / 276**	226 / 243	152 / 156	+87 / +41	+57 / +84	-11 / -12
Pharmacy						
Retail Pharmacy	642 / 639	578 / **724**	**699** / 685	+2 / +2	-34 / -38	+43 / +31

Blue font represents the highest number of providers and locations reported.

Table 37. Counties with no Provider Access by MCO and County Type, CY2016									
Provider type	Number of Counties with 0% Access (of 105 Counties)								
	Urban & Semi-Urban			Non-Urban			Counties with 0% access from all 3 MCOs' providers		
	AGP	SSHP	UHC	AGP	SSHP	UHC	Urban	Non-Urban	# members no access
Physicians									
Primary Care Provider	-	-	-	-	-	-	-	-	-
Allergy	2	2	1	11	3	1	1	-	6,731
Cardiology	-	2	-	1	3	3	-	1	273
Dermatology	-	-	1	2	3	5	-	-	-
Gastroenterology	-	-	1	22	24	4	-	4	1,828
General Surgery	-	-	-	-	-	-	-	-	-
Hematology/Oncology	-	3	-	-	14	-	-	-	-
Internal Medicine	-	-	-	-	-	-	-	-	-
Neonatology	4	3	3	39	21	19	1	5	10,598
Nephrology	-	-	2	4	17	3	-	2	1,174
Neurology	-	-	-	3	-	-	-	-	-
Neurosurgery	3	3	1	12	2	-	-	-	-
OB/GYN	-	-	-	1	6	-	-	-	-
Ophthalmology	-	-	-	-	-	-	-	-	-
Orthopedics	-	-	-	-	-	2	-	-	-
Otolaryngology	-	-	-	5	8	-	-	-	-
Physical Medicine/Rehab	1	1	-	13	5	31	-	2	1,174
Plastic & Reconstructive Surgery	4	5	4	15	18	18	3	15	27,905
Podiatry	-	2	-	8	19	6	-	-	-
Psychiatrist	-	-	-	-	-	-	-	-	-
Pulmonary Disease	-	1	-	2	1	3	-	-	-
Urology	-	-	-	2	3	-	-	-	-
Hospital									
Hospitals	-	-	-	-	-	-	-	-	-
Eye Care - Optometry									
Eye Care - Optometry	-	-	-	-	1	1	-	-	-
Dental									
Dental Primary Care	-	-	-	1	6	5	-	1	221
Ancillary Services									
Physical Therapy	-	-	-	-	-	-	-	-	-
Occupational Therapy	-	-	-	-	5	4	-	-	-
X-ray	-	-	-	-	-	-	-	-	-
Lab	-	-	-	-	-	-	-	-	-
Pharmacy									
Retail Pharmacy	-	-	-	-	-	-	-	-	-

Urban and Semi-Urban Counties. In CY2016, the MCOs reported that 69.3% (273,640) of the KanCare members were residents of Urban or Semi-Urban Counties. In CY2012 - CY2014, KanCare members who were residents of any of the 16 Urban/Semi-Urban counties had access to at least one provider in all provider types. In CY2016 there were three provider types where Semi-Urban counties did not have access through at least one MCO: Allergy – Montgomery County; Neonatology – Saline County; and Plastic & Reconstructive Surgery – Geary, Montgomery, and Riley Counties.

Frontier, Rural, and Densely-Settled Rural (Non-Urban) Counties
In CY2016, 30.7% (121,327) of KanCare members were residents of Frontier, Rural, or Densely-Settled Rural counties. KanCare members who lived in some of the Densely-Settled Rural, Rural, or Frontier counties did not have access to provider types from any of the MCOs. In CY2016, there were seven provider types where one or more county had no access through any of the three MCOs in 2016. The seven provider types and numbers of non-urban counties without access included:

- Cardiology - one county (Cheyenne) in 2016 and 2014; two counties in 2015;
- Gastroenterology - four counties in 2016 (Cheyenne, Decatur, Rawlins, and Sherman); four in 2015; 28 in 2014; 27 in 2013; and 12 in 2012;
- Neonatology - five counties in 2016 (Cheyenne, Greeley, Rawlins, Sherman, and Wallace); five in 2015; 13 in 2014; 36 in 2013; and 28 in CY2012;
- Nephrology - two counties in 2016 (Cheyenne and Sherman); two in 2015; and one in 2014;
- Physical Medicine/Rehab - two counties in 2016 (Cheyenne and Sherman); two in 2015; one in 2014;
- Plastic and Reconstructive Surgery - 15 counties in 2016 (Cheyenne, Clark, Grant, Greeley, Hamilton, Haskell, Kearny, Meade, Morton, Seward, Sherman, Stanton, Stevens, Wallace, and Wichita); 17 counties in 2015; and 15 in 2014; and
- Dental Primary Care -one county in 2015 (Lane); one in 2015; six in 2013; and two in 2012.

The counties with the least amount of access to providers in 2016 were Cheyenne and Sherman Counties, Frontier type counties in the northwest corner of Kansas. Both counties did not have access from any MCO to five provider types listed above, including Gastroenterology, Neonatology, Nephrology, Physical Medicine/Rehab, and Plastic/Reconstructive Surgery. Cheyenne County also did not have access to Cardiology. Of the other 16 counties with no access to one or more provider types: three counties had no access to two provider types, and 13 had no access to one provider type. Not factored into this analysis are the numbers of counties with no access to one or more providers that are adjacent on all sides to counties with no access to these same provider types.

Table 37 also only reports the number of counties where the MCOs reported 0% access. Including counties where over 90% of the members do not have access to particular provider types from any MCO would greatly expand the list. One example is Dental - only one county, Lane County, in western Kansas had no Dental provider access through all three MCO. In Logan and Wallace Counties, over 99% of members did not have access to dental services within their counties.

Access also varies by MCO; members in Seward County have over 99% reported access to dental services from one MCO, while only 3-5% of members in the other two MCOs have access to dental services through the MCO. In Table 38, the number and percentage of members without access to provider types are listed by provider types. (Not included in the table are provider types, such as PCP, Internal Medicine, and Behavioral Health that have 100% access, based on distance standards.) The provider types with least access in 2016 were Neonatology and Plastic/Reconstructive Surgery.

Table 38. Number and Percentage of Members not Within Access Distance by Provider Type and MCO, CY2016					
Provider type	AGP	SSHP	UHC	Total	% of all members
Neonatology	32,737	23,598	21,439	77,774	19.7%
Plastic/Reconstructive Surgery	20,084	25,965	18,971	65,020	16.5%
Physical Medicine	11,763	9,922	16,221	37,906	9.6%
Allergy	15,131	11,128	7,945	34,204	8.7%
Gastroenterology	11,830	13,188	6,112	31,130	7.9%
Podiatry	9,123	17,146	2,559	28,828	7.3%
Dermatology	9,283	13,714	4,148	27,145	6.9%
Neurosurgery	10,943	11,518	4,487	26,948	6.8%
Nephrology	2,975	12,282	7,263	22,520	5.7%
Hematology/Oncology	168	15,610	181	15,959	4.0%
Cardiology	250	10,035	1,731	12,016	3.0%
Dental	3,615	2,578	3,494	9,687	2.5%
Otolaryngology	2,723	2,760	2,577	8,060	2.0%
Pulmonary Disease	583	3,484	3,358	7,425	1.9%
OB/GYN	1,381	2,541	2,701	6,623	1.7%
Occupational Therapy	-	2,106	2,547	4,653	1.2%
Retail Pharmacy	757	1,752	1,270	3,779	1.0%
Lab	-	2,115	899	3,014	0.8%
X-ray	-	2,115	899	3,014	0.8%
Psychiatrist	421	1,423	998	2,842	0.7%
Urology	500	1,551	635	2,686	0.7%
Neurology	667	1,095	566	2,328	0.6%
Optometry	665	427	674	1,766	0.4%
Orthopedics	291	676	465	1,432	0.4%
Hospitals	-	473	899	1,372	0.3%
Opthalmology	-	121	181	302	0.1%
Physical Therapy	-	41	37	78	0.02%

The provider types that had the biggest improvements over time in reductions in numbers of counties without access were:

- Neonatology – In 2016 members in six counties did not have access through any MCO, compared to 36 counties in CY2013 and 13 counties in CY2014. It should be noted, however, that, while at least one MCO provided access to a Neonatologist in all but 5 counties, AGP had no access for 43 counties, SSHP had no access in 24 counties, and UHC had no access to Neonatologists for members in 22 counties.
- Neurosurgery – In 2015 and 2016, access was available through at least one MCO in all 105 Kansas counties. In CY2013, members in 20 counties did not have access, and in CY2014, members in 11 counties did not have access. UHC reported access for members in all but one county, compared to no access in five counties for SSHP (down from 32 in 2015) and 15 counties for AGP.

Average distance to a behavioral health provider

Average distance to one, two, three, four, and five BH providers by county type and by MCO in CY2016 are described below. As of December 2016, the MCOs reported the following number of BH providers and number of locations of the providers:

- Amerigroup – 2,805 providers at 977 locations
- Sunflower – 3,104 providers at 875 locations
- UnitedHealthcare – 3058 providers at 934 locations

Urban/Semi-Urban – Access standard is one provider within 30 miles.

- Amerigroup – 84,115 members in Urban/Semi-Urban counties. The average distance to a choice of five providers was 2.0 miles; to four providers was 1.8 miles; to three providers was 1.7 miles; to two providers was 1.5 miles; and to one provider was 1.2 miles.
- Sunflower – 98,854 members in Urban/Semi-Urban counties. The average distance to a choice of five providers was 2.2 miles; to four providers was 2.1 miles; to three providers was 2.0 miles; to two providers was 1.8 miles; and to one provider was 1.5 miles.
- UnitedHealthcare– 90,690 members in Urban/Semi-Urban counties. The average distance to a choice of five providers was 2.0 miles; to four providers was 1.9 miles; to three providers was 1.8 miles; to two providers was 1.7 miles; and to one provider was 1.4 miles.

Densely-Settled Rural – Access standard is one provider within 45 miles

- Amerigroup – 25,892 members in Densely-Settled Rural counties. The average distance to a choice of five providers was reported as 4.6 miles; to four providers was 4.3 miles; to three providers was 3.6 miles; to two providers was 3.2 miles; and to one provider was 2.4 miles.
- Sunflower – 25,834 members in Densely-Settled Rural counties. The average distance to a choice of five providers was 6.1 miles; to four providers was 5.8 miles; to three providers was 5.7 miles; to two providers was 4.9 miles; and to one provider was 4.0 miles.
- UnitedHealthcare – 24,066 members in Densely-Settled Rural counties. The average distance to a choice of five providers was 4.3 miles; to four providers was 4.3 miles; to three providers was 4.2 miles; to two providers was 4.0 miles; and to one provider was 3.3 miles.

Rural/Frontier - Access standard is one provider within 60 miles

- Amerigroup – 14,800 members in Rural/Frontier counties. The average distance to a choice of five providers was 19.3 miles; to four providers was 17.1 miles; to three providers was 14.5 miles; to two providers was 12.1 miles; and to one provider was 8.1 miles.
- Sunflower – 16,496 members in Rural/Frontier counties. The average distance to a choice of five providers was 17.6 miles; to four providers was 16.4 miles; to three providers was 15.1 miles; to two providers was 13.6 miles; and to one provider was 11.9 miles.
- UnitedHealthcare – 13,396 members in Rural/Frontier counties. The average distance to a choice of five providers was 12.8 miles; to four providers was 11.8 miles; to three providers was 11.1 miles; to two providers was 10.3 miles; and to one provider was 9.2 miles.

Percent of counties covered within access standards for behavioral health

BH providers were available to members of all three MCOs within the State access standards for each county type.

Urban/Semi-Urban - The access standard for Urban and Semi-Urban counties is a distance of 30 miles. This access standard was met in CY2015 for 100% of the 16 Urban and Semi-Urban counties in Kansas,

as reported by the three MCOs. Based on the GeoAccess map reports, the access standard was also met in the four previous years, CY2012 to CY2015.

Densely-Settled Rural - The access standard for Densely-Settled Rural counties is a distance of 45 miles. This access standard was met in CY2015 for 100% of the 21 Densely-Settled Rural counties in Kansas, as reported by the three MCOs. Based on the GeoAccess map reports, the access standard was also met in CY2014, CY2013, and CY2012.

Rural/Frontier - The access standard for Rural and Frontier counties is a distance of 60 miles. This access standard was met in CY2015 for 100% of the 32 Rural counties and 36 Frontier counties in Kansas, as reported by Amerigroup, Sunflower, and United. Based on the GeoAccess map reports, the access standard was also met in CY2012 to CY2015.

Home and Community Based Services (HCBS) - Counties with access to at least two providers by provider type and services.
Table 39 provides information reported by the three MCOs indicating the number of counties that have at least two service providers, and the number of counties that have at least one service provider, for each HCBS provider type. The baseline for this measure is CY2013 since no comparable pre-KanCare reports of HCBS provider type by county were identified for review. Information on the counties without access or limited access is not yet reported through GeoAccess mapping.

As indicated in Table 39, as in CY2015, 17 of the 27 HCBS services were available in CY2016 from at least two service providers in all 105 counties for members of all three MCOs. Of the remaining 10 Home and Community Based Services:

- Adult Day Care
  - Amerigroup - Services were available from at least two providers in 102 counties in CY2015, same as reported in CY2016. In CY2014, services from at least two providers were available in only 82 counties, and in CY2013 only 74 counties. At least one service provider is available in the three remaining counties.
  - Sunflower - Services were available from at least two providers in only 50 counties in 2016 and 2014, two fewer than in 2015 and five more than in CY2013. At least one service provider is available in 81 of the 105 counties, six more than in CY2015.
  - UnitedHealthcare - Services were available from at least two providers in only 47 counties in CY2016 and CY2015, 27 fewer than in CY2014. At least one provider was available in 68 counties, down from 72 counties in CY2015.
- Intermittent Intensive Medical Care
  - Amerigroup – In CY2016 and CY2015, 77 counties had access to at least two service providers; compared to 84 in CY2013 and CY2014. In CY2016 and CY2015, 102 counties had at least one service provider 2 fewer counties than in CY2014.
  - Sunflower reported in CY2016 and CY2015 at least two service providers are available in 94 counties, 3 more than in CY2014, and 16 more than in CY2013. SSHP reported in CY2013 to CY2016 that all 105 counties had at least one service provider.
  - UnitedHealthcare reported in CY2013 through CY2016 that there were at least two service providers available in all 105 counties.

Table 39. Number of Counties with Access to Home and Community Based Services (HCBS) CY2016 Compared to CY2015*

Provider type	Amerigroup		Sunflower		UnitedHealthcare	
	2 or more	at least 1	2 or more	at least 1	2 or more	at least 1
Speech therapy - Autism Waiver	**7↓**	**7**	**12**	**27↓**	**2**	**2**
Speech therapy - TBI waiver	105	105	**50**	105	**9↑**	**28↑**
Behavior therapy - TBI waiver	105	105	105	105	**72↑**	**105↑**
Cognitive therapy - TBI waiver	105	105	105	105	**26↑**	**55↑**
Occupational therapy - TBI waiver	105	105	105	105	**12↑**	**33↑**
Physical therapy - TBI waiver	105	105	105	105	**30↑**	**55↑**
Adult day care	**102**	105	**50↓**	**81↑**	**47**	**68↓**
Intermittent intensive medical care	**77**	**102**	**94**	105	105	105
Home modification	**27↑**	**101↓**	105	105	105	105
Health maintenance monitoring	**69**	**103**	**95**	105	105	105
Specialized medical care/medical respite	105	105	105	105	105	105
Assistive services	105	105	105	105	105	105
Assistive technology	105	105	105	105	105	105
Attendant care services (Direct)	105	105	105	105	105	105
Comprehensive support (Direct)	105	105	105	105	105	105
Financial management services (FMS)	105	105	105	105	105	105
Home telehealth	105	105	105	105	105	105
Home-delivered meals (HDM)	105	105	105	105	105	105
Long-term community care attendant	105	105	105	105	105	105
Medication reminder	105	105	105	105	105	105
Nursing evaluation visit	105	105	105	105	105	105
Personal emergency response (installation)	105	105	105	105	105	105
Personal emergency response (rental)	105	105	105	105	105	105
Personal services	105	105	105	105	105	105
Sleep cycle support	105	105	105	105	105	105
Transitional living skills	105	105	105	105	105	105
Wellness monitoring	105	105	105	105	105	105

* Arrows indicate whether the number of counties with access to the service increased or decreased compared to CY2015

- Speech Therapy (Autism Waiver)
  - Amerigroup – In CY2016, AGP reported this service to be available from two or more providers in only 7 counties. In CY2015 and CY2014, Amerigroup reported that in 79 counties there were two or more providers available for specialized speech therapy for those on the Autism Waiver. In CY2013, Amerigroup reported services from at least two providers were only available in three counties.
  - Sunflower - In CY2016 and CY2015, SSHP reported that in only 12 counties there were two or more providers available for specialized speech therapy for those on the Autism Waiver, 3 fewer than in CY2014. At least one service provider was available in 27 counties in CY2016, down from 28 counties in CY2015 and CY2014.

  - UnitedHealthcare – In CY2015, CY2014, and CY2013, UHC reported that these specialized services were only available from one or two providers in only 2 counties.
- Speech Therapy – TBI Waiver
  - Amerigroup - In CY2013 to CY2016, Amerigroup reported that at least two providers were available in all 105 counties for this specialized speech therapy for those with TBI.
  - Sunflower – In CY2013 and CY2014, Sunflower reported that at least two providers were available in all 105 counties. In CY2015 and CY2016, this dropped to 50 counties. All 105 counties continue to have at least one provider reported to be available.
  - UnitedHealthcare reported that at least two providers were available in CY2016 in 9 counties, up from 4 counties in CY2015, 5 counties in CY2014 and 7 counties in CY2013. At least one provider was available in 28 counties, up from 10 counties in CY2015 and 21 counties in CY2014 and CY2013.
- Behavior Therapy – TBI Waiver
  - Amerigroup and Sunflower again reported that at least two providers were available in all 105 counties for this specialized behavior therapy for those with TBI.
  - UnitedHealthcare reported that at least two providers were available in 72 counties, up from 18 counties in CY2015, 12 counties in CY2014 and 1 county in CY2013. At least one provider was available in all 105 counties in CY2016, up from 43 counties in CY2015, 41 in CY2014, and 4 in CY2013.
- Cognitive Therapy – TBI Waiver
  - In CY2013 to CY2016, Amerigroup and Sunflower reported that at least two providers were available in all 105 counties for this specialized cognitive therapy for those with TBI.
  - UnitedHealthcare reported that at least two providers were available in 26 counties in CY2016, up from 18 counties in CY2015, 12 counties in CY2014 and 1 county in CY2013. At least one provider was available in 55 counties in CY2016, up from 43 counties in CY2015, 41 counties in CY2014, and 4 counties in CY2013.
- Occupational Therapy – TBI Waiver
  - In CY2013 to CY2016, Amerigroup and Sunflower reported that at least two providers were available in all 105 counties for this specialized occupational therapy for those with TBI.
  - UnitedHealthcare reported that in CY2016, at least two providers were available in 12 counties, up from 11 counties in CY2013 to CY2015. In CY2016, UHC reported that at least one provider was available in 33 counties, up from 19 counties in CY2014, 26 counties in CY2014, and 32 counties in CY2013.
- Physical Therapy – TBI Waiver
  - Amerigroup and Sunflower reported that at least two providers were available in all 105 counties in CY2013 to CY2016 for this specialized physical therapy for those with TBI.
  - UnitedHealthcare reported that at least two providers were available in 30 counties in CY2016, up from 23 counties in CY2015, 24 counties in CY2014, and 14 counties in CY2013. At least one provider was available in 55 counties, up from 40 counties in CY2015 and 53 counties in CY2014.
- Health Maintenance Monitoring
  - Amerigroup – In CY2015 and CY2016, Amerigroup reported that at least two service providers were available in 69 counties, compared to 70 counties in CY2014 and CY2013. In each of the four years, Amerigroup reported 103 counties had at least one service provider.
  - Sunflower – In CY2015 and CY2016, Sunflower reported that two or more providers were available in 95 counties, compared to 91 in CY2014 and 105 in CY2013, and that at least one provider was available in 105 counties (all four years).

  - UnitedHealthcare – In CY2015, CY2014, and CY2013, UHC reported that at least two service providers were available in all 105 counties.
- Home Modification
  - Amerigroup reported only 27 counties had at least two service providers in CY2016, up from 14 in CY2015 and 23 counties in CY2013 and CY2014. In CY2016, Amerigroup reported 101 counties had at least one service provider, down from 102 in CY2015 and 105 counties in CY2013 and CY2014.
  - In CY2013 to CY2016, Sunflower and UnitedHealthcare reported that at least two service providers were available in all 105 counties.

As discussed in the 2013 and 2014 KanCare Evaluation Annual Reports, there is a wide gap in reporting of availability of the TBI-related services that indicates potential discrepancies in reporting by the MCOs and/or differences in defining the criteria required for service providers for these specialized services.

There is no indication in the report again this year as to which specific counties do not have at least two services available. The provider network adequacy reports indicate specific providers, but do not separately provide a list of counties that have access to no providers (or less than two providers).

Population – The HCBS reports do not indicate whether members needing these services are residents of the counties where there are no providers or less than two providers. If this information was provided by each MCO, members, program managers, and reviewers could more easily identify counties where services may be provided by one of the other MCOs, and alternatively whether none of the MCOs have providers in the particular county (and in neighboring counties). The MCO GeoAccess reports provide information on the total number of members in each county; however, the reports do not indicate whether members in sparsely populated counties are in need of services that are not commonly needed or available.

I/DD Provider Services

I/DD provider services by county availability are listed in Table 40. Services reported in 2016 to be available from at least two I/DD providers by all three MCOs include: Targeted Case Management, Residential Support, Sleep Cycle Support, Personal Assistant Services, Financial Management Services, and Respite Care (Overnight).

Services not available from at least two I/DD providers by all three MCOs in all 105 Kansas counties include:

- Supported Employment Services – AGP reported this service to be available from at least two I/DD providers in 51 counties, and from at least one provider in 81 of the 105 counties. SSHP reported this service to be available from at least two I/DD providers in 98 counties, and from at least one provider in all 105 counties. UHC reported this service to be available from at least two I/DD providers in 25 counties, and from at least one provider in 48 of the 105 counties.
- Wellness Monitoring - AGP reported this service to be available from at least two I/DD providers in 92 counties, and from at least one provider in all 105 counties. SSHP reported this service to be available from at least two I/DD providers in 95 counties, and from at least one provider in 102 counties. UHC reported this service to be available from at least two I/DD providers in 80 counties, and from at least one provider in all 105 counties.

Table 40. Number of Counties with Access to at Least Two I/DD Providers, by MCO, CY2016						
Provider type	Amerigroup		Sunflower		UnitedHealthcare	
	2 or more	at least 1	2 or more	at least 1	2 or more	at least 1
Targeted Case Management	105	105	105	105	105	105
Medical Alert Rental	105*	105	**55**	105	105*	105
Residential Support	105	105	105	105	105	105
Supportive Home Care	105	105	105	105	**103**	105
Sleep Cycle Support	105	105	105	105	105	105
Supported Employment Services	**51**	**81**	**98**	105	**25**	**48**
Personal Assistant Services	105	105	105	105	105	105
Assistive Services	**104**	105	105	105	105	105
Respite Care (Overnight)	105	105	105	105	105	105
Wellness Monitoring	**92**	105	**95**	**102**	**80**	105
Day Support	105	105	105	105	**58**	**98**
Financial Management Services (FMS)*	105	105	105	105	105	105
Specialized Medical Care - RN	**101**	105	**104**	105	105	105
Specialized Medical Care - LPN	**101**	**104**	**104**	105	105	105

* Provider specialty not specific to I/DD

- Medical Alert Rental - AGP and UHC reported Medical Alert Rental to be available from at least two providers in all 105 counties, but not specifically from I/DD providers. SSHP reported this service to be available from at least two I/DD providers in 55 counties, and from at least one I/DD provider in all 105 counties.
- Supportive Home Care - AGP and SSHP reported Supportive Home Care to be available from at least two I/DD providers in all 105 counties. UHC reported this service to be available from at least two I/DD providers in 103 counties, and from at least one provider in all 105 counties.
- Assistive Services - SSHP and UHC reported Assistive Services to be available from at least two I/DD providers in all 105 counties. AGP reported this service to be available from at least two I/DD providers in 104 counties, and from at least one provider in all 105 counties.
- Day Support - AGP and SSHP reported Day Support to be available from at least two I/DD providers in all 105 counties. UHC reported this service to be available from at least two I/DD providers in 58 counties, and from at least one provider in 98 counties.
- Specialized Medical Care – RN - UHC reported this service to be available from at least two I/DD providers in all 105 counties. AGP reported this service to be available from at least two I/DD providers in 101 counties, and from at least one provider in all 105 counties. SSHP reported this service to be available from at least two I/DD providers in 104 counties, and from at least one provider in all 105 counties.
- Specialized Medical Care – LPN - UHC reported this service to be available from at least two I/DD providers in all 105 counties. AGP reported this service to be available from at least two I/DD providers in 101 counties, and from at least one provider in 104 counties. SSHP reported this service to be available from at least two I/DD providers in 104 counties, and from at least one provider in all 105 counties.

Recommendations:

- KFMC again recommends this year that reporting be revised to require MCOs to report the specific counties where there are no providers contracted for specific services and specific counties where only one provider is contracted for specific services.
- KFMC again recommends that the State follow up with the MCOs to clarify the availability of the TBI-related HCBS service providers.
- For those counties with no providers, it would be important to know the number of members needing these services that reside in that county and their average distance to a provider. It is possible members needing these services are able to obtain them in a nearby county (or through arrangement by the MCO in a neighboring state). It is also possible, particularly in low-population Frontier counties, for there to be no members in need of a particular service.

Provider Open/Closed Panel Report

The MCOs submit monthly Network Adequacy reports that include a data field for indicating whether the provider panel is open, closed, or accepting only existing patients. This is primarily populated for PCP types.

In previous years, KFMC recommended that, due to a high frequency of duplicate entries (including exact duplicates, address variations for the same address, P.O. Box address and street address in a small town, etc.), the MCOs should review this report and remove duplicate entries. While the MCOs have been making efforts to improve reporting, in reviewing 2016 Network Adequacy reports, KFMC identified duplicate entries continue to be an area for improvement (e.g., including exact duplicates, variations of the same address with all other information the same, variations of the same provider name, provider addresses that only differed by one number).”Real time” information available to members on-line or through customer service contacts varies by MCO in timeliness. KFMC also found some inconsistencies and errors in how providers are classified (e.g., a Urologist and a Pulmonologist were listed instead as Neurologists, an Orthopedic Surgeon was listed instead as a Urologist, and an Anesthesiologist was listed as a Plastic Surgeon). Many providers have multiple locations in multiple counties; the Network Adequacy report does not indicate how often providers provide services at each location and whether their availability, particularly in non-urban counties, meets access requirements for the particular service and region. Provider panel status also is not included for all applicable providers. In a 2016 provider survey conducted for the State, a number of providers were found to have moved to distant states, were no longer in the networks for other reasons, or had moved to another city/practice.

Provider After-Hour Access (24 hours per day/7 days per week)

The MCOs are required by the State to ensure that the 24/7 requirement is met. No tracking report templates, however, are required of the MCOs by the State for tracking this. This is due in part to differing methods and systems used by the MCOs for monitoring provider adherence to these standards.

- Amerigroup conducts an annual survey of providers. After hours compliance in CY2016 was reported as 89% for PCPs and Pediatrics. Amerigroup staff members meet with providers not in compliance. In previous years, they indicated they then followed up with “secret shopper” type activities to confirm that changes have been put in place.
- Sunflower uses a nurse advice line, an affiliated organization, to conduct an annual telephone survey of PCPs regarding after-hours access; it appears the survey is conducted during office hours. SSHP also continues to contract with NurseWise to provide after-hours services to members and providers. NurseWise reports daily numbers of calls received. For CY2016, SSHP reported 100% PCP

compliance of PCP offices who were successfully contacted; 59% of the 342 sampled providers were successfully contacted. The inability to contact a PCP indicates the members may not be able to reach the PCP. The 139 PCPs that either refused to answer the survey questions, had an out-of-service phone number or wrong number, or that did not answer the phone or have an answering service should not be excluded from the denominator in determining compliance. SSHP is researching the incorrect or out-of-service phone numbers to identify correct information. KFMC recommends Sunflower follow up after office hours to verify appropriate after-hours access, at a minimum for the providers that refused to complete the survey or did not answer the phone.

- UnitedHealthcare contracts with a vendor (Dial America) that calls a random sample of providers after hours to ensure on-call service is available. In 2016, compliance with the 24/7 access requirement was 76.5%. UHC indicated they conduct follow-up phone calls related to the after-hours access results.

Amerigroup and UnitedHealthcare also included a supplemental question in their CAHPS surveys in CY2014 and CY2015 addressing after-hours appointment access. In CY2015, Sunflower added a supplemental question related to after-hours advice.

Amerigroup asked in their adult survey, "***In the last six months, if you called your doctor's office after office hours for an urgent need, how many minutes did you usually have to wait between making a call to the office and speaking to the doctor or doctor's representative?"***

- In CY2016, 24.4% of adult survey respondents indicated they called after hours for an urgent need.
- In CY2016, 71.2% adults who called their doctor's office after hours said their wait to speak to a doctor or the doctor's representative was less than 20 minutes.
- The CY2016 rate of respondents reporting a wait over 60 minutes decreased to 8.3%, from 17.4% in CY2015 and 13.8% in CY2014.

UnitedHealthcare asked in their adult survey, ***"In the last 6 months, did you call a doctor's office or clinic after hours to get help for yourself?"*** A similar question was included in the child survey. A follow-up question was also added for both adult and child surveys of those who responded positively: ***"In the last 6 months, when you called a doctor's office or clinic after hours, how often did you get the help you wanted?"***

- **Adults** - In CY2016, 11.0% of adults called their doctor's office or clinic after hours. Of those who indicated they called their provider after hours, 69.2% said they always or usually got the help they wanted, and 15.4% said they never got the help they wanted.
- **GC survey population** - In CY2016, 8.9% of GC survey respondents called their doctor's office or clinic after hours. Of those who indicated they called their provider after hours, 87.0% said they always or usually get the help they wanted, and 2.80% (compared to 14.4% in CY2015) said they never got the help they wanted.
- **CCC survey population** - In CY2016, 10.0%of CCC survey respondents indicated they called after hours to get help. Of those who indicated they called their provider after hours in CY2016, 80.0% said they always or usually got the help they wanted, and 4.2% (compared to 8.8% in CY2015) said they never got the help they wanted.

Sunflower asked in their adult survey, ***"In the past 6 months, did you phone your personal doctor's office after regular office hours to get help or advice for yourself?"*** A similar question was included in the child survey. A follow-up question was also added for both adult and child surveys of those who

responded positively: **"*In the last 6 months, when you phoned after regular office hours, how often did you get the help or advice you needed?*"**

- **Adults** - In CY2016, 14.0%of adults called their doctor's office or clinic after hours. Of those who indicated they called their provider after hours, 75.0% said they always or usually got the help or advice they needed and 15.0% said they never got the help or advice they needed (compared to 12.9% in CY2015).
- **GC survey population** - In CY2016, 13.6%of GC survey respondent called their doctor's office or clinic after hours Of those who indicated they called their provider after hours, 83.1% said they always or usually got the help they wanted; 9.9%said they never got the help they wanted (compared to 6.8% in CY2015).
- **CCC survey population -** In CY2016, 16.7% of CCC survey respondents indicated they called after hours to get help. Of those who indicated they called their provider after hours, 87.2% said they always or usually got the help they needed and 4.7% said they never got the help they wanted (remained the same from CY2015).

Annual Provider Appointment Standards Access (In-office wait times; Emergent, urgent and routine appointments; Prenatal care – first second, third trimester and high risk)

The MCOs are required by the State to ensure that in-office wait time requirements are met. No tracking report templates, however, (as per the 24/7 access above) are required of the MCOs by the State for tracking these measures. MCOs submitted summaries that primarily focused on access to urgent and routine advice after hours. No information specifically related to in-office wait times and access to prenatal care visits was submitted for review.

Amerigroup – For CY2016, Amerigroup continued to report survey results by provider types, asking providers about availability of urgent and routine care.

- PCPs reported 95-97% compliance for urgent care and emergent care and 93% compliance for routine care.
- Specialists had 88% compliance for urgent care and 98%compliance for routine care.
- Pediatrics had 97-99% compliance for urgent and emergent care and 96% compliance for routine care.
- Behavioral health was reported as 92%-95% compliant and 92% compliance for mental health follow-up.

Sunflower – For CY2016, Sunflower reported survey results by provider type, asking providers about availability for urgent and routine care.

- PCPs reported 99% compliance for urgent care and 86% compliance for first available routine appointment.
- Oncology care for urgent appointments was 82% compliant and 88% compliant for first available routine appointment.
- OB was 86% compliant for routine care in the first trimester and 100% compliant for second and third trimester.

UnitedHealthcare – UHC employs a vendor to make calls on their behalf using a script in which the caller identifies themselves as representing the health plan (as opposed to a "secret shopper" approach), describes symptoms that represent either an urgent need or a routine need and requests the next available appointment with the specific provider named on the list. Script scenarios include both child and adult symptoms.

UHC reported the following survey results for CY2016 by provider type for CY2016, asking providers about availability of urgent and routine care.

- PCPs reported 58-71% compliance for urgent and emergent care and 93% compliance for routine care.
- Specialists had 25% compliance for urgent care and 73% compliance for routine care.
- Behavioral health was reported as 56% compliant for urgent care and 83% compliant for routine care.

Recommendations for the 24/7 and Appointment Access Requirements:

- KFMC recommends the State request a more consistent method of MCO tracking and reporting these measures. KFMC recommends that all MCOs confirm provider after-hour access through after-hours phone calls to the providers.
- MCOs should report compliance rates and appointment availability for calls to provider offices from "secret shoppers" separately from callers who first identify that they are representatives of an MCO.
- MCOS are encouraged to continue to include access to care supplemental questions in the CAHPS survey to help identify member experience in accessing appointments.
- When reporting outcomes related to member access to after-hours phone contact to providers, the MCOS should include in the denominator all out-of-service or wrong numbers, and offices that did not answer the phone or have an answering service alternative. MCOs should follow up after office hours to verify appropriate after-hours access, at a minimum for the providers that refused to complete the survey or did not answer the phone.

(20) Member Survey – CAHPS

Additional detail on the CAHPS survey In CY2015 can be found in Section 4 of this report in the Health Literacy section. CAHPS questions related to access of care include the questions in Table 41.

Questions on both adult and child surveys:

- **In the last 6 months did you (your child) have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?**
  The rate of respondents that indicated they needed care right away in the last 6 months was comparable within the populations and across years (Adults: CY2016 - 44.0%, CY2015 - 45.7%, CY2014 - 45.2%, CY2012 - 44.3%; GC: CY2016 - 35.7%, CY2015 - 37.9%, CY2014 - 35.2%, CY2012 - 32.1%; CCC: CY2016 - 43.1%, CY2015 - 47.4%, CY2014 - 43.6% in CY2014).
  - **In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?**
    The weighted aggregate rate for adults in CY2016 (86.2%) was comparable to CY2015 (87.2%) and CY2014 (88.1%), higher than in CY2012 (80.0%) and above the QC 75th percentile. The rate for the GC population in CY2016 (93.9%) was comparable to CY2015 (93.2%) and CY2014 (94.1%); the CY2016 results remained above the QC 66.67th percentile. The CY2016 CCC population rate (95.1%) was comparable to CY2015 (93.9%) and CY2014 (95.0%) and was above the QC 75th percentile.
- **In the last 6 months, how often was it easy (for your child) to get the care, tests, or treatment you (your child) needed?**
  The weighted aggregate rates remain generally comparable for all populations in CY2014 through CY2016 (Adult: 87.2% - 88.1%; GC: 92.0% - 93.4%; CCC: 91.9% - 93.0%). All results remain above the QC 50th percentile.

Table 41. Member Survey - CAHPS Access to Care Questions, 2014 - 2016							
Question	Pop	Weighted % Positive Responses			QC 50th Percentile		
		2016	2015	2014	2016	2015	2014
Questions on Adult and Child Surveys							
In the last six months, did you (your child) have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?	**Adult**	**44.0%**	45.7%	45.2%	NA	NA	NA
	GC	**35.7%**	37.9%	35.1%	NA	NA	NA
	CCC	**43.1%**	47.4%	43.6%	NA	NA	NA
In the last 6 months, when you (your child) needed care right away, how often did you (your child) get care as soon as you (he or she) needed?	**Adult**	**86.2%**	87.2%	88.1%	↑	↑	↑
	GC	**93.9%**	93.2%	94.1%	↑	↑	↑
	CCC	**95.1%**	93.9%	95.0%	↑	↑	↑
In the last 6 months, did you make any appointments for a check-up or routine care (for your child) at a doctor's office or clinic?	**Adult**	**76.3%**	77.1%	75.8%	NA	NA	NA
	GC	**69.5%**	68.9%	70.8%	NA	NA	NA
	CCC	**77.3%**	78.7%	80.0%	NA	NA	NA
In the last 6 months, how often did you get (when you made) an appointment for a check-up or routine care (for your child) at a doctor's office or clinic (how often did you get an appointment) as soon as you (your child) needed?	**Adult**	**82.5%**	82.7%	82.9%	↑	↑	↑
	GC	**90.0%**	89.7%	90.6%	↑	↑	↑
	CCC	**92.1%**	92.4%	92.2%	↑	↑	↓
How often was it easy to get the care, tests, or treatment you (your child) needed?	**Adult**	**87.2%**	88.1%	87.6%	↑	↑	↑
	GC	**92.1%**	92.0%	93.4%	↑	↑	↑
	CCC	**92.4%**	91.9%	93.0%	↑	↑	↑
Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments (for your child) to see a specialist?	**Adult**	**44.3%**	46.5%	43.0%	NA	NA	NA
	GC	**17.9%**	19.4%	17.9%	NA	NA	NA
	CCC	**39.8%**	39.5%	38.4%	NA	NA	NA
How often did you get an appointment (for your child) to see a specialist as soon as you needed?	**Adult**	**86.2%**	81.7%	84.8%	↑	↑	↑
	GC	**80.8%**	84.6%	83.2%	↑	↑	↑
	CCC	**86.2%**	83.3%	85.3%	↑	↑	↑

- **In the last 6 months, did you make any appointments for a check-up or routine care (for your child) at a doctor's office or clinic?**
  The rate of adult respondents making appointments for a check-up or routine care was comparable from CY2014 through CY2016, with a range from 75.8% - 77.1%, higher than the CY2012 rate of 73.5%. The percentage of the GC population that scheduled a check-up or routine care ranged from 68.9% - 70.8% in CY2014 through CY2016; the CY2012 rate was 77.8%. The CCC population ranged from 77.3% - 80.0% in CY2014 through CY2016.
  - **In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for (your child) for a check-up or routine care at a doctor's office or clinic as soon as you thought you needed?**
    Of the adults who scheduled an appointment, the percentage reporting they received an appointment as soon as they thought was needed remained above the QC 75th percentile in CY2014 through CY2016 (82.5% - 82.9%). The GC results were comparable across years (CY2016

-90%; CY2015 – 89.7%; CY2014 – 90.6%; CY2012 – 89.9%); the CY2016 rate was above the 66.67th percentile. The CC results were also comparable across years (CY2016 - 92.1%; CY2015 - 92.4%; CY2014 - 92.2%), and in CY2016.remained above the GC 50th percentile.

- **In the last 6 months, did you make any appointments (for your child) to see a specialist?**
  In CY2016, 44.3% of adults, 17.9% of the GC population, and 39.8% of the CCC population reported having one or more appointments with a specialist. The CY2016 rates were comparable to CY2015 and CY2014.
  - **In the last 6 months, how often did you get an appointment (for your child) to see a specialist as soon as you needed?**
    Of those who had appointments with a specialist in the previous six months, 86.2% of adults in CY2016 obtained an appointment as soon as they needed, compared to 81.7% in CY2015, 84.8% in CY2014, and 75.9% in CY2012. The CY2016 adult results increased from above the QC 50th percentile to above the 95th percentile. All three MCOs had increases in the adult populations' rates and QC percentiles. The CY2015 GC results continued to be higher than CY2012, although there were variations across years (GC: CY2016 – 80.8%, CY2015 – 84.6%, CY2014 – 83.2%, CY2012 – 79.0%). The CCC results in CY2016 increased to 86.2% from CY2015 – 83.3% and CY2014 – 85.3%, and were above the QC 75th percentile in 2016.

(21) Member Survey – Mental Health

The MH Surveys conducted in CY2011 through CY2015 are described above in Section 7 "Member Survey – Quality."

Questions and survey results related to member perceptions of access to MH services are listed in Table 42 and are described below:

- **Provider availability as often as member felt it was necessary**
  Results from the general adult population were lower in 2016 (84.0%) than in the previous five years. The 2015 rate (87.2%) was comparable to rates in 2014 (87.9%) and 2013 (88.2%).
- **Provider return of calls within 24 hours**
  Response results in 2016 (79.6%) were the lower than in the previous five years. Response results in 2015 (84.4%) were comparable to 2014 (83.3%) and 2013 (84.4%). Pre-KanCare rates were 88.1% in 2011 and 80.8% in 2012.
- **Services were available at times that were good for the member**
  - Positive response percentages in 2016 ranged from 83.9% (General Youth, family responding) to 90.4% (General Youth, youth responding).
  - Results from the General Adult population in CY2016 (87.4%) are the lowest they have been in the six year period. Trend analysis showed a significant decrease in positive response percentages from 2013 to 2016 (p=.01).
  - For General Youth (family responding), there was a significant decrease in positive responses in CY2016 (83.9%) compared to 2015 (90.9%; p<.01) and 2013 (88.7%; p=.03); the CY2016 rate is the lowest of the six-year period.
- **Ability to see a psychiatrist when the member wanted to**
  For the General Adult population, there was a significant decrease in positive responses in 2016 (73.6%) compared to 83.4% in 2015 (p<.01); 80.5% in 2014 (p=.02); 82.3% in 2013 (p<.01); and 82.1% in 2011 (p=.02). Also, there was a significant negative trend 2013 to 2016 (2013 – 82.3%; 2014 – 80.5%; 2015 – 83.4%; 2016 – 73.6%; [p=.02]). In the six-year period, the 70.8% rate in 2012 was the only rate lower than the 2016 rate.

Table 42. Mental Health Survey - Access-Related Questions

Item	Year	0% 100%	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
My mental health providers were willing to see me as often as I felt it was necessary.	**General Adult (Age 18+)**							
	2016		**84.0%**	**243 / 289**	**79.3% – 87.8%**		.08	.22
	2015		87.2%	332 / 381	83.4% – 90.2%	.24		
	2014		87.9%	706 / 804	85.5% – 90.0%	.09		
	2013		88.2%	927/1,051	86.2% – 90.1%	.05		
	2012		85.3%	233 / 273	80.6% – 89.1%	.65		
	2011		88.8%	262 / 295	84.7% – 92.0%	.09		
My mental health providers returned my calls in 24 hours.	**General Adult (Age 18+)**							
	2016		**79.6%**	**213 / 267**	**74.4% – 84.1%**		.15	.07
	2015		84.4%	292 / 346	80.2% – 87.9%	.12		
	2014		83.3%	618 / 742	80.5% – 85.8%	.17		
	2013		84.4%	840 / 995	82.0% – 86.5%	.06		
	2012		80.8%	202 / 250	75.4% – 85.2%	.74		
	2011		88.1%	251 / 285	83.8% – 91.4%	**<.01 -**		
Services were available at times that were good for me.	**General Adult (Age 18+)**							
	2016		**87.4%**	**258 / 294**	**83.1% – 90.8%**		**.01↓**	.08
	2015		90.0%	343 / 381	86.6% – 92.7%	.28		
	2014		89.8%	733 / 817	87.5% – 91.7%	.26		
	2013		92.1%	985/1,071	90.4% – 93.6%	**.01 -**		
	2012		87.7%	242 / 276	83.2% – 91.1%	.92		
	2011		92.3%	277 / 300	88.7% – 94.9%	.05		
	General Youth (Ages 0-17), Family Responding							
	2016		**83.9%**	**276 / 328**	**79.6% – 87.5%**		.16	.70
	2015		90.9%	297 / 327	87.2% – 93.6%	**<.01 -**		
	2014		86.9%	682 / 783	84.4% – 89.1%	.19		
	2013		88.7%	871 / 983	86.5% – 90.5%	**.03 -**		
	2012		88.0%	235 / 267	83.5% – 91.4%	.16		
	2011		85.9%	287 / 334	81.8% – 89.3%	.47		
	General Youth (Ages 12-17), Youth Responding							
	2016		**90.4%**	**141 / 156**	**84.6% – 94.2%**		.66	.53
	2015		88.5%	130 / 147	82.2% – 92.8%	.59		
	2014		87.5%	271 / 308	83.3% – 90.7%	.35		
	2013		88.7%	455 / 513	85.5% – 91.3%	.56		
	2012		83.0%	83 / 100	74.4% – 89.2%	.08		
	2011		89.5%	119 / 133	83.0% – 93.7%	.80		
	SED Waiver Youth and Young Adult, Family/Member Responding							
	2016		**84.1%**	**275 / 328**	**79.7% – 87.7%**		.66	.25
	2015		84.5%	283 / 336	80.2% – 88.0%	.88		
	2014		85.2%	356 / 418	81.5% – 88.3%	.66		
	2013		85.1%	415 / 487	81.6% – 88.0%	.70		
	2012		88.6%	287 / 324	84.7% – 91.7%	.09		
	2011		85.4%	243 / 285	80.8% – 89.0%	.65		
	SED Waiver Youth (Ages 12-17), Youth Responding							
	2016		**84.4%**	**139 / 164**	**78.0% – 89.2%**		.60	.47
	2015		85.7%	131 / 153	79.3% – 90.4%	.74		
	2014		86.0%	167 / 194	80.3% – 90.2%	.67		
	2013		82.6%	187 / 226	77.2% – 87.0%	.64		
	2012		82.2%	111 / 135	74.8% – 87.8%	.62		
	2011		83.7%	103 / 123	76.1% – 89.3%	.88		

Table 42. Mental Health Survey - Access-Related Questions (Continued)

Item	Year	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
I was able to see a psychiatrist when I wanted to.	**General Adult (Age 18+)**						
	2016	**73.6%**	**195 / 265**	**67.9% – 78.5%**		**.02↓**	.67
	2015	83.4%	291 / 349	79.2% – 87.0%	**<.01 -**		
	2014	80.5%	598 / 744	77.5% – 83.2%	**.02 -**		
	2013	82.3%	807 / 981	79.8% – 84.6%	**<.01 -**		
	2012	70.8%	187 / 264	65.1% – 76.0%	.48		
	2011	82.1%	225 / 274	77.1% – 86.2%	**.02 -**		
I was able to get all the services I thought I needed.	**General Adult (Age 18+)**						
	2016	**80.7%**	**235 / 290**	**75.8% – 84.9%**		.05	.05
	2015	84.9%	325 / 383	81.0% – 88.2%	.15		
	2014	86.5%	704 / 814	84.0% – 88.7%	**.02 -**		
	2013	86.0%	917/1,066	83.8% – 87.9%	**.03 -**		
	2012	78.8%	219 / 278	73.6% – 83.2%	.56		
	2011	91.3%	274 / 300	87.6% – 94.1%	**<.001 -**		
	General Youth (Ages 12-17), Youth Responding						
	2016	**83.1%**	**126 / 152**	**76.3% – 88.3%**		.55	.94
	2015	87.5%	126 / 144	81.0% – 92.1%	.28		
	2014	83.8%	260 / 309	79.2% – 87.5%	.85		
	2013	82.8%	427 / 518	79.1% – 86.0%	.94		
	2012	85.0%	85 / 100	76.6% – 90.8%	.68		
	2011	85.1%	114 / 134	78.0% – 90.2%	.64		
	SED Waiver Youth (Ages 12-17), Youth Responding						
	2016	**79.3%**	**127 / 161**	**72.3% – 84.9%**		**.03↑**	.27
	2015	81.5%	123 / 151	74.6% – 86.9%	.61		
	2014	74.8%	138 / 184	68.0% – 80.5%	.33		
	2013	71.8%	165 / 229	65.7% – 77.2%	.10		
	2012	76.3%	103 / 135	68.4% – 82.7%	.54		
	2011	77.6%	97 / 125	69.5% – 84.1%	.74		
My family got as much help as we needed for my child. (I was able to get all the services I thought I needed.)	**General Youth (Ages 0-17), Family Responding**						
	2016	**82.2%**	**264 / 320**	**77.6% – 86.0%**		.87	.62
	2015	86.3%	278 / 322	82.1% – 89.6%	.15		
	2014	79.7%	609 / 766	76.7% – 82.4%	.34		
	2013	83.2%	799 / 966	80.7% – 85.4%	.67		
	2012	82.9%	213 / 257	77.8% – 87.0%	.83		
	2011	84.2%	278 / 330	79.9% – 87.8%	.48		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**77.6%**	**253 / 325**	**72.7% – 81.8%**		.29	.68
	2015	78.9%	260 / 330	74.2% – 83.0%	.67		
	2014	76.4%	318 / 413	72.0% – 80.2%	.70		
	2013	75.2%	363 / 482	71.1% – 78.8%	.43		
	2012	77.3%	248 / 321	72.4% – 81.6%	.93		
	2011	77.4%	220 / 284	72.2% – 81.9%	.97		

Table 42. Mental Health Survey - Access-Related Questions (Continued)

Item	Year	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
During a crisis, I was able to get the services I needed.	**General Adult (Age 18+)**						
	2016	**80.7%**	**196 / 242**	**75.3% – 85.2%**		.15	.92
	2015	85.0%	265 / 312	80.6% – 88.5%	.18		
	2014	86.0%	586 / 682	83.2% – 88.4%	.05		
	2013	85.4%	742 / 870	82.9% – 87.6%	.08		
	2012	79.2%	183 / 231	73.5% – 84.0%	.69		
	2011	83.9%	209 / 249	78.8% – 88.0%	.35		
During a crisis, my family was able to get the services we needed.	**General Youth (Ages 0-17), Family Responding**						
	2016	**83.8%**	**209 / 248**	**78.7% – 87.9%**		.32	**.03↓**
	2015	84.6%	197 / 233	79.3% – 88.7%	.81		
	2014	83.4%	457 / 548	80.1% – 86.3%	.90		
	2013	86.2%	604 / 706	83.5% – 88.6%	.34		
	2012	87.4%	173 / 198	82.0% – 91.4%	.29		
	2011	89.5%	204 / 228	84.8% – 92.9%	.07		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**78.0%**	**205 / 260**	**72.6% – 82.7%**		.75	.83
	2015	78.3%	213 / 272	73.0% – 82.8%	.93		
	2014	81.5%	276 / 338	76.9% – 85.3%	.30		
	2013	76.4%	299 / 390	71.9% – 80.3%	.63		
	2012	79.1%	197 / 249	73.6% – 83.7%	.76		
	2011	80.0%	173 / 216	74.2% – 84.8%	.59		
Medication available timely*	**General Adult (Age 18+)**						
	2016	**92.9%**	**237 / 255**	**89.0% – 95.5%**		.96	
	2015	90.3%	296 / 328	86.5% – 93.1%	.26		
	2014	92.7%	661 / 713	90.5% – 94.4%	.91		
	2013	91.8%	827 / 903	89.8% – 93.4%	.57		
	General Youth (Ages 0–17), Family Responding						
	2016	**83.7%**	**171 / 204**	**78.0% – 88.2%**		.71	
	2015	88.0%	198 / 225	83.0% – 91.6%	.21		
	2014	85.3%	408 / 478	81.8% – 88.2%	.60		
	2013	86.1%	537 / 622	83.1% – 88.6%	.41		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**94.5%**	**262 / 278**	**91.1% – 96.7%**		.10	
	2015	93.3%	275 / 294	89.8% – 95.7%	.55		
	2014	94.8%	356 / 376	92.0% – 96.7%	.86		
	2013	90.9%	379 / 416	87.8% – 93.3%	.08		

*Not asked in 2012 and 2011

- **Ability to get all the services the members thought they needed**
  - Rates in 2016 ranged from 77.6% (SED Youth and Young Adult, family responding) to 83.1% (General Youth, ages 12-17, youth responding).
  - For the General Adult population, there was a significant decrease in positive responses in 2016 (80.7%) compared to 2014 (86.5%; p=.02), compared to 2013 (86.0%; p=.03), and compared to 2011 (91.3%; p<.001).
  - For the General Youth (family responding), the 2016 rate (82.2%) was lower than the 2015 rate (86.3%), but higher than in 2014 (79.7%).

  - The rate for General Youth (ages 12-17, youth responding) decreased in 2016 (83.1%) from 2015 (87.5%); the rate in 2013 (82.8%) was the only rate lower in the six-year period.
  - The rate for SED Waiver youth and young adults decreased in 2016 (77.6%) from 2015 (78.9%). Rates in the six-year period ranged from 75.2% in 2013 to 78.9% in 2015.
- **Ability to get services during a crisis**
  - Rates in 2016 ranged from 78.0% (SED Waiver youth and young adults) to 83.8% (General Youth).
  - For the General Youth, there was a statistically significant negative trend from 2011 to 2016 (2011 – 89.5%; 2012 – 87.4%; 2013 – 86.2%; 2014 – 83.4%; 2015 – 84.6%; 2016 – 83.8%; *p*=.03).
  - In CY2016, the General Adult percentage of positive responses decreased from 85% in 2015 to 80.7%.
  - For the SED Waiver youth and young adults (family/member responding), the 2016 rate (78.0%) was slightly lower than the 78.3% rate in 2015. In the six-year period, only 2013 had a lower rate (76.4%).
- **Timely availability of medication**
  - From 2013 to 2016 the General Adult rates for medication availability have been above 90%. The 92.9% rate in 2016 was the highest of the four-year period.
  - SED Waiver youth and young adults responses have also been over 90% positive over the four-year period, ranging from 90.9% in 2013 to 94.5% in 2016
  - General Youth rates continued to be lower, ranging from 83.7% in 2016 to 88.0% in 2015.

(22) Member Survey – SUD

Section 7 above provides background on the SUD survey conducted by the three MCOs in 2014. Questions related to perceptions of access to care for members receiving SUD services follow (see Table 43).

Table 43. SUD Survey - Access-Related Questions, CY2014 - CY2016

	CY2016	CY2015	CY2014
Thinking back to your first appointment for your current treatment, did you get an appointment as soon as you wanted? *(Percent of "Yes" responses)*	84.4%	87.7%	92.1%
In the last year, did you need to see your counselor right away for an urgent problem? *(Percent of "Yes" responses)*	28.4%	25.7%	28.5%
If yes:			
How satisfied are you with the time it took you to see someone? *(Percent of "Very satisfied" and "Satisfied" responses)*	94.1%	79.1%	98.2%
Were you seen within 24 hours, 24 to 48 hours, or did you have to wait longer than 48 hours? *(Percent of ">48 hours" responses)*	16.0%	19.0%	10.9%
Is the distance you travel to your counselor a problem or not a problem? *(Percent of "Not a Problem" responses)*	87.9%	88.0%	89.1%
Were you placed on a waiting list? *(Percent of "Yes" responses)*	21.2%	15.6%	12.2%
If you were placed on a waiting list, how long was the wait? *(Percent of "3 weeks or longer" responses)*	42.1%	46.2%	26.1%

- **Thinking back to your first appointment for your current treatment, did you get an appointment as soon as you wanted?**
  In 2016, 84.4% (270) of 320 members indicated they got an appointment as soon as they wanted, compared to 87.7% in 2015, 92.1% in 2014, and 89.6% in 2012.
- **For urgent problems, how satisfied are you with the time it took you to see someone?**
  - In 2016, 28.4% (92) of 324 members surveyed indicated that in the past year they had needed to see their counselor right away for an urgent problem, compared to 25.7% in 2015, 28.5% in 2014, and 26% in 2012.
  - Of the 92 members who reported needing to see a counselor right away for an urgent problem, 84 responded to the follow-up question related to satisfaction with the wait time to see someone. In 2016, 94.1% of the 84 members indicated they were very satisfied or satisfied, compared to 79.1% (34 of 43 members) in 2015, 98.2% (56 of 57 members) in 2014, and 98.0% in 2012.
- **For urgent problems, were you seen within 24 hours, 24 to 48 hours, or did you wait longer than 48 hours?**
  - Of the 92 members who reported needing to see a counselor right away for an urgent problem, 75 provided a response related to the length of the wait time.
  - In 2016, 16.0% (12) of the 84 members reported they had to wait 48 hours or longer, compared to 19.0% in 2015 (8 of 42 members), and 10.9% in 2014 (6 of 55 members).
  - In 2016, 64% (48) of the 84 members were seen within 24 hours, compared to 54.8% in 2015 and 58.2% in 2014.
- **Is the distance you travel to your counselor a problem or not a problem?**
  In 2016, 87.9% (275) of 313 members surveyed indicated travel distance was not a problem, comparable to 88.0% in 2015, 89.1% in 2014, and 90.5% in 2012.
- **Were you placed on a waiting list?**
  The number and percentage of members placed on a waiting list increased from 11.7% in 2012 to 12.2% (25 of 205) in 2014 to 15.6% (28 of 180) in 2015 to 21.2% (69 of 326) in 2016.
- **If you were placed on a waiting list, how long was the wait?**
  - In 2016, 57 of 69 members who reported they were placed on a waiting list responded. Of these, 42.1% (24) indicated their wait was three weeks or longer, and 38.6% (22) reported waiting one week or less.
  - In 2015, 26 of the 28 members placed on a waiting list responded. Of these, 46.2% (12) indicated their wait was three weeks or longer, and 23.1% (6) reported they waited one week or less.
  - In 2014, 23 of the 25 members that indicated they were put on a waiting list responded. Of these, 26.1% (6) indicated their wait was three weeks or longer, and 34.7% (8) waited one week or less.

(23) Provider Survey

Background information and comments on the Provider Survey are described in Section 8 above. In this section, results are reported for satisfaction with the availability of specialists. The provider survey results for the quality-related question are in Section 8, and results for the preauthorization-related question are in Section 17.

Providers were asked, "**Please rate your satisfaction with availability of specialists**." Table 44-provides the available survey results by individual MCO.

Table 44. Provider Satisfaction with Availability of Specialists, CY2014 - CY2016												
MCO	Very or Somewhat Satisfied			Neither Satisfied nor Dissatisfied			Very or Somewhat Dissatisfied			Total Responses*		
General Provider Surveys												
	2016	2015	2014	2016	2015	2014	2016	2015	2014	2016	2015	2014
Amerigroup	**59.4%**	59.5%	45.9%	**18.8%**	23.7%	37.0%	**21.9%**	16.8%	17.1%	**160**	333	257
Sunflower	**39.8%**	52.9%	40.7%	**51.7%**	30.9%	44.2%	**8.4%**	16.2%	15.0%	**261**	259	226
UnitedHealthcare	**43.7%**	45.2%	^	**39.4%**	32.9%	^	**16.9%**	21.9%	^	**71**	73	63
Behavioral Health Provider Surveys+												
	2016	2015	2014	2016	2015	2014	2016	2015	2014	2016	2015	2014
Cenpatico (SSHP)	**28.1%**	27.4%	**	**64.7%**	65.3%	**	**7.2%**	7.3%	**	**167**	124	**
Optum (UHC)	**44.1%**	38.6%	32.1%	**44.1%**	55.4%	54.8%	**11.7%**	5.9%	13.1%	**145**	101	84

*Providers may have responded to more than one MCO provider survey.
^UnitedHealthcare results for 2014 cannot be determined due to a typographical error in the survey instrument that included "Somewhat satisfied" twice and excluded "Somewhat dissatisfied."
+Amerigroup includes Behavioral Health Providers in their General Provider Survey
**Question was not asked in Cenpatico survey in 2014.

Amerigroup

In 2016, 59.4% of providers were very or somewhat satisfied, comparable to 59.5% in 2015 and higher than 45.9% in 2014. The percentage of providers very or somewhat dissatisfied with availability of specialists was 21.9% in 2016, up from 16.8% in 2015 and 17.1% in 2014.

Sunflower

- **Sunflower general provider survey** – In 2016, 39.8% of providers were very or somewhat satisfied with the availability of specialists, down from 52.9% in 2015 and 40.7% in 2014. The percentage of providers very or somewhat dissatisfied with availability of specialists was 8.4% in 2016, down from 16.2% in 2015 and 15.0% in 2014.
- **Sunflower (Cenpatico) BH provider survey** - In 2016, only 28.1% of BH providers were very or somewhat satisfied, comparable to 2015 (27.4%). The percentage dissatisfied was only 7.2% in 2016 and 7.3% in 2015. Approximately two thirds of the BH providers in 2015 and 2016 were neither satisfied nor dissatisfied.

UnitedHealthcare

- **UnitedHealthcare general provider survey** –In 2016, 43.7% of the 71 providers surveyed were very or somewhat satisfied, comparable to 45.2% in 2015; 16.9% of the providers were very or somewhat dissatisfied in 2016, down from 21.9% in 2015. (2014 survey results are not available due to a typographical error on the survey instrument.)
- **UHC (Optum) BH provider survey** – In 2016, 44.1% of 145 BH providers surveyed were very or somewhat satisfied, higher than in 2015 (38.6%) and 2014 (32.1%). The percentage reporting they were very or somewhat dissatisfied was 11.7% in 2016, up from 2015 (5.9%) and lower than in 2014 (13.1%).

Efficiency

(24) Grievances – Reported Quarterly

Compare/track number of access-related grievances over time, by population type.
Grievances are analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review.

(25) Calls and Assistance – Reported Quarterly

- **Evaluate for trends regarding types of questions and grievances submitted to Ombudsman's Office.**
- **Track number and type of assistance provided by the Ombudsman's Office.**
  The types of assistance and numbers of contacts provided to KanCare members by the Ombudsman's Office are analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review.

(26) Systems

Data for the following measures are reported for the KanCare population and stratified by HCBS waiver I/DD, PD, TBI, and FE, and by MH – members who had a MH visit during the year. HEDIS data reported for CY2013 and CY2014 for ED visits and Inpatient Discharges are also reported for the KanCare population based on data submitted to KDHE by the three MCOs. The HCBS and MH stratified data differ somewhat from the HEDIS data, primarily due to inclusion or exclusion of members with dual coverage through Medicare or through private insurance (in addition to Medicaid eligibility).

Emergency Department (ED) Visits
Population: KanCare (all members) and stratified by TBI, FE, I/DD, PD, and MH
Analysis: Comparison of baseline CY2013 to annual measurement and trending over time.
ED visit rates for HCBS (TBI, PD, FE, and IDD) were much lower in CY2013 – CY2015 compared to rates in CY2012 pre-KanCare. ED rates for MH members and for the KanCare population decreased from CY2012 to CY2013, but have increased above CY2012 rates in CY2014 and CY2015.

ED visit rates for the KanCare population, in HEDIS data reported by the MCOs for all KanCare members, were also lower in CY2014 compared to CY2013. HEDIS rates for ED visits, however, exclude ED visits that result in inpatient admissions, while the data reported for HCBS and MH include all ED visits whether or not they resulted in an inpatient admission. As such, the data reported for HCBS and MH members below should not be compared to the HEDIS rates for ED visits.

As noted above, reported rates can differ a great deal depending on whether members with dual eligibility are excluded or included. MCOs often do not receive data (or data are delayed) for claims paid entirely by Medicare or other private insurance. Dual-eligible members compose approximately 12% of the KanCare population, and compose approximately 70% of the HCBS population.

While there are differences in the numbers and rates of ED visits for the TBI, FE, I/DD, PD, and MH members in CY2012 through CY2014 when including dual eligible members (Table 45) and excluding dual-eligible members (see Table 46) no differences were noted in ED usage patterns based on dual eligibility. The summaries that follow are based on data that include members with dual eligibility.

Table 45. HCBS and MH Emergency Department (ED) Visits, Including Dual-Eligible Members (Medicare and Medicaid), CY2012 - CY2015

	CY2015	CY2014	CY2013	CY2012
Traumatic Brain Injury (TBI)				
ED Visits	1,098	1,291	1,181	1,452
Members	590	694	748	744
Member-Months	5,991	6,667	7,406	6,596
Visits per 1,000 member months	**183.27**	**193.64**	**159.47**	**220.13**
Frail Elderly (FE)				
ED Visits	4,000	4,220	3,889	6,199
Members	6,683	6,879	6,899	7,341
Member-Months	61,240	62,984	64,328	68,631
Visits per 1,000 member months	**65.32**	**67.00**	**60.46**	**90.32**
Intellectual/Developmental Disability (I/DD)				
ED Visits	5,005	4,890	4,217	5,601
Members	9,141	9,123	9,084	9,037
Member-Months	105,222	104,737	103,575	103,258
Visits per 1,000 member months	**47.57**	**46.69**	**40.71**	**54.24**
Physical Disability (PD)				
ED Visits	8,352	8,465	8,045	12,424
Members	6,368	6,166	6,340	6,984
Member-Months	66,098	64,782	68,468	75,087
Visits per 1,000 member months	**126.36**	**130.67**	**117.50**	**165.46**
Total - TBI, FE, I/DD, PD				
ED Visits	18,455	18,866	17,332	25,676
Members	22,714	22,762	23,071	24,106
Member-Months	238,551	239,170	243,777	253,572
Visits per 1,000 member months	**77.36**	**78.88**	**71.10**	**101.26**
Mental Health (MH)				
ED Visits	156,336	141,799	113,226	118,754
Members	114,237	105,602	97,307	94,750
Member-Months	1,260,156	1,155,804	1,054,167	1,020,723
Visits per 1,000 member months	**124.06**	**122.68**	**107.41**	**116.34**

Table 46. HCBS and MH Emergency Department (ED) Visits, Excluding Dual-Eligible Members (Medicare and Medicaid), CY2012 - CY2015				
	CY2015	CY2014	CY2013	CY2012
Traumatic Brain Injury (TBI)				
ED Visits	626	681	575	797
Members	260	290	311	404
Member-Months	2,618	2,743	3,153	3503
Visits per 1,000 member months	**239.11**	**248.27**	**182.37**	**227.52**
Frail Elderly (FE)				
ED Visits	280	225	193	296
Members	328	311	255	263
Member-Months	3,211	2,833	2,340	2,515
Visits per 1,000 member months	**87.20**	**79.42**	**82.48**	**117.69**
Intellectual/Developmental Disability (I/DD)				
ED Visits	2,073	1,897	1,681	2,372
Members	3,828	3,688	3,543	4,255
Member-Months	43,365	41,377	39,317	46,812
Visits per 1,000 member months	**47.80**	**45.85**	**42.76**	**50.67**
Physical Disability (PD)				
ED Visits	3,291	2,969	2,700	4,419
Members	1,839	1,673	1,668	2,215
Member-Months	18,858	17,316	17,692	22,999
Visits per 1,000 member months	**174.51**	**171.46**	**152.61**	**192.14**
Total - TBI, FE, I/DD, PD				
ED Visits	6,270	5,772	5,149	7,884
Members	6,255	5,962	5,777	7,137
Member-Months	68,052	64,269	62,502	75,829
Visits per 1,000 member months	**92.14**	**89.81**	**82.38**	**103.97**
Mental Health (MH)				
ED Visits	112,926	100,689	78,933	83,238
Members	87,640	79,819	72,479	69,813
Member-Months	971,216	877,314	786,883	753,839
Visits per 1,000 member months	**116.27**	**114.77**	**100.31**	**110.42**

- **HCBS** (total visits per 1,000 member-months for TBI, FE, I/DD, and PD) – ED visit rates in CY2015 (77.36) were lower than CY2014 (78.88) and much lower than in CY2012 (101.26).
- **TBI** – TBI members had the highest rate of ED visits in CY2012 to CY2015, compared to the other waiver populations. The ED visit rates, however, significantly decreased from 220.13 in CY2012 to 159.47 in CY2013. The rate increased from CY2013 to CY2014 (193.64) and then decreased in CY2015 to 183.27.
- **PD** – PD members also had high rates of ED visits, but dropped from 165.46 in CY2012 pre-KanCare to 117.50 in CY2013. The rate increased to 130.31 in CY2014, but decreased again in CY2015 to 126.36 visits per 1,000 member-months.

- **FE** – FE member rates followed the same patter as TBI and PD, initially decreasing from 90.32 visits per 1,000 member-months in CY2012 to 60.46 in CY2013, and then increasing to 67.00 in CY2014 before decreasing to 65.32 visits per 1,000 member-months in CY2015.
- **I/DD** – I/DD member ED rates were lower than those of PD, FE, and TBI members each of the four years. From CY2012 to CY2013, rates dropped from 54.24 to 40.71. In CY2014, the rate increased to 46.69 and increased again in CY2015 to 47.57.
- **MH** –MH member ED visit rates initially dropped from 116.34 visits per 1,000 member-months in CY2012 to 107.41 in CY2013. The rate increased in CY2014 to 122.68 and then increased again in CY2015 to 124.06 visits per 1,000 member-months.
- **HEDIS (KanCare Population**: HEDIS rates exclude visits that result in inpatient admissions, while the data reported above include all ED visits. The aggregate number of ED visits per 1,000 member-months for CY2015, as reported for HEDIS 2016 by the three MCOs, was 66.31 visits per 1,000 member-months, which was higher than the CY2014 rate (64.19) and higher than the CY2013 rate (65.17 ED visits per 1,000 member-months). The ED visit rate in CY2015 that includes visits that result in inpatient admissions was 73.60, which was higher than in CY2014 (72.33), CY2013 (65.86), and CY2012 (71.16).

Inpatient Hospitalizations

Population: KanCare (all members) and stratified by TBI, FE, I/DD, PD, and MH
Analysis: Comparison of baseline CY2013 to annual measurement and trending over time.
Data reported below for HCBS (TBI, FE, I/DD, and PD) and for MH are based on inpatient admissions. HEDIS data reported for all KanCare members are based instead on inpatient discharges. Inpatient admission rates were higher in CY2015 for TBI, FE, and I/DD members and lower for PD members than inpatient admission rates pre-KanCare 2012. From CY2014 to CY2015, rates increased for TBI and I/DD and decreased for FE and PD members (see Table 45).

- **HCBS** (total admissions per 1,000 member-months for TBI, FE, I/DD, and PD) – Inpatient admission rates decreased from 35.27 in CY2012 to 34.03 in CY2013. The rate increased in CY2014 to 36.12 before decreasing again in CY2015 to 35.58 inpatient admissions per 1,000 member-months.
- **TBI** – Inpatient admission rates for TBI members decreased from CY2012 (46.91) to CY2013 (45.50) and to 45.34 in CY2014 before increasing in CY2015 to 49.82 admissions per 1,000 member-months, the highest rate of the four year period.
- **PD** – PD member admission rates decreased from 54.17 in CY2012 to 50.92 in CY2013. The rate increased in CY2014 to 55.96 (higher than in CY2012), but then decreased in CY2015 to 53.82, below the CY2012 rate.
- **FE** – FE member admission rates increased from 48.27 in CY2012 to 49.94 in CY2013 and increased again in CY2014 to 53.31 before decreasing somewhat in CY2015 to 51.19 admissions per 1,000 member-months.
- **I/DD** – I/DD member inpatient admission rates were much lower than those of PD, FE, and TBI members in each of the four years. Admission rates increased slightly from 12.37 admits per 1,000 member-months in CY2012 pre-KanCare to 12.44 in CY2013 and to 13.16 in CY2014 and 14.39 in CY2015.
- MH – MH admissions are based on MH-related admissions. MH admissions decreased each year from 8.08 admissions per 1,000 member-months in CY2012 to 6.95 in CY2015.

Table 47. HCBS and MH Inpatient Admissions and Readmissions within 30 days of Discharge, CY2012 - CY2016					
		Inpatient Admissions		Readmissions after Discharge	
Year	Members	Admits	Admits per 1,000 Member months	Readmits	Readmits per 1,000 member months
Traumatic Brain Injury (TBI)					
2015	589	298	**49.82**	83	**13.88**
2014	693	301	**45.34**	46	**6.93**
2013	746	336	**45.50**	53	**7.18**
2012	743	308	**46.91**	55	**8.38**
Frail Elderly (FE)					
2015	6,613	3,091	**51.19**	479	**7.93**
2014	6,789	3,301	**53.31**	495	**7.99**
2013	9,797	3,144	**49.94**	444	**7.05**
2012	7,240	3,244	**48.27**	429	**6.38**
Intellectual/Developmental Disability (I/DD)					
2015	9,138	1,513	**14.39**	174	**1.66**
2014	9,115	1,376	**13.16**	179	**1.71**
2013	9,079	1,287	**12.44**	149	**1.44**
2012	9,033	1,276	**12.37**	136	**1.32**
Physical Disability (PD)					
2015	6,342	3,535	**53.82**	641	**9.76**
2014	6,136	3,601	**55.96**	696	**10.82**
2013	6,307	3,463	**50.92**	599	**8.81**
2012	6,953	4,043	**54.17**	674	**9.03**
Total - TBI, FE, I/DD, PD					
2015	22,682	8,437	**35.58**	1,377	**5.81**
2014	22,733	8,579	**36.12**	1,416	**5.96**
2013	25,929	8,230	**34.03**	1,245	**5.15**
2012	23,969	8,871	**35.27**	1,294	**5.14**
Mental Health (MH) - MH-Related Inpatient Admissions and Readmissions					
2015	87,640	6,750	**6.95**	911	**0.94**
2014	79,819	6,778	**7.73**	932	**1.06**
2013	72,479	6,167	**7.84**	875	**1.11**
2012	69,813	6,091	**8.08**	827	**1.10**

- **KanCare Population**: Inpatient for the KanCare population initially decreased from 70.91 admissions per 1,000 member-months in CY2012 to 65.67 in CY2013 before increasing to 72.12 in CY2014 and 73.39 in CY2015.

Inpatient Readmissions within 30 days of inpatient discharge
Population: KanCare (all members), and stratified by I/DD, PD, TBI, MH, FE, and MH.
Analysis: Comparison of baseline CY2012 to annual measurement and trending over time. Inpatient readmission rates decreased in CY2013 and CY2014 for TBI and MH members from CY2012 pre-KanCare but increased slightly for FE, I/DD, and PD members. (HEDIS data were not reported for readmissions for this time period.)

- **HCBS** (total readmissions per 1,000 member-months for TBI, FE, I/DD, and PD) – Readmission rates per 1,000 member-months increased each year from 5.14 in CY2012 to 5.15 in CY2013 to 5.96 in CY2014, but decreased in CY2015 to 5.81 readmissions per 1,000 member-months.
- **TBI** – TBI member readmission rates decreased from 8.38 in CY2012 to 7.18 in CY2013 to 6.93 in CY2014 before increasing to 13.88 in CY2015, higher than each of the three preceding years and higher than the other waiver population rates in the four-year period.
- **PD** – PD members had higher rates of readmissions than TBI, FE, I/DD, and MH members in CY2012 to CY2014. Readmission rates decreased slightly in CY2013 (8.81 readmissions per 1,000) compared to CY2012 pre-KanCare (9.03), but then increased to 10.82 in CY2014 before decreasing again to 9.76 in CY2015.
- **FE** – FE member rates increased from 6.38 readmissions (per 1,000 member-months) in pre-KanCare CY2012 to 7.05 in CY2013, increasing again in CY2014 to 7.99, and then decreasing slightly to 7.93 in CY2015.
- **I/DD** – I/DD member readmission rates were lower than those of PD, FE, and TBI members in each of the four years. Readmission rates increased slightly from 1.32 readmissions per 1,000 member-months in CY2012 pre-KanCare to 1.44 in CY2013 and to 1.71 in CY2014 before decreasing to 1.66 in CY2015.
- **MH** –MH members had much lower readmission rates than the HCBS members, but their readmission rates are based on MH-related readmissions only. Readmission rates were slightly higher in CY2013 (1.11 admits per 1,000 member-months) compared to CY2012 pre-KanCare (1.10) and decreased in CY2014 (1.06) and again in CY2015 to 0.94 readmissions per 1,000 member-months.

Quantify system design innovations implemented by KanCare such as: Person-Centered Medical Homes, Electronic Health Record use, Use of Telehealth, and Electronic Referral Systems
System design innovations for improved health care provision throughout Kansas, such as patient-centered medical homes, electronic health record use, use of telehealth, and electronic referral systems, were reported in the KanCare Evaluation Quarterly Reports in CY2013 and CY2014 and are now reported in the KanCare Evaluation Annual Reports. The following is a summary of 2016 activities.

To isolate the effects of the KanCare demonstration from other initiatives occurring in Kansas, KFMC researches and summarizes the various related initiatives occurring in Kansas that have the potential to affect a broad KanCare population. KFMC collects the following information about the other initiatives, as available, to help determine overlap with KanCare initiatives:

- Consumer and provider populations impacted,
- Coverage by location/region,
- Available post-KanCare performance measure data, and
- Start dates and current stage of the initiative.

Health Homes

The Health Homes program for KanCare members with SMI continued to provide care coordination services through June 30, 2016, when the program was discontinued. Care Coordination and Targeted Case Management services are available through MCOs and CMHCs.

Patient Centered Medical Homes

- Blue Cross/Blue Shield of Kansas (BCBSKS)
  BCBSKS has a Quality-Based Reimbursement Program (QBRP) that allows their contracting providers to earn additional revenue for performing defined activities.
  - *Consumer and provider populations impacted:* All specialty types contracted with BCBSKS and their patients.
  - *Coverage by location/region:* Kansas, excluding metro Kansas City
  - *Start dates and current stage of the initiative*: Since 2011, BCBSKS has incentivized a number of provider-based quality improvement initiatives such as Electronic Health Record (EHR) adoption, electronic prescribing, participation in a Health Information Exchange (HIE), and Patient Centered Medical Home (PCMH). These incentives change each year and continued in 2016.
- Children's Mercy Hospital & Clinics (CMH) DSRIP - Expansion of Patient Centered Medical Homes and Neighborhoods
  - *Consumer and provider populations impacted:* Children and youth with medical complexity (CYMC) and their siblings.
  - *Coverage by location/region:* Four practices in Northeast Kansas
  - *Start dates and current stage of the initiative*: The project started January 1, 2015. The four practices are in active stages of modifying their processes, per the PCMH model, in preparation for NCQA certification. One practice became PCMH recognized by NCQA in 2016.

Other Practice Redesign Initiatives

- Kansas Healthcare Collaborative – Practice Transformation Network
  The Kansas Healthcare Collaborative (KHC), a quality organization founded by the Kansas Medical Society and the Kansas Hospital Association is the lead organization in Kansas for the Practice Transformation Network (PTN). The PTN involves group practices, health care systems and others joining forces to collectively share quality improvement expertise and best practices to reach new levels of coordination, continuity, and integration of care. KHC provides coaching and assistance to clinician practices preparing for clinical and operational practice transformation from a fee-for-service payment model to performance-based payment.
  - *Consumer and provider populations impacted:* Primary care practices, health care systems, and the consumers they serve.
  - *Coverage by location/region:* More than 1,000 Kansas clinicians are expected to participate in this effort.
  - *Start date and current stage of the initiative*: The grant was awarded September 29, 2015, and KHC was in the first phase of the program in 2016.
  - *Outcomes/Performance Measurement Results*: Not applicable due to initial phase of the program.
- The University of Kansas Hospital (KUH) – Kansas Heart and Stroke Collaborative
  The Kansas Heart and Stroke Collaborative is an innovative care delivery and payment model to improve rural Kansans' heart health and stroke outcomes and reduce total cost of care. The grant program is funded by the Centers for Medicare and Medicaid Services Innovation. This Rural Clinically Integrated Network (RCIN) will expand the use of telehealth, robust health information

exchange, "big data" analysis, and population health management. The program includes the following objectives:

- Develop shared clinical guidelines for moving patients to the next level of care.
- Provide care coordination and management.
- Deliver more telemedicine resources.
- Leverage electronic health information exchanges.
- Establish standards and procedures to increase efficiency and economics of scale.
- Design and deploy payment models to support rural providers.
- Create a forum for sharing best practices and regional care strategies.

  - *Consumer and provider populations impacted:* All consumers of participating providers. *Coverage by location/region:* As noted in The University of Kansas Health System's 2016 annual report, "*The collaborative has expanded from its original 13 healthcare participants in 12 northwest Kansas communities to 38 hospitals in 37 Kansas counties*."
  - *Start date and current stage of the initiative*: The initiative started September 1, 2014, and extends through August 31, 2017.
  - *Outcomes/Performance Measurement Results*: The KHSC continues to collect data on outcomes. Data will be provided in the 2017 KanCare Evaluation report.

- Accountable Care Organizations (ACO)
  ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program. In CY2016, there were nine ACOs in Kansas.

  In November 2016, Blue Cross and Blue Shield of Kansas announced a partnership with the Aledade ACO to extend value-based reimbursement opportunities to smaller provider offices across Kansas. BCBS of KS has also entered into ACO agreements with larger hospital systems and provider groups.
- Kansas Association for the Medically Underserved – Health Center Controlled Network (HCCN)
  The HCCN is a group of safety net providers collaborating horizontally or vertically to improve access to care, enhance quality of care, and achieve cost efficiency through the redesign of practices to integrate services and optimize patient outcomes. Redesign includes a focus on health information technology systems, integration of electronic health record systems, Meaningful Use (MU) attestation, and quality improvement.
  - *Consumer and provider populations impacted:* Safety Net Clinics and their patients.
  - *Coverage by location/region:* Locations of participating safety net clinics include: Atchison, Dodge City, Garden City, Great Bend, Halstead, Hays, Hoxie, Hutchinson, Junction City, Lawrence, Liberal, Manhattan, Newton, Salina, Topeka, Ulysses, Victoria, Wichita, and Winfield.
- Sunflower Foundation – Integrated Care Initiative
  Since its inception in 2012, the Integrated Care Initiative has awarded 37 grants totaling nearly $3.3 million in its support of primary care and behavioral health safety net systems that are working to deliver health care for the whole person. The Sunflower Foundation 2016 annual report notes, "*In 2016, Sunflower began funding research and analysis of the systemic barriers to the implementation of integrated care in Kansas. The project is intended to lay groundwork and chart the course for policy changes needed to make integrated care sustainable in Kansas*."

Health Information Technology (EHRs and MU)

As mentioned in previous KanCare evaluation reports, the Health Information Technology for Economic and Clinical Health Act (HITECH Act) created provisions to promote the Meaningful Use (MU) of health information technology. Through the Office of the National Coordinator for Health Information Technology Regional Extension Center program, KFMC provided support to more than 1,600 Eligible Professionals (EPs) and 95 Eligible Hospitals (EHs) across the state to achieve MU. The Regional Extension Center program was sunset on April 7, 2016.

CMS operationalized MU by setting up core and menu set measures that must be met by EPs and EHs to receive incentive dollars or to avoid Medicare reduced payment adjustments. The State of Kansas is in charge of the program for Kansas Medicaid providers within CMS guidelines. Medicaid incentives are for providers that adopt/implement/upgrade to certified EHR technology and for MU. From January 2011 to January 2017, Kansas EPs and EHs have obtained the following incentive payments:

- Medicare Eligible Professionals: $332,195,109
- Medicaid Eligible Professionals: $88,927,455
- Eligible Hospitals: $292,305,116

KFMC, through funding by KDHE/DHCF, is providing technical assistance to Medicaid providers, assisting them with selection, implementation, and meaningful use of an EHR between February 2014 and September 2017. KFMC has worked with 232 Medicaid providers to date.

Health Information Exchange

Increasing HIE capabilities is also a component of the HITECH Act. The presence of HIE is becoming more central in the work of healthcare providers in Kansas. As reported previously, there are two HIE organizations in Kansas that have been provided Certificates of Authority by KDHE to provide the sharing of health information in Kansas. The organizations, Kansas Health Information Network (KHIN) and the Lewis and Clark Information Exchange (LACIE), have continued to expand their capabilities and to offer services to a wider audience. Below is a summary of the incorporation of HIE into the system for providing healthcare in Kansas.

- KHIN
    - Membership: Over 1,000 participating hospitals and clinics throughout Kansas. Personal Health Record (PHR): MyKSHealth eRecord is a PHR that is available to all consumers who receive care from Kansas health care providers. This allows consumers access to their records any time they need them.
    - KanCare MCOs: KHIN has worked with KanCare MCOs to ensure they have accurate, up-to-date information on their members. While a record of healthcare service is available to the MCOs upon receipt of a claim, KHIN provides the service information in real time at the point of care being received. KHIN can provide daily updates to the MCOs regarding member activity in the last 24 hours.
    - Quality Measure Reporting: Now that KHIN has a significant amount of clinical data, KHIN is beginning to focus more on quality measure reporting and has applied for NCQA certification; as well as to CMS to become a qualified clinical data registry. KHIN is able to perform data extracts for specified quality measures, e.g., hemoglobin A1c values, cholesterol levels, glucose monitoring, hypertension monitoring, etc., and report them back to the providers.
- LACIE
    - Patients queried: LACIE receives more than 100,000 queries per month.

- KS WebIZ: LACIE is working with providers to aid in their direct connection to KS WebIZ through LACIE.
- LACIE 2.0: LACIE is partnering with Health Metrics Services (HMS) in Palo Alto, California, to build a Private Health Information Exchange. This exchange can extract specific data that an organization wants to share with another provider or payer. The participating organizations have full control over their data. This allows participants to control what is shared, who it is shared with, duration of the sharing agreement, as well as the frequency of when data is shared. LACIE 2.0 is vendor agnostic and can extract data (with permission) from all nationally certified Electronic Medical Records (EMRs). LACIE 2.0 will be offered in connection with LACIE 1.0 or as a separate service for organizations that may not be connected to a Health Information Organization (HIO) or are connected to an HIO other than LACIE 1.0.

Telehealth and Telemedicine

Telehealth is a broad scope of remote healthcare services, including long-distance clinical healthcare, patient and professional health-related education, and health administration activities. Telehealth refers to a broader scope of remote healthcare services, while telemedicine refers specifically to remote clinical services using interactive televideo, including use of digital stethoscopes, otoscope cameras, general exam cameras, and intra-oral scopes.

- The University of Kansas Center for Telemedicine & Telehealth (KUCTT)
  KUCTT provides a wide range of telehealth services through its Heartland Telehealth Resource Center, as well as telemedicine services.
  - *Consumer and provider populations impacted:* Many hospitals and clinics across the state are equipped with video conferencing systems that allow providers to collaborate with KUCTT for specialty clinical consults. The KUCTT has provided consults to patients across Kansas in more than 30 medical specialties.
  - *Coverage by location/region:* More than 100 sites throughout Kansas
  - *Start date and current stage of the initiative*: This is an ongoing service provided since 1991

Timely resolution of grievances – Reported Quarterly

Timely resolution of grievances is analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review.

Compare/track number of access-related grievances over time, by population type – Reported Quarterly

Comparisons and tracking of access-related grievances over time and by population are reported in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review.

Timeliness of claims processing – Reported Quarterly

Timeliness of processing clean claims, non-clean claims, and all claims is reported and analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review. Included in this measure are the numbers of claims received each month, the number of claims processed within contractually required timeframes, and analysis of trends over time for turn-around times for processing clean claims.

(27) Member Surveys

CAHPS Survey

Additional detail on the CAHPS survey In CY2016 can be found in Section 4 of this report in the Health Literacy section. CAHPS questions related to efficiency include the following questions listed in Table 48.

Table 48. Member Survey - CAHPS

Question	Pop	Weighted % Positive Responses			QC 50th Percentile		
		2016	2015	2014	2016	2015	2014
Questions on Adult and Child Surveys							
In the last 6 months, did you get information or help from your (child's) health plan's customer service?	**Adult**	**32.6%**	33.2%	33.1%	NA	NA	NA
	GC	**28.9%**	27.3%	24.7%	NA	NA	NA
	CCC	**30.2%**	31.1%	28.3%	NA	NA	NA
In the last 6 months, how often did your (child's) health plan's customer service give you the information or help you needed?	**Adult**	**83.8%**	84.2%	80.0%	↑	↑	↓
	GC	**83.9%**	85.4%	86.7%	↑	↑	↑
	CCC	**82.2%**	84.4%	84.8%	↓	↑	↑

Questions on both adult and child surveys:

- **In the last 6 months, did you get information or help from your (child's) health plan's customer service?**
  Customer service contacts are similar across all survey populations and years, with some variation in the GC population (Adult: 33.1% - 32.6%; GC: 24.71% - 28.9%; CCC: 28.3% - 31.1%).
  - **In the last 6 months, how often did your (child's) health plan's customer service give you the information or help you needed?**
    Of adults who contacted their health plan's customer service in CY2016, 83.8% (CY2015 - 84.2%; CY2014 - 80.0%; CY2012 – 77.1%) received the information or help they needed; the adult rate remained above the QC 75th percentile. The GC results (CY2016 – 83.9%; CY2015 – 85.4%; CY2014-86.7%; CY2012 – 80.1%) decreased from above the QC 75th to above the 50th percentile. The CCC results (CY2016-82.2%; CY2015 -84.4%; CY2014-84.8%) decreased from above the QC 66.67th percentile to below the 33.33rd percentile.

Mental Health Survey

The MH Surveys conducted in CY2011 through CY2015 are described above in Section 7 "Member Survey – Quality." The question related to efficiency of MH services was: "**My mental health providers returned my calls in 24 hours**." As shown in Table 49, over 79.6% of the adults surveyed in 2016 indicated providers returned their calls within 24 hours, compared to 84.4% in 2015 and 2013, and compared to 83.3% in CY2014.

Table 49. Mental Health Survey - Efficiency-Related Questions

Item	Year	0% 100%	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
	General Adult (Age 18+)							
My mental health providers returned my calls in 24 hours.	**2016**		**79.6%**	**213 / 267**	**74.4% – 84.1%**		.15	.07
	2015		84.4%	292 / 346	80.2% – 87.9%	.12		
	2014		83.3%	618 / 742	80.5% – 85.8%	.17		
	2013		84.4%	840 / 995	82.0% – 86.5%	.06		
	2012		80.8%	202 / 250	75.4% – 85.2%	.74		
	2011		88.1%	251 / 285	83.8% – 91.4%	**<.01 -**		

SUD Survey

Section 7 above provides background on the SUD survey conducted by the three MCOs in 2014 and 2015. The question that follows is related to perception of efficiency for members receiving SUD services (see Table 50).

Table 50. SUD Survey - Efficiency-Related Question, CY2014 - CY2016

	CY2016	CY2015	CY2014
How well does your counselor communicate with you? *(Percent of "Very well" or "Well" responses)*	**92.1%**	**93.2%**	**93.9%**

- **How would you rate your counselor on communicating clearly with you?**
  Of the 330 surveyed in CY2016, 304 (92.1%) rated their counselor as communicating very well or well, comparable to CY2015 (93.2%) and CY2014 (93.9%).

Uncompensated Care Cost (UCC) Pool

Number of Medicaid Days for Uncompensated Care Cost Pool hospitals compared to UCC Pool Payments

The UCC Pool permits payments from the State to hospitals based on the uncompensated cost of furnishing services to Medicaid and uninsured individuals. The UCC Pool funding is based on historical costs. For instance, the UCC Pool funding for CY2015 is based on costs of care during FY2013, and funding for CY2014 is based on costs of care during FY2012.

There were 194,999 Medicaid days for UCC Pool hospitals in CY2012. This number increased substantially to 252,002 Medicaid days in CY2013, in part because of the influx of beneficiaries at the start of KanCare. The number of Medicaid days subsequently decreased to 206,882 in CY2014, to 186,396 in CY2015, and to 178,721 in CY2016.

UCC Pool payments increased from $20,568,567 in CY2012 to $41,026,795 in CY2013. This increase was partially due to a change in the Kansas Statute implemented at the start of the FY2013. The UCC Pool payments decreased slightly to $40,974,407 in CY2014 and to $40,929,060 in CY2015. The UCC Pool payments then increased slightly in CY2016 to $40,960,116.

Delivery System Reform Incentive Program (DSRIP)

The Kansas DSRIP projects, originally planned to be implemented as four-year projects from 2014 through 2017, are now three-year projects beginning in 2015. CMS provided feedback in 2014 and the DSRIP hospitals subsequently revised their project proposals based the feedback. CMS approval of the revised DSRIP projects was received on February 5, 2015.

The DSRIP program aims to advance the goals of access to services and healthy living by specifically focusing on incentivizing projects that increase access to integrated delivery systems and projects that expand successful models for prevention and management of chronic and complex diseases. Participating hospitals are to work with community partners statewide to implement projects that have measurable milestones for improvements in infrastructure, processes, and healthcare quality.

The DSRIP program in Kansas includes two major hospitals, Children's Mercy Hospital and Clinics (CMH) and the University of Kansas Hospital (KUH). The two hospital systems are major medical service providers to Kansas and Missouri residents. CMH projects include *Improving Coordinated Care for Medically Complex Patients (Beacon Program)* and *Expansion of Patient-Centered Medical Homes and Neighborhoods (PCMH)*. KUH projects include STOP Sepsis (*Standard Techniques, Operations, and Procedures for Sepsis)* and SPARCC (*Supporting Personal Accountability and Resiliency for Chronic Conditions).*

KFMC, the External Quality Review Organization (EQRO) for the Medicaid program (KanCare) for the State of Kansas, reviewed annual reports for activities completed in CY2015 and CY2016 submitted to the KDHE by CMH and KUH. The major focus of the DSRIP Evaluation is to assess the progress in meeting overall goals of each project, along with providing an independent evaluation of progress in meeting each of the metrics delineated in levels one through four of the DSRIP project proposals approved by CMS in February 2015.

The University of Kansas Hospital

STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis
KUH is using the DSRIP initiative to spread their internal quality programs that address sepsis to rural Kansas populations in order to reduce the disparity of care for sepsis patients in rural nursing facilities and hospitals. KUH will share best practices on the early identification and treatment of sepsis with a goal of reducing the need for hospitalization or minimizing the length of stay and intensity of hospital care.

As reported by the Centers for Disease Control and Prevention in their August 2016 Vital Signs focused on sepsis, "*Sepsis begins outside of the hospital for nearly 80% of patients*." This highlights the importance of focusing this DSRIP project on implementing protocols not only by hospitals, but also by NFs, long-term care facilities, and Emergency Medical Service (EMS) providers.

In 2016 KUH conducted training in 19 counties statewide. KUH reported 554 workshop attendees in the from 103 partner facilities in 2016, including 20 NFs, 24 EMS providers, and 44 hospitals. Workshop attendance ranged from 15 to 50 per workshop.

KUH greatly increased data tracking and reporting in 2016. Of 147 partner facilities, 43 have a sepsis protocol in place, 27 newly implemented in 2016. In CY2016, 33 partner facilities, including three NFs,

began entering sepsis-related data in the Kansas Sepsis Program Database. KUH has developed an NF-specific curriculum that includes slides and posters providing information on basic sepsis symptoms. Of special interest are training materials for licensed practical nurses and nursing assistants in development for distribution in 2017.

In 2015, KUH conducted four workshops in Southeast, Northeast, and South Central Kansas. There were 94 workshop attendees from 45 facilities, including 22 NFs, eight EMS providers, and 10 hospitals (including two critical access hospitals). Workshop attendance ranged from 19 to 29 per workshop.

Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC)
As described in the project proposal, *"Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC) will focus on heart failure patients around the state, with an emphasis on those counties having highest incidence of heart failure admittance to hospitals. A key goal of the SPARCC model is building heart failure patients' ability to care for themselves and be resilient in the face of their chronic condition. This goal ties directly to the major goal for the DSRIP SPARCC initiative: reduce hospital readmission from heart failure though improved self-care."*

KUH has provided SPARCC facilitation training to over 160 individuals and has over 85 partners statewide. Focus is now on expanding the number of group sessions led by these trained facilitators. In 2016, 46 facilitators trained through the SPARCC program in 2015 and 2016 conducted 24 groups (four sessions per group), with 86 patients and 10 caregivers/supporters participating in one or more session. KUH has, thus, been successful in first training facilitators the first year of DSRIP (2015) who then followed through in successfully implementing the SPARCC program for patients in NE, North Central, and SW Kansas. KUH reported that 86 patients participated in 24 groups in 2016, 43 in groups meeting in the first half of the year and 43 in groups meeting in the second half of the year. The first six-month booster session was also completed in 2016, with 43 heart failure patients and caregivers participating.

KUH has also been successful in developing eight training videos for SPARCC facilitators soon to be uploaded to a DSRIP YouTube website.

Children's Mercy Hospital and Clinics

Improving Coordinated Care for Medically Complex Patients (Beacon Program)
The Beacon program functions as an independent medical home for children and youth with medical complexity (CYMC) and their siblings. Beacon staff began seeing Missouri patients in October 2013 and reported in December 2014 that 63 patients were from Kansas. In 2015 there were 56 Kansas Beacon patients– 38 CYMC and 18 siblings. In 2016, there were 92 Kansas Beacon patients – 65 CYMC and 27 siblings.

Another major focus of the Beacon program is to provide consultation to PCPs of children living in rural areas or distant from the Kansas City area. In the first six months of 2016, Beacon staff conducted extensive outreach to 82 providers statewide. They also developed a flyer with responses to frequently asked questions and provided PCPs with information on characteristics of children eligible for the Beacon program. As a result of the outreach, Beacon provided 20 consults, an increase compared to only one Kansas consult in 2015.

In 2015, the Beacon program obtained Level III Person Centered Medical Home status and added several additional staff, including two social workers, a dietician, a PCP physician, and a nurse practitioner care coordinator.

Expansion of Patient-Centered Medical Homes and Neighborhoods
CMH is promoting the Patient-Centered Medical Homes (PCMH) model to transform the way pediatric primary care is organized and delivered in Kansas. Components of the PCMH DSRIP project include increasing access to effective and efficient primary care services and increasing the use of population health management through health information technology. CMH is partnering with four selected clinics that serve a high percentage or volume of Kansas Medicaid clients. The participating practices are delivering improved care that meets the Triple Aim.

Each practice continues to implement the concepts and processes specific to the PCMH model. One practice has achieved NCQA PCMH recognition. A second practice plans to submit their application for recognition in early 2017, after implementing the new NCQA PCMH standards for 2017. CMH continues to work with each practice, providing technical assistanceTA and monthly learning collaborative sessions. CMH has also implemented two new information technology-related (IT) improvements and is working on a third. CMH developed an online message board to serve as a forum for the practices to communicate with each other on an ongoing basis. They will be evaluating the use of the message board in 2017. CMH has also developed an integrated database platform, providing patient data from multiple sources in one database. This was developed in an effort to assist the practices with using health information technology for population health management. CMH is in the process of developing an online searchable community resource database, to be available in 2017. This database provides more functionality than the current hard copy resource books, allowing providers to more easily search for specific resources. The online database will also allow CMH to keep the database up-to-date and to evaluate the extent it is used.

Conclusions

In this fourth KanCare Evaluation Annual Report, KFMC has found that performance outcomes continue to be generally positive.

Comparison data varied based on the type of measure and availability of data.

- Many measures reviewed in this report include comparisons with pre-KanCare outcomes, including: SUD Services (Section 2); SUD Survey (Sections 7, 16, 22, and 27); five MH NOMS (Section 3); MH Survey (Sections 7, 14, 21, and 27); NF (Section 6); CAHPS Survey (Sections 4, 7, 14, 20, and 27); Provider Network Access (Section 19); and UCC Pool.
- In the performance measure validation process, KFMC worked with KDADS, KDHE, and MCO staff to improve the accuracy and completeness of the reporting of P4P metrics. As a result, some of the data reported in last year's report were updated to provide more accurate data.
- Measures reported in KanCare Quarterly Evaluation reports, beginning in Q4 CY2013, are referenced in this report (Sections 9, 24, 25, and 26) and are available for public review on the KDHE KanCare website (www.kancare.ks.gov).

Quality of Care
Physical Health
The baseline data submitted by the MCOs for 18 HEDIS measures, including results by age group,

demonstrate areas of strength (where results were above the QC 50th percentile, and some higher than the 75th percentile) and areas where additional efforts should be focused (where results were below the QC 50th percentile or lower). The summary below includes identification of metrics that were P4P and those identified by CMS as 2017 Core Health Care Quality Measures.

HEDIS measures in CY2015 with weighted aggregated results above the QC 50th percentile included:

- **Adults' Access to Preventive/Ambulatory Health Services** (AAP) - All age ranges were above the QC 50th percentile in CY2013 - CY2015. Aggregate weighted rates for Ages 45-64 were above the QC 90th percentile in CY2013 – CY2015; for Ages 20-44 were above the QC 75th percentile in CY2015; for Ages 65 and older were above the QC 66.67th percentile; and for Total (ages 20 and older) were above the QC 75th percentile in all three years.
- **Annual Dental Visit** (ADV) – Results for all age groups were above the QC 50th percentile in CY2013 – CY2015. CY2015 was the first year the rate for ages 19-20 was above the QC 50th percentile. The total rate (ages 2 to 20) in CY2015 was above the QC 75th percentile.
- **Comprehensive Diabetes Care** (CDC)
  - **Eye Exam (Retinal)** (P4P 2014-2016) Aggregate rates for Eye Exam (Retinal) were above the QC 75th percentile in CY2015 and higher than CY2014 and CY2013.
  - **HbA1c Poor Control [>9.0%];***(CMS 2017 Core Adult Health Care Quality Measure)* For this metric, the goal is to have a lower rate and lower QC percentile. The aggregate rate based on weighted hybrid data for CY2015 was 45.4%, an improvement compared to CY2014 (52.9%), CY2013 (54.4%), and CY2012 (83.4%) and was below the QC 50th percentile (which, for this metric is the goal).
- **Follow-up (within 7 days) after Hospitalization for Mental Illness** (FUH) – *(CMS 2017 Core Adult, Child, and Behavioral Health Care Quality Measure)* The aggregate rate in CY2015 was higher than in CY2014 and CY2013. SSHP and UHC were both above the QC 90th percentile in CY2015, and AGP was above the 66.67th percentile.
- **Initiation and Engagement in Treatment for Alcohol or other Drug Dependence** (IET) *(CMS 2017 Core Adult and Behavioral Health Care Quality Measure)*
  - **Initiation** rates were above the QC 50th percentile in CY2013 to CY2015 for ages 13-17 and for the total population ages 13 and older. For those ages 18 and older, the rate dropped from 41.3% in CY2014 (>66.67th QC percentile) to 37.7% in CY2015 (<50th QC percentile).
  - **Engagement** rates were above the QC 66.67th percentile in CY2015 for the total population, above the QC 90th percentile for ages 13-17, and above the QC 50th percentile for ages 18 and older.
- **Annual Monitoring for Patients on Persistent Medications** (MPM) – *(CMS 2017 Core Adult Health Care Quality Measure)* The aggregate rate based on administrative data for CY2015 was 90.2%, comparable to CY2014 (89.7%) and above the QC 75th percentile in both years. This is an improvement compared to CY2013 (84.9%) where all three MCOs' percentages were below the QC 50th percentile.
- **Follow-up for Children Prescribed ADHD Medication** (ADD) *(CMS 2017 Core Child Health Care Quality Measure)*
  - **Initiation Phase** - The aggregate weighted rate in CY2015 was above the 75th QC percentile. UHC had the highest rate (56.6%; >90th QC percentile); SSHP at 54.2% was above the QC 75th percentile; and AGP's 41.2% rate in CY2015 was below the QC 50th percentile.
  - **Continuation & Maintenance Phase** - The aggregate weighted rate was >66.67th QC percentile in CY2015. Rates for continuation and maintenance increased for all three MCOs. UHC had the highest rate (67.3%; >90th QC percentile); SSHP at 66.3% was above the 75th percentile; AGP at 50.4% was below the QC 50th percentile, but was a 10% increase compared to CY2014.

- **Medication Management for People with Asthma** (MMA) – *(CMS 2017 Core Child Health Care Quality Measure)* Rates are reported by age ranges (ages 5-11, 12-18, 19-50, 51-64, and total – ages 5-64). Rates were above the QC 50th percentile for each age group in CY2014 and CY2015, with the exception of the total range.

A number of HEDIS measures in CY2015 had weighted aggregate rates below the QC 50th percentile. For many of these, Kansas rates have been low for several years. Since the QC percentiles are based on comparison nationally, some metrics may have very high positive percentages but may still have a lower QC percentile due to high percentages nationally. In the summary below, metrics that are CMS Core Adult or Child Health Care Quality Measures for 2017 are first listed:

- **Adolescent Well Care Visits** (AWC) – *(CMS 2017 Core Child Health Care Quality Measure)* The aggregate rate based on administrative data for CY2015 was 43.0%, comparable to CY2014 (42.6%) and CY2013 (42.3%), and below the QC 50th percentile. Results for all three MCOs were below the QC 50th percentile; AGP again had the lowest rate, 40.6%, which was below the QC 25th percentile.
- **Controlling High Blood pressure** (CBP) – *(CMS 2017 Core Adult Health Care Quality Measure)* The aggregate rate based on weighted hybrid data for CY2015 was 48.2% (below the QC 33.33rd percentile), a decrease compared to 51.5% in CY2014 (<33.33rd QC percentile), and an increase compared to CY2013 (47.3%; <25th QC percentile).
- **Comprehensive Diabetes Care** (CDC) (P4P 2014-2016) – (HbA1c Testing is one of the two CDC rates included as a core measure.) Rates increased in CY2015 for HbA1c Testing (84.9%), Medical Attention for Nephropathy (89.2%), HbA1c Control (46.6%), and Blood Pressure Control (58.8%), but were below the QC 50th percentile.
- **Chlamydia Screening in Women** (CHL) – *(CMS 2017 Core Adult and Child Health Care Quality Measures)* The CY2015 and CY2014 aggregate rates and by age group were comparable and slightly lower than those of CY2013. Rates in CY2015 in total and for both age groups were below the QC 25th percentile for all three MCOs.
- **Prenatal and Postpartum Care** (PPC)
  - **Prenatal Care** (P4P 2016) *(CMS 2017 Core Child Health Care Quality Measure)* The aggregate rate based on weighted hybrid data for CY2015 was 67.4%, a decrease compared to CY2014 (70.4%) and CY2013 (71.4%) and below the QC 25th percentile in all three years.
  - **Postpartum Care** - *(CMS 2017 Core Adult Health Care Quality Measure)* The aggregate rate based on weighted hybrid data for CY2015 was 57.5%, above the CY2014 rate (55.8%) and below CY2013 (58.5%). The rates were below the QC 50th percentile all three years.
- **Weight Assessment and Counseling for Nutrition and Physical Health for Children and Adolescents** (WCC) **: Weight Assessment/BMI** – *(CMS 2017 Core Child Health Care Quality Measure)* The aggregate weighted hybrid HEDIS rates for reporting BMI have increased from CY2013 (34.7%) to CY2015 (48.6%) but have remained below the QC 25th percentile.
- **Adult BMI Assessment** (ABA) – *(CMS 2017 Core Adult Health Care Quality Measure)* The aggregate rate based on hybrid data for CY2015 was 77.6%, an increase compared to 72.2% in CY2014 was 72.2%, but below the QC 33.33rd percentile
- **Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life** (W34) – *(CMS 2017 Core Child Health Care Quality Measure)* The aggregate rate based on administrative data for CY2015 was 62.8%, a slight increase over CY2014 (62.1%), higher than in CY2013 (60.8%), but lower than in CY2012 (65.4%). The aggregate rates in CY2013 through CY2015 were below the QC 25th percentile.
- **Well-Child Visits in the First 15 Months of Life** (W15) – *(CMS 2017 Core Child Health Care Quality Measure)* Rates are reported by the number of visits (0 visits, 1 visit, 2 visits, 3 visits, 4 visits, 5 visits, and 6 or more visits). The aggregate rate for 6 or more visits was 55.1% in CY2015 (<33.33rd QC percentile), up from 44.7% (<25th QC percentile).

The following HEDIS measures had rates below the 50th percentile in CY2015 but were not CMS core measures:

- **Appropriate Testing for Children with Pharyngitis** (CWP) - The aggregate rate based on administrative data for CY2015 was 55.1% (<10th QC percentile), up from 52.2% in CY2014 and 51.6% in CY2013 (51.6%).
- **Appropriate Treatment for Children with Upper Respiratory Infection** (URI) – The aggregate rate based on administrative data for CY2015 was 76.3% (<25th QC percentile), up from 73.5% in CY2014 and 71.9% in CY2013 (71.9%).
- **Weight Assessment and Counseling for Nutrition and Physical Health for Children and Adolescents** (WCC)
    - **Counseling for Nutrition for Children and Adolescents** – The CY2015 aggregate weighted hybrid HEDIS rates in total (ranging from 46.9% in CY2013 to 49.5% in CY2014) and by age group were below the QC 25th percentile.
    - **Counseling for Physical Activity for Children and Adolescents** – The aggregate weighted hybrid HEDIS rate for each age strata (ages 3-11; ages 12-17; and ages 3-17) were below the QC 50th percentile in CY2013 through CY2015. Total rates ranged from 44.0% in CY2013 to 45.8% in CY2014.

SUD Services

- The percentage of members reporting employment at discharge in 2015 (41.8%) was 20.5% higher (7.1 percentage points) than in 2014 (34.7%)
- Attendance of self-help programs decreased from 44.5% in CY2014 to 39.5% in CY2015 to 39.0% in CY2016, lower all three years than in CY2012 pre-KanCare (59.9%).
- Three of the five measures (stable living at time of discharge from SUD services, decreased arrests, and decreased use of alcohol and/or other drugs) have had consistently high success rates (over 90%) pre-KanCare (CY2012) and in KanCare (CY2013-CY2016).

Mental Health Services

- The percentage of SPMI adults who were competitively employed increased by 4.5% from 15.6% in CY2014 in to 16.3% in CY2015.
- The percentages of SPMI adults and SED youth with access to services (P4P 2014-2015) is based on the number of members assessed as having SED (youth) and SPMI (adults). Rates increased in CY2014, which is due in part to more complete reporting by CMHCs in CY2015.
- Compared to CY2012 (45.7%), the average annual quarterly average of those who were homeless who were housed at the end of each quarter decreased from 58.0% in CY2013 (58.0%) to 49.1% in CY2014 49.1% to 44.6% in CY2015 to 44.6%. No data were available for review, however, for CY2016.
- The annual quarterly average number of SED youth who experienced improvement in their residential status was higher in CY2015 (84.9%) than in the three previous years (ranging from 80.6% to 81.7%). No data were available for review for CY2016.

Healthy Life Expectancy

<u>CAHPS Survey</u>

Overall, the CAHPS questions related to Healthy Life Expectancy had high positive responses, particularly in the following areas that were greater than 90%:

- Personal doctor explaining things in a way that was easy to understand

- Personal doctor listening carefully to you (your child)
- Provider talking about the reasons you (your child) might want to take a medicine
- Your child's provider answering your questions
- Your child's provider explaining things in a way your child could understand

Improvements continue to be noted in the smoking cessation related questions, with the rate of smoking slowly decreasing (CY2016 – 32.2%; CY2014 - 37.6%; CY2012 – 37.2%) and the rate of smokers being advised to quit smoking by a doctor increasing (CY2016 – 79.5%; CY2014 – 75.7%; CY2012 – 65.5%). Less than 50% of respondents who smoke or use tobacco, however, reported their doctor recommended or discussed medications or other methods/strategies to assist with smoking cessation.

Although the CY2016 rate (43.7%) of adults receiving the flu shot or flu spray remains above the QC 50th percentile, the rate has decreased each year from 47.5% in CY2014, and the Healthy People 2020 target is 70% (www.healthypeople.gov).

Another area for improvement is regarding providers talking about specific things to do to prevent illness, with CY2016 rates of 67.3% to 71.4%. The Adult rate was below the QC 33.33rd percentile; the GC rate was below the QC 25th percentile; and the CCC rate was below the QC 10th percentile.

HEDIS – Healthy Life Expectancy
Diabetes Monitoring for people with Diabetes and Schizophrenia (SMD) - The aggregate rate for CY2015 was 65.3%, an increase compared to 60.1% in CY2014 and 62.9% in CY2013, but below the QC 33.33rd percentile.

Healthy Life Expectancy for persons with SMI, I/DD, and PD
The following measures are HEDIS-like in that HEDIS criteria were limited to SMI, I/DD, and PD members (and were P4P in 2014-2015).

- **Preventive Ambulatory Health Services** - In CY2013 to CY2015, over 94% of adult members with PD, I/DD, and SMI were reported to have had an ambulatory preventive care visit during the year. Rates for this subpopulation were higher than rates for all eligible KanCare members in CY2013 – CY2015.
- **Breast Cancer Screening** *(CMS 2017 Core Adult Health Care Quality Measure)* - . Due to the multi-year HEDIS criteria, data for 2015 were the first HEDIS data reported by the three MCOs. The breast cancer screening rate reported for the CY2015 PD, I/DD, SMI population (50.5%) was higher than the aggregated CY2015 HEDIS rate for the eligible KanCare population (45.0%; <10th QC percentile).
- **Cervical Cancer Screening** *(CMS 2017 Core Adult Health Care Quality Measure)* - The cervical cancer screening rate reported for the CY2015 PD, I/DD, SMI population (52.1%) was higher than the aggregated CY2015 HEDIS rate for the eligible KanCare population (46.9%; <33.33rd QC percentile).
- **Comprehensive Diabetes Care**
  - **HbA1c testing** - *(CMS 2017 Core Adult Health Care Quality Measure)* Rates for HbA1c testing for PD, I/DD, and SMI with diabetes were higher in in CY2015 (87.6%), CY2014 (86.5%), and CY2013 (84.4%) than for all eligible KanCare members in CY2015 (84.9%), CY2014 (84.8%), and CY2013 (83.1%).
  - **HbA1c control <8.0%** - Rates for HbA1c testing for PD, I/DD, and SMI with diabetes were higher in in CY2015 (87.6%), CY2014 (86.5%), and CY2013 (84.4%) than for all eligible KanCare members in CY2015 (84.9%), CY2014 (84.8%), and CY2013 (83.1%).
  - **Eye Exam** - Rates for PD-I/DD-SMI members were higher in CY2015 (66.5%) than in CY2014 (63.7%) and CY2013 (58.7%). Rates for PD-I/DD-SMI members were also higher each year than

rates for all eligible KanCare members in CY2015 (62.5%), in CY2014 (58.6%), and in CY2013 (50.1%).

- **Medical attention for nephropathy** - Rates for the PD-I/DD-SMI population and for all eligible KanCare members greatly increased in CY2015 compared to the two previous years. The CY2015 rate for the PD-I/DD-SMI population (90.8%) was 20.7% higher than in CY2014 (75.2%), and was higher than the rate for all eligible KanCare members (89.2%).
- **Blood pressure control <140/90** - The CY2015 rate for PD-I/DD-SMI members (60.2%) was 18% higher than in CY2014 (51.0%) and higher than the rate for all eligible KanCare members (58.8%).

HCBS Waiver Services

- **PD and TBI waiver members participating in the WORK employment program** – In April 2015, there were 72 PD Waiver members and 15 TBI Waiver members participating in the WORK program. During the year, one additional TBI member participated in the program. In April 2014 there were 143 PD and 16 TBI members participating in the WORK program. From April to December 2014, 10 additional members participated (nine PD and one additional TBI).
- KDADS is working with the MCOs to improve documentation that waiver members are receiving the type, scope, amount, duration, and frequency of services identified in their service plans.

Long-Term Care: Nursing Facilities (NF)

- The percentage of NF claims that were denied increased from 11.5% in CY2012 (pre-KanCare) to 13.5% in CY2013, and then decreased to 10.4% in CY2014. The denial rate in CY2015 (13.2%) was comparable to CY2013.
- The percentage of NF Medicaid members who had falls with major injuries decreased from 0.62% in CY2012 (pre-KanCare) to 0.53% in CY2013 and CY2014. In CY2015, the fall percentage increased slightly to 0.56%, and during the first three quarters of CY2016, the rate was 0.57%.
- The percentage of NF Medicaid members who were readmitted to a hospital after being discharged from an NF increased from 7.18% in CY2012 (pre-KanCare) to 11.98% in CY2013 and increased again in CY2014 to 12.70%. In CY2015, the percentage decreased to 12.04%, and, during the first two quarters of CY2016, the percentage increased to 13.60%.
- PEAK – The number of Person-Centered Care Homes increased from eight in FY2013 to 15 by the June of FY2016.

Member Survey – CAHPS

Overall, responses to the Quality of Care related CAHPS questions are consistently above the QC 50th percentile. The ratings of health care, personal doctor, specialist, and health plan are consistently improving. Ratings are based on a scale of 0 to 10, with 10 being best possible and 0 being worst possible. The CY2016 results (ratings of 9-10) range from 54.9% - 75.9%, with the lowest ratings from Adults regarding their health care and the highest ratings from the GC population regarding their personal doctor. The percentage of respondents rating their health plan a 9 or 10 ranged from 60.9% - 73.8%. A high percentage of survey respondents indicate their personal doctor shows respect for what they have to say (93.4% - 96.0%) and spends enough time with them (89.7% - 91.2%).

Member Survey – Mental Health

Responses related to quality of care were generally very positive (over 80%) in CY2016.

The most notable CY2016 positive rates and improvement across years were for the population of SED Waiver youth and young adults (family/member and youth only responses), in the following areas:

- Feeling comfortable asking questions about treatment, medication, and/or children's problems (SED Waiver youth and young adults: CY2016 -89.9%)
- Choice of treatment goals (SED Waiver youth ages 12-17: 86.8%)
- Members being better able to do the things they want to do (SED Waiver youth/young adult: 73.5%)
- Members being able to understand their provider (SED Waiver youth ages 12-17: 95.5%)

While remaining positive, the general adult population's rates have consistently decreased across years, in all of the quality of care related questions:

- Feeling comfortable in asking questions about treatment, medication, and/or children's problems (CY2016 - 85.9%; CY2011 – 93.6%)
- Member choice of treatment goals (CY2016 -78.6%; CY2014 – 84.0%)
- Members being able to have assistance in obtaining information to assist them in managing their health (CY2016 - 82.7%; CY2011 – 89.3%)
- Being better able to do the things they want to do (CY2016 - 69.3%; CY2011 – 82.4%)
- Being able to understand their provider (CY2016 - 90.0%; CY2013 – 94.3%)
- Having better control of their daily life (CY2016 - 74.8%; CY2011 – 86.5%)
- Being able to deal with crisis as a direct result of services provided (CY2016 – 69.2%; CY2011 – 80.4%)

Member Survey – SUD

The SUD surveys in 2014 to 2016 and 2012 were convenience samples of members contacted in person, by mail, and by phone. The surveys included 342 members in 2016, 193 members in 2015, 238 in 2014, and 629 in 2012. Results were generally very positive. In 2012 to 2015, over 90% of those surveyed rated the quality of services as very good or good. The percentage of members who rated counselor involvement of members in decision making as very good or good was 92.6% in 2016, up from 88.4% in 2015, 92.0% in CY2014. The percentage who responded they were feeling much better or better since beginning treatment was 88.9% in 2016, 92.6% in CY2015, 87.1% in CY2014, and 98.8% in 2012.

Provider Survey

For the question on "provider satisfaction with MCO's commitment to high quality of care for its members," responses in 2016 for very or somewhat satisfied ranged from 40.3% (UnitedHealthcare general provider survey) to 60.9% (Amerigroup). For very or somewhat dissatisfied, responses in 2016 ranged from 7.0% (Sunflower/Cenpatico BH provider survey) to 16.3% (Amerigroup general provider survey).

Coordination of Care (and Integration)

Care Management for Members receiving HCBS Services

- KDADS is working with the MCOs to improve documentation of assessments of member needs and updates of service plans as needs change.

The following measures apply to members receiving waiver services (I/DD, PD, TA, TBI, Autism, FE, and MFP) and are HEDIS-like measures:

- **Increase in the number of primary care visits** - The percentage of HCBS members who had an annual preventive health visit increased from 92.0% in CY2013 to 93.1% in CY2014 and to 94.0% in CY2015. The rates for the HCBS member subpopulation were 4% to 8% higher than the rates for all

KanCare adult members in all three years (88.4% in CY2013, 87.5% in CY2014, and 87.1% in CY2015).

- **Increase in Annual Dental Visits** - The percentage of HCBS members who had an annual dental visit was higher in CY2015 (51.6%) compared to CY2014 (49.0%) and CY2013 (49.4%). The annual dentist visit rates for HCBS members were 15% to 18% lower than the HEDIS rates for the overall KanCare population in each of the three years – CY2015 (60.9%), CY2014 (60.0%) and (CY2013 (60.3%).
- **Decrease in number of Emergency Department visits** - From CY2013 to CY2015, emergency department (ED) visit rates (per 1,000 member-months) for the HCBS population increased slightly from 77.58 in 2013 to 78.06 in 2014 to 79.64 in 2015. The rates for the HCBS population were higher than the HEDIS rates for the overall KanCare population (65.17 in CY2013, 64.19 in CY2014, and 66.31 in CY2015).

Member Survey – CAHPS

A high percentage of respondents indicated it was easy to obtain the following services:

- Care, tests and treatment needed (87.2% - 92.4%)
- Appointment with a specialist as soon as needed (80.8% - 86.2%)
- Prescription medicines for child through their health plan (94.4% - 94.5%)

For respondents receiving care from more than one provider, 80.7% - 85.0% indicated their personal doctor seemed informed and up-to-date regarding the care from other providers. Only 55.2% - 57.7% of the related GC and CCC populations noted they received help from their doctor's office or health plan in coordinating their child's care; the question does not ask whether coordination assistance was needed or requested. When child survey respondents indicated they needed their provider to contact a school or daycare regarding their child's health or health care, 94.5% - 94.9% responded that they received the needed assistance. A high percentage (89.5% - 92.0%) of child survey respondents reported their providers understand how their child's longer term health conditions impact their child's and their family's daily life.

Member Survey – MH

While the responses to care coordination related questions were generally positive, rates for the general adult population have decreased over time and the rates for the SED Waiver youth (ages 12-17) have increased over time.

- General Adults' use of consumer-run programs and ability to access services the members thought were needed: CY2016 – 78.7%; CY2014 – 80.4%.
- Members perceiving they were able to access all of the services that they thought they needed:
  - General adult: CY2016 - 80.7%; CY2011 – 91.3%.
  - SED Waiver youth (ages 12-17, youth responding): CY2016 – 79.3%; CY2013 – 71.8%.

Member Survey - SUD

Of the 66.4% who indicated they have a PCP, 70.4% in CY2016 indicated their counselor requested a release of information to allow discussion of the member's treatment with their PCP. In 2016, 44.3% of those surveyed reported they received services from another counselor within the last year; 82.4% of these members reported they were asked to sign a release to share details with the other counselor.

Provider Survey

For the survey question on "provider satisfaction with obtaining precertification and/or authorization for (MCO's) members," responses for very or somewhat satisfied ranged from 32.3%

(Sunflower/Cenpatico BH survey) to 51.7% (Amerigroup), and for very or somewhat dissatisfied ranged from 8.9% (UHC/Optum) to 28.7% (Amerigroup).

Cost of Care

From CY2012 to CY2015, there were increases in utilization of the following services: Primary Care Physician (24% increase), Dental (32% increase), Home and Community-Based Services (23% increase), Transportation (33% increase), Vision (16% increase) and Non-Emergency Room Outpatient Services (10% increase).

Inpatient Hospitalization decreased 23% in CY2015 compared to CY2012, and Emergency Room Outpatient Visits decreased by 1%. Decreases in utilization of these services are a positive outcome, reflecting increased access of treatment from .the member's primary care provider instead of an ER and increased preventive care and home services to avoid lengthy hospital stays.

Access to Care

Provider Network – GeoAccess

Access Standards

- In CY2016 there were three provider types where Semi-Urban counties did not have access through at least one MCO: Allergy – Montgomery County; Neonatology – Saline County; and Plastic & Reconstructive Surgery – Geary, Montgomery, and Riley Counties.
- In CY2016, there were seven provider types where one or more non-urban county had no access through any of the three MCOs
  - Cardiology - Cheyenne County
  - Gastroenterology - Cheyenne, Decatur, Rawlins, and Sherman Counties
  - Neonatology – Cheyenne, Greeley, Rawlins, Sherman, and Wallace Counties
  - Nephrology - Cheyenne and Sherman Counties
  - Physical Medicine/Rehab Cheyenne and Sherman Counties
  - Plastic & Reconstructive Surgery -Cheyenne, Clark, Grant, Greeley, Hamilton, Haskell, Kearny, Meade, Morton, Seward, Sherman, Stanton, Stevens, Wallace, and Wichita Counties
  - Dental - Lane County
- The counties with the least amount of access to providers were Cheyenne and Sherman Counties. Of the other 16 counties with no access to one or more provider types: three counties had no access to two provider types, and 13 had no access to one provider type. Not factored into this analysis are the numbers of counties with no access to one or more providers that are adjacent on all sides to counties with no access to these same provider types

Behavioral Health - BH services in CY2014- CY2016 were provided in all counties within the access standards required by the State.

HCBS – Counties with access to at least two providers by provider type and services

Of the 27 HCBS services, 17 were available in CY2015 from at least two providers in all 105 Kansas counties from all three MCOs. Of the remaining 10 HCBS services

- **Adult day care** - Services were available from at least two providers in only 47 counties through UHC, 50 through SSHP, and 102 through AGP. UHC reported availability through at least one service provider in only 68 counties; SSHP reported availability in 81 counties, and AGP reported availability in 105 counties.

- **Intermittent intensive medical care** – At least two service providers were available in all counties through UHC, 77 through AGP, and 94 through SSHP. At least one provider was available in the AGP network in 102 counties, in the SSHP network in 105 counties.
- **Speech therapy – Autism waiver** – Services were available from at least one or two providers in 7 counties through Amerigroup. Through Sunflower network, there were at least two providers in 12 counties and at least one service provider in 27 counties. Services through UnitedHealthcare were only available from at least one or two providers in 2 counties.
- **TBI waiver therapies: Speech, Behavior, Cognitive, Occupational, and Physical** – Again in CY2016 there was a wide gap in the availability of these specialized services as reported by MCOs. Amerigroup and Sunflower, as in 2013-2015, reported that at least two service providers for each of these services were available in all counties in 2016. Sunflower's one exception was Speech Therapy/TBI Waiver, where they reported at least two providers available in 50 counties (and at least one provider in all counties). UnitedHealthcare reported, as in 2013-2015, far fewer available providers for these TBI waivers: Speech Therapy -at least two providers in 9 counties, and only 28 in at least one county; Behavior Therapy -at least two providers in 72 counties and 105 in at least one county; Cognitive Therapy -at least two providers in 26 counties and 55 in at least one county; Occupational Therapy -at least two providers in 12 counties, and only 33 in at least one county; and Physical Therapy -at least two providers in 30 counties, and only 55 in at least one county.
- **Home modification** – At least two service providers were available through Sunflower and UnitedHealthcare in all counties. In Amerigroup, only 27 counties had at least two service providers, and 101 counties had at least one service provider.
- **Health maintenance monitoring** – At least two service providers were available through UnitedHealthcare in all counties. In Amerigroup, only 69 counties had at least two service providers, and 103 counties had at least one service provider. Through Sunflower, two service providers were available in 95 counties, and all counties had at least one service provider.

I/DD Provider Services – Counties with access to at least two providers by provider type and services
Services reported in 2016 to be available from at least two I/DD providers by all three MCOs include: Targeted Case Management, Residential Support, Sleep Cycle Support, Personal Assistant Services, Financial Management Services, and Respite Care (Overnight).

Services not available from at least two I/DD providers by all three MCOs in all 105 Kansas counties include:

- Supported Employment Services – AGP reported this service to be available from at least two I/DD providers in 51 counties, and from at least one provider in 81 of the 105 counties. SSHP reported this service to be available from at least two I/DD providers in 98 counties, and from at least one provider in all 105 counties. UHC reported this service to be available from at least two I/DD providers in 25 counties, and from at least one provider in 48 of the 105 counties.
- Wellness Monitoring - AGP reported this service to be available from at least two I/DD providers in 92 counties, and from at least one provider in all 105 counties. SSHP reported this service to be available from at least two I/DD providers in 95 counties, and from at least one provider in 102 counties. UHC reported this service to be available from at least two I/DD providers in 80 counties, and from at least one provider in all 105 counties.
- Medical Alert Rental - AGP and UHC reported Medical Alert Rental to be available from at least two providers in all 105 counties, but not specifically from I/DD providers. SSHP reported this service to be available from at least two I/DD providers in 55 counties, and from at least one I/DD provider in all 105 counties.

- Supportive Home Care - AGP and SSHP reported Supportive Home Care to be available from at least two I/DD providers in all 105 counties. UHC reported this service to be available from at least two I/DD providers in 103 counties, and from at least one provider in all 105 counties.
- Assistive Services - SSHP and UHC reported Assistive Services to be available from at least two I/DD providers in all 105 counties. AGP reported this service to be available from at least two I/DD providers in 104 counties, and from at least one provider in all 105 counties.
- Day Support - AGP and SSHP reported Day Support to be available from at least two I/DD providers in all 105 counties. UHC reported this service to be available from at least two I/DD providers in 58 counties, and from at least one provider in 98 counties.
- Specialized Medical Care – RN - UHC reported this service to be available from at least two I/DD providers in all 105 counties. AGP reported this service to be available from at least two I/DD providers in 101 counties, and from at least one provider in all 105 counties. SSHP reported this service to be available from at least two I/DD providers in 104 counties, and from at least one provider in all 105 counties.
- Specialized Medical Care – LPN - UHC reported this service to be available from at least two I/DD providers in all 105 counties. AGP reported this service to be available from at least two I/DD providers in 101 counties, and from at least one provider in 104 counties. SSHP reported this service to be available from at least two I/DD providers in 104 counties, and from at least one provider in all 105 counties.

As in 2013-2015, there is no indication in the HCBS report as to which counties do not have at least two services available. The report also again does not indicate whether members needing services are residents of the counties where there are no providers or where there are less than two providers. In a "Frontier" county, in particular, it is possible that there are no members in the county that are in need of one of the more specialized HCBS services.

Open/Closed Panels

Network Adequacy Reports and submitted to the State, as well as "real time" information available to members on-line and through customer service contacts, continue to be in need of timely updating to provide information on provider availability.

Provider After-Hours Access and Provider Appointment Standards Access

In 2016, each of the MCOs included one or more supplemental question in their CAHPS survey related to appointment access. Various methods were used by the MCOs, including surveys and calls during and after office hours. Amerigroup provided an update on appointment availability for urgent and routine visits with PCPs, Specialists, Pediatrics, and Behavioral Health. UnitedHealthcare employs a vendor who contacts providers, with callers identifying themselves as calling on behalf of UHC, relate adult and child symptom scenarios, and ask about appointment availability.

Member Survey – CAHPS

CY2016 survey respondents had highly positive responses to the following access related questions:

- When care was needed right away for an illness, injury or other condition, how often was it received as soon as the respondent needed (86.2% - 95.1%). The Adult and CCC responses were above the QC 75th percentile and GC responses were above the QC 66.67th percentile.
- Check-up or routine care received as soon as respondent needed (82.5% - 92.1%). The Adult rate was above the QC 75th percentile; the GC rate was above the 66.67th percentile; the CCC rate was above the 50th percentile.

- Appointment with specialist as soon as respondent needed (80.8% - 86.2%). The Adult rate was above the QC 95th percentile; the GC rate was above the 50th percentile; and the CCC rate was above the QC 75th percentile.
- Ease of getting the care, tests, and treatment the respondent needed (87.2% – 92.4%). The Adult and GC rates were above the QC75th percentile and the CCC rate was above the QC 66.67th percentile.

Member Survey – MH

Responses for each of the seven access-related questions were for the most part positive in CY2016; however, there were significant decreases or negative trends noted in the following five questions.

- Provider returned their call within 24 hours - General Adult: CY2016 – 79.6%; CY2011 - 88.1%.
- Services being available at times that were good for the member
  - General Adult: CY2016 -87.4%; CY2013 -92.1%
  - General Youth: CY2016 -83.9%; CY2013 - 88.7%
- Being able to see a psychiatrist when they wanted to - General Adult: CY2016 -73.6%; CY2011 - 82.1%
- Perceive their medication is available - General Youth: CY2016 - 83.7%; CY2013 -86.1%
- Ability to get the services they thought they needed - General Adult: CY2016 -80.7%; CY2011 - 91.3%
- Ability to get services during a crisis - General Youth: CY2016 – 83.8%; CY11 – 89.5%

Improvements or high percentages of positive responses were noted with the following questions and populations.

- Perceive their medication is available- General Adults: CY2016 -92.9%; SED Waiver youth and young adults: 94.5%
- Ability to get the services they thought they needed - SED Waiver youth (ages 12-17, youth responding): CY2016 – 79.3%; CY2013 – 71.8%

Member Survey – SUD

- Of 326 surveyed in 2016, 69 (21.2%) reported they were placed on a waiting list for an appointment, compared to 15.6% (28 of 180) in 2015 and 12.2% of 205 surveyed in 2014. While 38.6% in 2016 reported their wait was one week or less, 42.1% reported their wait to be three weeks or more, compared to 46.2% in 2015 and 26.1% in 2014.
- Members surveyed in 2014-2016 had consistently positive responses to questions related to distance to travel to see a counselor.
- In 2016, 84.4% of members surveyed said they were able to get an appointment for their first visit as soon as they wanted, compared to 87.7% in 2015 and 92.1% in 2014.
- In 2016, 28.4% of members surveyed indicated they had an urgent problem (compared to 25.7% in 2015 and 28.5% in 2014). Of those who reported needing an urgent visit, 16.0% reported in 2016 they waited more than 48 hours for an urgent visit compared to 19.0% in 2015 and 10.9% in 2014.

Provider Survey

For the survey question on “provider satisfaction with availability of specialists,” responses in 2016 for “very satisfied” or “somewhat satisfied” ranged from 28.1% (SSHP/Cenpatico BH survey) to 59.4% (Amerigroup). Responses for “very dissatisfied” or “dissatisfied” ranged from 7.2% (SSHP/Cenpatico BY Survey) to 21.9% (Amerigroup).

Efficiency

Emergency Department Visits

ED visit rates for HCBS (TBI, PD, FE, and IDD) were much lower in CY2013 – CY2015 compared to rates in CY2012 pre-KanCare. Rates described below are based on ED visits per 1,000 member-months.

- ED rates for MH members and for the KanCare population decreased from CY2012 to CY2013, but have increased above CY2012 rates in CY2014 and CY2015.
- ED visit rates for HCBS members in CY2015 (77.36) were lower than CY2014 (78.88) and much lower than in CY2012 (101.26).
- TBI members had the highest rate of ED visits in CY2012 to CY2015. The CY2015 rate decreased from 220.13 in CY2012 to 183.27 in CY2015.
- The ED visit rate for PD members decreased from 165.46 in CY2012 to 130.31 to 126.36 in CY2015.
- The FE waiver member ED rate decreased from 90.32 in CY2012 to 65.32 in CY2015.
- The I/DD member ED rates were lower than those of the PD, FE, TBI and MH members. From CY2012 to CY2015, the ED rate decreased from 54.24 to 47.57.
- MH ED visit rates increased from 116.34 visits per 1,000 member months in CY2012 to 124.06 in CY2015.

Inpatient Hospitalizations

Inpatient admission rates were higher in CY2015 for TBI, FE, and I/DD members and lower for PD members than inpatient admission rates pre-KanCare 2012. From CY2014 to CY2015, rates increased for TBI and I/DD and decreased for FE and PD members. Rates described below are based on inpatient admission visits per 1,000 member-months.

- The inpatient admission rates for HCBS members in CY2015 (35.58) and CY2012 (35.27) were comparable.
- TBI member inpatient admission rates initially decreased from 46.91 in CY2012 to 45.50 in CY2013 to 45.34 in CY2014, but increased to 49.82 in CY2015.
- The inpatient admission visit rate for PD members decreased from 54.17 in CY2012 to 53.82 in CY2015.
- The FE waiver member Inpatient admission rate increased from 48.27 in CY2012 to 51.19 in CY2015.
- I/DD member inpatient admission rates were much lower than those of PD, FE, and TBI members in each of the four years. Admission rates increased slightly from 12.37 admits per 1,000 member-months in CY2012 pre-KanCare to 14.39 in CY2015.
- MH admissions are based on MH-related admissions. MH admissions decreased each year from 8.08 admissions per 1,000 member months in CY2012 to 6.95 in CY2015.

Inpatient Readmissions within 30 days of inpatient discharge

Inpatient readmission rates decreased in CY2013 and CY2014 for TBI and MH members from CY2012 pre-KanCare but increased slightly for FE, I/DD, and PD members. Rates described below are based on inpatient readmissions per 1,000 member-months.

- Readmission rates per 1,000 member months increased each year from 5.14 in CY2012 to 5.15 in CY2013 to 5.96 in CY2014, but decreased in CY2015 to 5.81 readmissions per 1,000 member months.
- TBI member readmission rates decreased from 8.38 in CY2012 to 7.18 in CY2013 to 6.93 in CY2014 before increasing to 13.88 in CY2015, higher than each of the three preceding years and higher than the other waiver population rates in the four-year period.

- PD members had higher rates of readmissions than TBI, FE, I/DD, and MH members in CY2012 to CY2014. Readmission rates decreased slightly in CY2013 (8.81) compared to CY2012 pre-KanCare (9.03), but then increased to 10.82 in CY2014 before decreasing again to 9.76 in CY2015.
- The FE waiver member Inpatient admission rate increased from 6.38 in CY2012 to 7.93 in CY2015.
- I/DD member readmission rates were lower than those of PD, FE, and TBI members in each of the four years. Readmission rates increased slightly from 1.32 in CY2012 to 1.66 in CY2015.
- MH members had much lower readmission rates than the HCBS members, but their readmission rates are based on MH-related readmissions only. Readmission rates decreased from 1.06 in CY2012 to 0.94 readmissions per 1,000 member-months in CY2015.

Member Survey – CAHPS
Over 80% of survey respondents who contacted their health plan's customer service reported they received the information or help they needed. The CY2016 Adult rate (83.8%) was above the QC 75th percentile. The GC rate (83.9%) decreased from 85.4% in CY2015 and decreased from being above the QC 75th percentile to being above the 50th percentile. While the CCC rate (82.2%) was similar to the other populations, it decreased from 84.9% in CY2015 and decreased to below the QC 33.33rd percentile.

Member Survey – MH
For adult members, 79.6% in CY2016 indicated their MH provider returned their calls within 24 hours. This is lower than rates in CY2013 – CY2015 that ranged from 83.3% to 84.4%. The CY2016 rate is statistically significantly lower than CY2011 (88.1%).

Member Survey SUD
In 2016, 92.1% of members surveyed rated their counselor as communicating very well or well in communicating clearly with them, comparable to 2015 (93.2%) and 2014 (93.9%).

Uncompensated Care Cost Pool (UCC)
There were 194,999 Medicaid days for UCC Pool hospitals in CY2012. This number increased substantially to 252,002 Medicaid days in CY2013, in part because of the influx of beneficiaries at the start of KanCare. The number of Medicaid days subsequently decreased to 206,882 in CY2014, to 186,396 in CY2015, and to 178,721 in CY2016. UCC Pool payments increased from $20,568,567 in CY2012 to $41,026,795 in CY2013. This increase was partially due to a change in the Kansas Statute implemented at the start of the FY2013. The UCC Pool payments decreased slightly to $40,974,407 in CY2014 and to $40,929,060 in CY2015. The UCC Pool payments then increased slightly in CY2016 to $40,960,116.

Delivery System Reform Incentive Program (DSRIP)
The University of Kansas Hospital

- **STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis**
  In 2016 KUH conducted training in 19 counties statewide. KUH reported 554 workshop attendees in the from 103 partner facilities in 2016, including 20 nursing facilities (NF), 24 EMS providers, and 44 hospitals. Workshop attendance ranged from 15 to 50 per workshop. KUH greatly increased data tracking and reporting in 2016. Of 147 partner facilities, 43 have a sepsis protocol in place, 27 newly implemented in 2016. In CY2016, 33 partner facilities, including three NFs, began entering sepsis-related data in the Kansas Sepsis Program Database. KUH has developed an NF-specific curriculum that includes slides and posters providing information on basic sepsis symptoms. Of

special interest are training materials for licensed practical nurses and nursing assistants in development for distribution in 2017.

- **Supporting Personal Accountability and resiliency for Chronic Conditions (SPARCC)**
  KUH has provided SPARCC facilitation training to over 160 individuals and has over 85 partners statewide. Focus is now on expanding the number of group sessions led by these trained facilitators. In 2016, 46 facilitators trained through the SPARCC program in 2015 and 2016 conducted 24 groups (four sessions per group), with 86 patients and 10 caregivers/supporters participating in one or more session. KUH has, thus, been successful in first training facilitators the first year of DSRIP (2015) who then followed through in successfully implementing the SPARCC program for patients in NE, North Central, and SW Kansas. KUH reported that 86 patients participated in 24 groups in 2016, 43 in groups meeting in the first half of the year and 43 in groups meeting in the second half of the year. The first six-month booster session was also completed in 2016, with 43 heart failure patients and caregivers participating. KUH has also been successful in developing eight training videos for SPARCC facilitators soon to be uploaded to a DSRIP YouTube website.

Children's Mercy Hospital and Clinics

- **Improving Coordinated Care for Medically Complex Patients (Beacon Program)**
  The Beacon program functions as an independent medical home for children and youth with medical complexity (CYMC) and their siblings. Beacon staff began seeing Missouri patients in October 2013 and reported in December 2014 that 63 patients were from Kansas. In 2015 there were 56 Kansas Beacon patients– 38 CYMC and 18 siblings. In 2016, there were 92 Kansas Beacon patients – 65 CYMC and 27 siblings. Another major focus of the Beacon program is to provide consultation to PCPs of children living in rural areas or distant from the Kansas City area. In the first six months of 2016, Beacon staff conducted extensive outreach to 82 providers statewide. They also developed a flyer with responses to frequently asked questions and provided PCPs with information on characteristics of children eligible for the Beacon program. As a result of the outreach, Beacon provided 20 consults, an increase compared to only one Kansas consult in 2015.
- **Expansion of Patient Centered Medical Homes and Neighborhoods**
  CMH is partnering with four selected clinics that serve a high percentage or volume of Kansas Medicaid clients. The participating practices are delivering improved care that meets the Triple Aim. Each practice is embracing the model and has successfully begun implementing the components required for PCMH transformation. One practice has achieved NCQA PCMH recognition and a second practice plans to submit their application in 2017. CMH continues to work with each practice, providing TA and monthly learning collaborative sessions. CMH has implemented an online message board to serve as a forum for the practices to communicate on an ongoing basis. They have also developed an integrated database platform, providing patient data from multiple sources in one database. This was developed in an effort to assist the practices with using health information technology for population health management. CMH is in the process of developing an online searchable community resource database, to be available in 2017.

Recommendations

HEDIS and CAHPS Surveys

- MCOs should pay particular attention to improving results, not only for P4P measures, but also for HEDIS measures that have been identified by CMS as adult, child, and/or behavioral health core measures, particularly where results are below the QC 50th percentile, including:

  - Comprehensive Diabetes Control (CDC)
    - HbA1c Testing
    - Medical Attention for Nephropathy
    - HbA1c Control (<8.0%)
    - HbA1c Poor Control (>9.0%)
    - Blood Pressure Control (<140/90)
  - Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)
  - Well-Child Visits in the First 15 Months of Life (W15)
  - Prenatal and Postpartum Care (PPC)
  - Chlamydia Screening in Women (CHL)
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Weight Assessment/BMI
  - Adult BMI Assessment (ABA)
  - Controlling High Blood Pressure (CBP)
  - Adolescent Well Care Visits
  - Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)
  - Breast Cancer Screening (BCS)
- MCOs should also focus efforts on improving percentages of members engaged in treatment for alcohol or other drug use, as only 10.7% of those age 18 and older and 26.8% of those ages 13-17 identified as being in need of alcohol or drug use treatment were engaged in treatment in CY2015.
- MCOs should encourage providers to talk with patients about specific things to do to prevent illness, including:
  - For those who smoke or use tobacco products, offer medication or other smoking cessation treatment alternatives.
  - Encouraging and/or offering the annual influenza vaccination.
- MCOs should encourage their internal departments (customer service and case management) and network providers to offer members assistance with coordination of care, particularly for members obtaining services/care through more than one provider.

Mental Health Survey

- Related to questions with statistically significant negative trends (2011 to 2016 and 2013 to 2016), monitoring is recommended to ensure they do not continue to decline over time.
- MCOs should explore barriers and work with providers on improving the following:
  - Adult member choice of treatment goals
  - Adult members being better able to do the things they want to do and having better control of their daily life
  - Adult members being able to deal with crisis
  - Adult and General Youth perception of access to services
  - Adults' rate of providers returning member calls within 24 hours.

SUD Survey

- MCOs should encourage SUD providers to help members who don't know if they have a PCP to identify that provider or to assist them in obtaining a PCP.
- The State should work with the MCOs to assess and address reasons for reported increases in members placed on wait lists and reported increases in wait times while on the wait lists.

Mental Health Services

- The annual quarterly average of homeless members with SPMI who were housed at the end of each quarter had decreased from 58.0% in CY2013 to 49.1% in CY2014 to 44.6% in CY2015. No data were available for CY2016. If the State is no longer tracking this measure as a NOMS quarterly measure, an alternative tracking and reporting should be considered to monitor annual, if not quarterly, progress.

Provider Survey

- UnitedHealthcare should make efforts to greatly increase the number of general provider survey respondents.

Care Coordination

- Efforts should continue to improve care coordination, particularly for children with chronic conditions, including communication of PCPs with other healthcare providers; assistance from the MCO in coordinating care; and assistance in acquiring prescriptions.
- MCOs should continue to work to improve the percentage of HCBS waiver members receiving annual dental visits.

Access to Care

Provider Access

- KFMC recommends reporting requirements be revised to require MCOs to report the specific counties where there are no providers contracted for specific services and specific counties where only one provider is contracted for specific services.
- KFMC recommends that the State follow up with the MCOs to clarify the availability of the TBI-related HCBS service providers.
- For those counties with no providers, it would be important to know the number of members needing these services that reside in that county and their average distance to a provider. It is possible members needing these services are able to obtain them in a nearby county (or through arrangement by the MCO in a neighboring state). It is also possible, particularly in low-population Frontier counties, for there to be no members in need of a particular service.
- Due to differences in availability of provider types by MCO, members enrolling or re-enrolling should be provided information on the number of providers and locations available by provider type in each MCO network (without need for additional approval processes), particularly if they reside in a Frontier or Rural County.
- The State should consider requiring MCOs to report for each provider/service type the specific counties that do not have access to at least one or two HCBS and IDD providers.
- KFMC recommends the State request a more consistent method of MCO tracking and reporting after hours and appointment access (by appointment type). KFMC recommends that all MCOs confirm provider after-hour access through after-hours phone calls to the providers.
- MCOs should report compliance rates and appointment availability for calls to provider offices from "secret shoppers" separately from callers who first identify that they are representatives of an MCO.
- MCOS are encouraged to continue to include access to care supplemental questions in the CAHPS survey to help identify member experience in accessing appointments.
- When reporting outcomes related to member access to after-hours phone contact to providers, the MCOS should include in the denominator all out-of-service or wrong numbers, and offices that did not answer the phone or have an answering service alternative. MCOs should follow up after office

hours to verify appropriate after-hours access, at a minimum for the providers that refused to complete the survey or did not answer the phone.

- In addition to the need to de-duplicate, MCOs should make efforts to update the Network Adequacy reports, review how providers are classified, expand reporting to include a more detailed level of reporting, and ensure provider panel status is reported for all applicable providers.

Systems

- Emergency Department (ED) Visits – Additional efforts are needed to reduce ED visit rates for members with MH diagnoses, such as ensuring members have a PCP and care coordination.

End of written report.

Appendix A

2016 KanCare Evaluation Annual Report

Year 4, January – December 2016

List of Related Acronyms

Kansas Foundation for Medical Care, Inc.

List of Related Acronyms	
Acronym	**Description**
AAP	Adults' Access to Preventive/Ambulatory Health Services (HEDIS)
ABA	Adult BMI Assessment (HEDIS)
ACO	Accountable Care Organization
ADD	Follow-Up Care for Children Prescribed ADHD Medication (HEDIS)
ADHD	Attention Deficit Hyperactivity Disorder
ADV	Annual Dental Visit (HEDIS)
AGP	Amerigroup Kansas, Inc.
Amerigroup	Amerigroup Kansas, Inc.
AWC	Adolescent Well-Care Visits (HEDIS)
BCBSKS	Blue Cross/Blue Shield of Kansas
BH	Behavioral Health
BMI	Body Mass Index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBCL	Child Behavior Checklist Competence T-Scores
CBP	Controlling High Blood Pressure (HEDIS)
CBS	Community-Based Services
CCC	Children with Chronic Conditions (CAHPS survey population)
CDC	Comprehensive Diabetes Care (HEDIS)
CHIP	Children's Health Insurance Program (Title XXI)
CHL	Chlamydia Screening in Women (HEDIS)
CMH	Children's Mercy Hospital and Clinics
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CWP	Appropriate Testing for Children with Pharyngitis (HEDIS)
CY	Calendar Year
CYMC	Children and Youth with Medical Complexity
DSRIP	Delivery System Reform Incentive Program
ED	Emergency Department
EH	Eligible Hospital
EHR	Electronic Health Record
EMR	Electronic Medical Record
EMS	Emergency Medical Services
EP	Eligible Professional
EQRO	External Quality Review Organization

List of Related Acronyms	
Acronym	**Description**
FE	Frail Elderly Waiver
FUH	Follow-Up after Hospitalization for Mental Illness (HEDIS)
GC	General Child - CAHPS Survey Population
HbA1c	Glycated Hemoglobin
HCBS	Home and Community-Based Services
HCCN	Health Center Controlled Network
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIO	Health Information Organization
HITECH	Health Information Technology for Economic and Clinical Health Act
ICF/MR	Intermediate Care Facility for Persons with Mental Retardation
I/DD	Intellectually/Developmentally Disabled
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (HEDIS)
KCPC	Kansas Client Placement Criteria
KDADS	Kansas Department for Aging and Disability Services
KDHE-DHCF	Kansas Department of Health and Environment, Division of Healthcare Finance
KFMC	Kansas Foundation for Medical Care, Inc. (the EQRO)
KHC	Kansas Healthcare Collaborative
KHIN	Kansas Health Information Network
KUCTT	University of Kansas Center for Telemedicine & Telehealth
KUH	The University of Kansas Hospital
LACIE	Lewis and Clark Information Exchange
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MFP	Money Follows the Person
MH	Mental Health
MHSIP	Mental Health Statistics Improvement Program
MMA	Medication Management for People with Asthma (HEDIS)
MPM	Annual Monitoring for Patients on Persistent Medications (HEDIS)
MU	Meaningful Use
NCQA	National Committee for Quality Assurance
NF	Nursing Facility
NOMS	National Outcome Measurement System

List of Related Acronyms	
Acronym	**Description**
P4P	Pay for Performance
PCMH	Patient Centered Medical Homes
PCP	Primary Care Provider
PD	Physically Disabled
PEAK	Promoting Excellent Alternatives in Kansas (Person-Centered Care Homes)
PHR	Personal Health Record
PLE	Poverty Level Eligible
PMPM	Per member per month
PPC	Prenatal and Postpartum Care (HEDIS)
PTN	Patient Transformation Network
Q	Quarter
QBRP	Quality-Based Reimbursement Program
QC	Quality Compass
RCIN	Rural Clinically Integrated Network
SED	Serious Emotional Disturbance
SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia (HEDIS)
SMI	Serious Mental Illness
SPARCC	Supporting Personal Accountability and Resiliency for Chronic Conditions
SPMI	Serious and Persistent Mental Illness
SSHP	Sunflower State Health Plan of Kansas
SSI	Supplemental Security Income
STOP Sepsis	Standard Techniques, Operations, and Procedures Sepsis Awareness Program
SUD	Substance Use Disorder
Sunflower	Sunflower State Health Plan of Kansas
TA	Technical Assistance
TAF	Temporary Assistance for Families
TBI	Traumatic Brain Injury
Title XIX	Medicaid
Title XXI	CHIP, Children's Health Insurance Program
UCC	Uncompensated Care Cost Pool
UHC	UnitedHealthcare Community Plan of Kansas
UnitedHealthcare	UnitedHealthcare Community Plan of Kansas
URI	Appropriate Treatment for Children with Upper Respiratory Infection (HEDIS)
VO	Value Options-Kansas

List of Related Acronyms	
Acronym	**Description**
W15	Well-Child Visits in First 15 Months of Life (HEDIS)
W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (HEDIS)
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (HEDIS)
WebIZ	Kansas Statewide Immunization Information System
WORK	Work Opportunities Reward Kansas program

Appendix H. Kansas State Register Public Notice (Abbreviated Public Notice)

[See following page.]

Kansas Register

Kris W. Kobach, Secretary of State

Vol. 36, No. 43 **October 26, 2017** **Pages 1187-1214**

In this issue … Page

http://admin.ks.gov/offices/procurement-and-contracts/bid-solicitations

Additional files may be located at the following website (please monitor this website on a regular basis for any changes/addenda):

http://admin.ks.gov/offices/procurement-and-contracts/additional-files-for-bid-solicitations

There Are No Bids Under this Website Closing in this Week's Ad

Information regarding prequalification, projects and bid documents can be obtained at 785-296-8899 or http://admin.ks.gov/offices/ofpm/dcc.

Tracy T. Diel, Director
Procurement and Contracts

Doc. No. 045810

State of Kansas

Department of Health and Environment Division of Health Care Finance

Request for Comments

The Kansas Department of Health and Environment (KDHE) is offering additional opportunities to attend public hearings regarding the State's renewal of the KanCare program, and to provide comments about the renewal request application.

KanCare – Summary of Program and Renewal Information

KanCare is the program through which the State of Kansas administers Medicaid and the Children's Health Insurance Program, CHIP. The State determined that contracting with multiple managed care organizations (MCOs) would result in more efficient and effective health care services to the populations covered by Medicaid and CHIP.

On August 6, 2012, the State of Kansas submitted a Medicaid Section 1115 demonstration proposal, KanCare, to CMS. CMS approved that proposal on December 27, 2012, effective from January 1, 2013, through December 31, 2017. Subsequently, CMS approved a one-year extension of the current demonstration on October 13, 2017 to extend the end the current demonstration to December 31, 2018. The State is preparing to submit an application to renew the KanCare program for five years, effective January 1, 2019, through December 31, 2023.

The KanCare demonstration is operating concurrently with the State's seven1915(c) HCBS waivers, which together provide the authority necessary to require almost all Medicaid beneficiaries to enroll in a managed care delivery system. KanCare includes a Safety Net Care Pool to support certain hospitals that incur uncompensated care costs for Medicaid beneficiaries and the uninsured. This Pool also provides incentives to hospitals for programs that result in delivery system reforms that enhance access to health care and improve the quality of care.

Building on the success of the current KanCare program, KanCare 2.0 will continue to:

- Maintain Medicaid state plan eligibility;
- Maintain state plan benefits; and
- Allow the State to require eligible beneficiaries to enroll in MCOs to receive covered benefits through the MCOs, except for American Indian/Alaska Natives, who have the option of opting out of managed care.

The goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by providing services and supports for social determinants of health and independence in addition to traditional Medicaid benefits. Although the basic structure of the KanCare program will remain the same, KanCare 2.0 will include select program improvements such as enhanced service coordination, employment support initiatives, and other improvements to streamline administrative processes.

The State of Kansas does not anticipate any changes to covered benefits and cost sharing requirements, or annual aggregate expenditures as part of the renewal application. However, the State is requesting the following:

- *Waiver expenditure authorities:* While all current waiver and expenditure authorities will remain the same, the State will request a new expenditure authority for Institutions for Mental Disease.
- *Populations:* All current populations will remain in KanCare 2.0. The State is considering the addition of certain MediKan enrollees who voluntarily discontinue pursuit of a disability determination in exchange for Medicaid benefits with employment support.
- *Enrollment Process:* The State is considering work requirements for able-bodied adults. However, the following KanCare members will **not** be subject to work requirements:
  - Members receiving long-term care, including institutional care and Money Follows the Person, or enrolled in the following Home- and Community-Based Services (HCBS) waiver programs: Autism, Serious Emotional Disturbance (SED), Technology Assisted (TA), Frail Elderly (FE), Traumatic Brain Injury (TBI), Intellectual and Developmental, Disabilities (I/DD), and Physical Disability (PD);
  - Children;
  - Women who are pregnant;
  - Members who have disabilities and are receiving SSI;
  - Caretakers for dependent children under six years or those caring for a household member who has a disability;
  - Medicaid beneficiaries who have an eligibility period that is only retroactive;
  - Members enrolled in the MediKan program;
  - Members presumptively eligible for Medicaid;
  - Persons whose only coverage is under a Medicare Savings Program;
  - Persons enrolled in Program of All-inclusive Care for the Elderly (PACE); and
  - Members with TBI, human immunodeficiency virus (HIV), or in the Breast and Cervical Cancer Program.

KanCare 2.0 will evaluate:

1. Expanding service coordination to include assisting members with accessing affordable housing,

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food security, employment and other social determinants of health and independence will increase independence, stability and resilience and improve health outcomes;
2. Increasing employment and independent living supports for members with behavioral health needs, or who have intellectual, developmental or physical disabilities or traumatic brain injuries will increase independence and improve health outcomes; and
3. Providing service coordination for all youth in foster care will decrease the number of placements, reduce psychotropic medication use, and improve health outcomes for these youths.

The State will maintain current information about the KanCare renewal process throughout the public comment and review process, during which CMS is reviewing and acting upon the State's renewal request. This information will be available at the KanCare Renewal page of the KanCare website: http://www.kancare.ks.gov/about-kancare/kancare-renewal. The request to renew the KanCare program will be posted by CMS on its website for viewing and commenting: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html.

Public Comment – Timing and Process

The public comment period will run from October 27, 2017 until November 26, 2017. Comments will be accepted until November 26, 2017 The State will submit the renewal request no later than December 31, 2017.

The KanCare renewal request, including the renewal application and documented comments from public comment meetings held in June 2017, is available for public review at the KanCare website: http://www.kancare.ks.gov/about-kancare/kancare-renewal. A copy of the renewal application will also be located at the reception desks for:

KDHE-Division of Health Care Finance
900 SW Jackson, LSOB – 9th Floor
Topeka, KS 66612

Kansas Department for Aging and Disability Services
New England Building, 503 S. Kansas Ave.
Topeka, KS 66603

Written comments about the KanCare renewal request may be sent to: kdhe.kancarerenewal@ks.gov; or mailed to:

KanCare Renewal
c/o Becky Ross
KDHE-Division of Health Care Finance
900 SW Jackson, LSOB – 9th Floor
Topeka, KS 66612

Public Hearings – When and Where

The same information and opportunity for feedback will be shared at each session.

Tuesday, November 14, 2017
Providers: 2:00 p.m. to 4:00 p.m.
Members: 6:00 p.m. to 8:00 p.m.

Pittsburg State University Overman Student Center, Ballroom A 1701 S. Broadway St. Pittsburg, KS, 66762	Dodge House Hotel & Convention Center 2408 W. Wyatt Earp Blvd. Dodge City, KS, 67801

Wednesday, November 15, 2017
Providers: 2:00 p.m. to 4:00 p.m.
Members: 6:00 p.m. to 8:00 p.m.

Kansas State University Olathe Great Plains A & B 22201 W. Innovation Drive Olathe, KS, 66061	Perkins Restaurant & Bakery Meeting Room 2920 10th St. Great Bend, KS, 67530

Thursday, November 16, 2017
Providers: 2:00 p.m. to 4:00 p.m.
Members: 6:00 p.m. to 8:00 p.m.

Ramada Topeka Downtown Jefferson Hall 420 SE 6th St. Topeka, KS, 66607	Wichita Marriott Corporate Hills Ballroom 9100 Corporate Hills Drive Wichita, KS, 67207

Monday, November 20, 2017
Conference Call Option

Providers: 12:00 p.m. to 1:30 p.m. **Please call: Toll Free:** 1-833-791-5968 **and Enter Code:** 871 777 85
Members: 6:00 p.m. to 7:30 p.m. **Please call: Toll Free:** 1-833-791-5968 **and Enter Code:** 871 807 85

(continued)

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All meeting rooms are Americans with Disabilities Act (ADA) accessible.

Language Accommodations

If you need language accommodations, such as sign language interpreter or large print or Braille, please contact Dawn Goertzen at 785-291-3461 or dawn.goertzen@ks.gov. Please make your request by October 27, 2017.

Si desea esta información en Español, por favor llame al 1-800-766-9012.

Michael Randol, Director
Division of Health Care Finance

Doc. No. 045809

State of Kansas

Kansas Development Finance Authority

Notice of Hearing

A public hearing will be conducted at 9:00 a.m. Thursday, November 9, 2017, in the offices of the Kansas Development Finance Authority (KDFA), 534 S. Kansas Ave., Suite 800, Topeka, Kansas, on the proposal for the KDFA to issue its Agricultural Development Revenue Bonds for the projects numbered below in the respective maximum principal amounts. The bonds will be issued to assist the borrowers named below (who will be the owners and operators of the projects) to finance the cost in the amount of the bonds, which are then typically purchased by a lender bank who then, through the KDFA, loans the bond proceeds to the borrower for the purposes of acquiring the project. The projects shall be located as shown:

Project No. 000988 Maximum Principal Amount: $280,710.66. Owner/Operator: Wilfred J Hund; Description: Acquisition of 193.07 acres of agricultural land and related improvements and equipment to be used by the owner/operator for farming purposes (the "Project"). The Project is being financed by the lender for Wilfred J Hund (the "Beginning Farmer") and is located at Tract #1: Southwest Quarter of Section 34, Township 10, Range 2, and Tract #2: Southeast Quarter of the Southeast Quarter of Section 34, Township 10, Range 12, both in Wabaunsee County, Kansas and both located on Turkey Creek Road, Maple Hill, Kansas.

Project No. 000989 Maximum Principal Amount: $188,400.00. Owner/Operator: Levi and Veronica Winkler; Description: Acquisition of 160 acres of agricultural land and related improvements and equipment to be used by the owner/operator for farming purposes (the "Project"). The Project is being financed by the lender for Levi and Veronica Winkler (the "Beginning Farmer") and is located at the Southwest Quarter of Section 25, Township 6 South, Range 13 East, Jackson County Kansas, approximately 6.5 miles southeast of Soldier, Kansas.

The bonds, when issued, will be a limited obligation of the KDFA and will not constitute a general obligation or indebtedness of the state of Kansas or any political subdivision thereof, including the KDFA, nor will they be an indebtedness for which the faith and credit and taxing powers of the state of Kansas are pledged. The bonds will be payable solely from amounts received from the respective borrower, the obligation of which will be sufficient to pay the principal of, interest and redemption premium, if any, on the bonds when they become due.

All individuals who appear at the hearing will be given an opportunity to express their views concerning the proposal to issue the bonds to finance the projects, and all written comments previously filed with the KDFA at its offices at 534 S. Kansas Ave., Suite 800, Topeka, KS 66603, will be considered. Additional information regarding the projects may be obtained by contacting the KDFA.

Tim Shallenburger
President

Doc. No. 045800

(Published in the Kansas Register October 26, 2017.)

City of Ellinwood, Kansas

Summary Notice of Bond Sale
$1,250,000*
General Obligation Bonds
Series 2017

Details of the Sale

Subject to the terms and requirements of the Official Notice of Bond Sale, dated October 10, 2017, of the City of Ellinwood, Kansas (the "City"), bids to purchase the City's General Obligation Bonds, Series 2017, (the "Bonds") will be received at the office of the City Clerk at City Hall, 104 E. 2nd, Ellinwood, KS, 67526 or by telefacsimile at 620-564-3375 or electronically as described in the Official Notice of Bond Sale until 11:00 a.m. (CDT) Tuesday, November 14, 2017. The bids will be considered by the governing body at its meeting at 7:00 p.m. (CDT) on the sale date.

No oral or auction bids for the Bonds shall be considered, and no bids for less than 100 percent of the total principal amount of the Bonds and accrued interest to the date of delivery shall be considered.

Good Faith Deposit

Bidders must submit a good faith deposit in the form of a wire transfer or certified or cashier's check made payable to the order of the City, or a financial surety bond (if then available), in an amount equal to 2% of the principal amount of the Bonds.

Details Of The Bonds

The Bonds will be dated November 30, 2017 and will be issued as registered bonds in denominations of $5,000, or any integral multiple thereof. Interest on the Bonds is payable semiannually on March 1 and September 1 of each year, beginning March 1, 2019. Principal of the Bonds becomes due on September 1 in the years and amounts as shown below:

Maturity Schedule

Principal Amount*	Maturity Date	Principal Amount*	Maturity Date
$30,000	2019	$100,000	2026
85,000	2020	105,000	2027
90,000	2021	110,000	2028
95,000	2022	110,000	2029
95,000	2023	115,000	2030

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Kansas Register
Secretary of State
1st Floor, Memorial Hall
120 SW 10th Ave.
Topeka, KS 66612-1594

Appendix I. Tribal Notice for KanCare Renewal

[See following page.]

From:	Bobbie L. Graff-Hendrixson [KDHE]
To:	trhodd@iowas.org; tony.fee@iowas.org; LJR3131@hotmail.com; BWhitewater@yahoo.com; Zachariah.Pahmahmie@ihs.gov; Jolene.walters@ihs.gov; paul.austin@ihs.gov; liana@pbpnation.org; landrijames@pbpnation.org; JayMooney@pbpnation.org; VSimon@pbpnation.org; VOlsen@pbpnation.org; kburnison@sacandfoxcasino.com; JJensen@sacandfoxcasino.com; vramos@sacandfoxcasino.com; egreen@sacandfoxcasino.com; tcarnes@sacandfoxcasino.com; JamesJensen@sacandfoxcasino.com; rbahr@sacandfoxcasino.com; vramos@sacandfoxcasino.com; cdavis@sacandfoxcasino.com; rgass@hunterhealthclinic.org; amy.feimer@hunterhealthclinic.org; GPierce@hunterhealthclinic.org; kelly.battese@ihs.gov; kelly.battese@ihs.gov; kyle.bakker@ihs.gov; Chelsea.Anglin@ihs.gov; Ben.Cloud@ihs.gov; Kevin.Meeks@ihs.gov; Max.Tahsuda@ihs.gov; Pamela.Strope@ihs.gov; Joe.Bryant@ihs.gov; tprather@spthb.org; csnider@spthb.org; Karen.Hatcher@cms.hhs.gov; Cynthia.gillaspie@cms.hhs.gov; Michael Randol [KDHE]; Chris Swartz [KDHE]; Jon Hamdorf [KDHE]; Kurt J. Weiter [KDHE]; Bobbie L. Graff-Hendrixson [KDHE]; Buck, Megan K. (CMS/CMCHO); Walker, Michala M. (CMS/CMCHO)
Cc:	Becky Ross [KDHE]; Roshni Arora; Hanford Lin; Anne Jacobs
Subject:	RE: Tribal Notice - KanCare Renewal
Date:	Thursday, October 26, 2017 9:55:35 AM

EXTERNAL EMAIL: Do not open attachments/click links if source is unknown.

Notice to Tribal Governments, Indian Health Programs and Urban Indian Organizations KanCare Renewal – Revised Notice

Public Notice and Comment Period – KanCare Renewal

The Kansas Department of Health and Environment (KDHE) is offering additional opportunities to attend public hearings regarding the State's renewal of the KanCare program, and to provide comments about the renewal request application.

KanCare – Summary of Program and Renewal Information

KanCare is the program through which the State of Kansas administers Medicaid and the Children's Health Insurance Program, CHIP. The State determined that contracting with multiple managed care organizations (MCOs) would result in more efficient and effective health care services to the populations covered by Medicaid and CHIP.

On August 6, 2012, the State of Kansas submitted a Medicaid Section 1115 demonstration proposal, KanCare, to CMS. CMS approved that proposal on December 27, 2012, effective from January 1, 2013, through December 31, 2017. Subsequently, CMS approved a one-year extension of the current demonstration on October 13, 2017 to extend the end the current demonstration to December 31, 2018. The State is preparing to submit an application to renew the KanCare program for five years, effective January 1, 2019, through December 31, 2023.

The KanCare demonstration is operating concurrently with the State's seven1915(c) HCBS waivers, which together provide the authority necessary to require almost all Medicaid beneficiaries to enroll in a managed care delivery system. KanCare includes a Safety Net Care Pool to support certain hospitals that incur uncompensated care costs for Medicaid beneficiaries and the uninsured. This Pool also provides incentives to hospitals for programs that result in delivery system reforms that enhance access to health care and improve the quality of care.

Building on the success of the current KanCare program, KanCare 2.0 will continue to:

- Maintain Medicaid state plan eligibility;
- Maintain state plan benefits; and
- Allow the State to require eligible beneficiaries to enroll in MCOs to receive covered benefits through the MCOs, except for American Indian/Alaska Natives, who have the option of opting out of managed care.

The goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by

providing services and supports for social determinants of health and independence in addition to traditional Medicaid benefits. Although the basic structure of the KanCare program will remain the same, KanCare 2.0 will include select program improvements such as enhanced service coordination, employment support initiatives, and other improvements to streamline administrative processes.

The State of Kansas does not anticipate any changes to covered benefits and cost sharing requirements, or annual aggregate expenditures as part of the renewal application. However, the State is requesting the following:

- *Waiver expenditure authorities:* While all current waiver and expenditure authorities will remain the same, the State will request a new expenditure authority for Institutions for Mental Disease.

- *Populations:* All current populations will remain in KanCare 2.0. The State is considering the addition of certain MediKan enrollees who voluntarily discontinue pursuit of a disability determination in exchange for Medicaid benefits with employment support.

- *Enrollment Process:* The State is considering work requirements for able-bodied adults. However, the following KanCare members will **not** be subject to work requirements:

    - Members receiving long-term care, including institutional care and Money Follows the Person, or enrolled in the following Home- and Community-Based Services (HCBS) waiver programs: Autism, Serious Emotional Disturbance (SED), Technology Assisted (TA), Frail Elderly (FE), Traumatic Brain Injury (TBI), Intellectual and Developmental, Disabilities (I/DD), and Physical Disability (PD);

    - Children;

    - Women who are pregnant;

    - Members who have disabilities and are receiving SSI;

    - Caretakers for dependent children under six years or those caring for a household member who has a disability;

    - Medicaid beneficiaries who have an eligibility period that is only retroactive;

    - Members enrolled in the MediKan program;

    - Members presumptively eligible for Medicaid;

    - Persons whose only coverage is under a Medicare Savings Program;

    - Persons enrolled in Program of All-inclusive Care for the Elderly (PACE); and

    - Members with TBI, human immunodeficiency virus (HIV), or in the Breast and Cervical Cancer Program.

KanCare 2.0 will evaluate:

1. Expanding service coordination to include assisting members with accessing affordable housing, food security, employment and other social determinants of health and independence will increase independence, stability and resilience and improve health outcomes;

2. Increasing employment and independent living supports for members with behavioral health needs, or who have intellectual, developmental or physical disabilities or traumatic brain injuries will increase independence and improve health outcomes; and

3. Providing service coordination for all youth in foster care will decrease the number of placements, reduce psychotropic medication use, and improve health outcomes for these youths.

The State will maintain current information about the KanCare renewal process throughout the public comment and review process, during which CMS is reviewing and acting upon the State's renewal request. This information will be available at the KanCare Renewal page of the KanCare website: http://www.kancare.ks.gov/about-kancare/kancare-renewal. The request to renew the KanCare program will be posted by CMS on its website for viewing and commenting: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html.

Public Comment – Timing and Process

The public comment period will run from October 27, 2017 until November 26, 2017. Comments will be accepted until November 26, 2017 The State will submit the renewal request no later than December 31, 2017.

The KanCare renewal request, including the renewal application and documented comments from public comment meetings held in June 2017, is available for public review at the KanCare website: http://www.kancare.ks.gov/about-kancare/kancare-renewal. A copy of the renewal application will also be located at the reception desks for:

KDHE-Division of Health Care Finance
900 SW Jackson, LSOB – 9th Floor
Topeka, Kansas 66612

Kansas Department for Aging and Disability Services
New England Building, 503 S. Kansas Ave.
Topeka, Kansas 66603

Written comments about the KanCare renewal request may be sent to: kdhe.kancarerenewal@ks.gov; or mailed to:

KanCare Renewal
c/o Becky Ross
KDHE-Division of Health Care Finance
900 SW Jackson, LSOB – 9th Floor
Topeka, Kansas 66612

Public Hearings – When and Where

The same information and opportunity for feedback will be shared at each session.	
Tuesday, November 14, 2017 **Providers:** 2:00pm to 4:00pm **Members:** 6:00pm to 8:00pm	
Pittsburg, KS, 66762 Pittsburg State University Overman Student Center, Ballroom A	**Dodge City, KS, 67801** Dodge House Hotel & Convention Center 2408 West Wyatt Earp Blvd.

1701 S Broadway St	
Wednesday, November 15, 2017 **Providers:** 2:00pm to 4:00pm **Members:** 6:00pm to 8:00pm	
Olathe, KS, 66061 Kansas State University Olathe Great Plains A & B 22201 W. Innovation Drive	**Great Bend, KS, 67530** Perkins Restaurant & Bakery Meeting Room 2920 10th Street
Thursday, November 16, 2017 **Providers:** 2:00pm to 4:00pm **Members:** 6:00pm to 8:00pm	
Topeka, KS, 66607 Ramada Topeka Downtown Jefferson Hall 420 SE 6th St.	**Wichita, KS, 67207** Wichita Marriott Corporate Hills Ballroom 9100 Corporate Hills Drive
Monday, November 20, 2017 **Conference Call Option** **Providers:** 12:00pm to 1:30pm. **Please call: Toll Free:** 1-833-791-5968 **and Enter Code:** 871 777 85 **Members:** 6:00pm to 7:30pm. **Please call: Toll Free:** 1-833-791-5968 **and Enter Code:** 871 807 85	

All meeting rooms are Americans with Disabilities Act (ADA) accessible.

Language Accommodations

If you need language accommodations, such as sign language interpreter or large print or Braille, please contact Dawn Goertzen at 785-291-3461 or dawn.goertzen@ks.gov. Please make your request by October 27, 2017.

Si desea esta información en Español, por favor llame al 1-800-766-9012.

Tribal members are reminded an in person consultation may be requested.

Thank you,
Bobbie Graff-Hendrixson

Bobbie Graff-Hendrixson
Senior Manager, Contracts and Fiscal Agent Operations
900 SW Jackson Avenue, Suite 900 N
Topeka, KS 66612

Bobbie.Graff-Hendrixson@ks.gov
(785) 296-0149

Appendix J. KanCare 2.0 Waiver Renewal Application Full Public Notice

[See following page.]

KanCare 2.0 Waiver Renewal Application – Full Public Notice

Public Notice and Comment Period – KanCare Renewal

The Kansas Department of Health and Environment (KDHE) will submit to the Centers for Medicare and Medicaid Services (CMS) a request to renew the KanCare demonstration under Section 1115(a) of the Social Security Act for five years, effective from January 1, 2019 through December 31, 2023.

KanCare – Summary of Program and Renewal Information

KanCare is the program through which the State of Kansas administers Medicaid and the Children's Health Insurance Program (CHIP). The State determined that contracting with multiple managed care organizations (MCOs) would result in more efficient and effective health care services to the populations covered by Medicaid and CHIP.

On August 6, 2012, the State of Kansas submitted a Medicaid Section 1115 demonstration proposal, entitled KanCare, to CMS. CMS approved that proposal on December 27, 2012, effective from January 1, 2013 through December 31, 2017. Subsequently, CMS approved a one-year extension of the current demonstration on October 13, 2017 to extend the end the current demonstration to December 31, 2018. The State is now preparing to submit an application to renew the KanCare program for five years, effective from January 1, 2019, through December 31, 2023.

The KanCare demonstration is operating concurrently with the State's section seven 1915(c) home and community-based (HCBS) waivers, which together provide the authority necessary for the State to require enrollment of almost all Medicaid beneficiaries across the State into a managed care delivery system to receive State Plan and waiver services. KanCare also includes a Safety Net Care Pool (also referred to as an Uncompensated Care Pool) to support certain hospitals that incur uncompensated care costs for Medicaid-eligible individuals and the uninsured and to provide incentives to hospitals for programs that result in delivery system reforms that enhance access to health care and improve the quality of care.

Building on the success of the current KanCare program, the demonstration renewal, titled KanCare 2.0, will continue to:

- Maintain Medicaid state plan eligibility;
- Maintain State Plan benefits;
- Allow the State to require eligible individuals to enroll in MCOs to receive covered benefits through such MCOs, including individuals on HCBS waivers, except American Indian/Alaska Natives, who are presumptively enrolled in KanCare but who have the option of affirmatively opting out of managed care; and
- Provide benefits, including long-term services and supports (LTSS) and HCBS, via managed care.

The goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by providing services and supports for social determinants of health and independence in addition to traditional

Medicaid benefits. Although the basic structure of the KanCare program will remain the same, KanCare 2.0 will include select program improvements such as enhanced service coordination, employment support initiatives, and other improvements to streamline administrative processes.

KanCare 2.0 is designed to advance the health and independence of Kansans. The vision for KanCare 2.0 focuses on the following four themes:

1. Coordinate services to strengthen social determinants of health and independence and person centered planning,
2. Promote the highest level of member independence,
3. Drive performance and quality improvement for better care, and
4. Improve effectiveness and efficiency of the State Medicaid program.

Eligibility

KanCare currently enrolls almost all Kansas Medicaid beneficiaries. See the current 1115 demonstration Special Terms and Conditions for the full list of groups included in KanCare at the following link: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/ks-kancare-ca.pdf (pages 12-19). Although most of the populations within the renewal will remain the same, the State is considering the addition of certain MediKan enrollees who voluntarily discontinue pursuit of a disability determination in exchange for Medicaid benefits with employment support.

The State is considering work requirements for ONLY some able-bodied adults.

The following KanCare members will **NOT** be subject to work requirements:

- Members receiving long-term care, including institutional care and Money Follows the Person, or enrolled in the following home and community-based services (HCBS) waiver programs: Autism, Serious Emotional Disturbance (SED), Technology Assisted (TA), Frail Elderly (FE), Traumatic Brain Injury (TBI), Intellectual and Developmental Disabilities (I/DD), and Physical Disability (PD);
- Children;
- Women who are pregnant;
- Members who have disabilities and are receiving Supplemental Security Income (SSI);
- Caretakers for dependent children under six years or those caring for a household member who has a disability;
- Medicaid beneficiaries who have an eligibility period that is only retroactive;
- Members enrolled in the MediKan program;
- Members presumptively eligible for Medicaid;
- Persons whose only coverage is under a Medicare Savings Program;

For more information visit: http://www.kancare.ks.gov/about-kancare/kancare-renewal

- Persons enrolled in Programs of All-inclusive Care for the Elderly (PACE); and
- Members with TBI, human immunodeficiency virus (HIV), or in the Breast and Cervical Cancer Program.

Covered Benefits

The KanCare program integrates medical, behavioral, and long-term care health delivery systems and covers mandatory and optional services under the approved Medicaid State Plan. Kansas is not requesting any changes in covered benefits for this renewal.

Cost Sharing Requirements

There are no co-payments under the KanCare MCOs. Kansas is not requesting any changes in cost sharing for this renewal.

Annual Enrollment and Aggregated Expenditures

Kansas does not anticipate a significant change in enrollment or aggregated expenditure trends for the demonstration period. The following table summarizes the projected annual enrollment and aggregated expenditures for KanCare, by demonstration year (DY).

	DY7	DY8	DY9	DY10	DY11
Total Member Months	4,469,538	4,558,290	4,649,371	4,742,845	4,838,778
Total Expenditures	$3,590,507,082	$3,698,071,133	$3,809,552,766	$3,925,063,252	$4,044,791,275

Waiver and Expenditure Authorities

Kansas is requesting the same waiver and expenditure authorities as approved in the current demonstration, described below. However, the State is also requesting a new waiver authority related to the work requirement and a new expenditure authority for Institutions for Mental Disease.

Waiver Authorities

1. Amount, Duration and Scope of Services

   To the extent necessary to enable Kansas to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, by providing additional services to individuals who are enrollees in certain managed care arrangements.

2. Freedom of Choice

   To the extent necessary to enable Kansas to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services. No waiver of freedom of choice is authorized for family planning providers.

3. Eligibility

   State requests new authority to require able-bodied KanCare 2.0 adult members, as a condition of eligibility, to meet work requirements.

Expenditure Authorities

1. Expenditures for Additional Services for Individuals with Behavioral Health or Substance Use Disorder Needs
2. Uncompensated Care Pool
3. Delivery System Reform Incentive Payment Program
4. Expenditures for Institutions for Mental Disease

Hypothesis and Evaluation Parameters

The KanCare 2.0 evaluation design will test the following hypotheses:

1. Expanding service coordination to include assisting members with accessing affordable housing, food security, employment and other social determinants of health and independence will increase independence, stability and resilience, and improve health outcomes;
2. Increasing employment and independent living supports for members with behavioral health needs, or who have intellectual, developmental or physical disabilities or traumatic brain injuries will increase independence and improve health outcomes; and
3. Providing service coordination for all youth in foster care will decrease the number of placements, reduce psychotropic medication use, and improve health outcomes for these youths.

In addition, Kansas will monitor quality measures and conduct member and provider surveys to evaluate the program. The State will update its State Quality Strategy to incorporate performance measures and reporting to support KanCare 2.0 initiatives. Service coordinators will use tools to assess initial and ongoing member needs and other systematic efforts to identify the health and social resources required to meet member needs. Kansas expects ongoing improvement within the more mature program, and contractual and program policy content will reflect these expectations.

Public Comment – Timing and Process

The public comment period will run from October 27, 2017 until November 26, 2017. Comments will be accepted until November 26, 2017. The State will submit the renewal request no later than December 31, 2017.

Information about the KanCare renewal request, including the renewal application and documented comments from public comment meetings held in June 2017, is available for public review at the KanCare website: http://www.kancare.ks.gov/about-kancare/kancare-renewal. A copy of the renewal application will also be located at the reception desks for:

KDHE-Division of Health Care Finance
900 SW Jackson, LSOB – 9th Floor
Topeka, Kansas 66612

Kansas Department for Aging and Disability Services
New England Building, 503 S. Kansas Ave.
Topeka, Kansas 66603

Written comments about the KanCare renewal request may be sent to this email address: kdhe.kancarerenewal@ks.gov; or may be mailed to:

KanCare Renewal
c/o Becky Ross
KDHE-Division of Health Care Finance
900 SW Jackson, LSOB – 9th Floor
Topeka, Kansas 66612

The State will maintain and keep current information about the KanCare renewal process and related documents throughout the public comment and review process, during which CMS is reviewing and acting upon the State's renewal request. This information will continue to be available at the KanCare Renewal page of the KanCare website: http://www.kancare.ks.gov/about-kancare/kancare-renewal. In addition, once the request to renew the KanCare program is submitted to CMS, it will be posted by CMS on its website for viewing and commenting: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html.

Public Hearings – When and Where

Additional public hearings about the KanCare renewal will be held as follows:

<table>
<tr><th colspan="2">The same information and opportunity for feedback will be shared at each session.</th></tr>
<tr><td colspan="2">Tuesday, November 14, 2017
Providers: 2:00pm to 4:00pm
Members: 6:00pm to 8:00pm</td></tr>
<tr><td>Pittsburg, KS, 66762
Pittsburg State University
Overman Student Center, Ballroom A
1701 S Broadway St</td><td>Dodge City, KS, 67801
Dodge House Hotel & Convention Center
2408 West Wyatt Earp Blvd.</td></tr>
<tr><td colspan="2">Wednesday, November 15, 2017
Providers: 2:00pm to 4:00pm
Members: 6:00pm to 8:00pm</td></tr>
<tr><td>Olathe, KS, 66061
Kansas State University Olathe
Great Plains A & B
22201 W. Innovation Drive</td><td>Great Bend, KS, 67530
Perkins Restaurant & Bakery
Meeting Room
2920 10th Street</td></tr>
</table>

For more information visit: http://www.kancare.ks.gov/about-kancare/kancare-renewal

Thursday, November 16, 2017
Providers: 2:00pm to 4:00pm
Members: 6:00pm to 8:00pm

Topeka, KS, 66607	**Wichita, KS, 67207**
Ramada Topeka Downtown	Wichita Marriott
Jefferson Hall	Corporate Hills Ballroom
420 SE 6th St.	9100 Corporate Hills Drive

Monday, November 20, 2017
Conference Call Option

Providers: 12:00pm to 1:30pm. **Please call: Toll Free:** 1-833-791-5968 **and Enter Code:** 871 777 85
Members: 6:00pm to 7:30pm. **Please call: Toll Free:** 1-833-791-5968 **and Enter Code:** 871 807 85

All meeting rooms are Americans with Disabilities Act (ADA) accessible.

Language Accommodations

If you need language accommodations, such as sign language interpreter or large print or Braille, please contact Dawn Goertzen at 785-291-3461 or dawn.goertzen@ks.gov. Please make your request by November 3, 2017.

Si desea esta información en español, por favor llame al 1-800-766-9012.

For more information visit: http://www.kancare.ks.gov/about-kancare/kancare-renewal

Appendix K. KanCare 2.0 Public Comment and State Response

[Attached under a separate cover.]

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) DY1 (CY13)	DY2 (CY14)	DY3 (CY15)	DY4 (CY16)	DY5 (CY17)	DY6 (CY18)	DY7 (CY19)	DY8 (CY20)	DY9 (CY21)	DY10 (CY22)	DY11 (CY23)	TOTAL
Medicaid Populations												
ABD/SD Dual	$ 41,597,095	$ 42,394,640	$ 40,021,288	$ 36,028,357	$ 35,383,011	$ 35,346,160	$ 37,906,336	$ 40,651,808	$ 43,596,066	$ 46,752,972	$ 50,138,685	$ 449,816,418
ABD/SD Non Dual	$ 376,943,580	$ 387,751,410	$ 383,310,227	$ 386,578,737	$ 401,422,196	$ 413,154,871	$ 443,616,291	$ 476,322,946	$ 511,442,724	$ 549,148,782	$ 589,634,357	$ 4,919,326,121
Adults	$ 249,176,403	$ 316,587,402	$ 370,330,765	$ 451,514,914	$ 471,612,927	$ 480,194,907	$ 507,910,721	$ 537,225,651	$ 568,236,054	$ 601,033,556	$ 635,723,299	$ 5,189,546,600
Children	$ 556,102,495	$ 608,695,919	$ 626,615,405	$ 702,066,021	$ 676,852,627	$ 701,484,076	$ 755,754,567	$ 814,238,895	$ 877,239,893	$ 945,110,255	$ 1,018,225,596	$ 8,282,385,750
DD Waiver	$ 400,503,057	$ 408,003,082	$ 417,980,395	$ 427,099,792	$ 435,790,134	$ 440,792,406	$ 461,933,728	$ 484,089,565	$ 507,308,154	$ 531,639,940	$ 557,138,654	$ 5,072,278,908
LTC	$ 912,372,685	$ 934,085,762	$ 959,066,684	$ 979,658,579	$ 1,010,873,478	$ 1,047,352,773	$ 1,097,783,322	$ 1,150,643,874	$ 1,206,049,436	$ 1,264,122,512	$ 1,324,990,686	$ 11,886,999,789
MN Dual	$ 21,537,841	$ 23,419,231	$ 24,065,039	$ 24,180,256	$ 25,728,653	$ 26,501,456	$ 28,284,035	$ 30,186,520	$ 32,216,983	$ 34,384,071	$ 36,696,855	$ 307,200,939
MN Non Dual	$ 24,355,559	$ 25,899,340	$ 26,310,167	$ 30,041,566	$ 32,357,345	$ 33,334,257	$ 36,247,982	$ 39,416,364	$ 42,861,680	$ 46,608,054	$ 50,681,913	$ 388,114,227
Waiver	$ 137,185,621	$ 131,701,928	$ 131,302,400	$ 153,510,708	$ 166,904,466	$ 173,042,045	$ 181,231,744	$ 189,809,134	$ 198,792,154	$ 208,200,334	$ 218,053,718	$ 1,889,734,252
DSH Allotment Diverted							$ -	$ -	$ -	$ -	$ -	$ -
Health Insurer Provider Fee (HIPF)	$ -	$ 32,000,000	$ 57,200,000	$ 52,056,083	$ -	$ 65,876,282	$ 67,193,808	$ 68,537,684	$ 69,908,437	$ 71,306,606	$ 72,732,738	$ 556,811,639
Privilege Fee	$ 25,336,083	$ 27,243,288	$ 96,934,122	$ 101,949,311	$ 102,558,174	$ 197,983,116	$ 209,192,003	$ 221,096,772	$ 233,744,265	$ 247,184,689	$ 261,471,864	$ 1,724,693,686
TOTAL	$ 2,745,110,417	$ 2,937,782,003	$ 3,133,136,492	$ 3,344,684,325	$ 3,359,483,011	$ 3,615,062,350	$ 3,827,054,537	$ 4,052,219,213	$ 4,291,395,846	$ 4,545,491,770	$ 4,815,488,366	$ 40,666,908,329

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) DY1 (CY13)	DY2 (CY14)	DY3 (CY15)	DY4 (CY16)	DY5 (CY17)	DY6 (CY18)	DY7 (CY19)	DY8 (CY20)	DY9 (CY21)	DY10 (CY22)	DY11 (CY23)	TOTAL
Medicaid Populations												
ABD/SD Dual	$ 50,301,695	$ 44,477,941	$ 47,028,441	$ 44,601,588	$ 43,968,854	$ 47,442,271	$ 50,706,886	$ 53,658,896	$ 56,782,171	$ 60,087,960	$ 63,585,914	$ 562,642,619
ABD/SD Non Dual	$ 354,513,305	$ 375,161,435	$ 362,352,591	$ 396,214,145	$ 392,344,795	$ 425,923,284	$ 458,426,847	$ 488,524,726	$ 520,599,061	$ 554,778,520	$ 591,203,042	$ 4,920,041,751
Adults	$ 212,527,053	$ 276,491,717	$ 281,473,540	$ 319,405,303	$ 311,701,220	$ 366,658,522	$ 390,517,597	$ 411,806,707	$ 434,257,161	$ 457,930,329	$ 482,894,554	$ 3,945,663,702
Children	$ 492,360,310	$ 551,251,864	$ 578,450,247	$ 634,005,637	$ 591,565,646	$ 712,573,621	$ 780,232,682	$ 845,886,391	$ 917,050,501	$ 994,207,708	$ 1,077,841,813	$ 8,175,426,419
DD Waiver	$ 392,668,951	$ 393,843,535	$ 462,182,070	$ 473,302,543	$ 496,262,620	$ 505,469,487	$ 536,053,325	$ 562,858,281	$ 591,004,407	$ 620,557,464	$ 651,588,675	$ 5,685,791,358
LTC	$ 816,946,525	$ 886,437,374	$ 935,006,262	$ 934,137,839	$ 975,957,014	$ 965,368,183	$ 1,011,178,570	$ 1,048,677,296	$ 1,087,567,692	$ 1,127,900,224	$ 1,169,727,878	$ 10,958,904,858
MN Dual	$ 18,085,429	$ 16,064,332	$ 10,896,282	$ 9,698,142	$ 9,620,492	$ 13,890,185	$ 14,670,289	$ 15,340,721	$ 16,041,768	$ 16,774,824	$ 17,541,457	$ 158,623,922
MN Non Dual	$ 21,645,250	$ 24,511,628	$ 17,509,653	$ 24,409,690	$ 26,994,836	$ 35,331,154	$ 38,601,738	$ 41,757,486	$ 45,171,176	$ 48,864,053	$ 52,858,791	$ 377,655,456
Waiver	$ 149,223,695	$ 128,845,671	$ 136,690,107	$ 142,315,412	$ 147,460,597	$ 160,605,708	$ 170,078,556	$ 178,326,883	$ 186,975,132	$ 196,042,839	$ 205,550,594	$ 1,802,115,193
Health Insurer Provider Fee (HIPF)	$ -	$ 32,000,000	$ 57,200,000	$ 52,056,083	$ -	$ 65,876,282	$ 67,193,808	$ 68,537,684	$ 69,908,437	$ 71,306,606	$ 72,732,738	$ 556,811,639
Privilege Fee	$ 25,336,083	$ 27,243,288	$ 96,934,122	$ 101,949,311	$ 102,558,174	$ 197,983,116	$ 209,192,003	$ 221,096,772	$ 233,744,265	$ 247,184,689	$ 261,471,864	$ 1,724,693,686
MediKan								$ 21,243,744	$ 22,638,536	$ 24,124,906	$ 25,708,866	$ 93,716,053
UC Pool : HCAIP	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 61,000,000	$ 61,000,000	$ 61,000,000	$ 61,000,000	$ 61,000,000	$ 551,000,000
UC Pool : BCCH/LPH	$ 39,856,550	$ 29,856,550	$ 19,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 168,422,050
DSRIP	$ -	$ 10,000,000	$ 20,000,000	$ 30,000,000	$ 30,000,000	$ 30,000,000	$ 30,000,000	$ 30,000,000	$ -	$ -	$ -	$ 180,000,000
APM	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 30,000,000	$ 30,000,000	$ 30,000,000	$ 90,000,000
TOTAL	$ 2,614,464,846	$ 2,837,185,334	$ 3,066,579,865	$ 3,212,952,243	$ 3,179,290,798	$ 3,577,978,363	$ 3,827,708,851	$ 4,058,572,138	$ 4,282,596,858	$ 4,520,616,672	$ 4,773,562,737	$ 39,951,508,706
VARIANCE	$ 130,645,571	$ 100,596,668	$ 66,556,627	$ 131,732,082	$ 180,192,213	$ 37,083,986	$ (654,314)	$ (6,352,925)	$ 8,798,988	$ 24,875,098	$ 41,925,629	$ 715,399,623
Transitional Phase-down of Savings	100%	100%	100%	100%	100%	90%	80%	70%	60%	50%	40%	
Accumulated Savings	**$ 130,645,571**	**$ 100,596,668**	**$ 66,556,627**	**$ 131,732,082**	**$ 180,192,213**	**$ 33,375,588**	**$ (523,451)**	**$ (4,447,048)**	**$ 5,279,393**	**$ 12,437,549**	**$ 16,770,252**	**$ 672,615,443**

	A	B	C	D	E	F	G	H
1		**5 YEARS OF HISTORIC DATA**						
2			**7/2006-6/2007**	**7/2007-6/2008**	**7/2008-6/2009**	**7/2009-6/2010**	**7/2010-6/2011**	
3		**SPECIFY TIME PERIOD AND**	**Ends FFY 2007**	**Ends FFY 2008**	**Ends FFY 2009**	**Ends FFY 2010**	**Ends FFY 2011**	
4			**SFY07**	**SFY08**	**SFY09**	**SFY10**	**SFY11**	
5		**Medicaid Pop 1**	**ABD/SD Dual**					**5-YEARS**
6		**TOTAL EXPENDITURES**	$ 44,236,459	$ 43,025,422	$ 42,691,201	$ 40,506,394	$ 40,532,103	$ 210,991,580
7		**ELIGIBLE MEMBER MONTHS**	208,752	202,688	198,906	200,134	210,200	
8		**PMPM COST**	$ 211.91	$ 212.27	$ 214.63	$ 202.40	$ 192.83	
9		**TREND RATES**						**5-YEAR**
10					**ANNUAL CHANGE**			**AVERAGE**
11		TOTAL EXPENDITURE		-2.74%	-0.78%	-5.12%	0.06%	-2.16%
12		ELIGIBLE MEMBER MONTHS		-2.90%	-1.87%	0.62%	5.03%	0.17%
13		PMPM COST		0.17%	1.11%	-5.70%	-4.73%	-2.33%
14								
15		**Medicaid Pop 2**	**ABD/SD Non Dual**					**5-YEARS**
16		**TOTAL EXPENDITURES**	$ 262,996,600	$ 287,521,460	$ 302,718,060	$ 318,094,717	$ 353,270,763	$ 1,524,601,599
17		**ELIGIBLE MEMBER MONTHS**	277,577	287,295	303,044	325,477	345,539	
18		**PMPM COST**	$ 947.47	$ 1,000.79	$ 998.92	$ 977.32	$ 1,022.38	
19		**TREND RATES**						**5-YEAR**
20					**ANNUAL CHANGE**			**AVERAGE**
21		TOTAL EXPENDITURE		9.33%	5.29%	5.08%	11.06%	7.66%
22		ELIGIBLE MEMBER MONTHS		3.50%	5.48%	7.40%	6.16%	5.63%
23		PMPM COST		5.63%	-0.19%	-2.16%	4.61%	1.92%
24								
25		**Medicaid Pop 3**	**Adults**					**5-YEARS**
26		**TOTAL EXPENDITURES**	$ 145,696,984	$ 178,511,453	$ 182,736,445	$ 192,965,697	$ 215,135,856	$ 915,046,435
27		**ELIGIBLE MEMBER MONTHS**	341,481	302,194	297,411	327,511	383,991	
28		**PMPM COST**	$ 426.66	$ 590.72	$ 614.42	$ 589.19	$ 560.26	
29		**TREND RATES**						**5-YEAR**
30					**ANNUAL CHANGE**			**AVERAGE**
31		TOTAL EXPENDITURE		22.52%	2.37%	5.60%	11.49%	10.23%
32		ELIGIBLE MEMBER MONTHS		-11.51%	-1.58%	10.12%	17.25%	2.98%
33		PMPM COST		38.45%	4.01%	-4.11%	-4.91%	7.05%
34								
35		**Medicaid Pop 4**	**Children**				**HY 5**	**5-YEARS**
36		**TOTAL EXPENDITURES**	$ 339,146,737	$ 391,345,646	$ 395,809,865	$ 395,188,873	$ 469,903,838	$ 1,991,394,959
37		**ELIGIBLE MEMBER MONTHS**	1,842,324	1,807,933	1,862,831	2,088,632	2,297,347	
38		**PMPM COST**	$ 184.09	$ 216.46	$ 212.48	$ 189.21	$ 204.54	
39		**TREND RATES**						**5-YEAR**
40					**ANNUAL CHANGE**			**AVERAGE**
41		TOTAL EXPENDITURE		15.39%	1.14%	-0.16%	18.91%	8.49%
42		ELIGIBLE MEMBER MONTHS		-1.87%	3.04%	12.12%	9.99%	5.67%
43		PMPM COST		17.59%	-1.84%	-10.95%	8.10%	2.67%
44								
45		**Medicaid Pop 5**	**DD Waiver**				**HY 5**	**5-YEARS**
46		**TOTAL EXPENDITURES**	$ 317,272,274	$ 333,079,826	$ 352,328,338	$ 361,930,538	$ 378,141,817	$ 1,742,752,793
47		**ELIGIBLE MEMBER MONTHS**	88,021	92,716	94,654	98,443	100,367	
48		**PMPM COST**	$ 3,604.51	$ 3,592.47	$ 3,722.28	$ 3,676.54	$ 3,767.57	
49		**TREND RATES**						**5-YEAR**
50					**ANNUAL CHANGE**			**AVERAGE**
51		TOTAL EXPENDITURE		4.98%	5.78%	2.73%	4.48%	4.49%
52		ELIGIBLE MEMBER MONTHS		5.33%	2.09%	4.00%	1.95%	3.34%
53		PMPM COST		-0.33%	3.61%	-1.23%	2.48%	1.11%
54								
55		**Medicaid Pop 6**	**LTC**				**HY 5**	**5-YEARS**
56		**TOTAL EXPENDITURES**	$ 714,587,999	$ 764,736,723	$ 837,320,779	$ 802,268,440	$ 893,612,115	$ 4,012,526,055
57		**ELIGIBLE MEMBER MONTHS**	278,125	285,098	295,461	288,224	284,917	
58		**PMPM COST**	$ 2,569.30	$ 2,682.36	$ 2,833.94	$ 2,783.49	$ 3,136.39	
59		**TREND RATES**						**5-YEAR**
60					**ANNUAL CHANGE**			**AVERAGE**
61		TOTAL EXPENDITURE		7.02%	9.49%	-4.19%	11.39%	5.75%
62		ELIGIBLE MEMBER MONTHS		2.51%	3.64%	-2.45%	-1.15%	0.60%
63		PMPM COST		4.40%	5.65%	-1.78%	12.68%	5.11%
64								
65		**Medicaid Pop 7**	**MN Dual**				**HY 5**	**5-YEARS**
66		**TOTAL EXPENDITURES**	$ 37,210,534	$ 34,425,301	$ 28,602,622	$ 42,253,903	$ 34,382,233	$ 176,874,594
67		**ELIGIBLE MEMBER MONTHS**	35,739	31,269	28,620	30,996	27,711	
68		**PMPM COST**	$ 1,041.17	$ 1,100.96	$ 999.38	$ 1,363.19	$ 1,240.76	
69		**TREND RATES**						**5-YEAR**
70					**ANNUAL CHANGE**			**AVERAGE**
71		TOTAL EXPENDITURE		-7.49%	-16.91%	47.73%	-18.63%	-1.96%
72		ELIGIBLE MEMBER MONTHS		-12.51%	-8.47%	8.30%	-10.60%	-6.16%
73		PMPM COST		5.74%	-9.23%	36.40%	-8.98%	4.48%
74								
75		**Medicaid Pop 8**	**MN Non Dual**				**HY 5**	**5-YEARS**
76		**TOTAL EXPENDITURES**	$ 24,500,245	$ 28,139,319	$ 30,191,137	$ 28,559,359	$ 31,471,604	$ 142,861,664
77		**ELIGIBLE MEMBER MONTHS**	21,421	26,080	21,895	19,534	19,602	
78		**PMPM COST**	$ 1,143.73	$ 1,078.96	$ 1,378.92	$ 1,462.00	$ 1,605.55	
79		**TREND RATES**						**5-YEAR**
80					**ANNUAL CHANGE**			**AVERAGE**
81		TOTAL EXPENDITURE		14.85%	7.29%	-5.40%	10.20%	6.46%
82		ELIGIBLE MEMBER MONTHS		21.75%	-16.05%	-10.78%	0.34%	-2.19%
83		PMPM COST		-5.66%	27.80%	6.02%	9.82%	8.85%
84								
85		**Medicaid Pop 9**	**Waiver**				**HY 5**	**5-YEARS**
86		**TOTAL EXPENDITURES**	$ 61,320,583	$ 79,821,639	$ 118,700,459	$ 138,297,856	$ 149,625,842	$ 547,766,379
87		**ELIGIBLE MEMBER MONTHS**	34,936	42,109	53,790	61,202	64,235	
88		**PMPM COST**	$ 1,755.22	$ 1,895.60	$ 2,206.74	$ 2,259.68	$ 2,329.36	
89		**TREND RATES**						**5-YEAR**
90					**ANNUAL CHANGE**			**AVERAGE**
91		TOTAL EXPENDITURE		30.17%	48.71%	16.51%	8.19%	24.98%
92		ELIGIBLE MEMBER MONTHS		20.53%	27.74%	13.78%	4.95%	16.45%
93		PMPM COST		8.00%	16.41%	2.40%	3.08%	7.33%

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR CY12	TREND RATE 2	Demonstration Years DY1 (CY13)	DY2 (CY14)	DY3 (CY15)	DY4 (CY16)	DY5 (CY17)	TREND RATE 3	DY6 (CY18)	TREND RATE 4	DY7 (CY19)	DY8 (CY20)	DY9 (CY21)	DY10 (CY22)	DY11 (CY23)	TOTAL WOW
Medicaid Pop 1	ABD/SD Dual																	
Pop Type:	**Medicaid**																	
Eligible Member Months		18			215,719	219,855	207,547	186,840	183,493	-0.10%	183,302	0.83%	184,819	186,348	187,890	189,444	191,012	
PMPM Cost	0.00%	18	$ 192.83	0.00%	$ 192.83	$ 192.83	$ 192.83	$ 192.83	$ 192.83	0.00%	$ 192.83	6.36%	$ 205.10	$ 218.15	$ 232.03	$ 246.79	$ 262.49	
Total Expenditure					$ 41,597,095	$ 42,394,640	$ 40,021,288	$ 36,028,357	$ 35,383,011		$ 35,346,160		$ 37,906,336	$ 40,651,808	$ 43,596,066	$ 46,752,972	$ 50,138,685	$ 219,045,867
Medicaid Pop 2	ABD/SD Non Dual																	
Pop Type:	**Medicaid**																	
Eligible Member Months		18			351,574	354,840	344,168	340,565	346,981	0.98%	350,396	0.95%	353,727	357,090	360,486	363,913	367,373	
PMPM Cost	1.92%	18	$ 1,051.96	1.92%	$ 1,072.16	$ 1,092.75	$ 1,113.73	$ 1,135.11	$ 1,156.90	1.92%	$ 1,179.11	6.36%	$ 1,254.12	$ 1,333.90	$ 1,418.76	$ 1,509.01	$ 1,605.00	
Total Expenditure					$ 376,943,580	$ 387,751,410	$ 383,310,227	$ 386,578,737	$ 401,422,196		$ 413,154,871		$ 443,616,291	$ 476,322,946	$ 511,442,724	$ 549,148,782	$ 589,634,357	$ 2,570,165,100
Medicaid Pop 3	Adults																	
Pop Type:	**Medicaid**																	
Eligible Member Months		18			394,860	478,366	533,564	620,298	617,796	-2.91%	599,801	0.39%	602,140	604,487	606,843	609,209	611,584	
PMPM Cost	4.87%	18	$ 601.72	4.87%	$ 631.05	$ 661.81	$ 694.07	$ 727.90	$ 763.38	4.87%	$ 800.59	5.36%	$ 843.51	$ 888.73	$ 936.38	$ 986.58	$ 1,039.47	
Total Expenditure					$ 249,176,403	$ 316,587,402	$ 370,330,765	$ 451,514,914	$ 471,612,927		$ 480,194,907		$ 507,910,721	$ 537,225,651	$ 568,236,054	$ 601,033,556	$ 635,723,299	$ 2,850,129,281
Medicaid Pop 4	Children																	
Pop Type:	**Medicaid**																	
Eligible Member Months		18			2,545,441	2,713,758	2,720,984	2,969,320	2,788,270	0.94%	2,814,605	2.80%	2,893,394	2,974,389	3,057,650	3,143,243	3,231,231	
PMPM Cost	2.67%	18	$ 212.79	2.67%	$ 218.47	$ 224.30	$ 230.29	$ 236.44	$ 242.75	2.67%	$ 249.23	4.80%	$ 261.20	$ 273.75	$ 286.90	$ 300.68	$ 315.12	
Total Expenditure					$ 556,102,495	$ 608,695,919	$ 626,615,405	$ 702,066,021	$ 676,852,627		$ 701,484,076		$ 755,754,567	$ 814,238,895	$ 877,239,893	$ 945,110,255	$ 1,018,225,596	$ 4,410,569,207
Medicaid Pop 5	DD Waiver																	
Pop Type:	**Medicaid**																	
Eligible Member Months		18			103,409	104,189	105,565	106,684	107,660	0.04%	107,700	0.03%	107,729	107,758	107,787	107,815	107,844	
PMPM Cost	1.11%	18	$ 3,830.48	1.11%	$ 3,873.00	$ 3,915.99	$ 3,959.46	$ 4,003.41	$ 4,047.85	1.11%	$ 4,092.78	4.77%	$ 4,287.93	$ 4,492.39	$ 4,706.60	$ 4,931.02	$ 5,166.14	
Total Expenditure					$ 400,503,057	$ 408,003,082	$ 417,980,395	$ 427,099,792	$ 435,790,134		$ 440,792,406		$ 461,933,728	$ 484,089,565	$ 507,308,154	$ 531,639,940	$ 557,138,654	$ 2,542,110,041
Medicaid Pop 6	LTC																	
Pop Type:	**Medicaid**																	
Eligible Member Months		18			261,529	256,593	252,475	247,147	244,393	-0.71%	242,658	0.04%	242,767	242,876	242,985	243,093	243,202	
PMPM Cost	4.35%	18	$ 3,343.21	4.35%	$ 3,488.61	$ 3,640.34	$ 3,798.66	$ 3,963.87	$ 4,136.27	4.35%	$ 4,316.16	4.77%	$ 4,521.96	$ 4,737.58	$ 4,963.48	$ 5,200.15	$ 5,448.10	
Total Expenditure					$ 912,372,685	$ 934,085,762	$ 959,066,684	$ 979,658,579	$ 1,010,873,478		$ 1,047,352,773		$ 1,097,783,322	$ 1,150,643,874	$ 1,206,049,436	$ 1,264,122,512	$ 1,324,990,686	$ 6,043,589,830
Medicaid Pop 7	MN Dual																	
Pop Type:	**Medicaid**																	
Eligible Member Months		18			15,606	16,262	16,014	15,420	15,724	-1.29%	15,521	0.34%	15,574	15,627	15,681	15,735	15,789	
PMPM Cost	4.35%	18	$ 1,322.58	4.35%	$ 1,380.10	$ 1,440.12	$ 1,502.75	$ 1,568.11	$ 1,636.31	4.35%	$ 1,707.48	6.36%	$ 1,816.10	$ 1,931.63	$ 2,054.51	$ 2,185.21	$ 2,324.22	
Total Expenditure					$ 21,537,841	$ 23,419,231	$ 24,065,039	$ 24,180,256	$ 25,728,653		$ 26,501,456		$ 28,284,035	$ 30,186,520	$ 32,216,983	$ 34,384,071	$ 36,696,855	$ 161,768,464
Medicaid Pop 8	MN Non Dual																	
Pop Type:	**Medicaid**																	
Eligible Member Months		18			13,638	13,898	13,530	14,805	15,282	-1.27%	15,087	2.24%	15,424	15,769	16,122	16,483	16,852	
PMPM Cost	4.35%	18	$ 1,711.43	4.35%	$ 1,785.86	$ 1,863.53	$ 1,944.58	$ 2,029.15	$ 2,117.40	4.35%	$ 2,209.49	6.36%	$ 2,350.05	$ 2,499.55	$ 2,658.56	$ 2,827.68	$ 3,007.56	
Total Expenditure					$ 24,355,559	$ 25,899,340	$ 26,310,167	$ 30,041,566	$ 32,357,345		$ 33,334,257		$ 36,247,982	$ 39,416,364	$ 42,861,680	$ 46,608,054	$ 50,681,913	$ 215,815,993
Medicaid Pop 9	Waiver																	
Pop Type:	**Medicaid**																	
Eligible Member Months		18			52,948	48,713	46,541	52,145	54,332	-0.64%	53,982	-0.03%	53,964	53,945	53,927	53,909	53,890	
PMPM Cost	4.35%	18	$ 2,482.96	4.35%	$ 2,590.95	$ 2,703.63	$ 2,821.22	$ 2,943.92	$ 3,071.96	4.35%	$ 3,205.56	4.77%	$ 3,358.41	$ 3,518.55	$ 3,686.32	$ 3,862.09	$ 4,046.24	
Total Expenditure					$ 137,185,621	$ 131,701,928	$ 131,302,400	$ 153,510,708	$ 166,904,466		$ 173,042,045		$ 181,231,744	$ 189,809,134	$ 198,792,154	$ 208,200,334	$ 218,053,718	$ 996,087,084

NOTES

"Base Year" is the year immediately prior to the planned first year of the demonstration.

"Trend Rate 1" is the trend rate that projects from the last historical year to the Base Year and is the minimum of the 5-Year Average Historical Trend and the President's Trend.

"Months of Aging" equals the number of months of trend factor needed to trend from the last historical year to the Base Year. There are 18 months between the midpoint of SFY11 (last historical year) and CY12 (Base Year).

"Trend Rate 2" is the trend rate that projects the first 5 DYs, starting from the Base Year, through the end of the first 5-year demonstration period.

"Trend Rate 3" is the trend rate that projects DY6, starting from DY5.

"Trend Rate 4" is the trend rate that projects DY7 through DY11, starting from DY6. These trends are based on the most recently approved 1115 waiver (Massachusetts) without-waiver trends, since the President's Budget trends by MEG are not publicly available.

Membership for DY1 through DY4 represents actual membership. Membership for DY5 is projected based on emerging membership for that year, and membership after DY5 is projected.

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP		Actual DY1 (CY13)	Actual DY2 (CY14)	Actual DY3 (CY15)	Actual DY4 (CY16)	Projected DY5 (CY17)	Projected Capitation Rate Update	Projected DY6 (CY18)	DEMO TREND RATE	Benefit Changes	Projected DEMONSTRATION YEARS (DY) DY7 (CY19)	DY8 (CY20)	DY9 (CY21)	DY10 (CY22)	DY11 (CY23)	TOTAL WW
Medicaid Pop 1	ABD/SD Dual															
Pop Type:	**Medicaid**															
Eligible Member Months		215,719	219,855	207,547	186,840	183,493	-0.1%	183,302	0.8%		184,819	186,348	187,890	189,444	191,012	
PMPM Cost		$ 233.18	$ 202.31	$ 226.59	$ 238.72	$ 239.62	8.0%	$ 258.82	5.0%	1.0%	$ 274.36	$ 287.95	$ 302.21	$ 317.18	$ 332.89	
Total Expenditure		$ 50,301,695	$ 44,477,941	$ 47,028,441	$ 44,601,588	$ 43,968,854		$ 47,442,271			$ 50,706,886	$ 53,658,896	$ 56,782,171	$ 60,087,960	$ 63,585,914	$ 284,821,827
Medicaid Pop 2	ABD/SD Non Dual															
Pop Type:	**Medicaid**															
Eligible Member Months		351,574	354,840	344,168	340,565	346,981	1.0%	350,396	1.0%		353,727	357,090	360,486	363,913	367,373	
PMPM Cost		$ 1,008.36	$ 1,057.27	$ 1,052.84	$ 1,163.40	$ 1,130.74	7.5%	$ 1,215.55	5.6%	1.0%	$ 1,295.99	$ 1,368.07	$ 1,444.16	$ 1,524.48	$ 1,609.27	
Total Expenditure		$ 354,513,305	$ 375,161,435	$ 362,352,591	$ 396,214,145	$ 392,344,795		$ 425,923,284			$ 458,426,847	$ 488,524,726	$ 520,599,061	$ 554,778,520	$ 591,203,042	$ 2,613,532,197
Medicaid Pop 3	Adults															
Pop Type:	**Medicaid**															
Eligible Member Months		394,860	478,366	533,564	620,298	617,796	-2.9%	599,801	0.4%		602,140	604,487	606,843	609,209	611,584	
PMPM Cost		$ 538.23	$ 577.99	$ 527.53	$ 514.92	$ 504.54	21.2%	$ 611.30	5.0%	1.0%	$ 648.55	$ 681.25	$ 715.60	$ 751.68	$ 789.58	
Total Expenditure		$ 212,527,053	$ 276,491,717	$ 281,473,540	$ 319,405,303	$ 311,701,220		$ 366,658,522			$ 390,517,597	$ 411,806,707	$ 434,257,161	$ 457,930,329	$ 482,894,554	$ 2,177,406,347
Medicaid Pop 4	Children															
Pop Type:	**Medicaid**															
Eligible Member Months		2,545,441	2,713,758	2,720,984	2,969,320	2,788,270	0.9%	2,814,605	2.8%		2,893,394	2,974,389	3,057,650	3,143,243	3,231,231	
PMPM Cost		$ 193.43	$ 203.13	$ 212.59	$ 213.52	$ 212.16	19.3%	$ 253.17	5.5%	1.0%	$ 269.66	$ 284.39	$ 299.92	$ 316.30	$ 333.57	
Total Expenditure		$ 492,360,310	$ 551,251,864	$ 578,450,247	$ 634,005,637	$ 591,565,646		$ 712,573,621			$ 780,232,682	$ 845,886,391	$ 917,050,501	$ 994,207,708	$ 1,077,841,813	$ 4,615,219,095
Medicaid Pop 5	DD Waiver															
Pop Type:	**Medicaid**															
Eligible Member Months		103,409	104,189	105,565	106,684	107,660	0.0%	107,700	0.0%		107,729	107,758	107,787	107,815	107,844	
PMPM Cost		$ 3,797.24	$ 3,780.09	$ 4,378.18	$ 4,436.49	$ 4,609.55	1.8%	$ 4,693.31	5.0%	1.0%	$ 4,975.95	$ 5,223.37	$ 5,483.10	$ 5,755.74	$ 6,041.94	
Total Expenditure		$ 392,668,951	$ 393,843,535	$ 462,182,070	$ 473,302,543	$ 496,262,620		$ 505,469,487			$ 536,053,325	$ 562,858,281	$ 591,004,407	$ 620,557,464	$ 651,588,675	$ 2,962,062,152
Medicaid Pop 6	LTC															
Pop Type:	**Medicaid**															
Eligible Member Months		261,529	256,593	252,475	247,147	244,393	-0.7%	242,658	0.0%		242,767	242,876	242,985	243,093	243,202	
PMPM Cost		$ 3,123.73	$ 3,454.64	$ 3,703.36	$ 3,779.69	$ 3,993.40	-0.4%	$ 3,978.30	3.7%	1.0%	$ 4,165.22	$ 4,317.75	$ 4,475.87	$ 4,639.78	$ 4,809.69	
Total Expenditure		$ 816,946,525	$ 886,437,374	$ 935,006,262	$ 934,137,839	$ 975,957,014		$ 965,368,183			$ 1,011,178,570	$ 1,048,677,296	$ 1,087,567,692	$ 1,127,900,224	$ 1,169,727,878	$ 5,445,051,661
Medicaid Pop 7	MN Dual															
Pop Type:	**Medicaid**															
Eligible Member Months		15,606	16,262	16,014	15,420	15,724	-1.3%	15,521	0.3%		15,574	15,627	15,681	15,735	15,789	
PMPM Cost		$ 1,158.88	$ 987.84	$ 680.42	$ 628.93	$ 611.85	46.3%	$ 894.94	4.2%	1.0%	$ 941.97	$ 981.65	$ 1,023.00	$ 1,066.09	$ 1,111.00	
Total Expenditure		$ 18,085,429	$ 16,064,332	$ 10,896,282	$ 9,698,142	$ 9,620,492		$ 13,890,185			$ 14,670,289	$ 15,340,721	$ 16,041,768	$ 16,774,824	$ 17,541,457	$ 80,369,061
Medicaid Pop 8	MN Non Dual															
Pop Type:	**Medicaid**															
Eligible Member Months		13,638	13,898	13,530	14,805	15,282	-1.3%	15,087	2.2%		15,424	15,769	16,122	16,483	16,852	
PMPM Cost		$ 1,587.13	$ 1,763.68	$ 1,294.14	$ 1,648.75	$ 1,766.49	32.6%	$ 2,341.85	5.8%	1.0%	$ 2,502.65	$ 2,648.01	$ 2,801.81	$ 2,964.55	$ 3,136.74	
Total Expenditure		$ 21,645,250	$ 24,511,628	$ 17,509,653	$ 24,409,690	$ 26,994,836		$ 35,331,154			$ 38,601,738	$ 41,757,486	$ 45,171,176	$ 48,864,053	$ 52,858,791	$ 227,253,244
Medicaid Pop 9	Waiver															
Pop Type:	**Medicaid**															
Eligible Member Months		52,948	48,713	46,541	52,145	54,332	-0.6%	53,982	0.0%		53,964	53,945	53,927	53,909	53,890	
PMPM Cost		$ 2,818.31	$ 2,645.00	$ 2,936.98	$ 2,729.22	$ 2,714.09	9.6%	$ 2,975.18	4.9%	1.0%	$ 3,151.73	$ 3,305.70	$ 3,467.19	$ 3,636.57	$ 3,814.23	
Total Expenditure		$ 149,223,695	$ 128,845,671	$ 136,690,107	$ 142,315,412	$ 147,460,597		$ 160,605,708			$ 170,078,556	$ 178,326,883	$ 186,975,132	$ 196,042,839	$ 205,550,594	$ 936,974,004

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections.
DY1 through DY4 represent actual expenditures. Expenditures for DY5 is projected based on emerging expenditures for that year.
Capitation Rate Update is used in conjunction with the CY17 PMPM, and the result is the average negotiated rate for CY18.
"Demo Trend" is the trend rate that projects DY7 to DY11, starting from DY6.
"Benefit Changes" represents a one-time adjustment to reflect preliminary estimated increase in care coordination services beginning in CY19.

Panel 1: Historic DSH Claims for the Last Five Fiscal Years:

RECENT PAST FEDERAL FISCAL YEARS	2013	2014	2015	2016	2017
State DSH Allotment (Federal share)	$ 43,299,536.37	$ 43,991,906.91	$ 44,695,777.94	$ 44,829,864.90	$ 44,012,998.73
State DSH Claim Amount (Federal share)	$ 43,299,536.37	$ 43,991,906.91	$ 44,695,777.94	$ 44,829,864.90	$ 44,012,998.73
DSH Allotment Left Unspent (Federal share)	$ -	$ -	$ -	$ -	$ -

Panel 2: Projected Without Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (2019)	FFY 01 (2020)	FFY 02 (2021)	FFY 03 (2022)	FFY 04 (2023)	FFY 05 (2024)
State DSH Allotment (Federal share)	$ 35,164,473.60	$ 33,097,908.00	$ 31,031,342.40	$ 28,964,776.80	$ 26,898,211.20	$ 24,831,645.60
State DSH Claim Amount (Federal share)	$ 35,164,473.60	$ 33,097,908.00	$ 31,031,342.40	$ 28,964,776.80	$ 26,898,211.20	$ 24,831,645.60
DSH Allotment Projected to be Unused (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 3: Projected With Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)	$ 35,164,473.60	$ 33,097,908.00	$ 31,031,342.40	$ 28,964,776.80	$ 26,898,211.20	$ 24,831,645.60
State DSH Claim Amount (Federal share)	$ 35,164,473.60	$ 33,097,908.00	$ 31,031,342.40	$ 28,964,776.80	$ 26,898,211.20	$ 24,831,645.60
Maximum DSH Allotment Available for Diversion (Federal share)						
Total DSH Alltoment Diverted (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Available for DSH Diversion Less Amount Diverted (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Projected to be Unused (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 4: Projected DSH Diversion Allocated to DYs

DEMONSTRATION YEARS		DY 06	DY 07	DY 08	DY 09	DY 10
DSH Diversion to Leading FFY (total computable)						
FMAP for Leading FFY		0.5616	0.5616	0.5616	0.5616	0.5616
DSH Diversion to Trailing FFY (total computable)						
FMAP for Trailing FFY		0.5616	0.5616	0.5616	0.5616	0.5616
Total Demo Spending From Diverted DSH (total computable)		$ -	$ -	$ -	$ -	$ -

Population Status Drop-Down
Medicaid
Hypothetical
Expansion

	Prior 1115 BN	*Actual*	*Actual*	*Actual*	*Actual*	*Projected*	*Projected*	DY *Projected*	DY *Projected*	DY *Projected*	DY *Projected*	DY *Projected*
MEG	**2012**	**DY1 (CY13)**	**DY2 (CY14)**	**DY3 (CY15)**	**DY4 (CY16)**	**DY5 (CY17)**	**DY6 (CY18)**	**DY7 (CY19)**	**DY8 (CY20)**	**DY9 (CY21)**	**DY10 (CY22)**	**DY11 (CY23)**
ABD/SD Dual	219,626	215,719	219,855	207,547	186,840	183,493	183,302	184,819	186,348	187,890	189,444	191,012
ABD/SD Non Dual	365,316	351,574	354,840	344,168	340,565	346,981	350,396	353,727	357,090	360,486	363,913	367,373
Adults	439,018	394,860	478,366	533,564	620,298	617,796	599,801	602,140	604,487	606,843	609,209	611,584
Children	2,610,087	2,545,441	2,713,758	2,720,984	2,969,320	2,788,270	2,814,605	2,893,394	2,974,389	3,057,650	3,143,243	3,231,231
DD Waiver	106,642	103,409	104,189	105,565	106,684	107,660	107,700	107,729	107,758	107,787	107,815	107,844
LTC	297,417	261,529	256,593	252,475	247,147	244,393	242,658	242,767	242,876	242,985	243,093	243,202
MN Dual	28,145	15,606	16,262	16,014	15,420	15,724	15,521	15,574	15,627	15,681	15,735	15,789
MN Non Dual	19,909	13,638	13,898	13,530	14,805	15,282	15,087	15,424	15,769	16,122	16,483	16,852
Waiver	68,250	52,948	48,713	46,541	52,145	54,332	53,982	53,964	53,945	53,927	53,909	53,890
	4,154,409	3,954,724	4,206,474	4,240,388	4,553,224	4,373,929	4,383,052	4,469,538	4,558,290	4,649,371	4,742,845	4,838,778

DY Projected	**DY Projected**	**DY Projected**
CY17	**Trend Rate 1**	**Trend Rate 2**
-1.79%	-0.10%	0.83%
1.88%	0.98%	0.95%
-0.40%	-2.91%	0.39%
-6.10%	0.94%	2.80%
0.91%	0.04%	0.03%
-1.11%	-0.71%	0.04%
1.97%	-1.29%	0.34%
3.22%	-1.27%	2.24%
4.19%	-0.64%	-0.03%
	0.21%	2.00%

Net Privilege Fee

MEG	DY1 (CY13)	DY2 (CY14)	DY3 (CY15)	DY4 (CY16)	DY5 (CY17)
ABD/SD Dual	$ 50,301,695	$ 44,477,941	$ 47,028,441	$ 44,601,588	$ 43,968,854
ABD/SD Non Dual	$ 354,513,305	$ 375,161,435	$ 362,352,591	$ 396,214,145	$ 392,344,795
Adults	$ 212,527,053	$ 276,491,717	$ 281,473,540	$ 319,405,303	$ 311,701,220
Children	$ 492,360,310	$ 551,251,864	$ 578,450,247	$ 634,005,637	$ 591,565,646
DD Waiver	$ 392,668,951	$ 393,843,535	$ 462,182,070	$ 473,302,543	$ 496,262,620
LTC	$ 816,946,525	$ 886,437,374	$ 935,006,262	$ 934,137,839	$ 975,957,014
MN Dual	$ 18,085,429	$ 16,064,332	$ 10,896,282	$ 9,698,142	$ 9,620,492
MN Non Dual	$ 21,645,250	$ 24,511,628	$ 17,509,653	$ 24,409,690	$ 26,994,836
Waiver	$ 149,223,695	$ 128,845,671	$ 136,690,107	$ 142,315,412	$ 147,460,597
	$ 2,508,272,213	$ 2,697,085,496	$ 2,831,589,193	$ 2,978,090,299	$ 2,995,876,074

	DY1 (CY13)	DY2 (CY14)	DY3 (CY15)	DY4 (CY16)	DY5 (CY17)
Privilege Fee	$ 25,336,083	$ 27,243,288	$ 96,934,122	$ 101,949,311	$ 102,558,174

	DY1 (CY13)	DY2 (CY14)	DY3 (CY15)	DY4 (CY16)	DY5 (CY17)
HIPF	$ -	$ 32,000,000	$ 57,200,000	$ 52,056,083	$ -

ABD/SD Dual	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
ABD/SD Non Dual	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
Adults	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
Children	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
DD Waiver	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
LTC	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
MN Dual	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
MN Non Dual	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
Waiver	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
Excluded Populations											-	-	-				
	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!

	% Change - Not Mix Adjusted					% Change - Not Mix Adjusted			
MEG	CY16	CY16 Mid Year	CY17	CY17 Mid Year	CY18	CY17 Avg/CY16 A\	CY18/CY17 Avg		
ABD/SD Dual		#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
ABD/SD Non Dual		#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
Adults		#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
Children		#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
DD Waiver		#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
LTC		#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
MN Dual		#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
MN Non Dual		#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
Waiver		#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
Excluded Populations									
		#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!

Privilege Fee

PMPM

MEG	DY6 (CY18)	WW Trend Rate	DY7 (CY19)	DY8 (CY20)	DY9 (CY21)	DY10 (CY22)	DY11 (CY23)
ABD/SD Dual	$ 15.85	4.95%	$ 16.63	$ 17.46	$ 18.32	$ 19.23	$ 20.18
ABD/SD Non Dual	$ 74.43	5.56%	$ 78.57	$ 82.94	$ 87.56	$ 92.43	$ 97.57
Adults	$ 37.43	5.04%	$ 39.32	$ 41.30	$ 43.38	$ 45.57	$ 47.87
Children	$ 15.50	5.46%	$ 16.35	$ 17.24	$ 18.18	$ 19.18	$ 20.22
DD Waiver	$ 287.39	4.97%	$ 301.68	$ 316.68	$ 332.42	$ 348.95	$ 366.30
LTC	$ 243.60	3.66%	$ 252.52	$ 261.77	$ 271.36	$ 281.30	$ 291.60
MN Dual	$ 54.80	4.21%	$ 57.11	$ 59.51	$ 62.02	$ 64.63	$ 67.36
MN Non Dual	$ 143.40	5.81%	$ 151.73	$ 160.54	$ 169.87	$ 179.73	$ 190.17
Waiver	$ 182.18	4.89%	$ 191.08	$ 200.41	$ 210.21	$ 220.47	$ 231.24

MMs

MEG	DY6 (CY18)	Trend Rate	DY7 (CY19)	DY8 (CY20)	DY9 (CY21)	DY10 (CY22)	DY11 (CY23)
ABD/SD Dual	183,302		184,819	186,348	187,890	189,444	191,012
ABD/SD Non Dual	350,396		353,727	357,090	360,486	363,913	367,373
Adults	599,801		602,140	604,487	606,843	609,209	611,584
Children	2,814,605		2,893,394	2,974,389	3,057,650	3,143,243	3,231,231
DD Waiver	107,700		107,729	107,758	107,787	107,815	107,844
LTC	242,658		242,767	242,876	242,985	243,093	243,202
MN Dual	15,521		15,574	15,627	15,681	15,735	15,789
MN Non Dual	15,087		15,424	15,769	16,122	16,483	16,852
Waiver	53,982		53,964	53,945	53,927	53,909	53,890

Dollars

MEG	DY6 (CY18)	Trend Rate	DY7 (CY19)	DY8 (CY20)	DY9 (CY21)	DY10 (CY22)	DY11 (CY23)
ABD/SD Dual	$ 2,905,042		$ 3,074,160	$ 3,253,123	$ 3,442,505	$ 3,642,911	$ 3,854,984
ABD/SD Non Dual	$ 26,080,657		$ 27,793,025	$ 29,617,821	$ 31,562,427	$ 33,634,709	$ 35,843,050
Adults	$ 22,451,480		$ 23,675,507	$ 24,966,266	$ 26,327,397	$ 27,762,734	$ 29,276,325
Children	$ 43,633,551		$ 47,304,378	$ 51,284,027	$ 55,598,477	$ 60,275,896	$ 65,346,819
DD Waiver	$ 30,951,473		$ 32,499,207	$ 34,124,335	$ 35,830,728	$ 37,622,449	$ 39,503,765
LTC	$ 59,112,537		$ 61,304,674	$ 63,578,105	$ 65,935,844	$ 68,381,018	$ 70,916,868
MN Dual	$ 850,542		$ 889,413	$ 930,060	$ 972,564	$ 1,017,011	$ 1,063,489
MN Non Dual	$ 2,163,439		$ 2,340,304	$ 2,531,629	$ 2,738,594	$ 2,962,479	$ 3,204,668
Waiver	$ 9,834,395		$ 10,311,336	$ 10,811,407	$ 11,335,731	$ 11,885,482	$ 12,461,895
	$ 197,983,116		$ 209,192,003	$ 221,096,772	$ 233,744,265	$ 247,184,689	$ 261,471,864

HIPF Growth[1]	2.00%

	DY6 (CY18)	DY7 (CY19)	DY8 (CY20)	DY9 (CY21)	DY10 (CY22)	DY11 (CY23)
HIPF	$ 65,876,282	$ 67,193,808	$ 68,537,684	$ 69,908,437	$ 71,306,606	$ 72,732,738

[1] Trend rate based on 26 U.S.C. 36B(b)(3)(A)(ii) for FPL < 133%

Historic Pool Expenditures

Name	SFY08[1]	SFY09[2]	SFY10	SFY11	SFY12
UC Pool : HCAIP	$ 24,151,085	$ 24,151,114	$ 24,151,114	$ 24,151,114	$ 23,723,342
UC Pool : BCCH	$ -	$ 2,575,155	$ 4,440,694	$ 5,491,365	$ 8,880,873
UC Pool : LPH	$ 8,373,120	$ 24,079,321	$ 28,836,150	$ 27,557,989	$ 28,900,000
DSRIP	$ -	$ -	$ -	$ -	$ -

[1] *LPH Outpatient based on paid dates 2/28/2008 - 7/1/2008.*

[2] *LPH Outpatient based on paid dates 7/1/2008 - 12/31/2009.*

Pools - WW

Name	SFY12	DY1 (CY13)	DY2 (CY14)	DY3 (CY15)	DY4 (CY16)	DY5 (CY17)	DY6 (CY18)	DY7 (CY19)	DY8 (CY20)	DY9 (CY21)	DY10 (CY22)	DY11 (CY23)
UC Pool : HCAIP	$ 23,723,342	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 61,000,000	$ 61,000,000	$ 61,000,000	$ 61,000,000	$ 61,000,000
UC Pool : BCCH/LPH	$ 37,780,873	$ 39,856,550	$ 29,856,550	$ 19,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550
DSRIP	$ -	$ -	$ 10,000,000	$ 20,000,000	$ 30,000,000	$ 30,000,000	$ 30,000,000	$ 30,000,000	$ 30,000,000	$ -	$ -	$ -
APM	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 30,000,000	$ 30,000,000	$ 30,000,000

Pool Trends WW

Name	DY1 (CY13)	DY2 (CY14)	DY3 (CY15)	DY4 (CY16)	DY5 (CY17)	DY6 (CY18)	DY7 (CY19)	DY8 (CY20)	DY9 (CY21)	DY10 (CY22)	DY11 (CY23)
UC Pool : HCAIP	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	48.78%	0.00%	0.00%	0.00%	0.00%
UC Pool : BCCH/LPH	2.19%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
DSRIP	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
APM	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Average Monthly Enrollment (CY17)	1,171
Benefit Change Impact[1]	1.5
Adjusted Monthly Enrollment	1,756
Annual Membership	21,076

	CY17 PMPM	Weight
Current MediKan	$ 450.23	50%
ABD Non Dual	$ 1,215.55	50%
Final MediKan	$ 832.89	100%

	CY17[2]	Trend[3]	Trend Months	DY8 (CY20)	DY9 (CY21)	DY10 (CY22)	DY11 (CY23)
Enrollment	21,076	1.0%	36	21,683.12	21,889	22,097	22,308
PMPM	$ 832.89	5.6%	36	$ 979.74	$ 1,034.23	$ 1,091.75	$ 1,152.48
Expenditures	$ 17,554,126			$ 21,243,744	$ 22,638,536	$ 24,124,906	$ 25,708,866

Notes:

[1]Members were previously eligible for 12 months, and will now be eligible for 18 months starting in CY20.

[2]CY17 PMPM based on a blend of the current MediKan experience and the ABD Non Dual MEG.
MediKan members currently receive a limited benefit package, and so expenditures are anticipated to increase once they are eligible for full Medicaid benefits.
MediKan members are in the process of pursuing their SSI designation, and almost all members are currently non-dual, and so have been blended with the ABD Non Dual PMPM to project their PMPM expenditures once they receive full Medicaid benefits.

[3]Trend is based on the projected increase in enrollment and projected increase in PMPM cost for the ABD Non Dual MEG.

Kansas Department of Health and Environment

KanCare Renewal Public Comment

10/27/2017 - 11/26/2017

Report prepared by:

The Center for Organizational Development and Collaboration

Wichita State University
Community Engagement Institute

Introduction

The State of Kansas is preparing to renew its 1115 Demonstration Waiver, reauthorizing Kansas' managed care model for Medicaid, known as KanCare. This renewal process is being referred to as KanCare 2.0.

Kansas accepted public comment on KanCare renewal from October 27 – November 26, 2017, renewal documents were posted online on the KanCare website (http://www.kancare.ks.gov/about-kancare/kancare-renewal) or could be reviewed in person at the Kansas Department of Health and Environment (KDHE) Division of Healthcare Finance or at the Kansas Department for Aging and Disability Services. Comments could be provided via mail, email, or during one of 14 public hearings that were held throughout the state and by conference call. Kansas notified stakeholders of the public meeting locations and ways to provide input by mail, press release, website publication, listserv email, and provider bulletins. Public hearings facilitated by the WSU Community Engagement Institute Center for Organizational Development and Collaboration were held between November 14th and 20th, 2017.

Date/Date	Time	Location
11/14/2017	2:00pm	Pittsburg, Kansas
11/14/2017	6:00pm	Pittsburg, Kansas
11/14/2017	2:00pm	Dodge City, Kansas
11/14/2017	6:00pm	Dodge City, Kansas
11/15/2017	2:00pm	Great Bend, Kansas
11/15/2017	6:00pm	Great Bend, Kansas
11/15/2017	2:00pm	Olathe, Kansas
11/15/2017	6:00pm	Olathe, Kansas
11/16/2017	2:00pm	Wichita, Kansas
11/16/2017	6:00pm	Wichita, Kansas
11/16/2017	2:00pm	Topeka, Kansas
11/16/2017	6:00pm	Topeka, Kansas
11/20/2017	12:00pm	Conference Call
11/20/2017	6:00pm	Conference Call

In total, 491 people attended these hearings and had the opportunity to share comments and questions live and/or by writing on comment cards. Total written comments included 59 on comment cards during public hearings and 52 received by mail or email.

Technical Note

Comments during the public input sessions were recorded. Basic transcription rules were utilized to eliminate filler words and statements, false starts, and repetitions. Non-verbal nuances are noted where appropriate and names are eliminated or enhanced to provide appropriate reference. When the commenter provided comments on multiple topics in one statement, when possible based on clear language breaks, the statement is segmented and categorized into different thematic categories. When the statement is unable to be segmented, it is themed in the category that it overwhelmingly represents. Some comments overlap multiple thematic areas and are not repeated in both to keep the report concise. All verbal comments, comment cards, and written and e-mailed are included in the themed document and are included only once. Comments received at public hearings begin on page 5. Summarized comments received by mail and email begin on page 62, they can be viewed in their entirety beginning on page 77.

Return to Index

Contents

Comments and Questions Received at Public Hearings

Theme 1: Strengthen Social Determinants of Health and Independence with Service Coordination

There were a large number of comments and questions about social determinants of health and independence with service coordination. These comments fell largely into seven (7) sub-theme areas: duplication, function of service coordination, conflict of interest, funding and billing, community capacity, network adequacy, and assessment. Additional comments not in one of these sub-themes are listed in the general section.

Sub-Theme 1: Duplication	State Response
There were many comments regarding duplication of services. Some of the comments expressed concern in the duplicated responsibilities between targeted case managers and care coordinators. One comment expressed concern over duplicative health screenings. One comment supported a need for alignment between state, local, and regional organizations, citing the discord as a source of duplicative services. One comment stated that the RFP is not in compliance with state law.	The State understands the concern regarding duplication of services, specifically related to service coordination activities. The intent of the service coordination program is to expand upon existing care coordination services to provide more comprehensive and inclusive care. The service coordination approach will allow all parties involved in the member's wellbeing (e.g., foster care case manager, primary care provider, family members) to communicate and work together. Service coordination is centered around the member and helps the member make well-informed choices. This type of choice counseling is not to replace the current choice counseling services offered by community developmental disabilities organizations (CDDOs). Please see Section 5.4 of the KanCare 2.0 Request-for-Proposal (RFP) for more information on service coordination. Health screenings and other needs assessments will be completed upon enrollment and re-enrollment. This screening will be completed by the community service coordinator or the party responsible for coordinating the member's care and will only need to be completed once. Please see Section 5.4.2.E.3. of the KanCare 2.0 RFP for more information on health screenings. No changes were made as a result of these comments.

Comments

1. Currently under the DRA CDDO services are responsible for choice, options counseling is what we call it, and I see that it's listed under the matrix as one of the responsibilities of the community service coordinator. Can you talk about how that will change for CDDOs, or will it change?
2. My comment is that I hope these requirements have been considered in alignment with other state organizations that are providing similar things, other local organizations, regional organizations that are providing similar things. Some of it sounds like duplicative services. People could be going through the same services at five different places and then their result is not coordinated care, but the individual has to do something again and again.
3. I work with the IDD waiver, we see duplication of services with the IDD waiver all the time with care coordination at our local targeted case managers, where parents and family members go to multiple meetings

	for the same thing. So just a comment for consideration of KanCare 2.0, we do see a lot of duplication and it's very frustrating for families.
4.	On those health screenings, you said when in KanCare, well what if you're already enrolled in KanCare?
5.	Concerning an RFP can be put out and waiver revision requested through CMS when it is not in compliance with state law. Specifically, DRA states CDDO provides choice. In the RFP service coordination RFP matrix options, counseling is included as a service they will provide.
6.	CMS is not requiring you to include nonmedical side. There is a problem with duplication on the other levels and you're trying to get rid of one?
7.	I have a question about community service coordination and how the roles and responsibilities of that person compare to the responsibilities of the foster care contactors as written in the RFP. It seems to be significant duplication of these responsibilities.
8.	About the only thing that I cannot do is to fill out applications. I'll admit to what I do. I don't charge for applications, I have a meeting with my families and we talk about the application and I talk them through the process. But bringing in a service coordinator to do my job. That happens and it happens to every single case manager. So why do we need a service coordinator?
9.	I get it's hard to put into words exactly how this goes, but at times I feel like you're trying to fit every person with a disability into the same box. I don't do it that way and I know a lot of other people that don't either. When you add another case management or a care coordinator, even now with the service that KanCare has, any interaction with nobody. I direct my own services, I'm on the work program, and the thing that works for me is, I need to have an independent living case manager. To tell you the truth I don't have a lot of interaction with him either. We have people that are very capable of making our own decisions on how we live our lives. The idea of having another person centered service plan or whatever you want to call it. I can't write my life down on paper, a lot of people can, I understand that, I wish I had a little of time to tell you what happened the first time when person centered planning started back in 97. It ended up being that, I found I had plenty of supports around me. I was getting services through a provider. I was in an independent living program. The people that I had on my person centered planning team were the ones that I talked too to try and decide what I was going to do when I had my first person centered service planning meeting. In that time my situation was a little different, I was getting services for about four years in a sheltered workshop, trying to get a job in the community. I had a case manager and employment services. Some of the jobs worked well but to make a long story short, I decided at the end of when I had my first meeting, I had come up with the idea to work as an advocate to for the provider that I was receiving services from. Let's say we had a little bit of a disagreement. I was having people tell me who I could associate with on my own time. A lot of that was other staff that were working. One of the things that I did was, I dropped my services in that first meeting. That was the best thing that I ever did because I knew that the best person that knows you is you. When you start asking other people to add extra layers on to a system that's very frustrating to navigate, I'm glad that I have people around me that I work with and I have friends and supports that know how I work. I've met a lot of people that are very capable of managing their everyday lives.

Sub-Theme 2: Function of Service Coordination	**State Response**
There were many comments regarding the function of service coordination. The majority of comments requested definitions explaining the differences between targeted case management and service coordination. The majority of these questions concerned the defined responsibilities of the service coordinator, and why the targeted case manager could not take on those responsibilities. Several commenters questioned the elimination of targeted case management as a service.	As a part of their response to the KanCare 2.0 RFP, managed care organizations (MCOs) will submit proposals for a comprehensive service coordination program that is designed to confirm that members receive appropriate care and are connected to other social supports and services. MCOs will make referrals for members who are eligible to enroll in home and community-based services (HCBS) waiver programs or to receive other long-term services and supports (LTSS). The State will assess each proposal and has the right to

Some comments requested clarification on the MCO's role within the process. Other questions requested clarification on the qualifications, training, and the licensure of the service coordinators. Some comments and questions surrounded the service coordinator's ability to be involved at the community level. There were questions regarding the person centered service plan or plan of care and where the responsibility of the document lay. Other comments and questions regarded the eligibility of individual contractors. There were a minority of comments requesting clarification on how individuals will be assigned service coordinators and whether they will have a choice in these assignments. Other commenters' questions surrounded turnover of care coordinators, how it relates to service coordination, their relative caseloads and ratios. One commenter asked about the method used to transition beneficiaries from targeted case management to service coordination. One commenter's question regarded foster care and service coordination.	amend the proposed service coordination program design framework. Please see Section 5.4 of the KanCare 2.0 RFP for more information on service coordination. The State expects MCOs to utilize the existing service coordination and case management structures at the local level by subcontracting with local entities for community service coordination. Community service coordinators will not replace existing case managers or care coordinators, they will instead create linkages with all parties involved in the member's care to promote sharing of information and maintain coordination efforts such as transition coordination. The goal of service coordination is to provide members a single point of contact and avoid duplication or gaps in services. Targeted case management (TCM) is a critical component of achieving greater integration of care and improved outcomes and will continue as a part of service coordination activities. The State stresses that members will be engaged in choosing a service coordinator. If the member feels that their current care coordinator or targeted case manager is appropriate for their level of care and needs, this person may serve as the member's service coordinator. Other providers or provider staff could also serve as the community service coordinator; however, it must be within their capacity. The community service coordinator must comply with all requirements described in K.A.R. 30-63-32-Articles 63 and 64 when providing community service coordination to individuals with IDD. The frequency of meetings will be determined together with the member during the initial meeting to develop the person-centered service plan or plan of service. Please see Section 5.4.4 of the KanCare 2.0 RFP for details on plans of service and person-centered service planning. Community Service Providers (CSP) are a community developmental disability organization or affiliate thereof, including but not limited to Area Agencies on Aging, Centers for Independent Living and Aging and Disability Resource Centers. Provider rates for participating in service coordination activities will be built into the rates that MCOs negotiate with the providers. The State will provide a code that can be used to bill for service coordination. The State will consider all concerns in reviewing and approving MCO proposals for service coordination program design. No changes were made as a result of these comments.

Comments
1. I'm interested about care coordination versus service coordination, and I'm wondering what some of the differences on what the MCOs are currently doing. I know the expanded population, that definitely made sense, but I'm wondering what the thoughts are on what to expect and what is different from what we're used to doing now? Kind of an expanded communication level between the MCO and local level to make sure we reach out to all services and options available?
2. A KanCare member has a care coordinator and TCM and there is already confusion on who they talk to for which issue. So in 2.0 there is a service coordinator and a community service coordinator those are the two people? That's confusing. Who do they talk too? How is that going to improve things?
3. Since you are anticipating the increase in service coordination does that mean targeted case management that was allowed to stay under the IDD waiver will go away or change in some way?
4. How is targeted case management going to fit in with service coordination for the IDD waiver population?
5. So service coordination will take the place of TCM?
6. You talked about the service coordinator, but what about the case manager with our MCO currently? Do you expect that we will be able to continue with the same people we've already established relationships with? Will this representative be from an insurance company?
7. My daughter has a case manager and she also has IDD. How does the new service coordination service change the way she receives services? So you are talking about this person would be with the MCO?
8. What circumstances or for what populations does KDHE anticipate the MCOs should contract with the community service coordinator? If there is a community service coordinator must the MCO also involve the MCO service coordinator? On behavioral health, are you talking about the target populations of SPMI and SED or are you talking about all behavioral health needs?
9. Is the role of the community service coordinator identical or strongly similar to the role of the targeted case manager (TCM); and if so, how would the state vision ensuring the conflict free case management when provided by the community service coordinator?
10. TCM in behavioral health is broader than it is for some of the other waiver services and so are you saying there would be a redefining of behavioral health TCM?
11. Care coordination would pick up those other things that don't fall into the four very specific categories is what you're thinking to get that coordination at the community level?
12. Are we talking about a model that looks like the health home model that we had a few years ago? I am hoping we will revisit that and see how effective that whole process was before we return to that model.
13. What is the vision for the MCOs service coordination which I'm hearing you talk about as it relates to the current and existing service coordination model for the IDD system? Is the intent to replace what is currently in place right now?
14. So when you're talking about service coordination and you're talking about the agencies and the service coordinator helping the member, what's your plan or vision for tying in the primary care provider, and are you eventually going to be looking at patient-centered medical homes, or is that in a different topic? I'm just wondering how the medical providers will fall into service coordination and reimbursement, and what that looks like.
15. As far as service coordination part, can you tell me how this will be different than health homes?
16. Who is responsible for doing the screening and who does health risk assessment?
17. Does the service coordinator act like a case manager or care manager, or does that function now disappear? There won't be those positions anymore?
18. Service coordinators not just through community health center, but open up to other mental health providers?
19. Will the service coordinators be located at the community mental health center buildings? Will they be the same people that are the targeted case managers today with training? Will each MCO be represented at the CMHCs?

20.	Service coordination: What are the qualifications, pay, and experience? Replace TCM? Currently TCM are licensed by the state. Will service coordinator also be licensed? Sixty hours now.
21.	TCM is narrowly defined in federal regulations on what can be paid for, it sounded like TCM is being rolled into service coordinator which will allow a wider range of referrals and services? How will that be reimbursed? Who will monitor activity?
22.	Will the local person have the same level of skills that the targeted case manager now has for the specialized groups?
23.	What kind of training requirements will there be and qualifications service coordinators?
24.	How will service coordinator increase access to LTSS?
25.	Regarding the PCSP, is there an expectation that the community service coordinator does one and also the managed care coordinator?
26.	Can you compare and contrast case management to your community service coordination? You say you're going to expand what case managers can do, and I'm not talking about the MCO, I'm talking about the community service coordinator with like the mental health case manager, or the IDD case manager, how do you see their roles being different, will it be a 15 minute increment or do you foresee it being a per member thing?
27.	Not the MCO role. How do you see the local case management role expanding for the ones that are already established? I don't know that you understand, I think we are speaking about different things. Have you had a lot of experience with current case manager roles?
28.	I'm not sure if you can answer this but, what prevented care coordination from strengthening social determinants in KanCare 1.0? What is the difference between the care coordination and service coordination?
29.	One slide mentioned that service coordination will oversee all of the aspects of the individual's care. Is that every aspect of the individuals care or is part of that service care? You're talking about the MCO or are you talking about the community service providers?
30.	Are the service coordinators going to be employed by the MCO or by the local community? I'm asking are the service coordinators going to be employed by the MCO or the local person we have?
31.	So they will have an employee in every community and know the resources in every community to be able to do this?
32.	So what will be the responsibility of the community service coordinators? If the MCO service coordinators will be doing everything what is the purpose of having community coordinators?
33.	So the service coordinator will fall under the MCO while the community service coordinator will be a part of the MCO?
34.	I'm still confused, who does the health screen is that the MCO?
35.	That information is provided back to the service coordinator at the MCO who oversees the total wellbeing of the individual?
36.	I'm a representative for this area and I'm here today as a provider. A couple of quick questions. Who will be the eligible contactors at the community level?
37.	So those that are providing currently through disability groups or public health providers will still be eligible contractors?
38.	Then skip back to the case management at the initial part of this slide. Is there an assumption that everyone enrolled Medicaid will have an automatic case manager or that be at request?
39.	Will those automatically be assigned to the individual? Let me give you an example of how it works in my world as a C13 special education provider. We are working with kids that are 12 months old. There is not a case manager automatically assigned to those. Those have to be sought out. How do we bridge that gap I see for some populations? How does that trigger happen?
40.	You have mentioned that the MCOs choose the care coordinator, they won't be the ones who choose the service coordinator?

41.	I'm representing HCA so inpatient hospitals one of our biggest concerns are the patients that we have a hard time getting placed after we have provided inpatient services.
42.	I'm from the hospital association, we worked with KDADS on the difficulty to place patients and part of that focus group was to figure out how to get these patients in the proper places when their acute needs are over. So I'd like some thoughts on how that fits in to what we are talking about here?
43.	I am the parent and guardian of a young adult receiving waiver services, we are here because we cannot attend the one this evening. I am happy to take my answer off line if it's not appropriate with what we are talking about right now. What happens to my daughter's case manager, someone that we have had a relationship for 15 years, now? That community based person has been at every meeting. I'm ready for your answer.
44.	Do you envision the targeted case manager function as a licensed service going away and being replaced by this community service coordinator? It won't be TCM?
45.	I'm with the Johnson County CDDO. First, working in IDD field the last few years having care coordination and then trying to get case management has been a confusing role with each other and with families. My initial reaction hearing about community service coordination is, that won't do anything to reduce the confusion of having a community service coordination and then an MCO service coordinator. With the community service coordinators replacing targeted case management, that was a licensed entity, do you still see that licensed under KDADS?
46.	Without community system our system for the IDD world would be in a lot tougher shape. Is the idea that MCOs would have to contract with service providers?
47.	In the RFP you're talking about ensuring the MCOs have an even distribution of caseload method. Is it the community service coordinator that the MCOs are going to be assigning who the community service coordinator is, or would the individual still have a choice?
48.	My question is in regard to service coordination at the MCO level. I've looked at the attachments and the handouts. Does the state define what reasonable ratio is for service coordination? Having heard so much about turnover, having too many cases assigned to one person, as a reason for people not getting the services they need, is there a reasonable case ratio that the state is defining for the MCOs?
49.	First of all when you talked about service coordination one comment was that it would be included the components of TCM with some additional services. But what could those additional services be?
50.	Question, one of the things we hear for our clients, I work with a community health center in Wyandotte County, is the number of people involved in consumers' lives, and who do they go to in the confusion that consumers have when too many people are involved. So is there talk to address that issue brought up by consumers? There is a thought in the RFP in terms of conflict free case management, to address that issue.
51.	Am I reading into that there is an expectation that those community service coordinators would be face to face with consumers and not just on the telephone?
52.	I thought that the reason TCM stayed in place for DD and mental health was that it was statutory that it stay with the CDDOs, am I mistaken about that? Is that something that can be taken or is TCM staying with those populations?
53.	Who at the MCOs would be in charge of developing the plans of care? I don't mean just about those populations at this point I'm asking questions more in broadly.
54.	You're not answering the question the targeted case management have no authority over the plan they can write a nice little plan of care. It then goes to MCO, they have all the ability to decide whether those particular paragraphs on the plan of care are going to be provided. Hours have been reduce, people have been harmed and in my sons' case, because we don't have enough staff, they have to call the police when he wonders away. The plan of care that the local people, the TCMs, have put in place is seemingly ignored by care coordinators who don't know our kids.
55.	I just talked to the legislature, we have some questions about the January 5th deadline when the MCOs have to turn in their applications. The very next week the legislature reconvenes. I know it does not take a lot of time to run through CMS for approval, it does seem rushed, because some people are saying its locked down

	the legislature won't be able to make changes because it would be violating contracts. You're saying you're making these changes to care coordination because CMS want to clear out any duplication. Was there consideration given to eliminating the level of care coordinators and keeping the targeted case managers that because that's the level that all of my constituents are happy with, and it's functioning well. I don't believe that they are forcing you to get rid of targeted case management. In other states they don't include the non-medical service that is not something CMS is requiring.
56.	One of the frustrating thing about dealing with multiple MCOs is the lack of consistency in standardization so I'm glad to hear you're looking into that. My concern is with local service coordinators and current TCMs, are those tasks consistent across MCOs?
57.	There is concern about the targeted case management and the families the MCOs work with health organizations so is there still going to be that divide?
58.	I would like to thank the KanCare and all the representatives here. I'm going to talk about a recipient in the facility. Will the service coordinator work with and discuss the needs of the recipient with the recipients' guardian? In the past I have had to hunt the down myself. Will the service coordinator work with the guardian?
59.	Will an individual on work program continue to refer to targeted case mangers? Are there still going to be living counselors?
60.	As far as changes taking place if the MCO is hiring people locally, will we not have, our situation our MCO is fantastic, if we lose that connection will there still be someone in between?
61.	What I hear from my constituents are that they are seeing care coordinators as another layer of bureaucracy and the targeted case managers are the ones who connect and engage the work to the patients. Earlier this afternoon you said you were doing this because CMS was requiring it to eliminate the duplication so why … why, it still seems like you are trying to squeeze out the targeted case managers. I think they could assume the responsibility of the care coordinators. I'm still not understanding why that wasn't a consideration.
62.	My current son's case manager can start doing more of what the care coordinator does? So I no longer have to deal with two people I can deal with just one?
63.	In 2.0 MCOs will contract out community service coordination? Who will those people be? That is not bee established and that could be a new business startup correct?
64.	I have a daughter in the system for 7 years so we have done pre KanCare and KanCare. We are confused about the comments you have made and some John has made. Just to be clear, who would the targeted case management report to under 2.0?
65.	So how many times do you plan to see my child?
66.	I've been doing case management for a few years. I have a few questions. I'm confused, first targeted case management is licensed by state under article 63 that protects that license is the service coordinator going to be licensed?
67.	First thanks for not shewing us out at 4:00. On behalf of parents I would like to ask why you are pulling the rug from under all of us who depend on our TCMs. This is something that nobody has asked for and it's going to make many of us unhappy. You have told us before that we could keep our case managers. The ones we have now we depend on. Why if there is no financial reason for you to set up a brand new little box. This system is working smoothly and as my daddy used to say, if something ain't broke don't break it.
68.	You don't know what the qualifications are? We looked up that during the break and there is nothing on your website like that. We went there. This lady talked about only having to worry about one person now, if you work for CDDO as a targeted case manager and you promised us we could still be TCMs that has not gone away right? Is targeted case management is done right?
69.	What are the qualifications? We looked at that during the break and it's not there. We went there, it's not there.
70.	Will MCOs also provide service coordination like they currently do?

71.	So far the experience has been, what the MCOs and care coordinators have brought, has been increased bureaucracy, more work, and meetings. What the targeted case managers have brought has been assistance, knowledge, they are a check and balance and an inviable resource to the family.
72.	If I understood something you said earlier is that a service coordinator or service entity cannot be a direct service provider entity correct? Today community mental health centers are able to provide targeted case management and bill for target populations and provide direct treatment. So under KanCare 2.0 the treatment centers have to decide if they will be a service coordination organization or direct care provider?
73.	I know that social determinants help is the new buzz word, but the problem that I see with this. First of all, did I hear correctly that the person who does the service coordination is now going to assume the TCM's responsibilities? Is that an accurate statement?
74.	How will the individuals select a care coordinator?
75.	So now everyone who's involved in assisting people is linked to the MCO? No, they're not, well, as a license, but as separate entities. They are separate entities. That's fine, as long as we don't lose the TCM.
76.	My question is, will the new service coordinator position in RFP that's getting developed, and they won't be employees of MCO? They'll be kind of local, kind of like the TCM role that people will have a choice, and they can pick who their service coordinator is, who knows about local resources? Will that person be able to help their families or their participants through the appeals process?
77.	My question has to do with Article 63. I wonder what you're going to do with that? Where it says that the Target Case Manager is licensed by state. Is the law, are you going to change that? Are you going to go to the legislatures and change that? It sounds to me like a lot of the things your service coordinators are going to be doing are similar to what TCM does already?
78.	What are the qualifications of the service coordinator going to be?
79.	Is community service coordination automatically available to someone in the waiver population or is that specifically authorized by the MCO service coordinator?
80.	I want to know if you have a service coordinator, are we going to lose that coordinator, or are we going to have to go to the state only. I'm worried about losing my coordinator.
81.	I have a question, I'm trying to figure out the relationship between the targeted case management and service coordination, and we have a couple of populations that currently receive targeted case management. Will service coordination supplant targeted case management or will service coordination expand TCM?
82.	I actually have a comment on service coordination. When they're looking at the client as to what their needs are, they need keep in mind those who are on severely limited incomes, because you said you could connect them with resources, service agencies – some of those cost money. And some of us don't have the money to pay for that
83.	As I have read some of the RFP, as it reads it sounds like community service coordinators cannot be attached to an agency that provides day res and or community personal care. With that in mid how would the role of the community service coordinator or the case manager as described in the RFP effect the function and working and payment of the current case management system as it relates to the CSP. If system change drastically what is the state's plan to effect such a major change in such a short period of time because as it reads it sounds like many people who currently have a case manager attached to the CSP will not be able to keep that case manager? If the organization is required to split that service as it is right now our agency can't provide that service, and we are caught because we are attached to an agency. It will be much more expensive to be separate.
84.	So historically we have been able to mitigate that. Will there be an option to provide mitigation so we can keep the structure as it is?
85.	You didn't answer my question, I listened to an ANCORE phone conversation yesterday, and there were some guidelines on how you can mitigate that. Will it be a possibility to provide those mitigating guidelines?
86.	It will be a big impact.

87. So my question is as an independent living advocate, hearing language about coordinated person centered care, is music to my ears. How is it going to become a reality? I didn't read the RFP and wouldn't understand it if I did. How is the state going to work with the MCOs? How are the MCOs going to coordinate with the organizations on ground and insure that the person, who is really at the center of all of this, has the choice and autonomy to make informed decisions about how to set and achieve their goals? Example housing, if you're somebody moving out of a nursing facility and you're got a disability, maybe you need access mods, and maybe you have some evictions, or have drug conviction against you. People have other issues that affect their ability, you can't go and find a listing in the paper and get your dream apartment. There are a lot of working parts. It's the kind of thing that just hooking people up with a phone number or an agency will not cut it. If must be and ongoing relationship to make sure the ball doesn't get dropped in the process. I guess what I'm saying is, from where I'm setting going from people singing blank plans of care to putting them in charge of their lives, is a long bumpy road.	
88. As an independent targeted case manager for the IDD population looking forward what the transition look like, the qualifications for the community service providers? We currently affiliate with all three MCOs looking forward, what are the changes and how will we continue to be a part of that and make sure our consumers maintain their services with us as well?	
89. Do you have the numbers for the IDD community? The number of individuals that will need a transition to another agency that only does the targeted case management coordination? I recommend doing that.	
90. I notice you mentioned having a coordinator for those on the waiting list. What would they be doing for those on the wait list?	
91. What you said was so important. From what I understand you will have the MCO contract out to have coordinators in the area? What's going to happen to people who are now TCMs working for themselves that are providers?	
92. Are they going to contract with individual companies or agencies, or is it up to them?	
93. My concern is that my children have been a part of the system for two decades it is a difference between now and back then. As time goes by I've seen things get whittled away. I can tell a big difference form when case management changed from one form to another how my children function. Even changing between case managers as well. So it mean a lot and the people that I'm close too have become an extension of my family, the MCOs are not.	
94. I was just a little perplexed on page 39 about one of the pilots. It's about improving foster care, I think that's fantastic, I'm concerned and confused about how service coordinators will help with the number of kids, the 3.1% in foster care obtaining permanency?	
95. Compare and contrast community service coordinator and targeted case manager.	
96. Define CSP.	
97. Will the community service coordinators be doing transition services? You talked about the MCOs helping people get – you know, make the transition from the hospital, the PRTFs back into the community. Then that would open up then for the community service coordinators to also be able to provide transition services	
98. So, not just people with IDD but everyone in KanCare would have those two persons? And IDD persons would no longer have targeted case management as all of the other waivers have now, is that true?	

Sub-Theme 3: Conflict of Interest	**State Response**
Many of the commenters expressed concern about potential conflicts of interest. Most comments expressed the issue that if the eligibility requirement is being decided by the MCO, who would control the coordination of the services. Some comments and questions expressed that they felt because the service coordinator was being	As a part of KanCare 2.0, the State seeks to ensure conflict-free case management by assuring that entities responsible for assessing individuals' needs are not the same entities providing direct services, in accordance with federal requirements in 42 CFR §431.301 and 42 CFR §441.730.

paid by the MCO it represented a conflict of interest as the service coordinators are perceived to be monetarily aligned with the MCO. Other commenters' questions requested clarification on the definition of conflict of interest as defined in the RFP.	As a part of their response to the KanCare 2.0 RFP, MCOs will submit proposals for how they can work to ensure that conflict free community service coordination is implemented. The State acknowledges that there are some exceptions and instances where only one entity in a geographic area is willing and qualified to provide case management and/or person centered service planning. In these cases, the State will develop conflict of interest protections, including separation of entity and participating provider functions within participating provider entities, which must be approved by CMS. The State will also develop accessible pathways for enrollees to submit grievances and appeals related to service delivery, quality, and choice. Please see Section 5.4.13 of the KanCare 2.0 RFP for more information on conflicts of interest. No changes were made as a result of these comments.

Comments

1. The fear has been, in a lot of cases with the new KanCare system, that you have a health screening, then care coordination with the same MCOs that are deciding what services someone needs. If there is a dispute between the family or the individual that they are not capturing services that they are used to or need, that is a conflict of interest in our view. How is that resolved? I hope that the care coordination works, and appreciate it but if the care coordinator is dependent upon the MCO they've contracted with or employed by, that conflict could still arise. Specifically with us, and with wheelchairs being denied and other things, there's been issues and probably will continue to be, we want to make sure there is someone we could go to outside of the MCO in order to get a fair hearing.
2. Targeted case managers do not currently work for the MCOs. The payer of the services who want to make money off of us has a conflict of interest in identifying what services we need. I find that very objectable.
3. I just listened to a presentation on conflict free case management. The presentation said "Managed care arrangements. CMS has permitted care managers in the MCOs to be case managers, but has required that the assessment be overseen and eligibility be determined by a separate entity, such as the state Medicaid entity. No provider of services listed on the plan do assessment or service planning." As you know, a lot of the targeted case management services are done by providers that are also on the plan, and from this presentation from CMS it sounds like "thou shall not do that anymore." So that service coordinator is going to be separate from a provider?
4. I am concerned about having MCOs in charge of contacting an "on the ground" coordination, which is currently targeted case management. Right now, having care coordinators separately organized than targeted case managers serves an important "check" to ensure a no-conflict-of-interest look at what is best for the consumer.
5. One of the topics we have not talked about is conflict of interest. How do we define it in the RFP? What providers will be able to provide community service coordination?
6. In terms of service coordination idea I don't understand how service coordination is not a conflict of interest. Specifically when the MCOs can provide service coordination they develop both sides of the plan. How is that not a conflict of interest, and ensuring that it is adequately staffed?
7. Then the RFP talking about conflict of interest in case management, can you address want level of separation would mitigate that conflict?

8.	Just on the conflict of interest, I guess the irony of it is, a conflict of interest occurs when someone has an incompatibility of their own private interest and that has to do usually with money. To me the MCOs are the ones who have all the money, and they are the ones who determines the cost of the plan of care and determine how many days of service your get, how many units of service you get. So to me it seems like that's where the conflict of interest is. If you have the money and determine what the care cost is, that's where the conflict of interest is.
9.	I'm cautiously optimistic about that, for example with health homes MCOs, and I know they don't do health homes anymore, MCOs had all the funds, two decided to contract with health home providers one did not and the state did not have the authority to do something about it. So I'm really cautiously optimistic, I hope there is MCO oversight in KanCare 2.0 there were many promises in KanCare that did not come to fruition.
10.	So when you talk about eligibility determination, and that's not something the MCOs contract or pay for, so how would they be in charge mitigating conflict when they don't have a role in that? You're basically saying that in the RFP you're ensuring that the MCOs have no part of it.
11.	KanCare 2.0 and the RFP has not satisfied issue of conflict of interest at all. You say that you are going to continue to separate the eligibility from the plans of care from the administration of these plans of care. What we've experienced is that there is an eligibility meeting that takes place the care coordinators hold up the plan of care there and without really knowing our kids needs they decided to reduce hours of care or change them in a way that is harmful to our kids or the parent. We don't see any reduction of conflict of interest. I'd like to hear about that as well.
12.	I have a couple of things that I want to talk about. I want to go back into conflict of interest, it's something that I've been talking about for a long time, since it started. We know that the CDDOs do the eligibility assessments, it used to be that they did the needs assessment along with the case managers. Now the MCOs do the functional analysis that determines the need of the individual. Then they turn around and decide how many hours they get. It is a total conflict of interest, I don't know why you let them get away with it. It's not right and it's not fair to our families. Are you going to do something about it?
13.	But won't they be paid by the MCOs, is that not a conflict of interest? This does not make sense and you know it doesn't.
14.	How are you going to do that? We don't have an inspector general or ombudsman that's neutral, how?
15.	This not specific to KanCare. How obvious it is at having organizations doing assessments for service delivery, controlling money, and doing everything else, they are going to be doing a lot more in KanCare 2.0. I don't see how you can say that is not the biggest conflict of interest ever. The role of the TCM is being weakened regardless of how you put it on paper. KanCare and Managed Care is such a conflict of interest, I am so disappointed at seeing this.
16.	Having the MCOs identify to you what the conflict of interest, is laughable. They have the money and they determine ultimately what the plan of care is. The MCOs are telling you this is conflict free correct?
17.	Just on the conflict of interest CMS had the thing we not supposed to provide service as sell coordinate the service, but there are ways to mitigate that. That's what Kansas has done all these years. You have different lines and ways that authority is, like a fire wall, in organizations like ours the director of case management is different than the director over services. I don't know if that is anything that you have talked to CMS about?
18.	That's going to be primarily dictated by the amount of funding the person gets that determines the person's ability to be able to live in the community. I don't understand why you would have the MCOs identify to you the conflict of interest that is ridicules.
19.	In line with conflict of interest is there a way to find out how much money has been made off of this? How much money has been given out? How much money given out opposed to services given out?
20.	I had a question about conflict-free case management, which has been mentioned. And I was wondering if the state had an idea on how that would be determined and when we would possibly have a plan so that – we probably do need a plan in order to make sure that it's not disruptive to the people we serve. And, so, I'd like – if you have any information on that, it would be helpful.

Sub-Theme 4: Funding and Billing	**State Response**
Numerous comments and questions requested clarification on how the program is going to be paid for. Questions ranged from identifying cost estimates, cost neutrality in lieu of expanding the program's range, the overall expense of the current program, and the perception that the current MCOs are not making money, and therefore could not afford to expand. Some commenters expressed concern regarding the elimination of targeted case management services. Other comments and questions regarded reimbursement rates, some of which requested information about its relation to behavioral health services. A few commenters requested information about coding, specifically how will service coordination be coded, and the adding of codes to assisted living and behavioral health. There were a minority of commenters with questions concerning capitation. Other questions regarded alternative fees, transfer to MCOs, and foster family billing.	The initial actuarially sound rate range will be developed by the State's actuary after the bids in response to the KanCare 2.0 RFP are submitted and will consider the cost proposal information provided by the prospective bidders. Provider rates for participating in service coordination activities will be built into the rates that MCOs negotiate with the providers. The State will provide a code that can be used to bill for service coordination. The State will consider all concerns in reviewing and approving MCO proposals for service coordination program design. No changes were made as a result of these comments.

Comments
1. I am not clear on the funding in regard to the service coordinator role. Is it going to be a waiver service or part of the state plan and modified?
2. You mentioned targeted case management (TCM) narrow and that billable hours are minimal, and that by doing service coordination you can increase the opportunities for somebody to coordinate the services. How would that differ? How is the reimbursement rate going to be changed from what can bill under TCM versus what service coordination is? To follow up then, the eligibility for these waivers and for Medicaid, will that still be separate from the MCO?
3. How will the capitation note pay for service coordination? Will it be a note that differs between MCOs?
4. Adding the requirement for high fidelity wrap around. Who provides that service? State, MCO, or provider? Will the state provide the coaching/training that goes to perform true high fidelity wrap around or will that be the responsibility of the provider? Will the state alter fees and codes to cover the lower case load/staff ratio? Lower supervision/staff ratio?
5. If CMS doesn't recognize service coordination as a comprehensive billing code how can it be "coded" to ensure billing effectiveness? Billing rejections in KanCare 1.0 have created business closures and other impacts on network adequacy and capacity.
6. With TCM the way it's being done now versus putting it in the 1115 and then being able, that allows us a lot more flexibility for that service and getting that service paid for with match money is really what you're saying isn't it?
7. Wouldn't it be up to the MCO, in their proposal, to tell you how they're planning on how they're going to do that?
8. Billable services that are currently under TCM model, are those going to change, some things go away?
9. Any idea what some of those billable services might be that will be transferred to MCO?
10. I guess it boils down to financing. Is somebody going to pick up the cost if they can find somewhere to move these patients? Particularly with foster kids on our units, they don't have a safe place to go, it's not safe for them to leave, and will we end up on the hook for that?

11.	In the Medicare world there is chronic care management that is paid to health care provider to oversee chronic care and other types of services the patient may have. I don't know how that will fall in future discussions but I think that the funds that back into the hands of providers that are taking care of the services should be taken into consideration.
12.	How will that be paid?
13.	First question, is there any exploration or discussion about adding codes for per diem for assisted living care, similar to or benchmarked across the skilled nursing per diem? We as a provider have an extraordinarily difficult time of providing business intelligence any type of reporting at the executive level with respect to the MCO systems.
14.	Are you going to do these things? And pay for them?
15.	I've heard that, although you responded today about how your service coordination would be paid for, you said that it hasn't been quantified, I've heard some discussion that it may move away for fee for service?
16.	I have a question related to that provider relatability because you can have the best in plan in the world, and I feel like we have very good plans, and I have nobody to execute them. Here is an example of why this is an issue, I have an adolescent that I was serving in rural north central Kansas. His EVA service provider traveled to his home one travels an hour each way the other travels an hour and a half each way and they get reimbursed at $25 an hour to pay the provider this doesn't include my billing that I do have to contract out to try and track the money that doesn't get paid adequately or directly. It takes me just to pay the provider $108.50 I can bill down $100 for that session. So this is pretty consistent across the board. We actually end up, our Medicaid clients cost us money we are not for profit we have to maintain a ratio to maintain out Medicaid clients we have to take on additional higher paying private insurance. So I think there's a, I'm wondering what kind of costs you are looking at especially in these rural areas where services providers are not going to be readily available they will have to travel?
17.	A lot of times when we are providing those direct services we are doing 25 – 40hrs of intensive intervention per week that's not including Telemedicine comes out to be what the direct service provider, for example this job trying to provide on the SED waiver coordinating with this local PD health center, he had been out of PRT for months now without a single service provider. So we are trying to find multiple funding sources to meet the needs of this child. This is just one example we work also with the IDD waiver it's kind of the same song and dance over and over again.
18.	Is that reimbursed by unit or per member per month? Where are you getting the proposed baseline rates for that?
19.	Starting January 2018 there is a substantial change to one of the codes on the TBI waiver. I'm not sure the state is aware of the implication of this who do I need to talk to?
20.	So first I think it's great, a lot of these things and ideas are good, and it shows some listening is going on, and being responsive to that so I appreciate that very much. At the same time I didn't go through the RFP so I can't say how it's going together. One thing I did going through the application, there wasn't detail and maybe that's in the RFP. I wish I knew how this was going to work. There were themes and concepts and ideas that were good but I wanted more and that may be my lack of looking at the RFP. One of the things I looked for was budget detail. All there is the global, we're going to spend this may hundred million on KanCare. The one thing that it said was that, we are asking for the same expenditures in KanCare1.0. You're not expecting new expenditures? As much as I love these great ideas massively expanding care coordination contacting with agency that are local and address social determinates, this is big very important. I can't believe it will be absorbed in the current budget. My question is: is there new money? I combine that with what I saw with the supplemental requests. This is a lot of money, this is not like you scrapped around and found some extra change. Where is the money coming from?
21.	First of all, I'd like to go back to the comments about all these expectations. I want to remind everyone when KanCare first started one of the first things that was promised was that there would be a pilot project to get things under control. Several years later the MCOs billing pay system is still not adequate. There are payments going to provider and providers have no idea why they got paid some don't get paid at all. Some people think

	this is intentional so the MCOs can keep all the money. After all these years something as simple as billing and getting paid this is not straightened out. I have no confidence that added MCOs will have a better of paying or their ability to pay. That needs to be taken care of. That has been in place ever since KanCare started and still hasn't go straightened out.
22.	I think part of the issue that parents and guardians have is a belief issue. A belief that what you say is going to happen. The reason I raise that question is that we have validation. We conducted a state wide satisfaction and their satisfaction with KanCare. Frankly, the MCOs have flunked when compared with the quality of care out kids get with target case managers. It's hard to believe that in the course of a year this is going to turn around and be better than it is now. Which is why I raise the question why fix something that's not broke. When I look at how the targeted case managers currently perform and the quality of work that they do. Then look at the experiences that parents throughout the state continue to have its hard to believe that anything is going to change for the better. When the state is paying for nonmedical supports, just for that portion of HCBS $27 million an year for care coordination, if you're ever going to achieve what you're saying, I don't know how much money that is going to cost the state. If they are currently paying $27 million for a program that has flunked. So we have grave concerns about KanCare 2.0 and the fact that targeted case managers are probably going to be replaced by service coordinators.
23.	With some of the other service that are contracted out, it's difficult to find providers. Like with behavioral services or nursing, the reimburse rate is so low some companies don't want to go with an MCO. How will you ensure that does not happen?
24.	In the current 1115 application the most striking thing to me is that a there was no cost estimates in the entire application. I find it disturbing as it makes it difficult to make comments and gain a full understanding of the program if there is no finances, to me if there's no finances there's no plan.
25.	If you attempt to do something cost neutral with 2.0 and expanding services. I know it's wonderful to expand services. I sat in on a number of meetings where you stripped targeted case management from other services a few years ago. I have horrible stories about how targeted case management was stripped, and in doing so services were also stripped. I don't know how you will keep it cost neutral and expand the services that TCMs provide and not strip money from somewhere else. MCOs are for-profit organizations, and we all know what for profit organizations are supposed to do, and that's make profit. A lot of us are questioning as this gentleman over here, where is the money?
26.	I'd like to say the targeted case managers, they do other services for us consistently, and they haven't been paid for them, but they care intensely about the people they serve. What happens in this new system when we get those new services and suddenly there is no money? Because it appears to me that the money situation is a critical mess here.
27.	It's really difficult to grasp this is going to be cost neutral. There is an assumption that each community in which these services are provide will be capable of finding the talent and the interest necessary to take on the initial responsibilities, I'm not sure that set of assumptions is reality.
28.	If it's true, what we hear are the MCOs are currently not doing well financially. How is that going to make sense? If in fact the MCOs are not doing well now under the current system, taking on additional duties and responsibilities that you described. How is that going to make good business sense for the MCOs and how does that translate to services?
29.	Back to uncompensated care pool and the proposal at changing the uncompensated care program. Those changes have not been run through the Health Care Access Improvement panel that oversees that program. So that is concerning to us. Those are the funds from the traditional program from a tax put on to hospitals. We are concerned and wondering where the extra money is coming from. We would like some discussion on how that will impact our hospitals.
30.	This has nothing to do with the state reimbursement for those? Just the hospital disproportionate share?
31.	The SED waiver noticing some of the requirements of high fidelity wraparound. So that program is expensive and I was wondering who is going to bear the cost of training providers around the state to provide that

service. Part of our feedback was that it was important to look at reimbursement rates the program could fail within two years.

32. We as an IDD provider will no longer bill for TCM after 2018, correct? That worries me, and that's a problem. I've been around about 35 years. I got a pretty good feel for this. We have a lot of families and a lot of great people on Kansas. What this means on human side is that odds are if goes through, Lake Mary as a provider will no longer be able to employ 14 coordinators. Most have been with us between 10-20 years. They know the people we serve as well as their parents in most cases and veterans some. These service coordinators serve 420 people a day. I know everyone well. I am concerned because this is an aging demographic. Most are over 40 not are not well, and are losing people at a high rate these days. I know 400 people on first name basis that will be devastated if they lose their service coordinator. And I think that's something you should know. I understand cost. The human side is bigger than anyone has given consideration to. This is a big deal in Kansas. We have to be careful that we don't make a big mistake here. You've got to take a look at yourself, take a look at the scenario. Over the last 35 years in Kansas Grace Med has done an amazing job providing community service to people with developmental disabilities. Most of us that took part in the pioneering effort in the late 70s and early 80s had a clear vision of what it was going to take to be there for folks. We have to be careful that through bureaucracy and cost that we don't sell out the real ability for us to do basic services. I have no idea of how to run my operation without our service coordinators that are intimately involved with the people we serve and supporting parents that are aging and dying, I want us all to understand the human side of what is going on here.

33. Targeted Case Management will still be allowed as a billable code for those entities?

34. So in theory these folks sitting in this room, their billing mechanism will change dramatically?

35. I had a question about the targeted case managers now and what their role will be in the new system, whether they – what their role will be? So, what would the rate be because the TCM had a rate of pay – what would the rate be for that?

Sub-Theme 5: Community Capacity	**State Response**
A smaller sub-theme category that emerged was community capacity. Some commenters had questions about the ability of the MCOs to operate within the community and provide services that addressed social determinants. Most concerns regarded MCO experience in accomplishing this role and the MCO capacity as far as personnel in order to provide adequate services. Additional commenters posed questions regarding the MCO's ability to fill service gaps that build capacity within the communities. One question requested clarification on the provider's ability to expand into service coordination.	As a part of their response to the KanCare 2.0 RFP, MCOs will submit proposals for a comprehensive service coordination program that is designed to confirm that members receive appropriate care and are connected to other social supports. MCOs must demonstrate their experience with working directly with community partners and will leverage existing relationships within the community to coordinate services. MCOs and the community organization must work together to identify where gaps to services exist. No changes were made as a result of these comments.

Comments

1. We've been very concerned that the social determinants haven't been addressed prior, so we're really glad to see that we're really looking to strengthen the service. Where my concern is, you had mentioned you need to support this financially, because what has been happening is that for the particular members of certain waivers, if they did not have TCM services available, the care coordinators would basically tell that person we'll call this entity. And that's all fine and good, but again when there is no financial support to help these other local communities provide these services to make sure that they've got their medication that they can afford it, to make sure they've got housing, so that they know where the food bank is, to make arrangements so they don't use their utilities or whatever it may be - I just hope that you really truly do, that there is some

	type of, if it's not happening at the MCO level, if it's going to be pushed back to the local level, that resources also follow in that direction.
2.	How will you assess the capacity within the community for the providers that will be contracted with or the MCOs will be contracted with?
3.	There are some gaps in the capacity of communities to have transportation, housing, whatever, available. Will the MCOs be responsible then for building that capacity within the communities?
4.	And you're confident that the MCO has the capacity to do that, since they haven't had a good track record?
5.	I'm just a retired physician interested in things. When I hear the discussion of a 360 degree view and concern about social determinates of healthcare, I don't see the MCOs as having much experience in dealing with neighborhood security or dealing with food markets in neighborhood or other things that have a great deal to do with health. I see that in order to address those things that's an enormous expense. That's really kind how I range what I think of KanCare being responsible for. So it strikes me that this idea that you provided the access for something is kind of a paper coding instead of really doing something about it?
6.	Has there been any thought given to MCO being able to contracting with providers to do the community service coordination?
7.	I'm sorry but some of your answers about community coordination I didn't understand. Are community agencies, you said the MCOs would work with community agencies, do agencies have opportunities to expand what they are doing or if dealing with a specific population?
8.	Another comment I had, you had made a statement that there would be local service coordination in each community as opposed to an 800 number that people call now if they want help, and they may not have to wait more than a day or two to get answers, or not get answers at all. That's a lofty goal.
9.	So 2.0 will result in the total number of people. Will the number of care coordinators be reduced?

Sub-Theme 6: Network Adequacy	**State Response**
During the comment period, a sub-theme emerged covering network adequacy. The majority of questions and comments were in regard to the perceived inability for the care coordinators to adequately service the IDD community versus the ability of the targeted case managers. Some questions and comments centered on the larger caseload sizes of the case coordinators as a burden in delivering service. Additionally, there were a few questions requesting clarification on how network adequacy will be determined and what would happen if an MCO network was found not adequate. Other comments cited that there are not enough case managers for waiver recipients, rural networks are too sparse for some services, and that care should be taken to include other ethnicities.	As a part of their response to the KanCare 2.0 RFP, MCOs will submit proposals on how they will assign and monitor service coordinator caseloads. See section 5.4.9 of the KanCare 2.0 RFP for more details on service coordination ratios and caseload assignment methodology requirements. MCOs will develop policies and procedures for identification, recruitment, and retention of participating providers. The State expects MCOs to ensure that services are provided in a culturally competent manner and is responsive to members' health literacy needs. See Section 5.5.4 for more details on cultural competency and health literacy in the delivery of care. No changes were made as a result of these comments.

Comments	
1.	With the community service coordination. Currently there are not targeted case managers for all waiver recipients. Do you anticipate a network adequacy problem in January 2019? Will they fit with the conflict free requirement you will have?
2.	You said members' coordinator will be in their community. What does coordination look like when you're 100 miles east or west of Wichita? Is it one coordinator per county when you get out toward the west or what are we talking about there? You talk about increase service coordination.

3.	With service coordinators, will there be any requirements for MCOs to take into account demographics, such as in southwest Kansas the increase in Somalians, Burmese, and different ethnicities? Will there be any additional support to help those populations that need the most help in KanCare, and yet those resources don't seem to be available all the time?
4.	It seems as though we are expanding the case management and the service coordinator as some to oversee and connect what I'm seeing is not necessarily a problem in connecting patients with providers. It's the lack of providers. As we expand case management that does not does address lack of providers in certain areas or the lack of providers that provide certain services. What does KanCare 2.0 do to incentivize the expansion of these networks?
5.	I've looked at several different services that my company does not provide trying to come up with a business model that would function without going in to some of those root causes the expansion of provider network doesn't seem that difficult.
6.	I come from IDD, it's interesting to hear from the hospital perspective, how they don't seem to be doing that well with the MCOs and that kind of thing. When you talk about network adequacy I feel like you're talking about if there enough doctor, hospitals dentists etc. you not speaking in my opinion to the provider who is doing that boots on the ground care with IDD for example. It is a fact that very few licenses for new providers have been given out in the last few years. What's up with that? Second it sounds the MCOs are doing all the work for KanCare, who is giving licenses? Secretary Keck asked for $94 million to work the IDD waiting list, where are you getting providers if you get the money? Who is doing the licensing of IDD providers? I'd like to know how new licenses may have been given out.
7.	What can 2.0 do to help with adult psychiatric care at this point? We have to pay for a second insurance policy for our children because KanCare does not have enough doctors. How are you going to convince providers to join the network?
8.	I should have been here tonight but I'm not going to be here. Several parents asked me to relay questions about KanCare 2.0. We are a group that we went through provisions that are online and we were devastated that there wasn't anything that assured us that 2.0 would be better for IDD. MCOs are not able to handle IDD needs, they can handle our medical needs, but the day to day needs cannot be handled with an 800 number. We need our targeted case managers. You promised us that we could keep our targeted case managers and that they would have eh same responsibility. Now they are going away. Care coordinators or whatever your call them now service coordinators, are no substitute for TCM. Your caseloads for care coordination are up to 200 per person even if you have that it's not going to be sufficient for the IDD population. We are fin with the medical portion of KanCare. We believe it's unsuited for non-medical care or the day to day needs that people have. To add to what Susan said we were grateful Secretary Keck asked for more money for the waiting list. The problem is there aren't enough providers in Johnson County if you took all of the people off of the waiting list. I think that there's 590 in Johnson County alone. I have a son that is being taken care of by 2 agencies neither one of them have enough people to take enough people that they could put a dent in that. You take 590 people and dump them into the provider network you're not going to have enough providers. One providers use money for every person they take into service. They are not incentivized. I would have rather seen that Secretary Keck asked for more money for a rate increase. With a rate increased providers can provide services and not go out of business, especially the smaller ones who don't have the ability to wait for reimbursement.
9.	If the case coordination case load is so huge it makes it impossible to have the level of interaction you're describing. Would the case load numbers increase?
10.	We provide TBI therapy services. What determines when a network is adequate for an MCO? What happens when a MCO network is determined not adequate? What are the next steps for the insurance company?
11.	So until 2019 there is not a threshold for adequacy?
12.	How many consumers will each service coordinator have?
13.	Right now service coordinators have hundreds of people and they can't help everyone.

14. They have unbelievable caseloads; how can they provide all that personal touch? I have experienced VR first hand and they have a big caseload.
15. Currently, it is our understanding that case coordinators have caseloads of 150-200 when the target case managers have caseloads of 30-35. What caseloads are you currently looking for these service coordinators? Is it going to be 30-35? I don't know how the MCOs are going to accomplish that. I speak from experience because I worked for a MCO, It's a tall order
16. I hear that you're trying to improve communication with the service coordinator. What I want to know is how are you going to address the lack of consistency and the high turnover rate of service coordinators, so we providers can be good providers for the people we work for?
17. Right now we can do up to 60 hours per person per year. Is that comparable to what a service coordinator will do? How many hours will we get as a service coordinator? You don't know? Unlimited hours?
18. I have a few questions about service coordination. I can tell by Brad's comments and others, this whole concept of service coordinators and TCM has been a hot ticket item since the beginning of KanCare, and I know that it sounds like you guys really took in people's feedback on that and some of the issues, so I appreciate that. I have a question and I have a comment. My comment about service coordination is I look on page 5 and that's a great diagram with service coordination and all the services, however my real-life concern is that if there aren't services and there's not network adequacy, then none of that matters. You can be the best service coordinator in the world, but if we don't fix the problem we have with network adequacy, the service coordinators, TCMs, aren't going to be effective at their job.
19. We need to be cautious and mindful of what we are asking to make sure that the services are provided for adequacy.
20. Obviously the needs in rural and frontier areas look very different than other areas. Specifically, behavioral health, the number of providers is very scarce, it's just hard to find and retain staff and meet those needs. Also being in the Southwest corner there are significant ethnic issues. In Seward County we have the highest percentage of Hispanics in the state, and that's just documented individuals, do of course we have a large undocumented population as well. Some of our experiences with the first version of KanCare and MCOs, just generally speaking, they were not always as aware of rural and frontier issues, there isn't always enough providers. Could you talk a little about that very real aspect of Kansas?
21. Will there be some kind of target or lead on how many persons can be served so that the case load don't get so big that are not manageable?

Sub-Theme 7: Assessment Process	**State Response**
The majority of the comments and questions in this sub-theme area concerned oversight and how services are determined. Commenters wanted to know how the highest level of independence would be determined, what the appropriate level of case management was, and who determines these levels. Comments and questions regarded how member participation and choice would be ensured in the process, as well as what oversight would be in place to ensure the right metrics are being collected.	The intent of service coordination is to provide more social supports that can help members reach their full potential for living independent lives. KanCare 2.0 MCOs will align the level of case management with the member's stated goals and needs in their person centered service plan or plan of service. The person centered service plan or plan of service is intended to involve and encourage members to participate in the development of their plan. Service coordinators working with specific populations will have certain minimum qualification requirements that are appropriate to the members' health care needs. The service coordinators will perform activities within their scope of practice in accordance with applicable licensing/credentialing rules. See Section 5.4.8 of the

	KanCare 2.0 RFP for more details on service coordinator qualifications. The State appreciates the feedback and will work to finalize evaluation metrics upon CMS approval. No changes were made as a result of these comments.

Comments
1. How is the highest level of independence determined? Denial of services?
2. What is the appropriate level of case management? How and who determines needs?
3. I can speak to the technology assisted waiver. There is a universal assessment tool that is run by an MCO. It is utilized and says that there must be a minimum level of service provided. You are saying that, "I don't know what the assessment tool looks like" if you are saying a similar thing that was being used then that has created a good dynamic for that waiver so the universal assessment tool goes into the flaws in the tool but as a proof of concept it has shown some success.
4. I've been working through the application and the still working through the RFP and trying to figure out how they work together. One of the concerns relayed by waiver participants is plan of care requires their presence but not evidence of their participation. I don't know if that's opportunities to ensure someone's input is sought and included into the plan of care.
5. I'm wondering what is your measure of success what kind of ongoing assessment are you going to do to show this is a better model that what you currently have now?
6. If the individuals that are going to be working on this now are not licensed what control do we have cover the quality of the service?
7. My next question is: how can you guarantee oversight of this service coordination person when we haven't seen oversight of service coordinators in three years when KanCare's been here? Because I work with four self-advocates, not one of them has ever been contacted by a service coordinator, they don't know who their service coordinator is, and there is virtually no oversight for that. [Changes made] on the part of KDADS and KDHE? We've had the state's expectations. My problem is with actual oversight. It hasn't happened because you don't have enough people. I'm sorry.
8. What would doing a good job look like in long term services?
9. I was hoping some of my cohorts would take it up. One observation on the list of exclusions it doesn't appear that the people on the waiting list are by default on that list of people that are excluded in the application. I would make sure that you explicitly express that. It may be implied but not specifically cited. Second thing in general and again we have had opportunities in various work groups you're going to get what you measure and I thin as it relates to independence, as I look through the application there is very little there that measures how we moving the bar on independence. There's a lot of medical and health care things that you're measuring. You've done a good job of listening and adding components. When you look at the data and the thing that you measuring it still tilts heavily medically. I would encourage you to look at additional ways to measure and gather that input. A lot of that is going to have to be member surveys beefing up the NCI options, or looking at other ways where you're getting information from the member.

Sub-Theme: General Comments	**State Response**
General comments in this themed category ranged from questions about individual services such as TBI additions and transportation, to how the renewal affects inpatient hospitals. There were general questions concerning all of the services in the 1115 demonstration waiver and what	The KanCare 2.0 demonstration waiver application is for calendar year (CY) 2019 and will exist with 1915(c) waivers. This start date will allow time for the State to go through the process to secure federal authority for the

benefits would still be available. Some commenters posited questions regarding the number of MCOs that will operate after the renewal and when these changes will be instituted. One commenter asked for a rationale for the change. There was also a comment regarding the strengthening of the Ombudsman program.	KanCare demonstration. In 2018, the KanCare program will continue as is. Members will be able to choose which MCO to enroll in. If a member's current MCO stays in KanCare 2.0, the member can choose to stay or change their MCO. If a member's current MCO does not stay in KanCare 2.0, the member will choose a new MCO. The member will only be auto-assigned if a selection is not made within the designated enrollment period. Members who are currently using the MCO care coordinator may continue to meet with the same person and choose to not have a community service coordinator. However, the current care coordinator would serve and function as the service coordinator. No changes were made as a result of these comments.

Comments	
1.	You talked about the choice of MCOs in 2.0. In 1.0 there was an auto assignment process. For folks that are with MCOs that may vacate Kansas will it be an auto assignment or will they have an opportunity to choose among the MCOs that are part of the plan?
2.	Once you get through your process does the 1115 demonstration have a maximum of MCOs or is there a possibility we could have more or less than three?
3.	A lot of my clients depend on transportation. Will that benefit still be available? That's one of the barriers my clients have.
4.	I believe these actions will address growing issues of youth having to deal with a parent guardian who has impairment. Proactive actions will lower teen pregnancy, drug abuse, high school dropouts, and incarceration.
5.	We are talking about KanCare 2019. What happens in 2018?
6.	We just got used to 1.0. The waivers have stayed under the 1915c, I think that's because the federal government said they wanted it, or its part of the special terms and conditions. Is that going to continue? Are you asking for everything to go under 1115?
7.	We have advocated for years for strong legal based Ombudsman it's been hung up in the legislature. The state agencies over KanCare have been our chief opponents. Here the Ombudsman program is not to advocate on behalf of the consumer which is the definition of the ombudsman in most cases except for Kansas. I think it would be important to consider building a much stronger Ombudsman program. And ensuring that it is adequately staffed
8.	I want to start out with one personal comment and a question. First question I noticed on the glossary of terms there is no reference to Targeted Case Management. Everything is the MCO terminology and I'm not sure why. The other thing is, this is a personal pet peeve. To me using the term member de personifies that person, that's an insurance term I'm offended by that term member to the people we support and that's my personal opinion.
9.	It offends me as a long time person serving in the support system. I've stressed this before and will continue to, it's a personal thing. Member is an insurance term. If I were a person with a disability I would be offended. There are several terms, person, individual, have been commonly used, beneficiary is one.
10.	In order for a service coordinators to promote independence consumers have to have adequate access to service. Will KanCare 2.0 consider including persons with acquired brain injuries into the Traumatic Brain

	Injury waiver that way they will have access to the intensive rehabilitative service? I would like to see that included.
11.	Just an observation on service coordination is also currently known as care coordination, why are we trying to fix something that isn't broken?
12.	What was the correct term for personal care management? Person center service plan? If I would have been able to implement that better I could have not wasted your tax money.
13.	Have you ask us if we want those expanded services?
14.	How long have you been with KDADS? So you have been her pre-KanCare? Couple of things, what's going to be incentive for current MCOs bid on this new contact? What kind of pay raise are you guys going to negotiate into this contract? If you think you have complaints about this current system, go ahead and do what our talking about where you're not going to have targeted case managers or they're going to be called something else. Sounds like you're going to call them whatever, those persons are not going to have the relationship as with the individuals that they currently have. Even if they provide the four services that you're talking about. I'd like for you to touch on those four services for everybody else. The bottom line is, have you asked any families what you thought we think? Because those of us who have a care coordinator through the MCOs will tell you we see them twice a year. The targeted case mangers know our people because they see them once a month. You are going to take them to the food pharmacy or whatever that sounds great so pie in the sky, but when it comes down to persons being taken to the psychiatric ward the first person the parent calls is the targeted case manager. Because you can't get through to the care coordinator. I think the fact that the state assumes that you know what is best for us and our kids is what is very irritating.
15.	I think that this is good. I would like to see more focus on providing community services. When we talk about the inpatient services, sort of what I was talking about, prison and foster care is the last resort. This is extremely disruptive and traumatic, I feel like there need to be much more focus on community based services to prevent people from getting to that point.
16.	I'm representing HCA so inpatient hospitals one of our biggest concerns are the patients that we have a hard time to me getting placed after we have provided inpatient services. This sounds like an extra layer of care. It sounds like possibly there will be some assistance in place after we provided services. We are already struggling getting those patients things. I'm not clear on that. How are we going to place those people that is going to be different that today?
17.	Are you going to get rid of article 63?
18.	We don't have a targeted case manager. We have a care coordinator from the MCO. And that is it. And if we continue with our current MCO will that be the same person at the MCO that is going to provide the service coordination that now provides the care coordination? And this would include anybody on HCBS as well? I think you didn't mention that in you last comment.
19.	Does this mean that there is yet another person for a person with – intellectual disability who already has targeted case management and the care coordinator that they'll also have a service coordinator?
20.	Will the individual in the HCBS program still have the opportunity to select who their local service coordinator is?
21.	The MCOs – would each MCO determine what the role of these community service coordinators would be? Or would that be something that's specified in KanCare 2.0 – what exactly the roles are between the two?
22.	I'm just going to refer to slide 20 on the service coordination. I'm still a little confused, I guess, on the WORK program and the ILC role. The list of people that the service coordination – I'm going to guess that's the MCO service coordination that includes the Work Opportunities Reward Kansans. But, I just wanted to make sure if that was the MCO service coordination or that was potentially the community service coordination
23.	On the plan of service, I just want to try to be clear about this. Does this include what is currently the integrated service plan and the person-centered plan – person-centered support plan? Is that like an inclusive thing of both of those items? And, then, who is doing this plan of service? And who would be responsible for that? Would that be the MCO care coordinator? It seemed like there's places where it says the plan – the

community service coordinator would be doing the plan of service and the person-centered support plan. So, it's like, well, what is it – they are two different things or the same thing? I don't know.

Theme 2: Promote Highest Level of Member Independence

KDHE received several comments concerning promoting the highest level of independence. These comments fell into three main sub-theme: administering the work requirements, losing access to care, and the work requirement overall. Additional comments not in one of these sub-themes are listed in the general section.

Sub-Theme 1: Administering the Work Requirements	State Response
KDHE received several comments in regard to the administration of the work requirements outlined in the presentation. The majority of comments centered on how capacity would be determined for the work requirements. A minority of questions asked how the State would implement the program, if it would be statewide or administered in counties. Comments and questions concerned the support systems needed to implement the program such as child care, whose responsibility is it to find the resources, and what resources would be available in rural areas where jobs are more scarce. Other commenters requested clarification on who would be providing employment. There were a few comments that supported the idea of employing peer mentors from the beneficiary population. Some questions regarded supports like education, job training, and job coaching as priorities. Other questions requested clarification on the MCO's role in administering the work requirements. Several questions requested clarification on the role of vocational rehabilitation within the program. Other questions related to tracking various outcomes such as compliance, how the state would manage community service hours, and how exceptions would be managed. A minority of questions asked if this was a priority given the low population numbers it is expected to affect.	The State understands that steady employment can provide the income, benefits, and stability necessary for good health. The State is in the process of designing the work program requirements, implementation steps, and procedures for monitoring. The State is also coordinating with other state agencies on employment programs. The State plans to implement the work requirements across the entire State of Kansas. The State will assess whether KanCare members must meet work requirements at the time of application for Medicaid or redetermination. Most KanCare members are not required to work, such as members receiving long-term care, members who have disabilities and are receiving supplemental security income (SSI), and members who are enrolled in HCBS waiver programs. KanCare members who are required to meet KanCare work requirements have a maximum length of 36 months of KanCare coverage. During this time, the member has a grace period of up to 3 months prior to meeting work requirements without losing coverage. The State may extend this grace period by a month in exceptional circumstances (e.g., natural disasters). The work requirements are similar to State Temporary Assistance to Needy Families (TANF) program requirements. Please see the KanCare 2.0 demonstration waiver application for more details on work requirements. The TANF program has been successful in increasing the number of Kansans with new jobs: from January 2011 through June 2017, 43,975 new employments were reported for TANF clients. Employment satisfying work requirements will be provided by employers in the community. KanCare will offer resources to assist members in finding employment.

	See the KanCare 2.0 demonstration waiver application for more details on accepted forms of work. The work requirements will operate concurrently with existing vocational rehabilitation programs. Vocational and rehabilitation workforce systems will continue to support voluntary work opportunities for members who have disabilities and are not subject to work requirements. Only some able-bodied adults who do not qualify in any of the exemption categories will be subject to work requirements. The State will also implement a pilot program for individuals who have disabilities or behavioral health conditions and who are living and working in the community. This program may include employment support, independent living skills training, personal assistance, and transportation. No changes were made as a result of these comments.

Comments	
1.	How will the state monitor and track compliance with the work requirements so that beneficiaries don't inappropriately use benefits?
2.	I have some questions around the work requirement, as far as managing that, is that going to be managed by the MCOs or by the state – as far as whether people qualify or not?
3.	I'm curious, how you are going to manage the community service and that kind of stuff? It seems that it would be a bit more difficult. If you've got a job, you've got a job, but if you're doing community service?
4.	The waiver does include a three-year limit on coverage for beneficiaries required to meet work requirements, but it didn't include exceptions for things like work, birth of additional children, etc. How will those things be handled?
5.	Can you just flush that out more? Who would be providing the employment? Would it be an MCO service, or contracting?
6.	Will the employment pilot be statewide or certain counties?
7.	What about education/capacity? How is employment capacity determined?
8.	Is this going to replace Vocational Rehabilitation or are they going to be working together?
9.	With the backlog the state has had for two years in eligibility it seems that this needs to be part of the eligibility process. The biggest part of the current eligibility issue has been losing the documents. We hear constantly about consumers that have been in the outpatient process and; some document was lost, and it put them back a lot, and they can't find their application, that kind of thing. I don't see how the state will be able to implement the work requirement with the amount of labor that is going to take without further causing harm to the eligibility system that's failing now.
10.	Employment service in the disability field requires a robust support system. You guys don't pay enough currently for that robust support system. You start out with all the good, and put more money on front end but you don't have the system to carry it though.
11.	If it's such a small percentage, and obviously KanCare had difficulty in managing and caring for all the complexity of these issues, why do you care?
12.	Why don't you spend time and resources for PSATS of the program that don't go so well? It just strikes me as a much lower priority than the complaints of the people at that table.

13.	My daughter who is IDD has had experience working with part of state that works with work and VocRehab I don't know their names because they have changed their name two or three time. We go and visit and they provide great services. Are you coordinating with that particular state agency?
14.	In times past the relationship between the IDD waiver and VR has not been highly collaborative. How is this going to change that?
15.	Will there be additional opportunities for job coaching to be paid for?
16.	For this work requirement program to work effectively there well have to be a robust set of resources, people will need child care because they won't be able to afford that. I can't even imagine what all will be involved for this program to work. How is that being developed and when will we be able to see those resources?
17.	Who will develop those resources?
18.	In terms of stakeholders, we really understand what it takes in terms of resources.
19.	I'm a double transplant survivor, and I've been disabled for quite some time and been on KanCare. I've never been contacted from anyone that said they were a service coordinator. I've never had any interaction with anyone trying to help me live my life better. Are you telling me that this is going to change in the next couple of years? I've never been contacted. Well, one of my organs went caput in August. But it's working again, happily. Another thing is I have wanted to work. I've wanted to try to work for a long time even though I've been told I could probably never work a full-time job. However, I do want to work, and so this sounds to me like if I am given more attention by a service coordinator or something that they could be helpful in that area?
20.	I have a few comments. I'm just going to run through some comments. There's good research that shows that Medicaid is actually work support, and that most people who are Medicaid-eligible who are not working, are not working because they are sick, and they need Medicaid to get better, so they can then work. So, it's the chicken and the egg, and I'm wondering how you're going to deal with that. I'm also wondering, there are areas of Kansas where there's very limited availability of jobs and job training, and how will that be factored in? Time limits become a problem during economic downturns. Medicaid is designed to get [inaudible] as the economy goes down the more people are eligible. If I ran my 36-months out, and I lose my job in an economic recession, what happens? And finally, just a general comment about work requirements. A lot of people who get a job under the work requirement provision would then make too much money to qualify for Medicaid, and would be in a coverage gap. So, without Medicaid expansion, I don't see how work requirements could work at all in achieving your goals.
21.	I think childcare should be another issue. We're looking at the type of jobs where mom has to work at McDonalds from 4 to 12? Children are home from school
22.	The individual is determined to be of a working age. How is the capacity for that individual to be working going to be determined, and will there be education opportunities to get that person to a level of employment?
23.	In the application there is a 36-month cap on service could you flush that out? Is that a hard lifetime cap?
24.	If someone hit 36 months and found a job, lost job, are they no longer eligible for Medicare? I'm still unclear, they exhausted that and then later on find themselves in need of KanCare are they still eligible?
25.	How do you find the employers or volunteer agencies?
26.	I'm wondering if you have something built-in for training, for transition age youth as they are moving from school to adult life in order to enhance their ability to find employment?
27.	Is there – do you anticipate that the people [in the pilot] will be provided health insurance from the employers once they begin to work? And if so, is there an amount that the employees required to pay with KanCare to be able to cover that?
28.	If they are working, you know, 30 hours a week and their employment provides health insurance but they have to pay part of it. Would KanCare cover that?

Sub-Theme 2: Losing Access to Care	**State Response**
KDHE received several comments that emerged in a theme regarding the loss of access to care. The majority of questions and comments in this section expressed concern in the perceived coverage gap produced when a person receiving benefits becomes employed. Most comments and questions expressed concern in the affordability and eligibility of individuals falling in this gap area. Other comments and questions expressed concern about the types of employment available, the perceived low pay in these employment areas, and the individual's ability to receive coverage after job loss. Additionally, some comments and questions regarded the 36-month lifetime cap negatively. One comment expressed the need for expanding Medicaid.	The State is assessing operational needs to support the work requirement initiative and will develop proposals for how to avoid prohibitive costs or divert money away from direct care. At this time, the State does not have estimates for administrative costs or staff needed to implement the waiver effectively; much of this discussion will occur through the review process with CMS. The TANF program has been successful in increasing the number of Kansans with new jobs: from January 2011 through June 2017, 43,975 new employments were reported for TANF clients. KanCare represents the State's commitment to building on this success. Additionally, members can meet work requirements through various means, including community service, vocational education, job search or readiness activities, secondary school attendance, and others as described in the waiver. The State will also offer two programs to support voluntary work opportunities for KanCare members who wish to or elect to work. KanCare 2.0 will include voluntary work opportunities for members in the MediKan program and members who have disabilities or behavioral health conditions living and working in the community. For MediKan members who are under 65 years old will have the option to pursue a disability determination from the SSA and be eligible for 12 months of MediKan, or to discontinue pursuit of a disability determination. If the member chooses to cease pursuing the disability determination, the member is then eligible for Medicaid benefits and employment support such as job skills training for a duration of 18 months. Most KanCare members do not need to meet work requirements, such as members receiving long-term care, members who have disabilities and are receiving supplemental security income (SSI), and members who are enrolled in HCBS waiver programs, among others. The State will determine if a member is required to meet KanCare work requirements when he or she applies for Medicaid or redetermination. A complete list of groups exempt from work requirements is available in the KanCare 2.0 demonstration waiver application. No changes were made as a result of these comments.
Comments	

1.	What if they are on the waiting list for waiver services, and they wouldn't fall into other categories because they are not receiving home or community based services?
2.	I'm also greatly concerned about the work requirements that are attached to the KanCare 2.0 proposal, and I know the goal of this system is not to create barriers to keep people from getting care, you are talking about diverting potentially millions of dollars away from direct care so that we can have more administrative oversight over something that is already difficult to access. Adding a work requirement for people who maybe want to work but who are maybe not able to be hired because they cannot afford clothes to go to an interview in, it shows to me, when I'm seeing 40-50 people a day, it shows to me how out of touch we are in setting up requirements like this and it's really concerning to me.
3.	On the work requirements, my understanding is parents who do not have a disabled child will now have a work requirement. I also understand that under the current system if you work minimum wage for a little over half time you are not qualified KanCare because of income limits. So what is going to happen to those we require to work and they go over the limit because of that requirement? Are they going to be kicked off as they are now? What about the three-year limit for receiving the KanCare benefit? Can they continue to receive it if they are not in the work program? Many people do not fit the requirement of a disability, because we use the definition of Social Security has found you disabled. Many people with mental illness don't have the documentation, which Social Security often requires, particularly for mental illness and that population will be kicked off and we will have more untreated mentally ill people in Kansas and on our streets. Do you not use Social Security as your definition for having a disability for KanCare eligibility? What other category is there? I'd like to see those 200 categories of disability, because in my experience they are not covered well, and with this, a three-year limit will really impact us.
4.	We've also been hearing too from people that they do want to work, if they can if they can employment, so I'm glad to hear that we're trying to support people. However, what we're hearing the real problem is for a lot of them is that many of them are uneducated and so the type of jobs that they get are lower paying jobs. So when they actually do go to work, they're losing their state assistance and so actually they're going backwards. And even if it's $50 or a $100 less a month, that might be difference of them being able to pay for the food they need, possibly the water bill. And so for a lot of them, they choose to not work because of that. Have we looked at possibly looking at income amounts that are allowable or else even looking at what's the expected average income at this job, and if its $300 and they've been getting $350 have we considered possibly the state reducing the amount that they use for assistance to the $50? So that at least these people aren't going backwards? So they truly are getting ahead and making improvements in their life, and getting out and improving their health and their experience? And also their ability to getting a higher paying job?
5.	I don't see any reason to have a work requirement other than to deny services to people one way or another. That doesn't meant that there is not a reason to have the work supports and the broad idea providing independence. But the requirement section, I've mentioned before the problems I have with the bureaucracy, the safety net of last resort are prison and foster care. When we get to these levels that's a break of the state. Right now both systems are in flux and I think this work requirement has the potential to put pressure on both particularly the foster care. I think that when we break this down and think who's going to be left, of 12,000 people over age of 6 household making $4000 a year. I'm think those families are in crises for one reason or another, many times it's going to be substance abuse issues, or mental health issues, which may not be to the level of SSI disability determination but that does not mean that the family Is not in flux. This potentially puts significantly more pressure on that family and foster care system and prison system.
6.	As one of those people with a physical disability, which 25 years ago I almost tell everybody it was like jumping out of an airplane without a parachute, because that's really what it felt like when I went off of all government assistance and so I've been working ever since then. One, I know it talks about that we need to encourage people with disabilities, and I guess I set a higher expectation of my brothers and sisters out there because I think people with disabilities should work - can work and should work and obviously to varying levels and degrees depending on the individuals. There are many, many disincentives in the last 25 years and it's amazing how many improvements we've made which has been great. But I think even with the WORK

	program - that even needs to be looked at - I think there's still some restrictions there for certain individuals. And in my situation, as I age, and I know of other people with disabilities as private paying for personal assistance, as you age, your needs increase and therefore you're out of pocket's increasing and pretty soon your income… [Trailed off] so then where do you find your balance? So, I think those are things that I, we need to also look at so that individuals don't end up going backwards and losing that footing and keep us as taxpayers, because I certainly don't want to go back and I also don't want to end up as many people do, at some point in my life, losing all my savings and ending up going on Medicaid someday. So, I think there's a lot of different things that we need to look at. But, I think we need to have a higher expectation than we do for persons with disabilities.
7.	The hope to find jobs for more folks - I have been involved in multiple sides of that. I'm just curious – that in a very perfect world that works, but when you have individuals that enter programs like that, that end up being employed sometimes a couple weeks or a month and then they're back out there. You get in a small area like this, you do not have a flood of employers for them to continue to go to. So you're talking about having service coordination to help people with that, how do they intend… there's only so many types of jobs that some of those folks can fit into and if we're going to base services and payments and things on that. How are we going to make that, I guess, fair to these people who qualify for services and all of a sudden they're supposed to be employed, and now they've proven that they can't continue to hold a job?
8.	If you require people to work, they may become ineligible because of their financial situation. Is that true? How will they get health insurance with a limited salary?
9.	What about no job market in area? Childcare?
10.	How will individuals who need medical, but lose their job because of a lay-off, business closing, circumstances beyond person's control, etc., get medical? Economics?
11.	Could you address more about the lifetime cap from the work requirement that's going to be implemented and how that will impact people as they get to the limit? As an example if person did have that work requirement and they were getting to the end of their 36-month limit, maybe they are employed but they can't afford private insurance, and they are losing their coverage through KanCare, will there be something like working healthy, or anything that they can get since Kansas didn't expand Medicaid through the Affordable Care Act?
12.	So because my income increases I am no longer eligible for Medicaid?
13.	One of our parents their child has IDD, the parents are able to go to community and rustle up jobs for him. After 3 or 4 months he is not doing a good job, something happens he gets fired, meanwhile care coordinators has reduced his hour. When the person is fired or is unable to work those hours don't come back, so the parents are saying that it's a huge disincentive get to work with such a penalty.
14.	Currently there are people in Kansas who would otherwise be in the coverage gap where they make too much to qualify for Medicaid and too little for subsidies under the ACA who because of their heath need decide to stop working or take a job that pays so little that they qualify. Many of those people under those requirements would now have to take a job that places them back in coverage gap and leaves them unable to afford their health care correct?
15.	There was a little confusion the other day when we talked about the 36 months as it appeared in the RFP. That appeared to be a hard cap. I wanted to give you a chance to clarify that.
16.	There is a step down provision in 1115 application not discussed. It says if you were on the work requirement section and you got a job that put you into that eligibility gap where you're over 34% of poverty, there would be some kind of supplemental coverage for either Medicaid coverage or private insurance. Some kind of step down program?
17.	Those two programs are complicated and could easily be replaced by the state expanding Medicaid and could get a better bang for the buck.
18.	Might have been some kind of has to transition to health insurance can we discuss that for a little bit I didn't understand?

19.	There are people who have been in this coverage gap because there expenses have mounted so much who choose to leave jobs, so that they may qualify for Medicaid, so that their health expenses are covered. We are in essence forcing them back into the coverage gap.
20.	I'm from Wyandotte County. You said there's about 12000 people who are going to be affected by the work requirement, is that right? So, with it being 12000 people, have you thought about the possibility of keeping the work requirement in place so that those people who can work are able to work, but keeping the KanCare support in, so keeping the work requirement, but not having it phase out in 36 months? Because with the state of health insurance being what it is, it is challenging sometimes for people in lots of jobs to get health insurance, and different jobs to provide health insurance. I'm just trying to think about somebody working a 20-hour [per week] job, and trying to get health insurance. I understand the desire of giving some incentive for people to be active if there's a possibility for that, but it worries me that it will be removed. So, is there any thought of keeping the work requirement but keeping that support in place?
21.	I think that was a very reasonable answer but I'm wondering if the state will give a commitment that it will not be rolling back that one-year eligibility. There are states that are asking for six-month eligibility reviews in an even shorter amount of time. I'm also wondering about other question: What if no jobs are available?
22.	The gentleman said something about the 779 dollars that maybe a lot of people are living on a month, the insurance would take a large portion of that. If someone was in that situation, would they have to prove, my rent is this, I need this much for food, I need this much for utilities and my bills? What comes first? Does their life come first, or their health? Because what we're talking about here is life or death situations for many people. With the price of prescription medications—I take 30 pills a day, and just one of my anti-rejection pills a month costs over 18000 dollars a month. If I was not to have what I have now, there's no way. There's people now going without their medication. What would that person with that 779 dollars a month be able to do?
23.	One to the things that was done was a policy decision, residential pay policy. We're helping people be as independent as possible so contact if they needed help. They did not have to have 24 hour support. A policy decision changed all of that, it was a cut to many providers that provided long term services. In the long run it's going to limit the independence of person because they will not have the ability to live on their own. Policy decisions have way of cutting services and reduce the independence of the person.
24.	In small communities were the employment opportunities are limited, the need for job coaching becomes paramount. My son had a negative experience trying to find the right place where he could be effective happy and productive. It ultimately failed, part of that was that he could not get the kind of job coaching that would enable him to be successful. The other thing was that in a small community the number of jobs is very limited. The idea that everybody is employable is not reality.
25.	If a person is physically or mentally disabled, and cant or not able or your unable to get a job, and SRS cuts income, and cuts health care insurance, and demands that they get a job or their cut living program, and you kicks out on the street or whatever what do they do?
26.	How can we work without losing SSI or social security?

Sub-Theme 3: Work Requirement Overall	**State Response**
KDHE received several questions in regard to individuals obligated to meet the work requirements. The majority of these questions and comments requested clarification on the work requirement's effect on recipients receiving SSDI and SSI. These participants expressed concern in areas of dual eligibility, income limits, and the program's overall effect on the benefit. Another large area of concern was the program's effect on caregivers. Several commenters questioned the program's effect on the	Generally, KanCare members who are able-bodied adults who are not pregnant or caretakers for dependent children or household members who have disabilities, and who are not enrolled in the MediKan program will be subject to work requirements. In response to public comments, the State added the following groups to those that are exempt groups from work requirements:

waiting list and if the program would be available to these individuals. Participants wanted to know if caregivers would be included within the requirement criteria. There were several questions regarding the lifetime limit. Many participants also requested clarification on the program's eligibility requirements' impact on the mental health community in particularly those beneficiaries that do not meet other disability criteria as well as other chronic conditions. Several participants needed amplification of the demographics of the eligibility requirements and exclusion categories. There were a minority of commenters with questions concerning use of secondary education programs as job preparation. There was a question concerning who determines the eligibility of the work requirements. Other commenters supported the idea of job coaching.	• Caretakers of KanCare members 65 years and older who meet criteria specified by the State; • Members on the waiting list for HCBS waiver programs; and • Members over the age of 65 years. Members with behavioral health conditions will not be exempt from work requirements; however, the State may consider an exceptions process for members who have a behavioral health condition and who are unable to maintain employment due to a related behavioral health diagnosis. A complete list of groups exempt from work requirements is available in the KanCare 2.0 demonstration waiver application. Approximately less than three percent of members must meet work requirements. Most KanCare members do not have to meet work requirements, such as members receiving long-term care, members over the age of 65, members who have disabilities and are receiving supplemental security income (SSI), and members who are enrolled in home- and community-based service waiver programs, among others. The State will determine if a member is required to meet KanCare work requirements when he or she applies for Medicaid or redetermination. The State will also offer two programs to support voluntary work opportunities for KanCare members who wish to or elect to work. KanCare 2.0 will include voluntary work opportunities for members in the MediKan program and members who have disabilities or behavioral health conditions living and working in the community. For individuals who have disabilities or behavioral health conditions and who are living and working in the community, the State is considering a pilot program that may include employment support, independent living skills training, personal assistance, and transportation. Regarding MediKan, KanCare offers an additional option to cease pursuing a disability determination from the SSA. If a member continues to pursue this determination, KanCare offers that member 12 months of MediKan benefits. If the member chooses to cease pursuing the

	disability determination, the member is then eligible for Medicaid benefits and employment support such as job skills training for a duration of 18 months. Upon review of public comments, the State will implement the MediKan pilot in 2020. The State will enroll MediKan members in a KanCare MCO. The State is not considering a pilot program specific to college or university education at this time. Vocational and rehabilitation workforce systems will continue to support voluntary work opportunities for members who have disabilities and are not subject to work requirements.

Comments	
1.	On your list, maybe I'm missing it, SSDI that are not on a waiver? Where are they at on the work requirement?
2.	I don't see waiting list - if a person is on the waiting list, would they have a work requirement, because I don't see it as an exclusion on here?
3.	Did I hear you correctly that caregivers of older adults will be exempt from work requirements? They're not specifically called out as such in the application so I wanted to make sure that was true.
4.	People who are on the waiting list, are they subject to the work requirements?
5.	We have supported the works supports for persons with disabilities, and the members outside of the work requirement group. So thank you for that and there seem to be some real positives there. As far as the work requirement goes, one of the groups that I don't see listed, and I think it's just a clerical error, but it should probably be noted that it says that folks receiving long term care or living institutional care money follows the person, enrolled in HCBS services, on the waiver but it does not include the people that are in the HCBS wait list. You should probably get that included. There not specifically listed in the exceptions.
6.	Could you give an example of what a person who would fall in the work group requirement would look like? Some demographics we are having a hard time picturing that. What was the phrase you used on the slide that was in yellow? Work something as opposed to work requirement? Volunteer and work opportunities what does that really mean?
7.	So a mom with a 10 year old who makes $3000 or $4000 a year, what is the number?
8.	That's determined in clearinghouse? Those folks are researching that? You feeling pretty confident in their ability to do that?
9.	Who it would be in the work requirement program? Needy adults' single parents or otherwise not disabled, SSI determinate that have to have kids with the youngest child being over the age of 6 for a household of 3 make less than $4000 a year?
10.	That side I might be able to support but it's the bureaucracy that is more than a little bit abrasive.
11.	Am I to understand there is a 36 month lifetime limit on the work requirement category
12.	That's a yes there is a 36 month lifetime cap on that category?
13.	Could you go and talk about more detail in the work requirements for those with mental health problems that are not on disability. How would the state assess being voluntary versus being required?
14.	Looking at the list it's clear, regarding the units that are a part of that because the SED waiver is related to minors. In terms of adults with mental illness that are not on disability you say that would be voluntary. Are there instances that it would be mandatory?
15.	Do you know the percent of Medicaid recipients today that do not meet those 13 requirements?
16.	My son is going to college to work towards his independence. Are you doing a pilot program for secondary education or are you relying on VR and the services that they provide?

17.	I'm talking about college, college is job training. You're talking about work programs another way to get to work is through college. My son is going to college and using the VR systems right now but they could be enhanced. What pieces? Structure and services, tutoring, currently Johnson County Community College their access services are limited for an individual with IDD they are more for an individual with dyslexia. They can't provide the level of services. I want to find somewhere here in the state of Kansas that will help individuals with IDD that can go to college. That have the opportunity to go to college to get that two year degree or four year degree or whatever so that they can be completely independent. There is nothing here in the state that can help that. There are a lot of certificate programs popping up throughout the state but there are no degree programs which we disparately need.
18.	For somebody that's on an IDD waiver, the work requirements don't apply to them. But would the services still be available? So, if someone on the IDD waiver wanted to do a volunteer job, or try something in the community that would probably need some personal care assistance or some other assistance while on the job, would that be available under this?
19.	I've got a question on number 3, someone with a disability and special mental SSI. I get SSDI and I'm working out in the community. So, if people with SSI lose their check, how can they get that back and still keep SSDI? No, SSDI. When people are out working in community, will they get the work requirement?
20.	On that SSDI question, how much can your make out of it?
21.	I have a question regarding Exception #3 also. It limits the exception to people with disabilities who receive only SSI, but there are people who are dual eligible. Under the Medicaid rules, currently anybody who receives as little as one dollar per month in SSI is categorically eligible for Medicaid. But they don't receive substantially any more than the SSI recipient does. Also regarding currently medically needy individuals who receive SSDI, who receive more than the SSI limit, are also eligible for Medicaid. Are those individuals going to be required to work even though they have medical needs? And in fact, one category, well both categories, have been found to be eligible by disability
22.	That was about waiting list, but I want to clarify. A person on a waiting list is excluded from the work requirement correct? But a person on the waiting list can get the expanded service coordination that can help them look for work while they are on waiting for services?
23.	So I want to go through those 12 exemptions one of the exemptions is that someone who has disabilities and receives SSI, that's the highest level of disability. Has there been any consideration to anything else that reflects real world situations? There are people with chronic conditions that have difficulty in working and other wise meeting the requirements but don't yet qualify for SSI.
24.	Another category that I need to include in that, people that are caring for seniors, parents and things of that nature not included. Has there been any thought to including care gives to senior family members? Unpaid care givers. It would be in a certain scenario, let's say it's me and my mother needed care, my children are over the age of six and I'm not working otherwise the income there's is met. I have left the work place because I'm caring for my mother.
25.	I would encourage you to reach out to disease advocacy organizations because of chronic condition issues. Folks are not to that level.
26.	MediKan I didn't understand what we are waiving when you can get the job placement supports but you are waiving your SSI and social security determination? The ceasing of applications for SSI benefit does not have time attached to it?
27.	Is the care taker medical category primary the 12000? Will the 401,000 folks who follow the exemptions fall into that category and have to prove they are in that category or only the 12000? So 401,000 will have to prove they are in that category?
28.	I would like to echo [redacted] comments for older adults to make sure they are recorded. They are exempt from those work requirements and they may not have children at home and they may be caring for a parent or grandparent.

29. Back to the work requirement, or verification, I guess in the first year those required to work have the opportunity to be eligible for KanCare and they will get a job. When does the cost start, on the second year? On the day they get the job? Do they have another full year?
30. It's based on when they qualify not when obtain a job?
31. People that are on the work program. My suggestion is, don't kick people off when turn 65. It's an ageist program. People want to keep working past age 65. There's no reason why they shouldn't be able too. I'm meeting with a consumer tomorrow that got kicked off, she would still be working if she could. It made a big difference in her life. It sent the message that people of a certain age aren't worthy of contributing. If people want to stay on the work program why not?
32. The 36-month cap is a lifetime cap, correct?
33. To clarify, you get to be on that and one year of transition?
34. I'd like a point of clarification work requirement issue that came up earlier. I would hate to come to a meeting like this and not go home with some clarity on this point. I'm looking at the waiver here, "the following table providers and overview of a new employee's maxim length of KanCare coverage they can receive based on proof of work", 36 months, just to be clear this is 36 months life time for people who meet the work requirements.
35. I'm going to be the caretaker for my sister-in-law who is disabled once my father-in-law passes away. And I just want – I have a question about the workforce, you said that there are some requirements she is going to – is this a requirement that she must have some type of work because I don't think that she never had to work, she never work before and I don't know if she is like, like something is going to be her choice to go into like on a job training or seeing what her skill level is?

Sub-Theme 4: General	**State Response**
KDHE received several comments related to the theme in this section but where not related to any identified sub-themes. Most of the comments regarded the work requirement's impact on other working programs presently implemented by the State. Comments and questions concerned the program's impact on Vocational Rehabilitation, Working Healthy, and WORK programs. Most questions needed explanation on the work requirement's effect on the requirements of these various programs. A few questions requested clarification regarding the MediKan program and its services. Other commenters requested explanations on provider payments tied to consumer employment. A few commenters requested clarification on the federal poverty level. There was one question regarding Medicaid expansion, and one asking if the current administration in Washington D.C. was going to allow the continuation of Medicaid. There was one comment concerning job coaching and a single comment concerning self-determination or person-centered care. A few commenters took issue with the use of the term able-bodied, citing that people with disabilities can still work in various ways although they may not be considered abled-bodied.	KanCare work requirements are similar to the TANF program requirements, which varies work requirements based on a person's life situation. Individuals that must meet work requirements can also meet these requirements by pursuing vocational education, performing activities that include Adult Basic Education or other courses, or through secondary school attendance. At this time, the State is not offering funding for education. Employment preparation services include job search, job-readiness activities, job-retention activities, education, job-skills training, case management, supervised community service and work experience. The State will offer two programs to support voluntary work opportunities for KanCare members who wish to or elect to work. KanCare 2.0 will include voluntary work opportunities for members in the MediKan program and members who have disabilities or behavioral health conditions living and working in the community. For individuals who have disabilities or behavioral health conditions and who are living and working in the community, the State is considering will implement a

	pilot program that will include employment support, independent living skills training, personal assistance, and transportation. Vocational and rehabilitation workforce systems will continue to support voluntary work opportunities for members who have disabilities and are not subject to work requirements. No changes were made as a result of these comments.

Comments	
1.	If a person with disabilities of any kind does want to work, is this only with the WORK program they would be working or would they still work with Voc Rehab?
2.	MediKan is for one year. Is the proposal for this one the same time frame?
3.	Regarding the working healthy program, will the requirements for work change under KanCare 2.0? What are the requirements right now, do you know?
4.	You said that is a different set of services that would be held. What are the differences?
5.	I think you mentioned it, but would you be coordinating with the workforce system and VR?
6.	Would the Working Healthy program be one of those programs you talked about or how would that work?
7.	With that work opportunity, there has been in the past some discussion of withholding payments from IDD providers that's tied to work, if the member would go to work or not. Are our payments going to be tied to whether they are community employed?
8.	Do you include childcare in this work requirement for parents? Funding for education?
9.	In addition the state currently has the Vocational Rehabilitation system VR, and one for the difficulties we have with that is getting any type of contacts from them in getting assistance in getting jobs. What we would like to know is will we be pushing VR as well?
10.	My comment is to the able-bodied work requirements. A person who has a disability might be able to function and work with tech assisted devises. I have a problem with able-bodied, just leave that word out.
11.	All the work support programs I've been clear that we support anything too particularly that supports the HCBS programs. We've talked about Voc Rehab and its problems a little bit but all of my members support integrated work and I think it's awesome.
12.	So most of the folks I work with are not a fan of the work requirements even if they are not a part of it. They have made the point that they don't like to be separated out at all. So we don't want there to be a work requirement we just want to quit talking about it because we don't like to be separated out. Anything that separates out people with disabilities they are not a fan of.
13.	My son had the same situation at VR that his son did. My son was in Overland Park so it's not a rural problem. He was determined to be unemployable there was no permanent job coach available. He goes to day service all day now.
14.	Work requirements have never been allowed in the 50 years of Medicaid. We're going straight to Federal court on this. How much state money is Kansas going to devote to fighting this in court?
15.	When talking about income requirement you keep saying 38% of poverty level you mean above or below?
16.	Have you priced insurance? How are you supposed to pay for health insurance out of 779 a month?
17.	So we also provide individual living counseling related to working healthy work. Would the same guideline rule apply?
18.	So in terms of highest member independence. A couple of themes in the application, you site 42CFR441, that's actually defines person centered under the federal regulation, it's sighted in there that you'll comply with that I don't know which rule. That's a real good definition, it says the individual will direct and control his or her services to the maximum extent possible. In the application it says the people will be encouraged to

	participate. It's a world of difference between being encouraged to participate and controlling and managing to the maximum extent as cited in 42CFR441. A little clean up there would be helpful in terms of being consistent. Second thing that I noticed in the application you talk about some good stuff but you completely leave out our state laws from 80s that give people the right to directly and control and manage their serves. We are the only state to have those kinds of laws on the books still. I point that out because self-direction has been dropping. Here is the thing, I think in terms of taking steps , its reasonable step to take control over your services, and help manage your services, before you say, "I'm gonna control my whole life and get a job, and leap off the public benefit highway into the private nirvana." So it seems like one would be a good precursor to the other. We need to make sure and focus on those very basic things in being person centered and remember that we had self-direction laws that included those aspects well before person centered was ever cool. I just though it should to be in there as something we should focus on too and I had not seen it in the application which I thought was a pretty big oversight
19.	Does the work requirement make more sense than if you expand Medicaid?
20.	Want to say the whole thing about working, the able-bodied and disabled. The term is insulting. It's been said those who appear able-bodied may have disabilities. Some people that appear to be disabled won't qualify because what you're calling disabled are those who qualify for a waiver and able bodied is everybody else. The disabled, I'm not sure that it helps a lot. The second thing I want to say Is this, if in our state there is an expectation that working aged people ought to work, I think that's a great philosophical statement. It ought to be said that way, then we need to support people to get that done. But saying that we want people with disabilities to work but not all of you have to work seems not really consistent. It doesn't send the strongest message. What we need are proper service and supports and imagination to make that happen. That ought to be the statement of philosophy and not you're labeled this. People with disabilities can work just like everybody else and what we need are supports.
21.	You have to understand what it boils down to for many people, it literally is life or death. Without anti-rejection meds, without people who can get their chemo paid for, whatever it might be, it literally is life or death for many people. I just hope that's all taken into consideration. Thank you.
22.	A second point is that I'm an advocate for people receiving adequate medical care. But I'm concerned, with the administration we have now, both in Washington and at the state level. These are all wonderful plans and they sound great. But is this set-in stone? Are we really going to have this? Are we going to have a continuation of Medicaid? Because when I'm on Twitter, I always put #savetheACA, #savemycare. If it was not for the Affordable Care Act, I would not be sitting here today. I'm very dependent upon my medical care. I just want to know if this is something that is really going to be there within two years, or if because the Administration is what it is at this point, are we sure about these things that you're telling us we're going to be able to get, and have provided for?
23.	Is there anything in 2.0 doing anything toward transitioning individuals from sheltered workshops to integrated employment?
24.	I was wondering forget work, I can't work I was wondering could someone her give me a list of places where I could volunteer? I know Sunshine Connection has some but they are only open two days a week. I need something to do to get out of the rotten prison I live in, to give me something to do to keep me out of trouble.
25.	I don't work but I'd like to get out of the rotten place I live at and give me something to do during the day, where I'm not stuck in a prison for the mentally ill all day.
26.	Well, my question is I got in on this meeting late. So I didn't get to hear totally what the employment pilot or the appointment programs were going to be. Is there – are they on your website or anything?
27.	I've said with my doctor quite a few times, I am 73 and he's not approving me to work, but I just want to visit anyway I could work…I just – I like to do something in return for society, but my doctor says I'm retired.
28.	One of the situations I had was I wanted to participate in the (Serve) program which I know is a job training opportunity. I'm currently on Working Healthy WORKs program. However, I had to make a choice either to stay on work or give that all up and take the (Serve) program. Is there any other – any way around that now?
29.	I was meaning to ask about Working Healthy. Is it still going to be – is it affected at all by this 2.0 KanCare?

30.	I had a question on the Working Healthy people – will they get the community service coordination?

Theme 3: Improve Performance and Quality for Better Care

There were not as many comments in this theme area as in the previous two. This theme generated two sub-theme categories, those include: changes to incentive programs and dental services. Additional comments not in one of these sub-themes are listed in the general section.

Sub-Theme 1: Changes to Incentive Programs	State Response
An emerging sub-theme centered on the changes made to incentive programs. Most questions regarded oversight of the various programs and metrics. Some wanted to know how value based purchasing would be implemented, how it would be measured, and if those measurements would be tailored for each individual provider category. Other commenters requested clarification on how payment was going to be made, the MCO's role, the State's role in developing incentives, and if participation in quality incentives will be required for providers.	The State will require KanCare 2.0 MCOs to implement to implement innovative provider payment and/or innovative delivery system design strategies that incorporate performance and quality initiatives in service delivery models. The State seeks to promote the goals of helping Kansans achieve healthier, more independent lives by providing services and connecting to supports for social determinants of health and independence in addition to traditional Medicaid benefits. As part of their response to the KanCare 2.0 RFP, MCOs will submit proposals for value-based models for the State to review and approve prior to implementation. The State will evaluate each proposal and reserves the right to modify the proposed metrics and reporting requirements described in the framework to develop standardized reporting across MCOs for similar arrangements. To promote effective implementation of these strategies and reduce provider administrative challenges, the State may select a proposal(s) to be standardized across KanCare 2.0 MCOs. Please see Section 5.7 of the KanCare 2.0 RFP for more details on the framework for MCO value-based models. The State will consider the questions and concerns raised under this sub-theme in reviewing and approving MCO proposals for value-based models. No changes were made as a result of this comment.

Comments	
1.	Do the incentives that MCO's come up with have to be part of their application or proposal for the RFP, and then the state will determine what incentives they can use?
2.	Will quality incentive programs be a requirement for providers to participate in? We normally focus on three to four quality measures every year, and when we have different payers saying to focus on these measures that don't align with our current outcome measures we can participate, but we won't be successful. Are you also working with MCOs on tailoring for certain groups of providers? One program is not going to fit all.
3.	How will value based purchasing be implemented? Negotiated individually with providers, or applied broadly to all?

4.	Value Based Purchasing. When these models are implemented by MCOs, will they be negotiated with individual providers or will that be applied broadly across all providers?
5.	On the rewards for providers who gives those rewards who pays those the MCO's?
6.	I'm curious about the pay for performance and long term services. I understand it from a medical provider's perspective. I'm a little confused as to how a MCO will pay a provider for going over and above long term services? It seems like the service provider are being pushed aside a little bit, you know, "we won't judge what's good and what's not" to me it doesn't jell.
7.	In KanCare the MCOs are granted the opportunity to provide value based purchase rates with providers. I don't know anybody that has happened to. I can't think of one. So what's going to be done in KanCare 2.0 to show that value based purchase. Is there of anything being done to ensure that happens?
8.	As I mentioned at the Pittsburg meeting I want more transparency around the uncompensated care pools and the comments you're making about adding additional dollars for the safety net programs. We need to know what that is because that is a Tax on hospitals. As far as the value based purchasing I would request that you use the expertise of those of us in the field who are already doing value based purchasing. You're are talking about reducing administrative burden. In some cases this will add administrative burden. Just engage us we are willing to sit down and talk to you.
9.	What are you looking at for metrics for pay for performance or quality outcomes in IDD? With KanCare 1.0 the state said it was all figured out. We are helping people live. We are not doing the medical side. It's not as quantifiable as far as how many days in the hospital.
10.	You listed that value based models and purchasing strategies including MCO provider level initiates. My daughter is a recipient of day services and residential services. With the challenges I think every provider finding staff that is qualified because the rates of reimbursement are low. My concern is not forcing providers to have more paperwork but for the state of Kansas to embrace those people and support them rather that creating more paperwork and more responsibilities for them above and beyond all the care they provide our loved ones.
11.	I work at the Wyandotte County Health Department, and we are very interested the health of the populations. I'm wondering, with the value-based care that you guys are thinking of, we have a similar concern in making the populations as a whole healthier. At least for me, that's a very exciting movement of the healthcare system in general—to move from fee-per service. Have you thought about any partnerships with any MCOs in any other organizations in the community?

Sub-Theme 2: Dental Services	**State Response**
One sub-theme that emerged in this area was dental services. The majority of commenters expressed the need for expanded dental services including fillings, partials, restorative care, tele-dental, sedation, and providing dental in facilities. Many cited the preventative health nature of dental services and expressed its addition to value added services. Others requested that rates be adjusted to attract providers. One commenter requested more attention to expanding rural networks.	The State appreciates these comments and encourages KanCare 2.0 MCOs to propose "value-added benefits" under Section 5.3.2 of the KanCare 2.0 RFP to promote healthy lifestyles and improved health outcomes. The KanCare 2.0 RFP encourages MCOs to consider including adult dental exams and cleanings as a value-added benefit. In addition to meeting KanCare 2.0 provider network adequacy requirements, MCOs must also submit value-based models and purchasing strategies that expand the use and effectiveness of telehealth strategies to enhance access to services for rural areas as part of the KanCare 2.0 RFP. No changes were made as a result of this comment.

Comments	
1.	KanCare 2.0 should include the current value-added preventive dental benefit for adults.
2.	A basic set of dental services need to be covered for all adults, including diagnostic and periodontal services, medications, tele dental services, and minor restorative services. The Kansas Dental Association, Kanas Association for the Medically Underserved, and Oral Health Kansas will share a list of the codes we believe need to be covered.
3.	In order to ensure adults are able to make use of these services, the rates paid for KanCare dental services need to be addressed. The rates for restorative and other services have not been adjusted since the 1990s, and the low reimbursement rates are leading to a shrinking dental provider network.
4.	Dental currently pays for extractions and does not pay for fillings on adults.
5.	Dental does not pay for partials or dentures on adults.
6.	Dental services is a preverbal problem when it comes to Medicaid, because dentist do not want to participate. What expectations or requirements have been asked of participating MCOs to build dental networks especially in rural areas?
7.	You talked about value added benefit, my daughter none of those value added benefits, she's doesn't smoke we pay for dental care. Are you paying for, in the capitated rate, are our paying value added benefits for every person and then is the MCO able to take that money that you're not using and call that profit?
8.	I'm talking about the New 2.0 expanding services to recipients in facilities. What about dental services in the facility? Are dental and eye glasses not important? I have a form from the social security department in the facility. I'm not sure how it works who do I talk to after the meeting?
9.	We believe that KanCare 2.0 should include the value added dental benefit for adults as well as a basic set of dental services that need to be covered for all adults including diagnostic, tele-dental paradostic, and minor restorative services. The Kansas Dental Association, the Kansas Association of the Medically Underserved, and Oral Health Kansas will share a list of the codes that we believe need to be covered. In order to that adults are able to make use of the services, the rates paid for KanCare dental services needs to be addressed. The rates for restorative and other services have not been addressed since the 1990s and the low reimbursement rates are leading to shrinking provider networks.
10.	Them not providing dental. Does that fall under this? Dental is so important. I almost didn't qualify for my double transplant because I had some teeth issues. I've been disabled for many years now, and when you're on Medicare and Medicaid, they do not provide dental services. That is a definite hardship that I would like to see someone do something about. It's devastating. I could get an infection that could end my life, simply because I did not have any type of dental coverage.
11.	I would like to pair with what this lady said about dental, because if you think about it, the youth are covered in a way, with school, or whatever. But the elderly, this is one of the reasons costs are so high. Let's say you have somebody who enters a program, and they're not taking care of their teeth, so they get bacteria. The next thing you know, it goes into their body and they have all kinds of health issues. So, you can propose the problem, but how do you solve it? One of the solutions, I would say, would be to work with some of the colleges and universities, and have them be proactive and go into the nursing homes.
12.	There's an ever-growing body of research that clearly indicates that diseases in the mouth can either cause or complicate other diseases in the rest of the body. So, I urge you to look at moving it [adult dental benefits] from the category value-added benefit to part of the basic fundamental contract.
13.	I think the whole thing about dental providers is important, but when you take one step further and you have kiddos with that have complicated health and developmental needs, you also need a dental provider that can do sedation, and that's nearly impossible to find in our state. I know when KanCare started there was the first year where the IDD population wasn't part of KanCare, and I look back now as a parent who wasn't involved in the beginning. I should have been on the bandwagon, because what I'm experiencing is that the IDD population and people who have more chronic or different needs, there are special considerations. You're not looking at rehabilitative type of things, you're looking at habilitative type issues. There's a lot of issues, dental

is one. There might be increased dental providers, but if they're none that do sedation dentistry then we really haven't moved the needle for people with IDD that need that kind of help.
14. Back to dental, my niece she is on Coventry they will pay for extractions but not fillings. That's ludicrous. It's because she is an adult, she's 27 going on 28 but she is mentally disabled. Can you work on that and change that? I'm asking for a filling not a crown.
15. They don't pay for partials or dentures on adults. You might want to address that too. There's a lot of people who need that.
16. Dental disease interacts with the body's system that can trigger strokes, heart disease, lung disease, inability to regulate insulin for people who have diabetes. Also trigger pre-term labor. All these diseases are expensive to treat, costing far more than regular dental care for people enrolled in KanCare.

Sub-Theme: General	**State Response**
General comments in this sub-theme surrounded the oversight of MCOs. Most commenters wanted to know what oversight would be applied to MCOs to ensure incentives were being applied, and what consequences would be prepared for the MCOs should they not meet the standards. Other comments expressed concern about uncompensated care in hospitals and home health agencies. One comment expressed interest in partnering with other agencies such as schools and building a national database for research. One commenter requested clarification on services not covered in Medicaid that the MCOs would still be required to cover.	The State appreciates these comments. The State uses a monitoring and oversight process to confirm that KanCare MCOs are meeting contractual and performance requirements. The State will continue to improve these processes for KanCare 2.0 using strategies such as performance measures, performance improvement projects, compliance reviews, member surveys, and quality assurance reporting from MCOs. In the event MCOs do not meet the State's standards, the State may impose liquidated damages and sanctions, as appropriate. Regarding the Uncompensated Care (UC) pool, the UC Pool currently consists of two sub-pools, the Health Care Access Improvement Program (HCAIP) Pool and the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool. Under KanCare 2.0, the State plans to maintain the HCAIP Pool for the five-year KanCare 2.0 demonstration period. The State proposes to increase the size of the Pool by $20 million each year, for a total of $61 million annually. The increase in the Pool amount will allow critical access hospitals to participate in the Pool and help defray their uncompensated care costs. In the version of the waiver renewal application posted for public comment, the State proposed to combine the LPTH/BCCH Pool funds into the Delivery System Reform Incentive Payment (DSRIP) program for DY 7 and DY 8. The State no longer proposes to combine the LPTH/BCCH Pool into DSRIP and instead proposes to maintain the LPTH/BCCH Pool for the five-year demonstration period. These changes are subject to CMS approval.

Comments
1. You were just talking about the extra services that the MCOs must provide that Medicaid doesn't cover. So, what does that mean in cost to the patient or member?

2.	When we look at the uncompensated care pool, it didn't look like it included all call hospitals currently. It looked like it was making a distinction there. What is being planned or discussion on distribution of funds?
3.	Thinking back to the homes health process, is there quality data that providers need to collect and report into MCOs? Do you know what any of that might look like in the future?
4.	Are there going to be more conversations in 2018 about what these different measures look like? Is that going to be meetings, or what will we see? Any kind of phone calls or anything to keep everyone on same page?
5.	Looking at the compliance review of the MCOS, sometimes that can be rather nebulous. Is there going to be any statistics developed to validate that based on their performance?
6.	Performance and quality improvement for better care. Recommend partnering with schools to provide services. Dental, focus on dental hygiene. Put data into a national or international database for research and development. Why does big pharma cost so much?
7.	Why don't we suspend eligibility vs revoke, and I guess that now we have to have a fast track back in for folks coming out of prison and state hospitals, other states do it. I don't know why don't we do it?
8.	I understand that there will be performance standards for MCOs providing specific things that the consumers need. Will there also be a smack on the hand if they don't provide them? There is a need for example nursing in Johnson County we are having challenges on some of the waivers getting adequate nursing. The MCOs say they are trying to get more nursing more money in order to get that provided. Is there going to be an incentivized thing in the benefit to get the consumers hours and things met? If they don't get them met after they have been determined that they need to be met in order for them to be well if they stay well and cost the state less money , They pay a little bit more now and less money being spent in the long run. Is the anything like that in the current 1.0. Is that going be ongoing?
9.	I have a son on IDD waiver he is seen by about 14 clinics, he is medically complex and has Autism, anxiety disorder, I've been advocating for a long time for in home nursing and started almost 2 years ago. It took almost 2 years in January. We've received almost 5 weeks of nursing over that time. You see you talk about accountability with the MCO to provide service, how does that touch on nursing in Kansas when the reimbursement rate is so low when compared to Missouri. I've been work on trying to get in home care. I read all of these statements about social determinates of independence and health. That's largely related to a lot of these kids that have autism, and huge behavior challenges when we can't even get in home behavior support. Again I've been advocating for years to get this in home support only to find out that there is one or two providers that will contract with our MCO now suffer from reimbursement issues. So I've been seeking out other agencies on my own and paying out of pocket for that. Which is a huge cost and huge financial strain for our family. I'm curious as to what accountability measures are going to be in place, I hear a lot of brainstorming going on with the MCO, but there is never an answer and never a solution and there is no service.
10.	First question, I hear the phrase hold MCOs accountable, but I don't really know what that means. Will part of the new contracts be to have some actual reformative measures? Because let's face it, money is usually where you hold people accountable. So, will there be something that people aren't meeting designated outcomes, will there be some way the state can have some teeth to those words? Some of those performance measures, who is writing those or orchestrating those? Is it the state with the MCOs, or is there stakeholder input about what really matter to the health and wellbeing of our families or the people we care for? Who gives input to what those should be? How is it determined what data measure you would use to track those? How is it determined what data measures you would use to track those? Do the MCOs determine that?
11.	I would like to know what protection will be put in place to ensure that when an individual is assessed for services that MCOs supply those services. I have an individual this week that has been assessed 3 times and never received services. This person is both [functionally eligible and financially eligible]. They're not going to get well, IDD disability that is lifelong. Your told use you had the answers four years ago.
12.	One thing I wanted to mention is we'd received reports that tell us what services are being provided from the MCO. And I have to say those reports are pretty much useless in terms of helping either the MCO or the state

be eternal whether or not the services are being provided. And, you know, it says on a report that we are supposed to let you know if we see anything that isn't correct so that we can help prevent fraud... While the reports that I get are basically a waste of paper, I get them in English, I get them in Spanish. You know, I haven't been able to request anything electronically or in more detail so that I can compare the services and we happen to get a lot of services at this point, whether those services are being provided or not…So, I don't know if part of your request or proposal that these MCOs, is it they provide more meaningful reports to their consumers so that we can help them, you know, especially in HCBS where we have people coming in the home and we can actually look at the report or meaningful report and say, yes, they were here, they weren't here or they were year now and a half, that they build for two, for example…So, I don't know if that's something that you can work on because I think it would be, you know, we want to – we appreciate what the government is doing for us and want to make sure that it's not being wasted. The money is not being wasted because if it is, then we're not going to get the services…The other thing is – yes, and if you wanted me to help you, I'm a CPA. I'd be happy to help you with those. You know, we work on auditing thing so… I know you got a lot of great people in the state that are working there and they can look at this but I would be happy to show you what I'm talking about.

Theme 4: Improve State Medicaid Effectiveness and Efficiency

Clear sub-themes in this area include clearinghouse, credentialing, standardization and streamlining, and data. Additional comments not in one of these sub-themes are listed in the general section. Additional comments not in one of these sub-themes are listed in the general section.

Sub-Theme 1: Clearinghouse	State Response
In the first sub-theme commenters expressed concerns about the clearinghouse. Most concerns supported the need for oversight. The majority of commenters voiced dissatisfaction with the clearinghouse and its practices. Many commenters reported that the clearinghouse took too long to review eligibility or return communications. Others reported lost paperwork including applications, forms, and powers of attorney. Many of these commenters interjected that powers of attorney were especially difficult to get processed given the nature of the disabilities of their charges. Some commenters cited training as a possible solution. Many commenters expressed further dissatisfaction over the phone system the clearinghouse employs. Commenters report wait times are long, and suggest that the clearinghouse employ local personnel to speak to them. Some commenters questioned if the KMMS system would help to improve the clearinghouse.	The State continues to work to make the Clearinghouse better and have put many fixes in place, including: • Process Improvements o Added extra training and training tools o Working to change the way we answer people's questions o Telling our staff to call people when we need more information • Responsibility o Making sure we know who is working on what o Making sure people with the right experience are working on the right cases o Developing new reports that tell us how well our staff are working • Overtime o Made our staff work overtime o Have longer hours when the Clearinghouse is open • Nursing Facilities o Continued our Nursing Facility Liaison Program to serve more Nursing Facilities

	○ Made new training videos and other guides to help answer questions that Nursing Facilities ask a lot Eventually, the Kansas Modular Medicaid System (KMMS) will be able to report certain performance measures of the Clearinghouse, which will help the State monitor how well the Clearinghouse is doing. No changes were made as a result of this comment.

Comments
1. My point of view is different. My experience with KanCare is through constituents who call me to get aid working through KanCare. My opinion of KanCare at this point is that it is a broken system, and my heart really goes out for constituents who call me and tell me of the things they are struggling with. Two years ago with somebody called me I could get on the phone and we could get things worked out about in a week. This last year it's taken 2-3 weeks, and sometimes I have to call again just to remind them.
2. Does that mean I will get less calls from constituents about service? They call and there has been many cases of lost paperwork, have to refile same paperwork two or three times. Will they be able to talk to the same person twice when they call? They have to give the same story to multiple people, which drags out, and then they'll get notices about information they have to turn in by certain deadlines, which they've already submitted, and when they get the deadline they find out the clock has been running for a few weeks.
3. Concerning clearinghouse issues, as a provider dealing with primarily guardians or parents, we get calls quite often about any problems that happen, and sometimes clients want us to help work with clearinghouse. There is a form that allows the clearinghouse to talk to us, but it's very confusing as to which form it is, and if you fill it out wrong you have to do it again. When you're looking at streamlining that would be something to consider, because when we get the call we get the panic and the grief, and we're trying to facilitate the best we can.
4. Standardization efficiencies. Dr. Mosier mentioned KMMS, sounded wonderful, across systems will any of the capability help with the clearinghouse?
5. In terms of claims processing you mentioned KMMS analytics. Is that going to cross over into the clearinghouse with all of the challenges we've faced over years? Is it all tied together?
6. The issues of lost applications, forms, and renewals get lost in clearinghouse for IDD. Are you working on any improvements within the clearinghouse for folks other than nursing facilities?
7. The issue we've had is the people trying to apply. They get their own paperwork from facilities and then are on their own to figure out how to fill it out. I've been doing that for a member of my own family. We've had numerous examples of not knowing how to fill out the report, and there's not really help there. If report gets kicked back you have to start over and we may not know what the issues are. We just know it wasn't accepted. I tried to work with the Ombudsman's office and basically scheduled an appointment to come to Wichita then when I got here no one was here, and no one knew I was there for me nor knew about my appointment. So I spent an hour on the way up and an hour on the way back and talked to no one. Fortunately, there was an individual that used to work for SRS I could talk to in my home town to give me some guidance on this, but I think guidance on how to fill out paperwork would really be helpful. I've looked at the support online and there are always certain things that you need for answers. If someone is getting partial veteran benefits but is doesn't seem to be a real good method of calling people for help. There needs to be a better system, and I hope they work on helping people with those forms.
8. We have been working with other individuals in the application process. Is there an attempt being made for the clearinghouse to speed up processing? We've had examples of 3, 4, 5 weeks of no information at all, with people being told they didn't get the form, yet it was sent in with registered mail and was signed for. Are there any efforts to make it a more responsive system?

9.	Also with the clearinghouse, changes in a member's status, when you have a parent who retires and gets Medicare retirement benefits the adult child gets a different funding amount, and sometimes it's more than SSI and they will be off the waiver. It causes panic, and seems like it should be a training issue for clearinghouse staff, I don't believe kicking someone off a waiver due to retirement of parents what the services are supposed to do.
10.	When local area offices were taking the applications, there were quirks, issues and problems, but you had a more helpful, personal experience in resolving concerns. The information of the clearinghouse has been, I feel, very detrimental to the vulnerable citizens of our state. It's not enough to have "initiatives;" it needs fixed. There has to be a better plan in place. This affects all areas of care for our consumers. The citizens of our state deserve better.
11.	To help KanCare 2.0 have a higher chance of success, the concerning issues with the clearinghouse must be resolved.
12.	Given our track record on the clearinghouse – once people are identified as not having to be, are they going to have to re-do that? Is that going to be an annually, if you're one of the exceptions?
13.	We are also a provider for meal services for some of the waivers. Some of the things we experience, is that it seems like the notification of ineligibility doesn't come down to the provider level the way it used to. In fact, in the old TCM days, if someone's Medicaid eligibility came up for renewal or if that person needed help with their paperwork, DCF at that time would notify the targeted case manager plus that person that those papers were going to be due. That way we could make sure that eligibility wasn't lost, because a lot of them could not do the paperwork completion on their own or maybe didn't have family supports that helped them. And also, providers weren't calling us saying, "Hey, why didn't I get paid this month? You know, there's something wrong". And then we would spend a lot of time fixing that. Just recently, back here in August, we had people who had lost eligibility August 1st; however, we didn't know until mid-September when we were denied payment because they weren't eligible any longer. So, we had a month and a half of meal service for a handful of people we weren't going to get paid for. When we called the care coordinator, they didn't know that person wasn't eligible and hadn't been eligible since August. Now whether or not that particular MCO, things weren't happening like they're supposed to happen - it happens with more than just one. I don't know if that's something moving forward, there can be some improvements just to make sure that people aren't losing eligibility or that the people that need to be notified can be so that they don't have problems like that happening. Because that takes up a huge amount of administrative time for everybody to get those kinds of things fixed and sometimes we end up eating services and to me, that's not okay as a service provider.
14.	The other thing is that we still keep hearing that people need in-person assistance. Calling the clearinghouse, it takes a really long-time to get through. When we give people that phone number, right away they say, "Am I going to get that answering service again? I was already on that for 20 minutes today and I didn't get anybody". "Well that is the current process and that's the number that you need to call". So if we could increase in-person assistance in the community for those people who need it, not everybody needs it, but there are quite of people who need who do need that type of in person help that we used to have with their Medicaid applications, their benefits, or to change their MCO.
15.	Right now we have a person who had an annual review and they needed a few things, so we sent on. It's been sitting in the clearinghouse for 2 1/2 months. The person is not eligible and when I call every week they say, "Yeah, we have everything we need, we just need an eligibility specialist to sign off on it." So, the poor person is hanging limbo.
16.	State intra application process. If a person is approved an on Medicaid in one state they can transfer to/from other states seamlessly.
17.	I cannot add attachments after online submission of application and no remarks section on KanCare website.
18.	You had said that KanCare 2.0 begins January first. My daughter is on the plan and her renewal came up in November, we sent that in and it's been taken care of. Do we need to another renewal in January for KanCare 2.0, or where do we go from here?

19.	Other than the new program are you going to help us with the clearinghouse? It's a mess we all know it is, you can get in. we have to go through all of this rigga-ma-roll to talk to Russel. I used to be able to pick up that phone and say Russel I have a problem. Now it takes 2 weeks I have to get the parents to lease sign a lease, I have to go back and talk to someone at the clearinghouse, then no one answers or sends you to someone else. How are you going to fix that?
20.	Why did you move it? Why didn't you keep it where it was? It was easier back in the old days.
21.	On the clearinghouse a suggestion would be some sort of a response. I'm and sending information asking for them to fix stuff, and I don't get anything back. It becomes a waiting game until I go back the next week and it's still a problem. Just any kind of feedback
22.	I just wanted to say about the clearinghouse if we had someone that was local that we could talk to, to see faced to face or get on the telephone. That would help a lot.
23.	What is the state doing about the eligibility turnaround time on a patient? We cannot serve the person because the state hasn't determined if they are eligible.
24.	One of the things we haven't mentioned are the issues with eligibility and the clearinghouse. I understand that we are talking about something different right now but just looking around the room I think we are all experiencing issues getting folks eligible specifically with Frail and Elderly populations. I think we still struggle with people with disabilities I think as a state that we have to look at the simple fact that many of these things are low tech conversations. We have to get back to having a real person that works for the state someone sit down and talk to a person and help them get through the system. We have created multiple levels of bureaucracy. I think we could have clean applications, be proactive and not reactive. People in this room know the community resources I think that we have to have a realization that there is some value in the fact that Stacy knows what's going on in Harvey County. Why are we hiring someone to work out of the office in Olathe to call Stacy and ask what are the resources in your area for persistently mentally ill persons. Instead of finding ways to disenfranchise local providers. I hope that we can have an honest conversation about how to use their expertise and their experience. You can say that you are have a work program, but Lesley can tell you who is hiring people with a disability.
25.	You were talking about accountability, for the MCOs. We're kind of new to this pathway for dealing with Medicaid. I received an application my son had urgent medical needs a year ago, I received an application for KanCare. On the bottom there was an 800 number. This was a simplistic voluminous application it wanted all sorts of information about everyone in the household where my son was. So like your application says I called the KanCare clearinghouse. I received incorrect information that delayed the application two months. Then continued frustration for the next 6 to 7 months before he was given the benefits. Now the Medicaid won't cover enough time span of the application. If we would have gotten the application in December it would have covered three months prior to that. His application was delayed because of the incorrect information from the clearinghouse. When this application went in it went in with an urgent medical need, we made them aware multiple times that it was urgent and the application needed to be back dated to the date that they received it. We've filed appeals, all of that. My understanding the people we received the incorrect information from are not accountable. What do you do with something like that? Because my son is 21 he is looking at more than $68000 in medical bills.
26.	You talk about tracking the MCOs, making sure they are doing everything correctly. Are you looking at clearinghouses? In the FMS world I get 5 or 6 people ineligible because they get mail sent to an address they have never lived at, or haven't lived there in 12 years. They become ineligible they know they have faxed the stuff in. They have to send it repeatedly, they won't talk to guardians because they say there is no guardianship paperwork but it's there. This person had same guardian for 15 years. Are we looking at their outcomes?
27.	I want to reiterate in terms of the clearinghouse, again with the application was completely silent on that as well. You're looking at performance and I think that is a key piece. You should make sure you including, weather its back log, looking at that turnaround, coding errors and then, for all the different work groups, provider networks, and individuals. People repeatedly fax things in, the same things over and over to the

	clearinghouse. Obviously it's very frustrating for them but it also effects performance. I think that is a very important thing to look at if you're evaluating how well it's working.
28.	I want to talk about the clearinghouse. So to help you fix the problem, where is the best place to report the problems we are having to the ombudsman? I can tell you all kinds of systemic problems we have.
29.	I tried to talk to people at the clearinghouse twice and they hung up on me because I did not have a power of attorney on file with the KanCare people. We faxed them one and for some reason the fax got lost. We don't have a fax machine and have to use the local library in Counsel Grove Kansas. S when they see that they automatically delete them as a bogus fax coming from somebody else.
30.	Last year I had an important issue on my mom's power of attorney, and she's on Medicaid, and I kept sending faxes, writing letters, trying to call, got no response. I finally filed an appeal, and we had a phone conference appeal before the judge, and so I got attention; got the matter resolved. As of last December, I've got a similar issue. I've sent several faxes pleading. I've said in the letter, 'Please respond, I'm worried about this; we need to get this resolved.' When I sent in my mom's April report it was 18 pages, and I put a personal letter at the end, 'Please respond.' I've called a couple of times, and the last time I couldn't get through at all. The last time before the lady said, 'I don't know why my supervisor hasn't done anything like this.' The time before that the young man said it hasn't been reviewed. It was four months after I sent in the report. Here I am, the year's almost over. I'm very worried about this issue. I'm hoping by being here tonight I can get somebody—I would like to go to the office. This is privatized. I used to be able to go down to the office and sit in the waiting room for an hour or two and finally somebody would talk to me and we'd get it straightened out. I don't know what to do. I don't even know where the office is. I tried to Google it and I couldn't find anything that would give me the address of the office, so I could go there. Somebody told me it's out of Forbes but I'm not sure where. What's a person to do? This is a serious issue to me that needs to be resolved. The other thing is, one of the letters I got said you can no longer appeal directly to the judge. I know how to do that, because I did it before. My last phone call, I was going to ask them how to appeal to KanCare; they said now you have to appeal to KanCare first. All those automations, there was never a button that allowed me to make a choice of how to find out how to appeal. I couldn't find any way to talk to a person. What do I do?
31.	I have a question about my mother. I understood that you're supposed to have a recertification every year. Are you? Because everything is backed up so much. Are you extending that further than a year? I've tried and tried and tried, to call out there to get somebody to answer my questions to whether she should be filling out these reports. I've received nothing so I'm assuming she's still ok. I thought it was to be done every year. We are getting to the point where, I don't want her kicked off of the program. But my concern is I've got no paperwork have nothing I've called and left my name to please call. My fear is it has been mailed and I didn't receive it. Then I'm going to get a letter because it was not turned in and she's no longer on the program.
32.	The recertification for my niece, called and they said that she did not need to be recertified until next year. She's been on KanCare for a year and I'm her legal guardian. I'm in same boat.
33.	I was on vacation I had to call four people to give a copy of my legal guardianship. How would I know if it went to your office?
34.	What kind of training do people at the clearinghouse have? I don't think we are getting much help form them. I called to check on my mother's application when I filed it. They told me that I was not allowed to talk to them about my mother. I'm the power of attorney I filed the application and I asked them, "ok what do I do?" I swear that the woman told me, "you write us a letter giving yourself permission to talk to us and then we'll talk to you." Are they really that stupid? Mom can't sign it. She is in the late stages of Alzheimer's, she doesn't even know me. I ended up getting an attorney. She's wonderful I love her she, costs less that it would have. They need training. Would you care to handle her interrogatory? What type of training do these individuals have?
35.	We had to put my mother at a nursing home last month and we'd been – we're trying to get her on Medicaid and get our resources down so we get on Medicaid but I'm now being told it takes up to six months. Is something being done to expedite that, suddenly clearing the house?...What are your qualifications to work at clearinghouse?

36. I just need to say or comment, you need to fix enrollment in KanCare 2.0. It is still not a friendly thing. I don't understand how you can decentralize. To centralize something, you lose all personal contact, thinking that people especially people with disabilities can deal with the phone from hell system that you have. It's a little better. But with stuff like this personal contact means more than a goal. Especially when you have to leave a message or stay on hold, it is asinine, what you've done to people with disabilities. You've made it so hard to get through and I still see denials, "oh you didn't turn in your insurance", that's happened twice to two different people, well they were never asked to turn in their insurance. I don't know if that's a way to run the 30 day or whatever out, but you have problems with that. So the first one needs to be fixed personally I think you need to put them back to the community.
37. At the application phase of KanCare, is the authorization and implementation of Medicaid going to be over – higher oversight so that it's not taking 45 to 60 days to qualify someone for Medicaid?

Sub-Theme 2: Provider Credentialing	**State Response**
An emerging sub-theme centered on provider credentialing. Comments and questions sought clarification on how the credentialing process and MCOs would receive oversight. Commenters wanted to know its impact on billing and potential payment delays with the addition of new MCOs. Other comments cited the difficulty in credentialing, and the perception of redundancy using the KMAP system and other credentialing mechanisms. Commenters asked about the verification process and if it would be automated. One commenter wanted to know how the credentialing process would impact hospitals.	KanCare 2.0 will implement a standardized provider application and enrollment process for all providers. At this time, each provider must still complete the credentialing process with each individual MCO and meet their credentialing standards. If one of the current KanCare MCOs is selected to continue providing services under KanCare 2.0, providers will not have to repeat the enrollment and credentialing process unless it has been more than three years. The credentialing process will remain the same for hospitals. To address provider concerns around the timeframe for credentialing, KanCare 2.0 requires MCOs to complete credentialing within 60 calendar days of receipt of all necessary credentialing materials. MCOs must also enter or load credentialed providers into the claims payment system within 30 calendar days of approval by the MCO's Credentialing Committee. In the future, the State may decide to contract with or require the MCOs to contract with a single credentialing verification organization (CVO) to standardize provider credentialing and re-credentialing processes across the KanCare program. No changes were made as a result of this comment.

Comments
1. So regarding the provider credentialing in KanCare 2.0 the providers would send something to KanCare and we won't have to have each individual physician credentialed at each MCO on top of KMAP, because that's the process currently today.
2. Will there be any requirement on the MCOs that are selected to credential within a certain number of days, and with claims processing are they going to be held accountable, because there are issues with current credentialing it seems that, I just wonder if there are going to be additional requirements that if we can't get claims out the door or if we have claims processing issues that the MCOs have so long to comply to make sure

	that we can get money claims out the door and money back in the door. It's around the provider credentialing. So if there's an issue in their system, something to do with provider credentialing and processing the claim.
3.	Verification on the credentialing, will that be an automated process?
4.	Provider credentialing. Is there going to be roll over for providers who have been in KanCare 1.0 for years?
5.	You mentioned that in July 2018 all providers have to be credentialed with Medicaid. If I have a hospital and a physician is independent and doesn't work at the hospital but performs surgeries there, and he chooses to not be involved with Medicaid will that choice inadvertently impact the hospital in July of 2018?
6.	Some of our members have been solicited to credential with potential MCOs. Do you advise for or against this? What would be the ramifications of delaying credentialing until the MCO contracts are awarded?
7.	The credentialing process is frustrating. I understand its going live for all new providers in January. As a provider we have gotten limited guidance on that and don't know how it will effect billing. What feedback are you as the state considering from consumers and providers in regards to incumbent MCOs?
8.	This goes with quality metrics and the provider shortage. Credentialing, one of the things you are talking about is removing redundancies. When we are doing credentialing working with KMAP using ABA and respite care providers it takes about 3 months to get through the KMAP process and another 3+ to get credentialing. That process seems like a redundancy. Additionally, we have issues with constancy between the MCOs. Even with the standard form the MCOs are allowed to include any other paperwork they want. So we have the exact same credentialing that we had before the form came out but now we have the additional form. All of these concerns I've brought up several times is there another avenue for me to voice these concerns?
9.	Some of our member clinics have been solicited by MCOs that are applying to be MCOs with the state. They have been solicited by them to get them to get credentialed with those companies. Is something that you would advise for or against? Would there be ramifications of delaying the credentialing.
10.	I have a question about credentialing about possible future MCOs. If they don't get credentialed now will that lead to payment delay if those other MCOs are awarded the contract? And having a new MCO come on and having 6 months to get everyone in Kansas to get credentialed and so on?
11.	The credentialing process is very long and redundant between state and MCOs. It is taking three months on average to get certified and able to bill. We are losing providers in the hiring process due to the period of time it takes to start working.
12.	As far as credentialing, you had indicated and I think it indicates in the actual waiver – or the waiver that's out there that the credentialing portal will be available soon…And I believe it was earlier this year when it was announced that it would be ready by January 1 of 2018. So, do you have a new go-live date in mind for that? The concern being that if there would be change and a – and a plan coming for the KanCare 2.0, you know, having that operationalized way before they come in would help not only with the current issues that we're having but also with the potential of getting new credentialing done with the new health plan should there be a change.

Sub-Theme 3: Standardization and Streamlining	**State Response**
This sub-theme covers standardization and streamlining. The majority of commenters questions centered on the standardization of MCO paperwork including eliminating the difference in the audit process and the development of a computer interface platform across MCOs. Some comments requested standardization of business reports for providers. Others requested clarification of the standardization of MCO access to behavioral health services across settings. Some commenters requested	KanCare 2.0 aims to reduce provider challenges in contracting with multiple MCOs by establishing standardized tools and standardized credentialing and billing processes across MCOs. As we prepare to implement KanCare 2.0, the State will work with MCOs to minimize unnecessary prior authorizations (PAs) and to streamline as appropriate. The State appreciates the feedback on standardizing MCO paperwork and audit processes and will continue to identify opportunities for standardizing and streamlining MCO processes.

clarification on the standardization of prior authorizations.	No changes were made as a result of this comment.

Comments

1.	Talking about streamlining or standardization in the different tools in HCBS waivers, each waiver has a different screening assessment. What's the future look like for those?
2.	I hear comments from providers, nursing home administration can there be some standardization of paperwork across MCO's? I think it would speed up the process and make it more pleasant.
3.	Will the state/KanCare establish uniform provider descriptions to eliminate differences in audits among different MCOs?
4.	Offices should all be linked together for individual documents - KanCare, UnitedHealth, Coventry, prescription. I am a legal guardian and have contacted all of the above and had to send legal guardianship documents to all offices stated above.
5.	I would like to thank KDADS, KDHE and MCOs for attempting to standardize credentialing. It's important that is quite a process. When it first started each one had their own little thing so standardization is really great
6.	I'd like to ask about, I have a son that's a senior this year, and the transition process as far as employment is there going to be more of a streamlining across the state to make MCOs more transparent? I've talked to parents who have kids out in western Kansas and all over the state. My son is in Shawnee Mission school district locally and the teacher has been in special ED or whatever for quite a while just kind of is discombobulated in the process and everything. When I say he is a senior we still have no idea, we haven't figured out which way is up and which way is down. We are supposed to have a meeting about that. My daughter is 8 and I want to get that process more concise that way when she goes through this you know I can't pull anymore hair out but this will help out a lot of adults and kids and families with special needs.
7.	We all have same needs, all of the MCOs presumably have the same business requirements. Is there a discussion or consideration about unifying the MCO platform across MCOs so they all use a similar platform across however many MCOs you have? So that they could all use a consistent platform or all interface across a similar system?
8.	The information right now is member specific which is valuable to members and those systems being largely from insurance companies, are focused on member centric systems. As a provider it is extremely difficult for us to navigate into members, so instead if there was any kind of visibility with respect to provider centric business reports, business intelligence and summary reports?
9.	That information, I have had access to. The MCOs have been extremely helpful in getting that. Our biggest challenge is in billing reconciliation. That right now is certainly possible, the level of effort that we have to go through right now with three MCOs vs one MCO and the LMAP system, we have tabulated that at roughly 6 fold the cost of prior system. The main reason is because the current system does not have a provider centric view on billing and claim reconciliation.
10.	We are all serving the same population, serving the same business requirement documents, is there any discussion or work groups looking at a unified system that the providers could use that would interface with all MCOs instead of three different systems with three different inputs?
11.	With care coordinator work with schools, so with our type of therapy we need to work across all environments especially with children with autism who have difficulty with spontaneous generalization skills. Right now all the MCOs and care coordinators will give us different feedback. Due to the double dipping issue we can't bill at same time someone is getting IEP services. I've had some MCO representatives tell me that we can go in and work in the school as long as the child is not actively IEP services in other cases the child can be checked out of school to receive services others say we can't provide services in school at all which is a violation of the mental health parenting law. How do we address that across all settings? Especially when working with schools? For ABA (Applied Behavioral Analysis) we are told we cannot bill in schools.
12.	I think the problem with that is as a provider it complicates everything, you're billing four different fees, and we've talked about all of that. That is a huge cost of doing business.

13. We appreciate the standardizing of everything and want let you know that's very helpful.	
14. Grievances trickle down to when the state mandates the MCOs and the MCOs follow up with the providers. It appears as though the MCO services are being treated similarly to hospitals. Whereas if your authorize service at any level of that authorization you can file a grievance. A significant amount of my day is spent responding to grievances to MCOs for natural thing that happen if a patient turns down services or doesn't need them. Utilization shows services were not provided. I have to fill out a grievance to justify why those services were not provided. It's already getting to be cumbersome and by conversation with the MCOs they are saying that it is only getting worse. What is something that is going to be addressed with that? It's going to get worse and be too expensive for us to scan hundreds of documents for a normal practice to justify HCBS services.	
15. Another issue is that you'll have three to four different MCOs and you go to Children's Mercy and they take one of the three or you go to St. Luke's and they take two of the three. So clients have to hop MCO to MCO in a year so that you can get the service for your child. The next time it comes up you have to switch and that really messes it up with your targeted case manager.	
16. Standardization of prior authorizations – The waiver refers only to pharmaceuticals, but KHA and the KanCare Technical Advisory Group have been asking for standardization for all services requiring authorizations.	
17. The prior authorizations. Is there a plan to standardize that across all services? It looked like it was just pharmaceuticals. Or is it all services?	
Sub-Theme 4: Data	**State Response**
A sub-theme covering data developed in the comments. The majority of these questions and comments centered around the creation of aggregate reports such as age, sex, medications, increases in medication, increases in hospitalization, ER visits, timely services, and co-morbidity. Many comments and questions arose concerning the possibility of a larger data warehouse to store all aggregate data. Other comments and questions concerned the application of quality assurance measures within KanCare 2.0. Commenters requested clarification on what metrics would be used to hold MCOs accountable such as claims data. Others questioned what metrics would be used to measure effectiveness or oversight. Other commenters cited a workshop that examined these metrics and questioned why those recommendations were not being used. These commenters cited that the workshop discovered that utilizations rates were insufficient for these metrics. One commenter sought an explanation as to why performance measures might not be delineated by population.	The State is in the process of implementing the new Kansas Modular Medicaid System (KMMS), a new information technology infrastructure which will allow the State to better connect with other state agencies and organizations to share information, including data to support initiatives addressing social determinants of health and independence. The State is still in the process of determining the data that will be shared with stakeholders and partners, including de-identified reports and aggregated data. The State included draft evaluation metrics in the application and will finalize the waiver design after it receives CMS approval. As a part of the new managed care regulation, the State develops a quality strategy that involves robust stakeholder involvement. In the event MCOs do not meet the State's standards, the State may impose liquidated damages and sanctions, as appropriate. No changes were made as a result of this comment.
Comments	
1. What we haven't heard yet is a timeline for the improved data analysis and how it will be made available to us stakeholders.	
2. Can the data be de-identified so that aggregate reports on ages, sex, medications, co-morbidities can be produced?	
3. Is the data warehouse, or will it be, available to universities, providers, and even consumers?	

4.	What does the data show for those who get timely medical services and those who don't? For example, ER visits, increased hospitalizations, increased medications, etc. What's the difference on other health care systems and networks?
5.	If you have a single point of contact, it'd eliminate some of the differences and variances between MCOs and many of the concerns of people in my district would be addressed. What metrics do you have in place to determine whether or not what you are providing and what will be effective? What metrics are there to measure if a difference is actually being made? You actually have to take action. The action hasn't been taken.
6.	On the performance metric for the MCOs, I'm wondering what those metrics are that the MCOs will be held accountable for? Are you considering correct claims payment as one of those metrics? I feel like MCOs make a lot of errors in claims. Providers then have to go chasing the claims a lot of times we are spending a dollar to make a dime.
7.	Who is providing oversight of functions in KanCare? What did quality assurance data show from KanCare 1.0 regarding service denials, waiting for services and corrections made?
8.	With KanCare do you have proof that this actually has improved quality for health outcomes?
9.	Can you tell us how much KanCare has saved state through IDD program? Just a cost analysis? Surly you know what that says?
10.	So you don't know how much this program has saved the state. I've gone to every single Bethel Committee since they started. I have never heard how much they have saved. The legislatures have asked for it. I would think the secretary would know. We would like to know IDD that's all I'm talking about. If you're not saving why don't we get out of to it and go back to what we had before?
11.	Along those lines you indicate you're going to continue your previous practice of data collection. I think as you're looking at LTSS, I don't think your collecting the right data I think that's something as your looking at those evaluation pieces. We had a couple of work groups that could give you some good data points that would give you an indication of how well that's performing. You're looking at utilization rates, transportation is the only thing LTSS when you're looking at utilization. That's a gaping hole.
12.	I want to underscore what's been said about LTSS and the work groups. I know we work pretty hard with KDHE and KDADS our work group to come up with some recommended LTSS measures to look over and then decide on metrics. I wonder where that is and if it's actually being looked at. It would be expected to be seen pretty soon because it really is a big gap. There are entirely different non-medical. Having something like that, something we could really see. What are the outcomes of Home and Community Services and LTSS and that would include some idea around achieving some independence, and more community involvement.
13.	The other thing you mentioned was about data. I'm a proponent of forming an international or national database, whereby your medical records follow you along. That information from cradle to grave is important to researchers. So, if you don't have that available, or it just disappears when you die, that's just a tragedy that it just gets lost. All the X-rays, all the MRIs, all that information just goes away. As far as your medication—18000 dollars for medicine. I'm just wondering why that is. Why can't we do something about Big Pharma, in that regard? They're going into our research, like KU or K-State, taking grants, and wherever they get the information, they keep it as proprietary. It doesn't make sense to me what's going on there. That's just my comment.
14.	I think when you look at performance measures, IDD folk's area part of KanCare now, I think we need to take a step back and see what did we miss? Do we need specific performance measures for a specific population? To make sure that, there is this big group but the there is this isolated part that has different needs. Are there forms that we could be providing to make sure that we are getting the performance measures that really matter?
15.	How has the HRA tool process been validated for persons with IDD dementia, TBI, or other disabilities? Validation that the questions deliver evidence of the health and social determinants that people with disabilities of all age's experience.
16.	What I see now, the MCOs and KDADS is looking at medical outcomes for people in long term services and counting those as the purposes in long term services that's not fair.

17. Then as far as the quality side, we have long been in quality programs, our main ask is that you make sure you equip your providers before you develop quality programs that may be different than what the standard is. Make sure there is consistency in the quality metrics.
18. I know my son gets a functional eligibility and he's in the TBI waiver. And it's my understanding in talking with the lady who does it from Jonathan County and I guess it's a third party that comes in and does the functional eligibility. And it's on a scale. So the TBI waiver it's a scale from like zero to six for certain activities in daily living, OK. They can do it on their own, it's zero. They need full help, it's a six, OK. So, as you develop this Medicaid Management Information System, if you could gather that information, not just OK, they're on the waiver but, you know, which people on these waivers are, you know, what is their functional eligibility scores. Because I think that information could be very useful in the future and maybe looking at different ways to compensate caregivers. Because certain people, you know, if you pay a caregiver based on the waiver, it really, you're paying someone (who) only needs housekeeping the same as you're paying someone who needs to have, you know, comprehensive all full activities in daily living. And I think if you have that data and you, you know, you can work through it, you might end up with the same amount money being paid but paying those caregivers that provide more services more compensation because they're probably going to be working for this people in the long run. Because the bottom line is you can't find caregivers. And it's a problem that we're going have to solve. And so I'm just suggesting that as you get this information systems together, get as much data as you can so that if you're looking for solutions, you have, you know, the big data, data analytics that you can work with to figure the stuff out and figure different solutions and maybe at the same cost that you would otherwise… Yes, I'm good. Good because, you know, you can identify those who are going to be long-term in KanCare recipients versus those that are going to be short-term. You know, you take somebody young with the TBI versus someone elderly, you know, who on their last league which I maybe, you know, after all of this, so anyway.
19. On the data analytics. You know, I know we've been kind of talking with KDHE throughout the whole KanCare program about consistency among the MCOs in certain definitions like claims denied versus content of service versus, you know, different types of remark codes that we're getting….So, we're hopeful that we will also be able to participate in making sure that those metrics when they developed them are developed consistently among the three MCOs so that we can paint a true picture and a clear picture across the MCO population of what is happening. Is that a plan in the works?

Sub-Theme: General	**State Response**
Several general comments were given in this theme section that did not relate to any of the identified sub-theme categories but were associated with the overarching theme. The majority of these centered around claims and late payments. Some commenters requested that specific codes be open for behavioral health providers. One asked for clarification on the readiness process. One asked for an explanation on the 15-day limit on PRS. One requested for more information on the wait list, and one for information on the TA waiver. The last question requested clarification on how legislative oversight would differ from KanCare 1.0 to KanCare 2.0.	The State appreciates these comments. Section 5.14 of the KanCare 2.0 RFP outlines payment timeframes that MCOs meet, such as processing and paying all claims where no additional information is required within 30 calendar days of receipt. MCOs will regularly submit claims processing and payment reports, and the State may assess liquidated damages for non-compliance with the State's standards. Regarding the 15-day limit, KanCare 2.0 is seeking an exemption to a federal rule that prohibits using federal funds for Medicaid patients in residential mental health or addiction treatment centers with more than 16 beds. The exemption will allow State and community hospitals to care for additional patients with mental health and addiction needs. The exemption will expand behavioral

	health services and access to inpatient care, especially for foster children. Regarding legislative oversight, the State anticipates that legislative oversight will remain similar under KanCare 2.0. No changes were made as a result of this comment.

Comments	
1.	What kind of readiness process will you have to do before you go live?
2.	Open Health and Behavior Assessment and Intervention (HABI) codes 96150-96155. This will help to increase patient's choice, facilitate coordination of behavioral health care across the continuum, and improve health outcomes while reducing costs.
3.	A second comment is that KAMU would like to see the opening of health and behavioral assessment intervention codes 96150 to 96155. This will help increase patients' choice, and take coordination of behavioral health across the continuum, and improve health outcomes while reducing cost.
4.	Last question had to do with the request from CMS to raise the 15-day limit. Were you talking specifically about PRPS?
5.	This improved process will help others.
6.	Would the simplification of the MCO process possibly include allowing people to change MCOs more frequently than just the open enrollment, or is that still going to be during the annual enrollment?
7.	It is still a nightmare to get Amerigroup to fix screwed up claims. Working on a claims problem now that has been going on for months.
8.	For MCOs that do not become a part of the KanCare 2.0 who will make sure they pay us?
9.	Just a challenge in terms of timelines of payment. Most of us work on very thin margins we shouldn't have to wait a year to be paid for performance that's what is happening now.
10.	I've been doing this pre KanCare and with KanCare, it was so much simpler. It used to take me seconds to correct a claim. Now it takes months depending on which MCO you work with. It takes me away from providing services or spending time with my staff because I'm chasing down paperwork. Something really needs to be changed.
11.	How is legislative oversight going to be differ from KanCare 1.0 and KanCare 2.0? How do you anticipate it to be different?
12.	When we started KanCare I know that one of the outcomes that we would save money and therefore we would bring down the IDD wait list. The IDD wait list I don't believe has come down. Where are we at with that and if saving money, where is money going and are we going to bring people off wait list?
13.	As the state is working on waiver changes with CMS and HCBS, the TA waiver is a pretty unique population, usually high medical needs, in nursing home. When they age into adult service bill and there might be a gap between school to IDD so a person the age of 22 might leave school and sit at home with no services, very frustrating for family to not have MCO working on a plan. Services for the TA waiver need to go to adulthood and not cut off at 21 or new waiver program services. It's a waiver that needs extra finessing for the adult and the world. If IDD providers service to the population, there may be funding issues because they are not prepared to have the nursing that may be involved or training for medical equipment. I hope state open up meetings with TA stakeholders and providers. Hasn't happened in a while, would be nice.
14.	One of the things that you mention was efficiency so that we could make sure we manage the cost that are being paid for by the state and the federal government and that effectively.
15.	You know, earlier this year, we passed Health Bill 2026 in the 2017 legislature that kind of with some KanCare reforms that required certain things like standardization of claims denial reason codes, readmission policy and

a few things like that as well as the implementation of an annual independent audit of claims. We didn't really see any reference to a number of those things in there. Is that still coming as you develop the waiver?

16. Thank you and good job on the presentation, Becky. I appreciate your insight on this. Just a couple of comments. On the Uncompensated Care Pool that you referenced, that in the current program is funded by a provider tax on the hospitals and fully funded by that. We are a little bit concerned that we have not heard anything about chances and opportunities to enhance that pool since that directly impacts money coming from the hospitals. So, any thoughts on that?... Just from, you know, our perspective here at the hospital association, since it definitely impacts hospitals, it would be awesome to have an earlier rather than later discussion on what the plans might be on that.

General

The questions and comments in this section pertain to other areas of KanCare that were not addressed in the four themed areas. Multiple questions and comments were given concerning access to presentation materials and the public comment report, how specific programs and services will change under KanCare 2.0, future stakeholder engagement opportunities, details about the RFP procurement process, the inclusion of IDD in KanCare, stakeholder input in designing the RFP, the Kansas legislature's involvement with the RFP, and network adequacy and provider rates.

General Comments and Questions- State Response

The State provides the following responses for general questions:

- The State acknowledges the concern on the waiver application process timeline and assures its adherence to federal regulations on the state public notice process in 42 CFR 431.408. The State will continue to gather stakeholder input going forward. The State values all public comment and involvement of associations, families, advocacy organizations, people participating in the process improvement workgroup, and others.
- See Attachment L of the KanCare 2.0 RFP for more details on the service coordination activities for each population group.
- The State will develop accessible pathways for members to submit grievances and appeals related to service delivery, quality, and choice related to MCOs.
- The initial actuarially sound rate range will be developed by the State's actuary after the bids are submitted and will consider the cost proposal information provided by the prospective bidders.
- The State has developed reporting standards for MCOs in effort to effectively monitor their performance and quality.
- Behavioral health needs are members who present a need for mental health or substance use disorder services. MediKan is an employment opportunity initiative that allows individuals to either receive 12 months of health benefits while applying for a disability determination, or discontinue pursuit of a disability determination and receive Medicaid benefits and employment support such as job skills training for a duration of 18 months.
- The Uncompensated Care (UC) Pool (also referred to as a Safety Net Care Pool) provides payments to hospitals to defray hospital costs of uncompensated care provided to Medicaid-eligible or uninsured individuals.

Comments

1. Will slideshow be on the site soon?
2. Will school based services be changed at all in KanCare 2.0?
3. I have a number of concerns. I'm concerned about the way the administration has rushed the process, pushing out the proposal for CMS, notifying us of these meetings, and then immediately publishing the RFP so that we

can have public meetings but not respond to issues the public is bringing up in these hearings. I hope that the administration can take into consideration some of the issues brought up in these hearings and potentially slow this process down so we can take time to adequately address concerns brought up across the state so we have enough funding to actually support the people who this program is supposed to be helping.
4. If it is a state plan service is it a part of the capitated rate that MCOs are to deliver? And you don't have yet a code for the provider to bill the MCO to get paid. The timing of the coding clarification would happen before the contracts are awarded? Is that the goal? I think that is where the special groups that you want to have assist you can bring a lot to the table – this is LTSS quality metrics, I don't think the current actuarial system as it currently exists has a grip on what your concept is and that means we can be a leader.
5. Are you looking at the unit or team unit or something more innovative like the bundling again?
6. I would vote for a per-member per-month concept for case management.
7. Nothing was mentioned to how this would specifically affect the SED waiver.
8. I just had a meeting with the coordinator for the IDD and they have just changed some requirements for the worker and the designated representative, and this is new to us because everything Okayed a year ago. They changed requirements for the in home service provider, and in our case I am the worker – I am the mother and my oldest daughter, who is also a co-guardian, was the designated representative. The person I talked to yesterday said I have to change, because another co-guardian cannot be a representative and now the conflict of interest is now an issue. We don't know how this is working and how it will affect us.
9. I have a question regarding eligibility obligation for gross income versus net income. Is there someone here I can talk to?
10. Is that also publicly available?
11. My sister is in a program at Encore with KETCH for people with disabilities over the age of 55. How will it impact that program there? She's on the IDD waiver. It is a wonderful program for my sister and those folks who are older and don't want to be hanging out with a bunch of twenty year olds and they can be around their own peers and go on community outings and it works perfectly. Do you know if it will be effected?
12. Who is here that is able to talk about KanCare renewal. My husband just went on in August and I need to know more about the process, because I'm new to it?
13. Will we have more public forums before KanCare 2.0 starts?
14. There might be different MCO's, but do you foresee more or less or do you foresee that changing?
15. As I listen to this, and I know you can't discuss the RFP, but is that online where it can be viewed?
16. If there's an RFP out there, how helpful is any of this? Because aren't they already asking for bids on a certain package? It's curious to me
17. Who do we visit with about the concerns and issues regarding MCOs?
18. I have a question about the MCOs. Am I right in understanding that the RFP is open to more MCOs than it has been?
19. PowerPoints and that kind of thing, are those available?
20. So if we have new babies or people that come to ER that need SOBRA, with KanCare 2.0 will the process still be Kansas or KDHE qualifying those people then send them to MCO or is there a different process you anticipate for eligibility?
21. Kansas does not get government money for Medicaid. If you received federal funds wouldn't that make a big difference? Kansas is not an expansion state. If they went through expansion they'd get a lot more funds. I'm sorry, but our governor doesn't want us to do that.
22. What is behavioral health services? Do you have a community mental health center in Dodge? Hospital pays for services, or KanCare?
23. With Applied Behavior Analysis services, all three MCOs indicate that we cannot provide services in the school setting. Is this actually not the case?
24. Please contract with savings in IDD for the state since KanCare was implemented.
25. Where is that information available? Is that on your website?

26. Process improvement group? Who is on it? What are they working on? What changes can we expect?
27. I'm on the sign up list for information about stakeholder input sessions. My first notice of this meeting came on Monday, November 13th and it was for this Wednesday, November 15th. That is not enough time to allow us as providers to arrange for alternate care for our consumers so we can attend these sessions. Consumers with IDD are not served well with these last minute notices.
28. How much has the state saved with having MCOs in the IDD/HCBS program?
29. Why does Lieutenant Governor Collyer insist on keeping IDD in KanCare? We are not a medical model.
30. Parents were originally asked to participate in the planning of the RFP. Secretary Keck stated that didn't happen and he apologized to one of the parents who originally had been invited. Why weren't families involved in this very important plan?
31. Conflict of interest with financial management by MCO. Eligibility with CDDO. Functional/health/needs assessment with MCO. Determination of funding with MCO.
32. KanCare care coordinators do not have the knowledge or skills to work with the IDD population. They have huge caseloads, there is high turnover, and it's not easy to find out who someone's service coordinator is. They are more concerned about annual assessments that the MCOs require and do not help individuals served and cutting hours than they are about helping people.
33. KDADS and KDHE don't care about individuals served. It's all about money and politics with MCOs.
34. Stop cramming IDD into a program that is not designed for this population.
35. Amerigroup will not let care coordinators give out direct phone numbers. You have to call an "LTSS team" and leave a message and wait for the coordinator to call back. If you miss the call you have to call LTSS team again, leave another message and wait again. They make it a complete "pain in the ass" to reach them.
All "KanCRAP" does is create more paperwork and red tape. It does not improve the lives of people with IDD.
36. With rates, $15 is still an issue. Indeed, glass door, over fifty applications, one hire. Dental and psych. So much simpler before.
37. What is the captitated rate?
38. What states are "successful" with MCO administration? How many hours of services are provided for each IDD participant? How much per cost is allotted each IDD participant? Do these states require licenses for targeted care managers? How can you accept the RFPs when no cost information was required?
39. Dental disease interacts with the body's system that can trigger strokes, heart disease, lung disease, inability to regulate insulin for people who have diabetes. Also trigger pre-term labor. All these diseases are expensive to treat, costing far more than regular dental care for people enrolled in KanCare.
40. KanCare, thank you for all you do. I am totally amazed. God bless KanCare.
41. Why does the wheel have to be reinvented?
42. Transportation drivers are very rude, dress sloppy, and very inconsiderate of the elderly! My father (deceased 2015) needed transportation, was on oxygen, used a walker, and the driver never opened medical building doors, complained because he was traveling with oxygen. I know this because I would meet my father at the doctor's office. Elderly feel that they don't want to be dependent, however at times they have to.
43. I see where we are going the MediKan program, and then spending another 20 million dollars on uncompensated care. Why not just expand Medicaid, you get more bang for buck, and eliminate those programs entirely, you can streamline the whole system? I don't understand why we would go about it in this more complicated way.
44. I'm curious, I'm assuming that KanCare and RFP have strong correlation. If CMS shoots down some of the stuff in the application for KanCare 2.0? What happens to the RFP?
45. Going back to the term "member." I do appreciate you bypass those. Will there be an attempt by state to not use the terminology? In documents and policies I've seen I always object to them because I know it is offensive to a person with disabilities. They are people they are not members. I think it will be greatly appreciated to the people to whom you refer.
46. Welcome aboard and good luck.

47. When we deal with issues with the MCOs. What checks and balances does the state have? Do we call on the state to audit, oversee the MCOs quality. The same contracts apply to all MCOs but the MCOs interpret the differently. Then we go to the state. Other states have an Ombudsman's office that's independent and has a lot of authority and a lot of power because CMS requires it. I don't see that too much from Kansas. Will there be a fair hearing court? When a consumer and MCO can't agree the states in the middle will it go to judge to make a determination? With 1.0 we had a lot of sympathy from state but the MCO got the tie breaker most of the time. I just want to know if the providers and the ones with disabilities have a voice.

48. What improvements from 1.0 to 2.0 will be made to providers who haven't had a pay increase in 20 years?

49. As providers, we to learned how to deal and got the governor's office involved. We need some education to the guardians to make sure things are being taken care of. They didn't know the office existed. They have a voice other than to call a representative. In other states they have a way for citizens to have a voice as a taxpayer.

50. I would like to know, if there are initiatives discussions or working groups investigating some mid-level reporting that we can get out of MCO systems?

51. I would like to volunteer the department workshop.

52. FMS provider. One concern we have that consistently comes up almost daily is that a person being released from a hospital that providers services for all the waivers, that person contacts us and says we are ready to be dismissed and they have a worker they want to sign up, we have to run backgrounds on that worker. That work cannot start until those backgrounds come back and are clean, that could take anywhere from 2 weeks to a month. Is there any plan to address that issue?

53. One of the concerns that we have is when someone in the hospital and ready to be released. Even if you speed that up we are looking at 2 weeks to get those back and right now we are running DMVs from 32 states, when you have to send off to Alaska for a DMV, it could take months, by then that person has moved on.

54. That's not what you communicated before, the state had all the authority and all of the ability to do it all in KanCare. That's not what the message was two or three years ago, it was that we can do it all now we don't have the best, to get the right service to the right person at the right time.

55. I am like a professional attender of these meetings, I also attend the KanCare oversight committee and the same thing happens there. When KDADS or KDHE takes about network adequacy they are taking about it's always the doctors the therapists and those kinds of people. I still feel after four years that there is a disconnect between KanCare with everybody else, and KanCare for the people with IDD. In my opinion it's still not working. I guess it's difficult to look into the future to KanCare 2.0 and say well you've had four year, you should have the best program ever. What I'm hearing today is, "we're going to so this we're going to make this better". I think the state has been under the gun from CMS when it refused to approve the extension of the current waiver. What's happening with that? I think that it's time for everybody in Kansas to wake up and hold you all accountable. IDD should not be in KanCare because we need our TCMs. We are a completely different duck, people who have babies low income medical care completely are different from people that need long term care. People who get on the IDD waiver are on for life. We have to support those people. We've had 4 years we should have the best program ever, what have you been doing? Especially since CMS didn't approve your extension the first go around and you had to come up with a corrective action plan.

56. Third thing we were promised by Secretary Keck and Secretary Mosier that parents would have a place a table at drafting 2.0 so that it meet the need of our folk and we were not invited, we were only invited here to offer comment. We feel that it was disrespectful. It's also disrespectful to have the applications back after the proposals to the MCOs and get bids in before legislature meets. These are high dollar contracts. If the legislature had no ability to review those and no ability to do anything about those, that seems devastating. Those are my issues.

57. Could you address the question about why we were not included in the planning process? This isn't at all transparent, we have no ability to make changes you don't allow the legislators to have any input. I know you have the ability to do that to you have the ability to sign these contracts without legislative oversight, it is so

disrespectful to the parents. Well are you going to change anything? I asked a couple of things why the January 5th deadline? For the input and for the applications to be back? But we don't even like these there is not time to make changes. I think the time lines are too quick.
58. You didn't answer the thing about nonmedical, why is it that the state of Kansas thinks that the non-medical long term care should be in KanCare? Why? Whose philosophy is that?
59. I'm on the KanCare renewal website and I don't see an attachment L or an attachment G. Where do I go?
60. In your slide you talk about youth with behavior health needs and then adults. Can you define behavioral health needs for kids and adult population? It's not anybody who has the mental health diagnosis, it's a certain population that falls into that? Through that risk assessment?
61. How do you expect retired farmer to get these services without selling the farm without selling the life insurance and all that other stuff that you guys are requesting to comply with the things that Medicare part B asks? Especially when your social security is less than $1200 a month. We have 26 pages of stuff we faxed to KanCare asking for burial plots, trust and life insurance amounts, all the other information you asked for and my parents were still denied benefits for Medicare part B.
62. I noticed you had a deadline of January 1, I thought it was January 5th?
63. Will the legislature have an opportunity to review this?
64. My other point is those of us in the legislature, Representative Parker and myself, feel like we've been cut out with this RFP and the dates and the way it's coming together. The contract will come due on the 5th that's the Friday before we reconvene, I do understand that you need some time next year for CMs to approve it but I think you can still have a few weeks for the legislature opt have some oversight. Another question you answered this afternoon you talked about conflict of interest and you said you were eliminating it you said that it was legislative oversight well I would like to see that date pushed back.
65. As far as the January 5th deadline? It's too quick.
66. I've been on Medicaid since 2009 one thing that I've tried to do is getting off of Medicaid. I'm also on SSI. I went to college and I ended up getting sick. I'm dependent on a shot that's 1000 a month so I had to keep Medicaid. Whenever I applied for a job even as a manager making 9.00 hr. I could not afford KanCare. I would have to get a job paying salary. If I get a job paying salary I will have insurance with them. My question is when are you going to have KanCare affordable to people on my level? Would that pay for my medication or just the insurance? Will I still get SSI? I know when you report income they take pay. If you lose SSI for a year you lose your Medicaid. My body is chemically dependent on this medication. I see on paper is says, "Having a career and a career path individuals on work programs can benefit from," what are our guys doing different this year? Is that affordable? They didn't mention anything to me when I went to the Medicaid office.
67. Are you coordinated with Valeo, are you part of Valeo Services KanCare?
68. I would like to start off by saying how much I appreciate KanCare and what they do. I think it's fantastic that [inaudible] people, and Valeo is really an outstanding program. I've lived in four states where not me, but my wife, has depended on KanCare, and raised three children in this. So, my impressions may not be for this particular slide you showed here, but what I've learned raising kids who have a terminal mother who has cancer and Alzheimer's would be that it's the children that are concerning to me. For example, they have a lot of anxiety anyway, so when they go to school, sometimes they're mistaken as bad kids. They're not bad kids, they're just staying up all night because they're worrying about their mother. But the counselors at school—I'm not faulting them—but in the states that I've lived in, the counselors are not versed in how to deal with the children, and they're not asking the right questions, appropriately, to get to the bottom of what's going on with this child. So, when he goes home, he or she may be faced with all kinds of things that could be detrimental to their mental growth. So, what you end up with is more and more children end up in juvenile detention, pregnancy, drug abuse, and those kinds of things. I also volunteer once every Friday at the juvenile center in Shawnee County to help, so I know exactly what I'm talking about on this. It's just something I wanted to bring to your attention. But I would like to thank you once again for such a wonderful program that you have to help the state and people here. One final note that I think would be helpful is if states would communicate across state lines so if you have to move because of a job change, it takes six months, and

possibly all of your money to try to keep a person in adult daycare, and then you're just lost because it takes six months trying to get them signed up

69. I have a question regarding apparent changes to your grievance and appeal procedures for people on the waivers, and also seniors in Kansas who are on waivers. I'm not sure that anybody here from KDADS or KDHE was involved in these discussions in 2013 and 2014, but at that time at the beginning of instituting KanCare, Kari Bruffett from KDHE, several staff from KDADS, legal staff from both agencies, met with our agency, stakeholders in the community, and I believe even some of the MCOs were present, to hash out how to set up a meaningful appeal and grievance procedure that provided necessary protection for people with disabilities and seniors in the community so they did not lose their services during appeal process. And they did not miss short deadlines that had been imposed previously. The result was a written agreement to provide that if the MCO is proposing to reduce or terminate services that the notice of action would specifically state that all services continue in effect for 33 days from the date of the notice of action. That was specifically to include the three-day mailing requirement that's in Federal law, and also the state recognizes that. That included not only during the time of the informal grievance procedure, but also the time to appeal for a state fair hearing if the informal grievance procedure resulted in adverse determination. It was worked out with all stakeholders, everybody agreed to it, and after it took a while to get the MCOs to finally adopt uniform language, since that time, we have had that appeal procedure in effect. In reviewing your attachment deed to the RFP, it appears that appeal procedure is changing substantially to the detriment of people with disabilities and seniors. While the 33-day rule for continuation of benefits still applies during the internal appeal procedure which is now mandatory, that is now eliminated if the MCO determines to continue with the reduction or proposed termination of services. In Attachment D it states that when that notice goes out, the member has only ten days from the date of the notice of action to file an appeal with the State Fair Hearing Agency, the Office of Administrative Hearings, and to request that benefits continue, instead of 33 days. Now, in representing numerous people for 14 years at the Disability Rights Center, I can attest that there are many people out there who are not sophisticated enough to really understand what significance that causes them if they fail to appeal in the ten days. They lose their services on day 11; they no longer have the services in the community. That was the reason why the stakeholders and the State got together at the beginning of KanCare, because of this critical need for the most vulnerable people in the state--people with disabilities on waivers, and seniors receiving frail and elderly waiver services--to make sure that their services were protected to the maximum extent possible. And particularly because when KanCare came into existence, all but the people on the IDD waiver lost their independent case management services, and those were the individuals who provided them with the most support in the community. Instead they end up with care coordinators at the MCO and they are by definition on the other side whenever a notice of action goes out. So, my question is, why are you deciding to reduce those protections to people with disabilities and seniors in the community? And also, whether you're willing to reengage with the stakeholders to discuss continuing what we already had and what has proven to be very valuable to everybody that receives these services? Do you want the sites where the changes have been made? Do you have any idea why it was proposed?

70. I have a question about the timeline. You talked about this timeline that was submitted to CMS for the proposed changes. I'm just trying to wrap my head around how that's paralleling with the RFP that's out. So, we're having public meetings, you're getting input, but there's already an RFP out to solicit MCOs and what they'll do. So then how will the input from these sessions be incorporated in that contracting process?

71. So typically, with RFP process that really drives the contracting, but you're saying that some of this input will be utilized and looked at to tweak things that maybe were missed in the RFP that are important?

72. So, to piggyback with the man from DRC, I think that his whole concern about the ten-day appeal process is very much valid. One of the comments made earlier with TCMs and their role really used to help families go through the appeal process because it is daunting. I know from my seat with KanCare I have two different MCOs I work with my children, and I do nothing but appeals. If it wasn't because I know the system really well, I would be scared to death about the complications that would leave for families that aren't savvy, that don't know the system, that don't know how to work through those appeals processes. So, it's getting a little

scary and frightening to me to think that that could be changed to ten days, because in ten days people might not even realize how that's going to affect their services.
73. The last slide says that KanCare 2.0 will be able to assist with building living skills including transportation, and also support providers and help them work. How is that any different from what's being done right now? What is going to be different? You don't have the RFP back yet. What do you fore see is going to be different than what is being done right now?
74. Once the transfer the decentralization took place a couple of years ago it smoothed out, but during that process it was kind of a mess. Which we expected. When KanCare was privatized when we went from Medicaid to KanCare. In that transition, that was the time when I was billing at our assisted living center for Medicaid. You would fill out everything online and it would not work and you couldn't get through to anyone to ask anybody questions. It was a bit frustrating at times but it's wonderful that we have KanCare now.
75. She has a care coordinator but I have no idea who that person is. We've not really had to ask that stuff. She is in a small nursing home. It's really nice it's a 44 bed home. It's skilled and it's great.
76. What's MediKan?
77. One of the biggest road blocks for IDD is the lack of transportation, I heard something about transportation assistance. What would that look like?
78. You mentioned transportation as being one of the services. What other services might there be in addition to transportation?
79. Does Valeo work with TANF? Do you do drug screening for these people that are on [assistance]? What kind of programs or education do you have in place to try to educate kids that are having kids? Maybe some sort of program in place that will help these kids, maybe interlace them with TANF that will get them a skillset like welding, or anything, to help them be marketable, and relying on the system. On the other side of the coin, do you have any programs about early onset? People that find themselves in a stressful situation, 65% of caregivers pass away before the people that they're taking care of. One thing I'd like to stress in our legal system is for lawyers, [instead of pushing toward divorce] to look to see if someone has Alzheimer's, because maybe they don't need a divorce.
80. Some interesting sociological issues tonight. Has any of the 12 of you ever tried calling your office as a member of the general public requesting help? What happened?
81. The Medicare Savings Program, what's that? Do you have to meet a spenddown for that?
82. I want to thank that lady for taking about her son going to college. I had a 3.75 GPA the lady at the ADA program said they mainly deal with people with dyslexia. My condition effects my mind, I got sick three times in the year I was going to college and college didn't stop got because I got sick. It kept rolling and I got three F's and that's enough for you to get eliminated from school. The lady in charge of the ADA program compared me going to college to her buying a car that was stick shift or manual and that maybe my views that I could even go to college were too far for my mind and I kind of think that if the state had better programs for people that want to go to college that maybe it would be a little bit easier for them to complete the program.
83. Has the state thought about hiring a person with a disability to go over some of these questions? So some can understand the questions lots of times you guys use big words and we don't understand them. We need in plain language.
84. I got a list here sorry if I sound like a broken record. If the person has a physical disability or mental disability and can't or not able to get a job and work and SRS cut health care insurance and SRS cut them off Medicaid or SSI cuts there income, and raises cost of living, rent, and can't afford to pay rent, and the nursing home, and housing authority refuses to help anyone to help with disability or help homeless or homeless shelter refuses to help because of past legal or behavior, or what if person living in a nursing home can't get help with problem? What do they do?
85. I live in a place here now, no one cares about me, and they won't do anything to help me when I need help.
86. In my experience in times past there have been parallel levels of accountability and responsibility, and those two parallel extremes just don't come together.

87. Just trying to stay educated. It's so complex, I think part of the problem is that, we have jails, nursing homes, we have and people. I'm not sure it was good to put in in one big coffer. I think its way to confusing. You can't even find the person you want to talk too. Any number you dial there's not a human being there anymore. Punch this number and punch that number and I just hang up after a while. I tried to call about client liability one day and after four tries and no human beings answered I get frustrated and what do you do I thought just l go on. I think it has grown too big. Maybe we need go back to have long term care. To separate them out because the bureaucracy has overgrown. It's untended anymore. You go to the nursing home and they say, "We don't know" and that was another thing of information that I had to deal with trying to switch her form in house to sheltered living. She turned 60 and she became frail very quickly they didn't have a home she had to be drug to the shelter everyday it was terrible. That transition was horrible. Who do you get to do the assessment? I don't know how to fill out all that paperwork and I have a master's degree I'm not stupid. Then you ask the people, then the lady could find my sister. So I get a call at 7:30, it's a nightmare. When they cut the funding. When I did the billing you could call and ask what code to enter and get the right amount not anymore. I have no idea I've got all these pile. I don't know who my mother's MCO is. You call they say when don't cover this. We are in Neosho County and we call the nearest Pittsburg and they don't cover us.

88. I stepped out at transition time. I had been through on to many transitions. Since 92 dealing with assisted living HCBS and nursing homes in-between. I'll let someone else deal with it because there was the period of no payments. If you enrolled in the wrong MCO then they decided they were out of the game at the middle of the year. I think its way to complex now how can you deal with long term services then prison then people with children.

89. My sister had to have a level one and level two care assessment. I had no idea and could not find someone to explain it. Finally I found someone at the agency on aging. But a lot of them work out of a shoe box, they don't have an office where I can come meet with them.

90. It all worked out but nowadays, what are we going to do when no one has money to pay. I'm not going back to work to pay. We need one number where a human being actually answers the phone.

91. Too many abbreviations and acronyms.

92. On the hand out on the language side, safety net pools means what? And does member access to behavioral health does that include substance abuse inpatient?

93. On the last section "member access to behavioral services" is that inpatient substance abuse also?

94. If I were on Medicaid could I get access to substance abuse treatment?

95. Please define Provider, and specially trained coordinator.

96. Is Kansas open to not just Authenticare but other systems?

97. I think the question of accountability is a MCOs question and raises a concern about the addition to the total number. There is without question an added cost to providers in managed care systems. The addition of positions that did not exist to keep up with the processes that are required. There are every day costs that occur. You would see that adding another MCO would only complicate that significantly more and increase challenges to the state in terms of being able to hold those contractors accountable. I understand the need for 3 but I question the need or value for 4. Another area of that possible from the point of view of the MCO is are there enough lives to sustain 4 MCOs. Can four be successful? I am asking to limit to 3 MCOs. Going to four would create additional costs and requirements and make the system burdensome.

98. It would be wonderful because, 3 provides choice, but the state should to take that issue off the table.

99. As far as quality improvement, there had been a significant increase year after year across the board of all HCBS populations in hospital readmissions. My hypothesis would be that is related to some of the cuts, labor shortages. I want to give you a chance to speak to that, what plan is there to address pretty significant readmission rates?

100. Questions related to quality metrics for applied behavior analysis services. Policies moved from autism the waiver this last January. This was something that providers and families all indicated that current soft caps are inappropriate. There is a soft cap for 25 hours a week of direct intervention and an average of about 2 hours a month of supervision. It's well below industry standards which indicates 30-40 hours a week of direct

supervision. And an average of 25 hours per week of supervisory parent training. When those went onto place we were assured that they were soft caps. What we've run into is that they are hard caps. We have to show the kid is going to be hospitalized usually. What are we going to do about the state soft caps that are incompatible with industry standards and when looking at the final rule with access to the same level of access with HCBS services for those on Medicaid and those with private insurance it's just not compatible and I'm not sure what you are going to do about that?
101. I request that in the spirit of transparency, that you get back to every single one of use about these issues and questions we have and your responses and how this I going to improve the RFP.
102. Where is the report going to be made available?
103. In the spirt of transparency, what's up with the process improvement group? What's going on with those things? I understood that the group was pretty secretive. We can't even find out who is on the RFP committee who's on that group?
104. In KanCare 2.0 will people with acquired brain injuries be able to access TBI services? What do we need to do to pursue that?
105. Are those written statements reviewed by each of the 41 revisers of the RFP at the same time? Who so we submit those statements too?
106. Are you going to get rid of article 63?
107. I've had multiple kids on the same waiver, to provide nursing is like pulling teeth from a bear, as far as assuming the responsibility of two kids at the same time. I've asked if you would make an exception but it's like, "ha". Anyway I'm just frustrated about it.
108. It's tough for a family to manage that. For people with disabilities being able to manage their own waiver and services that they need that is a full time job me, and I'm fully functional. My kids are not, when I'm gone they're not going to be able to navigate this system. How are you going to help these people who are not as functional to be able to realize when their Medicaid is expired? Or when they need to contact the MCO because somebody screwed up their paperwork and then follow through the chain to make sure it gets done? They have TCM but they can't drop everything because they have caseloads.
109. Don't understand why mental hospital waiving certain hours is going to bring more services? Your last slide had something about federal requirements on mental health services I don't understand that? That would allow for longer stays in state hospital? Would this have an effect on community mental health?
110. I have a question about the Medicaid waiver for physical disability. I've been on Medicaid for 43 years and the reimbursement rate is so low it is impossible for me to find care givers. Its 10.07 now and the rate has not changed in 4 years. I have a high level of multiple care needs. I work on it every day trying to find care givers. I don't have the resources to spend on Indeed or the different agencies to help out. Its $40 for one day to advertise. People want $15and $20 an hour I go through care.com to find people. I can't get hits on anything. I've written people on that list almost everybody. I know this is problem for everybody with my level of disability. I'm a high-level quadriplegic and everybody is having this problem. I even tried to go through the agency they don't have people. They aren't qualified, trained or even allowed to do the type of care she needs. A simple suctioning, they would not even want the people to be trained, and to deal with her urinary needs other issues would not even know what it would take to deal with it. We want quality people not just people looking for a job. They want more than 10.07 an hour. They want days off. There are only a few agencies that do it and they don't have the staff. 43 years, that's a long time to be trying to get care.
111. Thank you for coming today and listening I think you're very compassionate. One issue this I brought up this afternoon and I ask now so everybody can hear this is, two times ago at the Bethel oversight committee legislatures asked how much savings KanCare has been for the IDD population. I asked today you said that you didn't know they asked again last time, the answer did not come out last time. I believe that's very important for parents to hear how much savings KanCare has been for the IDD. Because it's our feeling is you're not saving anyone we would like to be carved out. One of the reasons we would like to be carved out is because of all the things we talked about today the provider issues, staffing, TCM getting slashed, why are you doing this? If you don't know how much you've saved that seems rather odd too me.

112. This evening there have been several references to other states success rates, and we are watching other states, and no names of the other state. It would be very beneficial for each of us I think to know what the states are and how many hours are provided in the states that are successful and the cost for those states to participate to be successful. That program I'm interested in the IDD program. If there are successful states that are using managed care organizations successfully we would like to know who they are. Nonmedical services would like to know the same thing.

113. Going back to the rates issue and trying to hire on indeed. I'm a service provider for residential supports. We have some divisions right now that are up to $15 an hour, we are not getting any hits on that. We went through 50 applications that resulted in one hire. So rates are still very huge. We offer medical dental vision and oral, paid vacation, this is a field that people avoid, it's not just being able to afford indeed. With dental and psychiatric services, it's very difficult to find the care. The feedback we get is the rates, and hassles with paperwork and red tape with the MCOs.

114. I'd like to know what the capitated rate you're paying MCOs in the current contract.

115. I have a comment about psychiatric care and medication care. My son is IDD he was in crisis a few months ago. He is autistic and has high OCD issues and significant anxiety. With all the changes he has been exposed to over the last few months his behavior has gotten worse resulting in self-injury. He was in ER two or three times required stitches in he was literally in crisis. I called every hospital in the greater Kansas City area, and asking for help and absolutely no one would accept him because, he was on Medicaid IDD or doing self-injury. One of those three or a combination of them knocked him out. The only place I could get help for him was [inaudible] West. Only because in years past he was an outpatient. They were going to limit his inpatient there to three days. We were able to get it extended to five days. Is the anything you can do to help the MCOs convince the psychiatric community to provide some services for out folks when they are in crisis?

116. One thing I wanted to add to the discussion about the provider rates. That is that at least one Johnson County provider has 33 vacancies because they cannot find people at the rates they are paying. This is not just a problem here it's a problem throughout the state. I think we are in a situation where we are putting kids at risk with that kind of under staffing. Last year we were able to get a 3% increase. Next year if it doesn't get vetoed there will be an additional 4% but even with that these people are not getting enough. They have options they can go flip burgers and fry rice for same amount of money without the stress. Someone had to ask the legislature for $94 million for the waiting list. It's nothing that I would like more than to see that happen but there is not enough capacity to bring those people off the waiting list and get into an agency that can provide support to them. We've got a major problem in the state and it's going to get worse before it gets better.

117. I would like to add on to what was said about in home care providers and the lack of bodies to provide good services. We are relying on high school students to provide care. I would ask if you had a medical complex would you give that responsibility to somebody that young. There's a lot of families that don't have a choice. They are alone with my child providing care and some of its medical, providing medication, high school kids. Doing tube feedings, all kinds of stuff.

118. You had mentioned or asked if there's a solution or anything that we could come up with to help with problems. Through the years it seems that the tasks or the things that are being paid for are narrowing, and that what the case managers used to be able to they don't get paid for, they can't anymore. What if you allow providers who are out there to help there residents to apply or reapply, the case manager can help and get paid for it?

119. Can you tell me, is there a team inside of KanCare called program integrity? Through my letter, I talked to a girl that said she was kind of in program integrity, but she was asking me specific information. She knew I was appealing and we went through that process and thing have been kind of shut in our faces. Now my son is still sitting there with the bills that have racked up and now collection agencies are calling.

120. If you don't fix the things on the front end with 1.0 it not going to get any better with 2.0.

121. I want to invite everybody to come to the oversight committee on 11.28.2017 in Topeka and you guys where awesome today so come out and give your testimony so they can hear what you have to say the more they hear the better. You can write Erica Haas is Erica.haas@ks.gov.
122. Recently there was a discussion because there was a relatively significant drop off in the RTF availability. It had been relatively stable around 450 then up to 700 it's now down to 200. There has been some push back stating that its expensive and other folks, the whole thing is kind the safety net of last resort. The number that is necessary is noble. I think that it ought to be considered when we talk about quality of outcomes. It's important to know how many RTFs may we need, and that number is entirely knowable through the assessments when kids are taken into the system. That's the more important number and I don't think that it's been made very public. We have to dig down to what is actually necessary and then make sure that there are enough community resources available to prevent kids from going to that level.
123. When it comes to MCOs you mentioned it could be 4 or 5 looking back to 2013 in the transition working with MCO I think we've made great progress with the three that we have. I think about welfare and privatizing and how that's difficult, and a transition every time a contract comes up. Have you given any thought and I don't know about rules and things about when soliciting to MCOs when biding, can there be a limit? Can you give thought to maybe can go with people we know rather that starting over with people we don't know?
124. What does the state plan on doing about the MCOs since they claim that Amerigroup is the best? Yet they refused mental health treatment unless they go to a crisis center which is limited mental health treatment and temporary. No other place where they have doctors that claim they're competent they won't take the insurance because the state only reimburses 40% and the MCOs only pays doctors 40% of that 40%. Most doctors won't take it. I had to take a cab to Kansas City to see a doctor he said he was too incompetent to get the job finished. Amerigroup got pissed off because they had to pay for it, because they claimed it was cheaper than me seeing a doctor here in Topeka. After that the social security wasn't talking about suing the MCO. The MCO says well, I no longer need treatment because of the crisis evaluation 2 years ago said that I didn't need it at the time. Therefore they just say until social security sues us or the state starts paying more, that mental health treatment isn't necessary.
125. I want some insight on a physical therapy program? They offer no physical therapy programs accessible.
126. On page 32 it talks about the average number of unique providers enrolled in KanCare, I think that's fantastic. My deeper dive in to that is, Ok you have this many people how many have openings. Maybe you have 500 now but they're only taking 2 patients instead of 4 because everything has become cumbersome with paperwork and everything. I think that data is a little inadequate.
127. My positive is, I'm excited about the IMD waiver exclusion. I have spent time working at KDADS, working with different places who fall under the IMD making it difficult for people to get services. Hopefully that goes through.
128. You ever consider going back to the way it was before you went into KanCare? That was a wonderful program. You could walk in and get your answers. This take months. I propose we go back to the way it was.
129. Who are the prospective MCOs interested in the bids? So if you have three or four MCOs that could look three of four different ways?
130. As it exists today, does the IDD exclusion apply to Osawatomie? So are they currently severed or suspended today? So there severed? If you're successful with this they will keep their Medicaid we will get additional dollars from Medicaid and we don't have to reapply once they are discharged? For how may days, you've mentioned 15 days, I'm not sure if I follow that?
131. If I am with one MCO and that MCO is not awarded the contract, I'll be automatically reassigned? It will be like it was when KanCare 1.0 rolled out that I can then change? That was a little bit of a mess the first round due to moving pieces. I implore whoever is in charge of that process to be careful, because it was confusing. The lists got messy.

132. I can't stress enough about network adequacy. Obviously, I have a passion because I have several kids in my home with IDD; that is a unique population. Perhaps people uninvolved in that system aren't as aware of some of the special needs. So one of the most important needs for people with severe developmental disabilities is the need for continuity of care. So, I saw on page 36, it talks about efficiencies and the emergency rates for HCBS were lower. However inpatient hospitalization rates were higher. That puts the spot light on the importance of continuity of care. That goes back to network adequacy. If you don't network adequacy to keep the same staff, or paying for folks with profound mental and developmental needs, and you're switching them all of the time, people are missing things. Even in my own home, my son I know very well, things get missed. I had a new person working with him while I was out of town, she didn't know his ques, and missed some pretty significant things during the day. We ended up hospitalizing him for 5 days. If you don't have people that know, and we don't fix the network, by paying people what they need to get paid, in order to keep them in their positions.

133. You also talked about creating a medical care advisory committee. Carrying on my other theme looking at LTSS as roughly half of the program, have you thought about adding an LTSS advisory committee to help with policy development and make the thing work better.

134. I think you do a great job. And I really appreciate what you do at the state.

135. I'm thinking about starting – I want to start Napoleon sandwich shop in Wichita. There's a vacant Sonic next door. It used to be Sonic. I thought about restarting Napoleons. They went bankrupt a few years ago because the guy who started Napoleon died, David McElhaney. And I was thinking about learning on my own. Independence University either computer networking, information system security, web development, software development, mobile apps, computer servicing, and that's technology or business and accounting. Accounting management, social media marketing, human services and entrepreneurship and I go to Breakthrough. It's a mental health club in Wichita. And I live on like 900 a month disability. I do suffer from lower back pains every now and then. When I wake up, my feet are numb and my legs are numb, almost up to my knees. But that's no excuse in my eyes. [state clarification: So you're interested in some support to help you get a job and get some training and be able to work?] Yes. Yes, the Department of Children and Families just down the street in Oliver. They moved from downtown. And I have a lot of mentally ill friends but I thought maybe if I had the knowledge to restart a small business, then I could probably pay my employees at least $15 an hour, but it would just be a few employees, I won't be able to employ a lot. I do have job experience with the health and hotels back in the '80s (Dillons, Edgemoor & Harry) and I had my identity stolen about 15 times... [clarification asking if commenter is seeking help or making a comment] Well, I can get help at Breakthrough Club. I can suggest what I need to do. And they can help me follow through with it… this advertisement is from Independence University, it's a place out of a admissions department, Salt Lake City and I really don't know what else I can do. I do want to go back to work but I suffer from lower back pain. My brother who live with me does all the shopping for me. He does the laundry. All I do is all of the cleaning and wash the dishes…OK. Well, thanks a lot. You all have a nice time. Have a nice day… I appreciate this time to speak on the phone about some of my plans.

136. I'm the power of attorney for my mother who's in a nursing home in Manhattan, Kansas. I didn't see very much in the KanCare 2.0 about the frail elderly, which I believe is the category that she falls into. And I wondered if you could summarize any expected changes to the KanCare Program for the frail elderly if I've – if I'm identifying your category correctly…That would be helpful because I was told after I went to the meeting in June and I heard from KanCare that she is not eligible for a care coordinator because she is frail elderly. I do feel ask you to consider with this application she had a number of extraordinary large dental bills pending that have not been taken into account with her – what she is paying for month for KanCare so both on the 2.0 and the RFP, we need a little better service on bills incurred.

137. I was on your website and it ask for handouts or has on here for a hands out and presentation material, do I enter a code to get those?

Comments and Questions Received by Mail or Email

Theme 1: Strengthen Social Determinants of Health and Independence with Service Coordination

In written correspondence received, comments about this theme area fell into four (4) main sub-themes, including: service coordination, person centered planning, social determinants of health and independence pilots, and language or technical suggestions. Additional comments not in one of these sub-themes are listed in the general section.

Sub-Theme 1: Service Coordination	State Response
Several comments voiced support of the principal and idea of service coordination and the partnership between MCOs and local resources to support members and help them connect to needed resources. One comment reflected support for the idea and fear of it being later terminated, as was the case with health homes.	The State appreciates the feedback on community service coordination. No changes were made as a result of this comment.
Many comments requested for more detail about service coordination, including the addition of a service coordinator for youth in foster care, roles and responsibilities for MCO service coordinators and community service coordinators (including suggestions that the MCO service coordinator does more problem solving and is responsive, while the community service coordinator coordinates transitions and the rest of the responsibilities), and what the difference is between the current and proposed systems, the assessment process and tools to be used for assessment and planning. There were many questions about who would receive a service coordinator and community service coordinator, specifically including those on waiver waiting lists, those with SPMI or SED, and in the WORK program. Additional questions were whether community service coordinators would be a licensed service, whether Article 63 applies to the service, and whether Community Service Coordinators would be local.	The State includes more details on service coordination in Section 5.4 and Attachment L of the KanCare 2.0 RFP. No changes were made as a result of this comment.
Several comments offered suggestions to help ensure the success of service coordination, including limits to caseload sizes, setting a floor for contact frequency and allowing for more at member discretion. Some also requested assurance of choice of provider and the ability to change the service coordinator. One requested clear and reasonable training requirements. Another comment suggested standard assessment and forms between MCOs.	As a part of their response to the KanCare 2.0 RFP, MCOs will submit proposals on how they will assign and monitor service coordinator caseloads. See section 5.4.9 of the KanCare 2.0 RFP for more details on service coordination ratios and caseload assignment methodology requirements. The frequency of visit or meetings is determined with the member in the initial meeting to develop the person centered service plan or plan of service. More details on service coordination training requirements is available in Section 5.4.10 of the KanCare 2.0 RFP. No changes were made as a result of this comment.

Numerous comments and questions requested clarification on how the programs are going to be paid for and billed. One comment requested flexible rates for Community Service Coordinator based on training, education, and/or populations served. Comments also requested a return to per member per month payment for TCM services.	The initial actuarially sound rate range will be developed by the State's actuary after the bids are submitted and will consider the cost proposal information provided by the prospective bidders. No changes were made as a result of this comment.
Many comments cited concerns of conflict of interest in several areas. Most were related to MCO staff doing screenings and assessments for services and authorizing services. One comment requested assurance that service coordinators would allocate services based on need, not financial incentive and a way to report occurrences. Several questions were also raised about how conflict free case management will be administered and when it applies. There were also questions about application of conflict free case management including applicability to different types of providers (residential, day, supportive home care, FMS providers), whether CDDO and TCM can be a part of the same agency, and whether a TCM can be employed by a day and residential provider at all or whether they are only prohibited from providing case management to people served by the agency in other ways. Commenters were also concerned about community service coordinator capacity development and its impact on TCM workforce.	As a part of KanCare 2.0, the State seeks to ensure conflict-free case management by assuring that entities responsible for assessing individuals' needs and whether they are being met are not the same entities providing direct services, in accordance with federal requirements in 42 CFR §431.301 and 42 CFR §441.730. As a part of their response to the KanCare 2.0 RFP, MCOs will submit proposals for how they can work to ensure that conflict free community service coordination is implemented. The State acknowledges that there are some exceptions and instances where only one entity in a geographic area is willing and qualified to provide case management and/or develop person centered service plans. In these cases, the State will develop conflict of interest protections, including separation of entity and participating provider functions within participating provider entities, which must be approved by CMS. No changes were made as a result of this comment.
There were several comments and questions about TCM, mostly about the impact of service coordination on the existing TCM service, differences in the two services, and whether TCM would be eliminated. One comment wondered if case managers would be able to serve other populations. One comment stated support of keeping IDD TCM.	Targeted case management (TCM) is a critical component of achieving greater integration of care and improved outcomes and will continue as a part of service coordination activities. Furthermore, the State stresses that members will be engaged in choosing a service coordinator. If the member feels that their current care coordinator or targeted case manager is appropriate for their level of care and needs, they may serve as the member's service coordinator. No changes were made as a result of this comment.
Other comments included concern about frequency of visits and whether members would be seen often enough to accurately assess their needs if visits were annual or every two years. One comment was received about each of these topics: members need to know who MCO Service Coordinator is and contact information, maintain CDDO/role, community service coordinators need to be able to talk to state agencies/MCOs on the person's behalf, restore TCM to all waivers, uncertainty that the proposal is better than the current system, and suggestion to remove barriers and disincentives to utilizing telehealth.	The frequency of visit or meetings is determined with the member in the initial meeting to develop the person-centered service plan or plan of service. No changes were made as a result of this comment.

Sub-Theme 2: Person Centered Planning	**State Response**
Several comments stated that person centered service planning should be member-driven and two comments suggested a peer participation model. Commenters also requested more details about person centered service planning.	Person centered service planning process involves documenting the member's strengths, needs, goals, lifestyle preferences, and therefore is member-driven with the assistance of the service coordinator and any other parties the member wishes to include. See Section 5.4.4 of the KanCare 2.0 RFP for more details on person centered service planning. No changes were made as a result of this comment.
Questions about person centered service planning included whether this was in response to the new CMS rule, where the State's PCSP policy can be found, who the will have a PCSP and who will develop the PCSP. There were also questions about the relationship between the person centered support plan required by K.A.R. 30-63-21 and the person centered service plan in the application and who would complete the person centered support plan.	Plans of Service are developed for KanCare Members who receive Service Coordination. Additionally, Members enrolled in HCBS Waiver services, children in foster care and Members with Behavioral Health needs receive a person centered service plan. Person centered service planning involves documenting the member's strengths, needs, goals, lifestyle preferences, and therefore is member-driven with the assistance of the service coordinator and any other parties the member wishes to include. See Section 5.4.4 of the KanCare 2.0 RFP for more details on person-centered planning. No changes were made as a result of this comment.
Sub-Theme 3: Social Determinants of Health and Independence Pilot Programs	**State Response**
Questions about potential pilots include whether they would be offered to CMHCs, whether they would be implemented, citing ambiguity in the language such as "considering" and "potential". Specific comments were received related to foster care pilots, including expanding services available to children and families at risk of entering state custody, particularly substance use disorder services, request for more detail related to types of transition included, and a need for step down services for children leaving PRTFs. Other comments about pilot projects in this area include requests for more detail and collaboration, raising protected income level amounts, including social determinants in member health assessments, and including specific language in the application around receiving federal match for integrating social determinants into the approach to support efforts.	The State is still in the process of designing the pilot programs based on responses to the KanCare 2.0 RFP and will consider these comments. No changes were made as a result of this comment.
Sub-Theme 4: Language and Technical Suggestions	**State Response**
• In figure 20 example 3.1, reintegration should be listed as the number one example of obtaining permanency.	The State appreciates your feedback and comments. No changes were made as a result of this comment.

• In figure 20 3.2 and 3.3 antipsychotic medication is referenced, but this greatly limits the population. It would be advantageous to expand 3.2 and 3.3 to children in foster care receiving psychotropic medication. • Language suggestions: o For Care Coordination, instead of person centered "care" a better description of "person-centered" would be that it is a philosophy of assessment of, planning for, and delivery of, services. o Instead of using "Provides person-centered care", perhaps instead use, "facilitates person-centered planning and delivery of services and supports". o Figure 4: The top circle which states "Provides person centered care", would be appreciated more by people with disabilities if the term used is "Facilitates person-centered planning and delivery of services and supports". o Change 3rd Community Service Coordinator bullet from "Promotion of self-care and independence" to "self-direction". o Instead of saying MCOs will develop plans based on their needs, say that plans should be based on individual member needs. o Include information about self-direction	

Theme 2: Promote Highest Level of Member Independence

Comments in this theme area fall into five (5) sub-themes: work requirement, lifetime limits voluntary pilots overall, independence account pilot, MediKan pilot. Additional comments not in one of these sub-themes are listed in the general section.

Sub-Theme 1: Work Requirement	State Response
The largest number of comments were related to the work requirement in KanCare 2.0. Many comments were in opposition and requested the State withdraw the request. Reasons for opposing the requirement were varied and included conflict with goals of Medicaid and existing case law, unintended consequences, negative impact on health, creation of barriers to employment, reduced access to healthcare, increased administrative	The State appreciates your feedback and comments. No changes were made as a result of this comment.

costs and burden, increased risk to children including removal from the home, harm caused to people with chronic illness or disabilities, applicability to adults who have aged out of foster care, the increased financial burden to needy families leading to increasing their poverty, and the wide variance in work and educational resources through the State.	
Several comments and questions were also received related to the exemptions to the work requirement. Questions include whether the exemption applies to all parents of children under 6 or only those caregiving and whether people on waiver waiting lists or SSDI are exempted. Commenters requested additional exemptions for those on waiver waiting lists, adults with mental illness, medically frail, and caretakers for older adults.	The work requirements are similar to State TANF program requirements, which vary requirements of hours worked by one's life situation. No changes were made as a result of this comment.
Additional work requirement questions include the number of people affected overall and those not already subject to TANF work requirements, whether jobs will fit education level of members and whether there is a penalty for not accepting a job, what the definition is of "able-bodied", whether there is full reciprocity with TANF requirements, and whether there is funding to utilize education option to meet the requirement.	Individuals subject to work requirements can also meet these requirements by pursuing vocational education, performing activities that include adult basic education or other courses, or through secondary school attendance. At this time, the State is not offering funding for education. No changes were made as a result of this comment.
Several comments voiced concern about the requirement including references to data that doesn't support hypothesis that this will encourage or increase employment, and shows the opposite effect, the grace period is too short, and citing a lack of detail including for monitoring.	The State is assessing operational needs to support the work requirement initiative and designing the program to support increased employment. No changes were made as a result of this comment.
Comments also were received related to providing enhanced protection for those to whom the requirement applies and the resources and structure necessary to support the requirement and impacted members. Protections include support for providing 12 months of coverage for families who lose eligibility due to increased earnings and provision of gap coverage people meeting the work requirement, ensuring protection from erroneous loss of benefit, and strong CMS oversight. Several comments suggested resources and structure necessary for work requirements, including alignment with SNAP and TANF requirements, several comments related to needed supports for those affected by the work requirement including job search and placement support, and assistance with childcare, transportation, clothing, and food to help ensure success.	The State is assessing operational needs to support the work requirement initiative and will develop proposals for how to avoid prohibitive costs or divert money away from direct care. At this time, the State does not have estimates for administrative costs or staff needed to implement the waiver effectively. No changes were made as a result of this comment.

Sub-Theme 2: Lifetime Limits	**State Response**
Many comments were received related to lifetime limits for coverage, most requesting the state withdraw the request for a variety of reasons. Reasons for opposition include limiting access to care, having access supports employment, working does not equate to the availability of affordable employer healthcare or that families are no longer in poverty, it is punitive to families working their way out of poverty. One question related to the limit was whether it is a lifetime limit.	The State appreciates your feedback and comments.
Sub-Theme 3: Voluntary Pilots Overall	**State Response**
Questions about voluntary pilots included how many will be able to participate, cost of pilots and how it will be paid for, whether long term services and supports service locations meet definition of "community" for this purpose, what additional resources will be provided, how pilots will be monitored, and when final decisions about whether to move forward with these pilots will be made.	The State is assessing operational needs to support the work requirement initiative and will develop proposals for how to avoid prohibitive costs or divert money away from direct care. At this time, the State does not have estimates for administrative costs or staff needed to implement the waiver effectively. No changes were made as a result of this comment.
Comments supported efforts to close gaps and help people gain employment, request additional detail, support utilization of a 1915i waiver to provide flexibility and additional supports, they also support incentivizing work over penalizing unemployment. Commenters support incentives for people with disabilities to work and would like to see higher expectations for people with disabilities to work, they also appreciated the requirement that MCOs work in local communities and cited need for vocational rehabilitation to do so too.	Vocational and rehabilitation workforce systems will continue to support voluntary work opportunities for members who have disabilities and are not subject to work requirements. No changes were made as a result of this comment.
Sub-Theme 4: Independence Account Pilot	**State Response**
There were several comments specifically related to the independence account pilot. Many comments expressed concern about the ability of participants to re-enroll in Medicaid, citing potential change in health (cancer relapse) or financial status; they suggest allowing re-enrollment in these situations. Some comments suggested making participation mandatory and/or expanding availability beyond TransMed to include people with disabilities and a behavioral health pilot. Other suggestions included central administration at one MCO and leveraging a health-plan like tools to support the program, treating the state contribution level as a deductible, and including a member contribution.	The State appreciates your feedback and comments. No changes were made as a result of this comment.

Sub-Theme 5: MediKan Pilot	**State Response**
There were also several questions and comments related specifically to the MediKan pilot. Questions included whether participants would be able to apply for KanCare and fall under the work requirements. If unable to work, would they only be able to get 3 months of KanCare service? If a member withdraws their application for disability determination, would the member now be determined as able-bodied? Comments included the need to ensure fully informed decision-making and for flexible time limitations, and concerns about health changes if someone enrolls in MediKan pilot.	MediKan members will not be required to comply with work requirements at this time. MediKan participants would be eligible for the Medicaid benefits package with employment support if they voluntarily give up their pursuit of a disability determination. No changes were made as a result of this comment.
Sub-Theme: General	**State Response**
General comments about this area included the lack of attention to self-direction, disapproval of the use of the term able-bodied and separation of requirements for those 'able-bodied' and those with disabilities, suggested use of a 1332 Innovation Waiver to remove employment disincentives by consolidating administration of KanCare and subsidized marketplace programs, and the need for more conversation about emergency preparedness and accessibility of those plans for people with disabilities and how long the TransMed lock-out period is.	The State appreciates your feedback and comments. No changes were made as a result of this comment.

Theme 3: Improve Performance and Quality for Better Care

In theme area three, comments and questions fell into three (3) sub-themes: value based purchasing, DSRIP and UC Pool, and MCO quality measures and improvement. Additional comments not in one of these sub-themes are listed in the general section.

Sub-Theme 1: Value Based Purchasing	**State Response**
Questions about proposed value based purchasing agreement include whether participation will be voluntary, whether penalty based models will be allowed, whether programs will be negotiated individually, what the impact would be to provider payments, and what provider types will be able to enter value based purchasing agreements. One question wondered how high-quality providers are identified and defined.	The State will require KanCare 2.0 MCOs to implement to implement innovative provider payment and/or innovative delivery system design strategies that incorporate performance and quality initiatives in service delivery models. The State seeks to promote the goals of helping Kansans achieve healthier, more independent lives by providing services and connecting to supports for social determinants of health and independence in addition to traditional Medicaid benefits. As part of their response to the KanCare 2.0 RFP, MCOs will submit proposals for value-based models for the State to review and approve prior to implementation. The State will evaluate each proposal and reserves the right
Comments related to value based purchasing include several requests that participation be voluntary and incentivized rather than penalty based, that participation be mandatory or heavily encouraged, the desire to collaboratively design programs to ensure success, request for additional detail including what types of	

agreements will be allowed, and request that agreements be negotiated individually. Other comments were related to potential benefits or uses for value based purchasing, including helping integrate behavioral health and substance use disorder care and to increase utilization of self-direction in long term services and supports. Two comments voiced support of the change to value based purchasing, one voiced concern that it is not workable for Medicaid and will increase provider/member dissatisfaction. One comment expressed concern about state micromanagement of services and agreement reviews, creating a barrier to MCOs and providers being able to negotiate agreements.	to modify the proposed metrics and reporting requirements described in the framework to develop standardized reporting across MCOs for similar arrangements. To promote effective implementation of these strategies and reduce provider administrative challenges, the State may select a proposal(s) to be standardized across KanCare 2.0 MCOs. Please see Section 5.7 of the KanCare 2.0 RFP for more details on the framework for MCO value-based models. The State will consider the questions and concerns raised under this sub-theme in reviewing and approving MCO proposals for value-based models. No changes were made as a result of this comment.
Sub-Theme 2: DSRIP & UC Pool	**State Response**
There were several questions about the Delivery System Reform Incentive Payment (DSRIP) and Uncompensated Care (UC) Pool changes, including how payments treated as a supplemental payment through Managed Care Final Rule and whether all added funds will be distributed, and request to identify the source of and distribution method (including eligibility) for additional UC pool funds. An additional question about the UC pool was around how the inclusion of Critical Access Hospitals (CAHs) in the pool would impact the cost adjustment factor currently distributed to CAHs.	The State is in the preliminary stages of considering changes to DSRIP and the UC Pool under KanCare 2.0, as described at a high level in the waiver renewal application. The State plans to work with stakeholders beginning in early 2018 to gather input on proposed changes to the DSRIP program and the UC Pool and recognizes that stakeholder engagement is an essential part of the process. The State is reviewing Federal regulations on state directed payments as it evaluates possibilities for the Alternative Payment Model (APM) approach as a potential replacement to the DSRIP program. Decisions regarding the distribution of funds under the APM approach are yet to be determined and will be discussed with stakeholders. As described in the waiver renewal application, the State is considering increasing the amount of funding in the UC HCAIP Pool. This increase and the inclusion of CAHs in the UC HCAIP Pool is intended to provide an opportunity to raise CAHs' Medicaid cost coverage. The State does not anticipate eliminating either of the enhanced rates that CAHs currently receive. The State is evaluating options to fund the state share of the increased Pool amount, and will discuss these options with stakeholders as part of the design process. An increase in the amount of the UC HCAIP Pool will

	continue to be a provision of KanCare 2.0 only if an appropriate funding source can be identified. The distribution method of any additional UC HCAIP Pool funds has not yet been determined. The current UC HCAIP provisions that are impacted by trauma and neonatal intensive care services will likely not be an appropriate methodology for distribution of funds to CAHs. Renewal of, and any changes to, the UC HCAIP Pool and DSRIP program are subject to CMS approval. The amount of any UC HCAIP increase will be limited to the individual hospital's Disproportionate Share Hospital payment limit. The UC HCAIP distribution in a year will be the lower of the UC HCAIP limit defined in the 1115 waiver or the sum of uncompensated care costs for the hospitals participating in UC HCAIP program. No changes were made as a result of these comments.
Comments about the DSRIP and UC Pool changes were that the transition needs to be collaborative and transparent. One comment believes changes being made without stakeholder input are in violation of state statute KSA 65-6218 (c). There was also a concern that the consolidation ignores the uncompensated care provided by hospitals involved and doesn't allow them to change DSRIP programs to address the shift.	The State agrees that any changes to DSRIP and the UC Pool should be made collaboratively with stakeholders and will engage stakeholders as it considers changes to the DSRIP program and the UC Pool. In addition, the State will involve the Health Care Access Improvement Panel, as described in KSA 65-6218 (c), in discussions regarding modifications to the UC HCAIP Pool. In the version of the waiver renewal application posted for public comment, the State proposed to combine the LPTH/BCCH Pool funds into the DSRIP program for DY 7 and DY 8. The State no longer proposes to combine the LPTH/BCCH Pool into DSRIP and instead proposes to maintain the LPTH/BCCH Pool for the five-year demonstration period. CMS approval is also required for the continuation of the DSRIP and UC Pools under KanCare 2.0. No other changes were made as a result of these comments.
Sub-Theme 3: MCO Quality Measures & Improvement	**State Response**
Many comments suggested specific additional measures, several requested adding measures related to long term services and supports/HCBS and one requested using United States Preventive Services Task Force (USPSTF) A- and B-rated cancer screening services for cancer related measures.	The original goals of the KanCare demonstration focused on providing integrated, whole-person care, creating health homes, preserving or creating a path to independence, and establishing alternative access models with an emphasis on HCBS. Building on the success of KanCare, the goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by providing services and supports for social determinants of health

Comments also requested continuing stakeholder engagement around quality measures and one suggested that stakeholders participating in national workgroups can help get blueprint to create measures. One comment requested the state reconsider independently analyzing claims data, rely on EQRO to help identify gaps in programs and only re-analyze if MCO not meeting standards One comment requested that the MCOs "deliver value for their price", and this value be tracked at each MCO, provider, and patient. One comment suggested analyzing evaluation of pediatric and adult populations separately.	and independence in addition to traditional Medicaid benefits. The State will modify and strengthen evaluation activities under KanCare 2.0 to measure progress in meeting this goal. The State will also prepare a detailed KanCare 2.0 Evaluation Design after receiving approval of the demonstration renewal application from CMS taking into consideration these public comments. The State will work with other State agencies and stakeholders in developing the KanCare 2.0 Quality Strategy which will inform the KanCare 2.0 Evaluation Design. No changes were made as a result of this comment.

Theme 4: Improve State Medicaid Effectiveness and Efficiency

In this area, five (5) sub-themes were apparent: clearinghouse, streamlining, provider credentialing, MCO data/quality, and network adequacy. Additional comments not in one of these sub-themes are listed in the general section.

Sub-Theme 1: Clearinghouse	State Response

Several comments were made voicing concern about the clearinghouse, these included ongoing delays in processing and backlog and errors and lost documentation causing people to lose Medicaid coverage. Commenters also stated that it is difficult to access the clearinghouse due to long hold times.	The State continues to work to make the Clearinghouse better and have put many fixes in place, including:
	
	• Process Improvements
	  o Added extra training and training tools
	  o Working to change the way we answer people's questions
	  o Telling our staff to call people when we need more information
	• Responsibility
	  o Making sure we know who is working on what
	  o Making sure people with the right experience are working on the right cases
	  o Developing new reports that tell us how well our staff are working
	• Overtime
	  o Made our staff work overtime
	  o Have longer hours when the Clearinghouse is open
	• Nursing Facilities
	  o Continued our Nursing Facility Liaison Program to serve more Nursing Facilities

	○ Made new training videos and other guides to help answer questions that Nursing Facilities ask a lot Eventually, KMMS will be able to report certain performance measures of the Clearinghouse, which will help KDHE monitor how well the Clearinghouse is doing. No changes were made as a result of this comment.
Sub-Theme 2: Streamlining	**State Response**
Related to administrative streamlining in general, there were many comments supporting efforts being made in this area. Several comments reported that current systems unique to each MCO are administratively and financially burdensome to follow and they support the State collaborating with MCOs and providers to reduce this administrative burden. One comment specifically requested to collaborate on development of health screening tools. Multiple comments report concerns that requirements of HB2026 were not included in the renewal application. Related to the State's transition to a single preferred drug list, two comments urged the state to reconsider use of single preferred drug list, saying it often doesn't result in the desired savings. Once comment also requested standardization of prior authorization for all services, not only pharmaceutical. A related comment stated that prior authorization requirements are excessive and approvals slow. One comment also stated that an excessive number of provider claims are determined incomplete. Commenters also stated that progress is needed in timely and accurate claims payment. One comment reflected that the long-term services and supports system is too complex and difficult to navigate, feeling it does not fit the medical model.	The State appreciates this feedback. The KanCare 2.0 waiver demonstration renewal application for public comment only includes initiatives that require federal authority to implement. The KanCare 2.0 RFP incorporates the requirements of House Bill 2026 (2017), such as required changes to MCO processes for provider education, documentation for denied claims, and uniform processes and standards for provider enrollment and credentialing, grievances and appeals, and utilization review of readmissions. Regarding the health screening tool, the State is working towards finalizing the health screen and algorithm prior to the execution of the KanCare 2.0 contracts and welcomes public input. Regarding provider claims payment, Section 5.14 of the KanCare 2.0 RFP outlines payment timeframes that MCOs meet, such as processing and paying all claims where no additional information is required within 30 calendar days of receipt. MCOs will regularly submit claims processing and payment reports, and the State may assess liquidated damages for non-compliance with the State's standards. No changes were made as a result of this comment.
Sub-Theme 3: Provider Credentialing	**State Response**
Related to credentialing specifically, two comments stated that the process needs to be standardized, two also stated that the current process takes too long, one comment cited the process as expensive. Two comments requested the state set a date and timeline for standardization, one suggested December 31, 2018 and one prior to June 2018.	KanCare 2.0 will implement a standardized provider application and enrollment process for all providers. To address provider concerns around the timeframe for credentialing, KanCare 2.0 requires MCOs to complete credentialing within 60 calendar days of receipt of all necessary credentialing materials. MCOs must also enter or load credentialed providers into the claims payment

	system within 30 calendar days of approval by the MCO's Credentialing Committee. In the future, the State may decide to contract with or require the MCOs to contract with a single credentialing verification organization (CVO) to standardize provider credentialing and re-credentialing processes across the KanCare program. No changes were made as a result of this comment.
Sub-Theme 4: MCO Data & Quality	**State Response**
There were several comments related to MCO data and quality, covering currently available data and future data. Related to current data, comments stated there isn't enough data available and the data that is not made available in a timely manner. Several comments also voiced concern that there is a decline in the number of older adults served in nursing facilities without a corresponding increase in FE & PD Waiver and there has been a decrease in WORK participation, and suggested evaluation of this. Regarding future data, multiple comments requested standard data metrics and definitions across KanCare, they also requested a timeline for implementation and release of data, and that this implementation occur after KMMS is fully implemented. Several comments asked who will be able to access the data once collected, including specifically providers and members and de-identified data being publicly available. Several comments were also concerned with ensuring that data is accessible both handicap accessible and to those without internet access. Related to data measures, several comments requested the inclusion of measures for long term services and supports and children in foster care, one comment also requested the addition of clearinghouse measures, and one asked that the State ensures focus on the person and not only data. One comment also stated that the scope of MCO compliance reviews is inadequate and that this review should be statistically valid. One comment suggested creation of a stakeholder council for system quality improvement. One comment suggested analyzing evaluation of pediatric and adult populations separately.	The State is in the process of implementing the new Kansas Modular Medicaid System, a new information technology infrastructure which will allow the State to better connect with other state agencies and organizations to share information, including data to support initiatives addressing social determinants of health and independence. The State is still in the process of determining the data that will be shared with stakeholders and partners, including de-identified reports and aggregated data, and will take these public comments into account. Regarding data measures and evaluation, the State will modify and strengthen evaluation activities under KanCare 2.0 to measure progress in meeting this goal. The State will also prepare a detailed KanCare 2.0 Evaluation Design after receiving approval of the demonstration renewal application from CMS taking into consideration these public comments. The State also plans to track KanCare 2.0 data by population group (e.g., adults, children, children in foster care), as appropriate for each measure. The State will work with other State agencies and stakeholders in developing the KanCare 2.0 Quality Strategy which will inform the KanCare 2.0 Evaluation Design. No changes were made as a result of this comment.
Sub-Theme 5: Network Adequacy	**State Response**
There were three focus areas for comments around network adequacy. Two comments requested that the	The State appreciates this feedback. In addition to meeting KanCare 2.0 provider network adequacy

availability (or lack of) direct support workers be included in the discussion of network adequacy. One comment also requested focus on dental capacity in rural or frontier areas. One comment requested the State maintain the requirement for MCOs to contract with any willing provider.	requirements, MCOs must also submit value-based models and purchasing strategies that expand the use and effectiveness of telehealth strategies to enhance access to services for rural areas as part of the KanCare 2.0 RFP. No changes were made as a result of this comment.
One comment suggested increasing rates based on certain criteria to help build capacity and address network adequacy problems. Criteria suggested includes treating a large number of Medicaid patients, having hospital admission privileges, avoiding ER visits, vaccine rates, and reimbursing all pediatric providers at rural rates to address a shortage of pediatric providers. Another comment suggested all providers receive the rural rate. One comment stated that reimbursement rates are inadequate across the board.	Section 5.5.15 of the KanCare 2.0 RFP outlines requirements for provider payment. MCOs must reimburse providers the rate that would be received in the fee-for-service Medicaid program and may pay higher than these rates at their option. No changes were made as a result of this comment.
One comment expressed fear of maintained or increased difficulty finding replacement direct support staff if MCOs are using community-based care coordinators.	The State appreciates your feedback. No changes were made as a result of this comment.

General

Other Application Comments and Questions	State Response
Commenters stated support for, or acknowledged efforts, in the application's efforts to make progress in the lack of capacity in the behavioral health system, efforts to maximize independence, social determinants of health focus, MCO/local partnership, person centered planning and service delivery, and proposed pilot programs.	The State appreciates your feedback and will consider this when finalizing the waiver application with CMS. No changes were made as a result of this comment.
Several comments expressed concern about the application and proposed changes. Many were concerned with the proposed change in reducing appeal timelines from 33 days to 10 (they also stated that this is a floor set by CMS and the state could set it higher). One comment stated that the plan doesn't address a lack of due process for kids in custody, reporting that they are discouraged from accessing state fair hearing processes. Multiple comments also expressed concern that the state didn't provide financing and budget neutrality documents with application during public comment. One comment stated the plan doesn't address the high hospital readmission rate among those served on the PD Waiver. Several comments are also concerned that the current application doesn't address existing problems in KanCare, including oversight (state	The State appreciates your feedback and will consider these concerns when finalizing the waiver application with CMS. No changes were made as a result of this comment.

and legislative), the ombudsman program and a desire that this be an independent position, consumer rights, and network adequacy, and that as presented the plan will create additional barriers for all stakeholders and will require additional resources from the state, MCOs and providers. Once comment. Multiple comments stated they believe provisions in 2.0 run counter to Medicaid's purpose to improve health. Two comments requested the state carve out the IDD Waiver, and two requested the state expand KanCare. One comment requested that the state keep current programs in place. One comment also found the plan lacking in commitment and plans to prevent youth from coming in to custody.	
Detail was requested overall, and specifically related to how changes will be made and how KanCare 2.0 will operate and reach the goals of KanCare 2.0, how the plan will promote community access, progress and plans for the state's corrective action plan. Detail including data and analysis was also requested by multiple comments about the performance of KanCare 1.0.	The State is working towards finalizing the operations in conjunction with CMS and the MCOs and welcomes public input. No changes were made as a result of this comment.
Other comments related to the application were specific to the application content. These included requesting clarification as to what success measures are referred to in the introduction and for more historical context in the introduction. Two comments requested adding long term services and supports to the services covered in KanCare (Pg. 2, 2nd paragraph) and more acknowledgement and emphasis on self-direction in Kansas. One comment requested more stakeholder input into KanCare 2.0.	KanCare expands services offered to members by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid benefits. In particular, KanCare expands service coordination by assisting members with accessing affordable housing, food security, employment, and other social determinants of health and independence to increase independence, stability, and resilience and improve health outcomes. No changes were made as a result of this comment.
Related to KanCare renewal, multiple comments requested that the state extend KanCare 1.0 for another year to allow time to fix concerns and plan with stakeholders, calling for a systemic fix to issues and barriers, and multiple comments opposed the State renewing KanCare at all.	The State has submitted to CMS a request to extend the KanCare program under Section 1115(a) of the Social Security Act. The current KanCare demonstration expires on December 31, 2017. The State requested a one-year extension of the current KanCare demonstration, including the Uncompensated Care Pool and the Delivery System Reform Incentive Payment Pool. The requested extension period is January 1, 2018 through December 31, 2018. KDHE did not request any changes to the demonstration for the one-year extension period, which was approved by CMS on October 20th, 2017. No changes were made as a result of this comment.
Behavioral Health	**State Response**
Many comments were related to behavioral health services. These comments included support for integrating behavioral and physical health with a	KanCare 2.0 includes service coordination, which is a comprehensive, holistic, integrated approach to person centered care. It allows for maximum access to supports

suggestion to also focus on those with co-occurring I/DD or traumatic brain injury & behavioral health. Several comments stated the Kansas Client Placement Criteria is ineffective and out dated revised or replaced. Several comments also stated a need for additional services or removal of barriers. This includes additional employment services, easier access to services for youth at risk of foster care who come in to custody due to their family being unable to navigate KanCare or not eligible for Medicaid until they're in custody, lack of appropriate services available to youth in foster care, significant variation in the allocation of services between MCOs, and the lack of PRTF placement availability or children being dismissed too early. One comment requested additional tobacco cessation services.	by coordinating and monitoring all of an individual's care, including acute, behavioral health, and long-term care through direct interventions, provider referrals, and linkages to community resources. Case management, disease management, discharge planning, and transition planning are also elements of service coordination for members across all providers and settings. No changes were made as a result of this comment.
Expanding Billing Codes	**State Response**
There were numerous comments received regarding expanding billing codes, stating this will improve care and increase capacity. Several comments requested opening the ability to bill for currently closed mental health and substance use disorder treatment Medicaid codes to all qualified providers as well as allowing LCMFTs & LCPCs to be eligible to bill the full PPS rate. There were also requests to expand available behavioral health codes for children's needs, codes to pay for Medication Assisted Treatment related to opioid use, and additional codes to allow for tobacco cessation as a reimbursable substance use disorder service.	Provider rates for participating in service coordination activities will be built into the rates that MCOs negotiate with the providers. The State will provide a code that can be used to bill for service coordination. The State will consider all concerns in reviewing and approving MCO proposals for service coordination program design. No changes were made as a result of this comment.
MCO Comments	**State Response**
A comment relayed that for emergency providers, some MCOs determine after treatment provided that it was not an emergency situation and reduce the rate they reimburse the emergency provide and they (MCOs) have lists of symptoms and conditions they have determined to be non-emergent and adjust payment based on this.	The State appreciates your feedback. KanCare does not permit MCOs to deny payment for treatment obtained when a Member had an emergency medical condition. No changes were made as a result of this comment.
Several comments stated that appeals and State Fair Hearings are burdensome and expensive, and one stated that even when they are successful, reductions are reinstated on the next plan of care.	The State appreciates your feedback. No changes were made as a result of this comment.
Some comments stated specific concerns with MCOs, this includes that people do not know who their care coordinator is or what is on their treatment plan. Another comment stated that people are asked to sign blank plans. Other concerns include that MCOs are difficult to reach and have long hold times. One comment cited a	KanCare is expanding service coordination, and more Kansans, including members who get home- and community-based services, adults with behavioral health needs, and people with chronic or complex conditions, among others, will have a specially trained coordinator to oversee all of their care. These members will know who

data breach at an MCO and believes there wasn't enough done to alert possible victims.	their coordinators are, meet them in person, and be able to reach them by phone. No changes were made as a result of this comment.
One comment requested that the state disallow MCO subcontracting of business lines.	The State appreciates your feedback and will consider these recommendations when finalizing subcontracting procedures. No changes were made as a result of this comment.
One comment stated need for a disincentive for MCOs if person is placed in an ICFMR or NFMH.	The State appreciates your feedback and will consider these recommendations when finalizing MCO incentives. No changes were made as a result of this comment.
One comment stated a number of difficulties with Amerigroup, and requested they not be awarded a new contract.	The State appreciates your feedback and will consider these experiences when selecting MCO contractors. No changes were made as a result of this comment.
One comment requested that there be a method for how MCOs assign primary care physicians.	KanCare 2.0 members will have 10 business days within enrollment in the MCO to choose a new primary care physician (PCP). If a member does not choose a new PCP within this period, MCOs will assign a PCP. MCOs must consider the following if they assign a PCP: • Current relationships with providers, • Language of the member, • Cultural competency, • Member location MCOs will send a letter to notify members of the PCP assignment. Members can change their PCP at any time. No changes were made as a result of this comment.
Dental Services	**State Response**
Comments related to dental services fell into three areas: that the State maintain the value added benefit for adult preventative dental care, expand coverage to include restorative dental care for adults, and to increase dental rates.	The State appreciates your feedback and will consider these experiences when selecting MCO contractors and value-added benefits. No changes were made as a result of this comment.
Other Comments: Unique and listed for individual response	**State Response**
One comment requested the ability to check all member eligibility information on one website.	The State appreciates your feedback and comments. No changes were made as a result of this comment.
There were several comments about the IDD waiting list growing and that there is less waiting list data is available. One comment stated that the supplemental appropriation request was a positive step.	The State appreciates your feedback and comments. No changes were made as a result of this comment.
One comment shared personal experience in finding caregivers for her son and cited several barriers,	The State appreciates your feedback and comments and intends to resolve these types of issues with better

including: provider reimbursement rates are too low, DSP training is unpaid, background checks are burdensome and take too long, a lack of flexibility to change ISP, and a lack of emergency help.	service coordination. No changes were made as a result of this comment.
One comment stated the public comment period is too close to the release of renewal documents.	The State acknowledges the concern on the waiver application process timeline and assures its adherence to federal regulations on the state public notice process in 42 CFR 431.408. No changes were made as a result of this comment.
One comment stated more supports are needed to help families re-apply for KanCare including more time, access, and assistance.	The State appreciates your feedback and will consider these recommendations regarding application. Currently, applicants can call the enrollment center at 866-305-5147 or TDD / TTY: 800-766-3777 No changes were made as a result of this comment.
One comment requested limiting the number of MCOs to two to offer choice and minimize idiosyncrasies among MCOs, and opposes more than three.	The State appreciates your feedback and will consider these recommendations when selecting MCO contractors. No changes were made as a result of this comment.
One comment stated an ongoing need to address ongoing problems with the KEES system.	The State appreciates your feedback and will consider this recommendation. No changes were made as a result of this comment.
One comment requested that KDADS resume the Autism Advisory Council.	The State appreciates your feedback and will consider this recommendation. No changes were made as a result of this comment.
One comment cited a need to address continuity of care for people who become incarcerated or are admitted to State hospitals.	The State will require MCOs to implement at least three clinical and two non-clinical performance improvement projects (PIPs). Clinical PIPs may include, but are not limited to projects focusing on prevention and care of acute and chronic conditions, high-risk populations, high-volume services, high-risk services, and continuity and coordination of care. No changes were made as a result of this comment.
One comment suggested creating a backup plan in case the managed care final rule is modified.	The State appreciates your feedback. No changes were made as a result of this comment.
One comment suggests better communication with all stakeholders including use of social media, direct alerts, and mail.	The State appreciates your feedback and will consider this recommendation before finalizing outreach procedures. No changes were made as a result of this comment.
One comment requested that the state conduct a comprehensive analysis of current programs, successes,	The State appreciates your feedback and comments. No changes were made as a result of this comment.

and failures, in order to determine the best direction forward for long term systemic improvements.	
Two comments were sharing personal stories about KanCare experiences and overall dissatisfaction with KanCare and MCOs.	The State appreciates your feedback and comments. No changes were made as a result of this comment.
One comment requested steps to consider population behavior issues, with an example of a nominal co-pay for emergency room use in some cases.	The State appreciates your feedback. No changes were made as a result of this comment.
MCO Responses	**State Response**
MCOs, both current and potential, provided comment on how they would or could support new pilots and initiatives in KanCare.	The State appreciates your feedback and comments. No changes were made as a result of this comment.

Additional 1115 Comments and Questions

Application pg. 2: the goal of KanCare 2.0 is to help Kansans…by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid and CHIP benefits.
Application pg. 5 : KanCare 2.0 will expand upon care coordination to provide service coordination. It allows for maximum access to supports by coordinating and monitoring all of an individual's care (acute, behavioral health and LTSS)…
Is this the care coordination that MCO's already provide? If not, will the CMHC's provide this? If CMHC's are providing, will that be through TCM billing?

Application pg. 5: Groups who will receive service coordination include:
- Individuals enrolled in a 1915 C waiver or on a wait list
- Youth (birth up to age 21) who have intensive behavioral health needs
- Youth who are in an out of home placement through the foster care system
- Individuals who are institutionalized in a nursing facility, intermediate care facility for individuals who have intellectual disabilities or hospital, psychiatric residential treatment facility, psychiatric hospital or other institutions.
- Adults who have behavioral health needs
- Individuals participating in the WORK program or other employment programs.

This would appear to apply to all SPMI and SED populations. Does it include SMI?

Application page 6: Person Centered Planning
For all members enrolled in HCBS waiver services, children in foster care and members who have behavioral health needs, MCO's will ensure that members will participate in the person centered planning process that is compliant with 42 CFR 441.301. CFR 441.301 refers to the Waivers.
The MCO's will be starting this process due to new CMS rules. Is this what they are referring to? When it refers to behavioral health needs, is this expanding the population for completing the Person Center Service Plan to members who have behavioral health needs and for all foster care members? If it is expanding, who will develop this plan?
42 CFR 441.301 describes required elements different from our traditional treatment plan or waiver plan.

The State is also interested in promoting member-driven health care decisions by supporting health care quality and cost transparency, and will work with MCO's to help members identify high quality, high value providers who can best meet their specific needs.
What will be the criteria for MCO's to identify high quality providers? How do CMHC's position themselves to be considered High quality, high value providers?

Application pg. 15: KanCare 2.0 promotes value based models and purchasing strategies. Value based models incorporate performance and quality incentives into service delivery.
Providers need to be prepared to be data driven in methods/models of service delivery. In the Q and A that KDADS provided for the MCO contract meetings, it states in that document that providers will get to choose what type of reimbursement model they use. Is that correct?

Finally, the State is considering the implementation of potential pilots to further improve services coordination for members. We describe the goals of these initiatives below. Figure 7. Potential Service

1

Coordination Pilots
Target Population Goals Individuals with Disabilities & Behavioral Health Condition • Help members obtain and maintain competitive integrated employment • Help members achieve their highest level of independence Children in Foster Care • Increase stability at home and school • Support the child and foster family to reduce adverse childhood experiences • Ease transitions Adults with Chronic Conditions • Improve outcomes for people with chronic conditions through direct primary care • Lower emergency room visits and hospital admissions Members Living in Rural & Frontier Areas • Expand services delivered through telehealth • Increase provider capacity through tele-mentoring days.
Will these pilots be offered to the CMHC's?

Hypothesis 2. Increasing employment and independent living supports for members with behavioral health needs, or who have intellectual, developmental or physical disabilities or traumatic brain injuries will increase independence and improve health outcomes.
2.1 Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen. Members ages 12 years and older Administrative Data; Medical and Case
This is a new measure. What screening tools will they expect? Will the MCO do screening, or provider? If provider, then how will it get billed or noted to count toward this outcome?

Aetna Medicaid Administrators
4500 E. Cotton Center Blvd.
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November 24, 2017

KanCare Renewal
c/o Becky Ross
KDHE-Division of Health Care Finance
900 SW Jackson, LSOB – 9th Floor
Topeka, Kansas 66612

Ms. Ross:

Aetna Medicaid appreciates this opportunity to offer feedback on the Department of Health and Environment's proposed renewal of the KanCare demonstration. We hope to leverage our experience with a person-centered, fully integrated care model to help residents of Kansas to improve and sustain long-term health and well-being.

Our parent organization, Aetna Inc., possesses more than 160 years of experience operating in all 50 states. Aetna is among the nation's leading diversified health care benefits companies serving 46.7 million individuals with information and resources necessary to help them make better-informed decisions about their health care. Our vast provider network, expertise in value-based purchasing, innovative technology, and rebalancing efforts help improve the quality of life for every member we serve.

Aetna Medicaid's experience implementing, managing, and caring for high-acuity beneficiaries results in improved access to care, higher quality of care in the most appropriate setting, and a simplified, culturally competent member experience. We take seriously our responsibility as a steward of public programs. Today, we serve approximately 3 million enrollees through Medicaid managed care plans in 14 states including Arizona, Florida, Illinois, Kentucky, Louisiana, Maryland, Michigan, New Jersey, New York, Ohio, Pennsylvania, Texas, Virginia, and West Virginia.

Aetna firmly believes that the key goals and objectives for transformation outlined in the State's waiver renewal are critical to improving health and health care delivery. We appreciate the value Kansas has placed in managed care companies like Aetna to help Kansas achieve its goals. Innovative approaches that coordinate whole-person physical and behavioral health, as well as the social determinants of health and independence, will help Kansas continue its progress toward improving health outcomes for its most vulnerable populations.

Aetna has carefully reviewed the wavier application issued by the Kansas Department of Health and Environment (KDHE), and we offer the following comments for your consideration.

aetna

What Aetna Supports

1) Social Determinants of Health

Aetna is committed to helping Kansans across the entire spectrum of health, and we applaud the State's focus on incorporating social determinants of health and independence to improve access and outcomes for Medicaid beneficiaries. We believe that Medicaid beneficiaries can only achieve independence and well-being through access to supports and services addressing social factors that influence health outcomes.

The state's proposed use of community service coordination with specific pilot programs is an innovative way to incorporate the social determinants of health and independence while leveraging managed care plans. Medicaid members should be in control of their health care decisions, especially when those decisions promote independence at home and in the community. Aetna believes that local organizations known to members are best able to help identify needs and connect people to local resources to meet goals of independence. This can include access to health care as well as connections to social support services for accessible housing, personal care attendants, access to healthy foods, and connections to community through work or service. Our health plan in Ohio partners with three Area Agencies on Aging (AAAs) to provide case management to members eligible for Home and Community Based Service through the MyCare Ohio program. Through a value based contract, we delegate the case management function to the AAAs with oversight from Aetna staff. We have found that using these trusted community partners provides access to other services in addition to services paid by Medicaid and Medicare with a level of local understanding that has improved health outcomes.

These approaches respond directly to the goals in the Kansas waiver including:

> Expanding service coordination to include assisting members with accessing affordable housing, food security, employment, and other social determinants of health and independence will increase independence, stability, and resilience and improve health outcomes (page 4, Renewal Application)

Aetna's approach to service coordination builds upon existing community infrastructure. As a managed care organization, we bring additional capacity for integrated physical and behavioral health services and a commitment to conduct person-centered needs assessments that can be shared across the community of care for our members. Our systems of care approach starts with the member at the center, but expands to include all of the services and supports, caregivers, and service providers that a member needs to have the healthiest possible life.

2) Value-Based Payments

An accelerated adoption of value-based payment arrangements ties innovative quality strategies to providers based on appropriateness of care and other measures of value. This transition serves as a foundation for changing behavior, engagement, and outcomes at the provider, beneficiary and health plan level. No one entity can accomplish these goals alone—it requires a solid relationship built upon trust and transparency, supported by data and reporting, with all parties aligned to the goals in the Kansas waiver.

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We support both types of value based strategies described in the waiver application. We have a commitment to provider payment approaches that focus on value. As a company, Aetna is committed to heaving 75% percent of provider payments made through value based contracts by 2020. We also support the state's contracting approach with a payment withhold for MCO payments. The state should hold MCOs accountable for outcomes and performance including incentives for improving quality and reducing costs and penalties for poor outcomes or administrative failure.

Aetna uses telehealth and telemedicine to expand the adoption and support of value based payment mechanisms. One of Aetna's approaches would be to deploy a statewide tele-behavioral health model and platform. While telehealth is not new, the way we are deploying it to our members is. We are using telehealth in primary care providers' offices to integrate behavioral health, and are working on creating remote group therapy visits. Wide use of tele-behavioral health could substantially increase the number of members who receive care and counseling, therefore improving the overall health of beneficiaries. To aid the self-management of chronic conditions, Aetna also provides beneficiaries with Web-enabled devices (e.g., blood pressure cuff, scale, pulse oximeter, glucometer). These technological tools are critical to serving beneficiaries at home who have chronic conditions such as heart failure, diabetes, hypertension, and high-risk pregnancy.

4) Administrative Simplification

Aetna believes in the state's goal to enhance the member and provider experience with KanCare through standardized tools and processes across MCOs. We have experience working within the managed care industry on simplifications. Our internal systems are built with compatibility in mind to simplify data sharing with our state partners and other critical stakeholders such as Health Information Exchanges and Quality agencies such as the National Committee for Quality Assurance and the National Association of Insurance Commissioners. As for the specific simplifications mentioned in the waiver application, Aetna has experience in working in these areas:

- Health Risk Assessments (HRA)—We can adapt our internal case management system to receive a variety of HRA forms depending on the states requirements. All of the HRAs we endorse collect information about behavioral health needs and screen for social determinants of health including housing and food security and desire to work.

- Prior authorizations—Aetna meets providers where they are in terms of billing and submitting prior authorization information. However, we encourage the use of electronic tools as much as possible and speed the transmission of information. We also customize our prescription drug formulary to meet the state's requirement including a required preferred drug list and associated coverage rules. This is standard practice for our health plan to meet contract requirements and Aetna will have no problem reaching the deadline of July 2019 for submission of electronic prior authorization requests.

- Grievances and appeals—The Medicaid Managed Care Final Rule places additional requirements on health plans for grievances and appeals. The intended standardization in

the final rule is consistent with our business practice and Aetna is prepared to comply with the states preferred approach.

- Provider credentialing—A common credentialing portal and repository will help simplify and standardize the credentialing application process for participating Medicaid providers. We currently participate with the Council for Affordable Quality Healthcare (CAQH) to ease the information requirements on providers and will exchange information with the Kansas Medicaid Management System (KMMS) as it becomes available. We have worked with the other MCOs in Texas and Arizona to engage a common Credential Verification Organization (VCO) for credentialing.

5) Behavioral Health Integration

We welcome the opportunity to share our integrated physical health and behavioral health experience with Kansas. In Arizona, Louisiana and Ohio Aetna provides services to beneficiaries with complex conditions, including those with substance abuse disorders, mental illness, and developmental disabilities within the health plan and can demonstrate how integrating care fully takes advantage of the benefits of managed care without sacrificing local control, program oversight, or continuity of services to members. With Aetna's care management, a separate health plan is not needed to gain the results the State is seeking on the management of individuals with mental health disorders.

We support the state's waiver to expand coverage to Medicaid-eligible individuals aged 21 through 64 who are enrolled in a Medicaid MCO and who are receiving services in a publicly-owned or non-public Institute for Mental Disease. This is an important location of care that belongs in a comprehensive, fully integrated behavioral health benefit. While MCOs should not be dependent on using institutions over the long term, using the full range of clinically indicated treatment options is vital to improving health outcomes for people with mental illness.

6) Service coordination for foster care youth

The state has a stated goal of providing service coordination to all youth in foster care to reduce the number of placements, psychotropic medication use and improve health outcomes. Aetna believes that children in foster care would benefit from specialized care coordination focused on the social determinants and system of care challenges along with health conditions that require active management. Aetna would particularly support an integrated model to serve foster care youth as part of the same managed care plans that could serve their siblings or family members.

What Aetna Recommends Changing

1) Single Statewide Formulary

Aetna would prefer the State allow MCOs flexibility in managing their formulary. Numerous studies have demonstrated that states with single statewide formularies experience higher pharmacy costs and lower medication use. One source[1] found that single statewide formularies increase state costs by using brands that are more expensive and de-incentivizing use of lower-cost generics. Such a model leads to higher drug costs for the State driven by more-expensive

[1] https://www.themenegesgroup.com/upload_file/report_on_texas_pdl_february_2016.pdf

drugs rather than by more beneficiaries using medication. Medicaid programs that allow managed Medicaid health plans the flexibility to administer their own formulary will help the State save money. We have positive experiences in states such as Ohio and Louisiana where the MCOs collaborated on the development of aligned formularies to streamline the provider experience.

Areas for Additional Clarification

1) Quality and Data Metrics

Aetna supports the State's efforts to include payment terms tied to quality outcomes. We also support the State's proposal to develop a quality strategy that assures data quality, consistency, and appropriate protections for patient health information. We recommend that quality measures reflect the current Medicaid Managed Care Final Rule requirements around common measures. The waiver application indicated that the state is "enhancing its data analytics capabilities to streamline all data sources into one central location for a more comprehensive review of MCO performance. The new Kansas Modular Medicaid System will allow the State to evaluate MCO performance against benchmarks and trend MCO data over time, providing a more robust analysis to all stakeholders regarding the performance of the KanCare program." (Page 17, Waiver application) Aetna supports the state's commitment to data evaluation and its connection to quality improvement. We would suggest involving MCOs as much as possible in the design of the KMMS and individual reporting modules to maintain alignment between the state's quality agenda, MCO internal efforts and national trends around common measures. Open and transparent processes reduce the risk of false starts and rework, particularly in a complex and changing policy environment of health quality measurement.

2) Supplemental Payments to Providers through DSRIP and Uncompensated Care Pools

The Delivery System Reform Incentive Program (DSRIP) has helped Kansas make significant advances in payment reform through the partnerships with the University of Kansas Hospital and Children's Mercy Hospital. As Kansas looks at moving those payments into the MCO contracts in 2021, Aetna is prepared to engage in that discussion. The state's goals to continue improving the health system through the incentive payments should be clearly stated in the proposed Alternative Payment Models. One key consideration is how these payments would be treated as a supplemental payment through the Managed Care Final Rule. Engaging both the managed care and provider communities in the redesign process helps to make sure providers are treated in a fair manner while ensuring that the states goals stay at the forefront of the payment mechanism.

Shifting the Uncompensated Care pool into DSRIP will face similar issues. Engaging all of the stakeholders through a transparent process will be critical for the state. Aetna is prepared to participate in those discussions and provide data that will inform the policy decisions of shifting these funds into an alternative payment model or value based agreement.

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3) Work and Employment Opportunities

The waiver application describes two pilot programs to promote independence. One pilot program would allow members in the MediKan population to choose a benefit package with health care and social support services including employment support in exchange for not pursuing a disability determination. The other pilot would provide independence accounts to individuals eligible for TransMed to support ongoing employment and transition to commercial insurance coverage. These two programs have potential to meet a gap in services for people who need support to overcome economic and social barriers to maintaining employment in addition to needed health care services. We have experience serving members with these concerns in states that expanded Medicaid to low income adults and where expanded services are offered to adults with severe mental illness. Based on that experience, we know that these services can be intense and involve services outside of the traditional health care provider network. We would like clarification from the state about the number of people that could be served by these pilot programs. Since the MediKan population is not currently covered under the KanCare program, we also ask for data on the cost of services that would be allowed or a target amount of spending per person that is included in the budget neutrality calculation for the KanCare expansion waiver.

A third program described in the wavier application is the consideration of a 1915(i) state plan amendment to test whether offering supported employment, combined with supportive housing, independent living skills training and personal assistance services, results in a significant increase in the number of members who have disabilities or behavioral health conditions who gain and maintain competitive employment. We support this concept as a state plan service to expand the base of eligible Medicaid members that could receive these supportive services. We would ask for additional clarification about the number of people Kansas would anticipate being eligible to move from existing Medicaid eligibility categories or new Medicaid members that could be served by this potential waiver amendment. Aetna has experience with Medicaid members with similar challenges due to a physical disability or mental illness or both that would be beneficial. We welcome the opportunity to engage in further discussions about the best treatment model of people seeking independence through work and how that intersects with the KanCare MCO contract.

4) Work or Community Engagement Requirements for Medicaid Members

Kansas is requesting authorization to require work, job training, education or service for Medicaid members able to work. This would primarily apply to adults and parents in the caretaker eligibility group and those eligible for Medicaid through cash assistance programs. Aetna has been working with states considering similar work requirements as a condition of legibility. We understand the states interest in ensuring that Medicaid for non-disabled adults is viewed as a transitional, temporary benefit program. States should encourage people who are able to move off Medicaid coverage and into the commercial health insurance market. We would ask Kansas to clarify the number of people that would be subject to the requirement to demonstrate allowable work activities and the expectation on managed care plans to monitor the work history of members. Aetna wants to support members that want to work as part of their personal health care goals.

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Conclusion

Aetna commends KDHE on the vast amount of work, foresight, and planning that has already taken place and looks forward to working with the State to ensure the continued success of Medicaid managed care in Kansas. We recognize that there are a number of details and operational questions that will be addressed as plans evolve. We are excited about the future of Medicaid in Kansas, and we appreciate the opportunity to participate in this process of transformation.

Thank you for the opportunity to participate in this process.

Respectfully,

Laurie A. Brubaker

Laurie Brubaker
CEO, Aetna Medicaid
[redacted]

November 26, 2017

KanCare Renewal
c/o Becky Ross KDHE
Division of Health Care Finance
900 SW Jackson, LSOB –9th Floor
Topeka, Kansas 66612

Dear Secretaries Mosier and Keck:

Thank you for the opportunity to submit comments regarding KanCare 2.0, Kansas' section 1115 Demonstration Waiver. I am writing on behalf of the Alliance for a Healthy Kansas.

The Alliance for a Healthy Kansas is a broad-based statewide coalition of organizations that have come together to improve the health of Kansans. Our first policy goal is to improve access to care by expanding KanCare, the Kansas Medicaid program. Alliance members include business leaders, doctors and hospitals, social service and safety net organizations, faith communities, chambers of commerce, advocates for health care consumers, and others.

While working to expand eligibility to KanCare, we consistently hear from providers, consumers and caregivers regarding deficiencies in the program. We regularly hear about problems with the HCBS waiting list, challenges in processing claims and enrollment, inadequate provider networks, administrative red tape, a lack of transparency in the development of treatment plans, and a general lack of responsiveness of the state and managed care organizations (MCOs) to the concerns of enrollees. There is a high and continuing level of dissatisfaction with the program, verified by Center for Medicare and Medicaid Services (CMS) denial of the initial request for a one-year program extension.

Given the serious and persistent problems with KanCare, it is disappointing that the Brownback/Colyer Administration has failed to directly address how it would fix the problems in the existing KanCare program. Instead, the administration plans to institute new barriers to services in the way of work requirements and lifetime caps, which will make the program more costly to administer and more difficult to access.

If the administration were serious about improving KanCare, increasing access to health services for Kansans, and putting Kansans back to work, it would expand KanCare and provide coverage to an additional 150,000 Kansans and bring state taxpayers' federal tax dollars back home to create jobs and protect rural hospitals.

Existing Problems with KanCare

As noted above, there are serious problems with KanCare. I urge the Kansas Department of Health and Environment (KDHE) and Kansas Department of Aging and Disability Services (KDADS) to focus on improving the existing KanCare program before submitting an 1115 waiver proposal that creates

additional barriers to services to underserved Kansans who rely on KanCare. Before moving forward, I would urge to address the following shortcomings in the existing KanCare program:

- Enrollment backlog.
- Enrollees having no knowledge of who their care coordinators are or what is included in their treatment plans.
- An excess of claims that are found to be incomplete and are rejected.
- Excessive requirements and slow approval for prior authorizations.
- Administrative complexity and lack of standardized processes for provider credentialing and other procedures.

Work Requirements

The administration's request to institute a work requirement for very low-income parents with dependent children age six and older is problematic and in conflict with the goals of Medicaid and existing case law. Under the state's proposal, single parents would have to work a minimum of 20-30 hours, depending on the age of their children. Two-parent households would have to work 35-55 hours. A grace period of three months during a 36-month period, would be allowed. This is too short of a time, however, for people to obtain gainful employment.

The Alliance for a Healthy Kansas strongly opposes work requirements for Medicaid beneficiaries and urges Kansas to withdraw this request. Work requirements—and disenrollment for failure to comply—are inconsistent with the goals of Medicaid because they would act as a barrier to access to health insurance, particularly for those with chronic conditions and disabilities, but also for those in areas of high unemployment, or who work the variable and unpredictable hours characteristic of many low-wage jobs.

While the state says the goal of the proposal is to encourage work, this effort is misguided. The American Enterprise Institute found that health is a top barrier to gainful employment. The reality is that Medicaid will help people get healthy, which is why states like Ohio have found that expanding Medicaid helps enrollees transition to gainful employment.

Beyond creating a barrier to services and a barrier to work, the work requirement will increase administrative costs and add more layers of unnecessary bureaucracy to the system. It would make navigating the KanCare program more difficult, not only for those who are subject to the work requirement, but also for enrollees who would have to prove they meet the conditions to be exempted.

Time Limits

In addition to a work requirement, Kansas proposes a 36-month lifetime limit on eligibility for the same population that would be subject to the work requirement. This policy will limit access to care and is dangerous and misguided.

Medicaid serves as an important work support, allowing unhealthy Kansans to receive the health services they need to transition to full-time employment. Unfortunately, not all employers offer health insurance, especially to low-wage and part-time employees. This population needs health insurance to stay healthy and working. Instituting time limits will make it harder for Kansans to stay employed and will worsen poverty in the state.

Like the work requirement, we urge the withdrawal of any time limit on Medicaid benefits from the proposed waiver.

Public and Legislative Input Should be Considered During the KanCare 2.0 Process

One of the most persistent criticisms of KanCare – raised by patients, families, advocates, providers, and even the Centers for Medicare and Medicaid Services (CMS) – is the poor communication between the state and stakeholders. As we move forward with KanCare 2.0, it is critical that the process of planning, developing, and implementing the program be done in an open and transparent manner.

Kansans should feel confident that proposed changes to KanCare are well planned and scrutinized and will enhance access, quality, and the value of care.

We urge the KDHE and KDADs to withdraw the 1115 waiver and request another one year extension to the current KanCare program in order to ensure that the public and the Legislature have an appropriate opportunity to weigh-in and actively shape the KanCare program. It is critical that KanCare 2.0 is developed to address the concerns with the existing KanCare program and include ample public and stakeholder input –the current proposal falls short of those goals.

Next Steps

The Alliance believes it is critical that we work together to improve KanCare. Most importantly, we need to agree that the goal is to strengthen access to care and improve the program rather than impose harmful new policies on the most vulnerable Kansans. The Alliance stands ready to work with KDHE and KDADs to improve KanCare.

Beyond addressing the issues outlined above, one of the best ways to improve the program KanCare program is by expanding it.

Thank you for your time and consideration.

Sincerely,

David Jordan
Executive Director
Alliance for a Healthy Kansas

From: Kathy Cain
To: KanCare Renewal
Cc: [redacted]
Subject: Amerigroup
Date: Sunday, November 5, 2017 12:48:16 PM

Dear Ms. Ross,

Amerigroup still owes me $31K , some of it from over 2 years ago. My private office Topeka Pediatrics, PA and Kids First Pediatric Urgent Care, Topeka's only pediatric urgent care, terminated our contracts with Amerigroup for nonpayment 12/22/16. Multiplan negotiated the Amerigroup contract and we negotiated payment of after hours and emergency codes, 99051, 99058 and telephone codes and health risk assessment codes, 994441-3 and 99420. Amerigroup did not like our contract and put us in prepayment review and denied payment for ADHD and asthma visits. I enlisted the help of a national pediatric coding expert and the national American Academy of Pediatrics who refuted their denials of payment and confirmed our correct coding based on current CPT guidelines.

We pride ourselves on being Topeka's only NCQA certified Level 3 Medical Home and take care of many chronically ill Kansas kids with ADHD and asthma. We have pay for performance contracts with other payers and are regularly rewarded with shared cost savings for our efficiency from other managed care companies but can't get Amerigroup to even pay us for an office visit.

Amerigroup has a pattern of unfair business practices and has been sued by the State of Illinois who received $344 million settlement from Amerigroup.
http://www.illinoisattorneygeneral.gov/pressroom/2007_03/20070313.html

If physicians are not paid, Kansas kids will suffer. Kansas kids deserve more. Please do not award a contract to Amerigroup.

Sincerely,

Kathleen Cain MD, FAAP
Topeka Pediatrics, PA
Kids First Pediatric Urgent Care
National Discount Vaccine Alliance
[redacted]
www.topekapediatrics.com
Www.nationaldiscountvaccinealliance.com

BEHAVIORAL HEALTH ASSOCIATION OF KANSAS

14 November 2017

KanCare Renewal
c/o Becky Ross
KDHE –Division of Health Care Finance
900 SW Jackson
Landon State Office Building 9th Floor
Topeka, Kansas 66612

Ms. Ross,

Please accept the following as public comment on the State of Kansas Department of Health and Environment request to renew the KanCare demonstration under Section 1115 (a) of the Social Security Act.

These comments represent the views of the Behavioral Health Association of Kansas (BHAK), a statewide network of providers dedicated to substance use disorder treatment services who want the ability provide mental health services for clients we serve. We seek to expand the access to and capacity of the behavioral health system in Kansas through the KanCare 2.0 wavier and the Kansas Medicaid Managed Care Request for Proposal for KanCare 2.0.

We believe the 1115 (a) waiver application—and the KanCare 2.0 renewal request for proposal—acknowledges the need to include flexibility and adaptability. Our experience reveals currently insufficient access and capacity in the behavioral health system. The current KanCare managed care companies and the State data surely reveals limitations in current network adequacy and capacity. The State must address these capacity and access issues in the waiver process and the final outcome of KanCare 2.0 request for proposal.

Our review of the KanCare 2.0 waiver application and request for proposal suggests positive steps to expand system capacity. These changes can help integrate care, allow consumer choice, and improve outcomes. These solutions focus on population health and the social determinants of health that reflect the co-occurring presence of addictions and mental health:

- Limited Access to Currently Protected Codes: KanCare 2.0 managed care providers should be allowed flexibility to reimburse qualified providers for the Medicaid

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behavioral health services available only to protected providers when they are currently being reimbursed while also treating Medicaid substance use issues.

- Examples of those services could include the following specific treatment codes for individuals already being treated by licensed and qualified SUD providers.
- H2017/H2017-HQ (adult psychosocial rehab individual and group); S5110/S5110-TJ (parent support and training, individual and group); 96150 (mental health assessment). These are only examples.

- Value Based Models: Value based purchasing models can be established to integrate and coordinate the eligible services Medicaid individuals need to address their substance use and mental health needs together, not separate due to restricted codes.

- Foster Care Youth: The waiver application and request for proposal includes much needed attention to youth in foster care, particularly those in transition and in need of mental health services. Because of the prevalence of substance use contributing to the child welfare crisis, we support expansion of the eligible provider network for the increasing population in the child welfare system or at risk of entering the system. At least one state used waivers to expand eligible treatment to include at-risk children's family treatment for substance use disorders.

- Medication Assisted Treatment MAT: MAT is discussed only as a mental health issue. The State's substance use disorder treatment provider system is the forefront of MAT and the response to the opioid crisis. Expansion and support for MAT must be expansive with mental health codes open to treatment providers who are also providing MAT. MAT without primary health services is not effective. SUD providers are front line of opioid response.
  - One necessary change for the waiver application and the request for proposal is to include MAT Induction codes opened to pay cost for this treatment (H0016, H0047).

We believe approval of the 1115 (a) waiver application and the KanCare 2.0 final agreements with these changes will result in:

- Reduced emergency department admissions and medical costs; increased care coordination and consumer choice; and improved network adequacy.
- Integrating behavioral health at the site of treatment for licensed and otherwise qualified providers will increase member outcomes, provider outcomes, and the managed care company outcomes.

The waiver application and the request for proposal make all of these improvements possible. We encourage the State to evolve beyond outdated protection of providers and truly integrate behavioral health care. We support and encourage the State and the managed care companies use of all the tools and options available to address the behavioral health needs of our citizens.

Respectfully,

Stuart J. Little, Ph.D.
President, Behavioral Health Association of Kansas

From: Cathy Pechin
To: KanCare Renewal
Subject: Can KanCareNot
Date: Tuesday, June 6, 2017 12:51:26 PM

Kansas had a miserable system. They played pass the buck to the CDDO and the service providers. What KanCareNot did was just add another place where the buck might fall, IF it ever did.

We had a lot of issues and were told by the KanCare advocate (the one that promotes KanCare, not helps those being serviced) that this could be the answer to our issues. It has only added to our issues.

I don't understand who came up with "capable" person, but that needs to go. That is SO wrong. Parents with "normal" adult children are not expected to be considered the "capable" person in their child's lives! I have had to fight to keep the hours that I have to take care of my son as it is 24/7 job and I managed to keep 40 hours since it keeps me from working an outside job. I don't see where they get the idea that parents with adult children with disabilities can get by with only one income. I want my son and he wants to be in a program, day & residential, BUT because he is lowering functioning and might interfere with their current staffing level, almost no one will even entertain the thought of having him in their program.

Also, there is no advocate for parents in this. I have NO ONE to help to find a program for my son and so many just say no or treat us very bad when we go to see the programs like letting us know that someone was beaten up in that residential unit and they did not know why the person did it because they usually only attacked staff - who would leave their child there.

All we did with KanCare is add another layer of "pass the buck". With all of these people on my son's team, I am still an "Army of One".

I just see no purpose in making it more complicated for everyone. Obviously, if KanCare is to make money, people will suffer.

It was VERY unfair to hire an advocate to promote KanCare and making it sound like the person would be an advocate for the clients.

There has to be a way to stop this. There are other ways to save money in the state. It is bad enough that everything is already contracted out. Too many contractors will spoil the whole bunch.

I am sure this isn't what you are really looking for. It is just they are useless and in order for KanCare to continue, people with DD will continue to see cuts. I am 62 years old and caring for a 30 year old that functions like a pre-schooler, I am not "capable" anymore.

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Comments on the "KanCare 2.0" Medicaid waiver application developed by KDADS and KDHE

November 26, 2017

Thank you for the opportunity to submit comments on the "KanCare 2.0" Medicaid waiver application developed by KDADS and KDHE. As the united voice for child welfare agencies serving children across the state, the Children's Alliance of Kansas is deeply concerned about the consequences of this proposal for the safety and well-being of Kansas kids.

The KanCare 2.0 waiver would drive up Kansas foster care caseloads, by increasing the number of children removed from their homes. Simply requiring work does nothing to help parents find and keep family-supporting jobs. Neither does denying families healthcare on the basis of a work. It just means parents are both unemployed and uninsured.

When that happens, children lose. Kids are removed from their homes for two reasons – abuse or neglect – and neglect accounts for three-fourths of maltreatment nationwide. In defining "child neglect," the Kansas Department for Children and Families lists examples like "failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child." In short, poverty. Even in cases of abuse, financial strain matters. A nationwide study of children's hospitals found that every 1 percent increase in parents' 90-day mortgage delinquencies corresponded to a 3 percent increase in hospital admissions for physical child abuse.

Denying families health insurance does not mean they no longer need healthcare or absolve them of its costs. It just means that a playground injury or a bout with pneumonia drives struggling families deeper into debt, adding to the financial strain that puts children at risk.

And such instances – routine injuries or illnesses – are the best-case scenario. When the loss of Medicaid coverage means parents are unable to address mental health or substances abuse needs, the risks for children are even greater.

The KanCare 2.0 work requirement also seems a solution in search of a problem. Kansas already has a Temporary Assistance for Needy Families (TANF) work

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requirement. And KDADS and KDHE have failed to provide data demonstrating that a Medicaid work requirement would reach a significant number of people not already subject to the TANF work requirement.

And it's not just that redundancy is inefficient. When bureaucrats increase the paperwork burden for families, families lose critical supports. Kansas' TANF work requirement is a concerning example. As currently administered, even people exempt from the work requirement are frequently required to demonstrate their eligibility for the exemption over and over again. The KanCare waiver saddles low-income Kansas families with a double-helping of burdensome paperwork. The predictable consequence that, despite qualifying for Medicaid, some parents will be unable to meet the paperwork requirements and become uninsured.

Alarmingly, the waiver application's work requirement may also apply to young adults who have "aged out" of foster care. Not surprisingly, research shows that former foster youth, whose childhoods were scarred by abuse or neglect, have higher-than-average incidences of chronic health problems. Compared to other young adults, they are more likely to be unemployed, and they are more likely to have unmet mental health needs. Given those facts, even the possibility of denying Medicaid coverage to a child abuse and neglect victim is reason enough for grave concern.

In addition to the concerning work requirement it includes, the KanCare 2.0 waiver also falls short because of what it omits.

The proposal commits to "providing service coordination for all youth in foster care," but it offers no concrete plan to do so. Today, care coordination is often an empty promise. It is not unusual to see care plans that call for services unavailable through KanCare managed care organizations (MCOs) and which MCOs and state agencies have not actively sought to make available. While it is commendable that the waiver indicates that care coordination for foster youth is a priority, intention is not action. In a proposal that offers detailed plans in other areas, the omission of a specific service coordination plan sends a clear signal that improving the health and well-being of foster children and youth is not a priority.

Another glaring omission is the waiver's failure to demonstrate a commitment to prevention. Under federal and Kansas law, the responsibility to make "reasonable efforts to prevent removal from the home" extends beyond the Department for

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Children and Families to include KDHE and KDADS. Children's Alliance member organizations already see children who come into care because they did not qualify for Medicaid and their parents were not able to meet their health care needs. They also see children come into care because their parents could not navigate the KanCare 1.0 bureaucracy. Yet the waiver proposal not only fails to articulate strategies to ensure that children at risk of abuse or neglect can get the healthcare they need, it actually erects new barriers to care with a work requirement that makes KanCare even harder to navigate.

It's as simple as it is brutal – when politicians or bureaucrats cut a family's lifeline, children fall right alongside their parents. The best way to keep kids safe at home is by supporting and strengthening their families. And the best way to help children recover from abuse or neglect is to support every aspect of their recovery. Simply requiring work in an economy starved of family-supporting jobs does nothing to strengthen families. Ignoring the responsibility of our state's healthcare agencies in meeting the needs of at-risk kids misses an opportunity to prevent abuse or neglect. And hollow commitments to care coordination do nothing to help foster children rebuild their lives.

Our member agencies stand ready to work with the KanCare Oversight Committee, KDADS, and KDHE to address these and other deficiencies with the waiver. Kansas children deserve better. We urge you to insist that they get it.

If you have any questions, please contact Christie Appelhanz at [redacted].

CLASP
policy solutions that work for low-income people

November 26, 2017

KanCare Renewal
c/o Becky Ross
KDHE, Division of Health Care Finance
900 SW Jackson, LSOB –9th Floor
Topeka, Kansas 66612

Re: Proposal to renew the KanCare 2.0 section 1115 demonstration waiver

Dear Secretaries Mosier and Keck,

I am writing on behalf of the Center for Law and Social Policy (CLASP). CLASP is a national, nonpartisan, anti-poverty nonprofit advancing policy solutions for low-income people. We work at both the federal and state levels, supporting policy and practice that makes a difference in the lives of people living in conditions of poverty. In particular, these comments draw on CLASP's deep experience with Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), two programs where many of the policies proposed in this waiver have already been implemented – and been shown to be significant barriers to low-income people getting and retaining benefits. These comments also draw on CLASP's experience in working with six states under the Work Support Strategies project, where these states sought to dramatically improve the delivery of key work support benefits to low-income families, including health coverage, nutrition benefits, and child care subsidies through more effective, streamlined, and integrated approaches. From this work, we learned that reducing unnecessary steps in the application and renewal process both reduced burden on caseworkers and made it easier for families to access and retain the full package of supports that they need to thrive in work and school.

CLASP submits the following comments in response to the KanCare 2.0 1115 Demonstration Waiver Amendment Application and raises serious concerns about the effects of the waiver, as proposed, on the coverage and health outcomes of low-income Medicaid beneficiaries in Kansas. In particular, the policies would have a dramatic and negative impact on access to care for vulnerable groups including deeply poor parents (leading to negative effects for their children as well) and former foster care youth. This waiver takes a big step backwards in coverage. We therefore believe that it is inconsistent with the goals of the Medicaid program.

Medicaid plays a critical role in supporting the health and well-being of low-income adults and children. Many work in low-wage jobs where employer sponsored health care is not offered, or is prohibitively expensive. Others may have health concerns that threaten employment stability, and without Medicaid, would be denied access to the medical supports they need to hold a job, such as access to critical medications.

The Medicaid statute is clear that the purpose of the program is to furnish medical assistance to individuals whose incomes are not enough to meet the costs of necessary medical care and to furnish such assistance and services to help these individuals attain or retain the capacity for independence and self-care. States are allowed in limited circumstances to request to "waive" provisions of the rule but the Secretary of Health and Human Services (HHS) may only approve a project which is "likely to assist in

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promoting the objectives[1]" of the Medicaid Act. A waiver that does not promote the provision of health care would not be permissible. This waiver proposals' attempt to transform Medicaid and reverse its core function will result in many adults losing needed coverage, poor health outcomes, and higher administrative costs. There is an extensive and strong literature that shows, as a recent New England Journal of Medicine review concludes "Insurance coverage increases access to care and improves a wide range of health outcomes."[2] This waiver is therefore inconsistent with the Medicaid purpose of providing medical assistance and improving health, and should be rejected. Moreover, losing health coverage will also make achieving work and education goals significantly more difficult for beneficiaries.

It is important to recognize that limiting parents' access to health care will have significant negative effects on their children as well. Children do better when their parents and other caregivers are healthy, both emotionally and physically.[3] Adults' access to health care supports effective parenting, while untreated physical and mental health needs can get in the way. For example, a mother's untreated depression can place at risk her child's safety, development, and learning.[4] Untreated chronic illnesses or pain can contribute to high levels of parental stress that are particularly harmful to children during their earliest years.[5] Additionally, health insurance coverage is key to the entire family's financial stability, particularly because coverage lifts the burdens of unexpected health problems and related costs. These findings were reinforced in a new study, which found that when parents were enrolled in Medicaid their children were more likely to have annual well-child visits.[6]

In our specific comments below we focus on two elements of the KanCare 2.0 proposal: work requirements and time limits.

Work Requirements

Kansas is requesting to implement a work requirement for very low-income parents whose dependent children are older than age six. Under the state's proposal, single parents would have to work or participate in countable activities for 20 or 30 hours minimum, depending on the age of their children. The document is unclear whether all parents with children under age six will be exempt or only those that are not "caregivers". Two-parent households would have to work 35 or 55 hours. The state is proposing a grace period of three months during a 36 month period, which is too short of a time for people to obtain gainful employment. It is also unclear whether the state is also proposing to implement a work requirement for former foster youth up to age 26 who are eligible for Medicaid under the Affordable Care Act (ACA).

CLASP strongly opposes work requirements for Medicaid beneficiaries and urges Kansas to withdraw this request. Work requirements—and disenrollment for failure to comply—are inconsistent with the goals of Medicaid because they would act as a barrier to access to health insurance, particularly for those with chronic conditions and disabilities, but also for those in areas of high unemployment, or who work the variable and unpredictable hours characteristic of many low-wage jobs. In addition, while the purported goal of this provision is to promote work, the reality is that denying access to health care makes it less likely that people will be healthy enough to work. This provision would also increase administrative costs of the Medicaid program and reduce the use of preventative and early treatment services, ultimately driving up the costs of care while also leading to worse health outcomes.

The request for a work requirement is especially troublesome given Kansas' extremely low income eligibility limit for Medicaid for non-disabled adults. Non-disabled adults in Kansas are only eligible for Medicaid if they are living in extremely deep poverty (38 percent of the poverty level, equivalent to $7,759.60 annually for a family of three) and raising dependent children or if they are former foster youth under 26. These families are facing enormous struggles to make ends meet, particularly after Kansas cut access to cash assistance and food assistance for many of these families. Placing extra burdens on these

families for the adults to receive health care is not only immoral, but may actually make it harder for them to find and keep employment.

Section 1931 of the Social Security Act ensures Medicaid eligibility for adults with children who would have been eligible for the Aid to Families with Dependent Children (AFDC) program according to 1996 income guidelines, regardless of whether they currently receive cash assistance. Kansas' request to implement a work requirement for this population (if not a caregiver for a child over age six) would effectively eliminate this guarantee of coverage. This request by Kansas appears to be in direct conflict with the law.

Work Requirements Do Not Promote Employment

Modeling the work requirement on Temporary Assistance to Needy Families (TANF) is misguided and short sighted. Lessons learned from other programs demonstrate that work requirement policies are not effective in connecting people to living-wage jobs that provide affordable health insurance and other work support benefits such as paid leave.[7] A much better focus for public policy is to develop skills training for jobs that are in high demand and pay living wages, help people get the education they need to climb their career ladder, and foster an economy that creates more jobs.

Another consequence of a work requirement could be, ironically, making it harder for people to work. When additional red tape and bureaucracy force people to lose Medicaid, they are less likely to be able to work. People must be healthy in order to work, and consistent access to health insurance is vital to being healthy enough to work.[8] Medicaid expansion enrollees from Ohio[9] and Michigan[10] reported that having Medicaid made it easier to look for employment and stay employed. Making Medicaid more difficult to access could have the exact opposite effect on employment that supporters of work requirements claim to be pursuing.

Administrators in Kansas may claim that work requirements in TANF and SNAP have "successfully" led to a decrease in enrollment. The truth is that numerous policy changes, including a shorter lifetime time limit for TANF, have led to significantly fewer people accessing basic safety-net services. In June 2011, 14,204 households in Kansas were receiving assistance from TANF. By July 2017 only 4,423 families were receiving assistance. Food assistance shows a similar drop. 140,761 households were receiving food assistance in June 2011 and only 106,626 households received food assistance in July 2017.[11] However, during roughly the same timeframe the percent of children living in deep poverty (below 50 percent of the poverty level) has remained relatively consistent.[12] This suggests that families are not improving their economic standing, although they are no longer receiving TANF and SNAP assistance. This aligns with data that suggests those who do leave TANF and SNAP are most likely to be employed in low-wage jobs with irregular hours, such as restaurant and retail work. It's important to note that these jobs typically do not offer health insurance.

The waiver language states that the training and employment support available via TANF will also be available to KanCare members subject to the work requirement. However, the state's own data about TANF employment support cast serious doubt on whether the program has the capacity to serve additional Medicaid enrollees. In fiscal year 2016 only 931 families were counted as participating in TANF employment activities. Of these families, 872 – or nearly 94 percent -- were in the "unsubsidized employment" category, meaning they had obtained jobs and were working and not necessarily receiving any employment services from the state (based on the numbers it is possible that some people are both working and in school).[13] In fact, Kansas is serving so few people through the TANF employment support program that it is almost inconceivable that will be able to absorb the number of Medicaid enrollees who will be subject to the work requirement. For example, only 31 people were in the "job search" category and only 79 people were in the "vocational education" category.[14] The state's suggestion that this

program could serve the approximately 12,000 parents who will be subject to the Medicaid work requirement is simply unrealistic[15].

Work Requirements Grow Government Bureaucracy and Increase Red Tape

The addition of a work requirement to Medicaid would add new red tape and bureaucracy to the program and only serve as a barrier to health care for enrollees. Tracking work hours, reviewing proof of work, and keeping track of who is and is not subject to the work requirement is a significant undertaking that will require new administrative costs and possibly new technology expenses to update IT systems. Lessons from other programs show that the result of this new administrative complexity and red tape is that ***eligible*** people will lose their health insurance because the application, enrollment, and on-going processes to maintain coverage are too cumbersome.

Work Requirements Do Not Reflect the Realities of Our Economy

Work requirements do not reflect the realities of today's low-wage jobs. For example, seasonal workers may have a period of time each year when they are not working enough hours to meet a work requirement and as a result will churn on and off the program during that time of year. Or, some may have a reduction in their work hours at the last minute and therefore not meet the minimum numbers of hours needed to retain Medicaid. Many low-wage jobs are subject to last-minute scheduling, meaning that workers do not have advance notice of how many hours they will be able to work.[16] This not only jeopardizes their health coverage if Medicaid has a work requirement, but also makes it challenging to hold a second job. If you are constantly at the whim of random scheduling at your primary job, you will never know when you will be available to work at a second job. This would lead to greater "churn" in Medicaid as people who become disenrolled reapply and enroll when they meet the work requirements.

Work Requirements Will Harm Persons with Illness and Disabilities

Many people who are unable to work due to disability or illness are likely to lost coverage because of the work requirement. Although Kansas is proposing to exempt individuals who receive Supplemental Security Income (SSI) for a disability, in reality many people are not able to work due to disability even if they do not receive SSI. A Kaiser Family Foundation study found that 35 percent of unemployed adults receiving Medicaid—but who are not receiving Disability/SSI—reported illness or disability as their primary reason for not working.[17] And an Ohio study found that one-third of the people referred to a SNAP employment program that would allow them to keep their benefits reported a physical or mental limitation. Of those, 25 percent indicated that the condition limited their daily activities,[18] and nearly 20 percent had filed for Disability/SSI within the previous 2 years. Additionally, those with disabilities may have a difficult time navigating the increased red tape and bureaucracy put in place to administer a work requirement. The end result is that many people with disabilities will in fact be subject to the work requirement and will be at risk of losing health coverage.

Those who are unable to work due to illness will also be harmed by this proposal. Several chronic conditions can inhibit someone's ability to work, and the language in the waiver proposal makes no acknowledgement of these situations. For example, depression is widespread among poor and low-income mothers and up to 50 percent of these mothers experience chronic or recurrent depression. In addition to having negative consequences for children, maternal depression also affect's a mother's ability to get and keep work.[19] Eliminating health coverage for someone in this position has only negative consequences – the mother, the family, and to society. There is no gain from eliminating health coverage for a mother who is unable to work due to mental illness.

The waiver language also does not address illness that require ongoing treatment, such as dialysis or another chronic illness. This means that someone on Medicaid and undergoing treatment would be cut off after three months if they did not meet the work requirement. Another population that will be harmed by this proposal is people undergoing substance use treatment and leaving treatment. The state's own data in the waiver document (page 91) shows that fewer than half of people leaving substance use treatment are employed. When considering a work requirement for this population (assuming some are very low-income parents), the data provided by Kansas leads to the assumption that at least 60 percent of people leaving substance use treatment would lose their health insurance due to unemployment. This is likely to reduce their overall stability in life and may contribute to future substance abuse.

For all the reasons laid out above, the state should reconsider their approach to encouraging work. If Kansas is serious about encouraging work and helping people move into jobs that allow for self-sufficiency (and affordable employer sponsored insurance) the state would be committed to ensuring that all adults have access to health insurance in order to ensure they are healthy enough to work. Instead, the state is asking to place additional barriers between the state's most vulnerable families and their health care.

Time Limits

Above and beyond the work requirements, Kansas proposes to impose time limits on participants EVEN if they are working or otherwise meeting the work requirements. Members who meet the work requirement will be limited to a total of 36 months of Medicaid coverage during their lifetime. All of the above reasons that work requirements are ill-conceived are also true for a time limit. However, a time limit goes further by assuming that people will not be in poverty for more than three years of their adult life. Kansas already has an extremely limited health insurance safety-net for adults, and the addition of a time limit further eviscerates the safety-net, leaving it practically non-existent for adults.
Proposing a time limit on access to health care is perhaps the most extreme and immoral request of all. The imposition of a lifetime time limit on Medicaid implies that people are able to quickly move out of deep poverty and into employment *that offers affordable employer-sponsored insurance (ESI)*. Unfortunately, this is simply not the reality of many jobs in America. Only 49 percent of people in this country receive health insurance through their jobs – and only 16 percent of poor adults do so.[20] The reality is that many low-wage jobs, particularly in industries like retail and restaurant work, do not offer ESI, and when they do, it is not affordable.[21]

Low-wage work in America does not fit into the "9 to 5" conception that many politicians and state administrators have of work. About half of low-wage hourly workers have schedules outside the traditional Monday-Friday, 9-5 routine and are patching together two or more part-time jobs to support their families.[22] Frequently, they aren't getting traditional employment benefits (such as health insurance) that middle- and upper-income Americans receive with their jobs. Recent data show that 5 million workers reported working part-time, despite wanting full-time jobs.[23] Involuntary part-time work is a symptom of the low-wage labor market that makes it difficult for people to gain economic security. People working multiple part-time jobs or in the gig economy are particularly unlikely to have access to employer-provided insurance.

This population needs a medical safety-net *in order to stay healthy enough to remain in the workforce*. Unfortunately, the Governor of Kansas has vetoed the legislature's will to expand Medicaid to provide this very safety-net. This request to add a lifetime time limit to Medicaid is another immoral action by the Administration.

A lifetime limit incentivizes people to enroll in Medicaid only when they are sick, rather than using their limited months during times when they are well. This will have negative consequences for enrollees and for the program. People will not receive preventative care, early treatment for new illnesses, or consistent treatment of chronic diseases. As a result, when people are enrolled in Medicaid their health costs will be high. For all these reasons, the request for a lifetime limit is contradictory to all the rhetoric in the waiver proposal about social determinants of health.

Once someone reaches the 36 month lifetime limit, they will have no medical safety-net left for future crises or hard economic times. Even if they would later qualify for an exemption to the time limit, they are unlikely to know that they are eligible if they have previously been turned away by the state.

Placing a time limit on parents' coverage will also have negative implications for their children's coverage and health. Research repeatedly demonstrates that children are more likely to have health insurance when their parents have health insurance. New research shows that when parents have insurance their children are more likely to receive annual check-ups and well child visits.[24] Limiting parents' coverage will have a trickle-down effect on children's coverage children will become uninsured and will be less likely to receive annual check-ups and well-child visits.

The reasons above make it clear that a work requirement and a lifetime limit on Medicaid coverage is not only immoral, but also not in the best interest of low-income Kansans and the state. The state should withdraw these components of the KanCare 2.0 plan and re-evaluate how to achieve their stated goal of promoting employment and independence.

Lastly, CLASP notes that Kansas is not providing financing and budget neutrality documents for the state public comment period. This lack of transparency is unfortunate and does not provide stakeholders with all the information they need in order to comment fully.

Thank you for your consideration of CLASP's comments. Please contact Suzanne Wikle [redacted] with questions.

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From: Dr. Jon Jantz
To: KanCare Renewal
Cc: [redacted]
Subject: Comments for KDHE
Date: Monday, November 13, 2017 12:26:01 PM

So here are our suggestions:

1. **Limit the number of MCOs to two.** That would mean they still compete, but they would not present way too much variation in the way providers have to deal with them.

We realize KDHE wants "choice," but how much choice is there when almost all of the same things are covered? And how can the "choices" really be appreciated when the recipient really doesn't understand? Most people DON'T UNDERSTAND INSURANCE -- whoever they are and whatever insurance they have.

Further, each of the MCOs has idiosyncrasies that must be handled.

- UHC likes to differentiate between Title 21 and Title 19 in their group number, but neither of the others (AMR,SUN) do. This leads to duplicate profiles and denied claims.
- Sunflower can't seem to get their ducks in a row - we have had much difficulty with Sunflower managed care organization (MCO), and several area organizations just don't take them anymore. They just don't seem to be deep enough at the bench to handle changes, especially of the IT variety.
- Amerigroup is a GIANT PAIN on the preauthorization front.

For these reasons, it is not a good idea in our opinion to have 5 Medicaid contractors. It's hard enough to handle three MCOs.

2. In order to really evaluate effectiveness of care, an analysis of the population served is important.

a. **Evaluate the pediatric population and adult population separately** – they have widely different needs and vulnerabilities. The biggest health issue for pediatrics is immunizations and yearly health checks – "It's better to build healthy children than repair broken adults." – more cost effective, too.

b. **Consider population behavior issues** – for example, use of the emergency room for non-emergency items – there needs to be a nominal copay for the ER, unless admitted to the hospital which is what commercial insurances do. Also, an acute injury such as stitches or broken bone should be seen with no copay.

c. **Make PCP designations mean something**. The MCOs are careless about who they assign to us, and we have had obstetric patients on our panel and 80-year-old women. Further, our patients may be listed with a different provider and we take care of them and the other provider gets credit, or we are listed with a patient we have never seen, and we are dinged for the lack of care by another PCP.

In short, MCOs need to deliver **VALUE** for their price, and this needs to be tracked, with each MCO, each provider, each patient. This is exactly what computers are good at, and if MCOs will work proactively with the providers, we are sure this can be accomplished.

3. **All pediatric providers should be at the Rural Rate** – There is a shortage of pediatricians in Kansas, with no less than 6 open pediatric places, and KU is not producing enough capable pediatricians for any area except Johnson County. A better pay rate will help two ways. First, more pediatricians are likely to open their panels to see the Medicaid patients. Second, it will help practices that are not located in cities with medical school presence be more competitive in offering a fair salary to new pediatricians.

Further, the pay rate should increase with certain components:

a. A greater number of patients on the panel – ie, 500, 1500, 2000, etc.
We see doctors around us with 10-15 MDD patients, closed MDD panels, discharge of patients when they go on MDD. You can't force doctors to accept MDD, but you can incentivize it.
b. Admission privileges at a hospital – more and more doctors have decided to be "clinic-only," and the result is

- the rest of the medical community has to carry the load of after hours care in the form of "unassigned" patients, who may have to just be transported to Wichita/KC, which is expensive.

OR

- the practices/hospitals just can't recruit more pediatricians because they can't pay for them. Then it's more expensive because parents take patients to the ER or immediate care, where they get lower quality care (more antibiotics, steroids, breathing treatments), and no immunizations/well child checks.

4. **Eligibility and PCP/Title 19 or 21 all needs to be AT ONE WEBSITE** – this is a HUGE time-waster for us. AND we can't use our electronic eligibility checking for it, so it has to be done manually, one by one, which is expensive and a hassle and the reason practice business office staff hate MDD and advise doctors against taking it.
5. **Credentialling should be at one main site, or use CAQH, for ALL MCOs** – a recent discussion with another clinic administrator focused on $22,000 per provider to get credentialing done. And it isn't even finished yet. This is ridiculous in an age of computers and cloud-based information.
Thank you for your consideration,
Jon Jantz MD FAAP
Pediatrician at Cottonwood Pediatrics
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September 13, 2017

KanCare Renewal
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kdhe.kancarerenewal@ks.gov

Ms. Ross,

DCCCA, Inc. has been serving Kansans for over forty years, coordinating substance abuse prevention and treatment services; outpatient mental health services; recruitment, training and support of foster homes; traffic safety education and resources; and facilitating residential and community based interventions for at risk youth and families. Many of our services are statewide, reaching the most vulnerable of our citizens in frontier, rural and urban areas.

DCCCA programs interact with multiple systems: child welfare, juvenile justice, adult corrections, primary medical care and safety net clinics, community mental health, the substance abuse treatment network, and Kansas Medicaid. Each system has unique challenges, but as KDHE considers KanCare renewal, please take into account and make preparations for the themes we have identified in this letter from our experience serving Kansans.

The KanCare 2.0 system needs to:

- Expand access to behavioral health services by:
  - Eliminating and/or reducing barriers to services
  - Increasing capacity by eliminating restrictions on qualified providers to provide and bill for needed services
- Provide choice for Consumers
- Eliminate and/or reduce administrative burdens for providers that work with multiple MCOs

Access to service

- Restricted mental health and other codes are a barrier to services and they should be modified to provide Consumers with greater access to necessary services.

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- The substantial increase in out of home placements in the child welfare system has strained the behavioral health system beyond current capacity. Funding for those services has not increased in order to meet the growing need of both children and their families to achieve timely permanency. Child Placing Agencies are in a great position to be able to provide immediate and less costly preventative intervention to decrease the number children going into out of home placement.
- When serving children as the identified client, the best intervention is often to provide support and education to the family and other caregivers. However, many service definitions do not allow this best-practice of dual-generation intervention, which is often also the most effective, efficient, and long-lasting.
- Community based organizations like DCCCA are struggling to meet demand resulting from the recent juvenile justice reform. Funding has been allocated for specialized interventions, but effective substance abuse and mental health treatment has not seen the proposed increase in local dollars.
- The state's decision to not expand Medicaid means the uninsured can only access substance abuse and mental health dollars if they meet eligibility requirements for the federal substance abuse and mental health treatment block grant. This finite pool is not sufficient to meet the need, resulting in many Kansans not receiving needed interventions.

Lack of consumer choice

- Consumers have limited choice based on where they live and the type of service needed. This is especially true for those living in frontier, rural and urban areas.
- Some needed services are restricted by funding or statute to limited provider types, even though organizations like DCCCA have the capacity and willingness to offer those services.
- Consumers who have multiple health and behavioral health challenges must often obtain services from more than one provider.
- Access to care is limited for Kansans because some services are only available through a specific category of provider, even though there are other qualified providers. Often, as a result, Consumers with behavioral health issues have no choice from whom they can receive services.
- When a person is already receiving some funded services such as drug and alcohol treatment from us, if they need additional services that are restricted by code restrictions, they cannot continue treatment and they have to change

DCCCA
IMPROVING LIVES

providers and wait weeks to access other services from a "qualified provider."

Administrative burdens

- As a licensed substance abuse treatment provider, we are required to use the Kansas Client Placement Criteria (KCPC). This system is outdated, fails frequently, delays client's access to services, and results in duplication of administrative and clinical effort. The implementation of Electronic Medical Records suggests there is no longer a need for this expensive, ineffective system.
- Medicaid and block grant funded behavioral health services are managed by four insurance companies. We support the benefits of managed behavioral health care, but our administrative costs have increased substantially as we try to navigate four entity's processes, billing and claims expectations, and differing approaches to medical necessity criteria.

In summary, DCCCA's varied work and geographic presence in Kansas allows us to readily see the impact of budget reductions, gaps in services, and potential solutions. The challenges we face as a state require us to stop doing business as usual and maximize our dollars in new, creative ways. The current segregation of service delivery, the limitations on funding and who is eligible to facilitate services is detrimental to timely access, consumer choice and making efficient use of state dollars.

The State of Kansas has a public policy and legal interest in resolving these issues that limit citizens' access to behavioral health services. The renewal of KanCare 2.0 provides the opportunity to correct that error. We respectfully recommend that KDHE consider financial and policy strategies in the KanCare renewal process that expand consumer choice, broaden access to a full continuum of services, and allow organizations like DCCCA to redirect unnecessary and burdensome administrative expenses to more important client care.

We sincerely appreciate the opportunity to participate in public input meetings and provide written comments. Please let know if you have any questions or would like further information.

Respectfully Submitted,

Lori Alvarado

Lori Alvarado, CEO

Below are comments on the KanCare 2.0 waiver renewal application. The comments are in reference specifically to children in foster care.

Figure 20. Example Measures for KanCare 2.0 Evaluation

#	Example Measures	Applicable Population(s)*	Data Source
Hypothesis 3. Providing service coordination for all youth in foster care will decrease the number of placements, reduce psychotropic medication use, and improve health outcomes for these youths.			
3.1	Percentage of youths in foster care obtaining permanency (e.g., guardianship, adoption, kinship, etc.).	Children in foster care	Administrative Data
3.2	Percentage of foster care members receiving an antipsychotic medication *without* evidence of a psychotic disorder or related condition.	Children in foster care	Administrative Data; Medical and Case Records
3.3	Percentage of foster care members receiving an antipsychotic medication *with* evidence of a psychotic disorder or related condition.	Children in foster care	Administrative Data; Medical and Case Records
*The State will track measures by subpopulation (e.g., adults, children, pregnant women, children in foster care, HCBS waiver population) as appropriate.			

- In figure 20 example 3.1, reintegration should be listed as the number one example of obtaining permanency. DCF's order of preference for permanency is as follows: reintegration, adoption, kinship, and guardianship.
- Also in figure 20 3.2 and 3.3 antipsychotic medication is referenced, but this greatly limits the population. It would be advantageous to expand 3.2 and 3.3 to children in foster care receiving psychotropic medication.
- In the KanCare 2.0 waiver renewal application KDHE referenced requiring the MCOs to provide service coordination for children in foster care. An appropriate ratio should be enforced so a care coordinator is assigned to a reasonable amount of youth in foster care. Requiring service coordination will not be effective if a care coordinator is assigned too many youth. In addition to providing service coordination, KDHE should require each MCO to establish dedicated foster care units. Specialized foster care units at each of the MCOs would allow these staff to better understand the unique needs of children in foster care and better meet these needs.
- In figure 7 below on service coordination pilots, the goal of easing transitions is mentioned for children in foster care. It is unclear what type of transitions are being referenced. One specific area where transitions need improved is step down services after a child has been released from a psychiatric residential treatment facility (PRTF). There is a lack of step down services upon PRTF discharge, and pilots that specifically address this transition could potentially be beneficial in addressing this gap.

Figure 7. Potential Service Coordination Pilots

Target Population	Goals
Individuals with Disabilities & Behavioral Health Condition	• Help members obtain and maintain competitive integrated employment • Help members achieve their highest level of independence
Children in Foster Care	• Increase stability at home and school • Support the child and foster family to reduce adverse childhood experiences • Ease transitions
Adults with Chronic Conditions	• Improve outcomes for people with chronic conditions through direct primary care • Lower emergency room visits and hospital admissions
Members Living in Rural & Frontier Areas	• Expand services delivered through telehealth • Increase provider capacity through tele-mentoring • Promote and expand the rural workforce

- The KanCare 2.0 waiver renewal application doesn't appear to address PRTFs. It is a conflict of interest if the MCOs continue to be able to screen children for a PRTF stay. An independent third-party assessing entity is needed to conduct the assessment and determine if medical necessity is met. The third-party assessing entity should also be involved in determining the appropriate length of stay based off their assessment.

Public Comment From the Kansas DD Coalition

November 26, 2017

The Kansas DD Coalition is a diverse group whose members include self advocates, family members of people with I/DD, providers, and other organizations who provide advocacy services for people with I/DD. Thank you for the opportunity to respond to the KanCare 2.0, 1115 Demonstration application. Our comments and concerns with the application included below.

Targeted Case Management Needs to Continue

Kansans with I/DD very much appreciate the quality of their relationships with their Targeted Case Managers and fear any disruption to these relationships. They very much appreciate the services they currently receive. While we have read about service coordination proposed in the application and cross-referenced that the RFP and attachments, the devil is in the details and these TCM related services are very important and need to continue to be provided by community service providers. It has been our experience that while care coordinators and targeted case managers may appear similar on paper, families need the hands on community support they receive from the targeted case managers which is very different from care coordination provided by the MCOs.

Also concerning is that the person-centered planning process proposed in KanCare 2.0 only "encourages" the individuals to attend their Person-Centered Support Plan Process. This process should require evidence of their participation in the process not just an encouragement of their attendance.

Our coalition members have more questions than answers about how Conflict Free Case Management will be administered. It appears that MCO Service Coordination is a Conflict. While some of the public comment forums included questions and brief

answers on this topic, it would have been very beneficial for the State of Kansas to elaborate on how they believe the change to service coordination will work in practice.

Systemic Problems Need to be Addressed

Many problems have plagued KanCare to date. While many of the concepts discussed in the application sound nice, it is very difficult to believe what is described will actually become the reality for Kansans with I/DD and help provide them with the services and supports they need. These problems continue to harm Kansans and also make life difficult for them, their family, natural supports, and providers.

- Systemic issues such as an inconsistent and often back logged application process. The lack of oversight of the contractor running the clearinghouse have been ongoing and after more than two years of backlogs and service issues have yet to be addressed.
- The current KanCare program lacks an Ombudsman Program that is either independent or adequately staffed to provide actual advocacy Kansans need.
- The current program creates a clear conflict of interest where the care coordinators work directly for the MCOs who have a vested financial interest in cutting services.
- Many Kansans have successfully appealed reductions in services only to see the same reduction proposed six months later in their next plan of care.
- The task of navigating the system for Long Term Supports and Services is challenging. Families do not know who to talk to and are not sure what questions to ask, resulting in people not receiving the services they need.
- There should be a financial obligation for the MCO if a person is moved from the community to an ICFMR or NFMH. Currently an MCO can increase profits when a high need member moves into one of these institutional settings.
- Clearly no one should ever be asked to sign a blank plan of care. Unfortunately, that has been the experience of many Kansas families.
- The Medical Model is the model by which the MCOs have had the most experience with and they responded to the RFP. The Medical Model is not appropriate or adequate for Long-Term Supports and Services.

I/DD Waiting List

Although the Special Terms and Conditions require the State of Kansas to invest part of the savings from KanCare in reducing the waiting list for the I/DD waiver, the waiting list has actually grown in recent times.

To make matters worse, prior to KanCare the State of Kansas published detailed reports that included very useful information that helped Kansas families, providers, and policy makers understand more about who was on the waiting list and how long the wait was. Around the time the I/DD waiver was included in KanCare, these reports were reduced to nothing more than the number of people waiting.

As it is advertised that KanCare has saved more than $1.4 billion, it would seem the waiting lists should have been reduced as opposed to seeing a slight increase.

Employment Supports

The DD Coalition is happy to see Kansas promote additional employment supports to help people with disabilities gain competitive, integrated employment.

- Employment Supports and Employment Requirements – (pg 37) – Figure 20 identifies Example Measures for KanCare 2.0 Evaluation. The indicator - Item 1.1 underrepresents adults with I/DD.

Work Requirement

In the application, there are 12 groups explicitly excluded from the work requirement. As drafted, the application does not exclude individuals on the I/DD Waiver Waiting List.

Also, throughout the application, the term Able-Bodied is used. This term is insulting to many people with disabilities and should not be used.

Administrative Burden

The existing KanCare program has created a significant administrative burden for providers. The State needs to align processes for all of the MCOs. Providers spend a great deal of time and effort (and cost) to deal with different processes of each of the MCOs. This is time and energy the providers are not able to provide services and supports for people with disabilities. While the application indicates this will be one of the areas the State will focus on, this is a huge problem of the current program that has not been fixed during the first five years of the program.

Provider credentialing is also a major issue as it can often take months, which is ridiculous.

Additional Emphasis Needed when I/DD and mental health needs are Co-occurring

While it is a positive to see an emphasis when mental health needs co-occur with substance use disorder, there are other glaring holes in services today for people with I/DD co-occurring with mental health needs and for TBI and mental health needs.

Lack of Performance Measures for LTSS

The MCOs are more likely to do a better job at what you measure. Considering the fact HCBS waiver services are roughly half of the Medicaid spending in Kansas, we expect the State would want to know how well the State's Medicaid program is doing to gauge the bang for its buck and more importantly to get an idea of how well it is serving the needs of the people it serves. The application almost completely ignores HCBS as far as performance measure are concerned. There are many examples of medical

performance measures in the pay for performance measures for the MCOs, example Performance Improvement Projects, and historical utilization ratios listed. Again, almost all of those are all still based entirely on a medical services, not HCBS.

Overall KanCare 2.0 Recommendation

Given the experience under the current managed care arrangement, and the well document deficiencies of the KanCare program for persons with I/DD, we recommend that prior to making changes outlined in the KanCare 2.0 proposal, and further disrupt the lives of Kansans with I/DD that there be a comprehensive analysis of the current programs successes and failures in order to inform state officials, legislators, and system stakeholders as to what the best direction forward should be in order to make long-term systemic improvements.

Thank you again for the opportunity to provide public comment on this application. Below is a list of the members of the Kansas Developmental Disability Coalition.

Enclosure: List of organizations in our coalitions

Kansas Developmental Disability Coalition Members

The Alliance for Kansans with Developmental Disabilities (Statewide)– its members:
- *Disability Supports of the Great Plains (McPherson & Reno counties)*
- *Easter Seals Capper Foundation (Shawnee & Cowley counties)*
- *Quest Services (Brown, Jackson, Osage, Coffee & Lyon counties)*
- *Rosewood Services (Barton, Pawnee, Stafford, Rice & Rush counties)*

Arc of Douglas County (Douglas & Jefferson Counties)
Autism Speaks
Disability Rights Center of Kansas
Families Together (Statewide)
InterHab
Kansas Council on Developmental Disabilities
KETCH, Inc.
Self-Advocates Coalition of Kansas (Statewide)
University Center for Excellence on Developmental Disabilities (KU)

DISABILITY RIGHTS CENTER of KANSAS
EQUALITY • LAW • JUSTICE

Disability Rights Center of Kansas
214 SW 6th Avenue, Suite 100 ♦ Topeka, KS 66603
Phone: 785.273.9661 ♦ Toll Free: 1.877.776.1541
Toll Free TDD: 1.877.335.3725 ♦ Fax: 785-273-9414
www.drckansas.org *info@drckansas.org*

Public Comment on KanCare 2.0 1115 Demonstration Project Application
November 26, 2017

My name is Mike Burgess. I am the Director of Policy & Outreach at the Disability Rights Center of Kansas (DRC). DRC is a public interest legal advocacy organization that is part of a national network of federally mandated organizations empowered to advocate for Kansans with disabilities. DRC is the officially designated protection and advocacy system in Kansas. DRC is a private, 501(c)(3) nonprofit corporation, organizationally independent of state government and whose sole interest is the protection of the legal rights of Kansans with disabilities.

While I would definitely like to acknowledge there are several areas where the State of Kansas has listened to concerns and attempted to address them, I would like to share some of the concerns DRC has with the application for new 1115 waiver demonstration.

Community-Based Service Coordinators and Employment Supports
Currently people with I/DD and SED received Targeted Case Management (TCM). The KanCare 2.0 application proposes to extend community-based service coordination (somewhat similar to the concept of TCM) to additional waiver populations. I would like to commend the State for proposing this. While it is such an important service that will definitely result in both efficiency and better outcomes for people with disabilities, the application does not include any of the fiscal estimates the State used to ensure cost neutrality of the entire 1115 demonstration, which is a requirement of all 1115 waiver demonstration projects.

It also suggests the State may implement additional supports to help Kansans with disabilities find competitive and integrated employment.

Our concern is that while these are both great ideas that will have a positive impact on Kansans with disabilities, they may be scrapped just as Health Homes were. Health Homes and coordinated services for certain populations was one of the four major hypothesis in the original KanCare demonstration yet it was discontinued after only a couple of years.

KanCare 2.0 Proposal Quietly Makes Harmful Changes to Appeals Timeline
The State of Kansas is making major changes to the appeals timeline despite no mention of this in the 187 page 1115 application document.

The current timeline for appeals was the result of compromise with the disability and senior advocacy community regarding appeals to the Office Administrative Hearings (OAH). Then

State Medicaid Director Kari Bruffet a few years ago met with people from both the senior and disability community. Everyone came together to agree on a policy for HCBS appeals. The agreement stated if the notice of action was a reduction or elimination of service, the service CONTINUES and the member has 33 days to appeal to the MCO grievance process and then 33 days to appeal to the OAH. During this time, the services continue.

Needless to say, KanCare has not been embraced by most of the disability advocacy community. This promise to have a 33 day period (essentially 30 days plus three days for the USPS to deliver the letter) is frankly one of the only things that has been a positive regarding the rights of seniors and people with disabilities.

The proposed changes to the timeline breaks that promise. Under the new proposal members will only have 10 days after the grievance to appeal to OAH before their services are cut. If they don't appeal within 10 days, the services are automatically cut to the proposed level. They can still appeal, but the service cut sticks unless the appeal overturns it. This is a big change. It is very harmful to seniors and people with disabilities. Please keep in mind under this proposed process, there is no guarantee the person has even received the outcome of their grievance in the 10 days (one of the reasons the existing process allows 33 days).

While the State may contend they are doing this to "comply" with a federal regulation, this regulation merely sets the absolute floor and the existing process clearly meets the federal regulations. Thus, this is an unnecessary change that will very clearly harm Kansans with disabilities and elderly Kansans.

KanCare Should be Investing to Eliminate or at least Significantly Reduce the Waiting Lists for HCBS Waivers

Although the Special Terms and Conditions require the State of Kansas to invest part of the savings from KanCare in reducing the waiting lists for the HCBS waivers, the waiting lists have actually grown in recent times.

To make matters worse, prior to KanCare the State of Kansas published detailed reports that included very useful information that helped Kansas families, providers, and policy makers understand more about who was on the waiting list and how long the wait was. Around the time the PD and I/DD waivers was included in KanCare, these reports were reduced to nothing more than the number of people waiting.

As proponents of KanCare have indicated KanCare has saved more than $1.4 billion, it would seem the waiting lists should have been reduced as opposed to seeing a slight increase. Recently KDADS requested a supplemental appropriation to eliminate these, we recognize this as a positive step we hope continues until the waiting lists are eliminated.

Proposed Work Requirement Includes People on the Waiting Lists for HCBS Waiver Services

The proposed work requirement lists 12 groups who are explicitly excluded from the proposed work requirement. While Kansans enrolled in a HCBS waiver are excluded from the work requirement, people on the waiting list for HCBS services are not. We hope the State will address this before the final application is sent to CMS.

Proposed Work Requirement with a Lifetime Cap will Potentially Harm People with Mental Illness

While HCBS waiver participants are excluded from the work requirement, there is not an HCBS waiver for adults with mental illness. Both the lifetime cap and the work requirement will likely make it more difficult for people with mental illness to get the healthcare they need and will at the very best, increase the paperwork and documentation required of people who are already facing significant challenges.

HCBS Performance Measures Few and Far Between

Considering the fact HCBS waiver services are roughly half of the Medicaid spending in Kansas, we know the State wants to know how well the State's Medicaid program is doing to gauge the bang for our buck and how well the program is working to serve the needs of Kansans with disabilities. Unfortunately, the proposed application almost completely ignores HCBS as far as performance measure are concerned. There are many examples of medical performance measures in the pay for performance measures for the MCOs, example Performance Improvement Projects, and historical utilization ratios listed. Again, almost all of those are all still based entirely on a medical services, not HCBS.

Unfortunately, currently Kansas is not collecting the right data to even be able to measure the outcomes for HCBS services. The measures currently for Home and Community Based Services Waivers, are outputs focused, so an analysis of those outputs in relation to outcomes is essential.

I appreciated the opportunity to participate in the Data Transparency work group. During the meetings of that workgroup, several folks who participated on national workgroups presented reports from those national workgroups. The good news is that there has been progress on this issue nationally and that work should provide a good blueprint we can customize for Kansas. These should be included to be able to definitively tell you how well our program does at providing HCBS services.

The State of Kansas should continue to engage stakeholders and to add HCBS performance measures, work with MCOs to develop PIPs that will address HCBS performance, and work to report data in ways that will be shed light as to the performance of the HCBS programs.

Major Issues Continue with the Clearinghouse

Through the various stakeholder groups I participate in, I continuously hear of problems that continue to persist at the clearinghouse. First, there is the ongoing backlog of applicants. People are also required to fax the same records in over and over again (thus further delaying their applications). Also, providers are experiencing issues where there are coding issues with how individual members are coded in the system creating ongoing issues for providers to get paid for services they are providing. For example someone who has been discharged from a nursing home continues to be coded as being in the nursing home sometimes for months (despite numerous calls and faxes to get that corrected). Everyone I have heard from who has any interaction with the clearinghouse immediately embarks on a rant of their frustrations with it.

I would think each of these clearinghouse issues are all important enough to measure, but none of the performance improvement projects that seek to measure how the Medicaid program is

performing include any of these. How many coding errors are occurring? How many orphaned records are sent to the clearinghouse that are never associated with a member? (If they were measured on this, I guarantee you there would be far fewer.) Previous reports that purported to show how quickly the clearinghouse answered the phone listed the time to answer, not the time until you spoke to a human that was helping you.

Please consider amending the application to include these and also please provide additional oversight and more transparency in the performance of these important functions. That needs to start with tracking the right data and sharing that with legislators, stakeholders, and the public.

Huge Opportunity for Innovation and Transparency

The 1115 demonstration waivers are designed to allow states to innovate. The State of Kansas has an amazing opportunity to allow some really smart people to help it innovate our Medicaid system. The new Medicaid Management Information System (MMIS) presents a significant opportunity to see (via data) in much closer to real time how the Medicaid system is performing. The new system includes data warehouse and uses several best of breed tools such as Tableau to query the data and enable us to visualize this data in new ways.

KanCare 2.0 purports to share additional data with providers and members via a portal. While this is a major opportunity to create a 360 degree view of each member. The key piece that has been missing is the **analysis** of available data. While I do not fault the existing staff, as they have significant resource constraints, as well as having plenty of major fires they have been fighting. Actually analyzing the data is the key. However, there is a very simple solution to this resource limitation.

I also want to encourage the state to embrace an open data approach, where feasible, with its disaggregated, unidentifiable data. Obviously, it is extremely important to protect the confidentiality and to comply with federal and state laws, but there is a real opportunity to allow third parties to help the Kansas Medicaid system to be as efficient and effective as possible. It is amazing what can happen when you allow a lot of really smart people to help innovate the system.

While I mentioned this at the last KanCare Oversight meeting, in reading the application and the RFP documents, I have seen no indication KDHE is going to make the policy decision to allow third parties to access this disaggregated and unidentifiable data to help them innovate. Real innovation is possible when you allow smart people to help. Look at the innovations that have happened in other areas such as in public transit.

The State and Legislature have taken it on the chin recently in the media over transparency. Here is an opportunity to be proactive.

Thank you in advance for your thoughtful consideration of our input. Feel free to contact me with any additional questions or to obtain more feedback.

November 22, 2017

VIA EMAIL
KanCare Renewal
c/o Becky Ross
KDHE, Division of Health Care Finance
900 SW Jackson, LSOB –9thFloor
Topeka, Kansas 66612
kdhe.kancarerenewal@ks.gov

RE: KanCare's Proposed 1115 Medicaid Waiver Renewal

Dear Ms. Ross:

We are writing on behalf of the Kansas Chapter of the American College of Emergency Physicians (KACEP), its parent organization, the American College of Emergency Physicians (ACEP), and the Emergency Department Practice Management Association (EDPMA), whose membership includes emergency medicine physician groups, billing, coding and other professional support organizations that assist healthcare providers in our nation's emergency departments.

Let us note as emergency providers, we greatly appreciate the Kansas' Medicaid system (KanCare's) focus on coordinated care on decreasing emergency room visits. As Kansas' 1115 renewal waiver reports, "[d]ecreases in utilization of these services are a positive outcome, reflecting increased access of treatment from the member's primary care provider instead of an ER and increased preventive care and home services to avoid lengthy hospital stays." While coordinated care may decrease visits, we want to ensure that a patient's access to the emergency department is not hindered by further erosion of the prudent layperson (PLP) standard found under State law[1]. Our comments focus less on the proposal but more on the process in which KanCare currently operates and requests the Kansas Department of Health and Environment (KDHE) for amendments to the waiver that address emergency providers' concerns related to maintaining the PLP standard.

The PLP standard obligates Medicaid carriers and managed care organizations (MCOs) to reimburse emergency medical providers for the delivery of emergency medical services and care to Medicaid recipients.[2] We have growing concerns that certain Medicaid managed care organizations operating as part of KanCare are not reimbursing emergency physicians in a manner that is consistent with this federal standard. Our concerns particularly relate to retrospective denials by which certain KanCare MCOs have determined, retrospectively, after emergency medical services treatment and care has been rendered to the patient. Those retrospective determinations assert that the conditions by which the patient sought out emergency services did not constitute an emergency medical condition. Consequently, these particular cases are deemed 'non-emergent' and are not reimbursed in

[1] KA Ins. Statute 40-4602
[2] Balanced Budget Act of 1997

accordance with the KanCare promulgated reimbursement rates, resulting in drastically reduced reimbursement at rates as low as $13.00.

In addition to this issue of retrospective reimbursement determinations, we are finding that certain KanCare MCOs have created and implemented lists of symptoms, conditions and diagnosis codes (which remain outdated) but which we have little transparency and no clear sense on the basis for the determination on those codes the MCOs deem non-emergent.

Moreover, we understand that KanCare and the KanCare Medicaid MCOs have an overly burdensome appeals process that can be utilized in these kinds of situations, but we find that working within the appeals process established is needlessly inefficient, expensive, and time consuming, particularly when individual claims need to be appealed for resolution of small dollar amounts (though in the aggregate, the impact to our providers is significant).

CMS already concluded that diagnosis lists should not be used to determine when it is appropriate to seek care in the emergency department. For instance, in the Final 2016 Medicaid Managed Care Rule, CMS stated: "Regarding the PLP requirements of the BBA of 1997 and the use of approved lists of emergency diagnosis codes, we remind commenters that consistent with our discussion in the 2002 managed care final rule at 67 FR 41028–41031, we prohibit the use of codes (either symptoms or final diagnosis) for denying claims because we believe there is no way a list can capture every scenario that could indicate an emergency medical condition under the BBA provisions. ... While this [PLP] standard encompasses clinical emergencies, it also clearly requires managed care plans and states to base coverage decisions for emergency services on the apparent severity of the symptoms at the time of presentation, and to cover examinations when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. The final **determination of coverage and payment** must be made taking into account the presenting symptoms rather than the final diagnosis. The purpose of this rule is to ensure that enrollees have unfettered access to health care for emergency medical conditions, and that providers of emergency services receive payment for those claims meeting that definition without having to navigate through unreasonable administrative burdens." [3]

Emergency departments are the nation's health safety net. Federal law – through the Emergency Medical Treatment & Labor Act (EMTALA)[4] - requires hospitals and physicians to evaluate and stabilize everyone visiting the emergency department, no matter the ability to pay. Even though emergency physicians are only 4% of physicians, they provide 50% of all care given to Medicaid and CHIP patients and 67% of all care to uninsured patients. Kansas is one of nine states that have uncompensated care (UC) fund pools and benefits by providing UC pool payments to hospitals to defray hospital costs provided to Medicaid-eligible or uninsured individuals. Under the 1115 waiver extension, these funding pools are available to go directly to health care providers, of which Kansas has or is expected

[3] (81 FR 27749 (May 16, 2016))
[4] 42 U.S. Code 1395dd

to budget $80 million[5] for two pools, one for uncompensated care and another for delivery reform incentive payments. The State benefits by renewing UC pools in their waiver because it represents a long-term investment in its healthcare safety net, especially for rural or economically distressed areas. However, consider the alternative. If emergency physicians continue to be undercompensated in Kansas, fewer emergency physicians may choose to practice in the state, lines in Kansas emergency departments will grow, and some emergency departments may even close down.

While we look forward to a continued dialog with the KDHE and other important stakeholders, we acknowledge the process needs to be collaborative to ensure that quality and access to healthcare in Kansas are not compromised. We encourage KanCare to take the opportunity through the current waiver process to reform the states' MCO system. We also encourage state investment in technologies that assist providers in the appeals process that focus more on transparency and accuracy and less on automatic downcoding by illegal diagnosis codes. Finally, we encourage the State to continue its commitment to improving its healthcare safety net by allowing 30 percent of the UC pool to go directly to EMTALA obligated providers. Making these improvements in the renewal process will ensure that KanCare 2.0 remains in compliance with state and federal law, while also creating a model other states can use going forward.

Thank you for considering our comments on improving Kansas' healthcare safety net.

Sincerely,

Andrea M. Brault, MD, MMM, FACEP, Chair of the Board Emergency Department Practice Management Association (EDPMA) [redacted]

Paul D. Kivela, MD, MBA, FACEP, President, American College of Emergency Physicians (ACEP) [redacted]

Jonathan Wilcher, MD, FACEP, President, Kansas Chapter, American College of Emergency Physicians [redacted]

CC: Secretary Susan Mosier, MD, Deputy Secretary for Public Health

[5] October 13, 2017 CMS Letter to Kansas Medicaid granting a 12-month temporary extension.

November 26, 2017

To: KanCare Renewal

c/o Becky Ross
KDHE, Division of Health Care Finance
900 SW Jackson, LSOB –9thFloor
Topeka, Kansas 66612
email: kdhe.kancarerenewal@ks.gov

From: Beverly Williamson, Chairperson, Family Support Organization for Life Centers of Kansas, Overland Park, KS

Members of our Board of Directors, general members of our organization, and myself have attended the public comment hearings throughout the summer and fall of 2017. Based on our careful review of the "Final Rule" regarding HCBS from the Centers for Medicare and Medicaid Services and a review of the KanCare 2.0 renewal application and RFPs for providers, we have the following questions/concerns:

1. Service Coordination and Conflict of Interest Issue:

Many of us have had family members in the HCBS program before and after KanCare . Up until this renewal application, we have depended heavily on independent Targeted Case Managers to serve as advocates and sources of information for our family members - either the client of KanCare services, guardians, parents, second generation family members, etc. With the implementation of Service Coordinators, we are very concerned about the *conflict of interest* developing because the Service Coordinators will be employees of the Managed Care Organizations - not independent as are the current Targeted Case Managers. During the public input sessions, comments from staff of KDHE and KDADS indicated that TCMs could certainly apply for Service Coordinator positions with the MCO's ,but payment to independent TCMs would no longer occur with the advent of Service Coordinators.

The role of MCOs in Kansas has been to reduce costs - that was one of the major themes when KanCare was introduced to Kansas citizens. Yes, streamlining services, improved medical care and service coordination, etc. were also stated, but the overarching issue was reduced Medicaid spending. With MCO Service Coordinators participating significantly in the development of the Person Centered Care Plan and present during BASIS meetings determining the need for service, there seems to be an opportunity for institutional bias favoring a reduction in services in an attempt to control Medicaid expenditures rather than supporting the HCBS waiver client in the least restrictive community environment.

Clearly, a conflict of interest.

a. What guarantees are in place to ensure this conflict of interest is addressed ?

b. What will be the pathway for clients, guardians, family members to report and follow-up on incidences involving conflict of interest ?

2. The role of Service Coordinators and their caseload allocation for HCBS clients.

During one of the November public comment sessions, a staff member of KDADS stated that Service Coordinators will see their clients once a year or every other year. The HCBS Final Rule states clearly that "Independent reevaluations of each individual receiving the State plan HCBS benefit must be performed at least every 12 months, to determine whether the individual continues to meet eligibility requirements." Currently, the assessment/reevaluations are conducted by the CDDO staff in Kansas. Leading to these questions...

a. If Service Coordinators are no longer available to see HCBS clients annually, will they be part of the BASIS review?

b. If our family members receiving HCBS services only see the Service Coordinator once every year or 2, how will that Service Coordinator prepare , monitor, or facilitate an intelligent, complete, and accurate Person Centered Care Plan?

c. Nothing was stated about the caseload for each new Service Coordinator - even when asked the question was ignored or tabled... What will be the caseload for the new Service Coordinator staff members? Currently, Kansas Targeted Case Managers for HCBS have caseloads of 30-35 individuals on the waivers. The current MCO Care Coordinators have more than 125 members on their caseloads - most report about 150. If the Service Coordinators have greater caseloads than our current TCMs, you can understand our disbelief when KDADS and KDHE staff members talk about increasing the services for HCBS clients that all require more work and time by those individuals fulfilling the TCM or Service Coordinator role.

We look forward to a reply with answers to satisfy the curiosity of our 100+ members.

Thank you for the opportunity to comment on and question the renewal documents and intentions.

Beverly Williamson

[redacted]

[redacted]

From: Jafferis, Joanna, JCD
To: KanCare Renewal
Subject: Feedback on Kancare 2.0
Date: Wednesday, November 22, 2017 5:56:53 PM
Attachments: image002.jpg

We appreciate the work that has been done to increase community service coordination to address the social determinants of health and independence. This is exactly what we have been asking for, as we see there is a great benefit to the people we serve with IDD. As a current Targeted Case Management, and WORK ILC provider, the general principals seem to be positive. However, the devil is in the details, and words are always open to interpretation whether you are an HCBS provider, the MCO administrator, or the case manager.

I am representing myself with 34 years of experience in the IDD field, and a team of 16 case managers. We have seen many changes over the years. Some changes were positive and some we would like to avoid in the future, as much as possible. We would like to be carved out of KanCare all together, but if that is not possible, here is what we see is needed in more specific detail in KanCare 2.0.

1. Very firm roles and responsibilities for MCO CC and Community Service Coordinators that is the same across all MCOs. In health homes, MCOs were able to say what tasks they wanted to do and what tasks the health home would do, and so it made our work very inefficient, confusing and unproductive. The state must be able to enforce their guidelines.
2. A firm rate with a Medicaid billing code, that is the same for all MCOs. We don't want to be subcontractors who must perform tasks assigned for whatever pay they can negotiate.
3. A fair rate that we can sustain community service coordination agencies. Current independent case managers are not able to pay benefits and their turnover is often as bad as the MCO care coordinators, because of the low pay. We are all losing money currently with the current payment system. TCM has not had a pay raise in over 10 years. If we are taking on more tasks with an expanded role, and with outcomes expected, we should be paid as professionals.
4. An end to Prior Authorizations for TCM and the "time in - time out" pay methodology. We think that the PMPM pay methodology makes sense for our service. We spend a great deal of time on documenting minutes which could be better spent providing actual service that people need.
5. Access to Community Service Coordination for everyone with IDD whether they have HCBS or on the waiting list or not. There are adults who are not interested in HCBS, but they need the CSC. We would also like to be able to provide CSC for those with IDD on the WORK program. ILC is not sufficiently broad to cover all the areas that individuals with IDD need.
6. All the MCO documents need to be the same, no matter what MCO you have - Health Risk Assessments, Needs Assessment, to Person Centered Plans or Plans of Service.
7. The MCO CC role should be to problem solve when a change is needed and to be there when help is needed. Responsiveness should be their main focus. Letting the CSC do all the other tasks should free them up to be present when needed – approve plans, and get the authorizations entered correctly. We need a response within 48 hours. Calling a "customer service" number should not be the response as they are seldom able to help.
8. Communication on who the MCO CC is, who the supervisor is, and how to contact them. We need to know before there are changes, or as soon as possible.

9. Visits/Contacts are determined by the individuals and they should not have to see their MCO CC at all, unless they initiate the interaction. The MCO is able to monitor their health and eligibility through the CDDO, clearinghouse, physicians, hospitals, providers and community service coordinators.
10. The "Conflict Free Case management" issue needs to be solved, as soon as possible. We need to discuss, and come up with a plan to become compliant, as soon as possible. Individuals served and their families, current TCMs, and providers all need to be involved, as it has the potential to be highly disruptive, if not handled thoughtfully.
11. Consider various pay methodologies for Community Service Coordination. It may be possible to pay a CSC more for extra education such as a Master's degree, expertise such as Positive Behavior Supports Facilitators, or Autism Specialists, or more experience. Another possibility is to pay for members based on their need for community service coordination. For example – a person with IDD, mental health diagnosis, chronic illness, day and residential HCBS services would be paid more than a person who lives happily with their supportive family, works in the community, is having no behavioral or health challenges, and is not wanting any changes.
12. Caseload Size must be limited. If Community Service Coordination caseloads get too large, we will not be able to do our job. For the IDD population, an average of 30, be the limit. We should be paid enough to be able to sustain the service. If the pay is not sufficient, community service coordinators will be forced to take on more than they can handle to make ends meet and then not be able to provide the quality service required, and turnover will increase.
13. Individuals have to be able to choose their Community Service Coordinators. This needs to be continued through the CDDO process that people are used too and not with the MCO. Individuals should be able to change their MCO CC as well.
14. Include transition service coordination as the role of the Community Service Coordinators with the MCO CC.. It is important that the person who is transitioning has one person who to work with them through the whole process, knows the community and will assure a successful transition. Currently TCM are often doing this with no reimbursement.
15. The appropriate number and type of visits should be determined by the individual and not by an arbitrary #. A minimum is the appropriate way to recommend contacts.
16. A realistic timeframe for required training. It would be better to give a time frame of what must be done in first 2 weeks, and then what is required in 3 months, and 6 months. Flexibility on how training is provided, would also be helpful, peer mentoring, job shadowing and increased supervision could be even more valuable training. It really takes a year to learn everything you need to know!
17. A clear endorsement of the continuing important role and responsibilities of the CDDO.
18. Community Service Coordinators, with the proper releases/representation designation from the individual, should be able to talk to the KDADS, DCF, the Clearinghouse, and MCO, on the behalf of a person on their caseload. There should be one form that works for each entity, that everyone can see and have access to. Individuals with IDD are often at a great disadvantage without someone to make calls for them and advocate for them.

The biggest problem with KanCare right now is the Clearinghouse. The delays, errors, and chaos at the Clearinghouse are causing people to lose their Medicaid for months at a time. In the past, we could call up a DCF worker and they could fix it the same day. Now it takes months and multiple calls

and faxes, to resolve. Individuals receive multiple conflicting letters, and receive incomplete, or incorrect information from the Clearinghouse. When people apply for the first time, it can take 6 months or more. This is unacceptable. Hopefully, this will be addressed as promised in the public meeting. Thank you for recognizing this as the serious issue it is.

Thank you for accepting our feedback. We look forward to working with the State and the MCOs to address these concerns in the coming year.

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November 21, 2017

Becky Ross
Director of Medicaid Initiatives
Kansas Department of Health and Environment
Division of Health Care Finance
900 SW Jackson
LSOB – 9th Floor
Topeka, Kansas 66612

Re: KanCare 2.0 Section 1115 Demonstration Renewal Application

Dear Director Ross:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Kansas' 1115 demonstration waiver application. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

We support Kansas' goal of expanding service coordination to assist members with social determinants of health to improve health outcomes of its KanCare members. However, we are extremely concerned that this proposed waiver could negatively impact the traditional adult Medicaid population, including cancer patients, survivors, and those who will be diagnosed with cancer in their lifetime. Over 14,000 Kansans are expected to be diagnosed with cancer this year[1] – many of whom are receiving health care coverage through the KanCare program. ACS CAN wants to ensure that cancer patients and survivors in Kansas will have adequate access and coverage under the KanCare program, and that specific requirements do not create barriers to care for low-income cancer patients, survivors, and those who will be diagnosed with cancer. The proposed waiver, particularly the work requirement in its current form, could limit eligibility and access to care for some of the most vulnerable Kansans, including those with cancer and cancer survivors. We urge the Kansas Department of Health and Environment ("the Department") to reconsider this waiver to ensure that low-income Kansans have access to quality, affordable, and comprehensive health insurance.

The following are our specific comments on the state's KanCare 2.0 1115 waiver application:

Work Requirements

The waiver proposes to require that all "able-bodied" adults covered under traditional Medicaid must be employed, attending school, or participating in an activity consistent with Section 407 of the Social Security Act (SSA) and the Temporary Assistance for Needy Families (TANF) program for 20 or 30 hours-

[1] American Cancer Society. *Cancer Facts & Figures 2017*. Atlanta, GA: American Cancer Society; 2017.

per-week in a one-adult household and 35 or 55 hours in two-adult households to maintain eligibility or enrollment in KanCare. Many Medicaid enrollees are already working, as evidence by a recent Kaiser Family Foundation report that found over seven in ten adult Medicaid enrollees in Kansas are already in a working family and nearly six in ten are already working themselves.[2] While we understand the intent of the proposal is to further encourage employment, many cancer patients in active treatment are often unable to work or require significant work modifications due to their treatment.[3,4,5] If this requirement is included as a condition of eligibility for coverage, many cancer patients could find that they are ineligible for the lifesaving cancer treatment services provided through KanCare.

We appreciate the Department's acknowledgement that not all people are able to work and the decision to include several exemption categories from the work requirement and associated eligibility time limit and lock-out period. We particularly appreciate the Department proposing to exclude from the work requirements participants in the Breast and Cervical Cancer Program, but other cancer patients and recent survivors should also be exempt. Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to six months depending on the treatment.[6]

We urge the Department to consider implementing a medically frail designation that would exempt individuals with serious, complex medical conditions from the proposed work requirement and associated eligibility time limit and lock-out – particularly those with cancer and recent survivors. Specifically, if the Department continues forward with this provision, ACS CAN urges the Department to consider implementation of the "medically frail" designation as defined in 42 CFR §440.315(f), which allows certain individuals with serious and complex medical conditions be exempt from specific provisions. With respect to cancer, the definition of medically frail should explicitly include individuals who are currently undergoing active cancer treatment –including chemotherapy, radiation, immunotherapy, and/or related surgical procedures – as well as new cancer survivors who may need additional time following treatment to transition back into the workplace.

Maximum Length of KanCare Coverage

ACS CAN is opposed to the 36-month maximum length of KanCare coverage for adults subject to the work requirements. This proposal fails to acknowledge that many low-income working individuals on

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[2] Garfield R, Rudowitz R, Damico A. *Understanding the intersection of Medicaid and work*. February 2017. Washington, DC: Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[3] Whitney RL, Bell JF, Reed SC, Lash R, Bold RJ, Kim KK, et al. Predictors of financial difficulties and work modifications among cancer survivors in the United States. *J Cancer Surviv*. 2016; 10:241. doi: 10.1007/s11764-015-0470-y.

[4] de Boer AG, Taskila T, Tamminga SJ, et al. Interventions to enhance return to work for cancer patients. *Cochrane Database Syst Rev*. 2011; 16(2): CD007569. doi: 10.1002/14651858.CD007569.pub2.

[5] Stergiou-Kita M, Pritlove C, van Eerd D, Holness LD, Kirsh B, Duncan A, Jones J. The provision of workplace accommodations following cancer: survivor, provider, and employer perspectives. *J Cancer Surviv*. 2016; 10:480. doi: 10.1007/s11764-015-0492-5.

[6] Ramsey SD, Blough DK, Kirchhoff AC, et al. Washington State Cancer Patients Found to be at Greater Risk for Bankruptcy than People Without a Cancer Diagnosis. *Health Affairs*. 2013; 32(6): 1143-1152.

Medicaid have low paying jobs that do not offer health insurance coverage[7] and prevent them from being able to afford comprehensive health care coverage through the private insurance market.

Cancer patients undergoing an active course of treatment for a life-threatening health condition need uninterrupted access to the providers and facilities from whom they receive treatment. Disruptions in primary cancer treatment care, as well as longer-term adjuvant therapy, can result in negative health outcomes. Failure to consider the care delivery and/or treatment regimen of patients and the effects that a 36-month maximum length coverage could have on their continued care, especially those individuals managing a complex, chronic condition like cancer, could have devastating effects on patients, their families, and providers.

Lock-Out Period

We are deeply concerned about the proposed lock-out period for non-compliance with the work requirement. Although we appreciate the Department's decision to provide a three-month grace period, subjecting enrollees to the proposed lock-out until they comply with the work requirement could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for cancer survivors (who require frequent follow-up visits) and individuals battling cancer. As previously mentioned, research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to six months depending on the treatment.[8] If low-income cancer patients or recent survivors are subjected to the proposed lock-out period, they will likely have no access to health care coverage, making it difficult or impossible to continue treatment or pay for their maintenance medication until they can comply with the requirements. For those cancer patients who are mid-treatment, a loss of health care coverage could seriously jeopardize their chance of survival. Being denied access to one's cancer care team could be a matter of life or death for a cancer patient and the financial toll that the lock-out would have on individuals and their families could be devastating.

Independence Accounts for TransMed Program Members

ACS CAN appreciates that the Department provides an additional 12 months of coverage for families previously eligible for Medicaid who lost financial eligibility due to increased earnings. Allowing TransMed program members to continue receiving coverage for the 12 months following Medicaid coverage helps to maintain continuity of care for cancer patients and recent survivors and we commend the Department for providing this coverage.

We note, however, that the KanCare 1115 waiver amendment prohibits adults enrolled in TransMed from re-enrolling in Medicaid for an unspecified period of time if they participate in the *Independence Account*, or health savings account, offered to its members. Prohibiting these individuals from re-enrolling in Medicaid if they fall on hard times fails to consider the care delivery and/or treatment regimen of patients, especially those individuals managing a complex, chronic condition like cancer. As the 1115 waiver amendment is finalized, we ask the Department to consider adding additional

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[7] Garfield R, Rudowitz R, Damico A. *Understanding the intersection of Medicaid and work*. February 2017. Washington, DC: Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[8] Ramsey SD, Blough DK, Kirchhoff AC, et al. Washington State Cancer Patients Found to be at Greater Risk for Bankruptcy than People Without a Cancer Diagnosis. *Health Affairs*. 2013; 32(6): 1143-1152.

continuity of care provisions that would minimize disruptions in coverage and care for individuals in active treatment for life-threatening illnesses, such as cancer.

Quality Improvements

We note that the State intends to update its "Quality Strategy" to incorporate performance measures and reporting to support KanCare 2.0 initiatives. We encourage the Department to ensure that all United States Preventive Services Task Force (USPSTF) A-and B-rated cancer screening services are included in the performance measures. We note that breast and cervical cancer screenings are included in the 2016 KanCare Evaluation Annual Report, but does not appear to include colorectal or lung cancer screenings as part of the Managed Care Organization (MCO) performance measures. Regular screening is the most effective way of detecting cancers at an earlier stage when they are more easily treated, and lead to greater survival.[9] Educating, encouraging, and raising KanCare members' awareness of the benefits and services provided in the program will significantly contribute to the stated goal of the program to improve health outcomes for all members. Additionally, appropriate utilization of health benefits, specifically primary and preventive care services, will help to reduce the state's cancer burden.

Conclusion

We appreciate the opportunity to provide comments on Kansas' KanCare 2.0 waiver amendment application. The preservation of eligibility and coverage through KanCare remains critically important for many low-income Kansans who depend on the program for cancer prevention, early detection, diagnostic, and treatment services. Upon further consideration of the policies that will be included in the final waiver application, we ask the Department to weigh the impact such policies may have on access to lifesaving health care coverage, particularly those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime.

Maintaining access to quality, affordable, accessible, and comprehensive health care coverage and services is a matter of life and survivorship for thousands of low-income cancer patients and survivors, and we look forward to working with the Department to ensure that all Kansans are positioned to win the fight against cancer. If you have any questions, please feel free to contact me at hilary.gee@cancer.org or 816.305.7885.

Sincerely,

Hilary Gee

Hilary Gee
Kansas Government Relations Director
American Cancer Society Cancer Action Network

[9] American Cancer Society. Cancer Facts and Figures 2017. Atlanta: American Cancer Society; 2017.

Jan Gallagher
[redacted]

KanCare Renewal
c/o Becky Ross
KDHE-Division of Health Care Finance
900 SW Jackson,
LSOB – 9th Floor
Topeka, Kansas 66612

November 26, 2017

KDHE KanCare Renewal Committee

The Medicaid HCBS program is necessary and absolutely vital to the livelihood, health, and independence of my son, who has Muscular Dystrophy and utilizes the PD waiver for 24/7 care.

Help members achieve their highest level of independence is a Potential Service Coordination Pilot on page 8, figure 7 of the KanCare, State of Kansas KanCare 2.0 Section 1115 Demonstration Renewal Application document, Draft for Public Comment October 27, 2017, http://www.kancare.ks.gov/docs/default-source/about-kancare/kancare-renewal-forums/kancare-renewal/kancare-2-0-waiver-renewal-application---for-public-comment.pdf?sfvrsn=4. I sincerely hope you mean it and take serious the policies and procedures that are a barrier to achieving independence.

I have outlined below five policies and procedures in place that make it extremely difficult for my son to get the help he needs to live independently. Currently he is barely surviving and I am watching his health deteriorate daily. The current practices will have to change substantially in order to achieve his highest level of independence.

1. Pay Rate
Currently, the pay rate for direct support workers is on average $9.75 and no higher than $10.00 with no healthcare or other benefits. The work involves taking care of personal needs including bathing, toileting, changing catheters, cleaning tracheotomy, change ostomy bags, preparing food, feeding, cleaning etc. Basically, everything we take for granted that we can do for ourselves has to be done by caregivers. This pay is extremely low for the type of work, and it is extremely difficult to impossible to find people who will accept this low wage for the responsibilities.

My son's level of care requires highly qualified direct support workers (DSWs) in order to meet his health and safety needs, and maintain independence living in the community. The standard rate has proven inadequate to hire the necessary staff to meet his needs. Without any assistance, which has occurred in the past, he could die. His level of care is

individualized to his body. He requires detailed-oriented, coordinated, and confident DSWs who can learn complex and precise movements from other DSWs, and listen carefully to his precise instructions around spatial relations. High quality people are necessary because of the extreme physical and mental focus it takes to work with his body and position him. DSWs need to be able to understand and process high level concepts such as depth proximity, pivoting, angles, rotation, height and reverse left/right perceptions. DSWs must be physically fit with good lower body and core strength, have an understanding of body mechanics, and intuitively know their own kinesthesia (muscle sense) and proprioception (the ability to sense the relative positions of body parts without looking or thinking about it). DSWs must have critical thinking and higher reasoning skills to process this information, learn from mistakes, and figure out how to improve their movements relative to his body. For instance, his wheelchair has custom seating that conforms to his uneven buttocks. It takes precise positioning to hit the correct spot.

Even putting on underwear or pants must be done in a precise manner, or his hips and butt muscles will be strained and he will not be able to sit properly. Without proper positioning his body suffers both in the short term and long term - problems include: pain, extreme discomfort, breathing difficulties, headaches, exhaustion, loss of concentration, depressed mood, irritability, bed sores, loss of muscle control, muscle fatigue, and inability to sit-up.

My son's life, safety, and health are on the line. It's imperative to have high quality reliable workers. The current pay simply is not a competitive rate that is commensurate with the level of importance of the job and the skill required.

Finding DSWs with these attributes has been near impossible. The problem is that the market pays high quality workers with these skills at a higher rate, especially in the healthcare field. Even outside the healthcare field, people can get jobs doing less work and responsibility for the same or more pay. My son has been looking for people for two (2) years and has only been able to hire a few people on and off after much effort and turnover. It has become a full time job and nearly impossible to find good people. Time after time people back out before even starting. He is in crisis mode most of the time. Many nights he sleeps in his wheelchair, and during the day goes with out drinking water because he has no one to transfer him to his bed or to the toilet.

Currently, Amerigroup has no contracted agencies that can provide qualified care. He recently tried some agencies and it was a disaster. The caregivers did not turn up on time if they showed up at all. And when they did show up, the worker wasn't able to proficiently help (they could not transfer him). It is a common problem for consumers to deal with agencies that cannot provide qualified reliable people. Keep in mind that when my son does not know when, or if, a person is going to show up, he is alone and in danger.

Agencies, pay their people higher wages and the Agencies are reimbursed at a higher rate. Dedicated caregivers deserve and require a competitive pay. According to this

comprehensive study by Genworth 2015 Cost of Care Survey, the going rate in Kansas is between $14 and $25 and hour. https://www.homehealthcareagencies.com/resources/home-health-care-costs/. Keep in mind that encouraging people to live independently and out of nursing homes is much more cost effective. The care is better and consistent when the rate is competitive.

With the low reimbursement rate and high turnover, the cost of advertising is approximately $100 a month. We run around town putting ads in coffee shops and grocery stores.

Solution

Increase pay to compare with the going market rate. For those individuals with specified high needs, provide a higher rate than the standard rate.

Complete a financial study on the cost of care givers who receive health benefits and 401k's working in Nursing Homes providing comparative care. Eliminating the profit margin the Nursing Homes receive, would still be a savings to the State. In the past, these studies show it is more cost effective to allow individuals to stay in their own environment.

2. Training

(a) According to the IICBS PD Waiver, the State of Kansas requires consumers to train all self-direct workers;

(b) According to the Federal Labor Standards Act (FLSA) employees must be paid for all work related activities, including training;

(c) The only way for a worker to learn the complicated nature of the movementsmy son and other high needs consumers is to learn from someone who has previously been trained. It takes multiple sessions to not only learn, but to hone skills. This means two people working at the same time;

(d) Therefore, he is currently asking new workers to train unpaid, which means the State is mandating that he illegally train new workers.

According to the Department of Labor's Fact Sheet specifically dedicated to healthcare workers (at https://www.dol.gov/whd/regs/compliance/whdfs53.htm). Attendance at lectures, meetings, training programs and similar activities are viewed as working time unless all of the following criteria are met:

- Attendance is outside of the employee's regular working hours; • Attendance is in fact voluntary;
- The course, lecture, or meeting is not directly related to the employee's job; and
- The employee does not perform any productive work during such attendance.

Attendance for my son's trainings is mandatory and they are directly related to the job, since without the very specific training for lifting, transferring, positioning, and putting on pants, the DSW would not be able to do the job.

For my son, it takes between 3 to 10 hrs (depending on the person's ability to learn) of training to get someone proficient in helping him. That equates to 24 hours per month, by taking the average amount of time, six (6) hours, and multiplying by four (4) new hires in a month. In a busy month when he is short multiple workers (as in his current situation), four new hires would not be unrealistic. This training is very specific to the

consumer's needs, not generalized training.

Solution
Provide funds to access for training. The training hours would only be billed when training actually happens, so the full 24 hours would not be billed every month, but would be available as needed.
With higher pay rates and higher retention rates, the training hours needed would be minimal.
Paying for training complies with State and Federal laws

3. Background Checks
In addition to a Kansas Bureau of Investigation (KBI) criminal check, it is now (since January 1st, 2017) required to also have Department of Children and Families (DCF) Adult Abuse and Neglect and Child Abuse and neglect registry checks done, as well as some other checks. These DCF checks create an undue burden on both the consumer and FMS financially.

The KBI check is immediate.

The DCF checks take up to three (3) weeks each. It is a manual process that has proven to be unnecessary and inefficient. The DCF check is based on an internal investigation and may not result in the person being charged with a crime. The law says a person with a criminal background cannot receive funds from the Kansas taxpayer. Therefore, if a person who is investigated, and not charged with a crime, should be free to be hired. When a person is investigated, and charged with a crime, the KBI check identifies the person. The three (3) week delay is extremely limiting as many potential hires find jobs while waiting. Many potential workers are out of work and need to start working immediately, and will take another job while waiting. It is important to start the working relationship as soon as possible. Plus, he is usually short of workers, and needs them to start immediately. He has no one otherwise. Waiting means he doesn't know if they will be available once the background check comes back, and has to start the process over. His disability does not go away while these checks are taking place and he is left without care. This is dangerous and a threat to his life.

Currently, these background checks are mandatory, and there is no way for him to refuse/waive them. And there is no procedure in place to be able to hire someone on a "conditional" basis until the background check comes back.

The State is charging the Financial Management Service (FMS) providers for every background check. FMS receives $115 a month per consumer to cover all costs related to payroll services provided. Some FMS providers are passing the background check fees onto the consumer, my son was asked to pay $35 per background check (this is not the full price of the check).

My son has experienced hiring three (3) or more people in a month. He had to have more background checks ordered when people drop-out, changed there mind, and/or do

not show up for work after accepting the job and filling out the paperwork. People are finding other employment during the three week wait period. Some FMS pass the cost on to the employee and reduce their first paycheck. The scope of work for FMS involves administering extremely rigorous payroll rules, (extensive new hire package) imposed by the State of Kansas, and comply with IRS requirements etc. Processing pay checks for up to eight people when my son is fully staffed is part of the expenses of the S115 monthly reimbursement. This is prohibitive to conducting business and many FMS have gone out of business. Due to the high turnover in DSW these companies loose money in this process. This caused my son to have to change payroll agency several times, and adds to an already stressful lifestyle.

Solution
One, create a system where background checks provide immediate results similar to KBI. And Secondly, if the DCF background check is not considered unconstitutional and/or violates privacy act, require the potential employee sign a waiver for any pay received if the background check comes back negative. This would weed out potential employees who know they have a record, and allow for the consumer to have their daily needs met. In the case of my son, these are life sustaining needs.

3. Lack of Flexibility
Every time a consumer makes a change in hours between Agency hire and direct hire workers, the Individual Service Plan (ISP) has to be changed. They have to provide the exact hours the Agency will provide vs. Self Direct hours. When the agency fails to send someone and the consumer's direct hire person works as emergency back up, the direct hire cannot be paid. In situations where a direct hire worker leaves or the situation changes suddenly, the agency cannot take on those hours without a change in the plan. The MCO requests a week notice to make the changes. The case manager has to make the changes in the system as well as all the paperwork, which has to be faxed to the agency and the FMS provider. It has to show up in the Authenticare system first. This lag in time is a hardship and could cost lives. It has been my son's experience with several agencies that they take their time in responding, then sending someone out for intake, and finding people for your case which has taken three or more weeks.

Possible Solutions
- Provide accessible case managers/social workers with knowledge of healthcare industry and needs of consumers, not corporate data managers.
- Require MCO's to vet and monitor the Agencies that sign on to provide caregivers. The system has to become more responsive either via electronic means or emergency practices in place.
- Allow consumer hours to be interchangeable between self-direct and agency direct. As long as no more hours are billed than what the consumer has on his plan, then it shouldn't matter which agency(s) or FMS provider bill.

5. Lack of Emergency or Extraordinary Help/Procedures
Currently, there are no procedures in place when there is an emergency.
What does a consumer do when they can't find anyone to work, or agency hire workers

fail to show up to work? The consumer is alone and unsafe.
What is the process when the consumer does not want to go to the nursing home and has a right not to be, but there are no services available to fill in the gap of services?
What happens when a consumer contacts Nursing homes and they say the case is not within their scope of work (or case is too difficult or costly)?
What does a consumer do when they know the Nursing homes won't be able to keep them safe?
We have experienced these situations and asked these questions of the MCO and State officials, but no one has provided an answer.

Solution
Qualified case managers with access to resources need to be available. It is critical to share of information between agencies, and have access to emergency funds during critical situations.
Paying a going rate, would be the solution because the consumer could retain workers and reduce turnover and lower the burden on case managers/MCO agents.

Thank you for providing the period for us to make comments. As you have identified in your proposal for KanCare renewal, there are problems with the program as it currently stands. I implore you to consider making changes to the program, in order to make it truly and fully meet the needs of Kansans like my son. His life and independence depends on it.

Jan Gallagher

KANSAS ADVOCATES for BETTER CARE
making elder care better every day

Nov. 25, 2017

KanCare Renewal
c/o Becky Ross
KDHE, Division of Health Care Finance
900 SW Jackson
LSOB –9th Floor
Topeka, Kansas 66612

Re: Proposal to renew the KanCare 2.0 section 1115 demonstration waiver

Dear Secretaries Mosier and Keck,

These comments are submitted on behalf of Kansas Advocates for Better, a statewide organization committed to improving the quality of life and health of older adults. For more than 40 years we have been a trusted source of information and resources to assist older adults and their families in making long-term care decisions.

KABC recommends that the implementation of KanCare 2.0 be extended to at least January of 2020. The additional year provides the time and opportunity for stakeholders to thoroughly vet the State's proposed changes and discuss changes with the State, the potential impact on providers, and the people they serve. This also gives the State the time needed to develop a clearer, more complete vision for KanCare 2.0.

We also make this recommendation because the significant problems, which have existed since the beginning of KanCare, still are unresolved today. The KanCare demonstration waiver has not effectively or efficiently served Medicaid eligible older adults in Kansas. As we recently testified to the Joint Committee on Home and Community Based Services and the KanCare Oversight Committee, it is critical for Kansas to address and eliminate the problems which continue to challenge KanCare before implementing significant changes through KanCare 2.0.

KABC has closely monitored the State's move to managed care for the Kansans who are eligible for Medicaid. Since implementation of KanCare in 2013, we have received numerous calls, questions and complaints from consumers and their families related to KanCare. Their focus of those calls today haven't changed much since KanCare began – the reduction of services for persons on HCBS waivers has been a central theme. Consumers and families also express concerns and dissatisfaction about their care coordinators (or lack of care coordinators) and most are looking for help self-advocating and navigating a complicated, cumbersome system with no local contact points for personal assistance.

KABC, along with other advocates and stakeholders continue to access and evaluate the effectiveness of the current KanCare Demonstration project in meeting the healthcare and long-term services and support (LTSS) needs of older adults. The continuation and all future modifications should logically rest on whether KanCare has achieved the goals and projected improvements which the State originally set.

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Once again, we face a compressed timeline and a rush toward implementation of a program that has not yet been fully vetted by the State, providers, consumers and their families. The public forums hosted by the State have been narrow in focus and without an opportunity for consumers to express their concerns. The application provides a broad overview without the details necessary to determine the scope or impact of the proposed changes.

The proposed pilot projects that were the key component of the public forum are, according to the application, still "under consideration" and lack specificity regarding who would be included in the pilots, how long they would last, how success would be measured and when/if the project would be expanded statewide. Given the experience with the Kansas health homes project, there is a reluctance among providers of long term supports and services to participate in such projects without more detail and an assurance that the project will proceed.

KABC has specific concerns about policy changes proposed under 2.0:

Work Requirements

We are pleased that waiver recipients are exempt from the work requirements that are under consideration by the State. However, we would ask that caretakers of older adults be added to the list of persons who are subject to the work requirements. It is not unusual for spouses or adult children to provide 24/7 care for family members which limits their ability to be employed. For clarity, we ask that the application reflect this exemption and be added to the bulleted list of exemptions.

We would also ask that the list of exemptions include people on the waiting lists for home and community based waiver services. The question about this exemption was asked several times during the recent public forums and attendees were assured that they would be exempt. But without written clarification, this exemption could be misinterpreted or overlooked. It also should be included in the bulleted list of exemptions.

Service Coordination

There are too many details yet to be determined and disclosed regarding the proposed change to service coordination from care coordination. As described in the application and during the public forums, service coordinators will be employees of the managed care organizations. The service coordinators will be responsible for contracting with local entities to provide HCBS services. As explained in the public forums, some consumers will have a service coordinator, some will have a community coordinator, some will have both. No detail could be given as to how this would be structured or who would be eligible for what kind of coordination. This adds yet another burdensome layer of bureaucracy, confusion and complexity to a system that is difficult for older adults to navigate.

The care coordinator model has not proven to be effective for older adults, particularly those who reside in nursing homes. Most nursing homes residents have never been contacted by their care coordinators and there is no assurance that this will change under service coordination.

The application doesn't reflect the process for maintaining and growing the capacity of community coordination. Explanations made during public forums were clear that the State didn't consider the community capacity its responsibility. At a time when the LTSS provider network is struggling, it is risky to rely on the "if you build it they will come" model without adequate commitment and leadership from the State.

We hear from persons served through the waivers that services go unprovided if a direct care worker fails to show up for an appointment. The MCOs claim it is not their responsibility to find a replacement worker to

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provide the care. There is no specific guarantee that this will change under 2.0, in fact may worsen as MCOs hand off those care coordination responsibilities to community coordinators, increasing the risk that home-based services won't be delivered. For older adults and persons with disabilities, being able to rely on consistent services is critical to their health and quality of life.

Rather than creating a new cumbersome, multi-layered process, KABC recommends the restoration of Targeted Case Management (TCM) as an option for persons across all waivers, including older adults, particularly elders with dementia. Since TCM was eliminated under KanCare, KABC has heard from older Kansans and their families about their struggles in coordinating and integrating home and community based services. Before KanCare, TCM had proven to be key in facilitating older adults' ability to remain living in their home – which is where they want to be and is the most affordable option.

TCM is still offered for persons with intellectual/developmental disabilities and for children with serious and emotional disturbances so the infrastructure is still in place to restore it for the remaining five waivers. It continues to efficiently and effectively serve persons through these two waivers. This option should be restored across all seven waivers.

It is encouraging to see references in the KanCare 2.0 application giving consideration to the importance of social determinants. Without a doubt, living in poverty has a detrimental impact on health and quality of life. For that reason, we recommend raising the monthly Protected Income Level (PIL). The current PIL allows older adults and persons with disabilities to keep $727. The PIL hasn't been increased since 2008, when it was increased $10. The protected income level hasn't kept up with inflation and is simply inadequate.

Specifically, the following problems must be resolved:

Infrastructure:

- The State has failed to create systemic solutions to consistently identified barriers and breakdowns/failings. Problems are addressed on a case-by-case basis when the situation rises to the crisis level, is brought before the KanCare Oversight Committee, an individual contacts his/her local legislator(s), and/or the situation receives press coverage. These are not isolated incidents nor outlier situations. They are illustrative of larger system issues but generally receive little recognition or attention to the underlying problems.
- Many older adults don't have ready access to computers and/or have visual impairments which limit their access to online information. When contacting the Medicaid Clearinghouse, consumers and family members have consistently reported waiting months for a determination, long wait times on hold, the inability of staff to answer questions and/or lost or misplaced paperwork, often requiring the application to start the process all over again. These all deter and discourage people to apply which ultimately compromises their health, safety and quality of life.
- The technical problems within the KEES IT system have been well documented. The system needs to be fully functional before KanCare 2.0.

Legislative Oversight

- Legislative Oversight is critical to ensure workable solutions are in place prior to any move forward or significant changes are made to KanCare. The magnitude of the problems which continue to challenge KanCare and the lack of improvements or improvement trend data, point to clear and urgent need for a greater level of legislative engagement with KanCare policies and budget. Medicaid is the State's second largest expenditure and should be closely monitored by the legislature.

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- An example of inadequate health and safety oversight is illustrated by Kansas' continued ranking as the *51st worst in nation* for drugging elders with dementia; delayed health safety inspections, ineffective response to serious harm complaints. Increased legislative oversight will increase the State's accountability and improve the health and safety of Kansans served by KanCare.

Access to Services

- KABC continues to hear from older adults and their family members about months-long delays in getting applications approved. Applicants report that they must submit documentation multiple times. This inefficient process slows down the approval process and creates a financial and access obstacle for families who don't have access to a fax machine.
- The inability to process applications in a timely manner has resulted in a lack of access to hospice/palliative care services for persons with a terminal illness. Many Kansas nursing facilities no long admit residents whose KanCare application is pending because of the uncertainty and the long delay in determining eligibility. For persons who are dying it is even harder to find a facility because they will not be paid if the application is not processed before the patient dies. At this time, Kansas has no presumptive eligibility options for patients who are not expected to live long enough to see their KanCare application processed, leaving the hospital their only option. KanCare 2.0 does nothing to address the eligibility backlog or provide an alternative to persons who need hospice care while their application is held up at the Clearinghouse.
- Significant decline of older adults being served, even as the older adult population expands. According to the State's Medical Assistance Report (MAR), there has been a steady decline in the number of older adults being served at home **and** in a nursing homes. That data show that 2,702 fewer older adults are being served under KanCare through the Frail Elderly waiver or in nursing facilities. This is counterintuitive and deserves a closer look. The reasons why fewer older Kansans are being served is central to any evaluation of KanCare's effectiveness before moving forward.
- Diminishing access to nursing facilities due to backlog. At the same time persons served by the HCBS FE waiver is declining, occupancy of nursing facilities is down to 81%. Previous standards have set 85% occupancy to assure adequate staffing and reimbursement to effectively provide care.

Network Adequacy

- KanCare consumers report diminishing provider network for home and community based (HCBS) services.
- There is minimal data to show that the provider network is sufficient to meet the needs of persons being served by the program. For a complete picture, the following data should be analyzed:
    - a) HCBS capacity
    - Trend data across the life of the KanCare demonstration project
    - What obstacles exist regionally? Consumers report that they can't get access to services (Goodland, call from consumer approved on 8/23 for in-home assistance, still hasn't heard from Amerigroup on 9/6)
- Workforce issues are not being addressed – Nursing facilities and in-home providers are understaffed and undertrained for level of care needs they are serving – dementia, respirator, wound care, non-English speaking care
- As stated earlier, the strength and adequacy of the network must be assessed before being burdened by significant changes or restructuring.

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Consumer Rights

- Consumers have no access to effective, legally-based advocacy/ombudsman program, including for those with diminished cognitive capacity KABC. Creating such an ombuds program is critical for consumers should be Priority One for KanCare 2.0.
- KanCare 2.0 appears to break the agreement between stakeholder organizations and the State which allowed consumers to continue to receive services during the 33 days they were allowed to appeal to the MCO and an additional 33 days to appeal through the State Fair Hearing process when services to their plans of care were cut or elimination. KanCare 2.0 reduces the time to appeal to the Office of Administrative Hearings to 10 days before services are discontinued. They may still appeal but service cuts happen during that time unless OAH overturns the decision. This is a serious change and was not disclosed or discussed during the public forums. There is no need for this change. CMS sets a minimum standard not a hard requirement and the current policy meets the federal standard.
- KDHE fails to give required notice of the right to appeal whenever a person's eligibility application is delayed or backlogged
- Informing consumers about their rights and the process for accessing those rights is limited and inconsistent. Relying on a notice on the application is not adequate and there should be multiple opportunities for consumers to access this information. Consumers report delays in paperwork, reducing their time to appeal; decisions being communicated verbally without proper written notice and conflicting information from care coordinators.

Kansas Advocates for Better Care recommends the Kansas Department on Aging and Disability Services and the Kansas Department of Health and Environment coordinate with CMS to extend the existing KanCare program while they work to more fully develop the application for KanCare 2.0. The plan should include a detailed, operational plan that includes a specific plan for evaluation that has been developed in conjunction and cooperation with advocates, consumers and their families.

There is no reason to rush to implement a plan which is still undeveloped, does not fully outline policy changes and has not had public input. Without proper planning and resolution of the outstanding problems that still plague KanCare, the program cannot succeed risking the health, safety and quality of life of the people who depend on it.

As Kansas considers the possible renewal of the KanCare demonstration and negotiates the contracts with Medicaid providers – for both medical and HCBS supports and services – it is critical that we make the health and safety of older adults and persons with disabilities the priority.

Mitzi E. McFatrich, Executive Director

Kansas Advocates for Better Care

On Behalf of the Board of Directors, Members and Volunteers

KABC is a not-for-profit organization, beholden to no commercial interests and is supported almost entirely by donations from citizens who support our mission of improving the quality of elder care in all long-term settings. KABC was among a handful of non-profit consumer advocacy groups which worked to win passage the Nursing Home Reform Act of 1987. Our interest is in quality elder care at ho

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Kansas Association of Centers for Independent Living
Comments on KanCare 2.0 Section 1115 Demonstration Renewal Application

We appreciate the opportunity to provide feedback. Centers for Independent Living have been closely involved since the beginning of the Medicaid Waiver programs and have a particular interest in seeing the KanCare program move to the next level of service, increasing accessibility to quality healthcare, improved health outcomes and overall improved lives for individuals with disabilities, seniors and others who rely on Medicaid for their health insurance. The Association members have reviewed the draft application available for public comment and offer the following observations.

In the introduction, the Renewal Application states that KanCare 2.0 will build on the success of the current KanCare demonstration. It is unclear what successes this application is referring to. It would be helpful if the document provided specific success measures intended to be the platform to build the revised program on.

This application states that KanCare 2.0 will further improve health outcomes, coordinate care and social services, address social determinants of health, facilitate achievement of member independence, and advance fiscal responsibility. But we can't connect the dots between the information provided in the application and these KanCare 2.0 goals.

This plan as written is more concept, than framework, making it difficult to provide comment. Our review led to more questions than critique. There is little substance to help us understand how these concepts will be implemented or if they will in fact lead to the desired outcomes.

On page 9 data from two sources site health impacts for workers who have been "laid-off" or those who report themselves as "unemployed". This data is not relative to the targeted population for KanCare; individuals with disabilities who qualify for nursing home or institutional level of care. This population, in fact faces new "health impacts" when they seek employment; often requiring additional behavioral and health supports including medication adjustments and counseling for anxiety. The elevated emphasis on employment as a social determinant of health is questionable. We are not in disagreement that employment may bring individuals a sense of accomplishment and personal satisfaction but it needs to be recognized that approaching employment as someone with a long-term, chronic disability is entirely different than assisting a displaced worker to get back into the workplace. These individuals face numerous barriers, including risk to their health due to additional physical exertion, extended time standing, walking, sitting in a wheelchair etc.

Access to transportation is consistently listed as the number one barrier to employment for persons with disabilities, this application makes no mention of this.

Services and definitions are not clearly defined. We are confused if the State is going to leave it up to the MCO's to determine the definitions and/or parameters of services or how it will be accomplished. As noted above, it's difficult to make comments on this application when so much of it is undefined.

Below are a few specific examples;

MCO's will be held to a standard of "timely Communication" with no definition for "timely". This currently can range from 2 days to "never returning phone calls". Without clear definitions on "timely", it's difficult to measure.

Service Coordination – there is a rather lengthy definition on the concept of service coordination but no explanation on how it will be accomplished. In one section it appears that MCO's will be fully responsible for service coordination and a second section state that MCO's will be required to work with local entities to perform community service coordination with a list of potential activities which includes

- Development, implementation, monitoring, and approval of the plan of service or PCSP,
- Choice counseling,
- Member contacts and home visits,
- Linkage and referral to community resources and non-Medicaid supports,
- Referrals for education, employment, and housing, and
- Education to the member regarding self-direction and the WORK program and other employment programs.

Is it the intent of the State that MCO's subcontract for this work? If so, what conflict of interest would that be if the organization is also a FMS provider? Again, we would like to see more clarity on this issue.

Areas of concern not addressed in this application;

The current care coordination system leaves much to be desired between high caseloads and high turnover, Waiver consumers are not receiving the level of service needed to be successful in achieving their service/life goals. New, reasonable caseload standards must be set, with increased contact mandates so that care coordinators are able to adequately assist consumers.

The application, in several places references how this plan will "promote community access"? We see nothing in this document that addresses community access supports and services.

The PD Waiver population has the highest re-admittance to hospitals of all the Waiver populations. This application doesn't address this problem.

While we remain confused on the elevated focus on employment as a social health determinant when there are other stronger social health determinants that should be addressed; we would like to see coordination between KanCare and current programs set in place to address vocational habilitation and rehabilitation. This continual pursuit of new programs and pilot projects prohibits providers from focusing on improvement of current programs and service models. Kansas used to be considered a leader in the Independent Living Movement, known for creative models and innovative thinking. We strongly urge the return to this collaborative model that has served us well in the past.

Again, thank you for the opportunity to provide feedback. With a majority of our staff and board members being individuals with disabilities, Centers for Independent Living have a unique perspective on long term care supports and services and are strongly invested in making our Kansas programs work to improve individual's lives.

KAMU strength unity advocacy
THE PRIMARY CARE ASSOCIATION OF KANSAS

TO: Kansas Department of Health and Environment

FROM: Denise Cyzman, Executive Director

DATE: November 22, 2017

RE: KAMU Response to KanCare 2.0 Waiver Proposal

The Kansas Association for the Medically Underserved (KAMU appreciates the opportunity to submit comments and questions on the KanCare 2.0 Section 1115 Demonstration Renewal Application (waiver proposal). We agree KanCare 2.0 provides an opportunity to improve the program by building on the successes of the current program. Some of the proposed changes in the waiver proposal, however, could be detrimental to the state-run program, the Kansas safety net system, and the entire healthcare system serving Kansans. Additionally, KAMU and our member primary care clinics have concerns that implementation of some of the proposed changes will add administrative burdens and costs to the State. These include but are not limited to: implementation and tracking of employment status, lock-out periods and health savings accounts. The state resources for running and improving the current KanCare program are already stretched. Adding more will negatively affect the ability to reach KanCare 2.0 goals.

Our specific comments, concerns and questions on the proposal are below.

Integrated, Whole-person Care

A major goal of KanCare 2.0 is to provide integrated, whole-person care. Yet, the program plan, as outlined in the waiver, does not support integration of behavioral or oral health care into primary care settings. KAMU is in full support of integrated care, as many of our member primary care clinics already provide care in a whole-person manner. Not only does integrated care help better serve and care for the patient, it is also a more cost effective delivery system for the KanCare program.

Behavioral Health Care

We are pleased to see the *behavioral health integration* mentioned in the KanCare 2.0 waiver proposal. However, the waiver primarily addresses integrated care when presenting at a hospital with an emergent medical condition. Integrated care begins at the clinic level to prevent unnecessary hospital visits and stays. It is important to support the care that is being provided at that level. Currently, primary care clinics are not able to bill for the behavioral health services provided during an integrated care visit, due to the fact that the Health and Behavioral Assessment and Intervention (HBAI) codes are unavailable. KAMU has worked closely with the state on this issue and requests that HBAI codes 96150-96155 be opened to allow for billing.

The opening of these codes will provide several benefits to patients, providers and the health care system —

- Increases and honors patient's choice of provider
- Facilitates coordination of behavioral health care across the care continuum
- Improves health outcomes and reduces costs of care
- Provides payment for integrated services provided

Oral Health Care

Unfortunately, the KanCare renewal proposal does not emphasize strong support for *integrated oral health care*, including benefits to KanCare members or supporting payment. Adult dental services remain a value added service and are only preventive or emergent care. The Medicaid population often needs more services beyond one to two cleanings per year or emergency care. Our mouths and bodies are connected; oral health can have a significant impact on our physical health. We do not believe that oral health care is any less important than primary and behavioral health care.

KanCare 2.0 should include, at minimum, the following services for all adult members —

- The current value-added preventive dental benefit for adults should be a standard benefit.
- Adult members have a fundamental right for a basic set of dental services that need to be covered for all adults in order to have a positive impact on overall health, including diagnostic and periodontic services, medications, teledental services, and minor restorative services. (see attachment A)
- Having coverage for adult dental services will not guarantee access to services if KanCare does not have enough participating providers. In order to ensure adults are able to make use of these services, the rates paid for KanCare dental services need to be increased. The rates for restorative and other services have not been adjusted since the 1990s, and the low reimbursement rates are leading to a shrinking dental provider network. It is essential that this trend be reversed in order to meet the growing oral health needs across the state, especially for KanCare adult members.

Credentialing

Providers continue to struggle with the credentialing process, although the Lt. Governor is leading a work group to address this and other issues in the current KanCare system. The waiver proposal suggests the state will eventually automate provider credentialing but does not include a timeline KAMU would like to see the automated provider enrollment system in place prior to June of 2018, when the contracts are awarded, to help prevent duplication of application and unnecessary delays that providers currently encounter.

Value Based Purchasing

In the KanCare 2.0 proposal there is an emphasis placed on "value-based models and purchasing strategies, including MCO and provider-level initiatives." The waiver does not define the parameters for these initiatives and leaves the following questions unanswered —

- Will value-based models, purchasing strategies, and provider initiatives be negotiated with individual providers or will they be transparent across the health system?
- Will participation be voluntary or mandatory?
- How will the value-based programs impact payment to providers?

KAMU would like to see these programs made available to all types and sizes of primary care clinics. Smaller communities could benefit greatly from these types of programs, and taken collectively, those smaller community clinics can offer significant results.

Work Requirements/Independence Accounts

KAMU has strong concerns for the addition of a work requirement for able-bodied adults. Our biggest concern is the additional administrative burden to the State to verify the employment status of beneficiaries. In addition to the administrative burden, tracking the work status of beneficiaries could potentially add a significant increased cost to the State. KAMU also has concerns of poor health outcomes that could result from a beneficiary who might lose KanCare coverage. If they have a chronic health condition, such as heart disease or diabetes, they may be unable to pay for needed health services and medication. Loss of coverage will increase the uninsured rate, forcing additional patients to seek care at a KAMU member primary care clinic and increasing the uncompensated care they provide.

Among these concerns, we have several unanswered questions.

- What is the definition of an "able-bodied" adult?
- Is there a life-time limit for an able-bodied person to receive KanCare? The waiver proposal mentions a maximum amount of coverage of 36 months. Does this mean that at the end of the 3-year period, the KanCare beneficiary would be removed from the program for a certain period of time – or permanently, never being able to access benefits for the remainder of their life?
- The KanCare waiver proposal states that work requirements will build upon Temporary Assistance for Needy Families (TANF). Will there be full reciprocity between the requirements and the system used to track work status?

Exceptions to the work requirements include parents caring for children under the age of six, but it is unclear why this is the threshold, or KanCare or other state resources available for childcare for parents of children over the age of six who may need after school or evening care. GED or vocational education can meet work requirements, however, there is no mention of special

resources set aside to fund these pursuits for KanCare beneficiaries, who would arguably already be doing so if they had sufficient resources. In addition, the proposal does not recognize the wide variance and the availability of living wage work or educational resources across the state, putting rural beneficiaries at risk with fewer available resources and a distinct disadvantage to the urban counterparts.

The proposal includes the implementation of independence accounts for Transmed beneficiaries and would prohibit participants from re-enrolling in KanCare for a specified lock out period. The duration of this lock-out period is unclear. During this period, the consumer could utilize an Independence Account to use to cover the cost of health care expenses. It is far reaching to assume that people who have lost KanCare benefits will have excess resources to establish an Independence Account.

Other Concerns

Service Coordinators

The KanCare 2.0 waiver proposal states that Targeted Case Managers (TCM's) will be replaced with Service Coordinators that are either employed or contracted with the MCO's. This section is not clear on details surrounding the operation of Service Coordinators

- Are Service Coordinators required to be local?
- What provider types are allowed to hire Service Coordinators?
- How will the Service Coordinators be paid? Will this be an expense to the MCO or the provider employer?
- Will patients have the choice to retain existing care coordination services?

Work Opportunities for MediKan Members

A person with a combination of physical and behavioral health conditions is more fragile and requires more support and care. The proposal for a beneficiary to give up their rights to Social Security Administration disability determination in exchange for one year of service on MediKan is worrisome, especially due to the fact that the details of the actual program are not clearly defined. We have the following questions.

- After withdrawing their application for disability determination, would the member now be determined as able-bodied?
- After the 12-month MediKan period is complete, would they be able to apply for KanCare and now fall under the work requirements? If not able to work, would they only be able to get 3 months of KanCare service?
- What additional support and health care services will be provided to this new population?

Kansas primary care clinics served by the Kansas Association for the Medically Underserved are committed to providing quality, whole-person care to all Kansans, regardless of their ability to pay. KAMU and the member clinics are strong partners with the Kansas Medicaid Program and the Managed Care Organizations contracted to serve KanCare members. We appreciate and thank you for the opportunity to provide comments to the KanCare 2.0 Section 1115 Demonstration Renewal Application.

Attachment A

BASIC DENTAL SERVICES

DIAGNOSTIC SERVICES:
D0120 Periodic oral evaluation – established patient - Limited to two in 12 months
D0140 Limited oral evaluation – problem focused – Limited to one in 12 months
D0150 Comprehensive oral evaluation – new or established patient – Limited to one in 12 months
D0210 Intraoral – complete set of radiographic images – Limited to one every 48 months
D0220 Intraoral – periapical first radiographic image
D0230 Intraoral – periapical each additional radiographic image
D0274 Bitewings – four radiographic images – Limited to one in 12 months
D0277 Vertical bitewings – 7-8 radiographic images – Limited to one in 12 months
D0330 Panoramic radiographic images – Limited to one every 48 months
D0411 In-office point of service testing – HbA1c glucose testing to assess periodontal risk factor

PREVENTIVE SERVICES
D1110 Prophylaxis – Adult – Limited to two in 12 months
D1206 Topical application of fluoride varnish
D1208 Topical application of fluoride – excluding varnish – Limited to two in 12 months
D1345 Interim caries arresting medicament application – per tooth
D9110 Palliative (emergency) treatment of dental pain – minor procedure

PERIODONTIC SERVICES
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis

MEDICATIONS
D9610 Therapeutic parenteral drug administered in-office (antibiotics, steroids, anti-inflammatory drugs)
D9630 Other drugs and/or medicaments dispensed in the office for home use
D9910 Desensitizing gel (in office)

CONSULTATION
D9995 Teledentistry – synchronous: real-time encounter
D9996 Teledentistry – asynchronous; information stored and forwarded to dentist or subsequent review

MINOR RESTORATIVE SERVICES
D2140 Amalgam – one surface, primary or permanent
D2150 Amalgam – two surfaces, primary or permanent
D2160 Amalgam – three surfaces, primary or permanent
D2161 Amalgam – four or more surfaces, primary or permanent
D2330 Resin-based composite – one surface, anterior
D2331 Resin-based composite – two surfaces, anterior
D2332 Resin-based composite – three surfaces, anterior
D2335 Resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2391 Resin-based composite – one surface, posterior
D2392 Resin-based composite – two surfaces, posterior

D2393 Resin-based composite – three surfaces, posterior
D2394 Resin-based composite – four or more surfaces, posterior
D2910 Recement or rebond inlay, only, veneer or partial coverage restorations
D2920 Recement or rebond crown
D2931 Prefabricated stainless steel crown – permanent tooth
D2951 Pin retention – per tooth, in addition to restoration

An independent voice for those served by KanCare.

Nov. 25, 2017

KanCare Renewal
c/o Becky Ross
KDHE, Division of Health Care Finance
900 SW Jackson
LSOB –9th Floor
Topeka, Kansas 66612

Re: Proposal to renew the KanCare 2.0 section 1115 demonstration waiver

Dear Secretaries Mosier and Keck.

The KanCare Advocates Network (KAN) appreciates the opportunity to comment on the State's proposed application for KanCare 2.0. KAN is a group of advocates for persons with disabilities and older adults whose collective interests focus on Kansans served by the Kansas Medicaid program, KanCare. These comments reflect the common, overarching concerns identified by KAN partners and have been given as testimony to the KanCare Oversight Committee at its November 28-29, 2017 quarterly meeting.

It is KAN's recommendation that implementation of KanCare 2.0 be extended to at least January 2020.

We recognize this requires another one-year extension for the current KanCare demonstration project but believe that this extension provides the time needed to fully vet the State's proposed changes and the potential impact on providers and the people they serve. We make this recommendation because significant problems, which have existed since the beginning of KanCare, are still unresolved today.

The KanCare 2.0 application fails to lay out a detailed plan for the new program. It lacks financial estimates, and without those, particularly given the State's financial position, we don't have a complete picture of what's to come. Outside pressures such. as a record numbers of children in foster care, state hospitals that are not compliant with federal regulations, inadequate funding, and high turnover and understaffing within State agencies put undue and unsustainable pressure on the KanCare program. These issues should be receiving immediate attention and should be resolved before moving forward with any other significant changes.

Instead, the State instead asks that the bidders come up with a plan. This is not acceptable. The State must

provide leadership and all stakeholders should be involved with a high level of transparency

One of the lessons learned during the initial planning and implementation of KanCare was that the process was rushed. Moving all medical and long term supports and services (LTSS) into a managed care model was a monumental task and not without bumps along the way. We also learned that legislative oversight is a critical missing component.

Like the first KanCare 1115 demonstration application, KanCare 2.0 is being rushed through the process with few details or data and a lot unanswered questions. After reviewing the application, the RFP and attending the recent public forums we conclude that:

KanCare 2.0 does not:

· address or fix the core systemic problems such as an inconsistent and often backlogged application process, the lack of an independent ombuds program and the need for Targeted Case Management across all waivers.

· provide for legislative oversight

· create an independent, legally-based ombuds program for consumers

· make provisions for local contacts to help people with their application and navigate the complex KanCare system

KanCare 2.0 will:

· require an immense amount of red tape and bureaucracy for everyone: the State, MCOs and KanCare members, particularly related to the work requirements. The State needs additional staff and resources to adequately meet its core responsibilities for managing the Medicaid program

· off-load even more of the State's responsibilities to insurance companies. The current MCOs have not demonstrated the capability of providing the LTSS duties for the waiver populations.

· will discourage otherwise eligible persons to apply for KanCare services.

· reduce consumer protections and due process.

· expand the state's MediKan program, increase payments for uncompensated care and and create a new Health Savings Account (HSA) subsidy program. All of these programs have admirable goals but could all be eliminated by expanding the state's eligibility per the ACA. This would have a much broader positive effect in a much more streamlined manner.

KanCare 2.0 does not provide adequate detail to determine:

· how KanCare 2.0 will improve access to care or services

· the process for determining readiness?

· predict the geographic/regional economic impacts of KanCare 2.0. What provisions are made for persons living in parts of the state with high unemployment

On-going issues not addressed under KanCare 2.0

Ombuds Program: The current KanCare program continues to struggle with an absence of local points of

contact to help persons who depend on KanCare services. Without an independent, legally-based, conflict-free ombuds program recipients have little to no one to help them navigate a system that is stacked against them.

Eligibility Backlog: We still hear from consumers who have been waiting for months beyond the 45-day requirement for their eligibility to be determined. The Clearinghouse continues to "lose" documents forcing applicants to re-submit the same information over and over again and puts them at the end of the line each time. This creates an unnecessary administrative burden on applicants and their families who struggle to navigate this complicated and cumbersome system. KanCare 2.0 will exacerbate this problem with a new work requirement that will further burden the eligibility process.

Legislative Oversight The legislature has repeatedly expressed a desire for increased oversight of the KanCare budget and policy directives. Provisos passed in FY 2016 and 2017 budgets prevented such an action without legislative consent and did so again in 2017 for the 2018 and 2019 budgets. The Governor vetoed that language. The legislative intent couldn't be more clear; it wants oversight of the KanCare budget and overall program. We believe that this committee should strongly oppose any attempt to make substantive changes to the KanCare system without legislative approval.

Service Coordinators vs TCM: KanCare 2.0 introduces a new MCO position of "service coordinator" which appears to replace the current "care coordinator." It appears that this service coordinator then contracts with community providers to coordinate care. During the recent public forums, State staff said that some people will have a service coordinator, some will have both a service coordinator and a community coordinator but had no details about the responsibilities of the service coordinator, the ratio of caseloads to service coordinators or the capacity of community organizations to provide services. This creates more burdensome bureaucracy and adds to the confusion. More details are necessary to ascertain how this will work. Without careful and critical examination of the yet-to-be-disclosed details, a rushed implementation could be very disruptive to them and their families.

TCM is still offered for persons with intellectual/developmental disabilities and for children with serious and emotional disturbances so the infrastructure is still in place to restore it for the remaining five waivers.

Waiting Lists: The plan fails to address providing services for the 4,653 persons with physical and intellectual/developmental disabilities, many of whom face a wait of eight years.

Work Requirements: The experience of other states show us that work requirement will almost certainly cost more money that it saves. The requirements have proven to result in an immense amount of bureaucracy and red tape with little return on that investment. Helping people achieve a high level of independence is a worthy and admirable but without supports and regional employment conditions, the only reason to have a work requirement is to deny services, particularly to single parents.

The goal of independence could be achieved with employment support programs without having the punitive sections of this provision. This would also reduce the bureaucratic burden on an eligibility system that has been failing for over 2 years. The exemptions need to be looked into more deeply. As of right now, people on the waiting lists are not explicitly exempted from the requirement, caregivers for seniors are not exempted, and SSI disability is the highest possible definition of disability to use and we should consider the fact that many people have chronic conditions that do not yet meet that level, but still would experience challenges meeting the

requirement.

Punitive 36-month lifetime limit: A new provision for the work requirement population caps health coverage for some at 36-months for life. We strongly oppose this provision. Once again we underscore the undue stress on families, many of those single parents, that are already struggling. The 36-month lifetime cap will leave many Kansans facing a life without health coverage, further exacerbating chronic and/or mental health conditions.

Consumer due process: During the early days of KanCare, the State and members of the disability and older adult advocacy community negotiated an appeals process for HCBS consumers. We agreed that a person who received a notice of action which reduced or eliminated services, those services would continue during the appeals process. We agreed that the person would have 33 days to appeal to the MCO and then an additional 33 days to appeal to the Office of Administrative Hearings (OAH) through the fair hearing process. KanCare 2.0 reduces the time to appeal to OAH to 10 days before services are cut or eliminated. They can still appeal, but service cuts happen unless OAH overturns it. This is a serious change that was not disclosed during the public forums.

The current process was negotiated between stakeholders and then-Medicaid Director Kari Bruffet. With 2.0 the State appears to be arbitrarily breaking that agreement without input from stakeholders. There is no need for this change. CMS sets a minimum standard not a hard requirement and the current policy is fine under that standard.

The plan as described in the application is weak. Details are few and there appears to be a number of ideas that are still "under consideration" even though the State plans to implement Jan 1, 2019. Lacking the opportunity to comment on specific policy changes and a commitment to the pilot projects it is difficult to trust that KanCare 2.0 will improve the health and quality of life of those it serves. Without engagement on the front-end between the State and stakeholders it is difficult to trust that the promises made here will be kept or there will be any recourse when/if they are broken.

This plan calls for $20 million for uncompensated care, a huge expansion of service coordination without outcomes to measure its effectiveness, a variety of pilot programs which lack detail or even a commitment that they will actually be implemented. The State proposes a broader array of services including work supports, with little detail. How can all of these "improvements" be accomplished without cutting services, limiting eligibility and still be cost neutral? Until more details are released we do not think this is feasible, and we do not have enough of the detail to know that it will be a quality system. .

It is for all of the above reasons that we ask that the this committee pass out a recommendation to the 2018 legislature that "KanCare 2.0" be delayed until at least 2020. State staff repeatedly told public forum attendees that they have a year to flesh out the details. Those details and policy changes will make or break an already fragile system and should be worked out in advance and in cooperation with consumers and stakeholder in advance of the implementation of the next 1115 demonstration project. As we learned in 2012, rushing to implement an ill-defined program without adequate planning will guarantee problems for providers, consumers and families.

We believe that the State has not demonstrated the ability to handle the most basic of tasks required to run the program and to make drastic changes while these concerns still exist drains much needed resources from the problems at hand. The State should be required to show competency in these tasks before it is allowed to make

drastic changes that we believe it lacks the capacity to handle.

A thorough and inclusive planning process is necessary if KanCare is to meet its goals of serving families, older adults and persons with disabilities in a financially responsible manner. Another rush toward implementation without adequate State resources or legislative oversight undermines the program and puts at risk 400,000 Kansans who depend on KanCare for their health care and supports. KAN stands ready to participate in that planning process.

Kansas Action For Children

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Topeka, KS 66603

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Shaping policy that puts children first

November 22, 2017

Amanda Gress, Director of Government Relations
Kansas Action for Children
Public Comment for KanCare Renewal

Thank you for the opportunity to offer comment on the proposed renewal of KanCare. Kansas Action for Children's (KAC's) vision is to make Kansas the best state to raise a child and to be a child, and KAC shapes health, education, and economic policies that improve the lives of Kansas children and families. For that reason, KAC promotes policies that strengthen KanCare, which provides one in three Kansas children with health care coverage. As Kansas considers how KanCare can best serve Kansas children, we offer the following comments:

KAC opposes the proposed work requirements for Medicaid in the KanCare 2.0 renewal application. Adding these requirements for some parents to maintain health insurance is counterproductive and ultimately risks their children's health, well-being, and potential to succeed in school and in life:

- **Ending health care coverage makes it *less* likely parents will be able to work.** Chronic or acute conditions can make working difficult or impossible for parents who are sick. Punishing parents who are unable to find work by ending their eligibility for Medicaid will prevent them from getting the treatment they need to be healthy. Medicaid is a critical work support that helps parents find work and keep working, and it is inappropriate to condition coverage on current work status.

- **Ending parents' health care coverage will harm Kansas children.** Children's health reflects the health and well-being of their parents. When parents do not have health insurance, children are less likely to get regular checkups and essential preventative care, like immunizations. When parents are not physically and mentally healthy themselves, they are not able to provide the best possible care for their children. Families without health insurance are also financially vulnerable to unexpected medical emergencies.

- **This provision will increase the number of Kansas children without health insurance.** Kansas' experience with other public programs indicates that this type of requirement will likely cause a sharp reduction in the number of both parents **and** children served. Children are three times more likely to be insured when their parents also have health insurance – and ending parents' health coverage risks that their children will become uninsured as well.

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KAC opposes the proposed lifetime limits for Medicaid in the KanCare 2.0 renewal application. Adding a 36-month lifetime limit for some parents will similarly reduce their ability to work and risk children's health and well-being. This limit will cut off care for Kansans with chronic conditions who are working in low-wage jobs that do not offer health insurance, jeopardizing the health and well-being of parents and their children.

Medicaid's purpose is to improve health, and these provisions included in the KanCare 2.0 renewal application run counter to that goal. Adding new eligibility requirements will further strain KanCare administration, creating additional red tape as the state monitors and verifies work activities. Given ongoing challenges regarding the KEES system, the Clearinghouse, and application backlogs, Kansas should not add complexity to the KanCare administrative system. **We encourage the state to reconsider proposals that will risk the health and well-being of children and their parents.** Thank you for the opportunity to provide comments, and please do not hesitate to contact me [redacted] if Kansas Action for Children can answer questions.

Sincerely,

Amanda Gress, Director of Government Relations
Kansas Action for Children

Return to Index

From: Anna
To: KanCare Renewal
Subject: KanCare 2.0 questions
Date: Monday, November 20, 2017 4:34:27 PM

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1. How would the role of the community service coordinator as described in the RFP affect targeted case managers working for community service providers through the IDD waiver?
2. Is it just terminology or is the community service coordinator fundamentally different from the IDD targeted case manager of today?
3. Will both the MCO Care Coordinator and Targeted Case Manager produce separate PCSP documents?
4. Who will be responsible for developing the PCSP that meets the requirements of K.A.R. 30-63-21 for IDD providers?

Long term supports and services for persons with developmental disabilities do not fit into a medical model, and several states have carved them out when adopting a managed care model. IDD services should be carved out from KanCare.

From: Steva Stewart
To: KanCare Renewal
Subject: KanCare 2.0 questions
Date: Monday, November 20, 2017 2:33:47 PM
Importance: High

To whom it may concern,

I have been a Targeted Case Manager for nearly 10 years and have worked in the IDD field since 1995. I am curious regarding some proposals to the KanCare renewal. Below are my questions and hope you are able to provide some clarification. Thank you for your time and consideration.

1. How would the role of the community service coordinator as described in the RFP affect targeted case managers working for community service providers through the IDD waiver?
2. Is it just terminology or is the community service coordinator fundamentally different from the IDD targeted case manager of today?
3. Will both the MCO Care Coordinator and Targeted Case Manager produce separate PCSP documents?
4. Who will be responsible for developing the PCSP that meets the requirements of K.A.R. 30-63-21 for IDD providers?

Sincerely,

Steva Stewart

SKIL Resource Center Inc.
More Resources for People with Disabilities
SKIL of Western Kansas • PO Box 366 • Hays, KS 67601
www.skilonline.com

TO: KS Department on Health & Environment
KanCare 2.0 Renewal Application Comments

Thank you for the opportunity to comment on the KanCare 2.0 application! In general, after reviewing the document it was obvious that the State paid attention to previous comments about issues and concerns made by the people with disabilities, advocates, and providers. One big concern, while I was reviewing the document in its entirety, was how difficult it could be to understand for many people with disabilities, seniors, and family members. It seems to me that these are the most important individuals to hear from, so the document should have been written and formatted for them to understand. I have worked in disability rights and advocacy for 40 years but still found it somewhat difficult to follow. Even in the public comment sessions for the providers, the information was covered too fast for the average person. I hope the sessions for consumers went slower and given people enough time to comprehend the information to ask questions. I am sure there are still some people who are apprehensive about asking questions in front of people.

On **page 1** the original goals of KanCare are stated in the second paragraph, as well as a very brief Historical Summary below. It would have been helpful to see some data or analysis supporting moving forward with renewal of KanCare. This does not tell us much. The goals of the 2.0 at the end of paragraph 2, are wonderful if supported into fruition.

Page 2, paragraph 2, "The KanCare program integrates medical, behavioral, and long-term care health delivery systems and covers mandatory and optional services..." Where is LTSS? Long Term Services & Supports are not the same as long term care. LTSS is provided and directed in the community, not in a facility. LTSS must be added into this sentence.

Page 3, 3rd paragraph, "... the goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid..." So positive for the State to have the social determinants connected to people with disabilities achieving healthier independent lives. SKIL will be pleased to work with the State on transportation, housing, employment, etc. These issues are major deterrents for independence and success for Kansans with disabilities, especially in the rural areas of our State.

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Page 4, Three hypotheses to accomplish the goal of KanCare 2.0 are very valuable and reachable. To do this, there needs to be more details as to how it will happen and be paid for to succeed. We know Care Coordination has certainly not been very successful in assisting individuals to succeed in healthy, independent lives. There have been many holes that individuals have fallen through proving care coordination to be ineffective for countless people. Local community based organizations are the best to carry out the service direction using peers/people with disabilities of all ages that can assist from experience. Sufficient funding must be available for these local community based organizations to be successful in providing the service coordination needed by individuals to lead healthier independent lives. Pertaining to **Figure 3 Themes and Initiatives Under KanCare 2.0**, in order to make progress to have significant impact in the areas, funding and collaborative efforts will be required. Again, local community based organizations as true partners will be essential to assure these proposals are successful.

Page 5, *Coordinate Services to Strengthen Social Determinants of Health and Independence, and Person Centered Planning*, Care Coordination under the current KanCare did not meet the promises that individuals and advocates understood would be available. The term "Care" bears a medically supervised philosophy. The term "person centered" brings with it a larger spectrum of services available, as well as the planning and delivery with them. In **Figure 4. Key Elements of the KanCare 2.0 Service Coordination Model**, shows how expansive the plan for this service is. It would be much more beneficial if more details had been presented as to the budgets available and how the costs will be covered for this wide array of services. The top circle which states "Provides person centered care", would be appreciated more by people with disabilities if the term used is "Facilitates person-centered planning and delivery of services and supports".

Page 6, Plans of Service and Person Centered Service Planning, First the tools that are discussed are so important to the approach of the philosophy of this effort that it would have been very helpful to have them attached for review. If the tools are to be truly person centered then why not make them available for people to review them? I give credit in using plans of service and person centered service plans, not plan of care or person centered care plan in some areas of the application but it should have been carried throughout. In the third paragraph, MCOs do <u>not</u> develop the plan. Individuals should guide and develop their plan along with the MCO and others that the individual chooses to be involved. Then the bottom paragraph states members receiving service coordination are <u>encouraged</u> to participate in their individualized plan of service development process. Not Encouraged! Members should lead/guide and direct their plan to the maximum extent feasible with others they choose to assist, if anyone. But individuals must absolutely be involved in leading their plan toward independence. Person centered philosophy and approaches should used at all steps, including service coordination, assessment, planning, implementation, and evaluation and monitoring.

Page 7, Person Centered Service Planning states " MCOs will ensure that members participate in the person centered service planning process that is compliant with federal requirements, (e.g., 42 C.F.R 441.301(c)), State law, and the State's PCSP policy. What is the State PCSP policy?

It would have been helpful to attach this? According to the Federal regulation cited, "the consumer should lead and direct the planning process and all interactions with the MCOs with as much control as possible". More details on the procedures and execution of the service plan would be helpful and are important. Sometimes having MCOs "considering" unpaid and natural supports can be a conflict of interest. The MCOs many times feel that people who can be considered as natural supports should automatically be unpaid. It is very important that these situations are looked at very carefully because many times a natural support works outside the home to the extent that it is extremely difficult for them to offer a great deal of support. And in other situations the member may choose a family member to be their DSW to the level that the person cannot work outside the home, so it is important that this person be paid for the supports. This can be common with seniors who do not easily trust strangers. And sometimes there are parents that want to be there for their children who needs assistance but must have an income also. I visited with a woman who was approved for HCBS but the MCO gave her very few DSW hours because of her husband living in the home. But the husband who was a truck driver worked six days a week, leaving in the morning at 6:00a.m. and arriving home between 6:00-8:00p.m. Yet the MCO expected him to cook all her meals, do laundry, shop, and do housekeeping. He made her breakfasts before he left in the morning. They set up Mom's meals for several days a week for lunch. But he still had to make up the rest of the meals. The poor man was getting no sleep. The woman was feeling guilty and like a burden on her husband. And the stress on their marriage after being together almost 40 years was terrible. This is too much to expect of people. The MCOs in charge of making certain that members "participate" carries with it a huge conflict of interest. There needs to be more discussion on this or the MCOs will be allowed to follow their own concern which may not follow the Federal regulation and most importantly may not be best for the member. The MCOs are in charge of too many pieces of the puzzle that undoubtedly causes problems. Peers to members, people with disabilities should be utilized by having them use their own experience with planning and using services and supports that make them the best experts.

Pages 7 & 8, Community Service Coordination, bullet points are great to see listed. I would suggest a change to the third bullet point, "Promotion of self-care and independence". I would suggest changing it to "self-direction". Wonderful plan requiring MCO's to work with community agencies locally who are well positioned to assist people with disabilities who sometimes need extensive, far reaching supports to attain their goals and independence. It would be beneficial to see more details regarding costs and resource plan. I believe this was an area that was requested by advocates, which we appreciate.

Page 8, Service Coordination Pilots, "the State is considering the implementation of potential pilots"? This sounds very "iffy" as to what or if and how they will happen. These are important projects that I know are significant to the disability and provider communities. The use of the words "considering" and "potential" does not seem to give these projects a lot of weight. Does the State see them in a certain priority ranking? More detail on each of the projects would be helpful, although the projects will overlap for some people's needs. It would good if the public could give input after details are determined. In **Figure 7, Individuals with Disabilities & Behavioral Health Conditions**, both bullet points are extremely important, while reaching the

first bullet, assists in making the second bullet less insurmountable. The third population, Adults with Chronic Conditions makes sense in helping individuals to reach goals of healthier lives. Given that SKIL serves many of our customers in rural and frontier counties in KS, this project is of great interest to us. The lack of medical professionals in these areas has become detrimental to the health of many of our people. The definition of "provider" needs to include direct support workers. This project could connect potential workers with information, support, and training needed to provide critical personal assistance to individuals. The lack of direct support workers in the rural and frontier areas is really becoming critical.

Page 9, *Promote Highest Level of Member Independence*, the introductory paragraph to this initiative was written really well. The only piece that would have improved it is "self-direction". KS passed a self-direction law in 1989, the only of its kind, which gives individuals with disabilities the right to self-direct without regard to age or disability. An individual having the ability to self-direct their own goals, plan, and services is the ultimate example of " *Promote Highest Level of Member Independence*", therefore self-direction needs to be encouraged and elevated if we are to truly lead a pathway to increasing the independence and community integration, as well as employment, of members. Having control over the services and supports on our lives is integral to our full integration and employment that is the visualization of our State and KanCare program.

Page 9, Employment Programs, having a separation line between "able bodied" and "disabled" does not warrant encouraging people on both sides of the line to reach their goals of independence. Expectations should be set higher for people with disabilities to become employed. Most people with disabilities want to employed but still have a great deal of fear and concern. Even individuals on the WORK program tend to stay below their limit of earned income as to not jeopardize their SSI/SSDI, and other benefits they access. Their needs to be more incentives for people with disabilities to become successful in employment. Even the WORK program has some limitations that exclude people. Increasing the Protected Income Level is needed or at least allowing earned income to be exempt from the PIL.

Page 10, Population, the following KanCare members will **not** be subject to work requirements listed. I heard clarification at a public forum that this list includes individuals on a HCBS wait list. I see #5 says "Members who have disabilities and are receiving Supplemental Security Income (SSI)". What about members on SSDI but not receiving or on a waitlist for HCBS? We do not see this population listed.

Page 13, Work Opportunities for MediKan Members, second paragraph, "State is <u>considering</u> providing a voluntary choice..." Again this is sounding very wishy washy for a non professional term. Speaking on a more professional term, this sounds very noncommittal by the State. The requirement of MCOs to work with local community partners is positive. Also Vocational Rehabilitation needs to build their partnerships up again across the State. Many of these relationships have weakened because of VR's inability to hire staff and some staffs lack of interest in partnering with others in the community. We hear this may be making some improvements in some areas but it will be vital for these types of projects to be successful.

Page 14, Work Opportunities for Members who have Disabilities or Behavioral Health Conditions, we believe a program that will not punish but incentivize members toward gainful employment would be well received. Offering the services listed would definitely be beneficial in helping members to be successful. Independence Accounts, could be beneficial to members wanting to or currently working by allowing them to create savings or assets that they are currently restricted from. Employment should be encouraged but by including a penalty that would prohibit members from re-enrolling in Medicaid for a period of time will definitely deter members from trying. The fear that individuals would not be able to go back to KanCare if their health, disability or family status were to change, would definitely discourage members from taking those steps.

Page 16, Figure 10. Examples of Value-Based Model and Purchasing Strategies, We support this improvement in service delivery and payment structures. More information on details would be helpful.

Page 23, *Improve Effectiveness and Efficiency of State Medicaid Program*, Aligning MCO Operations and standardizing the tools and processes of MCOs is very much welcome news.

Page 25, Figure 13. Enhanced User Experience, In order for some members to use the data system, it will have to be accessible and interface with screen readers, plus many access features required. The other concern is how do we assure that members have internet access? We should discuss some possibilities for this to occur.

Page 27, Performance Measures, the performance measures of MCOs providing LTS&S should be included into state policy and standardized.

Page 31,Network Adequacy, This discussion should include the shortage of direct support workers which as stated earlier, is getting very critical.

Pages 31 & 32, we believe there is some need for discussion when looking at the decrease in NF residents, whereas looking at the FE and PD numbers, what is happening to people. These numbers do not correlate as they should.

Page 32, Dental Issues, Not sure what the plan is to close the gaps in access to dental care for members in the rural, frontier counties, but this has been a major health issue for a very long time.

Page 42, CAP, We appreciate the inclusion of the CAP to this. It would be helpful if we were given more details on each bullet as to the status of where it is and where it is going.

SKIL would like express appreciation for the opportunity to comment on this renewal application. We wish there was more details and budgetary information in many areas. Our overall thoughts are that the State must assure that ALL individuals who need LTSS have them

available to them and that these individuals have the right to lead and develop their plan, and to self-direct their plan which includes goals that they set. If they need assistance with these things, then they should have the right to chose others, such as a family member, friend, or advocate to assist them. For the strategies to reach their goals the individual can be assisted by the team but again the member must be in control. PWDs needing LTSS have the right to have as much control as possible in their lives but this level should not be determined by others, and certainly not by the MCO who benefits from the potential outcomes for the individual. The member guiding and directing their own plan also helps the individual to gain some skills that could benefit them in other areas of their life such as employment. So if we want people with disabilities to truly be successful in their lives then let them direct their own lives and guide their independence. of course none of this is possible if we do not take on the development of our direct support workforce. It is vital that we make people understand what an important position this is to have, making such a difference in a person's life. Also requiring MCOs to partner and work with local community based organizations is important for this plan to work. We believe this has been a huge missing piece. Individuals want to have successful lives just like everyone else. Partnerships between MCOs, local community based organizations, and vocational rehabilitation offices can make a difference in whether or not a member is successful.

SKIL is committed to partner with entities that are similarly dedicated to assuring that Kansans with disabilities and seniors receive the LTSS, along with additional services, necessary for them to achieve healthier lives and independence. I hope we have the opportunity to comment further after more details are presented.

Sincerely,

Lou Ann Kibbee, Systems Advocacy Manager
Southeast KS Independent Living (SKIL) Resource Center
[redacted]

On Behalf Of:

Shari Coatney, President & CEO
Southeast KS Independent Living (SKIL) Resource Center
[redacted]

From: Vicki Doyle
To: KanCare Renewal
Subject: KanCare 2.0
Date: Tuesday, November 21, 2017 5:00:21 PM

Will these jobs the state helps us find, will they fit our educational level? Are there any penalties if the consumer chooses not to take that particular job?
Thanks
Vicki L. Doyle

UnitedHealthcare
Community Plan

November 26, 2017

KanCare Renewal
C/o Becky Ross
KDHE, Division of Health Care Finance
900 SW Jackson, LSOB –9thFloor
Topeka, Kansas 66612
Submitted to: kdhe.kancarerenewal@ks.gov

RE: KanCare 2.0 Demonstration Renewal Request - UnitedHealthcare Community Plan Comments

UnitedHealthcare Community Plan of Kansas appreciates the opportunity offered by the Kansas Department of Health and Environment (KDHE) to provide feedback on the state's draft waiver application for the KanCare 2.0 1115 Demonstration Waiver.

We support the state's mission to leverage the success of the KanCare program to further improve health outcomes, coordinate care and social services, address social determinants of health, facilitate achievement of member independence, and advance fiscal responsibility to help Kansans achieve healthier, more independent lives.

As an experienced Managed Care Organization (MCO), UnitedHealthcare Community Plan is honored to serve approximately 130,000 Kansans through the KanCare program today. Through our service to 6.4 million Medicaid consumers across 26 states, including 14 managed long term services and supports programs, two Financial Alignment Demonstrations, and Duals Special Needs Plans (DSNP) in 27 markets, we have actively partnered with states in implementing transformational Medicaid program design. We have reviewed the draft waiver application through the lens of our experience and offer the following comments for KDHE's consideration.

If any additional information or insights would be helpful, please contact me.

Kevin Sparks, CEO
UnitedHealthcare Community Plan, Kansas
[redacted]

UnitedHealthcare
Community Plan

COORDINATE SERVICES TO STRENGTHEN SOCIAL DETERMINANTS OF HEALTH AND INDEPENDENCE, AND PERSON CENTERED PLANNING

Plan of service and person centered service planning

The KanCare 2.0 waiver application includes significant new programmatic requirements to social determinants of health and independence in the service coordination for many KanCare members. To support this, the state is seeking to use a state-designed health screening tool to support assessment and service planning. Given the focus on, and intention to advance, person-centered approaches to support the integration of social determinants of health and independence in care planning and management for KanCare members, we recommend that social determinants be incorporated into the overall health assessment process for members.

To do so, the state can work with the MCOs to leverage a separate assessment tool specifically intended to determine needs relative to social determinants of health and independence, or alternatively, Kansas can incorporate relevant questions into the state-designed health assessment tool. Aligning the assessment of health with social determinants will allow MCOs to efficiently and effectively define the individual's full spectrum of needs and incorporate the required services into the Plan of Service and/or Person-Centered Planning tools and processes.

Funding to support integration social determinants of health and independence

With the inclusion of new requirements for KanCare to incorporate social determinants of health and independence in the state's waiver application to the Centers for Medicare and Medicaid Services (CMS), it appears that Kansas is seeking federal funding to support the integration of social determinants into the Medicaid care management processes. However, the current draft of the waiver application is not explicit in its request for federal Medicaid matching dollars to support the integration of social determinants, outside of the value-based purchasing strategies the state intends to pursue through dollars provided via the safety net pools.

Other states, including California and Washington, have received federal match for integrating social determinants into traditional Medicaid care management approaches through their recent 1115 Demonstration Waiver projects. That funding is unique and differentiated from the dollars traditionally received as federal match for Medicaid-covered services that are built into the capitation rates paid to the MCOs.

To ensure the appropriate allocation of federal dollars to support the screening and the integration of social determinants of health and independence into the service coordination process, we recommend that the state include explicit language in the KanCare 2.0 waiver indicating that the state is seeking unique and differentiated federal funding, separate and apart from federal matching dollars, that reimburse the state for the provision of traditional Medicaid services.

UnitedHealthcare Community Plan

Telehealth

Throughout the state's waiver application, there are references to the expanded use of telehealth to support service coordination, including face-to-face monitoring. We believe that telehealth is a powerful avenue to help expand care delivery and provide access to care and improve outcomes for members across Kansas, particularly those living in rural/frontier areas of the state experiencing provider shortages.

We encourage Kansas to consider evaluating its state telehealth-related policies and remove regulatory barriers that create restrictions for patients accessing telehealth services limiting the use and scope of telehealth as a care delivery model. We recommend that KDHE work with state policymakers to consider the following regulatory best practices we have found support expanded use of telehealth and increase patients' access to needed care:

- Ensure originating site requirements are flexible to accommodate the patient where they are located (home, clinic, facility) for all appropriate services;
- Allow providers the flexibility to determine the need for establishing an in-person relationship as a prerequisite for telehealth on a patient-by-patient basis, considering the patient's capabilities and limitations;
- Allow sufficient flexibility in the value based purchasing requirements for MCOs to include models that incentivize telehealth practices.
- Consider including bonus payments for thoughtful use of telehealth that provides cost savings (e.g., avoids use of medical transportation from a rural clinic/hospital to an urban hospital for specialty care/consult);
- Expand facility fee reimbursement to originating site facilities through value-based payment models/contracts;
- Ensure that within a value-based model, telehealth visits are not reimbursed at a lower rate than in-person visits for the same service.

PROMOTE HIGHEST LEVEL OF MEMBER INDEPENDENCE

Independence Accounts

We support the state's goals to leverage the capacity and infrastructure of its MCO partners to assist members in a successful transition from Medicaid to commercial health insurance coverage. Introduction of the Independence Account to the TransMed program can be a helpful tool in helping keep Kansans working while obtaining the health care services their families need.

The waiver application provides minimal detail regarding the design of the Independence Account structure, however standing up an account infrastructure with the capability to manage state-approved transactions, even for a small number of enrollees, will require significant funding and infrastructure investment to implement and require resources to manage ongoing administration. To ensure the state's investment in the Independence Accounts is viable, we recommend mandatory enrollment of all eligible individuals in the Accounts rather than a voluntary model. If enrolling in the Account is voluntary there is potential that not enough

UnitedHealthcare Community Plan

TransMed consumers would enroll to support the level of resources required to stand up the program.

Given the intention to limit use of the Accounts to the small number of individuals in the TransMed population (which includes fewer than 6,000 citizens), we recommend the state centralize the administration of the Accounts to one MCO. Centralizing the accounts with one vendor will minimize the administrative cost of the program such that KanCare is paying for only one instance of the program rather than three. Leveraging one MCO will eliminate any challenges that could be experienced by providers who will be interacting with the Accounts and support the state's efforts to reduce the challenges providers face in interfacing with multiple MCOs account platforms.

Kansas should consider an MCO partner with significant experience and strong track record in managing health reimbursement and health savings accounts and both Medicaid and commercial populations. This type of experience will ensure that the MCO managing the Accounts is fully prepared to manage not only the technical and financial administration of the program but also the unique clinical and social needs of individuals and families who are transitioning off of Medicaid coverage due to increased income.

If the state is interested in leveraging its investment in Independence Accounts for the TransMed population to support independence among the broader KanCare population, we recommend that Kansas consider the following design elements for a future state of the program:

- To support broader goals of supporting independence and successful transition and further leverage the planned investment in the Account infrastructure, extend the availability of Independence Account to the "able bodied" population targeted for work requirements;
- Leverage consumer-focus, high-deductible-health plan-like tools to assist in successful member transitions to commercial coverage;
- Treat the defined state contribution level as a deductible for medical services; and
- Include some level of member contribution (very modest premium) tied to straightforward, basic incentives and financial literacy tools.

The affordability gap in insurance coverage for those transitioning off of Independence Accounts (just above 38% of the federal poverty level) before qualification for cost-sharing reductions and premium subsidies in the marketplace (100% of the federal poverty level) is significant. Barring members from re-enrolling in Medicaid after participating in Independence Accounts (as currently written in the waiver application) could lead to an increase in uninsured Kansans and potentially exacerbate uncompensated care challenges. To that end, we recommend that the state modify its position and allow members who have Independence Accounts to become Medicaid eligible again if/when his/her income drops below the state's income threshold for Medicaid eligibility.

As Kansas considers its coverage strategies for individuals achieving independence through the new tools to be introduced to the KanCare program as well as the state's broader system transformation goals, we recommend that Kansas consider a new approach: achieving coverage and supporting independence by removing disincentives to work and family growth created by the current system of fragmented eligibly and financial rules and consolidating the

UnitedHealthcare Community Plan

administration of KanCare and the state's subsidized marketplace programs (individuals receiving federal subsidies to purchase cover on Healthcare.gov, those earning 100-400% of the federal poverty level (FPL)). To achieve this model, Kansas could couple its 1115 Demonstration Waiver with a Section 1332 Innovation Waiver request. Such an approach would:

- Consolidate the Medicaid and individual market options into a single, subsidized state-based market that tailors benefits and cost sharing requirements across the income continuum from 0-400% FPL;
- Be supported by the existing Medicaid managed care system and aligned with the concepts outlined in KanCare 2.0;
- Allow individuals to enroll and remain enrolled with a single insurer regardless of income change from 0-400% FPL, thereby reducing the impact of churn as individual income level changes and analogous coverage options change;
- Support individuals and families in growing their incomes and career paths without threat of losing coverage due to income level changes and offering affordable coverage as individuals earn income above Medicaid financial eligibility thresholds;
- Streamline eligibility and program administration for public medical assistance to address eligibility cliffs and coverage affordability issues as individuals increase income;
- Provide consistent access to services and supports for individuals whose permanent reliance on public assistance is necessary;
- Maximize federal funding mechanisms;
- Emphasize the shift towards commercial market insurance models for the Medicaid population and more effectively supports independence in alignment with state goals; and
- Simplify system administration to accelerate integration of services, penetration of value-based purchasing strategies and advance innovations from the private sector (such as commercial insurance strategies).

If these concepts resonate with Kansas policymakers, we would welcome the opportunity to discuss these concepts further with KDHE officials at a time that is convenient for you.

Employment programs, including work requirements and voluntary work opportunities

The waiver application includes details regarding KanCare member eligibility and maximum coverage for individuals who are subject to work requirements. The language and table on page 11 of the state's application imply that individuals who are subject to work requirements and meet those requirements are only provided up to 36 months of KanCare coverage. We recommend that the state provide additional clarity on this section of the application to ensure stakeholders understand the state's intention with the proposed time limit.

Limiting coverage for those who meet work requirements could create challenges in achieving health outcomes as individuals who are working and exceed a 36-month timeline will be required to dis-enroll from the MCO managing their care. Research has shown that continuity of care, particularly among the Medicaid population, is critical to keeping individuals healthy and maintaining health care costs. According to the Kaiser Family Foundation, interruptions in

UnitedHealthcare Community Plan

Medicaid coverage can lead to greater emergency department (ED) use as well as significant increases in hospitalization for conditions that can be managed on an ambulatory basis.[1]

Kansas could consider the affordability gap for insurance coverage for individuals meeting work requirements under this program design. If an individual is meeting work requirements but is not exceeding the financial eligibility limits for KanCare through the wages earned from their job, it is unlikely they will be able to afford other health care coverage, particularly because subsidies to purchase coverage on the health insurance marketplace start at an income level significantly higher than the top financial eligibility level for KanCare. This approach could lead to an increase in uninsured Kansans and potentially exacerbate uncompensated care challenges. To that end, we recommend that Kansas not include a time limit for KanCare coverage for individuals subject to, and successfully meeting, work requirements.

Additionally, the work requirements detailed in the waiver application for able-bodied KanCare enrollees closely align with TANF program work requirements. We encourage Kansas to ensure that work requirements for KanCare also similarly align with the state's requirements for the Supplemental Nutrition Assistance Program (SNAP) as there is likely significant overlap in the populations accessing SNAP, TANF, and KanCare. Aligning requirements across programs will ensure that individuals are able to work to access needed benefits, streamline the state's administrative burden in managing multiple fragmented work programs and eliminate undue burden for individuals attempting to navigate varying requirements.

DRIVE PERFORMANCE AND QUALITY IMPROVEMENT FOR BETTER CARE

Value-based models and purchasing strategies, including MCO and provider-level initiatives

We are supportive of the state's goals to drive innovative delivery system reform by expanding value-based purchasing strategies. Leveraging the capabilities and infrastructure of the MCOs to drive stronger engagement in quality improvement at the provider level is a smart and efficient use of the state's resources.

Through our experience implementing value-based models in other state Medicaid programs, we have found that when provider participation is voluntary, there is often limited engagement and enthusiasm among providers to enter into a value-based contract arrangement. The administrative burdens facing providers can be significant and value-based contracting can compound those challenges, creating a barrier for MCOs in meeting value-based contracting thresholds. To help ensure widespread adoption of value-based models to drive system transformation at the provider level, we recommend that Kansas mandate or heavily encourage

[1] Kaiser Family Foundation, "What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence". August 2013. Available at: http://kff.org/report-section/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence-issue-brief/

(potentially through the use of enhanced incentives) provider participation in value-based contracting with the MCOs.

This requirement should be coupled with the recognition that "one size does not fit all". The incentive structure that motivates one provider to engage meaningfully in a value-based arrangement will not necessarily motivate all other providers. MCOs will need to work with providers to understand their motivations, pain points, and opportunities to design reimbursement structures that drive value for the provider. MCOs should be afforded flexibility in the state's value-based purchasing requirements to work with various providers in designing alternative payment models and value-based contracting schemes that meet them where they are in their ability to accept risk and achieve quality measures across the continuum of reporting, process, and outcomes.

Quality improvement

The waiver application highlights the state's intentions to conduct its own analysis of MCO claims data and work with each individual MCO to strengthen network adequacy and improve quality of care. We encourage the state to reconsider this process as it is costly and duplicative.

In contracting with MCOs, Kansas outsources both the care management and administrative components of their Medicaid programs to trusted, experienced health plans, while the state provides key oversight. MCOs are contractually obligated to meet quality and access standards set by the state and CMS. Kansas also separately contracts with Kansas Foundation for Medical Care (KFMC) to serve as an external quality review organization (EQRO) to provide the state an unbiased evaluation of the performance of the MCO against these standards.

Re-analyzing MCO claims data will duplicate the work already conducted by KFMC (and paid for by KanCare) and processes conducted by each MCO internally to meet contract requirements and continually improve quality and access. Most importantly, re-analyzing MCO claims data will increase the administrative cost of the program through these duplicative processes.

We recommend that the state rely on its EQRO to identify gaps in the program. If an MCO meets requirements, the state should waive the requirement to re-analyze MCO claims data. The state can instead target re-analyzing claims data for MCOs that do not meet/pass standards as determined by the EQRO. Following this recommendation will retain limited state resources, prevent the expansion of state administrative costs, and make smart use of state investments in managed care and an EQRO.

UnitedHealthcare Community Plan

IMPROVE EFFECTIVENESS AND EFFICIENCY OF STATE MEDICAID PROGRAM

Among the MCO operations that KDHE intends to align in KanCare 2.0 is the use of a single preferred drug list (PDL) across the state. We encourage the state to reconsider its transition to a statewide PDL and instead retain administration with the MCOs.

Several states still require managed care plans to leverage a statewide Medicaid PDL to decrease administrative burden. However, studies have shown that such policies actually lead to increases in overall drug spending rather than containing cost. When MCOs are provided the latitude to administer the PDL, they can leverage their clinical data and analytical tools to promote the use of the least expensive, clinically effective medication. Drugs placed on the PDL can be prescribed without authorization by the plan and non-preferred drugs can be accessed by plan members through prior authorization.

Retaining administration of the PDL with the MCOs will allow the state to control Medicaid pharmacy costs, optimize the drug mix to achieve programmatic cost savings, and ensure member access to appropriate, cost-effective medications.

Through their clinical and analytical capabilities, MCOs have access to the data and tools to understand the most clinically-effective drugs across the wide price spectrum prescribed to their members. As true drug prices are not transparent to prescribers or members, under a broad and uniform statewide PDL there is no mechanism to prevent the prescription of a high cost medication even in the case when a cheaper generic option may be available.

When given the latitude to manage the PDL, MCOs can leverage their insights to ensure that the most cost-effective, clinically-appropriate medical interventions are administered, including deploying strategies to combat the opioid crisis.

Ensuring the appropriate mix, balanced among generic and brand name drugs, is the most effective tool states have to control pharmacy costs. Statewide PDLs are intended to drive administrative, and therefore cost, efficiencies in the Medicaid system, but are actually more likely to be overly inclusive of high-cost, brand name prescriptions that increase overall cost. [2] This outcome is likely driven by the nature of drug rebate negotiations by states versus MCOs.

States administering the Medicaid PDL often secure large rebates on higher-cost medications but do not ultimately achieve optimal net-cost for the drug treatment. For example, an 80% rebate on a $300 medication creates a net cost of $60, which is a higher net-cost above a generic alternative that has an initial cost of $22 and a 10% rebate. Through the management of evidence-based prescribing, enabled by their analytical capabilities, MCOs are able to achieve

[2] "Comparison of Medicaid Pharmacy Costs and Usage between the Fee-For-Service and Capitated Setting," sponsored by the Center for Health Care Strategies and prepared by The Lewin Group in collaboration with ACAP, January 2003. Available at: http://www.lewin.com/~/media/Lewin/Site_Sections/Publications/MedicaidPharmacyCosts.pdf

UnitedHealthcare Community Plan

overall lower post-rebate costs by focusing on the most clinically-effective drugs, rather than maximum rebates.[3]

Florida Case Study

A 2016 study of the transition from MCO-managed PLDs to a statewide PDL in Florida demonstrates this trend. In 2011, Florida moved away from a model in which the managed care plans administered their PDLs to a statewide Medicaid PDL. Express Scripts, which authored the study, reviewed drug cost and utilization among the MCOs before and after the transition to the statewide PDL. In the transition to the statewide PDL, among the MCOs, the study found the following: [4]

- Overall drug utilization declined, but overall drug costs among the MCOs increased by 45%;
- Utilization of overall traditional, non-specialty, drug claims declined by 9% with generic drug utilization declining by 13%; and
- Brand name drug utilization increased by 49%.

[3] The Menges Group, "State Policies Regarding Medicaid MCO Preferred Drug Lists". March 2014

[4] "Florida Medicaid's State-Mandated Formulary: Impact on Utilization and Cost." Prepared by Express Scripts. October 2016. Available at: http://lab.express-scripts.com/lab/insights/government-programs/florida-medicaids-state-mandated-formulary-impact-on-utilization-and-cost?ec_as=8506d8b96d1347a5b54005213f8fc660#sthash.bxUVsCVG.dpuf

From: Nancy Atwater
To: KanCare Renewal
Subject: KanCare Feedback - Preferred Family Healthcare
Date: Tuesday, November 21, 2017 1:15:28 PM

KanCare Renewal
c/o Becky Ross
KDHE-Division of Health Care Finance
900 SW Jackson, LSOB – 9th
Topeka, Kansas 66612
Dear Becky Ross,

I am Nancy Atwater with Preferred Family Healthcare. Preferred Family Healthcare provides SUD services in Olathe, Wichita and Winfield in Kansas. I am submitting the following comments regarding the State of Kansas KanCare demonstration 1115 (a) waiver for KanCare 2.0. I would like to see the waiver and accompanying KanCare managed care request for proposal and final negotiated contracts expand the capacity of and access to behavioral health services.

We serve Medicaid eligible members for the current managed care companies in KanCare and hope to do so in the future. In order to serve our members better we want to see currently closed mental health Medicaid codes available for our members. Allowing us to serve these members will increase the capacity in the system, give them access to treatment, provide member choice, and increase the outcomes for members, my agency, and the managed care companies.

All locations provide IOP and OP, while Winfield provided Intermediate and Reintegration. PFH has licensed Therapists qualified to provide mental health and are limited on getting paid for the services the client needs. In a contract with one county in Kansas, they are requesting our program to provide COD services. Opening up the codes would ensure that contract need is met. When clients are looking for services outside the scope of services PFH will get reimbursed for, the desired services are not timely. Clients need immediate access and ideally all in one setting. That also ensures their needs are met and avoiding them not making it to the referred location.

In addition to better integrating behavioral health services, we would also like to see in the KanCare 2.0 a replacement for the Kansas Client Placement Criteria (KCPC) as well as other reductions in the administrative burden including uniform credentialing processes.

Thank you for the opportunity to provide input and I am happy to answer any questions you might have.

Nancy
Nancy Atwater
Vice President Treatment Services
Preferred Family Healthcare
[redacted]

[redacted]

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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Return to Index

From: Sue Ann Jantz
To: KanCare Renewal
Subject: KanCare Renewal
Date: Sunday, October 8, 2017 3:57:46 PM

Kansas Medicaid has potential to decrease expenditures on Medicaid if it would increase payments to primary care providers. Currently providers have no financial incentive to see Medicaid. That means that patients are seen at higher cost through FQHCs. IN bigger cities very few physicians see Medicaid outside of FQHCs at present. If payments were improved, physicians would have incentive to open their doors to more Medicaid payments.
A simple first step would be to insist that everyone in the state be bumped up to rural health rates. This should be followed with payments for relavent high quality care including vaccine rates and avoiding ER visits.

From: Bryant Anderson
To: KanCare Renewal
Subject: KanCare Renewal Comments - KanCare 2.0
Date: Tuesday, June 20, 2017 5:26:37 PM

To Whom it May Concern:

Generally, I am not opposed to renewing (KanCare 2.0) the quasi privatized KanCare program as long as the following changes are made:

1.) **Open the behavioral health intervention and assessment codes 96150 - 96155.** These codes incentivize clinics and practitioners to practice good medicine by dealing with behavioral/mental health issues from a first frame thinking approach. This is good for a couple of reasons. The sooner behavioral issues can be identified and addressed, the better the chance of preventing more complex mental health issues from developing. This improves a patient's mental health and saves the healthcare system money by avoiding more costly long-term therapy, expensive medication, and inpatient psychiatric care. Often times a patient's mental health also affects their physical health. By addressing behaviors immediately, patients become more compliant with the physician's plan of care resulting in improved physical health. Improved physical health saves the healthcare system money because patients become less sick and therefore require less services. The bottom line, money aside, adding these codes will be good for patients because it will result in the improved mental and physical health of many patients.

2.) Currently, for a visit (face-to-face encounter), the Kansas Medicaid State Plan only allows FQHCs to be reimbursed the full Medicaid PPS rate (enhanced rate) for mental health services, if those service are provided to patients by a Clinical Psychologist or a Clinical Social Worker. The State Plan excludes Licensed Clinical Marriage Family Therapists (LCMFT) and Licensed Clinical Professional Counselors (LCPC) from the list of healthcare professionals that are eligible to be reimbursed at the Medicaid PPS (enhanced rate). Understandably, the State Plan is likely just following the language from CMS, but the State of Kansas has the flexibility to include LCMFTs and LCPCs.

Due to the difficult nature of recruiting qualified, "Clinical," Social Workers, it is important that the State of Kansas understands that excluding LCMFTs and LCPCs can restrict patient access to the integrated behavioral health model. This affects the mental and physical health of patients because they can't access the care they need. When patients become more mentally and physically sick because they don't have access to the care they need, they require more expensive services that cost the healthcare system more money. There is no question that LCPCs and LCMFTs are on par with CSWs and should be reimbursed at the same rate. In some instances, LCMFTs and LCPCs are even better prepared than CSWs to deal with daily issues that patients present with. All three of these mental health professionals are master's prepared, clinically trained to deliver therapy, certified through KMAP and are licensed by the same board, the Kansas Behavioral Sciences Regulatory Board, to provide mental health services. **Therefore, we are requesting that LCMFTs and LCPCs be included as eligible healthcare professionals that can receive the full Medicaid PPS rate under the Kansas Medicaid State Plan.**

3.) The absence of common sense adult dental benefits continues to be a problem. The current KanCare policy of only paying for exams, x-rays, extractions and preventative cleanings is

bad policy that results in the worsening of the dental health of low income patients. For example, when a patient has a painful cavity they are forced to have their tooth extracted instead of having the cavity filled because KanCare will not pay for the filling. While in the short run this solves the patients problem and saves KanCare money, in the long run it leads to poorer dental health and more costly dental issues. Having a missing tooth can cause excessive wear on other teeth, bone loss, drifting of other teeth, and even a change in a person's bite which can lead to muscle soreness and tension. It is clear that KanCare's current approach to adult dental benefits is bad policy and does more harm to patients than good. **Therefore, we are requesting that at a minimum, KanCare add a benefit for fillings.** It makes no sense to perform an extraction which leads to more problems when a simple filling can fix the issue.

4.) **We are requesting that KanCare develop a common insurance empanelment (enrollment) process where providers can submit the information one time to a secure website and all MCOs be required to obtain the information from that location.** The current process results in delays, unnecessary staff time and confusion.

5.) **We are requesting that, as a requirement for participating in the KanCare program, that MCOs not be allowed to subcontract with another company to handle one or more lines of business.** For example, Sunflower (Centene) only handles the medical reimbursements, while they subcontract the behavioral health business to Cenpatico, which then uses Envolve. Each of these companies use different process and it is very time consuming and confusing dealing with so many companies. If an MCO wants to participate in the KanCare program, they should be able manage all lines of business.

6.) **Payments should continue to become more timely and accurate**.

7.) Value Based Reimbursement is a reasonable model for Medicare and commercial insurance, but it isn't a workable model for Medicaid. It is not a one size fits all model. Value Based Reimbursement only works with patient populations that have a reasonable level of compliance and responsibility. As a level 3 PCMH, we do a very good job of managing the Medicaid population by utilizing multiple strategies, but there are simply limitations to what can be accomplished. Further, it comes at a financial cost to providers that they must be reimbursed for. If the State of Kansas implements Value Based Reimbursement as the payment model for KanCare 2.0. **it will** lead to increased provider and patient dissatisfaction resulting in less access to care. If you must implement this model, then you must ensure that the goals are realistic, the reimbursement will truly cover the cost of the additional resources it will take to improve health, hold patients accountable for their non-compliance - not the doctors, and be willing to accept that this model will cost the state more money. **Our recommendation is that the State of Kansas not implement Value Base Reimbursement for KanCare 2.0.** There are no gold standard studies that prove Value Based Reimbursement results in a positive ROI when it is the payment model for Medicaid.

Thank you for your consideration of PrairieStar's position on each of the above issues.

Sincerely,

Bryant

J. Bryant Anderson
Chief Executive Officer
[redacted]

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From: Carody Wise
To: KanCare Renewal
Subject: KanCare renewal
Date: Saturday, November 25, 2017 8:36:14 PM

To Whom It May Concern:

I am writing to voice my objection to the renewal of KanCare for individuals within the Intellectual Disability/Developmental Disability (ID/DD) community.

Our son has Down syndrome and lives in a group home. KanCare is a model for individuals who are primarily sick, not one for those whose lives need constant, life long oversight, and oversight that must be carefully crafted for each individual, or hope of success is small.

My husband and I support the exclusion of the ID/DD waiver from KanCare.

Sincerely,
Mary Wise

UNITED METHODIST HealthMINISTRYFund

100 East First Avenue P.O. Box 1384 Hutchinson, Kansas 67504-1384 (620) 662-8586 Fax: (620) 662-8597 www.healthfund.org

November 21, 2017

KanCare Renewal
c/o Becky Ross KDHE-Division of Health Care Finance
900 SW Jackson, LSOB – 9th Floor
Topeka, Kansas 66612

Dear KanCare Renewal Team:

The KanCare Waiver application states the strong desire to have KanCare 2.0 address the social determinants of health and youth with behavioral health needs between birth and 21 years old (Waiver application pages 3-4). Our comment addresses one piece of this important direction—adequate access of children ages 0-6 (and their families) to needed and beneficial behavioral health care services.

During our experience in funding young children's social and emotional health since 2010, we have heard many providers' frustration with the billing codes available in Kansas for these services. The codes, as currently designed and authorized, make it difficult to provide services which fully engage the family in the treatment of young Medicaid beneficiaries; with young children, effective modalities focus on the whole family, making family engagement essential to delivery of services. Also, existing ICD-10 codes force clinicians to place variations from typical development into "pathological categories" to justify and classify services. Finally, some early childhood codes in Kansas, specifically H0031 and H0032, are not sufficiently open to all qualified providers and need additional clarity on the stated required training beyond appropriate licensure for utilization.

There are a few small steps which can be taken to address these concerns:

1. Kansas Medicaid and the MCOs sanctioning the utilization of the developmentally appropriate diagnostic system DC: 0-5, produced by the national organization ZERO TO THREE for use with children birth to five years old. This set of classifications, with its crosswalk into ICD-10, enhances professionals' ability to accurately diagnose and treat mental health disorders in the earliest years. DC: 0-5 is already adopted in state Medicaid policy by at least ten states (Arizona, Illinois, Indiana, Michigan, Minnesota, Nevada, New Mexico, Oregon, Virginia and Wisconsin).
2. Train providers in the use of DC: 0-5. ZERO TO THREE has available trainings for providers which enable their use of these friendlier and more relevant codes. The Health Ministry Fund would be willing to partner with Kansas Medicaid and the MCOs to offer these trainings in Kansas.
3. Develop, through consultation with the field of young children's behavioral health providers, appropriate trainings for providers to have confidence in their abilities to serve young children and possess the skills necessary. The current endorsement program offered by Kansas Association for Infant Mental Health is one approach which should be recognized whenever additional

Return to Index

training/credentialing is to be required for use of specific codes. However, other approaches should be developed in a consultative manner with the field and implemented. Again, the Health Ministry Fund is interested in partnering to convene professional design of these training approaches and support implementation of these training experiences.

4. Permit all appropriately licensed providers to bill early childhood behavioral health codes. As implied in the earlier points, having an adequate workforce to handle behavioral health services for young Kansans is a current problem. We need to use all public and private, appropriately licensed, interested and trained providers if there is to be adequate access to these services.

Enhanced access to behavioral health services for young children enrolled in KanCare and their families can materially improve the long-term health of many Kansas children and the functioning of their families. These early interventions reduce other costs of the state medical care and child welfare systems. We hope serious consideration will be given to making the coding and billing changes for these services to facilitate access and encouraging professionals to train for and deliver the services. We are willing to work with KanCare, the MCOs and our excellent Kansas professionals serving young children to make these services more available and effective.

Sincerely,

Kim Moore
President

cc by email: [redacted]

Return to Index

From: Nancy Pence
To: KanCare Renewal
Subject: Kancare
Date: Saturday, November 18, 2017 10:01:31 PM

Please keep the current care programs in place for Kansas citizens. This is a vital program and many, many people depend on the services and assistance provided by this program.
Sincerely,
Nancy Pence
[redacted]

Sent from my iPhone

Tom Bell
President and CEO

TO: Kansas Department of Health and Environment

FROM: Tom Bell, President and CEO
Chad Austin, Senior Vice President Government Relations

DATE: November 22, 2017

RE: KHA Response to KanCare 2.0 Waiver Proposal

The Kansas Hospital Association appreciates the opportunity to respond to the KanCare 2.0 waiver proposal on behalf of our 127 community hospital members. In general, KHA believes the KanCare 2.0 waiver proposal significantly adds to the complexity of the underlying KanCare program, which continues to present lingering challenges for Kansas hospitals and health care providers. While many of these deficiencies should be adequately addressed upon the successful implementation of the contents of House Bill 2026, KHA is concerned about the ability of the state to effectively manage and implement the proposed KanCare 2.0 waiver in a cost effective manner. The administrative burden of tracking and operating programs that include independence accounts, eligibility lock-out periods and work requirements is likely to be cost prohibitive, as admitted by the agency in its responses to implementing those items as part of a KanCare expansion in the state (attached document from first Bridge to a Healthy Kansas Testimony). Our specific comments on the waiver, in order of importance to our members, are below.

Alignment of MCO Operations

Kansas hospitals, both individually and through the KHA KanCare Technical Advisory Group, have spent a significant amount of time and energy addressing issues and concerns related to the KanCare program that impact not only hospitals, but all healthcare providers in the state. After over four years of discussion and negotiation with the Kansas Department of Health and Environment to address many of these issues, KHA,

along with a number of healthcare providers felt it was necessary to introduce legislation to address some ongoing issues. The 2017 Legislature ultimately passed that legislation in Senate Substitute for House Bill 2026.

We are disappointed to see that the waiver does not mention several of the key items in House Bill 2026: provisions in relation to furnishing accurate and uniform encounter data upon request from providers; requirements that the KanCare managed care organizations provide specific and uniform claims and denial reason codes using HIPAA standards;; required changes in readmission policies; and the implementation of an annual independent audit of claims paid and denied by each MCO and their contractors. We believe that these items are invaluable in achieving the aims of quality, reduced administrative burden and accountability necessary for the waiver proposals goal of an "enhanced provider experience."

Prior authorization has continued to be an issue for providers, leading to its inclusion in House Bill 2026. The waiver proposal indicates that the State's preferred drug list will be used in lieu of prior authorization for drugs, but does not address any other healthcare services, and provides relief to only a narrow band of the KanCare provider network, which is out of compliance with the requirements of Section I(e)(2) of the legislation.

Further, the waiver proposal suggests that the state will eventually automate provider credentialing. KHA, along with a number of our member hospitals, have been part of a KDHE credentialing work group for the past 3 years. The purpose of the work group is to help guide KDHE towards the goal of uniformity in credentialing as well as assistance in the development of a web portal for enrollment. The web portal, which is part of one of the new modules within the Kansas Modular Medicaid System (KMMS), was to be operational by October 1, 2017. This portal, which would allow KanCare providers the ability to enroll or re-validate an existing enrollment with the Kansas Medical Assistance Program and for the KanCare MCOs, has been delayed until a future date. Unfortunately, the waiver proposal does not include a timeline for the portal to be completed. KHA suggests the state develop a firm timeline for implementation to avoid the possibility of continued delays.

Safety Net Pools

The waiver includes major changes to both the Health Care Access Improvement Program Uncompensated Care Pool and the Large Public Teaching Hospital/Border City Children's Hospital Uncompensated Care Pool. The changes proposed to both pools are being proposed without review or discussion with the impacted stakeholder groups. In the case of the HCAIP UC pool, this is in direct violation of Kansas statute, which specifically states in KSA 65-6218 (c) the Health Care Access Improvement panel is established to administer and select the disbursement of funds through the Health Care Access Improvement Program.

In the case of the HCAIP UC pool, the waiver proposal adds $20 million to the pool, increasing it from $41 million to $61 million, and then includes critical access hospitals in the distribution of funds from that pool. The waiver proposal is unclear on several points:

1. What is the source of the additional $20 million?
2. Which CAHs are being added to the UC pool – all CAHs or only public CAHs?
3. Is the expectation that the CAHs will receive the entire $20 million?
4. What is the anticipated distribution methodology to achieve this, given that under the current distribution formula, the CAHs would not receive one-third of the total funds available?
5. How does the inclusion of the CAHs in the UC pool impact the Cost Adjustment Factor, or CAF, currently distributed to CAHs?

In the case of the LPTH/BCCH UC pool, the waiver proposal eliminates the pool and shifts the funds in the Delivery System Reform Incentive Payment Pool, increasing the pool from $30 million to $39 million for demonstration years 1 and 2. This consolidation ignores the extensive amount of uncompensated care provided by the two hospitals involved and does not allow them to change their DSRIP programs to address this shift in resources and focus. In addition, it appears the agency may not have the necessary staff to distribute effectively the incentive payments in a timely manner with the current resources, suggesting that additional funds will only exacerbate the delays.

The waiver proposal includes a shift in Demonstration Year 3 to a new Alternative Payment Model in place of the DSRIP program. This change has not been discussed with the two DSRIP participants to determine its feasibility or their interest in participating in the new program, given that the DSRIP program is funded in part from intergovernmental transfer dollars provided by the DSRIP hospitals. The new APM model proposed would include more than just the DSRIP hospitals and an unspecified amount of funding, creating a potential for greatly reducing payments to providers by up to $40 million.

Once again, the waiver proposal creates an added level of complexity with no clear plan by the agency to implement these initiatives.

Value-Based Purchasing

The waiver proposal includes a value-based purchasing component that is not unexpected as "pay for performance" becomes the norm in healthcare. Kansas hospitals are currently participating in a number of quality-based payment programs by a variety of payers. In order to reduce administrative burden, the creation of a value-based program under KanCare should be developed with provider input and with consideration to programs already in place. . The waiver proposal not only does not define the parameters for this value-based component, it leaves the following questions unanswered:

1. How are these models to be implemented by the MCOs – are they going to be negotiated with individual providers or are they expected to be applied broadly to all providers?
2. Will participation in these value-based purchasing programs be voluntary or mandatory?
3. Will the value-based programs enhance or reduce payments to providers?
4. Will there be withholds pending certain performance measures?

Kansas hospitals believe that these new models need to negotiate with individual hospitals in recognition of the different challenges experienced by our members of varying size and location. In addition, quality-based programs should allow for and adequate transition period should be voluntary and only enhance payments to providers, since KanCare payments never cover the actual cost of providing care.

Quality/Data

Data has been a longstanding issue for the KanCare program. The agency appears to struggle to provide data regarding its managed care program beyond aggregate expenditures and beneficiaries up until 2017. Even now, little data is available and rarely is it provided in a timely manner. We have concerns about the ability of the state to implement quality and data systems given the delays with the KMMS system implementation. Before any new quality metrics can be implemented that require new data resources and analysis, the KMMS system needs to be fully implemented and functioning successfully.

Even after full, successful KMMS implementation, there are still concerns. The waiver application does not reflect a standardization of metrics for quality between participating managed care organizations. In addition, there are no clear timelines in the waiver application for the implementation of quality initiatives and the availability of data resources to stakeholders. The waiver focuses on being able to provide a 360-degree view of the patient to providers to improve service and outcomes; however, there is no indication how providers are going to be able to access this information to meet metrics created by the agency.

The waiver proposal indicates that as part of its review of MCO compliance with contracts it will review 60 cases for provider credentialing and 300 cases for physical and behavioral health records, grievances, appeals and denied claims. This scope of review appears wholly inadequate to provide appropriate contract compliance. The total number of claims submitted to the MCOs in calendar year 2016, according to the State's quarterly KanCare report to CMS for the quarter ending March 31, 2017, exceeded 4 million and the total number of unique provider credentialed across the three MCOs exceeded 60,000.

Work Requirements/Independence Accounts

Kansas hospitals support the idea of helping KanCare beneficiaries to become self-sufficient, as long as reasonable standards are put in place to insure that beneficiaries do not erroneously lose coverage due to administrative errors and delays. The waiver proposal does not explain how the state will monitor beneficiary compliance with work requirements, a task that will certainly require a significant number of additional staff so that beneficiaries do not lose coverage because of inefficient tracking of work activities. If, instead, the MCOs are going to be tasked with tracking these work activities, what systems is the state putting in place to monitor that the tracking is appropriate and timely?

The waiver proposal includes work requirements for "able-bodied" beneficiaries, most of whom will be low-income parents. Exceptions to this requirement include parents caring for children under the age of six, but it is unclear why this is the threshold, or what resources are made available for childcare for parents with children over the age of six who may need afterschool or evening care. GED or vocational education can meet the work requirements, however, there is no mention of special resources set aside to fund these pursuits for KanCare beneficiaries, who would arguably already be doing so if they had sufficient resources. In addition, the waiver proposal does not recognize the wide variance in the availability of work or educational resources across the state, putting rural beneficiaries with fewer available resources at a distinct disadvantage to their urban counterparts who have more opportunities to meet the work requirements set by the agency.

The waiver proposal appears to include a three-year limit on KanCare eligibility for "able-bodied" beneficiaries, with no indication of any exceptions for beneficiaries who cannot achieve self-sufficiency within that window. This time limit is a mirror of the limitations imposed on the Kansas TANF program, which added both work requirements and time limits for food stamps. Making people ineligible for services through work requirements and time limits does not equate to self-sufficiency or earnings levels that would allow them to purchase health insurance coverage.

The waiver proposal includes the implementation of independence accounts for Transmed beneficiaries, and would prohibit participants from re-enrolling in KanCare for a specified period. However, the waiver proposal does not indicate the length or potential exceptions to this "lock-out" period. The waiver proposal does not identify additional resources to manage these accounts and "lock-out" periods – resources that will be

necessary to manage such a requirement. In addition, the waiver proposal states that families would be prohibited from reenrolling, although the Transmed program only applies to adults. Will children lose coverage despite their eligibility for KanCare when their parents lose coverage? Once again, Kansas hospitals are concerned about the ability of the state to administer such a requirement without inappropriate loss of coverage for beneficiaries.

Lack of Financial Information

The lack of any financial information available for the public during the comment period on the waiver is of great concern to Kansas hospitals. The additional staff and resources required to administer the additional requirements of the program regarding work, independence accounts, care coordination, data and quality activities and the additional UC pool funding is not identified. KHA believes more detailed information should be shared that clarifies how the KanCare 2.0 waiver will be funded and sustained.

Kansas hospitals appreciate the opportunity to response to the KanCare 2.0 waiver proposal. Kansas hospitals are committed to providing high quality care to all Kansans and take very seriously our role as stewards of our communities. Thank you for your consideration.

Presentation on Medicaid Expansion

by

Susan Mosier, MD, MBA, Acting Secretary
Kansas Department of Health and Environment

House Health and Human Services Committee
March 19, 2015

Current KanCare Beneficiaries

- Children
- Pregnant Women (up to 400% federal poverty level, or FPL)
- Individuals with disabilities (physical, intellectual, developmental)
- Technology assisted children
- Kids with autism
- Frail elderly
- Individuals with traumatic brain injury
- Individuals with severe emotional disturbance
- Individuals with breast and cervical cancer
- Individuals with tuberculosis
- Individuals with HIV and AIDS
- Able-bodied parents and caretakers under 38% FPL

2

KanCare

Newly Eligible Population

- Able-bodied, low income adults between 0 and 138% FPL

KanCare

Actuarial Assumptions

- 0.5% population growth among all populations
- 3.0% cost growth
- 75.0% uptake on newly eligible population in 2016, increasing to 98.0% by 2025
- Federal Medical Assistance Percentage starts at 100% and never goes below 90%
- Only 35% of those that would qualify for KanCare and have employer sponsored insurance are dropped and convert to KanCare
- Based on a January 1, 2016 implementation date

4

KanCare

Caring for Individuals with Disabilities

- Caring for individuals with disabilities is the highest priority
- Since the inception of KanCare, 2,600 individuals from the waiting lists have been offered services
  - Total cost of $64.8 million
- Currently waiting for services are:
  - 3,088 individuals with intellectual and developmental disabilities
  - 2,536 individuals with physical disabilities
  - 230 children with autism

5

KanCare

Waiting List Elimination

- Eliminating the waiting lists will cost $2.60 billion from 2016 to 2025, including $1.15 billion in state funds
- Kansas' share is $97.6 million in 2016, increasing to $133.2 million by 2025
- This population does not qualify for enhanced match, will be matched at 56/44
- Estimates do not include additional woodwork effect, including any increases from in-migration

6

KanCare

KanCare Newly Eligible

- Newly eligible population includes 157,469 able-bodied adults by 2025
- 100% federal match ends 12/31/2016
- $771.4 million in state funds needed for first 10 years
- In 2016 average per member per month cost is $467.09, increasing to $609.44 by 2025

7

KanCare

KanCare ACA Woodwork

- Woodwork effect of ACA increases Medicaid enrollment by another 36,085
- $455.2 million in state costs over 10 years for woodwork population
- This population does not qualify for enhanced match, will be matched at 56/44

KanCare

Total Costs of ACA/Expansion

- $13.2 billion in total costs between 2016-2025
  - These costs include woodwork effect, newly eligible able-bodied adults, and providing all essential services to individuals with disabilities
- $2.4 billion in additional costs to Kansas for these populations over the 10 year period
  - $125.6 million in calendar year 2016
  - $307.5 million by calendar year 2025

9

KanCare

Populations

- Currently there are roughly 1 in 7 Kansans on KanCare
- Assuming expansion, by 2017 that number would be roughly 1 in 5.
- Newly eligible population in 2017 represents 45.7% of uninsured adults in Kansas

10

KanCare

Challenges to Providers

- Increases total KanCare population by 45.5%
- Fees for Medicaid Services are much lower than other payers
  - For the ten most frequent billing codes KanCare pays, on average:
    - 71.3% of Medicare maximum allowed
    - 44.0% of the State Employee Health Plan
    - 40.9% of private pay insurance

11

KanCare

Medical Workforce Impact

- KHA's Regional Economic Models Inc. study identifies 2,426 new health facility jobs as a result of expansion
- Kansas already has medical staffing concerns
  - 92 counties are already designated as shortage areas for primary care
  - 100 counties are already designated as shortage areas for mental health
  - Kansas already needs an additional 3,827 nurses
  - Kansas ranks 37th in the percent of physicians retained in state from GME programs

12

KanCare

Supplemental Hospital Payments

$319.2 million all funds in calendar year 2014

- Rate adjustment for hospitals - $123.0 million
  - 25.8% above regular fee, funded through provider assessment
- Disproportionate Share Hospital - $79.9 million
  - Payments made to hospitals that have a disproportionate share of uninsured patients
- Health Care Access Improvement Program - $41.0 million
  - Payments made to hospitals based on their uncompensated care costs, funded through provider assessment

13

KanCare

Supplemental Hospital Payments

- Large Public Teaching Hospital/Border City Children's Hospital - $39.9 million
  - Payments to KU Hospital and Children's Mercy
- Graduate Medical Education -$15.0 million
  - Payments made to hospitals that have a residency program
- Supplemental Medical Education - $11.6 million
  - Payments to KU for teaching physician time designed to offset lost wages due to teaching rather than practicing
- Critical Access Hospital Adjustment Factor - $8.8 million
  - Rate adjustment added on to each claim

14

KanCare

Hospital Impact

- In 2016, the costs of the newly eligible population would be $645 million, $250 million of that would go to hospitals, and would be distributed as follows:

All Hospitals	$250 million
• *Top 2 Hospitals*	*$63 million*
• *Hospitals 3-10*	*$62 million*
• *Other Non-CAH Hospitals*	*$106 million*
• *Critical Access Hospitals*	*$19 million*

15

KanCare

Additional Administrative Costs

- Current administrative costs are approximately 6% of Medicaid spend
  - Staff needed to administer the program and provide effective program oversight; projecting between 40 and 60 new employees would be needed assuming simple implementation
  - Contractual costs for eligibility determinations
  - Contractual costs for implementation

16

KanCare

Expansion Issues

- We need to encourage independence in the system, not remove incentives to achievement
- No state has been approved with a Work program as part of the expansion package
- State will be in the middle of renegotiating KanCare with MCOs, CMS, providers, and patients; in addition to being in the process of implementing a new Clearinghouse and a new Medicaid Management Information System
- A number of recent CMS policy changes support cost shifting to the states

17

KanCare

What If

- If the federal government rolls back to regular FMAP in 2018?
  - increases Kansas' costs by $319.1 million in 2018, increasing to $391.6 million by 2025
  - $2.75 billion in additional state funds by 2025 at regular FMAP

18

KanCare

Other Issues

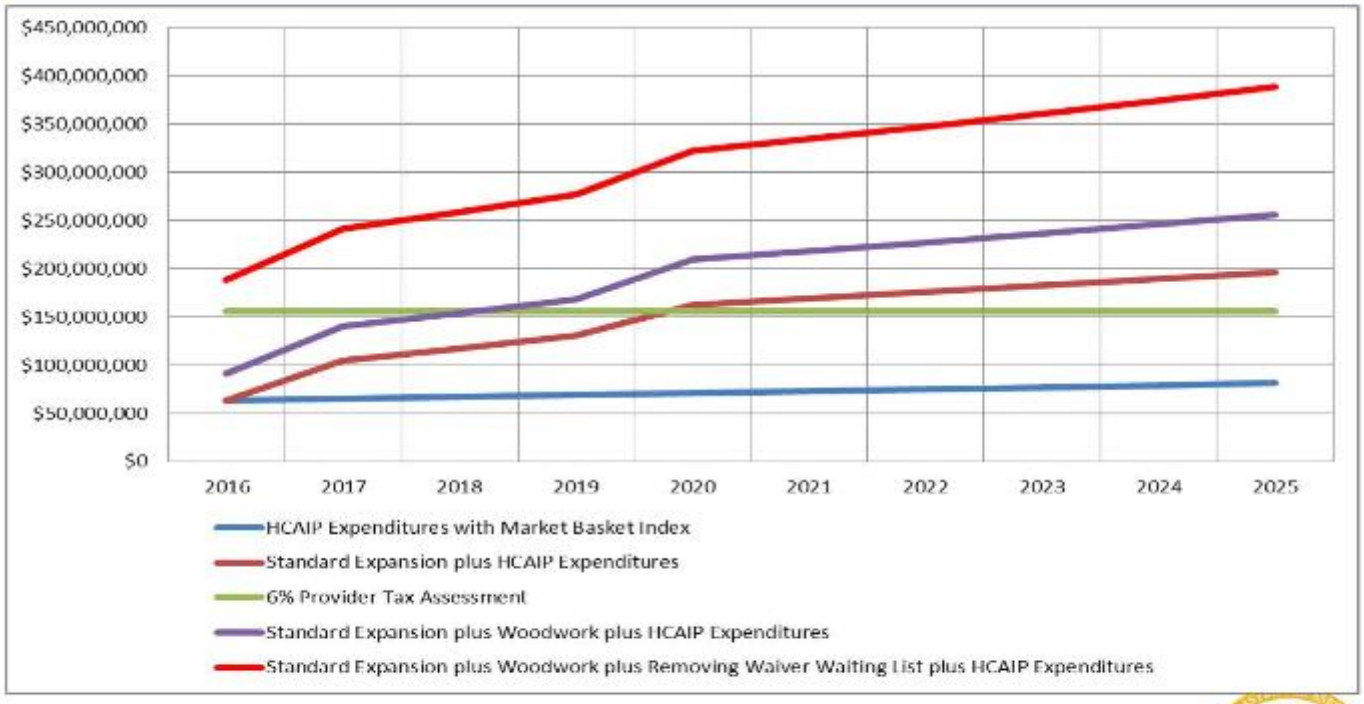
- If our assumptions are off, even slightly, it can have major consequences
  - Each additional 0.5% in population growth above assumptions would increase the Kansas share of costs by an additional $89.8 million over the 10 year period

- We do not know this population
  - Could be a much higher percentage of high-cost individuals than is being predicted
  - Very little comparable data

19

KanCare

Expenses vs Revenue



20

KanCare

A Kansas-Based Solution

- Take care of our individuals with disabilities first
- Be fiscally sustainable
- Reflect Kansas Values, e.g. provide pathways to independence

21

KanCare

KanCare 2.0 Waiver Proposal Talking Points

Kansas hospitals have been committed to the improvement of the KanCare program over the past five years, both individually and through the work of the KHA KanCare technical advisory group. It is in that spirit that we offer the following comments regarding the KanCare 2.0 waiver application.

Alignment of MCO Operations (pg. 23)

Kansas hospitals appreciate the inclusion of some of the provision of the KanCare contract legislation, HB 2026, in the waiver and suggest the inclusion of the following items:

1. The standardization of prior authorization for all services – the waiver appears to include only pharmaceuticals.
2. Provisions for accurate encounter data use in state reporting to providers upon request.
3. Inserting language that indicates the automation of provider credentialing would be implemented no later than December 31, 2018.
4. Electronic submission of prior authorization requests should be in place by January 1, 2019.

Uncompensated Care Pool (pg. 22)

1. The changes to the UC pool have not been reviewed or approved by the Health Care Access Improvement Panel, which is statutorily responsible for the distribution of all of provider assessment funds, including the UC pool. This is in direct violation of state statute.
2. There is no source identified for the additional funding the agency proposes to add to the UC pool for critical access hospitals.
3. It is unclear whether all critical access hospitals or only public critical access hospitals are going to be included in the UC pool.
4. The additional funding is added to the UC pool with no plan for distribution of the funds.

Value Based Purchasing (pg. 15)

Kansas hospitals are committed to providing high quality, accessible healthcare to all Kansans. In reviewing the KanCare 2.0 waiver, we believe there are some additional clarification that is needed regarding the state's initiatives.

1. How are these models to be implemented by the KanCare MCOs – are they going to be negotiated with individual providers or are they expected to be applied broadly to all providers?
2. Will participation in these value based purchasing programs be voluntary or mandatory?
3. Will the value-based programs enhance or reduce payments to providers? Will there be withholds pending certain performance measures?

Quality/Data (pg. 17)

Access to data has continued to be a concern for Kansas hospitals and we believe there are some key data items that should be included in the waiver.

1. The data metrics and definitions for quality should be standardized across KanCare MCOs and providers to avoid confusion and guarantee the best data resources.
2. The waiver indicates that more robust analysis of data will be available to stakeholders, but does not provide a clear timeline for when those resources will be available, or how those resources will be made available.
3. The state standards for KanCare MCO compliance review should be statistically valid.
4. Engage provider associations in the development of meaningful, standardized quality—based performance measure to ensure appropriateness and consistency of measures across KanCare MCOs and avoid increased administrative burden on providers.

Work Requirements /Time Limited Benefits (pg. 10)/Independence Accounts (p14)

Kansas hospitals recognize the state's commitment to moving KanCare beneficiaries towards independence, but have a few questions/concerns about the implementation of these initiatives.

1. How will the state monitor compliance with the new program requirements for beneficiaries in a timely manner to insure that no beneficiary inappropriately loses service?
2. The waiver includes work requirements beneficiaries, but does not address issues like childcare for parents of children age 6 and older, or funding for education.
3. The waiver includes a three-year limit on coverage for beneficiaries required to meet work requirements but does not include exceptions for issues like work and training availability, birth of additional children, etc.

Denny L. Leak, Ed.S.
Autism Specialist / School Psychologist
[redacted]

September 14, 2017

KanCare Renewal
C/o Becky Ross
KDHE Div. of Health Care Finance
900 SW Jackson
LSOB 9th floor
Topeka, KS 66612

Greetings.

I am writing to express my deep concerns about the terrible things you have done to Kansas Medicaid autism services. This letter is intended to be included the KanCare renewal process as feedback from a highly invested stakeholder.

First, I want to explain my perspective on this matter. I have been a school psychologist for 27 years. I was one of the very first Autism Specialists in the State of Kansas in 2008, when the Kansas Autism Waiver began. I have participated as a solo Autism Specialist provider and a member of the Kansas Autism Advisory Committee since about 2010. As you may know, I do this as a service to kids with autism. It is not paid nor are my expenses paid for me to drive across the state to attend those meetings.

The Autism Waiver, as a program administered through KMAP and KDADS, worked pretty well. I did not have pervasive problems with claims and payments. I want to emphasize that I have I have successfully billed claims on the KMAP website for years, but this year has been a wreck. I would like to make a list of my deep concerns over how your KanCare program has turned out.

1. Claims payments have been terrible. This year has been a disaster. At one point in May I was looking at my claims and out of 36 claims submitted, 18 of them had been denied. I called Sunflower today to ask for an update on several denied claims. Earlier this year, after months of denials from Sunflower, I called and asked for help. I was told, ' Well, darn there's the problem. Your claims were all sent over to the medical side and they don't have your authorization. We'll reprocess them on behavioral. Call us if you don't get anything back.' Well, that was on 7/13/17. Today I was told that there is no record of my claims in the system. I was asked to resubmit my claims for May 16, 19, and June 7th once again. I have serious complaints about the failure to achieve timely payment of services. I wish that the employees and expensive managers of the billing and claims departments got paid with the very same efficiency that they pay me.

I used to have one code that I used for billing H2019 and I was given 50 hours of service to a child with severe autism for 1 year. At the start of this year I was told to bill under the new T-codes. Now, I have a list of 4 or 5 different codes AND I have to fill out forms and ask for authorization every 4 months. I have to divide up my allotted number of units

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Autism Specialist / School Psychologist
[redacted]

of service into codes that no one trained us on. In fact, I have not even been sent an invitation to the training programs that have been offered to agency billing staff.

So. at the start of this year, my new claims for the T-codes were returned. denied. I was told to go back and bill under the old H-codes and I should get paid in 60 days. Months go by and I was rejected again and told to bill under the new T-codes. This was the worst under Amerigroup. So, I billed again with the Tcodes and those claims were rejected because they were duplicate claims for previously filed claims on the same date. I still have not been paid for some of them. I had to re-file claims because it was too confusing for them to bill a week or a month at a time. I had to re-file with each single date of service on one claim. Now, to make things terribly sweet, they have sent me a Notice of Recovery of overpayment. What a terrible terrible thing you have created. Not only do they change the rules all of the time, fail to provide training, but they want money back because they overpaid me. Also, I have had claims rejected because I billed too many units of certain obscure code numbers in one day. No one ever trained me on how many units of a code I was allowed to bill in one day. How am I supposed to gather vast amounts of data on an autism training program with 25 goals, convert to graphs, write Individual Behavior Plans, create spread sheets, write detailed behavioral instructions, and print documents in 1 hour. Please enlighten me.

One more issue with claims. The situation with billing a primary insurance carrier before billing Medicaid is terrible. Blue Cross Blue Shield has different requirements for paperwork, documentation, and procedures. I am totally spending more time on billing than I spend on working with kids. I am so angry, I could puke.

2. Processing all of the arcane procedures needed for credentialing and contracting is far too long. First off, why does it take CPS 6 to 8 weeks to process a background check when all of the other checks are done in one day. It's hard to find an IIS in-home ABA worker. I found a wonderful college student in the speech language program that wanted to work for us. She wanted to work with kids with autism. That was November. She was not trained. checked, credentialed, numbered, and approved until September. It took near 10 months. GUESS WHAT ? She found another job. This has happened multiple times for me. Are you wondering why you are spending millions of dollars on training autism providers and you don't have an adequate pool of workers. It takes too long and it's too convoluted and obscure. No one wants to deal with your billing problems, poor payment history, and the reimbursement does not cover the cost of billing time.

3. You have created a system which precludes the possibility of having solo providers. I am a solo provider for several rural counties and I also take clients as an employee of Rainbows United in Wichita. Kansas. I will not take any more solo clients. I can't afford it. Literally, I spend more time on billing, re-billing, and trying to find out what is wrong than I spend serving kids.

Denny L. Leak, Ed.S.
Autism Specialist / School Psychologist
[redacted]

You have killed my private practice. I could not pay my property tax on time because I was over $2,000 behind in receiving payments. You won't have solo providers in 90% of Kansas because it's too hard to get training, credentialed, contracted, complete billing, and get paid. I am so happy that I never hired any of my own IIS workers. I would not have been able to pay them.

So, I'm SURE that you are saving money because you are not serving kids. You are spending a vast amount of money on a massive insurance industry that is set up to make it hard to bill and survive. Take a look at how many providers you have and how many kids receive services for autism. I would have to think it is falling like a rock.

4. Participation of the Autism Advisory Committee. Apparently, KDADS does not need an advisory committee any more. The Kansas Autism Waiver was started by a wonderful group of people who wanted to see this very special group of disabled kids receive early intervention. The original waiver was written by unpaid volunteers with passion and love for kids. It WAS a very cool program. It is not anymore. I think it has been over a year since there was a meeting of the Autism Advisory Committee. We do not receive any news or updates from KDADS. I guess KanCare does not need a public steering group of committed stakeholders for its autism program.

OUTCOMES:

1. I cannot afford to work for you. I have 8 years of college; I am a licensed school psychologist and Autism Specialist; and I made about $12,000 last year after expenses. Literally, I could have made more money working at McDonalds flipping burgers. Thank you so very much. I live in Sumner County, the 25th most populous county in KS, and have worked with clients in Sumner, Cowley, Butler, and Sedgwick. With this population, I cannot make enough money for this job to be worth the problems. The other 80 counties in Kansas with less population than Sumner will not have enough population for anyone to make a decent living as an Autism Specialist either. Just a reminder, you don't pay for mileage, travel time, or client expenses. So, for a one hour home visit for me to see a client in El Dorado, I spend over 2.5 hours on travel. Look at the math. I get paid $70 for a that home visit and I have a $40 travel expense and it takes me 3.5 hours of the day for a 1 hour home visit. After mileage costs, I get $30 divided by 3.5 hours = $8.57 per hour AND I still have to bill my session and see if it gets rejected, which happens at a rate of 50% lately, and then I have months of follow-up calls and resubmissions. My wage per hour drops to about $2/ hr when I have disputes and rejected claims. I have recruited 2 speech therapists to work on the Autism Waiver. The first one quit after the first month when she started billing. She remains, to this day, very angry at me for getting her into KanCare. *She will not talk to me.* The second one quit after one year and the new changes in billing codes. Just for fun. Take a look at how many speech therapists are working with kids on the Autism Waiver. It's only going to be 2 or 3 who work in large organization and provide only office-based services. No one else can afford to work for you. Is that your objective ? It looks like it is.

Denny L. Leak, Ed.S.
Autism Specialist / School Psychologist
[redacted]

2. I love working in early intervention with kids with autism. I really do. We have some amazing IIS workers that pour their soul into this work. I really have learned so much about ABA and how well it works with kids with autism. I can tell you that my experiences with kids have been profound. We have changed the trajectory of entire lives. We teach kids how to learn; how to communicate; and how to take care of themselves. The earlier we can start the better. When you get to work with young children, you create a scaffold for learning that changes the complete track of their lives. This reduces the amount of special education services that are needed in future years in public school. This reduces the life time costs of support services. I have seen our participants dismissed from special education and enter regular education. I have clients who will hold jobs and will pay taxes. For all of this, I wish to thank the kind people who started the Kansas Autism Waiver and to Dr. Linda Heitzman-Powell at KCART for my training.

3. I want to thank you at KanCare. If it wasn't for the complete mess that you have created, I wouldn't have found my new job. I wouldn't have been looking if you paid my claims. I would have continued working for less than a McDonalds employee because it was so amazing to change lives for kids with autism. I quit. I am taking a job out of state. For the past 9 years I have served 8 to 10% of your total Autism Waiver as the Autism Specialist. You just lost 10% of your work force.

4. Rural Kansas will never have access to ABA for Medicaid kids. Solo providers cannot make a living doing this. There will only be a few nonprofit agencies that struggle to serve children with autism. Take a look at the map of providers that you have now. Isn't it curious how much money you spent on training and no one joined the party.

Sincerely,

Denny L. Leak, Ed.S.

November 20, 2017

KanCare Renewal
c/o Becky Ross
KDHE-Division of Health Care Finance
900 SW Jackson, LSOB – 9th Floor
Topeka, Kansas 66612

Dear Secretary Mosier,

The Kansas Chapter, American Academy of Pediatrics (KAAP) represents over 90% of the practicing pediatricians in the state. The KAAP has the fundamental goal that all children and adolescents in Kansas have the opportunity to grow safe and strong. It is with this goal in mind that we want to thank you for the opportunity to provide comments on the proposed Kansas Department of Health and Environment (KDHE) KanCare 2.0 Section 1115 Demonstration Renewal Application.

We write today to express our concerns with this proposed renewal application for KanCare 2.0, which would create significant barriers for some low-income parents as well as former foster care youth. Unlike other state waivers that increase access to care via the Affordable Care Act's (ACA) Medicaid expansion, Kansas is seeking waiver authority to make changes to Medicaid that would affect traditionally eligible Medicaid populations. These changes could have a negative effect on the health of our state and halt the progress we have made in decreasing our uninsured rate.

Specifically, we are concerned with the following proposed waiver provision:

- **The work requirement/36-month Medicaid coverage limit**. This provision would only allow certain adult beneficiaries, including former foster care youth, to only receive coverage for a 3-month cumulative time limit over 36 months, unless stated work requirements are met. Even those who meet the new work requirement would only be eligible for 36 months of Medicaid coverage, when previously there was no time limit on coverage for this population. As Kansas has not expanded its Medicaid program as allowed under the ACA, this means the newly established work requirements would apply to traditionally eligible beneficiaries, many of whom are at significantly low incomes. While we appreciate there are several populations that would be exempt from these requirements, such as children, pregnant women, and parents and caregivers of children under 6 or taking care a family member with a disability, we remain concerned that Medicaid coverage might be punitively denied for those who are unable to meet this work requirement.

Studies have shown that 8 in 10 Medicaid eligible adults live in working families and almost 60% work themselves.[1] A 2014 study showed that only 28% of employees of private firms with low average wages obtain health insurance through their jobs, and 42% are not even eligible for employer sponsored coverage,[2] demonstrating that simply being employed does not guarantee these individuals will be able to obtain health insurance.

Additionally, as former foster care youth are not specifically exempt from this proposal, we are concerned about their inclusion. Former foster care youth are a particularly vulnerable population that has disproportionately high rates of both physical and behavioral health issues. Between 35-60% of youth entering foster care has at least one chronic or acute health condition that requires treatment, while between 50-75% has a behavioral health issue that may require mental health treatment.[3] Putting up barriers to needed care for this population would result in both medical and financial hardships for those with the most need at a time when they are just starting out on their own. This is at a time when the state's foster care program is already under scrutiny

From an administrative standpoint, there is no specific process in place for tracking this proposed provision, nor is there an accounting of potential costs to the program. If additional resources are necessary to implement the work requirement and time limited eligibility, would those funds come from the existing Medicaid budget, to the determinant of providing care? We are concerned that this additional administrative burden to KanCare could result in fewer resources to provide services and improve outcomes.

The original intent of the Medicaid program is to provide needed coverage to low-income residents—most of whom already work—who cannot afford private insurance. Adding an onerous work requirement and coverage time limit as proposed contradicts the very nature of Medicaid as a health care lifeline for those most in need.

This waiver proposal creates additional complexity to the Medicaid program for traditionally eligible beneficiaries while likely adding to administrative costs. The waiver is also likely to increase health care system costs, including that of uncompensated care for the individuals who inevitably lose coverage.

We commend the state's efforts to increase care coordination and transition the Medicaid program to a more value-based payment system, and appreciate the opportunity to offer additional comments on those provisions:

- **Coordinating services to strengthen social determinants of health.** We support greater coordination of services in order to integrate health care and health-related social services to better address the social, environmental, and behavioral factors impacting children's health. Expanding services to include assisting beneficiaries with accessing affordable food and housing and providing job training and skills are all important supports that would serve to benefit those living in poverty. However, as clearly stated above, we do not support a work *requirement* as an appropriate means to determine eligibility for health coverage as this would only serve as a barrier to coverage for some populations.

[1] http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work
[2] https://meps.ahrq.gov/mepsweb/survey_comp/insurance.jsp
[3] http://childwelfaresparc.org/wp-content/uploads/2014/07/3-The-Affordable-Care-Act-and-Youth-Aging-Out-of-Foster-Care.pdf

- **Value-based payment models.** We understand the state's desire to transition to value-based payment models in the Medicaid program and support efforts to make such a payment system work for the state, pediatricians and other providers, and children and families. However, as you develop a strategy to incentivize providers by incorporating performance and quality initiatives, we would request that you engage pediatricians in that work. There are inherent differences between adults and children which require special consideration when developing value-based payment models for pediatric populations. Children make up more than 63% of the total Medicaid population in Kansas,[4] so any payment model should take children, as well as pediatrics, into consideration when being developed.

- **Alignment of MCO operations.** The KAAP appreciates the state's efforts at simplifying and streamlining various processes providers must manage due to contracting with multiple managed care organizations (MCOs). We would request that as you work to create single processes for health screenings, risk assessments, prior authorizations, and credentialing across MCOs, you also work with providers to produce systems that serve to limit the administrative burden on practices, so that so the provider's focus can be on patient care and improved outcomes. Additionally, as you develop a single health screening tool and health risk assessment tool, we would appreciate the opportunity to offer our expertise as pediatricians so that these tools will consider the different and specific needs of children versus adults.

Thank you for the opportunity to provide comments on this renewal application. We hope the state takes the thoughts of Kansas' pediatricians into consideration as it contemplates changes to this renewal request. If you have questions regarding our concerns, please contact KAAP President, Jennifer Mellick, MD, FAAP, at [redacted]
Sincerely,

Jennifer R Mellick MD FAAP

Jennifer Mellick MD, FAAP
President
Kansas Chapter, American Academy of Pediatrics

Lisa Gilmer MD

Lisa Gilmer, MD, FAAP
President-elect

Dennis Cooley, MD, FAAP
Treasurer

[4] https://www.aap.org/en-us/Documents/federaladvocacy_medicaidfactsheet_kansas.pdf

To: Kansas Department of Health and Environment

From: Debra Zehr, President/CEO and Rachel Monger, Vice President of Government Affairs

Date: November 22, 2017

Re: KanCare 2.0 Section 1115 Demonstration Renewal Application

LeadingAge Kansas appreciates the opportunity to offer our response to the KanCare 2.0 Section 1115 Demonstration Renewal Application, on behalf of our 155 senior care member organizations.

Value Based Models and Purchasing Strategies

In KanCare 2.0 the state plans to promote "provider payment and/or innovative delivery system design strategies between MCOs and their contracted providers." While it is not a surprise that the state of Kansas plans to follow the current trend of value based purchasing in health care, it is very concerning to us that the waiver application gives no detail on what types of strategies MCOs will be allowed to use. The only limit is a requirement of state approval.

The waiver application remains silent on many questions, the answers to which may have a profound effect on providers, and their ability to continue operating. LeadingAge Kansas strongly objects to any value based purchasing strategies in which an MCO withholds a percentage of payment pending certain performance outcomes. Any alternative payment models must involve enhancements, not withholds. We also believe it is very important to make participation in value based purchasing voluntary, and individually negotiated between each provider and MCO.

It is absolutely essential that KanCare 2.0 retain the current requirement that MCOs pay no less than the reimbursement rate set by the state for each provider type. Any alternative payment methodologies put forth by an MCO must not cause the reimbursement to dip below the state established rate, unless it has been individually negotiated with the provider, and approved by the State.

A pay for performance system that withholds payments is based on the assumption that the provider was receiving an adequate payment in the first place. That is not the case for Medicaid

providers. Long term care and community based services are struggling mightily under changes that Kansas has made to the Medicaid program in the last two years. They are severely underfunded, and they are struggling with a workforce crisis that some days feels insurmountable. The idea that a mandatory value based purchasing strategy would take away money that providers desperately need to operate, and then instruct them to operate better if they want to earn it back, is absurd. Quality of care is strongly connected to reimbursement – money for staff, for services, for equipment, for specialists. The list is a mile long. A value based purchasing system that withholds payments will not drive up quality, it will only drive out providers.

Alignment of MCO Operations

The administrative burden that comes with the challenge of working with three insurance companies with three different sets of rules and procedures has not lessened. We anticipate that it will continue throughout the life of KanCare, and we do not want the hidden administrative costs of this new system to fall to the wayside in the managed care discussion.

The burden being borne by providers is significant, and adds to the cost of care for persons on Medicaid. Costs with which Medicaid reimbursement has never been able to keep pace. The increased administrative costs for our members make their service to vulnerable elders harder to sustain. It is a danger to the quality and capacity of the Medicaid system.

We appreciate the inclusion of provider experience and administrative burden in the waiver application. However, we found it very concerning that the changes referenced in the application do not address the new requirements set into place under Senate Substitute for House Bill 2026. Legislation that was passed by the state legislature this year, and was supported by LeadingAge Kansas, along with every other Medicaid provider type and association. Some of the key items not mentioned in the waiver application involve detailed explanations of claims denials, independent claim audits, and encounter data for providers. It was also disappointing to see that the only prior authorization change referenced in the waiver application is for the state's preferred drug list. We believe this to be in contradiction to S Sub for HB 2026.

Network Adequacy

The waiver application addresses standards for measuring MCO network adequacy, however it does not indicate whether the current open network standard of "any willing provider" will continue with KanCare 2.0. We believe it is essential to the health of consumers, and the long term care providers that serve them, to preserve an open provider network with every MCO.

Consumers must be able to access the services that they need, and whenever possible, in the setting they choose. Consumer choice in aging services is essential to quality of life. Restrictive networks decide where people live, often for many years – and may also cause a long-term care

resident to uproot their home once they spend down to Medicaid eligibility. In order to support and promote consumer choice, KanCare must continue to require contracts with any willing provider.

MIRROR

316.283.6743
316.283.6830
www.MirrorInc.org

KanCare Renewal
c/o Becky Ross
KDHE-Division of Health Care Finance
900 SW Jackson, LSOB – 9th
Topeka, Kansas 66612

Dear Ms. Ross,

Please accept the following comments regarding the State of Kansas KanCare demonstration 1115 (a) waiver for KanCare 2.0. As the leader of a statewide substance use disorder treatment program, I would like to see the waiver, accompanying KanCare managed care RFP and final negotiated contracts expand both the capacity of and access to behavioral health services. This, I feel, would meet a critical need in our state.

Mirror serves Medicaid-eligible members of the current MCOs in KanCare and hopes to continue doing so in the future. In order to better serve our members, we need access to currently closed mental health Medicaid codes. Such a change will allow us to better serve these members through a managed continuum of care. It will increase the capacity in the current system, giving members access to treatment, better choice and improved health care outcomes.

Mirror currently serves about 600 clients at any given time through four residential and ten outpatient facilities across the state. We try to coordinate work with community mental health centers as best we can, but often face road blocks. For example, in one region in which we work, the community mental health center refuses to provide service to anyone who does not have commercial insurance. As a result, we have had to hire our own psychiatric personnel to provide mental health services for which we cannot be compensated.

In addition to better integrating behavioral health services, we also advocate that KanCare 2.0 include a more functional replacement for the Kansas Client Placement Criteria (KCPC) as well as other reductions in administrative burdens, including uniform credentialing processes.

I will be happy to answer any questions you might have. Thank you for the opportunity to share my recommendations.

Sincerely,

Barth Hague
President & CEO

130 East 5th Street · PO Box 711 · Newton · Kansas · 67114

NAMI Kansas
National Alliance on Mental Illness

November 21, 2017

KanCare Renewal
c/o Becky Ross
KDHE, Division of Health Care Finance
900 SW Jackson, LSOB – 9th Floor
Topeka, KS 66612

Dear Ms. Ross:

Following are comments from NAMI Kansas on the KanCare renewal application beginning with general comments and then addressing more specific concerns about the program.

General Comments

The proposed application does not address the problems which have plagued the KanCare program since its inception relative to improving access to care and services and improving outcomes. The application lacks details about how the state will implement key provisions. We are concerned that critical legislative oversight has not been incorporated and that no effective ombuds program has been incorporated. No provisions have been made for local resources to help individuals apply for and navigate the system or to address the continued backlog in processing applications. Key consumer protections and due process have been lacking in KanCare and remedies are not addressed in the application.

Based on our review, we believe that the renewal application will perpetuate bureaucratic red tape for the state agency, MCOs, providers and KanCare members. The proposed renewal creates the need for additional state staff and resources for managing the Medicaid program and we are concerned that without the commitment to put those resources in place that the management of the program will suffer.

We are deeply concerned that KanCare 2.0 creates additional barriers for individuals and families to access the program when we should be simplifying the process of meeting the health care needs of Kansans who depend on the essential services offered through Medicaid.

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Employment Services

We have been disappointed with the lack of employment supports provided to KanCare members with mental illness. Unemployment among individuals with serious mental illness is more than 80%. We have an established evidenced-based practice in mental health settings for engagement of individuals who are seeking to become productively employed. This practice is known as IPS Supported Employment (Individual Placement and Support).

There have inadequate incentives and lack of leadership by the state in advancing the IPS program among Community Mental Health Center (CMHC) providers. The data around employment of persons with serious mental illness is compelling with 60% of individuals expressing a desire to work at least part-time. However, only half of Kansas CMCHs offer the IPS program and overall the penetration rate for the program among the target population is around 20%. Even at the CMHCs which offer a strong program which meets fidelity standards at a high level, we are not reaching the desired numbers of individuals in the target population with these essential employment services.

State agencies have pointed to MCOs as bearing responsibility for making progress and MCOs have consistently looked to the state for direction and guidance. Meanwhile, we've lost ground with the implementation of IPS during the last few years. Any continuation of KanCare beyond 2018 must address our continued neglect of employment services for our population. We believe that employment (along with housing) is a cornerstone of recovery for individuals with mental illness.

Continuity of Care

Medicaid benefits are currently terminated for individuals who are incarcerated and those who are committed to state hospitals. KDADS and KDOC have developed work arounds to remedy the problems associated with the termination of benefits, yet the key policy issue requiring termination of benefits has not been addressed in the renewal application. What's at stake here is the continuity of mental health care for KanCare members who end up in the state hospital or county jail and who, upon release, find themselves with no coverage and having to re-apply for Medicaid benefits. Given the historic backlog in application processing, this is especially cruel and disruptive to one's continuity of care at critical times of re-entry following a hospitalization or incarceration. Given the fact that we have five times as many beds for people with mental illness in jail and prison than we provide in state hospitals, there is a particular need to address this policy gap for individuals entering and leaving our county jails.

Tobacco Dependence

KDHE should strengthen support for and use of tobacco cessation benefits by KanCare recipients.

There is some encouraging data in the application about engagement with beneficiaries around smoking cessation. However, Kansas has been among the five states that make it hardest for smokers to get anti-smoking medication. This bottom tier of states provides medication support for only 1% to 6.5% of Medicaid recipients who smoke. The utilization rate for tobacco cessation services in Kansas was actually below previous measures and we have been unable to get a more recent update from KDHE about any expected increase in that utilization rate.

Currently, the annual Medicaid costs caused by smoking in Kansas is estimated to be $237.4 million with 36% of Kansas Medicaid participants reporting use of tobacco products. Use of cessation benefits among these participants is very low – for example, an analysis of 2013 claims data found that only 3% of estimated smokers filled a script for a quit smoking medication. Likewise, an analysis of 2010-2013 Kansas claim data found that less than 1% of estimated pregnant smokers had claims for counseling.

Tobacco use is one of the most preventable causes of morbidity and mortality in Kansas, causing an estimated 3,900 preventable deaths in our state every year. Although there has been a decrease in smoking prevalence over the years, higher prevalence persists among certain subpopulations, including adults with mental illness.

There are numerous barriers to accessing tobacco cessation treatment for existing KanCare participants. Eliminating the limit on quit attempts per year is a simple way to improve utilization and thereby outcomes. Kansas Medicaid currently covers some cessation treatment options – but participants are limited to 1 quit attempt per year. Moreover, combination nicotine replacement therapy (NRT)—which is now the standard of care because it is more effective than solo NRT—is not permitted. In addition, individual and group counseling are only available for pregnant women. This means that any time that providers spend on counseling non-pregnant beneficiaries is not reimbursable. This probably accounts, at least in part, for the low rates of claims for cessation medications because providers aren't reimbursed for the time it takes to treat tobacco dependence – including the time it takes to appropriately prescribe medications.

By removing limits on medications and opening the codes for cessation counseling for all Medicaid recipients, more Kansans will have access to the type of longitudinal, dynamic treatment that is the most effective for helping people quit and stay tobacco free. These changes will also incentivize providers to initiate treatment, because the changes will remove guesswork related to patient access to medications. Lastly, providers will be able to get reimbursed for the time they take to help their patients through the quitting process.

There is strong evidence from other states that this change will quickly yield savings and improved health. Medicaid programs that cover all medications without barriers substantially reduce tobacco use, tobacco related disease, and healthcare costs among Medicaid enrollees. Increasing cessation coverage maximizes the number of smokers who attempt to quit, use evidence based cessation treatments, and successfully quit by removing cost and administrative barriers that prevent smokers from accessing cessation counseling and medications.

With reference to the population of individuals with behavioral health disorders, we have determined that providing treatment will be cost-effective for Kansas. NAMI Kansas recently commissioned a cost-benefit analysis which finds that the state of Kansas stands to save millions of dollars by proactively treating tobacco use among people with mental illness – because of the cost savings and economic benefits that will accrue.

From the experience of other states, it is clear that Medicaid programs that cover all medications without barriers substantially reduce tobacco use, tobacco related disease, and healthcare costs among Medicaid enrollees. By strengthening cessation coverage – through eliminating limits on quit attempts, permitting combination pharmacotherapy, and broadening coverage for counseling - KanCare can improve health, yield substantial cost savings, and bring enhanced federal matching funds. Under current law, the state would be eligible for an enhanced match of 1% for providing these benefits to the standard Medicaid population.

Thank you for the opportunity to offer these comments on the renewal application. We look forward to constructive dialogue with KDHE regarding the future of the Medicaid program in Kansas.

Respectfully,

Rick Cagan
Executive Director

New Dawn Wellness & Recovery Center

4015SW 21st Street
Topeka, KS 66604
785 266-0202
785 267-3439
www.newdawnrecovery.org

Via Email: kdhe.kancarerenewal@ks.gov
KanCare Renewal
c/o Becky Ross
KDHE-Division of Health Care Finance
900 SW Jackson, LSOB – 9th
Topeka, Kansas 66612

Dear Becky Ross,

I am Nancy Lollman, Director of New Dawn Wellness and Recovery Center, in Topeka, Kansas. I am submitting the following comments regarding the State of Kansas KanCare demonstration 1115 (a) waiver for KanCare 2.0. I would like to see the waiver and accompanying KanCare managed care request for proposal and final negotiated contracts expand the capacity of and access to behavioral health services.

We serve Medicaid eligible members for the current managed care companies in KanCare and hope to do so in the future. In order to serve our members better we want to see currently closed mental health Medicaid codes available for our members. Allowing us to serve these members will increase the capacity in the system, give them access to treatment, provide member choice, and increase the outcomes for members, my agency, and the managed care companies.

We are provide Substance Use Disorders (SUD) treatment for members 13 years old and up. In addition to the traditional alcohol and drug treatment we also provide tobacco cessation treatment. Tobacco cessation is not a service that is reimbursable to SUD treatment providers at the present time. New Dawn also employes licensed social workers that can provide services for members with mental health diagnoses. We need to be able to treat our members with mental health disorders and receive reimbursement.

In addition to better integrating behavioral health services, we would also like to see in the KanCare 2.0 a replacement for the Kansas Client Placement Criteria (KCPC) as well as other reductions in the administrative burden including uniform credentialing processes. Our facility continually has problems with the KCPC, which amounts to thousands of dollars per year for maintenance and repairs to the system on our end. These are problems are the result of an antiquated system. When the system is down it is frustrating for the employees at New Dawn, the State employees that try to help us, and it is also costly.

Thank you for the opportunity to provide input and I am happy to answer any questions you might have.

Sincerely,

Nancy Lollman

Nancy Lollman LSCSW, LCAC, KCGCII

From: Therese Bangert
To: KanCare Renewal
Subject: Public Comment for KanCare Renewal
Date: Wednesday, November 22, 2017 10:48:16 AM

Sister Therese Bangert

Social Justice Office

Sisters of Charity of Leavenworth

Public Comment for KanCare Renewal

It is with deep concern that I contact you concerning the proposal to add work requirements and time limits to the KanCare program.

I have watched these past years as policy changes have weakened the Social Safety Net for vulnerable families and children. Though the rate of decline in the TANF assistance program has been widely promulgated by the DCF staff, there has been no follow-up study to show what has truly happened to the families who have left the TANF caseload.

To advertise this move with Medicaid as a replica of the successful implementation of these changes to TANF leaves many questions for me.

If the KanCare leaders want to truly implement such a policy, I ask that they have an independent follow-up study conducted on what has happened to families who have left TANF.

- One of the statistics DCF shared with the Legislature in the 2017 session was that 540 TANF clients reported employment in Aug. 2016 and the average hourly wage was $10.17.
- If these parents were employed 40 hours a week they would make approximately $1,600 a month . . . and that is not take-home pay.
- The Federal Poverty Guideline 2016 for a household of 3 is $20,160.
- This full-time job would not even bring a family up to 100% of poverty.

One criteria for looking at public policy is **"Who benefits and who is burdened."** As someone who has advocated for vulnerable families for several decades, I find this latest proposal placing burdens on families that will not bring benefits to the children of Kansas.

Peace be with YOU,

Sister Therese Bangert

[redacted]

[redacted]

From: Aurie Wornkey
To: KanCare Renewal
Subject: Public Comment Question
Date: Monday, November 20, 2017 2:26:55 PM
Attachments: Outlook-1463605275.png
Outlook-1463605244.png

On the voluntary work opportunity, where it identifies members who have a disability or behavioral health condition, and live in the community...what constitutes live in the community? In other words, does that include folks that live in the community with LTSS in provider owned or managed sites, or a location rented by community landlords that LTSS are provided in?

Many thanks,

Aurie Wornkey
Vice President of Supports and Services

[redacted]

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From: Scott Anglemyer
To: KanCare Renewal
Subject: Public comment submission
Date: Wednesday, November 22, 2017 2:53:39 PM

On behalf of the membership of the Kansas Association of Community Action Programs (KACAP), thank you for the opportunity to submit comments on the State of Kansas's draft application for KanCare renewal. KACAP's member agencies form a statewide network of agencies dedicated to addressing the causes and conditions of poverty in Kansas. A large share of the Kansans served by these agencies are individuals and families who currently receive or are potentially eligible for KanCare. Our member agencies work to better focus local, state, private, and federal resources to assist low-income individuals and families become more self-sufficient. Together, our agencies provide services to over 14,000 low-income Kansans each year.

KACAP members have deep concerns about the KanCare 2.0 renewal application's proposals to impose work requirements and lifetime time limits. While proponents offer a number of reasons for such proposals, the most common reason is that without these restrictions, recipients have little incentive to seek employment, and that, therefore, public assistance programs reduce employment and perpetuate poverty. The available evidence, however, shows conclusively that these claims are not true. In fact, it is clear that the type of restrictions presented in the state's draft renewal application are not only not effective, but would harm thousands of low-income Kansas families.

Work requirements and time limits do not increase employment. Numerous studies have shown that when states impose or strengthen work requirements and/or time limits on programs such as Temporary Assistance for Needy Families (TANF), families receiving such assistance are no more likely to obtain employment than they were prior to the imposition of such restrictions. In fact, analysis of data on TANF exiters obtained from DCF via a legislative request shows that households that exited the TANF program because either they met their time limit or their cases were terminated for failure to meet work requirements actually had lower rates of subsequent employment and lower average earnings after exit than did households that exited the program for any other reason.

Supporters of such restrictions point to the number of placements of TANF recipients in new employment since the tightening of work requirements and time limits in Kansas, but these numbers are never compared to placement rates prior before these new requirements were added. And while it is true that the likelihood that TANF exiters are employed after exit has increased slightly since 2011, that increase coincides almost perfectly with the overall improvement in the job market, suggesting that overall economic conditions, and not more restrictive TANF policies, have accounted for better employment rates. There is no reason to believe that time and work restrictions on KanCare will be any more likely to increase employment than have such restriction on TANF, whether in Kansas or in other states.

Time limits are especially punitive to low-income families who are working to get out of

poverty.

Families that leave public assistance for employment most often obtain jobs that are low-paying, are part time or have unpredictable and varying hours, and provide little or no benefits —including health insurance. As a result, families rely on KanCare to give them access to healthcare that they are not able to obtain through employment, either because it is not available, they do not work enough hours to qualify, or because they don't earn enough to afford to pay their share of the insurance costs. Families can find that their efforts to obtain employment result in significantly higher healthcare costs, making them susceptible to returning to poverty when medical issues arise.

Contrary to the narrative that is used to justify these restrictions—that the programs remove the motivation to seek employment—our members see low-income individuals every day who recognize the importance of having a job, and are working every day to obtain and maintain employment that supports their families. These restrictions send them the message that, rather than giving them needed support while they are working to escape poverty, Kansas wants to push them into jobs that jeopardize their families by keeping health insurance beyond their reach. That is not a recipe for reducing poverty in the state.

Scott Anglemyer
Executive Director
Kansas Association of Community Action Programs
[redacted]

Saint Francis Community Services®
Serving Children and Families Since 1945

Public Comments on Application for Section 1115 Waiver
Rachel Marsh, Executive Director of Public Policy
November 21, 2017

Thank you for the opportunity to submit comments on KanCare 2.0, the current application by KDADS and KDHE for a five-year Section 1115 demonstration renewal from CMS.

Saint Francis Community Services (SFCS) is a non-profit, mission-driven provider of a range of quality services for children and families across Kansas. SFCS provides mental health services, substance abuse treatment services, and child welfare case management services in Kansas. In our case management services alone, SFCS cares for over 3,400 Kansas children placed in out-of-home care for communities from **Manhattan, Wichita, and Emporia to Liberal, Colby, and Hays.** SFCS provides residential services for youth in child welfare and juvenile justice Foster Care Homes, three Youth Residential Centers, and a state-of-the-art Psychiatric Residential Treatment Facility for children and youth.

As a provider of foster care, residential, and mental health services across Kansas, SFCS is uniquely positioned to describe the critical role of Medicaid services for the most vulnerable Kansas children and families. Access to quality, timely, and effective health care services is critical in **strengthening Kansas families, reducing the likelihood of out-of-home placement for children**, and **improving the lives of abused and neglected Kansas children.** As a provider of services for vulnerable children and youth, we have experience with the successes and challenges of KanCare 1.0, which we ask you to consider as part of decision-making.

Overview: The impact of Medicaid on serving youth in foster care

(1) Access to quality services through Medicaid strengthens Kansas families and reduces the likelihood of out-of-home placement for children.

(A) The proposed KanCare 2.0 program limits eligibility for at-risk families, and creates unduly burdensome bureaucracy for otherwise eligible parents.

Kansas parents need access to care for critical health needs. Work requirements and lifetime eligibility limits proposed in KanCare 2.0 will decrease the likelihood that a parent will access essential services such as mental health services or substance abuse treatment, increasing strain and stress on families caring for children. **Children are at higher risk of suffering from neglect and abuse in homes where parents are experiencing unmet behavioral health needs.**

The proposed KanCare 2.0 program does not indicate the number of Medicaid recipients who would be subject to work requirements *who are not already subject to TANF work requirements*. Without this data, Kansas has not shown a demonstrated need to implement this eligibility barrier and create increased bureaucracy for otherwise eligible Medicaid applicants. Further, evidence indicates that work requirements don't improve health outcomes under Medicaid. **The work requirement creates an unnecessary and ineffective layer of bureaucracy for otherwise eligible applicants to navigate and for the State bureaucracy to manage.**[1]

Finally, the KanCare 2.0 application is unclear as to whether *work requirements will apply to youth who have aged out of foster care* – a population among the most vulnerable across our state. **How do the work requirements – and lifetime eligibility – of KanCare 2.0 impact former foster youth?** Conceivably a child could age out of foster care at 18, attend college with Medicaid coverage, and have maximized her lifetime limit of Medicaid eligibility before she even enters the workforce. Is this intended? If so, SFCS advocates that **Kansas youth aging out of foster care need and deserve more support in accessing needed health services to grow, learn, and recover from their trauma history.** Creating barriers for former foster youth as they enter adulthood – who are very likely to have ongoing physical and mental health challenges - by making them ineligible for health care due to work requirements and lifetime limits is contrary to effective public policy.

(B) The proposed KanCare 2.0 program does not address the need to strengthen services for children who need critical mental health services to avoid placement in foster care.

The most severely mentally ill Kansas children require critical services to avoid out-of-home placement. The number of children placed into foster care has reached an all-time high placing strain on system resources. **Some Kansas children entering foster care are coming solely because their parents could not navigate access to care under KanCare 1.0 and/or because they did not qualify for Medicaid until placed in foster care.** The State of Kansas has a legal obligation under federal and state law to make "reasonable efforts to prevent removal from the home" under the Kansas Child in Need of Care Code. Under KanCare 2.0, the State of Kansas has the opportunity to focus on expanding access to children at risk for coming into foster care and ensuring those children already on Medicaid are accessing needed services without having to enter foster care. The KanCare 2.0 application is silent on both of these critical needs for Kansas children – and silent on the obligation of KDHE and KDADS to operate in conjunction with DCF to ensure the State of Kansas' obligations to at-risk children are met.

[1] Many individuals subject to this new work requirement may already be receiving Temporary Assistance to Needy Families (TANF) and therefore are already subject to work requirements. Adding a work requirement to Medicaid/KanCare creates a new and additional bureaucratic hurdle without the promise of effectiveness.

(2) Access to quality services through Medicaid is essential to improve the lives of abused and neglected Kansas children in foster care.

(A) The KanCare 2.0 application does not articulate a discernable, operational plan to improve the health and wellbeing of foster youth.

Strategies and tactics to strengthen health outcomes for foster youth must be clear, accompanied by a discernable plan and accountability measures. SFCS agrees with the recognition by KDHE and KDADS in the KanCare 2.0 application that the State of Kansas has an obligation to ensure the health of foster youth in our Medicaid program. Setting the goal under KanCare 2.0 of "providing service coordination for all youth in foster care" is essential. However, **the KanCare 2.0 application does not provide any level of operational information to indicate how health outcomes for foster youth will be achieved**. How will service coordination be accomplished? What target populations will be the focus? What will change in the new design? Similarly, the reference to improved service coordination for members living in rural and frontier areas – where many foster children live - is also lacking in operational detail.

(B) Serious concerns for the health of the most severely challenged youth in care have not been addressed or acknowledged by the KanCare 2.0 application.

Under the present KanCare 1.0, many foster youth suffering from the most severe behavioral health needs have struggled to access services needed to improve health.

- Mental health services are recommended by MCOs that are **not actually available** in Kansas communities where the foster youth reside.
- MCOs recommend treatment in family settings for youth whose level of care exceeds what most family foster homes can provide, leaving children both **untreated and without appropriate placement.**
- MCOs have declined treatment authorization for mental health symptoms that manifest as aggression because "the child needs consequences" – yet in Kansas under juvenile justice reform, detention consequences are in large part no longer available, **leaving these children without consequences or effective treatment.**
- Screening/authorization criteria for acute care and psychiatric residential treatment are **unclear and vary between MCOs.**
- Screening/authorization for acute care and psychiatric residential treatment for youth with suicidality or physical aggression in mental health symptomology are denied.
    - The State of Kansas has a legal responsibility to ensure the best interests of children placed in foster care under the Kansas Child in Need of Care Code. Unfortunately, MCOs have applied the medical model of "baseline" to youth in care who are suicidal or physically aggressive – thereby **denying critical medical care to the most**

vulnerable Kansas children. This abdicates Kansas' responsibility to seek the best interests of children in favor of short-term costs savings to the MCOs. Of course, the State of Kansas still pays in the long-term for higher levels of care for children who cannot be safely cared for in family foster homes.

- Network adequacy for psychiatric residential treatment facilities has not been ensured. Children who are authorized/screened **wait between 2 weeks to 3 months for treatment in psychiatric residential treatment**. Girls, younger children, and the most symptomatic youth wait the longest.
- Length of stay authorized in psychiatric residential treatment has shortened to that more resembling an acute care model – leaving **children who need longer term treatment for more chronic conditions without an effective treatment alternative.**

Unfortunately, **none of these concerns are addressed in the KanCare 2.0 proposal** with the specificity to comment on efficacy of any proposed approach, appropriateness of outcome measurements for this population, or accountability standards.

(C) The KanCare 2.0 application includes no commitment to any specific performance measure, outcome standard, or criteria for accountability for the improved health of foster youth.

Clear and certain accountability measures related to health for children in foster care should be incorporated into KanCare 2.0. Standards to which the State of Kansas is accountable for foster youth include length of time to permanency, placement in a family-like setting, and placement stability. All of these outcomes are dependent on access to effective and timely health treatment. **KDADS, KDHE and DCF must work together to identify performance and accountability standards to ensure foster youth receive necessary health services that support broader State objectives and legal obligations.** That the State is "*considering* the implementation of pilots" commits Kansas to no action to improve the health of foster youth. That the State references only "*potential* measures that the State *may* use to test the KanCare 2.0 hypotheses" commits Kansas to develop no evaluation measures at all. A Section 1115 waiver application for a demonstration project should contain adequate detail and accountability by the State, such that both Kansas and CMS can discern whether the project was a success or failure. This application does not include the requisite level of detail to determine success, especially insofar as it relates to improving the health of foster youth in Kansas.

(D) The KanCare 2.0 application does not address the issue of due process for foster youth under Medicaid.

Children in foster care have the same Medicaid rights as other populations – services should not vary by provider, and the right to the full range of appeal and grievance procedures should apply. At this time, children in foster care receive different outcomes with different MCOs.

Processes are different, standards are not public or clear, and decisions are made differently by provider. Compounding this concern, **KDHE has discouraged foster youth from using the State Fair Hearing process** - otherwise available to all Kansans - to seek redress on Medicaid determinations. Due process rights are a significant legal and substantive issue for youth denied access to necessary care and should be addressed in the KanCare 2.0 proposal.

Recommendations:

SFCS recommends CMS/Kansas ***extend the existing KanCare 1.0 program one year*** *and work to develop a subsequent waiver application for KanCare 2.0 in which meaningful, specific, and detailed operational and evaluation plans can be described.* SFCS is happy to join KDHE and KDADS with others to identify legal obligations the State of Kansas has to vulnerable children and families at risk of or experiencing foster care, and to identify approaches for performance goals and outcomes to ensure the health of this population.

Thank you for your consideration.

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[redacted]

KanCare 2.0 Comments

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Summary

There are many good ideas and concepts presented in the KanCare 2.0 application. It is clear that efforts have been made to address issues and concerns raised by providers, advocates and people with disabilities. Examples include themes, goals and initiatives important and worthy of pursuing in a demonstration Waiver:

•Maximizing independence of people with disabilities

•Identifying and focusing on social determinants of health and independence

•Significantly expanding service coordination

•Requiring MCOs to contract with local, community organizations and experts to provide key services and supports to address social determinants such as housing, employment, social connections, community life, etc.

•Improving and expanding Person-centered Planning and Service Delivery

•Interesting ideas for Pilot Projects including increased support toward employment and independent living for people with disabilities.

Notwithstanding the good ideas, themes, concepts and goals, however, concerns that remain include:

•MCO conflicts of interest

•Lack of implementation details

•No detailed budget or cost information

•More thorough analysis and discussion of past performance

•Need for more thorough study, analysis and discussion of performance of KanCare 1.0

•Truncated, inadequate input process

TILRC has for many years shared the broad goals, themes and initiatives as they relate to people with disabilities outlined in KanCare 2.0, but (including funding to end wait lists) it is going to take substantial increases in expenditures, and time and effort to really make progress. More time and more planning would be welcomed and would maximize conditions for success. For years, TILRC has joined with other

cross-disability organizations in impleading the State of Kansas to develop an *Olmstead* Plan, to create a cogent, cohesive plan for addressing the current needs and the inevitable demographic facing the future long term service and supports demands that will be placed on the state. With several years of the KanCare demonstration behind us, this represents a perfect time to undertake this type of planning process. With the current flexibility and deference afforded States by CMS, there should be no need to have to needlessly rush into anything.

Finally, about work and employment – The artificial and unnecessarily confusing distinction between so-called "able bodied" and people with disabilities is insensitive and creates almost class distinctions. 30 years of teaching Independent Living Philosophy leave me feeling quite uneasy about this framework. There is no fine crisp line between "able-bodied" and having a disability. The disability population actually being referenced is a much smaller subset of the disability community, folks that are institutional/HCBS eligible. There are many, many people with disabilities that have more or less hidden disabilities, chronic health conditions and/or combinations of these, that are not necessarily eligible for an institution/HCBS or even Medicaid, but still could benefit from increased, long-term assistance and supports to pursue and maintain employment and living a good life.

All of the above being said, it is also not the best policy to declare that people with disabilities do not have to work. To be clear, no one is arguing to have hard requirements for working neither for institutionally/HCBS eligible individuals, nor for the larger universe of people with disabilities. It might be better to state a clear philosophy that the culture and social mores of Kansas are that we are hard working; that the State is committed to supporting Kansans with pursuing the job or career of their dreams. Creating two social classes, one that must work and one that doesn't have to, just isn't necessary.

Detailed Commentary- KanCare 2.0

Detailed input about the KanCare 2.0 application is found below. Page numbers, headings and/or paragraph are provided for ease of reference.

Page 1, second paragraph

"The original goals of KanCare focused on: integrated, whole-person care, creating health homes, preserving or creating a path to independence and establishing alternate access models with an emphasis on HCBS."

There should be an analysis on how we did on these goals after 6 years of KanCare. Discussion of successes and barriers and what was learned would be very helpful. Linkages could be more clearly drawn between lessons learned and how those lessons are being applied to the KanCare 2.0 proposal. To the extent there is continuity between KanCare 1.0 and 2.0, more thorough hashing out of how 1.0 performed is necessary to best implement 2.0 and maximize future performance with the new theses and various programmatic goals.

The new goals listed in the last sentence of this paragraph ("improve health outcomes, coordinate care and social services, address the social determinants of health, facilitate achievement of member independence and advance fiscal responsibility") sound great and are universally supportable.

Page 2, second paragraph

Long Term Services & Supports (LTS&S) have been left out of the list of delivery systems to be integrated. LTS&S represent a significant budgetary outlay and populations served and really need to be specifically and separately listed. LTS&S are not the same as "long-term health care" and should not be conflated. The former includes non-medical, unlicensed services delivered under a social-model philosophy. The latter are licensed, medically supervised provided under a medical-model philosophy such as nursing facilities or home health.

Page 3, **Requested Changes**

The inclusion of the social determinants of health and independence is great. TILRC looks forward to working with the state and MCOs on these important factors such as transportation, housing, employment, recreation and so on. An additional determinant of independence is self direction of attendant services. The importance of having control over when one gets, what activities are performed when and so on cannot be overstated in terms of being involved in community life, including being employed. A person that cannot exercise control (with or without support) over when to get up in the morning and what to wear, likely isn't pursuing her chosen dream job or career path.

Page 4, top of page

The three hypotheses are very supportable and are worthy of pursuing. Expansion of care coordination is much needed. What has been available in the first demonstration was inadequate. It will be important, however, that the MCOs do not try to cover these requirements in-house. Work on these social determinants will be best carried out by local, community-based organizations with deep ties and connections in communities and it is a very welcome addition to see that contracting with local community organizations will be required. Further, hands-on social determinants efforts should be carried out by peers, people with disabilities of all ages that have experienced similar situations. Adequate funding to support local, community organizations' involvement must be available.

Substantial outlays of additional financial resources and increased attention to increasing provider capacity will have to be made in order to make real progress with expansion of service coordination and its goals such as increasing employment and independent living.

Page 4, **Figure 3. Key Themes and Initiatives under KanCare 2.0**

The themes and initiatives are all worthy and it is great to see this language included, but funding and concerted efforts will be needed to advance person-centered planning, to have a lasting impact and to make progress on social determinants of health and independence, and to promote the highest level of member independence. Translating these themes and initiatives from great ideas into services and supports with solid outcomes will require alignment of philosophy with funding, programming and quality oversight. It will take time and individual attention to move many individuals toward increased independence.

Page 5, *Coordinate Services to Strengthen Social Determinants of Health and Independence, and Person Centered Planning*

The definition of service coordination is promising. Not to parse words too much, instead of "care" a better description of "person-centered" would be that it is a philosophy of assessment of, planning for,

and delivery of, services. It entails a much broader universe than "care" which usually applies to medically supervised services. It also would help for the promise entailed by a "holistic, person-centered approach" to be be fleshed out to give a better understanding as to why it is needed and why "service coordination" is a better conceptual model than "care coordination". More discussion as to how the new service coordination will work be very helpful.

Figure 4. Key Elements of the KanCare 2.0 Service Coordination Model

This figures shows the significant expansion of service coordination. It would be helpful for discussion of this ambitious effort to include more detail, in particular budgetary detail and how increased costs that are reasonably expected are to be covered. Instead of using "Provides person-centered care", perhaps instead use, "facilitates person-centered planning and delivery of services and supports".

Page 6, **Plans of Service and Person Centered Service Planning**

Second Paragraph.

The tools mentioned (initial health screening, HRA and other assessments) should be at least described and better yet included as an attachment, or a link. These tools are very important in this new, comprehensive, holistic, person-centered effort. Imbuing the tools with person-centered philosophy form part of the foundation upon which the goals of KanCare 2.0 are built.

Another comment about the process described in this paragraph is that it seems unwieldy for people with disabilities needing Waiver and other LTS&S. First a health assessment is performed, then a health-risk assessment and then there is yet another type of needs assessment? Perhaps this process is not correctly understood, but the description in this section is confusing. A clear and more in-depth discussion is needed to spell out how the tools mentioned interface with person-centered philosophy and service coordination.

Third paragraph

Instead of saying MCOs will develop plans based on their needs, say that plans should be based on individual member needs. "Person-centered" is not an object or a thing, but rather it is a philosophy and process that makes the individual member the center of, as well as the driver of, planning and implementation of services. Person-centered philosophy and approaches should be the underlying basis for all processes and interactions with consumers and their families whether it be Service Coordination, service planning, plan implementation and evaluation and monitoring of final delivery of services.

Page 6 & 7, *Plan of Service*

Whether a "plan of service" or a "person-centered plan", person-centered planning philosophy and approaches should be used. "Encouraging" members to participate in their planning is too weak and wish-washy. Members should lead and direct their planning and all interactions with MCOs to the maximum extent feasible (See below, 42 CFR, Part 441). "The Plan of service is a written document...in accordance with state policy." What state policy? If there is a state policy that dictates service plans,

then that policy should be described, including how the policy governs service plans, and appended to this application by footnote or link.

The rest of the description of service plans is good. More detail as to the process and implementation would be helpful.

Unpaid or natural supports' availability and duties should be driven and controlled by the individual member and her family, as appropriate. If just left to the MCOs, unpaid supports in planning have the appearance of being a conflict of interest and an unfair imposition because the MCOs can benefit financially if services and supports do not have to be paid for.

Page 7, Person Centered Service Planning

According to the federal regulation cited, "42 CFR 441.301", the consumer should lead the planning process and exercise as much control as possible. This requirement is more stringent than just "participation". Having the MCOs in charge of ensuring that this occurs is a huge conflict of interest. There ought to be more discussion about how this would actually occur. Otherwise the MCOs will pursue their self-interest which may be more or less in keeping with the regulation cited. The MCOs wear too many hats – service planner, service coordinator, payer for services, monitor of person-centeredness and so on. Firewalls between such functions as assessing, plan of service development, and payment need to be developed. Otherwise, at least an appearance of conflict of interest will always remain.

Peers should be included in the inter-disciplinary teams as much as possible. People with disabilities who have experience with planning for and using services and supports are the best experts in the field.

Page 7, **Figure 6. KanCare 2.0 Planning Process**

The diagram modeling the flow of the planning process further points out concerns raised about MCOs wearing too many hats. They develop the plans, monitor them for compliance and services provision, and then re-evaluate the appropriateness of service coordination. There needs to be a neutral third party to do independent evaluation and re-evaluation of appropriateness of plans, services and related coordination of same. With the addition of social determinants such as employment, community involvement and so on, as well as the enhancement of person-centered philosophy in assessment, planning and delivery of services, the new planning requirements may deserve some extra evaluation and attention as they roll out in order to maximize alignment with and positive impact on the themes, initiatives and hypotheses of the demonstration.

Community Service Coordination

These bullets describing community service coordination are important and good to see. Coordination and close communication with community agencies and different providers will be necessary to achieve results. It looks like the new KMMS data system is expected to address these needs. Notwithstanding KMMS, other avenues for communication and coordination will have to be explored to maximize success in efforts toward person-centeredness, self-care and independence, community access and participation and so on.

Page 8, top of page, **Community Service Coordination**, cont.

Requiring MCOs to work with local community agencies is a great idea. The examples listed of the types of activities that community agencies should be involved in are instructive and important to success. Community organizations are best situated to provide the extensive and longitudinal assistance sometimes needed by people with disabilities to realize their goals and further their independence. This responsiveness to issues raised by advocates is appreciated. One of the issues our agency has encountered in our attempts to work with MCOs in the current system is State agencies' insistence in inserting State agency review into the agreements the MCOs and service providers are negotiating. State micromanagement of specific services has been a significant barrier to the development of creative, responsive community-based systems in the current KanCare. This issue should be addressed so it does not continue to be a barrier in KanCare 2.0, especially with the stated commitment to community service coordination and expanded consumer services. More detail including any projected extra costs and other budgetary information would be helpful.

Page 8, **Service Coordination Pilots**

Figure 7. Potential Service Coordination Pilots

Again, it is appreciated that the state listened and responded to concerns and issues raised by the disability and provider communities. These are all worthy projects, but detail is lacking, especially budgetary information. That pilot projects being considered seem awfully iffy; "considering" "potential projects". Are there priorities amongst these potential projects? Will detail, including budgets and time-frames, be fleshed out and shared with the concerned public before the decision to implement a given project?

One issue that pops out right away after reviewing Figure 7, is that there is considerable overlap between the different target populations – people with physical disabilities may also have mental health needs and live in rural or frontier areas of Kansas. Likewise, people with chronic health conditions may also have disabilities and mental health needs and so on. On the other hand, many services and supports needs of the various disability groups can be quite different from group to group when generalized across populations. The best way to cut through these seeming inconsistencies is to focus on each individual and individual needs and not so much on general labels of groups with limited and distinct menus of options for each group.

Another comment about Figure 7 is to highlight the need to make sure and define "provider" to include direct services and supports workers, in the bullet, "Increase provider capacity through tele-mentoring". This would allow those that provide the daily, critical hands-on assistance to benefit from information, training and support that could be made better available through use of technology. In the same vein, workforce and consumers in rural and frontier areas would benefit from getting help with access to equipment and service in order to connect to the information superhighway.

Page 9

Promote Highest Level of Member Independence

There is good language and excellent supporting footnotes in this paragraph. A curious oversight, though, is the lack of any mention of self-direction of HCBS. Kansas, in 1989, was one of the first states

to set out the right of consumers to self-direct without regard to age or disability label. Kansas remains the only state to have enshrined comprehensive rights to self-direct in state law. This unique achievement needs to be included in discussion of member independence, but more importantly, as self -direction has dropped off in recent years, it needs to be encouraged and advanced if we are to embark on a path to increase member independence, and community integration, including employment. After all, if an individual has no control over when they get up, where to go, how to use transportation, etc., then we are describing someone that is not going to be competitively employed in an integration setting at a job chosen by that person. Control over one's services and supports is a basic precursor to the full integration and employment that is vision of our a State and its programs.

Pages 9 & 10

Employment Programs

The Protected Income level (PIL) of $737 needs to be eliminated. At the very least, the PIL needs to be increased and earned income ought to be allowed to be exempted from the regular PIL. This would encourage folks to better explore the benefits of employment without moving from current services on an HCBS Waiver and before transferring to the relatively stricter requirements to work and earn of the WORK program.

Flexible services and supports that encourage and backstop employment are needed in the HCBS Waivers (as in the WORK) program. These supports would encourage people with disabilities to be able to explore volunteer and intern possibilities as a precursor to more permanent employment.

If the policy of the state is that working age adults are expected to work, then exempting people with disabilities, categorically, from expectations of employment is not the best policy. Everyone can be encouraged to work given the support needed. It really doesn't illuminate the discussion to refer to "able bodied" vs. "disabled" as these two categories really overlap broadly as opposed to distinctly existing along a clear, thin line. Most people with disabilities want to work and could work given sufficient, appropriate supports especially those needed to maintain employment in the long term.

Page 11.

Eligibility

There are a couple of points raised about natural disasters in this paragraph that merit more discussion. One is emergency preparedness and the other is flexibility and continuity of eligibility for services.

There is a significant need for more intensive emergency preparedness planning and training. From Hurricane Katrina in 2005 to this year's Harvey, too little has been learned and too little changed when it comes to accommodating and coordinating the needs of people with diverse disabilities and chronic health conditions that are living in the community. Kansas, thankfully, does not experience hurricanes. We do, however, experience devastating tornados, flooding, ice storms and fires.

In the event of a severe catastrophe, where do people with disabilities evacuate? Will transport such as boats, vehicles be wheelchair accessible? If not how will mobility and other assistive equipment be transported and repatriated with the owners as quickly as possible? What assurances will exist that service animals can stay with their humans? How will home and community series and supports be

continued or restarted with as little disruption as possible, especially if evacuation is across state lines? How will individuals evacuated to facilities and institutions be repatriated to their own homes and communities as rapidly as possible? Etc. Etc.

Natural disasters can cause severe disruptions in housing, transportation, health care, food supplies and other necessities and, ultimately, in employment. If a severe disaster strikes, more than one month in additional benefits may be necessary. There should be some additional flexibility for individual situations.

Page 13.

Work Opportunities for MediKan Members

This could be an interesting pilot. One concern is the need for extra careful advice and coordination before the member's decision is made; to ensure a fully informed decision is reached. There will be cases when an individual, due to unforeseen, extenuating circumstances, needs to go back and file for permanent social security benefits. This ought to be discussed. A related is concern is around the time-limitation for receipt of services. This needs to be carefully reconsidered to be flexible, individualized and person-centered because some individuals need ongoing therapies and supports to be successful, especially in the long-run because many (especially entry-level) employers do not provide benefits or pay enough for private-pay arrangements. An affordable, sliding-scale arrangement similar to that in the WORK program would be good for those that need ongoing and otherwise unaffordable services and supports in order to maintain or advance job or career goals and live a good life.

Requiring the MCOs to work with local community partners is a good idea. There is also a need to work with all types of employers and businesses around the state to foster hiring of this target population. For employment initiatives to be successful, many more private sector employers have to be developed. The State having a preference for hiring people with disabilities would be an important display of leadership in employment of individuals with disabilities.

Page 14

Work opportunities for a Members who have Disabilities or Behavioral Health Conditions

A 1915i Waiver pilot to test increasing of employment of people with disabilities by offering otherwise unavailable supports and services would be welcomed. I believe that a 1915i Waiver is allowed to interface with a 1915j (e.g. the WORK Program) in a seamless manner. A creative, flexible approach to advancing employment of people with disabilities that is based on best practices will be necessary.

Additional details would be very helpful in better understanding what such a 1915i Waiver would look like, how it work, what it would cost and so on. Moreover, clarity about what would trigger a decision to go ahead needs more discussion and should be clearer. Reference is made to making a final determination "after public comment and additional analysis...under each option". This is very confusing. What "options"?

Independence Accounts

Please also consider that this concept could also benefit people with disabilities wanting to work or currently working by allowing them to build up savings and assets beyond the current limits set by the PIL and the asset limitations of HCBS. An additional improvement would be for pilot projects to work together. For example, could the 1915i program also include access to "Independence Accounts"?

Independence and employment need to be encouraged. Including a penalty that risks being barred from even applying for Medicaid is unnecessary and too harsh. An individual' s health or disability or family status can change suddenly and necessitate the assistance afforded by Medicaid. If the program is effective, it will support people to engage in and maintain long term employment without holding a metaphorical sword over peoples' heads.

Private insurance is not always available or affordable. Moreover, private insurance doesn't always cover the health needs, or service and supports needs of the individuals such as case management. It should be noted that out-of -pocket expenses for individuals with private health insurance have also been going up at a steep rate right along with public insurance. These dynamics between public and private insurance can be a driver for individuals' needing to enter the public systems.

Page 15 & 16.

Value-Based Models and Purchasing Strategies

Encouraging innovation in service delivery and payment systems is a welcome idea. Some of the "Descriptions" are intriguing. More detail is needed about how this would work, including financially, and what the budgets and/or other limitations as to the scope of the projects.

Figure 10. Examples of Value-based Model and Purchasing Strategies

In this chart, the "Description" of the "Approach", Long-Term services and Supports, should include increasing the use of self-directed options in HCBS that increase individual independence and autonomy.

Page 17.

Quality improvement

Quality measures and metrics for LTS&S are missing from the discussion on quality and the data sets referenced are for health, not LTS&S. A working group (I was a participant) was formed by KDH&E and a set of LTS&S Quality Measures was drafted based on current research. These are being reviewed by KDADS. It would be great to incorporate LTS& S quality measures in this demonstration application since we have never really had them before.

Page 23, **Alignment of MCO Operations**

Administrative standardization would be a positive step. Alignment between state and MCO administration operations would also be of benefit. For example, it is extremely difficult to have to address MCO financial claw-back requests that are are two or even three years old and well after the state has required that all excess funds be accounted for and paid in full to the workers and/or to the state and the provider's books closed out.

A final thought around alignment of MCO operations and quality is that a council ought to be formed between MCOs, providers and other community members that would provide continuous quality improvement and feedback as it relates to service systems.

Page 24, **Data Analytics Capabilities**

The new data system sounds really good. However, a 360 degree view of an individual's data is not the same thing as meeting individual needs holistically. Needs are still best met by people working with people.

An additional point is that access to the data by watchdog groups or the concerned public is not addressed. Will there be generalized information (not violative of HIPPA) available?

Page 25, **Figure 13. Enhanced a user Experience**

The data system will need to be accessible and interface with screen readers, include captions for any audio and so on. Section 508 compliance is a federal legal requirement. Conversely, many people that TILRC serves do not have internet access so automated systems do not provide good information interfaces. Finally, many members do not read and comprehend well enough to make good use of displays of technical information. We should explore creative ways to increase internet access of older Kansans and people with disabilities while we also advance person-centered methods of communicating and understanding information and options of concern to members.

Page 27, **Quality Reporting Summary**

There is a need for LTS&S performance measures. These are quite distinct (Outcomes) from HCBS Waiver reports which are generally outputs.

MCO performance measures for LTS&S ought to be included in this discussion and they should be enshrined in state policy and standardized across all MCOs.

Page 28, top of page.

The Final Evaluation Design cited and referenced by link doesn't include LTS&S quality measures. LTS&S is too important, and expensive, to be left out of evaluation design.

Page 31 & 32.

The discussion of network adequacy needs to include Direct Support Workers (DSW). The shortage of DSWs is getting critical. It is harder and harder for people to find and retain good workers. Data should be collected and reported about adequacy of availability and quality of DSWs.

Page 34. **Figure 18. Projected KanCare 2.0 Enrollment and Expenditures**

Disaggregated and more detailed budget information would better illuminate expenditures and trends. It would be helpful to see breakdowns by major program or cost center such as by 1915c Waiver, for acute vs. preventative health care, hospital, and so on.

There are substantial increases amounting to hundreds of millions of dollars each year. These need to be bette detailed and explained. How are the increases being targeted? How are increases tied to (what) outcomes? Earlier in the document, things like substantial increases in service coordination activities, new pilot projects, and a new data system are presented. It would be helpful to see cost and budget information and discussion tied to the expanded or new endeavors.

Page 35, **Evaluation Design**, third paragraph down from top.

The new goals of KanCare 2.0 are laudable. As the state modifies and strengthens evaluation activities, people with disabilities and advocates should be involved in a substantial manner.

Evaluation of the demonstration is critical to success. There needs to be discussion about key elements of the design, how they will differ from those used previously and why they will be remain the same. Understanding the evaluation answers key questions about how services are to be provided, monitored for person-centeredness and other newly proposed features and indicators of quality. As the evaluation is developed, outside experts such as researchers, people with disabilities with experience living successfully in the community, advocates and providers ought to be deeply involved.

Page 35. **Previous Evaluation Findings**

Once again, the lack of LTS&S performance metrics are noted.

Page 36, top of page, **Cost of care**.

There needs to be a more thorough discussion about the drop in NF stays in light of the absence of a corresponding increase in numbers served on the PD and FE Waivers. Drops in NF stays, combined with static or even lower numbers on the main HCBS alternatives to NFs could be cause for concern; begging the question, "Where did folks go? What assistance are they receiving? These questions are important because we re talking about people at institutional levels of need.

Page 40. **Figure 22. Quantitative and Qualitative Reports**

Again, LTS&S elements are needed here.

VII. Compliance with Special Terms and Conditions, second paragraph

Discussion of a backup plan in case the Managed Care Final Rule is modified or replaced entirely (a rumored possibility) would be helpful. What would the State's oversight scheme look like in the absence of the cited federal rules (Managed Care Mega-rule).

Page 43, second bullet from the top.

More effective consumer and provider communication would be a good idea. Examples would be direct alerts with links to all policy changes, proposed changes, requests for comments and so on. Social media is used by consumers more and more to communicate while at the same time many do not have good internet and email access. This necessitates using direct mailings to consumers which costs more

than just posing to a website. An effort to increase the "connectivity"of older Kansans and Kansans with disabilities should be considered.

Appendix E., 2016 KanCare Evaluation Annual Report

Year 4, January – December 2016

Page 29 & 30.

There are some significant reductions in some pretty important metrics. Examples include a significant drop in a WORK program participation and numbers of Waiver participants whose service plans meet their needs. Performance of a gap analysis is cited. What happened? What was learned about gaps? More thorough discussion of how to address the problem areas and continue to improve in success areas would be welcomed.

From: Robbin Allen
To: KanCare Renewal
Subject: Written comments about the KanCare renewal
Date: Wednesday, November 15, 2017 11:23:54 AM

My Written comments about the KanCare renewal

I have a son on the IDD wavier and have a number of complaints about the KanCare system. It is my belief that KanCare has some flaws that need attention. MCO care coordination system should be eliminated I have found no value in a care coordinator.

1. **MCO care coordinators conflict of interest.**

"Usually, in HCBS waivers, a person is considered to have a conflict of interest if s/he is paid to provide services to a participant, and also has authority to decide what services are provided or who will be paid to provide them." How does this not apply to MCO care coordinators?

1. MCO's care coordinators conduct's needs assessment of waiver participants. "Limitations on the amount and type of waivered services are governed by the assessed need of the participant and monitored by the participant's KanCare MCO".
2. MCO care coordinators work for the MCO's to provide services to a participant. MCO's make their profits from cost saving.
3. MCO care coordinators have authority to decide what services are provided on the participant's integrated service plans.
4. MCO's have authority to decide who will be paid to provide services as they contracts with providers of service.

Example of how MCO's apply conflict of interest: MCO's have applied an occupational therapy and physical therapy evaluation rule to IDD waiver of assistive service(s) but if a member cannot find occupational therapies and physical therapies to do the evaluation because MCO's do not pay for home evaluations then they make assistive service inaccessible.

Example of how MCO's apply conflict of interest: MCO Service Coordinator refuses to add need DME supplies and equipment to the integrated service plan so they do not have to support finding contracting providers.

Example of how MCO's apply conflict of interest: MCO's have applied limitations on type of waivered services a participant can access not by the assessed need of the participant but by the difference in revenues. From a MCO Service Coordinator *"Regarding the service you are requesting. I don't see a service that is meeting* participant's *needs being replaced by a service that is at a higher cost and provides the same core. I'm not saying that we can't request it, but the only need is for the difference in revenues and that isn't a realistic request"*.

Example of how MCO's apply conflict of interest: MCO's have applied limitations on the amount and type of waivered services not governed by the assessed need of the participant but by their own extended capable person policy. No time will be allowed on the integrated service plans for PCS to complete activities such helping participant make phone calls, money management, doctor visits or transportation. Sure thought this was the State's capable person policy "specifically, no time will be allowed on the Plan of Care for PCS to complete activities such as lawn care, snow removal, shopping, ordinary housekeeping or laundry or meal preparation as these tasks can be completed in conjunction with activities done by the capable person".

Example of how MCO's apply conflict of interest: MCO care coordinators are required by state regulation to meet with members a minimum of twice per year, once for the annual and once for a 6 month review of services. Integrated service plans are written for a full year, participants have been told if they do not meet with care coordinators they may lose their insurance.

2. MCO care coordinators do not have the same training as Case Mangers; it is my belief MCO care coordinators should not be doing needs assessment without the state certifying their training to do so.

3. MCO care coordinators and their little I pads and asking participants to sign integrated service plans they cannot read.

4. MCO care coordinators and participant's lack of abilities to contact them directly.

5. MCO care coordinators losing or miss placing participant's provided paper work and then demanding participant's supply paper work again.

6. MCO care coordinators have little or no knowledge of community resources.

7. MCO care coordinators have little or no knowledge of participant's they work with.

8. MCO care coordinators have little or no knowledge of a person centered planning process.

9. MCO 's have made it participants responsible to get Authorizations from their Doctor's for needed services and make sure those Authorizations get to a provider for services if they can find a provider. There is no care coordination in this process and it must be done each year. Case managers use to help with this process before Managed Care. This is not better.

Example of how MCO's have made it difficult to find or have choice of providers had oral surgeon that had treated participant for years under state medicaid chose not to contract with MCO's. The closes contracted oral surgeon was a 145 miles away.

Example of how MCO's have made it difficult to find or have choice of providers had physical therapist that had treated participant for years under state medicaid chose not to contract with MCO's. The only Physical therapy provider that is contracted within 60 miles is not very good at working with a participant with IDD.

Example of how MCO's have made it difficult for service authorizations every year for some service every 6 weeks for others, all services must be reauthorized. Providers are no longer making the request for reauthorizations participant are now expected to request and get authorizations for services they need. I have worked in the medical and insurance field and this was a big learning curve for me, I would expect many participant just go without needed services. Miss a reauthorizations date and participant must pay out of their own pocket for services.

10. Grievances, Appeals and Fair Hearing before KanCare I had never had to file a Fair hearing request. Sense KanCare I have filed two.

I have filed grievances with MCO and been told they agree with me and have fixed the problem, only to find out later the problem was not address and needed to file another grievances. It has taken me 10 months to get some needs address.

Appeals are a waste of time. If MCO did not agree with the grievance there is little to no chance they will agree in the appeal.

The fair hearing process is not for the faint of heart, it is you against state lawyers. Some times when you challenge the big bear the big bear challenges back. But the fair hearing process is sometimes the only way to open the door to having a conversation with the state about their policies and how they affect participants.

Grievances, Appeals and Fair Hearing can take months; participants will have hours invested in fighting for their rights.

11. Calling MCO 's member services plan to spend at least an hour on the Process and answer the same questions over and over before get the department you need just to leave a message for them to call you back. Getting help on issues most likely will be an all day process and sometimes a

two day process.
12. MCO's data breach exposed personal health information, Person Centered Support Plans, Social Security numbers and medicaid ID numbers of participants. The State's quality improvement strategy has been silent in how participants should response and monitor their credit and identity. MCO's offer participants whose data was exposed with free credit monitoring and identity theft restoration services for two years, But you had to sign up. Notice was a small post card, seems to me the state should made it a automatic sign up for all Kancare enrollees affected. As well offer participants better support.
Submitted by,
Robbin Allen
Newton, KS

Return to Index

From: Rob Nahmensen
To: KanCare Renewal
Subject: Fwd: Comments on KanCare 2.0
Date: Friday, November 17, 2017 11:45:54 AM

-The standardization of prior authorizations for all services not just pharmacy as included in the current waiver.

-Establish a date of 12.31.18 to automate provider credentialing to be implemented by.

-Identify a source of funding for the uncompensated care pool for the proposed additional funding for critical access hospitals

-Identify how the new funding to the uncompensated care pool will be distributed.

-Will participation in the new value based purchasing programs be voluntary or mandatory.

-The data metrics and definitions for quality should be standardized across Kancare MCO and providers to avoid confusion and guarantee best data resources.

-The state standards for Kancare MCO compliance review should be statistically valid.

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Rob Nahmensen
Regional Hospital
[redacted]

KanCare 2.0 Questions from Interhab's TCM Resource Network
Submitted November 26, 2017

1. What services will people receive who aren't on a waiver or on the wait list? These people are currently receiving TCM; some have Medicaid and some are private pay. Will they continue to receive Targeted Case Management? Will they be eligible for Community Service Coordination?
2. Where will the additional Service Coordinators come from to serve the additional populations? CSPs are already struggling to find qualified TCMs. There is concern that MCOs hiring additional staff will only further reduce the CSPs hiring pool. Is this the next step in eliminating TCM?
3. Will Community Service Coordination be a licensed service? Will Article 63 apply?
4. We would like to express frustration that the comment period is so close to the proposal being posted. Professionals have barely had time to read the document and develop questions. How can the public be expected to do so in such a short time? They often rely on the professionals for this information, but there has been insufficient time to provide a thorough review.
5. Regarding Conflict of Interest - Will the Conflict of Interest apply to SHC/FMS providers as well as Day and Residential providers? Can CDDOs and TCMs be part of the same agency? Will TCMs be prevented from working for a day or residential provider OR will they simply not be allowed to provide TCM to persons served by the agency which employs them?
6. Will people be able to keep their TCM as promised?
7. Will the Community Service Coordinator do the same things for people as the TCM currently does?
8. Will Independent Case Management continue?
9. Will IDD TCMs be allowed to serve other populations based on their expertise with Person Centered Support Planning as well as community resources?

Submitted on behalf of the Interhab Targeted Case Management Resource Network by
Tracey Herman
Director, Case Management
TARC, inc.

KANSAS DENTAL ASSOCIATION

KAMU strength unity advocacy

ORAL HEALTH KANSAS
ADVOCACY • PUBLIC AWARENESS • EDUCATION

November 22, 2017

KanCare Renewal
c/o Becky Ross
KDHE, Division of Health Care Finance
900 SW Jackson, LSOB – 9th Floor
Topeka, KS 66612

Oral Health Kansas, the Kansas Dental Association, and Kansas Association for the Medically Underserved respectfully submit the following comments regarding the application for KanCare Renewal.

We applaud the focus on social determinants of health in the KanCare 2.0 application. Social determinants such as access to healthy food, housing, employment and transportation disproportionately affect people who are marginalized by socioeconomic status, race and ethnicity, geography, or a combination of these.[1] Healthy People 2020 recognizes social determinants as key factors in impeding or improving people's health with a goal to "create social and physical environments that promote good health for all."[2] Because access to health and dental care are factors that can help people affected by these social determinants, we encourage the department to include three key issues in KanCare 2.0 in order to meet the basic needs of low-income Kansans.

1. **KanCare 2.0 should include the current value-added preventive dental benefit for adults.**

As statewide organizations dedicated to improving the dental health of all Kansans, we believe KanCare 2.0 should continue to focus on dental services for adults. When KanCare went into effect in 2013, it included an important benefit by offering value-added preventive dental services. One of the most important ways people can maintain their overall health is by maintaining their oral health. Many Medicaid beneficiaries face multiple medical problems. Improving access to dental care and investing in prevention pays off in the long run. The addition of the preventive benefit is arguably one of the most important changes KanCare introduced, and we encourage KDHE to maintain it.

2. **A basic set of dental services need to be covered for all adults, including diagnostic and periodontic services, medications, teledental services, and minor restorative services.**

We know that the preventive dental benefit has been the most popular of the value-added services, but we also know that many adults enrolled in KanCare are not able to make use of the service because they need to have infection removed from their mouths first. A report published this month by the Center for Health Care Strategies showed that adult Medicaid beneficiaries use preventive dental services more often in states that offer restorative dental services. The report, found the highest levels of preventive dental service use were in states with more comprehensive coverage.[3]

During the KanCare public forums this month, adult dental services were mentioned several times. We heard a few stories we believe illustrate the need people in Kansas have for basic restorative services:

- One adult woman told the crowd that she was a double organ transplant recipient. She shared her story that illustrated the importance of dental care, "An infection that starts in my mouth could easily kill me. For me, it literally is a matter of life or death."
- Another woman spoke to the difficulty she encountered getting dental services for her adult son who lives with an intellectual disability. Sedation services are very rare, and she struggles to access them.

- A third woman said she appreciates the prevention services, but she said, "Why wait to extract my teeth that have a cavity, when a simple filling would prolong the life of the tooth."

Included with this letter is a list of the codes that are considered to be the basic services necessary to begin to meet the dental needs of KanCare beneficiaries. Providing these basic services will help people remove dental infections, as well as help them manage other chronic conditions such as diabetes and cardiovascular disease. Basic dental services also will help adults enrolled in KanCare be better positioned to get and keep jobs. Employers like to hire people who have healthy smiles. More and more organizations agree that it is time to provide basic dental care in addition to preventive services.

3. **In order to ensure adults are able to make use of the preventive and basic dental services, the KanCare rates need to be addressed.**

The rates for restorative and other dental services have not been adjusted since the 1990s, and the low reimbursement rates are leading to a shrinking dental provider network. The last time Medicaid dental provider rates were adjusted was shortly after 2000 when the preventive service rates were increased slightly. Dental providers, like any other health care providers, must be able to cover their cost of providing service. Because the rates paid for KanCare dental services have not been addressed for at least 20 years and the cost of providing dental services has gone up over time, the rates are not sufficient to create and sustain a meaningful KanCare dental provider network. We ask that KanCare 2.0 address this historic problem and build a sustainable dental provider network by adjusting the rates paid for services for children and adults.

Everyone recognizes the value of the current limited dental benefit. With changes included in this wavier, the RFP process should include agreement on the next logical step: a broader array of the most necessary services. It is our hope the State and the bidders include the current adult dental value-added benefit, add necessary and basic adult dental services, as well as provider rate increases.

Thank you for the opportunity to provide this feedback. If you have any questions or need additional information, please contact us:

- Kevin Robertson, Executive Director of the Kansas Dental Association, [redacted]
- Denise Cyzman, Executive Director of the Kansas Association for the Medically Underserved, [redacted]
- Tanya Dorf Brunner, Executive Director of Oral Health Kansas, 785-[redacted]

[redacted] Center for Health Care Strategies, "A Community Framework for Addressing Social Determinants of Oral Health for Low-Income Populations," January 2017, https://www.chcs.org/media/SDOH-OH-TA-Brief_012517.pdf

[2] Healthy People 2020, Social Determinants of Health, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

[3] Center for Health Care Strategies, "Examining Oral Health Care Utilization and Expenditures for Low-Income Adults," November 2017 https://www.chcs.org/media/FOM-Oral-Health_111617.pdf

BASIC DENTAL SERVICES

DIAGNOSTIC SERVICES:

D0120 Periodic oral evaluation – established patient - Limited to two in 12 months
D0140 Limited oral evaluation – problem focused – Limited to one in 12 months
D0150 Comprehensive oral evaluation – new or established patient – Limited to one in 12 months
D0210 Intraoral – complete set of radiographic images – Limited to one every 48 months
D0220 Intraoral – periapical first radiographic image
D0230 Intraoral – periapical each additional radiographic image
D0274 Bitewings – four radiographic images – Limited to one in 12 months
D0277 Vertical bitewings – 7-8 radiographic images – Limited to one in 12 months
D0330 Panoramic radiographic images – Limited to one every 48 months
D0411 In-office point of service testing – HbA1c glucose testing to assess periodontal risk factor

PREVENTIVE SERVICES

D1110 Prophylaxis – Adult – Limited to two in 12 months
D1206 Topical application of fluoride varnish
D1208 Topical application of fluoride – excluding varnish – Limited to two in 12 months
D1345 Interim caries arresting medicament application – per tooth
D9110 Palliative (emergency) treatment of dental pain – minor procedure

PERIODONTIC SERVICES

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis

MEDICATIONS

D9610 Therapeutic parenteral drug administered in-office (antibiotics, steroids, anti-inflammatory drugs)
D9630 Other drugs and/or medicaments dispensed in the office for home use
D9910 Desensitizing gel (in office)

CONSULTATION

D9995 Teledentistry – synchronous: real-time encounter
D9996 Teledentistry – asynchronous; information stored and forwarded to dentist or subsequent review

MINOR RESTORATIVE SERVICES

D2140 Amalgam – one surface, primary or permanent
D2150 Amalgam – two surfaces, primary or permanent
D2160 Amalgam – three surfaces, primary or permanent
D2161 Amalgam – four or more surfaces, primary or permanent
D2330 Resin-based composite – one surface, anterior
D2331 Resin-based composite – two surfaces, anterior
D2332 Resin-based composite – three surfaces, anterior
D2335 Resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2391 Resin-based composite – one surface, posterior
D2392 Resin-based composite – two surfaces, posterior
D2393 Resin-based composite – three surfaces, posterior
D2394 Resin-based composite – four or more surfaces, posterior
D2910 Recement or rebond inlay, only, veneer or partial coverage restorations
D2920 Recement or rebond crown
D2931 Prefabricated stainless steel crown – permanent tooth
D2951 Pin retention – per tooth, in addition to restoration

NEK-CAP, INC.
Northeast Kansas Community Action Program, Inc.
P.O. Box 380 ~ 1260 – 220th Street
Hiawatha, KS 66434
(785) 742-2222 ~ (785) 742-2164 fax
(888) 904-8159 ~ (785) 742-3087 TDD
www.nekcap.org

June 23, 2017

RE: KanCare Renewal

NEK-CAP, INC. Head Start and Early Head Start provides services to many clients receiving Medicaid assistance. NEK-CAP, INC. helps support children and families, to maintain up to date appointments and in understanding the importance of ongoing medical care including dental. An issue that families seem to run into is when going to schedule an appointment finding out insurance has expired and finding providers to except Medicaid.

Recommendations:

- Having expiration dates/renewal dates on cards so families are reminded when they use their card.
- More time to reapply.
- Improvement to application processing speed.
- More access to eligibility.
- Increasing reinstatement time.
- More dentists willing to see children ages 1 to 3 receiving Medicaid.
- Locations locally where people are assisted in applying.
- Trainings for employers such as Head Start and contracted foster care agency regarding ins and outs of enrollment to better assist clients.
- Better education for families regarding their insurance.

Anna Lundergard, LBSW
Health and Safety Manager

NEK-CAP, INC.
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CHARLES A. WESTIN
[redacted]

It is assumed that comments such as this will be accepted on November 27, 2017, since November 26, 2017 is the Sunday after Thanksgiving.

November 22, 2017

KanCare Renewal
c/o Becky Ross
KDHE, Division of Health Care Finance
900 SW Jackson, LSOB - 9th Floor
Topeka, KS 66612

It is requested that KDHE also submit this letter to CMS.

My dear Ms. Ross:

THIS LETTER REQUESTS THAT CMS NOT APPROVE THE 5 YEAR DEMONSTRATION REQUEST.

These are comments having to do with the KS Dept of Health and Environment applying to the federal government for an approval of a renewed 5 year waiver to run Kansas' Medicaid program (KanCare) through a private managed care company. I believe KanCare is most easily defined as the "privatizing of part or most of the Kansas Medicaid program." I am an active Republican and I receive no assistance (that I know of) from the State of Kansas, so I do not believe that I am personally or directly affected one way or the other by CMS' decision to approve or not approve this 5 year extension.

IT IS MY OPINION THAT THE REQUESTED 5 YEAR EXTENSION SHOULD NOT BE APPROVED.

It is (again) my opinion that KanCare has simply not served the "needy" in Kansas well including it has simply not served those clients in a timely manner and has not offered them reasonable access to the services that they need. I BELIEVE THAT AN INDEPENDENT EXAMINATION BY CMS HAS AND WILL AGAIN FIND THAT KANCARE HAS SIMPLY NOT PERFORMED IN A WAY THAT WOULD ALLOW CMS TO APPROVE THIS REQUESTED 5 YEAR EXTENSION (of course, if CMS finds that everything is positive and the KanCare program is well run and a program that CMS is proud to support, then CMS should and must approve the State's request).

Also, it was earlier reported that Dr. Seema Verma of CMS said that she would approve proposals that promote community engagement activities. I believe that what she meant by this was that she would approve a "work requirement" as one way of promoting that community engagement. This is fine so long as Kansas or CMS provide necessary program support services so that the program is a success, to include child care while the client is away from home, appropriate job training, effective and realistic job search, placement and counseling services, on site on the job mentoring and transportation and a clothing and food allowance. Any "work

requirement" program that lacks these basic and minimal support services is simply a way to reduce those persons eligible for program assistance regardless of their actual needs and must not be approved.

Then there appears to be a clause that limits a person receiving KanCare and working, to 36 months of KanCare services. This is a "one size fits all" clause that is simply not reasonable on its face. If a person no longer needs services one day after becoming eligible for KanCare, they should end their involvement at that time. By the same reasoning, if a person has been on KanCare and working for 36 months they should remain eligible until they no longer need KanCare services. It is also necessary to recognize that much or most of the work performed under a "work requirements" clause simply does not pay a high enough wage to get most clients to a financial place that they no longer need Medicaid and can afford to purchase health insurance. WHILE WORK REQUIREMENTS MAKE US ALL FEEL GOOD, OFTEN THEY REALLY DO NOT WELL SERVE THE NEEDY, SO I ASK CMS NOT TO APPROVE ANY WORK REQUIREMENT THAT DOES NOT INCLUDE THE STATE AND CMS DIRECT SUPPORT SERVICES NECESSARY FOR THE SUCCESS OF THE NEEDY PERSON. (Should a "work requirement" be approved such approval must include a strong and effective CMS oversite.)

I certainly appreciate the opportunity to share my observations with KDHE and CMS and I look forward to hearing from you.

While I can't imagine that I will ever hear from anyone, I do wish to here formally offer my services to improve the Medicaid services to the needy here in Kansas - please let me know if I may ever be of service!

Most sincerely,

[redacted]

Charles A.Westin, PhD, LFACHE

Copies to others concerned.