



Topeka Independent Living Resource Center

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Date: January 30, 2018

To: Senate Committee on a Ways and Means
Senator Carolyn McGinn, Chair

From: Mike Oxford, Exec. Dir.
Topeka Independent Living Resource Center

Re: Support for SB 300

The Topeka Independent Living Resource Center (TILRC) is a civil and human rights organization. Our mission is to advocate for justice, equality and essential services for a fully integrated and accessible society for all people with disabilities. TILRC has been providing cross-age, cross-disability advocacy and services for 36 years to people with disabilities here in Shawnee County and across the state of Kansas. Our agency has been particularly interested in and committed to assuring that people who require long term services and supports have access to information, services and supports that offer choices; choices that promote freedom, independent lifestyles and dignity, including the dignity of risk.

TILRC supports delaying KanCare 2.0 and any otherwise substantive changes to KanCare until current deficiencies are rectified. Detailed comments that support this request and that were provided to KDADS and CMS are attached below.

Thank you for your hard work and for your attention to KanCare.



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KanCare 2.0 Comments

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Detailed comments on KanCare 2.0

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

Advocacy and services provided by and for people with disabilities.

Self-Direction (Legal right under state law since 1989) not included

- 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 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 asking the State of Kansas to develop an *Olmstead* Plan, to create a cogent, cohesive plan for addressing the current needs and the inevitable demographics affecting 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. More time to plan, budget and fix current problems is needed before dropping the existing 1115 Waiver and starting over.

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 SSI or institutionally/HCBS eligible. There are many, many people with disabilities that have more or less hidden disabilities, chronic health conditions and/or combinations of these, but that do not rise to level of SSI institution/HCBS or even Medicaid eligibility, but still could benefit from increased, long-term assistance and supports to pursue and maintain employment and live 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 SSI nor 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 hardworking; 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. We need an implementation plan and budgets to get to these great goals.

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 that ought to have been included is self-direction of attendant services.

The lack of any mention of self-direction of HCBS is a curious oversight. Kansas, in 1989, was one of the first states to set out the right of HCBS consumers to self-direct without regard to age or disability label. Kansas remains the only state to have enshrined comprehensive, cross-age, cross-disability 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 to 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 integrated 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 the vision of our State and its programs. The importance of having control over when one gets up, 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, but 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 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.

A further concern is the potential loss of agency and consumer control that seems a very possible outcome from this proposed service coordination model. Kansas Department of Aging and Disability Services (KDADS) and the Kansas Department of Health and Environment philosophically support advancing independence and self-direction, but do not seem to know how to completely implement this philosophy in the programs they oversee.

The concern is that the proposed Service Coordination will entail too much of the medical model by unnecessarily requiring advanced education and professional credentialing. TILRC has a long established reputation for successfully integrating folks and advancing independence that includes expertise in the array of (currently non-Medicaid) community services and programs envisioned by the desire to strengthen social determinants through increasing service coordination. However, it is unclear if TILRC would meet the credentialing and education requirements; which could obviate decades of experience and hands-on knowledge.

Under state law, self-directing individuals should be able to arrange and make use of community organizations and services without having to have an extra layer of “professional” oversight and approval. State law says that there is a right to control and direct services to the maximum extent feasible. Finally, Kansas should include true budget authority for those that self-direct.

Finally, if an insurance company is responsible for emergency and backup services, and if a service coordinator is responsible for coordinating virtually all aspects of one's life, then where does consumer control and self-direction come in? Once again, state law says that the consumer has a right to choose to maximize direction and control over HCBS. History has shown that placing credentialed professionals in charge does not lead to advances in control and direction by program participants.

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

This figure 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 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 the vision of our State and its programs.

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 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 KDHE 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 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 better 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 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.