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Chair McGinn and members of the Senate Committee on Ways and Means:

The KanCare Advocates Network (KAN), a coalition of more than 50 organizations and individuals who advocate on behalf of the 400,000 Kansans who depend upon the Kansas Medicaid program, KanCare, and its seven HCBS waiver programs for their health care and long-term supports and services, support SB300 due to KanCare 2.0's shortcomings as described below.

The KanCare Advocates Network asked that the Kansas Legislature pass SB300 and move to address systemic problems, diminishing resources of staff and budget, a lack of transparency and oversight. While there appears to be some progress being made, it is early in the process and the key leaders within the Kansas Department of Health and Environment (KDHE), the Secretary, Medicaid Director and the State Medical Director, are held by persons who were not involved in crafting the 2.0 proposal.

The current failings are most clearly illustrated by this week's joint statement by Gov. Brownback and Lt. Gov. Colyer announcing their plans to "stop KanCare 2.0." Days later, advocates and stakeholders are still waiting for direction from the Brownback/Colyer administration regarding what this really means. Media reports quote agency staff saying they don't intend to withdraw the application, just "amend" it. We hear through the grapevine that pieces of the plan will be withdrawn but hear nothing from State officials. Once again, we face what appears to be a last-minute bait-and-switch that lacks clarity, transparency, full-disclosure in an attempt to circumvent CMS requirements for public disclosure and comments.

Since the beginning of KanCare, we have asked for a transparent and inclusive process of policymaking that engaged KanCare members, their family members, advocates and all stakeholders. We continue to remind State officials that KanCare performance measures must include more than medical metrics and that policy changes must include ongoing dialog with those impacted by those changes. That message continues to fall on mostly deaf ears. Like its predecessor, KanCare 2.0 was drafted without a thorough analysis of whether the program has

met its original goals, timelines or consideration of variations among the needs of the populations served.

We believe the comments submitted by the National Health Law Program (NHeLP) sum up our concerns as well:

"Instead of addressing these systemic failings, KanCare 2.0 proposes to shift even more "coordinating" responsibility to the MCOs without sufficient oversight or safeguards for beneficiaries. As a result, KanCare's shortcomings will likely be exacerbated in KanCare 2.0. Specifically, we have concerns regarding:

- *The failure to meet the need for increased state oversight of managed care entities and the ability to compel those entities to make changes;*
- *The lack of any objective, quality control measures—such as maximum caseloads or minimum qualifications—for the MCOs' plan of service coordinators;*
- *The continued reliance on MCOs, rather than independent coordinators, to draft and approve plans of service, which creates potential conflicts of interest without adequate protections;*
- *The failure to describe the mechanisms by which the State will ensure due process and monitor beneficiary protections throughout the system; and*
- *The proposal's failure to create adequate policies to promote self-directed care options.*

There is one key lesson learned over the past five years that everyone -- advocates, legislators and State officials -- agree on, the original implementation of KanCare was rushed. We learned the hard way that to be successful KanCare must have robust and ongoing stakeholder input, adequate resources for the State agencies who oversee the program, a solid, detailed plan developed in cooperation with all stakeholders over a realistic timeframe. Without these components we risk the health, safety and quality of life of the 400,000 Kansans who depend on KanCare for health care and home-based supports and services. Trying to meet arbitrary deadlines without a well-developed plan that is adequately funded and staffed is a recipe for failure.

Administrative Issues

- Serious and persistent problems exist with KanCare now: HCBS waiting list, challenges in processing claims and enrollment, inadequate provider networks, administrative red tape, a lack of transparency in the development of treatments plans and a general lack of responsiveness of the State and managed care organization to the concerns of enrollees. None of those problems are addressed in the KanCare 2.0 proposal.
- The proposed program changes will require an immense amount of red tape and burdensome bureaucracy for everyone: the State agencies, MCOs, providers and KanCare members, particularly related to the work requirements. The State needs additional staff and budget resources to meet the current core responsibilities to manage the KanCare program. The current proposal does not address those limitations.
- KanCare 2.0 does not address or fix the problems that have persistently plagued the current program. Consumers are still finding it difficult to get applications through the Clearinghouse and the backlog still exists. The Clearinghouse is not equipped to help consumers navigate the complicated process. While there appears to be progress being made to hold the Clearinghouse contractor accountable, it will be months if not more than

a year, before these issues are resolved. We should have demonstrated proof that these problems are solved before we move forward with 2.0

- KanCare 2.0 appears to off-load even more of the State's responsibilities to the MCOs. To date, the MCOs have not demonstrated the capability to effectively provide the long-term supports and services (LTSS) through the seven waiver programs. Giving them additional responsibilities won't improve their track record.
- None of the KDHE leadership were involved with the drafting of KanCare 2.0. They need the opportunity to review the current KanCare problems and hear from stakeholders before implementing a plan they did not have a hand in creating.

Arbitrary 36-month lifetime cap

- Time limits on coverage are very problematic and stray even further from the statutory purposes of the Medicaid program. A hard 36-month limit on benefits does not reflect the reality of the lives of low-income parents who typically cycle off and on KanCare and if employed, often work in low-wage jobs with unpredictable hours. An arbitrary lifetime cap on health benefits will not help people become self-sufficient and will prevent persons who need health care from receiving the care they need to help them join the workforce.
- Medicaid serves as an important work support, allowing unhealthy Kansans to receive the health care they need to transition to full-time employment. Unfortunately, not all employers offer health insurance, especially to low-wage and part-time employees. Health insurance is critical to supporting employment.

Work Requirements Provision

- Research and 50 years of law and administrative process supports the fact that work requirements do not promote the objectives of Medicaid.
- Research also shows the top reason Medicaid recipients don't work is because they are not healthy enough to work. This acts as an obstacle not a support.
- The benefits related to employment are not in dispute, but work requirements and disenrollment for failure to comply creates barriers to healthcare and make it less likely that people will be healthy enough to work.
- Kansans with chronic conditions and disabilities, those who live in areas where jobs are in short supply and those lack transportation or child care be disproportionately impacted. KanCare 2.0 includes no information about how these situations will be addressed.

Service Coordination vs Targeted Case Management

- KanCare 2.0 introduces a new MCO-supervised position: the "community service coordinator." Details are few about how this position will be implemented. More discussion with stakeholders is necessary to ascertain how this process will work. Without careful and critical examination of the yet-to-be-disclosed details, a rushed implementation could be very disruptive to consumers and their families.
- KanCare has failed older adults and persons with disabilities, due in large part to the lack of targeted case managers (TCM). The State's promise to maintain TCM for all waiver populations was broken within first months of KanCare. Community service coordination appeared to be the State's work-around of this issue rather than restore TCM for all

waiver recipients, but it was difficult to gauge because the proposal did not involve stakeholders in the development.

- The grapevine tells us this provision may be removed from the current proposal which leaves those not served through the ID/DD waiver without effective case management. This lack of coordination is devastating to frail elders and persons with physical disabilities who shouldn't have to do without these critical services.

What's missing in KanCare 2.0:
Ombudsman Program

- Advocates have called for the creation of an independent, legally-based KanCare ombuds program since the original KanCare application. Without such a resource, consumers have no one to help them navigate a system that is stacked against them. Despite persistent resource issues and a demonstrated need for a conflict-free program that is not accountable to a State agency, there is no plan for addressing these needs in KanCare 2.0

Waiting Lists

- The plan fails to address the needs of the 4,653 persons with physical and intellectual/developmental disabilities who are waiting for services, many of whom have been told they face a seven-year wait.
- While there is no official waiting list for older adults we have seen a decrease of 1,013 fewer persons served under the FE waiver and nearly 2,000 persons served in nursing facilities despite the fact that the number of older adults in Kansas is increasing. This is simply unacceptable.

Consumer Help

- KanCare 2.0 does not provide for local contacts to help people with their application, help track its status or answer questions. This has been an issue since local positions through DCF were eliminated. This was not addressed in the KanCare 2.0 proposal.

Self-direction:

- KanCare 2.0 makes no mention of supporting or building upon the opportunity for persons to self-direct their services.

Consumer and Stakeholder Involvement

- Consumers, family members and advocates have had to fight to be heard about the systemic problems associated with KanCare. Rather than improve and increase the opportunities for input, it appears that KanCare 2.0 will operate with less input and transparency. The lack of detailed and coordinated plan for communicating with stakeholders and members has been an ongoing issue and is not addressed within KanCare 2.0.
- The Consumer & Specialized Interest Workgroup has been disbanded under KanCare 2.0. This was one of the few opportunities for the State and the MCOs to regularly hear directly from consumers and families. At its last quarterly meeting, workgroup members asked that the group be retained. KanCare leadership denied this request.

Adult Dental Coverage

- A set of basic dental services should be available for adults on KanCare. These services should include diagnostic and periodontic services, medications, teledental services and minor restorative services.
- To ensure beneficiaries have access to dental services, the reimbursement rates must be adjusted. The rates for restorative and other dental services have not been adjusted since the 1990s. This has lead to a shrinking dental provider network.
- KanCare 2.0 does not address the dire need of adult KanCare members who need dental care.

HCBS Performance measures

- Current KanCare performance measures continue to be focused on medical outcomes/outputs but few that measure the performance of the Home and Community-Based Services waivers.
- Before moving forward, HCBS-related outcomes and output measures should be developed to measure the effectiveness of KanCare and identify improvements for KanCare 2.0.
- KanCare 2.0 makes no provision for the public availability of transparent, disaggregated, unidentifiable data.

An Alzheimer's State Plan

- Despite the 52,000 Kansans diagnosed with Alzheimer's or dementia and their 150,000 caregivers, Kansas still has no State Plan for providing care and services to them.
- KanCare 2.0 does not address creation of this plan or how to provide for the unique needs of these Kansans.

Our list of persistent program failings are well-documented. They have been identified and detailed multiple times by KAN, individual advocacy groups, desperate family members and consumers. We have testified before legislative committees, the KanCare Advisory Council, public forums and talked directly with State staff. Legislators tell us that problems with KanCare are the #1 complaint they hear from their constituents. KanCare 2.0 ignores them all.

These problems are significant. The timeline should be slowed down to enable the administration, legislators, health care and social services support providers, families and others the time to carefully consider the needs of KanCare enrollees and their families and how they can best be met. Enrollees and their families should be intimately engaged in this process. We risk the health, safety, and quality of life of the more than 400,000 Kansans who depend on KanCare if we again try to meet arbitrary deadlines without a well-developed plan that is adequately funded and staffed. Bottom line: the KanCare 2.0 application should not be approved.

Thank you for your attention to this issue and we ask that you support SB300. We will be available for questions at the committee's request.

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