big lakes developmental center, inc.

Community Developmental Disability Organization
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To: Senator Mary Pilcher-Cook, Chairperson
Members of the Senate Public Health and Welfare Committee

From: Cindy Wichman, Director of CDDO Administration
Big Lakes Developmental Center, Manhattan, KS

Date: March 12, 2013

RE: Opposition to SB194 concerning CDDO eligibility determination and assessment

Senator Pilcher-Cook and members of the committee, thank you for conducting this hearing today. I am grateful for the opportunity to offer testimony in opposition to SB194 which seeks to alter the statutory role of Community Developmental Disability Organizations (CDDOs) as currently prescribed in K.S.A. 39-1609. My name is Cindy Wichman and I am the Director of CDDO Administration at Big Lakes Developmental Center in Manhattan, Kansas. As CDDO, Big Lakes performs eligibility determination and assessment for the geographic area including Clay, Geary, Pottawatomie, and Riley Counties in Kansas. For additional context, please see the service delivery data and references which are attached as Appendix A. Following are some of the problems created by SB194.

First, SB194 erodes the single point of entry model already in place. Single point of entry systems are predicated upon there being "no wrong door". The CDDO becomes the wrong door for initial eligibility determination and assessment under SB194. Local incoming requests for eligibility determination would instead be shuffled to another bureaucratic entity that would ultimately refer the consumer back to the CDDO, where the process began. For people with developmental disabilities, SB194 creates not only a wrong door but also a revolving one.

Second, SB194 lacks sufficient input from persons with intellectual developmental disabilities. This is in contrast to spring 2012 when legislators heard strong opposition to managed care proposals on the part of constituents with disabilities. Consequently, a one-year carve out for home and community-based waiver services for people with intellectual developmental disabilities was successfully achieved. Also at that time, state administrators publically assured constituents that CDDOs would retain their statutory role (www.kancare.ks.gov; Appendix B, C, D). Now constituents are presented with a statutory measure that dramatically alters how CDDOs can operate in local communities and does so in the absence of any input from families and consumers being served. Such an approach not only ignores the important role of collaboration when re-engineering public systems but also marginalizes the ability of Kansans with developmental disabilities to have a say in critical decisions that affect their lives.

Third, SB194 contains terminology that has already triggered confusion. For instance, eligibility determination can mean several things. While most states do not allow the point of entry entity to conduct *financial* eligibility determination, many operate under a CDDO-like model similar to Kansas, where the point of entry entity performs *service system* eligibility. Functional assessment, as mentioned in SB194, is also a broad term. For CDDOs, functional assessment is equated to the BASIS assessment. BASIS stands for the Basic Assessment and Services Information System. BASIS 6.0 was implemented by the State of Kansas in July 2001 and is an integral part of the local CDDO and statewide service delivery system. Local demographic information is regularly collected, updated and maintained along with an individualized profile that captures daily living skills, diagnosed medical conditions, challenging behaviors, current services, and waiting list information. Without the ability to maintain such critical service system and assessment data, CDDOs are rendered incapable of carrying out their current statutory role.

Finally, SB194 could diminish the reliability and validity of the assessment process. For example, Big Lakes' BASIS screeners share a combined 31 years of overall experience in developmental disability services with 16 of those specific to eligibility determination and assessment. Similar longevity is likely evident at other CDDOs. This prolonged period of engagement is a priceless enrichment that has cultivated a vital sense of trust for people with developmental disabilities and their families. Literature has shown that people with developmental disabilities can feel anxious or apprehensive of strangers who have not taken the time to really get to know and understand them (McDonald, 2012; McDonald, Kidney, & Patka, 2012). The prior relationship formed between the individual and their BASIS screener helps yield more accurate, detailed information reflective not only of their current situation but also from a rich, historical context that encompasses the whole person.

In summary, SB194 is misguided for the aforementioned reasons. Strategies aimed at improving the developmental disabilities service system must include input from people with developmental disabilities and their families. As the mantra of the disability rights movement first stated, "Nothing About Us Without Us" (McDonald, 2012). I implore the committee to dispense with statutory tweaking of an already functional system and instead devote attention to the greatest challenge facing the public health and welfare of people with developmental disabilities—the thousands of Kansans currently on the developmental disability waiting list which, by recent and conservative estimates from state officials, includes 3,176 individuals statewide (Shields, 2013). Vote NO to SB194.

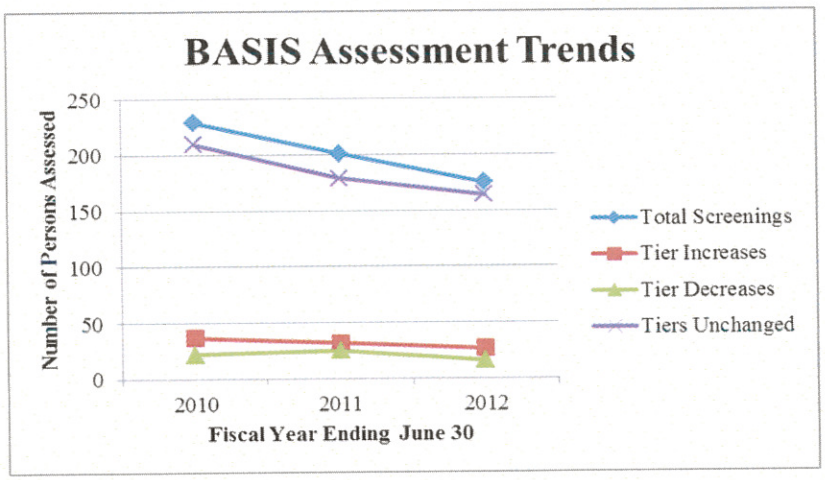
See enclosures: Appendices A – D

APPENDIX A

ELIGIBILITY STATISTICS by calendar year

Calendar year ending December 31, 2012	2009	2010	2011	2012
Total Referrals per CDDO database	76	65	56	58
Referrals deemed eligible	24	15	20	24
Referrals deemed ineligible	3	3	4	5
Closed cases	38	31	45	31
Open Referrals per CDDO Database as of year end	11	12	8	9
Total number of persons on BASIS at year end	265	275	277	277
Number of persons on local CDDO waiting list	125	134	146	139

Source: CDDO Monthly Reports, Big Lakes Developmental Center, Manhattan, Kansas.



713 Annual assessments completed over past 3 years

13% Have resulted in increased level of care

9% Have resulted in decreased level of care

78% Have resulted in no change in level of care

Source: Weekly BASIS Download Reports, Big Lakes Developmental Center, Inc., Manhattan, Kansas.

References

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Shields, M. (2013, February 6). Parents urge legislators to do more to reduce waiting lists for social services. *Kansas Health Institute*. Retrieved from http://www.khi.org/news/2013/feb/06/parents-urge-legislators-do-more-reduce-waiting-li/

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KanCare Frequently Asked Questions

KanCare Frequently Asked Questions

What are the major changes with Kansas Medicaid?

- Person-centered care coordination
- Clearer accountability
- Agency streamlining and name change
- Financing consolidation

Is KanCare being implemented on an appropriate timeline? KanCare is the result of an involved, detailed planning process that began more than a year ago. Lt. Governor Jeff Colyer, M.D. and the Secretaries of Health and Environment, Aging and Social and Rehabilitation Services met with people from around the state – consumers, legislators and the general public to get their ideas on the best way to deliver Medicaid care to clients.

Full implementation of KanCare will take more than 14 months. This is a far different than the paths taken by other states feeling the same budget pinch. Other states chose to simply impose rate cuts and stop providing care to thousands of needy citizens. These quick actions taken by other states do not work for Kansans.

Delaying KanCare will only guarantee continued cost increases, put providers at risk of rate cuts, and threaten the quality of care being provided to vulnerable Kansans. The status quo is not serving us well, and delay will not improve the health of anyone. To ensure a smooth transition, we will conduct readiness reviews and consult with providers. We will only move to final implementation if those reviews indicate we are ready.

How does KanCare compare to other states such as Kentucky who have moved forward with their own Medicaid reforms? Comparing Kentucky's reform plan to KanCare is like comparing apples and oranges. From concept to implementation, Kentucky completed its transition in only eight months. In Kansas we are taking more than two years to study, plan and implement KanCare. Also, Kentucky abruptly transferred 77% of its Medicaid consumers from a fee-for-service model into managed care, causing great confusion for consumers and health care providers. But in Kansas nearly 75% of Medicaid consumers already are part of managed care programs involving their doctors, hospitals, pharmacists and mental health providers.

Kansas is drawing from the best examples from around the country. We have put in place policies to avoid the stumbling blocks that have tripped up other states. Medicaid consumers will receive better services under KanCare. We will work with Kansans to ensure they understand the plan before it is implemented. KanCare contractors will be held accountable. Kansas expects to be on the leading edge when it comes to implementing an integrated system of care that focuses on Medicaid consumers as individuals, with individual needs, not numbers.

Will providers get paid on time under KanCare? The contracts stipulate that providers must be paid within 30 days or KanCare companies will face significant financial penalties. To further encourage timely claims, we also include a pay for performance measure for contractors to process 100% of clean claims within 20 days.

Will DD consumers be able to keep their case manager under KanCare? Persons with developmental disabilities will continue to work with their current case managers. The law ensures community developmental disability organizations (CDDOs) will conduct – either directly or by subcontract – the waiver eligibility assessments, case management and service.

What will be done to ensure Kansas Medicaid Consumers understand KanCare? We are planning an extensive educational campaign so all Kansas Medicaid consumers and their families, legal guardians and caregivers understand KanCare and the transition process.

Why is it important that all populations be included in KanCare? Why not carve out all long-term care and services? Nearly 75% of Kansas Medicaid patients already are part of integrated care. Carving out all long-term care and services from KanCare would maintain the existing, separated Home and Community Based Services system. Coordinating all care – including long-term services -- is critical if we are going to improve the health outcomes of all Kansans enrolled in the program.

A 2010 study by Kansas Medicaid and the KU Medical Center found Medicaid for Kansans with intellectual and developmental disabilities and those with physical disabilities was fragmented and poorly coordinated. It did not consistently provide recommended health care most people take for granted, such as screenings for breast, cervical or colorectal cancer. Lack of care coordination, and therefore lack of access, led to increased care costs and poor results.

The best way to rearrange this system that has been separating one kind of care from another is by coordinating all care for the each individual. KanCare also attaches financial incentives to the system. These are designed to encourage contractors to integrate behavioral care, medical care and long-term services and supports in a way that will provide more effective overall care for each individual.

Will the state continue to contract with existing providers? The KanCare contracts require that contractors use established community partners to deliver care and services. This includes hospitals, physicians, community mental health centers (CMHCs), primary care and safety net clinics, centers for independent living (CILs), area agencies on aging (AAAs), and community developmental disability organizations (CDDOs). It will allow these community partners to do an even better job. The state will continue to use CDDOs and other provider groups in their established roles, which are outlined in Kansas law.

How will KanCare result in cost savings without provider cuts or cuts in services? Savings in Kansas will be achieved by reducing the number of people who are being kept in institutional settings unnecessarily, by decreasing repeated hospitalizations, by better managing chronic conditions and by coordinating each individual's overall care. KanCare companies will be rewarded for paying for preventative care that keeps people healthy, so they don't get so ill that they need very expensive services. Over time this will help to slow to slow the fast-rising costs of the Medicaid system and ensure it continues to function effectively for those who need it.

Over five years, the state expects to reduce growth in Kansas Medicaid spending by 8-10 percent. This amounts to a one-third reduction in total Medicaid growth. Based on a conservative starting point of 6.6% growth in Medicaid without reforms (the actual growth rate over the past decade was 7.4%), KanCare is expected to achieve savings of **$853 million** (all funds) over the next five years.

All Funds	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**5 Yr. Total**
	29,060,260	113,513,129	198,041,997	235,439,877	277,004,864	853,060,127
SGF	12,522,066	48,912,807	85,336,296	101,451,043	119,361,396	367,583,609

How will improved health outcomes be achieved? Kansas is in the process of crafting ironclad agreements with the integrated care companies which will become KanCare companies. These agreements have been part of the plan since we began developing the bidding process. They will be included in the signed contracts that spell out to the contractors what is expected of them, and the penalties the contractors are subject to if they fail to achieve better health outcomes for Kansans.

The state will require KanCare companies to create "health homes" revolving around our consumers' core health care companies, and to provide these health homes with technology, funding, individualized care coordination and communication required to improve the quality of the consumers' care.

These reforms create the first-ever set of comprehensive goals and targeted results in Kansas Medicaid. These new standards exceed the federal requirements and set Kansas on a path to historic improvement and efficiency.

In addition, Kansas is looking for the best ideas in the industry, so we announced to potential KanCare contractors that we expect them to put forth additional ideas on how to achieve meaningful improvements to consumer health.

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Sam Brownback, Governor

KanCare
Frequently Asked Questions

What are the major changes with Kansas Medicaid?

- Name change to KanCare
- Person-centered care coordination
- Clearer accountability
- Agency streamlining
- Financing consolidation

When will these changes take effect?

The state will issue the Request for Proposal on Wednesday November 9, 2011. The deadline for proposals to be submitted is set for January 2012. KanCare will take effect in January 2013.

Most of the changes KanCare will bring entail partnerships, engagement, and even new business relationships in the Medicaid provider community. These innovations at the ground level will be KanCare's true legacy. The RFP anticipates a steady but intense period of change over the next three years, with corresponding increases in expected patient outcomes and savings.

How will improved health outcomes be achieved?

The State of Kansas Medicaid program will provide superior service by implementing an integrated model of care that focuses on the whole person. Through the contracting process, the state will require bidders to create health homes centered around consumers' core provider and to undergird these health homes with technology, funding, person centered care coordination and communication required to engage the consumer and improve their care.

The Administration has identified specific outcomes to be achieved for various population groups within Kansas Medicaid. The state is also looking for the best ideas in the industry, so we expect managed care organizations to put forth additional ideas on how to achieve meaningful improvements to consumer health.

We are crafting ironclad agreements with MCOs, beginning with this RFP, and culminating in signed contracts that establish enforceable outcomes. These reforms create the first ever set of comprehensive goals and targeted outcomes in Kansas Medicaid. These new standards exceed Federal requirements and set Kansas on a path to historic improvement and efficiency.

Have other states moved forward with similar program models?

Kansas is drawing from the best examples from around the country and expects to become a national leader in performance-oriented strategic purchasing of Medicaid services. Other states have used similar models: Texas, Tennessee, Michigan and Pennsylvania.

Kansas does expect to be on the leading edge when it comes to implementing a whole person centered model of care that looks at all aspects and needs of Medicaid consumers and not viewing their needs in silos.

Why is it important that all populations be "carved in"?
Services for all Kansans served by Medicaid will be incorporated into the KanCare system so that the benefits of care coordination will be available to them.

Contractors will be accountable for functional as well as physical and behavioral health outcomes. Providing Kansans with developmental disabilities enhanced care coordination will improve access to services supporting independence as well as health services and continue to reduce a the disparity in life expectancy while preserving services that improve quality of life.

Will the state continue to contract with existing providers?
The KanCare RFP mandates contractors to use established community partners, including hospitals, physicians, community mental health centers (CMHCs), primary care and safety net clinics, centers for independent living (CILs), area agencies on aging (AAAs), and community developmental disability organizations (CDDOs).

The state will continue to use CDDOs and other provider groups in their statutorily established role.

With these changes, will consumers be partnered with the same care manager they have today?
Person-centered care coordination is not something that currently happens in Kansas. Care managers should have the social service, behavioral health and physical health background to coordinate all these providers to best serve Kansans.

Managed Care Organizations are being mandated in the RFP to partner with established community partners, so some case managers may become care managers. However, even if your care manager DOES change, this person will still be required to meet with you and your family and provide services to meet your individual needs.

Will KanCare result in cost savings?
Over five years, the state expects to reduce growth in Kansas Medicaid spending by 8-10 percent, which equates to 1/3 reduction in total Medicaid growth.

Based on a conservative baseline of 6.6% growth in Medicaid without reforms (the actual historic growth rate over the past decade was 7.4%), the outcomes-focused, person-centered care coordination model executed under the RFP is expected to achieve savings of **$853 million** (all funds) over the next five years.

	FY 13	FY 14	FY 15	FY 16	FY 17	5-year Total
All Funds	29,060,260	113,513,129	198,041,997	235,439,877	277,004,864	853,060,127
SGF	12,522,066	48,912,807	85,336,296	101,451,043	119,361,396	367,583,609

What functions and programs are moving to other agencies/entities?
Public interaction with the Medicaid program will be streamlined by a realignment of state agencies.

Medicaid fiscal and contractual management will be consolidated within the Kansas Department of Health and Environment's Division of Health Care Finance.

Home and Community Based Service waivers and mental health program management will be housed in a reconfigured Kansas Department on Aging, to be renamed the Kansas Department for Aging and Human Services.

Social and Rehabilitation Services will add select family preservation, social and prevention programs from KDHE and the Juvenile Justice Authority to strengthen its targeted focus as a renamed Department for Children and Families.

Will the Reorganization result in cost savings?
While the primary purpose for reorganizing state agencies is to increase coordination for programs, the state does expect to achieve some administrative cost savings. Any administrative savings will be reinvested to reduce waiting lists for waiver services.

We are restructuring to increase coordination and are focused on the efficient use of administrative resources to assure quality of care and contract oversight.

Transcript from 12/7/12 news conference announcing CMS approval of KanCare

Gov. Sam Brownback

Welcome you all today, and thank you for joining us for a long-awaited announcement. After two years of gathering input from stakeholders, consumers and advocates, traveling thousands of miles around the state and holding numerous meetings, phone calls and webinars. While we are finalizing the terms and conditions, today we are excited to announce that the Center for Medicare and Medicaid Services has given Kansas the go ahead to fully implement KanCare, beginning January 1, 2013.

I want to particularly congratulate the team that's here and Dr. Colyer for putting this together and getting this accomplishment. It is extraordinary. It has been tedious. And it's very important. KanCare is truly what Kansas needs—a way for us to improve the coordination and quality of care for more than 380,000 Kansans, while making the Medicaid program more fiscally sustainable. And these are things we've been after all along, to do both improve the quality of care, maintain and improve its fiscal sustainability of this program. This is something that governors all across America are searching for the way forward with expanding Medicaid portfolios and costs.

I want to thank CMS and the thousands of Kansas consumers and providers for working with us on making KanCare a Kansas solution. I'd like to especially thank Lt. Governor Dr. Colyer, Dr. Moser, Secretary Sullivan and their staffs for working tirelessly to improve the Kansas Medicaid system for all consumers and providers.

Now I'd like to turn this over to Lt. Governor Jeff Colyer to talk more specifically about what today's announcement means, Jeff?

Sec. Dr. Jeff Colyer (by phone)

Thank you Governor. Sorry that I couldn't be there. I had a family thing that came up this week, so I'm missing the fun in Topeka. But we're very excited about today's announcement. In the last two hours, CMS and the State of Kansas have been reaching out to Kansas stakeholders to let them know about the CMS decision that we are removing any uncertainty about KanCare beginning on January first. (Inaudible) uncertainty for both consumers and providers. And it offers us a great opportunity to move forward.

Now, when we began this effort nearly two years ago, Kansas faced skyrocketing Medicaid costs. We had growing waiting lists. We had high Medicare and poor outcomes. None of these were acceptable for our most vulnerable Kansans. So that is why we chose to go the route of KanCare rather than (inaudible) saving money.

KanCare is based on three criteria—number one, improving quality of care; number two, controlling costs; and number three, making sure we have long-lasting reforms that improve the quality of health and the quality of wellness Kansans. We could have done some things like other states. KanCare will not cut off thousands of Medicaid recipients by reducing (inaudible) like the neighboring state Missouri. KanCare will not make double-digit rate cuts to providers like was done in Kansas or in California previously. Instead, KanCare is going to coordinate our care for our patients to focus on the best outcomes for the individual Kansans, especially for those who have the greatest needs. By doing that, we can actually save money.

KanCare will reward positive outcomes for patients and not the simple fee-for-service model. KanCare provides choices and creative options for Kansans, unlike the situation now. Under KanCare, every

Kansan in Medicaid will have at least three different choices that will make the best sense for them to achieve their care. And, instead of cutting rates and instead of cutting people off and instead of cutting benefits, because we are able to save money and improve health care, we're actually able to expand the services that are available in Kansas Medicaid. And this is an important change. We are now able to offer heart and lung transplants for adults, obesity care and bariatric surgery and also providing dental care benefits for adults. These are new additions, new benefits we have by using the KanCare model.

KanCare will also allow Kansans with developmental disabilities to continue to work with their current case managers. And that is very important that we keep that continuity. State law ensures that the CDDOs will conduct either directly or by subcontract, their waiver determination, case management in their services. KanCare will also reduce the number of people unnecessarily living in institutional settings. It will decrease rehospitalizations. We're going to manage chronic conditions through coordinating and integrating behavioral health, their medical care and their long-term services.

Another unique thing about KanCare is that KanCare will provide an off ramp to help route people, dependent to Medicaid through work. And in the end, not only can we expect to have better results and better outcomes for Kansas patients, but the state also expects to net more than $1 billion savings through improved care coordination during the next five years.

I want to thank Governor Brownback for allowing us to spend two years to totally revamp our Kansas Medicaid program and that was one that was a very difficult decision, but a very important one, because we are so concerned about the situation with our patients (inaudible) in the State of Kansas. This really moves us forward in a very positive way. I also want to thank especially the whole team—Dr. Moser, Secretary Sullivan, but also Kari Bruffet and Dr. Susan Mosier, our Medicaid Director and Health Finance Directors for their hard work. There's a very large team that's been involved with this process. And they have really done a fabulous job for the State of Kansas. Thank you Governor, thank you very much.

Gov. Sam Brownback
Thank you Jeff, appreciate it. One of the things I'm really excited about it is the expanded services that we're going to be able to provide—heart transplant, bariatric and then preventative dental, really is a big deal. So, instead of cutting services, cutting providers, we're adding.

This is the way forward, folks. This is the way forward. You're going to see a lot of states doing this sort of model.

I next want to call up Shawn Sullivan, the Secretary for disabilities and aging services for comments. Shawn.

Sec. Shawn Sullivan
Thank you. Thank you Governor and Liuetenant Governor. It's an honor and great to be with you this afternoon.

Now that KanCare has been approved, we want to know that, consumers to know that our outreach efforts will not stop and they will continue. We'll continue to try and reach out and provide education and help people understand the plans and what their options are and how they can choose between the plans.

We believe KanCare will provide a stronger safety net for the over 383,000 that we will serve. Our vision when we set out this process almost two years ago was to have a Medicaid program that would be fiscally sustainable program and that provide high-quality care and services to all that we serve.

I want to also acknowledge the hard work of our staff that have put in so many hours, probably thousands of hours into this effort.

This is interesting, this conferences and I talk to my colleagues and some states, the long-term services and supports agencies, like ours, can't even get their Medicaid agency, like KDHE to pick up the phone and return a call. So, it's been amazing to watch this process over the last two years and the amazing team work between the two agencies, the collaboration between the two as we've jointly worked forward with trying to provide better care to those we serve.

So, in addition to that, I do want to highlight a couple of things that we think are extremely important to help us ensure that we're providing services in as seamless as possible transition to KanCare on January first. So, a couple of those things are excuse me, the State of Kansas believes it's extremely important to maintain a continuity of care for the 380+,000 that we serve. So, the consumers and persons we serve that have appointments and established relationships with providers will be able to keep those for the first 90 days of KanCare after January first.

The three plans will honor all plans of care and all services plans will honor all appointments and they will honor all established member/provider relationships. So, what that means, if there is a provider, whether that be a hospital, a nursing home, HCBS provider, whoever it may be, if they are currently not signed up into one of the three managed care plans or any of them, they will still be treated as an in-network provider and be paid 100 percent of the current rate as they move forward for the first 90 days. And that will allow them to have more time to work through the specifics and to sign up with contracts with one of the three plans.

In addition to that, for any members that we serve that live in residential settings, so an example of that would be a nursing homes or assisted living facilities, the plans will pay those homes and providers for one year, the first year, in network reimbursement rate. So, if there are any residential facilities that are not within the provider networks, so they'll continue to be paid the in-house, in-network plan for one year. And that's our provision to maintain that we don't have any consumers that are having to move out of their primary residences, where they live.

On the Home and Community Based Services side of things, or HCBS for short, we've added some continuity of care provisions that are very important as we work forward, move forward. As a person has what's called a "plan of care" on December 31st, through the current system, fee-for-service system, the plans must honor that plan of care for the first 90 days of KanCare or until a new plan of care is established—whichever comes first. And if the KanCare plan, one of the three is not able to or does not develop a plan of care for that person in the first 90 days then there will be a new 90-day time frame that will start, that will allow for that continuity of care and then also for that person to change plans should they need to and desire to.

Um, one, couple more things, the three plans will be required to make sure that specialty care is available to all that we serve and to meet federal and state distance or travel time standards. If the managed care organization does not have a specialist available to members within those standards, they must allow members to see out-of-network providers.

And then finally, if one of the three plans is unable to provide medically-necessary services in the network, then it must cover those services out-of-network and have a single case arrangement or agreement so non-network providers to provide those covered services.

So, those are all important things that we consider continuity of care requirements to help us serve better those that we serve as we roll into KanCare with this transition.

Two more things and then I'll turn it over to Dr. Secretary Moser. We have created and developed a plan for a new KanCare consumer ombudsman. That person will be available to all that we serve that will try to focus on the long-term services and supports consumers and families and guardians within nursing facilities in the Home and Community Based Services programs to assist them with what they need. So, we have several different avenues for a person to file grievances and appeals and work through differences that may be there, both at the state level and the managed care organization level.

This ombudsman will be housed in Department for Aging and Disability Services. (dial tone), we're disconnecting here. and also, will be reporting to me within our agency. So, that will be a new resource that will be up and going by January 1st of next year when we start.

And then lastly, to help with the transition, there will be daily calls that will be available, starting the day after Christmas on December 26. I believe those start at nine in the morning, for stakeholders. And that would involve providers, consumers, family members, guardians, anyone that wants to can call in and participate on this and ask questions and as they have concerns as this starts, bring them up to us so we can address them and resolve them as expeditiously as possible.

Thank you again to our staff and also to CMS for the great work that they've done to get to this point. At this point, I'll turn it over to Secretary Moser.

Sec. Dr. Bob Moser

Good afternoon. First I want to thank Governor Brownback and Lt. Governor Dr. Colyer for their leadership and also echo Sec. Sullivan's comments about the great working relationship between our sister agencies and of course our staff and their dedication in making this happen.

It has been a great working relationship with CMS, both their regional and central office. And we definitely wouldn't have gotten here without their work. And we'll have to just admit, basically this is great news. It's uh, perhaps a mile post. We've had a great deal of work to continue moving forward. You've heard a couple of terms, as a family physician, I'm really excited about the model of care that is coming with KanCare to our Medicaid consumers.

Continuity of care we know, particularly in primary care, whether that's behavioral health, social services or the medical side, goes a long ways in addressing health care costs and improving health care quality. So, to have that as part of the core component in this model, I think is outstanding. And I know lt. Gov. Dr. Colyer has talked in the past about holistic care. And I think at times, that's a little bit confusing. And at times we call it the bio/psych/social model of care. And that again, just comes back to the fact that we look at the care the patient needs and what needs to be surrounding them in order to get the outcomes and the improvement in quality that we're looking for. And, so that again, doesn't matter whether they need social services or whether it's behavioral health or the physical health. But, as a physician, I knew even if I knew the right medication to prescribe for a patient, if they didn't have the

funds to buy that prescription or they didn't have the transportation to come back and get the laboratory, no matter if it was the correct diagnosis or the right prescription medication, the outcome and the care wasn't going to be optimum.

So, the model that we've come up with—KanCare—goes a long ways to start improving the care that we give to those vulnerable citizens in Kansas and will in the long run, also start controlling the cost growth.

So, very excited about this. And again, thank you for your patience and your work with us.