

# **Report of the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight to the 2015 Kansas Legislature**

**CHAIRPERSON:** Representative David Crum

**VICE-CHAIRPERSON:** Senator Mary Pilcher-Cook

**OTHER MEMBERS:** Senators Jim Denning, Marci Francisco, Laura Kelly, and Michael O'Donnell; and Representatives Barbara Ballard, Willie Dove, John Edmonds, Ron Ryckman, Jr., and Jim Ward

## **CHARGE**

- The Committee is to oversee long-term care services, including home and community based services (HCBS). In its oversight role, the Committee is to:
  - Oversee the savings resulting from the transfer of individuals from state or private institutions to HCBS and to ensure that any proceeds resulting from the transfer be applied to services for long-term care and HCBS;
  - Review and study other components of the state's long-term care system; and
  - Oversee the Children's Health Insurance Program (CHIP), the Program for All-Inclusive Care for the Elderly (PACE), and the State Medicaid programs (KanCare); and monitor, and study the implementation and operations of these programs including access to and quality of services provided and any financial information and budgetary issues.

# **Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight**

## **ANNUAL REPORT**

### **Conclusions and Recommendations**

Based on testimony heard and Committee deliberations, the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight makes the following conclusions and recommendations:

#### **Committee Meeting Days**

- The Committee recommends it meet twice during the legislative session and twice when the Legislature is out of session in different quarters, as required by statute, with the non-session meetings to be for two days each.

#### **Hearings to Review the Legislative Post Audit Report on Community Developmental Disability Organizations (CDDOs)**

- The Committee recommends separate hearings be scheduled during the 2015 Legislative Session before the House Social Services Budget Committee and the Senate Committee on Ways and Means' Social Services Subcommittee to address the March 2014 Legislative Post Audit Report *CDDOs: Reviewing Issues Related to Community Services Provided for Individuals with Developmental Disabilities (R-14-006)*.

#### **Software Issues Regarding Data Accuracy and Reporting on Waiting Lists**

- The Committee recommends a meeting of the Joint Committee on Information Technology be held to review software issues regarding data accuracy and reporting on waiting lists. The Committee noted concerns with the agency's ability to provide accurate data and reporting on waiting lists and expressed it was important to investigate the issue.

#### **Anti-psychotic Medications**

- The Committee recommends separate hearings be scheduled during the 2015 Legislative Session before the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare to consider the repeal of KSA 2014 Supp. 39-7,121b for the purpose of allowing Kansas Medicaid to manage anti-psychotic medications like other drug classes.

***Proposed Legislation:*** None

## **BACKGROUND**

The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services (HCBS) and KanCare Oversight operates pursuant to KSA 2014 Supp. 39-7,159, *et seq.* The previous Joint Committee on HCBS Oversight was created by the 2008 Legislature in House Sub. for SB 365. In HB 2025, the 2013 Legislature renamed and expanded the scope of the Joint Committee on HCBS Oversight to add the oversight of KanCare (the state's Medicaid managed care program). The Committee oversees long-term care services, including HCBS, which are to be provided through a comprehensive and coordinated system throughout the state. The system, in part, is designed to emphasize a delivery concept of self-direction, individual choice, services in home and community settings, and privacy. The Committee also oversees the Children's Health Insurance Program (CHIP), the Program for All-Inclusive Care for the Elderly (PACE), and the state Medicaid programs.

The Oversight Committee is composed of 11 members, 6 from the House of Representatives and 5 from the Senate. Members are appointed for terms that coincide with their elected or appointed legislative terms. The Committee is statutorily required to meet at least once in January and once in April when the Legislature is in regular session and at least once during both the third and fourth calendar quarters, at the call of the chairperson. However, the Committee is not to exceed six total meetings in a calendar year, except additional meetings may be held at the call of the chairperson when urgent circumstances exist to require such meetings. In its oversight role, the Committee is to oversee the savings resulting from the transfer of individuals from state or private institutions to HCBS and to ensure proceeds resulting from the successful transfer be applied to the system for the provision of services for long-term care and HCBS, as well as to review and study other components of the state's long-term care system. Additionally, the Committee is to monitor and study the implementation and operations of the HCBS programs, CHIP, PACE, and the state Medicaid programs including, but not limited to, access to and quality of services provided and financial information and budgetary issues.

As required by statute, at the beginning of each regular session, the Committee is to submit a written report to the President of the Senate, the Speaker of the House of Representatives, the House Committee on Health and Human Services, and the Senate Committee on Public Health and Welfare. The report is to include the number of individuals transferred from state or private institutions to HCBS, as certified by the Secretary for Aging and Disability Services, and the current balance in the HCBS Savings Fund. (See Addendum A for the 2014 Report.) The report also is to include information on the KanCare Program as follows:

- Quality of care and health outcomes of individuals receiving state Medicaid services under KanCare, as compared to outcomes from the provision of state Medicaid services prior to January 1, 2013;
- Integration and coordination of health care procedures for individuals receiving state Medicaid Services under KanCare;
- Availability of information to the public about the provision of state Medicaid services under KanCare including accessibility to health services, expenditures for health services, extent of consumer satisfaction with health services provided, and grievance procedures, including quantitative case data and summaries of case resolution by the KanCare Ombudsman;
- Provisions for community outreach and efforts to promote public understanding of KanCare;
- Comparison of caseload information for individuals receiving state Medicaid services prior to January 1, 2013, to the caseload information for individuals receiving state Medicaid services under KanCare after January 1, 2013;
- Comparison of the actual Medicaid costs expended in providing state Medicaid services under KanCare after January 1,

2013, to the actual costs expended under the provision of state Medicaid services prior to January 1, 2013, including the manner in which such cost expenditures are calculated;

- Comparison of the estimated costs expended in a managed care system of providing state Medicaid services under KanCare after January 1, 2013, to the actual costs expended under KanCare after January 1, 2013; and
- All written testimony provided to the Committee regarding the impact of the provision of state Medicaid services under KanCare upon residents of adult care homes.

All written testimony provided to the Committee is available at Legislative Administrative Services.

In developing the Committee report, the Committee also is required to consider the external quality review reports and quality assessment and performance improvement program plans of each managed care organization (MCO) providing state Medicaid services under KanCare.

The Committee report must be published on the official website of the Kansas Legislative Research Department (KLRD). Additionally, the Kansas Department for Aging and Disability Services (KDADS), in consultation with the Kansas Department of Health and Environment (KDHE), is required to submit an annual report on the long-term care system to the Governor and the Legislature during the first week of each regular session.

## COMMITTEE ACTIVITIES

The Committee met twice during the 2014 Legislative Session (January 17 and April 29) and held two days of meetings during the 2014 Interim (August 12 and November 18). In accordance with its statutory charges, the Committee's work focused on specific topics described in the following sections.

**KanCare overview and update.** At the January meeting, the Secretary of Health and Environment provided an overview of the KanCare goals of integrating public health with primary care efforts across the whole spectrum of health to improve the health of the community, with a focus on not just the medical model of KanCare but on an integrated approach using a system of integrated resources. He explained the State Quality Strategy, which includes the pay-for-performance approach and quality measures. The Secretary explained, in 2014, KDHE shifted pay-for-performance measures from operational to outcomes, and he explained the outcomes reporting timeline.

At the April meeting, the Secretary for Aging and Disability Services updated the Committee on statistics for the first year of KanCare and the benefits experienced by Kansans through care coordination, in-lieu-of services, and value-added services. He stated there had been a large decrease in emergency room usage for those on the Physical Disability (PD), Frail Elderly (FE), and Intellectual/Developmental Disability (I/DD) waivers. The KDHE Division of Health Care Finance (DHCF) Director confirmed the reduction in emergency room usage would fall into the four main categories of calendar year 2013 population expenditures.

*KanCare enrollment.* The DHCF Director provided information on the KanCare open enrollment process at the January meeting, noting KDHE had sent out approximately 330,000 enrollment packets and about 8,000 recipients had changed plans as of that date. The Director also reviewed the KanCare Executive Summary.

At the April meeting, the DHCF Director stated KDHE continued to see an increase in enrollment through March 2014 and addressed an Aon Hewitt report that projected an increase of 12,000 in Medicaid enrollment due to the woodwork effect. She noted, while most of the anticipated growth had already been realized in current enrollment, KDHE projected additional growth of 3,200 in the remainder of state fiscal year (SFY) 2014 and 10,200 in SFY 2015. She also provided the calendar year 2013 Top Ten Population Expenditures.

The DHCF Director noted at the August meeting the steady growth in enrollment in Medicaid had leveled off over the previous months. She stated a slightly higher KanCare enrollment might be seen due to the woodwork effect, but she believed most of those increases had been realized. The Director also indicated she expected to see an increase in applications with the activation of the account transfer from the federal Health Insurance Marketplace relating to the Kansas Eligibility Enforcement System (KEES) project that would be occurring later in August.

The KDHE Chief Information Technology Officer (CITO) provided an update on the KEES project at the August meeting, noting the system had been built and tested, and the basic functions of the system were working. He noted KDHE was working on enhancements to help with worker efficiencies, to reduce error rates relating to benefit enrollment, and to ensure the system provided consumers with information with better quality, readability, and understandability. The KDHE CITO stated KDHE also was working to ensure healthcare workers who would use the system had received adequate training.

The KDHE Director of Finance provided cost and enrollment comparisons of KanCare and Medicaid pre-KanCare at the November meeting. He also provided updated information on the improvement in the financial positions for the three MCOs.

*Eligibility determinations.* During the January meeting, the DHCF Director discussed the status of Kansans for whom KDHE had received general information from the federal Health Insurance Marketplace regarding potential eligibility for services. She noted the information received for these individuals was not complete enough to determine actual eligibility. The Director stated, as of January 14, 2014, KDHE had sent approximately 7,000 letters to these potentially eligible individuals for whom contact information was complete in order to proceed with eligibility determinations.

At the August meeting, the KDHE CITO explained KEES would implement an account transfer, which meant Kansans who had applied for health insurance in the federal Health

Insurance Marketplace and had been assessed by the Centers for Medicare and Medicaid Services (CMS) as possibly eligible for Kansas Medicaid would have their applications transferred directly to the Clearinghouse. He noted the process in the federal Marketplace allowed CMS to make an initial assessment of possible applicant eligibility and electronically transfer the applicant's account to Kansas for determination of actual eligibility. He noted the CMS assessment did not result in automatic eligibility for Medicaid because states are responsible for making the determination on eligibility, so it would not be proper for CMS to make that determination.

At the August meeting, the KDHE CITO was asked to address the letter from CMS placing Kansas on a "watch list" and whether that was due to a backlog problem. The KDHE CITO stated CMS had not placed Kansas on a "watch list" but had notified the state that its contingency plan, approved prior to October 2013, needed to be updated and include a faster timeline to accept account transfers. With regard to when the account transfer part of the KEES system would be fully functional, he noted the agency was ready to start transferring accounts but had to go through a formal protocol with CMS, so the agency was working with CMS to complete that process in August. The KDHE CITO said the agency would put in a revised contingency plan on August 15, 2014, that would allow the state to accept account transfers, which was not the full implementation of the KEES system. He noted full implementation was expected in November 2014, so the system would be in a pilot-program status during the interim, allowing the agency to conduct training and finish preparing for implementation.

The KDHE CITO provided an update on KEES at the November meeting, stating KDHE was then in Phase 3 Build 3 in system testing. He noted KDHE was in the final stages of identifying and prioritizing change requests received from the KDHE program staff.

*Pay-for-performance measures.* The KDHE Director of Finance addressed questions regarding actual dollars for pay-for-performance measures during the August meeting. He noted, for the first year of KanCare, these were operational performance measures. He stated KDHE withheld approximately \$62.4 million from the MCOs'

capitation payments, and the MCOs had earned back approximately two-thirds. However, the state had not released the funds back to the MCOs, as an independent validation of the metrics was then underway. The Director indicated the review should be completed and funds released later in 2014 in the amount of approximately \$42.0 million and approximately \$23.0 million would be held back and placed into general revenue.

*Affordable Care Act insurer's fee.* During the April meeting, the DHCF Director discussed the Affordable Care Act (ACA) insurer's fee, a new fee being imposed on states by the federal government. The DHCF Director stated the ACA created an \$8.0 billion annual fee on the health insurance industry nationwide starting in 2014, which will increase to \$14.3 billion by 2018. She explained the fee was allocated to qualifying health insurers based on their respective market shares of premium revenue in the previous year. She noted, while Medicaid managed care plans were not excluded, premiums associated with long term services and supports (LTSS) were excluded.

The DHCF Director stated the impact of the fee on the state Medicaid budget with regard to the State General Fund (SGF) would be \$14,045,392 in SFY 2015, \$19,545,760 in SFY 2016, and \$18,268,476 in SFY 2017. In order to put the cost into perspective, she provided a scale, noting \$14.0 million SGF per year would remove 725 persons from the PD wait list and 375 from the DD wait list.

*KanCare inspector general position.* At the August meeting, the Secretary of Health and Environment discussed the status of the vacant KanCare inspector general (IG) position. He noted interviews would be scheduled for later in August with plans to have a new IG in place by late October. The Secretary noted, based on existing statute, another vacant position in the Office of Inspector General (OIG) could not be filled until the new IG was hired. Concern was expressed by a Committee member Kansas had had a KanCare [Medicaid] IG for only approximately one of the past three years. The Secretary stated it had been difficult to recruit and maintain someone in the KanCare IG position. Discussion also was held on the placement of the KanCare IG within KDHE and the measures implemented to ensure IG independence allowing for actions against KDHE,

if necessary. The Secretary noted the OIG was placed directly under the Secretary of Health and Environment during the recent agency reorganization, instead of within one of the divisions of the agency, to ensure independence.

An update provided by the Acting Secretary of Health and Environment at the November meeting indicated the person selected for the IG position had not accepted the offer, so the search for a KanCare IG continued.

**Kansas Health Information Technology Act update.** The Deputy Secretary of KDHE provided an oral briefing on the Kansas Health Information Technology Act and the secondary use of medical information. He explained a review process was in place to ensure organizations met the established criteria for receiving medical data. He also noted the agency wanted to ensure the way the data was shared or sold was fair, and universal access was allowed for organizations that met the standards for utilization. The Deputy Secretary also confirmed federal funding for health care providers for electronic health records equipment was independent of the state's health information network, as long as providers purchased certified electronic health records and met the criteria.

**Health Homes implementation.** During the January meeting, the KDHE Director of Medicaid Services discussed the new Health Homes program to be implemented on July 1, 2014, as a Medicaid State Plan option. She noted the Health Homes program was designed to provide coordination of physical and behavioral health care with LTSS and available to those who met the eligibility criteria. The Director indicated 12 other states were operating Medicaid Medical Health Homes programs, and Kansas was one of three states operating the model using two state plan amendments. She noted the two primary target populations were individuals with serious mental illness and those with asthma or diabetes who also were at risk for another chronic condition. The Director discussed the enrollment process and payment and project structures.

Health Homes' funding was discussed at the January meeting, with confirmation of a 90/10 split between federal and state funding. The KDHE DHCF Director clarified each Health

Homes member could receive eight quarters of the enhanced match that would begin from the implementation of the state plan amendments. She noted if subsequent amendments of additional populations were added, the number of quarters for those populations could be extended. The Director stated, after the eight quarters of enhanced match, the match would revert back to the typical Medicaid match rate. She noted, with eight quarters of data, the state could determine whether the program reduced emergency department utilization and hospitalizations and could then decide if Health Homes was the model desired moving forward. The Director also clarified the 90/10 match applied to both current and newly added Medicaid recipients and only to Health Homes services.

During the Health Homes program update provided at the April meeting, the KDHE Medicaid Initiatives Coordinator, DHCF, noted KDHE intended to implement the Health Homes program on July 1, 2014, for Kansans with serious mental illness and those with asthma or diabetes who are at risk of another chronic condition. She noted enrollment in the Health Homes program was passive, with an option to opt out. She stated those who were eligible would receive letters notifying them of their eligibility, but individuals could opt out initially or at any time by calling or returning a form included with the letter. She responded to questions regarding the cost of Health Information Technology technical assistance and whether funding was available for consulting or for actual hardware and software, noting the grant funding was for consulting only.

The KDHE Medicaid Initiatives Coordinator testified at the August meeting that the Health Homes for individuals with serious mental illness was implemented July 1, 2014. She indicated there had been an issue as CMS would not pay for duplicative services. CMS viewed targeted case management (TCM) and some of the core services in Health Homes as being duplicative, so persons in Health Homes could not receive Medicaid TCM services. The Coordinator indicated the state had worked through the issue, so individuals would not have to choose between TCM and the Health Homes program. She indicated about 17.0 percent of the 2,200 persons who opted out of Health Homes were I/DD.

The Coordinator also explained at the August meeting that implementation of the Health Homes program for chronic conditions had been delayed due to an insufficient number of primary care providers interested in participating. She indicated KDHE was continuing to engage providers and looking at networks to determine the possibility of implementing in January 2015 or implementing the program regionally for those areas with sufficient primary care provider interest.

The Acting Secretary of Health and Environment provided a Health Homes update at the November meeting. She stated at that time, 25,630 persons were enrolled and more than 98 public outreach events had taken place.

At the November meeting, the Secretary for Aging and Disability Services discussed the state's efforts to provide transparent and frequent information regarding Health Homes. She noted the federal rules regarding Health Homes state a member cannot be enrolled in a Health Home and also have a targeted case manager who is not part of the member's Health Home. The Secretary indicated Kansas designed its Health Home model to provide I/DD consumers with the opportunity to enroll in a Health Home but also keep their targeted case manager. However, she noted the state cannot force or require third parties, such as Health Home partners (HHPs) or I/DD TCM providers, to contract with each other. As a result, if a targeted case manager is not contracted with a HHP, the member may choose another HHP or opt out of the Health Homes entirely.

At the November meeting, a targeted case manager with Jenian, Inc., expressed concern the letters regarding Health Homes were sent to persons who cannot read or write, limiting their ability to opt out. She also noted her organization wanted to become a HHP, but the cost of the required electronic health records software made it impractical.

The KDHE Medicaid Initiatives Director responded to concerns regarding the receipt of the Health Homes letters, or lack thereof, by stating CMS required letters be sent to the actual beneficiaries, unless someone was listed as a responsible person in the Medicaid case file. She noted KDHE would encourage families and

guardians to be on file as responsible persons with KDHE, so they would receive copies of letters as well.

With regard to the availability of funds to help those implementing electronic health records systems, the KDHE Medicaid Initiatives Director said the federal funds available were limited to traditional healthcare providers. However, she noted KDHE contracted with a company to provide technical assistance to those wanting to become HHPs.

**Transition of LTSS for individuals on HCBS I/DD waivers.** The Secretary for Aging and Disability Services provided an update at the January meeting regarding delays in transitioning LTSS for individuals on the HCBS I/DD waiver into KanCare. A detailed update was provided by the Secretary at the April meeting regarding the LTSS transition and outlining provider payments, percent of claims denied, average turn-around time from claim submission to payment, reasons for claim denials, education and outreach efforts, client obligation issues, and the process used to address the underserved I/DD waiting list.

**MCO financial losses during the first year of KanCare.** At the April meeting, a Committee member posed questions regarding the financial losses experienced by the three MCOs during the first year of KanCare and whether KDHE had a back-up plan if one of the MCOs pulled out of KanCare. The Secretary of Health and Environment stated the first year was expected to be more costly, but the second and third years were expected to improve. He also noted the state chose to contract with three MCOs to avoid some issues that occurred in other states when an MCO pulled out.

Representatives of the MCOs expressed knowing at the start of KanCare the first-year costs might be an issue and loss could be expected, so contingencies were put in place. The Chief Executive Officer of Amerigroup stated one factor contributing to the first-year losses by the MCOs was upfront costs due to "pent-up demand." The Sunflower Chief Executive Officer and Plan President indicated he usually expected it to take about 18 months, assuming a good start, for a program like KanCare to make money. Because

Sunflower had issues early on, he anticipated it would take four or five months longer for Sunflower to see a change in its financial situation. A Committee member asked the MCO representatives how long their shareholders would be willing to accept losses. The Sunflower representative indicated the trend line on the losses was improving, that Kansas had done KanCare right by selecting three companies with significant financial assets in multiple states, and the MCOs knew it would take time for these programs to stabilize.

A Committee member requested confirmation at the April meeting that the MCOs were required to provide services for the duration of the three-year contract with the state and could not back out earlier due to the negative cash flow situation. The Secretary for Aging and Disability Services stated the MCOs had committed to three years. The DHCF Director confirmed the same and clarified it was a three-year contract with two possible one-year extensions, as determined by the state. With regard to whether the MCOs and the state were required to renegotiate after the initial three years, the Secretary stated rates were renegotiated every year, so at the end of the base contract the parties would have to renegotiate the entire contract and the rates.

The KDHE Director of Finance provided information shortly after the November meeting regarding the improved financial status of the MCOs during the first two quarters of calendar year 2014.

**KanCare Ombudsman.** The Secretary for Aging and Disability Services updated the Committee on the organizational structure of the Office of the KanCare Ombudsman at the January meeting. He noted the KanCare Ombudsman would continue to be housed in KDADS and would be independent from the MCOs and KDHE. He stated a Volunteer Director would be added in the Ombudsman Office to develop a volunteer network across the state.

The KanCare Ombudsman provided an update of statistics on case data and resolutions at the January meeting. He also informed the Committee of a KanCare customer survey to be completed by

Wichita State University, and some of the proposed questions were included in his testimony.

The new KanCare Ombudsman reviewed the KanCare Ombudsman Quarterly Report for the first quarter of calendar year 2014 at the April meeting. She reported the focus had been on accessibility and outreach, including revising the KanCare Ombudsman website. She noted the KanCare Ombudsman Office was in the process of hiring a volunteer coordinator, who would be responsible for creating a volunteer program across the state. The KanCare Ombudsman also provided information on the Ombudsman's role in the appeals process.

The KanCare Ombudsman provided Committee members with an update of office activities at the August meeting. She stated new tracker information was implemented in early June 2014 that would allow her to provide additional data in future reports. She also noted an Ombudsman Volunteer Coordinator had been hired and would start within a couple of weeks. She provided an update on the third-quarter statistics at the November meeting.

**Provider reimbursement.** With regard to claims denials and increased timeliness of payments, at the April meeting the Secretary for Aging and Disability Services indicated the agency was working closely through weekly telephone calls with various stakeholders and with outreach, training, and other matters. The Secretary stated denial rates and historical payment rates would continue to be monitored for discrepancies.

In response to whether the change in rate adjustments to semi-annual from quarterly being considered for nursing homes was being considered for other providers, the Secretary for Aging and Disability Services stated consideration was being given to making the rate adjustment consistent for all providers.

**Hospital claims.** At the August meeting, the Committee heard concerns regarding hospital claims processing timelines and delayed payments of accounts receivable. A representative of the Kansas Hospital Association (KHA) discussed the KanCare Implementation Technical Advisory

Group (TAG), which included representatives of the KHA, the three MCOs, and KDHE. He noted the TAG addressed systemic issues hospitals were seeing in the field, including a current issue regarding accounts receivable that were more than 90 days past due. His written testimony included statistics regarding this issue.

One Committee member expressed concern the data in the KanCare Executive Summary indicated Sunflower, which was the major provider in the member's district, seemed to have a negative upward trend in denied claims. The DHCF Director responded the agency had discussed this matter with Sunflower, and she expected improvement. She responded the agency continued to meet regularly with all of the MCOs to discuss these issues and to develop corrective action plans.

The Committee member asked why none of the MCOs had met the measure regarding claims processing timelines and said it seemed to be a problem. The DHCF Director replied each MCO had different claims processing projects in place and KDHE was working to remedy the problem.

A Committee member asked the Chief Executive Officer and Plan President of Sunflower State Plan about the status of hospital reimbursement. He responded accounts receivable issues mostly were resolved. He further indicated the other piece that was helping was the TAG group.

**Community Developmental Disability Organizations services.** At the April meeting, the Secretary for Aging and Disability Services was asked to address the Legislative Post Audit (LPA) Community Developmental Disability Organization (CDDO) audit and the reworking of the grant so as to draw down federal dollars to provide services to more of the DD community. The Secretary responded \$5.0 million SGF was available to be used for persons who were Tier 0 DD-qualified, and there was ongoing discussion about using \$2.0 million to \$3.0 million of these funds to draw down waivers that would result in receipt of federal funds. He indicated he would report back at the Committee meeting scheduled for August 2014.

A Committee member noted at the April meeting the LPA CDDO audit also discussed the possibility of reducing the number of CDDOs to align more closely with the number of Aging and Disability Resource Centers (ADRCs) and asked whether this had been discussed. The Secretary for Aging and Disability Services responded there were 11 ADRCs and 27 CDDOs, but he was not aware of any dialogue about adjusting the number of CDDOs. He further stated he would be hesitant to consider that at a time with many other ongoing changes.

The Acting Secretary for Aging and Disability Services was asked at the August meeting about any discussion regarding the shifting of CDDO grant funds to address the waiting lists, and she replied it was not part of the ongoing conversation with the CDDOs.

A Principal Auditor with LPA briefed members on the audit titled *CDDOs: Reviewing Issues Related to Community Services Provided for Individuals with Developmental Disabilities* (R-14-006). The auditor noted the report looked at two questions: whether the CDDOs have a substantial conflict of interest and how those conflicts could be resolved, and how the community services system could be changed to maximize the amount of funding available to provide services for individuals with DD. He indicated there was an inherent conflict of interest built into the system, but the audit did not find any evidence CDDOs took advantage of the conflict. He indicated KanCare added oversight but did not eliminate the inherent conflict of interest. The auditor also stated the audit found steps could be taken to make the system more efficient.

**Presentations on KanCare from individuals, providers, and organizations.** The Committee heard from multiple KanCare beneficiaries regarding both favorable experiences and difficulties faced in navigating the system.

Positive experiences were described by multiple individuals receiving KanCare services. Among the favorable testimony heard were comments related to the ease of navigating the process, valuable assistance provided by the support teams and case manager, MCOs' efforts at keeping members informed, services provided by

the MCOs to facilitate the members' ability to remain in their homes, additional hours of care received, benefits provided to assist with weight loss, newly-added lung and heart transplant surgeries and bariatric surgery, support provided in addressing both physical and mental health problems, and appreciation for the MCOs' goal of finding employment for persons with disabilities.

Difficulties described by KanCare members and those on the waiting list for services included the inability to obtain information regarding the basis for reductions in plans of care hours; lack of knowledge regarding the status of individuals on the waiting lists; difficulty navigating the system and administrative burdens; medication, treatment, and extension of treatment denials; provider and supply company changes; difficulty in understanding and navigating the appeals process; the type and limitations of the assistance provided by the KanCare Ombudsman, including concerns about the placement of the Ombudsman Office; the lack of dental care for individuals with I/DD; and feeling intimidated by a care coordinator.

Representatives of the following organizations and providers testified or provided written testimony before the Committee at the four meetings: Kansas Home Care Association; Kansas Council on Developmental Disabilities; LeadingAge Kansas; Newman Regional Health; Children's Mercy Hospital; Hillside Village, LLC; Community Living Opportunities; Phoenix Home Care; Kansas Association of Centers for Independent Living; Disability Rights Center; Briar Payne Meade Insurance; Johnson County Commission on Aging; Vintage Park Assisted Living Facility; KHA; Kansas Action for Children; E.C. Tyree Health and Dental Clinic; Kansas Health Consumer Coalition; InterHab; Kansas Advocates for Better Care; Topeka Independent Living Resource Center; Kids TLC; Mercy Home Care; AARP Kansas; Mosaic; Jenian, Inc.; Kansas Neurological Institute Parent Guardian Group; Kansas Health Care Association; Oral Health Kansas; Association of Community Mental Health Centers of Kansas; Kansas Mental Health Coalition; National Alliance on Mental Illness Kansas; and Mental Health America of the Heartland.

Some organizations and providers praised KDHE and KDADS for the agencies' willingness

to work with them on issues that arose. The MCOs also received praise for their cooperative efforts from organizations and providers, though some expressed difficulty with particular MCOs. It was suggested greater latitude should be provided to the MCOs to be able to manage the care. Several providers indicated progress had been made with payment issues, but encouraged continued oversight. Other providers stated they had no issues with payments.

Various areas of concern or need expressed by organizations and providers included the potential loss of needed services to a number of individuals on the PD waiting list because KDADS had been unable to contact them; confusion in navigating the process and the members' lack of knowledge as to available assistance; the limited nature of the assistance provided by the KanCare Ombudsman; the proposed allocation of designated PD waiting list funds to address the I/DD underserved waiting list; difficulty with the I/DD pilot billing system and its impact on small providers with limited cash flow; notice and due process problems, including misinforming or the failure to inform recipients of reductions in services; increased costs and financial burdens for providers; problems with accounts receivable, slow payments, denials, and inaccurate payments; challenges facing Financial Management Services (FMS) providers, such as the cost prohibitive nature of increasing worker's compensation insurance and the inability to find coverage with the standard insurance market; the need for more KanCare reports; concerns the PD waiver money may be affected in light of possible budget cuts and the impact of the U.S. Department of Labor (DOL) rule; the need for management and control of waiting lists to be with the Centers for Independent Living; providing consumers who wanted to testify before the Committee with more time to speak; the need for support for older adults; concerns as to the use of anti-psychotic drugs as chemical restraints in the treatment of dementia in the elder population; ensuring the availability of anti-psychotics for use in the treatment of mental illness; the need for increased reimbursement rates for HCBS professional staff providing services and supports to those with disabilities; concern with the new DOL rules; the need for expanded dental care for adults; request for enrollment data to be published monthly to enable closer tracking of trends; and the requirement to move individuals from the PD

waiver to the FE waiver at age 65, resulting in the direct care worker receiving a reduction in pay because reimbursements under the FE waiver are lower than under the PD waiver.

**Use of anti-psychotic drugs as chemical restraints of elders with dementia.** The Executive Director of Kansas Advocates for Better Care testified at the August meeting regarding the need to address the use of anti-psychotic drugs as chemical restraints in the treatment of dementia in the elder population. She noted Kansas was 47th out of 50 states in the use of anti-psychotic drugs. The Executive Director stated the use of anti-psychotic drugs for elders with dementia was not authorized, and the rest of the nation as a whole had reduced the use of anti-psychotic drugs, while the use in Kansas had increased.

At the August Committee meeting, the DHCF Director stated there was a state statute that would not allow KDHE to manage behavioral health medicine, and she suggested the Legislature look at that issue during the 2015 Session. The Secretary of Health and Environment added anti-psychotic drugs were on a list used by the medical field that included drugs which may be more harmful to elderly people than others. He stated it was generally recommended anti-psychotics not be used for elders with dementia, but physicians may feel there were no other options and would use them although they would be going against the general guidelines of care. The Acting Secretary for Aging and Disability Services stated, while Kansas was doing very well on elder care overall, KDADS was working across organizations on this particular issue.

The Chief Executive Officer and Plan President for Sunflower State Health Plan also expressed concern about the use of anti-psychotic drugs and indicated he would like to see the state manage them. He indicated he had been talking to doctors about issues with the use of anti-psychotic drugs, and they had been very receptive.

At the August meeting, the Chief Executive Officer of Amerigroup Kansas Plan said the MCO was in the process of looking at the frequency of prescriptions by prescriber and geography with regard to the use of anti-psychotic drugs, particularly as it applied to children and the elderly.

**Agency responses to presentations by individuals, organizations, and providers.** The DHCF Director addressed concerns expressed regarding the appeals process during the January meeting. She indicated an inter-agency team was working on uniform language for the three MCOs to include in their notices and handbooks, with stakeholder input to ensure language was understandable, and the team also planned to clarify other issues raised about the appeals process. During the April meeting, she stated KDHE had worked with the MCOs and CMS to develop one uniform Notice of Action form to be used by all MCOs to help avoid issues with access to appeals and state fair hearings. A copy of the uniform notice was provided.

With regard to issues expressed by providers, at the April meeting the DHCF Director noted KDHE worked on a Provider Experience Improvement Project to resolve provider-specific issues.

During the August meeting, the DHCF Director addressed concerns regarding redaction of information in KanCare reports. She noted KDHE had to take into account the sample size of the data because, if the sample size was too small, individuals might be identified. The DHCF Associate Chief Counsel expressed KDHE's desire to have the reports as transparent as possible. However, with regard to the timeliness of the agency's response to requests for information, the Associate Chief Counsel noted KDHE had received requests for dozens and dozens of reports following the April Committee meeting, and the volume of the requests had made it difficult to respond quickly. He also noted the state and the MCOs had worked together to determine what should be redacted from the reports and believed the information needed by the requestors would be available, but KDHE was glad to meet with persons to discuss what had been redacted and work with the persons if they wanted to contest the redactions.

At the August meeting, the DHCF Director informed the Committee KDHE had a request for the reprocurement of the Medicaid management information system and the reprocurement of the data analytics interface, and part of that would include making available a public dashboard on the website with information about KanCare.

**MCO testimony and responses to presentations by individuals, organizations, and providers.** Representatives of the three MCOs testified at the four Committee meetings. At the January meeting, representatives of the Amerigroup Kansas Plan, Sunflower State Health Plan, and UnitedHealthcare provided an update of each MCO's experience during the first year of KanCare. The representatives discussed the preparation and readiness for inclusion of LTSS for the I/DD population, efforts taken to ensure no harm was caused to providers due to cash flow, and the commitment to making the appeals and grievance process less confusing.

The Chief Executive Officer of Amerigroup shared stories of individuals who had received beneficial services under KanCare and the implementation of hospital operational enhancements in response to concerns expressed by the KHA at a previous meeting. The Chief Executive Officer and Plan President of Sunflower State Health Plan discussed efforts to improve care for the individuals being served, especially in the area of diabetic care and treatment for alcohol and other drug disorders. The Plan President of UnitedHealthcare discussed member programs and engaging members in their own health, such as encouraging pregnant mothers to complete prenatal exams and adopt healthy habits and a community-based weight management program. He also shared information on a three-year \$1.5 million commitment focused on finding meaningful employment for the DD population.

The representatives of the MCOs were asked about each company's policy of pursuing refunds from consumers who appealed decisions and maintained services pending the appeal, but ultimately lost the appeal. Confirmation was subsequently provided that none of the MCOs sought refunds from members who lost on appeal.

At the August meeting, the Chief Executive Officer and Plan President of Sunflower State Plan responded to concerns expressed about Sunflower's higher claim denial rate. He stated the higher denial rate was due to prescription drugs consumers attempted to refill prior to refill eligibility, as each of these would show up as a denial. He indicated Sunflower's denial rate without the medications was about eight percent. In response to a Committee member's question

regarding what made Sunflower different from the other two MCOs who also had prescription medications, he responded Sunflower filled more prescriptions than the other MCOs.

The three MCOs provided updates at the November meeting regarding achievements for the year. The Chief Executive Officer of Amerigroup reported the MCO moved 119 persons from institutional care back into the community and another 68 persons transitioned to employment. She also noted seeing overall reductions in emergency care and a decrease in in-patient admissions for chronic care situations.

**Human Services Consensus Caseload Spring Estimates.** At the April meeting, a Kansas Legislative Research Department (KLRD) staff member presented an overview on the Human Consensus Caseload Estimates for FY 2014 and FY 2015. She stated the combined impact for all human services caseloads for both years is an all-funds increase of \$38.0 million and an SGF decrease of \$30.4 million. For FY 2014, the revised estimate was a decrease of \$17.1 million from all funding sources and \$24.5 million in SGF. For FY 2015, the estimate is an all-funds increase of \$55.2 million and a SGF decrease of \$6.0 million, as compared to the Governor's recommended budget.

In response to questions regarding the decrease in funding for Temporary Assistance to Families (TAF) in spite of an increase in the number of poor Kansans, a KLRD staff member explained policy changes had been implemented over the past couple of years regarding eligibility for the TAF program, and the estimates would reflect those changes and any changes in law. The Committee was reminded the Spring Consensus Caseload Estimates are displayed as changes to the Fall estimates and may not indicate a decrease or increase in actual numbers. Requirements for TAF eligibility and the inability to precisely determine the amount of the caseload estimate attributable to the woodwork effect also were discussed.

**Human Services Consensus Caseload Fall Estimates.** At the November meeting, a KLRD staff member presented an overview on the Human Consensus Caseload Estimates for FY 2015, FY 2016, and FY 2017. She reported the estimate on

human services caseload expenditures for FY 2015 was an increase of \$106.6 million from all funding sources and \$46.2 million from SGF. She noted the estimate for FY 2016 was an increase of \$126.4 million from all funding sources and \$76.6 million from the SGF above the FY 2015 revised estimate. She stated the estimate for FY 2017 was an increase of \$31.9 million from all funding sources and \$44.5 million from the SGF above the FY 2016 estimate. The combined estimate for FY 2015, FY 2016, and FY 2017 was an all-funds increase of \$265.9 million and a SGF increase of \$167.3 million.

The KLRD staff member noted the estimate for TAF in the FY 2015 revised estimate was a decrease of \$200,000 from all funding sources and \$3,437,508 from the SGF expenditures from the amount approved by the 2014 Legislature. She indicated the all funds decrease was due to a series of policy changes which began in fall 2011 and resulted in a declining TAF population, and the SGF reductions were the result of meeting the federal maintenance of effort requirements through other allowable expenditures, mainly the refundable portion of the Earned Income Tax Credit.

The KLRD staff member explained the estimate for contracted foster care services was anticipated to decrease by \$300,000 from all funding sources, and increase by \$10.2 million from the SGF. She noted there was an ongoing conversation with the federal Administration for Children and Families regarding expenditures from the Title IV-E foster care funding source. The final decisions on the issue were not anticipated in calendar year 2014, and the estimate for FY 2014 included the addition of \$13.1 million, all from SGF, to provide adequate cash flow to the program.

In addition, the KLRD staff member reported the FY 2015 estimate for KanCare Medical is \$2.7 billion from all funding sources, including \$1.0 billion from the SGF, reflecting an increase of \$108.4 million from all funding sources and \$39.0 million from the SGF above the amount approved by the 2014 Legislature. She noted the increase in KanCare Medical was largely attributable to a slight growth in the population served and the costs associated with the ACA insurer's fee

included in the capitated rate payment (except for long-term care services and supports which are excluded from the federal requirements). The KDADS KanCare estimate included an addition for payments to the MCOs for mental health assessments for both the current year and prior years, which had not been previously included in the capitation payments. She stated the estimate included funding from the Problem Gambling and Addictions Grant Fund.

A Committee member asked for clarification on FY 2017 estimates, with a rise of \$21.0 million between FY 2016 and FY 2017, and the difference between the All Funds and SGF. The KLRD staff member responded the report showed a change from the FY 2016 estimate, which could be the result of Federal Medical Assistance Percentage (FMAP) changes in 2016.

In clarifying the formula for FMAP, the staff member stated the complicated formula was developed and used by the federal government, and it not only looked at Kansas numbers but how Kansas compared to other states. She noted the formula came from CMS, and additional information may be obtained from CMS.

The staff member responded to a request for clarification on the major areas driving changes in FY 2016, indicating the major areas were the FMAP, the ACA insurer's fee, and the extra week of payments in FY 2016. She also indicated the IV-E funding was decreasing in FY 2016 because, in FY 2015, the federal government withheld a portion of the funds normally provided to the state and, for purposes of the report, an assumption was made the issue would be resolved by FY 2016. In addition, she responded to a question about the DOL ruling, stating the ruling was not factored into the estimates.

**Quarterly HCBS report.** At each Committee meeting, the Secretary for Aging and Disability Services provided information on average monthly caseloads and average census for state institutions and long-term care facilities, savings on transfers to HCBS waivers, and the HCBS savings fund balance. With regard to the savings fund balance and money saved on transfers to the HCBS waiver, the Secretary noted HCBS savings are realized only when an individual is moved to a community

setting from an institutional setting and the bed is closed. As a result, she noted, despite individuals moving into community settings, which does have the effect of cost avoidance, the current balance in the KDADS HCBS Savings Fund was \$0 (as of November 13, 2014).

The quarterly report provided at the November meeting indicated during the fourth quarter of FY 2014, 8,734 Kansans received I/DD waiver services per month. Also during the fourth quarter of FY 2014, on average 5,443 Kansans received HCBS PD waiver services per month, 5,280 received HCBS FE waiver services per month, and 577 received HCBS Traumatic Brain Injury (TBI) waiver services.

At the November meeting, the Secretary for Aging and Disability Services discussed Osawatomie State Hospital, which had a review by CMS surveyors during which deficiencies were identified that required correction. She noted the hospital would be resurveyed by December 8, 2014. The Secretary explained Osawatomie also has had an issue with being over census as compared to the license level. She stated one of the challenges was, over the past few years, some community hospitals in Kansas and the surrounding region that had adult psychiatric beds either were closing whole units or reducing the number of beds. The Secretary noted this increased the pressure on the state hospitals. She addressed some of the steps being taken to deal with the census issue. A Committee member expressed concern Medicare payments could be terminated based on the deficiencies.

**Waiting list reduction.** The Secretary for Aging and Disability Services stated at the April meeting an additional \$52.6 million had been invested in the PD, DD unserved, and DD underserved waiting lists. He noted his staff was continuing efforts to verify current waiting list information. He confirmed the state had agreed with CMS that, when DD LTSS were rolled into KanCare on February 1, 2014, part of the transition plan would include elimination of the DD underserved list. The Secretary stated at the August meeting the HCBS DD underserved list had been eliminated.

An update on efforts to reduce the waiting lists was provided by the Secretary for Aging and Disability Services at the November meeting. As of the meeting date, in calendar year 2014, KDADS has offered services to more than 1,200 individuals on the PD waiting list (excluding individuals in crisis) and would continue to make offers to reach a target of 6,092 on the PD waiver by the end of the year. She outlined the process KDADS uses to contact individuals on the waiting list, and the assistance provided through the eligibility process for those who accepted PD services. The Secretary noted the MCOs had assessed every individual on the PD waiting list. She stated, in 2014 through October, 167 previously unserved PD waiting list consumers had been placed on HCBS services.

**HCBS waiver renewal applications.** At the August and November meetings, the Secretary for Aging and Disability Services provided updates on the renewal applications for I/DD, FE, and TBI waivers. She noted CMS granted a temporary extension on these waivers until December 31, 2014. Public comment sessions on the proposed changes to the waiver applications were held both in person and by conference call. The public comment period was open until December 20, 2014. A summary of transition plans and proposed changes to the HCBS programs could be found on the KDADS website.

The Secretary provided a summary of the proposed changes included in the waiver renewal applications at the November meeting, as follows:

- A standardized definition of personal care services and clarification of informal supports and the capable person policy;
- Standardized requirements for background checks and adopting standard prohibited offenses;
- A multi-functional eligibility instrument which was in the testing phase and review phase and a study of the Basic Assessment and Services Information System (BASIS) assessment which is to take place in 2015; and
- The creation of a military exception for

Kansas residents separating from military service and receiving Tricare Echo, with the ability to receive HCBS and bypass the waiting list, if applicable.

The Secretary for Aging and Disability Services responded to concerns expressed at the November meeting about the requirement to move individuals from the PD waiver to the FE waiver at age 65. She stated this was proposed in the waiver renewal, which was still out for public comment. She also added the proposal grandfathered those above 65 years of age currently on the PD waiver, so it would apply only to those who turn 65 years of age in the future.

**U.S. Department of Labor HCBS setting rule.** At the April meeting, the Secretary for Aging and Disability Services provided information on new HCBS rules from CMS effective March 17, 2014. He indicated his staff was working on a transition plan because the rules would impact several areas, including changes in the characteristics for HCBS settings that might preclude any nursing home from having an assisted living facility in the same building.

At the August meeting, the Secretary for Aging and Disability Services discussed the new DOL HCBS settings rule, which was intended to ensure HCBS services were delivered in community-based settings and were not community-based in name only. She also expressed concern about a DOL ruling that potentially would have significant impact on direct service workers serving HCBS self-directed clients in Kansas. The Secretary noted, in Kansas, the FMS model had provided administrative support to self-directed consumers (tax id number, workers compensation, and other administrative assistance), and the new rules changed the definition of “employer” in a manner that would impact consumer choice and flexibility for direct support workers.

The Secretary stated at the August meeting KDADS had asked the DOL to delay implementation of the rule and requested an exemption specifically for Kansas self-directed consumers. She indicated approximately 14,500 direct care workers would be impacted by the new rule. The Secretary also noted the changes could result in a future budget impact, but how much and when was unknown.

The Secretary responded to a question at the August meeting regarding the effect on sleep-cycle support services if direct care workers were limited to 40 hours or less per week by clarifying sleep-cycle support currently was not paid on an hourly rate and that would change with the new rule, so costs would be higher. The Secretary stated there would need to be more attendants, so additional workers would have to be recruited.

The Chief Executive Officer of Amerigroup Kansas Plan responded to questions regarding the DOL rulings, specifically sleep-cycle support at the August meeting. She noted sleep-cycle support was paid by the case rate at a set fee and the support could go from six to ten hours because the care provider was allowed to sleep during that time. She indicated if the care providers would be required to be paid an hourly rate instead of a case rate, the cost of such support would really increase.

At the November meeting, the Secretary for Aging and Disability Services stated a hybrid FMS model has been proposed to CMS that allows some features of Agency with Choice and Vendor Fiscal/Employer agent models. She noted one model would be chosen on the waiver application, but elements of both would be described. The Secretary stated the new model would require the beneficiary or client to make decisions on worker funds (range of pay, hourly rate, bonuses, and similar matters), while FMS agents would be asked to offer information and assistance. She also stated consumers would be required to obtain Federal Employer Identification Numbers. The FMS workgroup is to propose a transition plan to KDADS to comply with Internal Revenue Service procedural requirements, with proposed implementation by June 1, 2015.

According to testimony provided by the Secretary for Aging and Disability Services at the November meeting, the DOL announced on October 7, 2014, its plan to not enforce the rule changes between January 1, 2015, and June 30, 2015. She noted, except for egregious circumstances, “back wage” liability is likely to extend back to the effective date of enforcement, rather than to January 1, 2015.

**Conflict of interest.** A parent expressed concern at the November meeting regarding what he deemed as a potential conflict of interest, as the organization charged with saving money currently also determined the level of care provided. He noted the need to return to a disinterested third party who determined the level of care needed. The individual also noted if he did not declare himself a guardian, he could not make decisions for his son but, if he declared himself a guardian, he disqualified himself from the ability to determine the level of care his son received.

The Secretary for Aging and Disability Services stated at the November meeting the agency was looking at setting up a system with a third party with guardian-like responsibilities who could sign off on the plan of care. She noted this model already exists in other states and would allow guardians to provide services. The Secretary proposed using elements of the Oregon model.

In response to questions regarding MCO conflicts of interest expressed at the November meeting, the Amerigroup Chief Executive Officer indicated there were checks and balances in the system and internal processes that looked for large variances in support, and service coordinators did not benefit directly from services they approved or denied. She noted, while the MCO determined who was paid, there was no benefit to the MCOs to deny services or claims.

**Historical spending for HCBS waivers and historical waiting lists.** At the April meeting, a KLRD staff member reviewed HCBS waiver expenditures from all funding sources and from SGF for FY 2008 through the agency’s estimate for spending for FY 2015. She also reviewed the HCBS Historical Waiting List for each fiscal year and each Omnibus period from 2008 through 2014. With regard to Omnibus 2014 data, the staff

member noted the most recent numbers available for the waiting list from KDADS were for a varied time frame: the HCBS/DD numbers were as of December 2013; the PD numbers were estimated, as KDADS indicated the individuals on the waiting list were undergoing verification; and the autism waiver waiting list number was as of April 15, 2014.

**Federal Health Insurance Marketplace update.** Information was provided by representatives of the Kansas Insurance Department (KID) at each of the Committee meetings updating the members on the federal Health Insurance Marketplace. At the April meeting, the KID Special Counsel and Director of Health Care Policy and Analysis noted the quality of the federal exchange website and the enrollment data being sent to the insurers was improving, although there continued to be some cases in which the process was not working smoothly.

## **CONCLUSIONS AND RECOMMENDATIONS**

Based on testimony heard and Committee deliberations, the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight makes the following conclusions and recommendations:

### **Committee Meeting Days**

The Committee recommends meeting twice during the legislative session and twice when the Legislature is out of session in different quarters, as required by statute, with the non-session meetings to be for two days each.

### **Hearings to Review the Legislative Post Audit Report on CDDOs**

The Committee recommends separate hearings be scheduled during the 2015 Legislative Session before the House Social Services Budget Committee and the Senate Committee on Ways and Means' Social Services Subcommittee to address the March 2014 Legislative Post Audit Report, *CDDOs: Reviewing Issues Related to Community Services Provided for Individuals with Developmental Disabilities (R-14-006)*.

### **Software Issues Regarding Data Accuracy and Reporting on Waiting Lists**

The Committee recommends a meeting of the Joint Committee on Information Technology be held to review software issues regarding data accuracy and reporting on the waiting lists. The Committee noted concerns with the agency's ability to provide accurate data and reporting on waiting lists and expressed it was important to investigate the issue.

### **Anti-psychotic Medications**

The Committee recommends separate hearings be scheduled during the 2015 Legislative Session before the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare to consider the repeal of KSA 2014 Supp. 39-7,121b for the purpose of allowing Kansas Medicaid to manage anti-psychotic medications like other drug classes.

### **Proposed Legislation**

The Committee did not propose legislation for consideration during the 2015 Legislative Session.

## ADDENDUM A

### **ROBERT G. (BOB) BETHELL JOINT COMMITTEE ON HOME AND COMMUNITY BASED SERVICES AND KANCARE OVERSIGHT**

#### **ANNUAL REPORT FOR THE 2015 LEGISLATIVE SESSION**

The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight is charged by statute to submit an annual written report on the statewide system for long-term care services to the President of the Senate and the Speaker of the House of Representatives at the start of each regular legislative session. The authorizing legislation (KSA 2014 Supp. 39-7,159) creating a comprehensive and coordinated statewide system for long-term care services became effective July 1, 2008.

The Committee's annual report is to be based on information submitted quarterly to the Committee by the Secretary for Aging and Disability Services. The annual report is to provide:

- The number of individuals transferred from state or private institutions to home and community based services (HCBS), including the average daily census in state institutions and long-term care facilities;
- The savings resulting from the transfer of individuals to HCBS as certified by the Secretary for Aging and Disability Services; and
- The current balance in the Home and Community Based Services Savings Fund.

The following table and accompanying explanations are provided in response to the Committee's statutory charge.

**Number of individuals transferred from state or private institutions to home and community based services including the average daily census in state institutions and long-term care facilities:**

*Number of Individuals Transferred* – The following table provides a summary of the number of individuals transferred from developmental disability (DD) institutional settings into home and community based services during state fiscal year 2014, together with the number of individuals added to home and community based services due to crisis or other eligible program movement during state fiscal year 2014. The following abbreviations are used in the table:

- ICF/MR — Intermediate Care Facility for the Mentally Retarded
- SMRH — State Mental Retardation Hospital
- MFP — Money Follows the Person program
- SFY — State Fiscal Year

<b>DD INSTITUTIONAL SETTINGS AND WAIVER SERVICES*</b>	
Private ICFs/MR: Avg. Mo. Caseload SFY 2014	143
State DD Hospitals – SMRH: Avg. Mo. Caseload SFY 2014	321
MFP: Number discharged into MFP program - DD	24
I/DD Waiver Community Services: Avg. Mo. Caseload SFY 2014	8,734

\*Monthly averages are based upon program eligibility.  
Sources: SFY 2014 – Medicaid eligibility data as of November 10, 2014. The data includes people coded as eligible for services or temporarily eligible.

The following table provides a summary of the number of individuals transferred from nursing facility institutional settings into home and community based services during state fiscal year 2014. These additional abbreviations are used in the chart:

- FE – Frail Elderly Waiver
- PD – Physical Disability Waiver
- TBI – Traumatic Brain Injury Waiver

<b>FE / PD / TBI INSTITUTIONAL SETTINGS AND WAIVER SERVICES*</b>	
Nursing Homes-Avg Mo Caseload SFY 2014	10,746
MFP FE: Number discharged into MFP program receiving FE Services	37
MFP PD: Number discharged into MFP program receiving PD Services	107
MFP TBI: Number discharged into MFP program receiving TBI Services	11
Head Injury Rehabilitation Facility	28
FE WAIVER: Avg. Mo. Caseload SFY 2014	5,280
PD WAIVER: Avg. Mo. Caseload SFY 2014	5,443
TBI WAIVER: Avg. Mo. Caseload SFY 2014	577

\*Monthly averages are based upon program eligibility.  
Sources: SFY 2014 – Medicaid eligibility data as of November 10, 2014. The data includes people coded as eligible for services or temporarily eligible.

<b>Average Daily Census in State Institutions and Long-Term Care Facilities</b>	
Kansas Neurological Institute: Avg. Daily Census	FY 2010 – 157
	FY 2011 – 153
	FY 2012 – 152
	FY 2013 – 145
	FY 2014 – 143
Parsons State Hospital: Avg. Daily Census	FY 2010 – 186
	FY 2011 – 186
	FY 2012 – 175
	FY 2013 – 176
	FY 2014 – 174
Private ICFs/MR: Monthly Avg.	FY 2010 – 194
	FY 2011 – 188
	FY 2012 – 166
	FY 2013 – 155
	FY 2014 – 143
Nursing Facilities: Monthly Avg.	FY 2010 – 10,844
	FY 2011 – 10,789
	FY 2012 – 10,761
	FY 2013 – 10,788
	FY 2014 – 10,787

\*Monthly Averages are based upon Medicaid eligibility data.

### Savings Resulting from the Transfer of Individuals to HCBS

The “savings” through *Money Follows the Person* are realized only if and when an individual is moved into a community setting from an institutional setting and the bed is closed. This process would result in a decreased budget for private ICFs/MR and an increase in the MR/DD (HCBS/DD) Waiver budget as a result of the transfers.

For nursing facilities and state ICFs/MR, the process is consistent with regard to individuals moving to the community. The difference is seen in “savings.” As stated above, savings are seen only if the bed is closed. In nursing facilities and state ICFs/MR, the beds may be refilled when there is a request by an individual for admission that requires the level of care provided by that facility. Therefore the beds are not closed. Further, even when a bed is closed,

only incremental savings are realized in the facility until an entire unit or wing of a facility can be closed.

As certified by the Secretary for Aging and Disability Services, despite individuals moving into community settings which does have the effect of cost avoidance, the savings resulting from moving the individuals to home and community based services, as of November 13, 2014, was zero dollars.

#### **Current Balance in the KDADS Home and Community Based Services Savings Fund**

The balance in the Kansas Department for Aging and Disability Services Savings Fund as of November 13, 2014, was zero dollars.