

Committee Reports to the 2017 Kansas Legislature



Supplement

Kansas Legislative Research Department

March 2017

2016 Legislative Coordinating Council

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Supplement

Special Committee on Larned and Osawatomie State Hospitals
Special Committee on Organization of Public Health Boards

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



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Foreword

This publication is the supplement to the *Committee Reports to the 2017 Legislature*. It contains the reports of the following committees: Special Committee on Larned and Osawatomie State Hospitals; Special Committee on Organization of Public Health Boards; and Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight.

This publication is available in electronic format at <http://www.kslegresearch.org/KLRD-web/Publications.html>.

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Summary of Conclusions and Recommendations

Special Committee on Larned and Osawatomie State Hospitals

The Committee made recommendations related to funding, partnerships, recruiting, and workplace bullying, as listed below.

Request for proposal. The Committee recommended, before vendors submit bids for the Kansas Department for Aging and Disability Services (KDADS) request for proposal for operations at Osawatomie State Hospital (OSH), they consult with Community Mental Health providers.

Crisis center funding. The Committee recommended full funding of all crisis centers, including Rainbow Services Inc. in Kansas City, COMCARE in Wichita, and Valeo Behavioral Health Center in Topeka.

OSH beds. The Committee recommended KDADS provide an interim plan to utilize 20 additional beds at OSH or through third-party facilities and such plan be included in the 2017 rescission bill.

Partnership with University of Kansas. The Committee recommended the University of Kansas and the state hospitals establish a working relationship that will create partnerships such as internships, fellowships, and other collaborative ventures.

Recruitment through fellowships and internships. The Committee noted staffing shortages at the state hospitals and urged Larned State Hospital and OSH to establish programs such as internships, fellowships, and similar initiatives to enhance recruitment measures.

Recruitment through salary schedule. The Committee recommended KDADS develop a comprehensive salary and benefits schedule to enhance recruitment.

Workplace bullying. The Committee noted the destructive nature of bullying in the workplace and condemned it at all employment levels in state hospitals. The Committee recommended KDADS investigate incidents of employee bullying and develop policies to curtail such behavior.

Special Committee on the Organization of Public Health Boards

The Committee recommended the Board of Nursing and the State Board of Healing Arts not be consolidated at this time. Additionally, the Committee recommended the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare review and consider combining the Board of Examiners in Fitting and Dispensing of Hearing Instruments with the Kansas Department for Aging and Disability Services.

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

The Committee made recommendations on several topics.

Managed care organization (MCO) operations. The Committee recommends the Secretary of Health and Environment develop standards to be utilized uniformly by each MCO serving the State of Kansas pursuant to a contract with the Kansas medical assistance program for each of the following: documentation to be provided to a health care provider by any MCO when it denies a claim for reimbursement submitted by such provider, with the requirement that denial reason codes be compliant with the Health Insurance Portability and Availability Act and MCOs consistently apply denial reason codes in the same manner to ensure accurate reporting to the state; and documentation to be provided to a health care provider by any MCO when recoupments are made pursuant to a post pay audit of such provider, to include transparency of methodology used in the audit and a specific explanation of the reason for recoupment, and requiring that MCOs may not arbitrarily remove codes (*e.g.*, ICD-10, CPT, DRG) submitted by the provider or change the level of care provided to reduce payment without using the proper appeal protections in place.

The Committee further recommends the Secretary complete a quarterly review of claims denials and appeals to determine whether a high percentage of denials are overturned on appeal and, if so, address the issue with the MCO(s) and, if a certain procedure or codes are denied more often than others, whether those denials are appropriate and address the issue with the MCO(s). A notice of a right to appeal, including the details and specific action required, is to be sent no later than December 15, 2016, to individuals who were assessed under the Capable Person Policy and, as a result, had their plans of care adversely affected. MCOs are to report to the Committee on the first pass denial rate. The Committee further recommends all MCOs work together to develop one standardized credentialing application, respond to all submissions within 15 working days, use a Council for Affordable Quality Healthcare portal for processing credentialing applications, standardize the underpayment and overpayment process, and provide notices of changes to a Plan of Care to both individuals and providers.

Mental health. The Committee recommends legislation be introduced by the House and Senate health committees to work on the Mental Health 2020 Initiative plan from the community mental health centers.

Medicaid Clearinghouse operations. The Committee recommends eligibility applications over 45 days old be sent to a team formed exclusively to get applications through the process and finished. Kansas Department of Health and Environment officials should set a goal that 75 percent of long-term care applications be cleared in the first 45 days.

Administration of KanCare. The Committee recommends extending the current 1115 Waiver for one year and delay the request for proposal until the State clearly understands federal changes to the Affordable Care Act and Medicaid; delaying expansion of the Kansas Eligibility and Enforcement System to Phase 3 until there has been a clear demonstration of system functionality, operational integrity is determined, and all problems have been resolved; and requesting the Legislative Division of Post Audit update the information technology audit on the Kansas Eligibility and Enforcement System (KEES) published in December 2015 and report satisfactory performance before Phase 3 expansion can occur.

KanCare reporting and rates. The Committee recommends all uncompensated care numbers presented to the Committee be based on 100 percent of Medicare allowable and the 4 percent Medicaid reimbursement cut and corresponding policies be reversed.

Report of the Special Committee on Larned and Osawatomie State Hospitals to the 2017 Kansas Legislature

CHAIRPERSON: Senator Jim Denning

VICE-CHAIRPERSON: Representative J. R. Claeys

OTHER MEMBERS: Senators Mitch Holmes, Laura Kelly, Caryn Tyson, and Ralph Ostmeyer (substitute); and Representatives Pete DeGraaf, Nancy Lusk, Charles Macheers, and Jack Thimesch

STUDY TOPIC

Study of Various Issues Regarding Larned State Hospital and Osawatomie State Hospital

The Committee's study includes the following:

- Monitor the patient populations and review and study the activities and plans of the treatment programs and correlation to patient outcomes;
- Tour each state psychiatric hospital, considering the evaluating facility issues relating to plan management and safety;
- Review and study the Kansas Department for Aging and Disability Services' (KDADS') policies relating to each state psychiatric hospital;
- Review and study KDADS' responsiveness and efforts in identifying and resolving issues relating to facility, staff, and patients;
- Review and study KDADS' staffing and policies relating to staffing, recruitment, retention, employee morale, and employee relations issues;
- Review and identify patient and employee safety concerns; and
- Review and study any other issues brought to the attention of the Committee concerning state psychiatric hospital oversight.

Special Committee on Larned and Osawatomie State Hospitals

REPORT

Conclusions and Recommendations

The Committee makes the following recommendations:

- Before vendors submit bids for the Kansas Department for Aging and Disability Services' (KDADS') request for proposal (RFP) for operations at Osawatomie State Hospital (OSH), they consult with community mental health providers;
- Full funding of all crisis centers, including Rainbow Services Inc. in Kansas City, COMCARE in Wichita, and Valeo Behavioral Health Center in Topeka;
- KDADS provide an interim plan to utilize 20 additional beds at OSH or through third-party facilities and such plan be included in the 2017 rescission bill;
- The University of Kansas and the state hospitals establish a working relationship that will create partnerships, such as internships, fellowships, and other collaborative ventures;
- Noting staffing shortages at the state hospitals, urge Larned State Hospital and OSH to establish programs, such as internships, fellowships, and similar initiatives, to enhance recruitment measures;
- KDADS develop a comprehensive salary and benefits schedule to enhance recruitment; and
- Noting the destructive nature of bullying in the workplace and condemning it at all employment levels in state hospitals, KDADS investigate incidents of employee bullying and develop policies to curtail such behavior.

Proposed Legislation: None

BACKGROUND

The Legislative Coordinating Council (LCC) in 2016 appointed a Special Committee on Larned State Hospital (LSH) and Osawatomie State Hospital (OSH), composed of nine members. The Committee was tasked by the LCC to study various issues regarding LSH and OSH as follows:

- Monitor the patient populations and review and study the activities and plans of the treatment programs and correlation to patient outcomes;
- Tour each state psychiatric hospital, considering and evaluating facility issues relating to plan management and safety;

- Review and study the policies of the Kansas Department for Aging and Disability Services' (KDADS') policies relating to each state psychiatric hospital;
- Review and study KDADS' responsiveness and efforts in identifying and resolving issues relating to facility, staff, and patients;
- Review and study KDADS' staffing and policies relating to staffing, recruitment, retention, employee morale, and employee relations issues;
- Review and identify patient and employee safety concerns; and
- Review and study any other issues brought to the attention of the Committee concerning state psychiatric hospital oversight.

The Committee was granted four meeting days by the LCC and met on December 19 and 20, 2016, at the Statehouse. The Committee did not tour the state psychiatric hospitals.

COMMITTEE ACTIVITIES

The Committee held all-day meetings on December 19 and 20, 2016, at the Statehouse.

Osawatomie State Hospital

History and virtual tour of OSH. At the December 19 meeting, the Superintendent of OSH provided a history of OSH, stating it is the oldest mental hospital in Kansas, having admitted its first patient on November 5, 1866. The campus currently consists of 2 hospitals with a 146-bed capacity, OSH and Adair Acute Care (Adair) at OSH. The campus is licensed for 206 beds; however, 60 beds are being kept vacant due to the self-imposed moratorium on admissions above 146 patients.

The Superintendent provided a virtual tour of the OSH campus, commenting on the age of most of the buildings and focusing on the seven-

building Adair complex where most of the patients are housed.

Decertification. On December 21, 2015, the federal Centers for Medicare and Medicaid Services (CMS) decertified OSH. The Acting Secretary for Aging and Disability Services reviewed the events following decertification of OSH by CMS. He stated, for the previous year, KDADS had been working with staff at OSH toward recertification and OSH is ready to be surveyed by CMS; however, CMS has not set a date to conduct the survey required to recertify OSH. The Acting Secretary did not have a time line for when a date will be set.

Responding to Committee members' questions, the Acting Secretary stated The Joint Commission (a third-party agency that certifies and accredits state hospitals) will accede to CMS for recertification. The initial plan is recertification and then accreditation. The Acting Secretary stated OSH has a maximum capacity of 206 beds, including the 146 currently in use, none of which are currently certified. Adair has 60 beds ready to be recertified; the preparation cost for 30 beds was \$700,000. All 206 beds are needed to meet the adult-continuum-of-care goals.

Time line. The OSH Superintendent discussed the time line of The Joint Commission complaint survey (October 2014) and the State Fire Marshal's findings (October 2014) that led to a comprehensive survey by CMS in January 2015. The CMS survey found OSH to have the following conditions out of compliance: governing body; quality assessment/performance improvement; medical records (active treatment); discharge planning; staffing; and physical environment. The survey findings resulted in the decertification of OSH in December 2015.

Cost. The KDADS Director of Finance and Budget reviewed the costs of the decertification of OSH. The Director of Finance and Budget noted budget enhancements are needed to compensate for loss of funding and provide budget allocations for OSH and LSH. She stated the budget shortfall in FY 2016 for OSH was \$7.2 million and is estimated to be \$20.1 million in FY 2017 and \$14.2 million in FY 2018, assuming recertification of 60 beds by July 1, 2017.

Progress toward recertification. The Chief Executive Officer, Adair, OSH, stated one step in the process of recertification was to divide OSH into two distinct entities, one of which is Adair Acute Care, and to institute a moratorium on admissions at 146 patients. He outlined changes made by OSH in an effort to move toward CMS recertification as follows: reviewed close to 200 policies, revising at least half; revised medical staff bylaws; revised the Risk Management Plan (approved by the Kansas Department of Health and Environment); revised several position descriptions; increased physician coverage (seven days a week); implemented internal monitoring changes (new metrics and satisfaction surveys); increased the staffing schedule on units, resulting in reduced mandates and reduced overtime; reduced nursing staff caseloads; increased safety for patients and staff on units; increased focus on individualized treatment planning; increased focus on patient and staff safety; refined the triage process; increased communication and streamlined workflow; strengthened focus on determining the medical stability of patients prior to admission; revised pharmacy protocols; strengthened the discharge planning process; implemented a new dress code; implemented vigorous training; developed support tools that will monitor distribution of admissions, admission/triage process effectiveness, and staffing variance; and defined OSH's mission and vision.

Audit. A Senior Auditor for the Legislative Division of Post Audit (LPA) reviewed the findings of an audit, released in July 2016, of OSH's loss of funding as a result of CMS decertification. The Senior Auditor stated the decertification was prompted by OSH's failure to comply with federal regulations relating to staff and patient safety. He explained noncompliance resulted in an estimated \$15.0 million loss of funding and additional expenses to address the deficiencies present as of June 2016, an impact that will continue in some degree until the entire facility is recertified. He stated no Medicare or Medicaid funding will be available for OSH until the facility is recertified.

Request for proposal (RFP). The Acting Secretary for Aging and Disability Services indicated KDADS was pursuing recertification of the facility but also looking at other options, including through the release of a RFP.

Enacted 2016 House Sub. for SB 161 included proviso language that, for FY 2016, FY 2017, and FY 2018, prohibits the expenditure of any moneys appropriated for the relevant fiscal years to privatize the operations of LSH or OSH without prior specific authorization in an act of the Legislature or in an appropriation act of the Legislature.

Enacted 2016 House Sub. for SB 249 also included proviso language that, for FY 2017 and FY 2018, prohibits the expenditure of any moneys appropriated for the relevant fiscal years to KDADS to enter into any agreement or take action to outsource or privatize the operations or facilities of LSH or OSH without prior specific authorization by an act of the Legislature or an appropriation act of the Legislature. At the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight meeting on November 18, 2016, the Acting Secretary for Aging and Disability Services indicated the agency's interpretation of this provision was that the agency may not privatize either hospital without legislative approval but may pursue a RFP to evaluate options. On November 14, 2016, KDADS issued the RFP titled "Operation of Osawatomie State Hospital (OSH)." The bidding closed at 2 p.m. on December 29, 2016.

Overview of the RFP. Staffing: The contractor must maintain adequate staffing levels to meet the needs of OSH, and it must provide monthly staffing reports to the Secretary for Aging and Disability Services for the first year of the contract, followed with quarterly staffing reports every year thereafter. Penalties may be assessed if a staffing shortage persists longer than 45 days.

Treatment beds: Currently, OSH is licensed for 206 inpatient psychiatric treatment beds. All submitted proposals must include at least 206 inpatient psychiatric beds in the OSH catchment area. The contractor must maintain a minimum of 94 inpatient beds at the current OSH campus, and the remaining inpatient beds may be maintained at the current OSH campus or at another KDADS-approved facility within the OSH catchment area.

Certification: The RFP requires the contractor to bring OSH into accreditation with The Joint

Commission and certification under CMS within 24 months of the effective date of the contract. Additionally, the contractor could be fined if it fails to maintain federal certification and quality or if inspectors find issues that could harm patients.

Incentives and penalties: Incentives are outlined in the RFP for reducing the number of preventable readmissions and the number of patients residing in the hospital long term. Penalties for several types of damaging events are included in the RFP.

Staffing ratios, recruitment, and retention.

A representative from KDADS stated OSH's 2016-2018 strategic goals include filling vacancies, increasing staff satisfaction, and reducing turnover. The representative explained the steps taken to fill vacancies, which included a mental health developmental disability technician and registered nurse wage increase and new job advertising practices. She stated these changes improved hiring rates.

The Acting Secretary presented vacancy and turnover rates for mental health technicians at both OSH and LSH. He noted, in one year, vacancy rates dropped from 40 percent to 10 percent and turnover rates were lowered from 70 percent to 30 percent. He also stated overtime costs were steadily decreasing and the patient to staff ratio had improved from 15:1 to 12.5:1.

Public comment. A representative from the Association of Community Mental Health Centers of Kansas cited the experiences of Indiana and Oregon to express concern regarding the negative effect privatization might have on Kansas' state hospitals. He also expressed concern regarding the deleterious effects that state hospital overcrowding creates for community mental health centers.

A representative from Equi-Venture Farms explained Equi-Venture Farms acts as a facilitator, providing placement options for those discharged from a state hospital.

A representative of the Kansas Mental Health Coalition and co-chair of the Adult Continuum of Care Task Force addressed issues raised in the KDADS' Adult Continuum of Care Committee final report. She stated gaps in the continuum of

care, staffing issues, the staffing moratorium, and the waiting list create serious obstacles in providing the continuum of care the report recommends. The representative recommended the patient moratorium be ended at the OSH facility. She stated the moratorium has created a crisis for law enforcement officials and violates the Adult Continuum of Care Task Force recommendations. She noted only 6 of the 26 community mental health centers have residential housing available. Answering questions, the representative said she was aware of no partnerships between universities and mental health hospitals and an ancillary effect of budget cuts is the loss of grant funding.

A representative of Valeo Behavioral Health Care (Valeo) provided a community mental health care perspective. He outlined a variety of services provided by Valeo, and he noted Valeo offers "upstream" services for those not yet needing state hospitalization. He commented on a pilot program partnering with OSH to accept patients ready to move into a community setting. Responding to questions, the representative stated 60 percent of Valeo funding comes from Medicaid and state grants account for 10 percent Valeo's funding.

A mental health advocate, who also was the superintendent of OSH from 1993 to 1997, stated the goal of mental health treatment is not to avoid institutional care, but to offer a continuum of care, which includes state hospitals. He expressed hope OSH could again become a quality treatment center and a center of excellence for mental health.

Written-only testimony was provided by the Kansas Hospital Association (KHA). KHA's written-only testimony stated that last year KHA formed a Behavioral Health Task Force consisting of behavioral health providers in the state as well as representatives from the Association of Community Mental Health Centers, law enforcement, KVC Health Systems, Prairie View Inc., the Kansas Mental Health Coalition, and the Governor's Behavioral Health Service Planning Council. The following comments were provided by the KHA Task Force members after they toured the renovated Adair Unit at OSH on November 9, 2016:

- Task Force members were very surprised to see the cramped common area, voiced

concerns about seeing curtains in patient rooms which could be used by patients to harm themselves or other patients, and thought it was unsafe to have an unpadding brick wall in a seclusion room; and

- The Task Force members were told that since OSH is seeking CMS recertification for just the Adair Unit, this area has been classified as a separate hospital from the rest of the campus. In essence, patients are not permitted to use any of the recreational and activity services provided in other buildings, such as the indoor swimming pool, or walk to activities in other buildings. In fact, patients on the Adair Unit are not permitted to go outside. The group felt strongly that keeping 50 involuntary patients housed closely together indoors, around the clock, was unsafe and did not foster a therapeutic environment. There is no avenue for patients to benefit from exercise other than walking the short hallways on Adair. In fact, a OSH staff member mentioned that at least one patient assault takes place daily. An outdoor patio is being built for the Adair Unit and, when weather permits, will provide another area for patients to use.

Larned State Hospital

History and virtual tour of LSH. At the December 20 meeting, the Superintendent of LSH related his experience with mental hospitals. He noted LSH is unique in that, besides the juvenile facility operated by the Kansas Department of Corrections, there are three separate hospital programs with three distinct sets of staff on the grounds: the Psychiatric Services Program (PSP), the State Security Program (SSP), and the Sexual Predator Treatment Program (SPTP). He gave a brief history of the facilities, which began as a state hospital and farming operation in 1914.

The Superintendent gave a virtual tour of the grounds, explaining the services offered for each of the programs. He stated the PSP patients generally are civilly committed adults with mental illness and receive services for crisis stabilization, treatment, and rehabilitation. The SSP patients generally are criminally committed persons, and

the hospital provides a secure setting for forensic evaluations and psychiatric inpatient treatment. The SPTP's mission is two-fold: to provide for the public safety to prevent further victimization of others by sexual offenders assigned to the program and to work with those residents willing to engage in the work of personal change through quality treatment programming, with the ultimate aim of reducing the individual's risk for re-offense to a level that would allow the return of the individual to society as a contributing, productive citizen.

Answering questions, the Superintendent stated the SPTP census is 261 individuals, including patients in the 4 reintegration facilities. One reintegration facility is located at OSH, two facilities are on the grounds of Parsons State Hospital, and the fourth facility is located at LSH. When asked about affiliations between the state hospital and Kansas universities with applicable degree programs, the Superintendent noted LSH is pursuing a partnership with the University of Kansas. He noted University of Kansas School of Medicine doctors had provided telepsychiatric services for LSH patients for several weeks.

Summary of recent LPA audits of LSH. A Performance Audit Manager, LPA, reviewed a two-part comprehensive audit of the SPTP at LSH. Noting the patients were involuntary but civil, rather than criminal, commitments, she reported the first audit (2013) found the facility had inadequate control over access doors and keys and inadequate oversight over prohibited items, and staff felt unprepared to deal with resident altercations. Further, direct-care vacancies resulted in significant overtime. The program often failed to meet its internal minimum staffing goals, even with significant overtime. The audit report indicated the SPTP resident population has grown steadily, adding an average of about 18 residents per year from 2002 to 2012. Further, the audit predicted, based on the average growth rate, the program would reach its current physical capacity during 2018. As a result of few residents being released, resident population growth was anticipated to exceed LSH's physical capacity. She stated the follow-up audit documented all recommendations had been met or were being met.

Regarding the second part of the audit (2015), the audit found, unlike other states with similar programs, Kansas did not emphasize

individualized treatment programs. Although the SPTP met most statutory requirements, those related to education and rehabilitation may not have been adequately addressed. Residents who were ready for the reintegration program lacked necessary skills for finding a job or simple life skills, such as knowing how to cook. Further, the SPTP, which as of December 2014 housed 243 residents, would soon reach maximum capacity and program costs were estimated to more than double by 2025.

The 2015 audit offered 6 options for reducing the SPTP census, such as placing low-risk residents in a community setting, removing medically infirm residents to a separate secure nursing facility, and increasing the reintegration allocation from 16 to 32. The audit recommended better alignment of the program with current research-based recommended practices and that the program identify the need for additional resources and develop a strategy for obtaining those resources. The implementation and review of various processes to address management of the program was also recommended. Additionally, the development of a strategic plan to address program growth and limited labor force issues was recommended.

SPTP update; response to LPA reports; update on litigation; update on new program. The Chief Forensic Psychologist, LSH, provided an update regarding the SPTP. He reported the treatment program has been revised with a three-tiered individualized treatment program that provides special accommodations for those with intellectual or other disabilities. He noted staff training includes enhanced assessments and testing.

The Chief Forensic Psychologist explained each of the tiers in the three-tiered individualized treatment program. Tier One provides residents with the skills to live an offense-free life through therapy and supplemental groups focused on the resident's individual risk and needs. Tier Two begins the process of moving from a highly structured inpatient treatment program toward an essentially independent lifestyle through a graduated series of individualized and escorted community outings where residents demonstrate the ability to make appropriate decisions within the community. Tier Three (community

reintegration) provides continued treatment and community integration by establishing employment, a viable means of transportation, financial stability, and an approved support network. Successful Tier Three residents are recommended to the court for transitional release, and those who complete an approved conditional release plan may be recommended to the court for conditional release into the community. Conditional release requires the individuals discharged from the SPTP live in the community under court supervision for a minimum of five years.

The Senior Litigation Counsel, KDADS, responded to the LPA recommendations for the SPTP. Actions by KDADS to address the LPA recommendations include providing individualized resident treatment plans that are reviewed and updated every 90 days, conducting the annual mental exams using impartial clinical staff, implementing specific curriculum for any individual with an intellectual or developmental disability, providing residents with the skills needed for successful reintegration during Tier Two classes and supervised outings, implementing a roster system to track data related to treatment services and tier progression and participation, and forming a committee that has met periodically to evaluate the recommendations of the LPA report and the SPTP Task Force report related to population growth and program location.

The Senior Litigation Counsel explained the SPTP is statutorily prescribed, and the program accepts only high-risk residents and focuses exclusively on treatment, with the goal of reintegration into the community. She noted the 80 percent program participation rate, adding that 90 percent of residents have enrolled in classes or groups for the next quarter. She stated KDADS continues to evaluate LPA's six options to reduce the census. Answering questions, the Senior Litigation Counsel replied low- and medium-risk individuals are not eligible for the SPTP, and only high-risk individuals are in the program. She stated eight individuals have completed the program, three of whom have finished the program in the previous three months. Typically, it takes a resident three to five years to complete the program.

When asked, given the new changes to the SPTP, how long it should take a patient to be able to complete the program, the Chief Forensic Psychologist stated a range of four to six years, but noted the range could be shorter or longer depending on unique factors for a particular patient.

Review of programs at LSH: PSP and SSP.

The Clinical Director, LSH, reviewed the services provided by the PSP and the SSP. He said the PSP daily census averages 75 to 82, with a readmission rate of 10 percent. (The national average is 15 to 20 percent.) He explained the Active Treatment/Activity Therapy approach focuses on improving behavioral and emotional skills. Regarding the SSP, he reported the daily census averages around 90, which is approaching capacity. The Clinical Director outlined staff and treatment needs and announced new recruitment and training initiatives, such as working toward becoming a residency training site for post-graduate students. Responding to questions, he replied the new treatment approach is evidence-based and follows best practices.

Current status of LSH. The Superintendent related the process for improving staff morale. He stated town hall meetings, small groups, and individual contacts identified a negative working environment and staff feelings of hopelessness and being ignored. By developing a series of reports every two weeks over a period of several months, the following initiatives were developed to address staff concerns:

- Volunteers from the other hospitals were recruited;
- Salaries were improved;
- The practice of mandating overtime and pulling staff from other units was discontinued;
- A float pool was created;
- Staffing agencies provided 258 new employees;

- A career path was instituted to license mental health technicians;
- Supervisors took steps to create a more positive environment; and
- Statewide notices of vacancies and referrals produced 565 new employees.

The Superintendent also announced that a contract with the University of Kansas will create a partnership to provide a residency-type training facility.

Community, staff, and other operational meetings. The Acting Secretary commented on human resources (HR) issues, noting HR staff had a turnover rate of 100 percent. Citing a recent centralization of HR resources by the Department of Administration in Topeka rather than at LSH, the Acting Secretary noted the agency was experiencing some complications and complaints by staff. He emphasized the importance of keeping lines of communication open among staff, leadership, and the community. The Acting Secretary noted quarterly meetings by the Citizens Advisory Committee, and he referenced training to match law enforcement with mental health information and resources.

Future of LSH; juvenile corrections facility; no privatization. The Acting Secretary, commenting on the future of LSH, expressed gratitude for the dedicated staff at LSH. He stated leadership training was being instituted and a partnership with Wichita State University will enhance leadership training. With the imminent closing of the juvenile correctional facility, the SPTP might be able to utilize the vacant building. Responding to a question, he replied working toward recertification and accreditation will continue regardless of the outcome of the recently issued RFP by KDADS.

Public comment. The Executive Director for the Kansas Organization of State Employees (KOSE) expressed appreciation for the recent initiatives to improve working conditions for employees. Then, she identified continuing concerns: excessive overtime, increases in health insurance premiums, unpredictable days off, and timely release of vacancy reports.

The Executive Director noted employees have not felt the increase in their take-home pay, such as in 2016 when the Legislature appropriated funds for a pay increase, because the full increase plus some has been absorbed by increases in state employee health insurance premiums. She stated the State Employee Health Plan financial report reflects the plan's intention to increase the employees' share of plan costs over the next ten years, resulting in annual *de facto* pay cuts. The Executive Director noted this is not a favorable environment for employee recruitment and retention.

Although progress had been made from August 2016 through October 2016 in the staff vacancy rates, the Executive Director noted there are still significant vacancy rates for direct care positions, as reflected in the overtime experience of both state hospitals. She noted KOSE is cautiously optimistic about staffing and overtime trend reductions at LSH. Her testimony mentioned KDADS does not provide KOSE with weekly vacancy rate reports on a regular basis and does not provide turnover rates by position for either state hospital. The Executive Director noted the overall turnover rates for both OSH and LSH are over 30 percent.

A LSH employee and KOSE representative offered praise to the Acting Secretary and superintendents for reducing overtime. He then identified concerns needing to be addressed: workplace bullying (usually by a supervisor); ineffective promotion practices; and punitive, rather than instructive, disciplinary practices. Responding to a question, the Acting Secretary replied a bullying policy can be developed.

Another LSH employee and KOSE representative expressed appreciation for the improvements evident at LSH. She expressed the following concerns: a long vacancy list of positions, unqualified HR employees, an incomplete investigation before disciplining an employee, and disciplining an employee for calling in sick. She expressed special concern regarding supervisors bullying employees and

hiring and advancement decisions based on favoritism.

CONCLUSIONS AND RECOMMENDATIONS

The Committee adopted the following recommendations:

- Before vendors submit bids for the KDADS' RFP for operations at OSH, they consult with community mental health providers;
- Full funding of all crisis centers, including Rainbow Services Inc. in Kansas City, COMCARE in Wichita, and Valeo Behavioral Health Center in Topeka;
- KDADS provide an interim plan to utilize 20 additional beds at OSH or through third-party facilities and such plan be included in the 2017 rescission bill;
- The University of Kansas and the state hospitals establish a working relationship that will create partnerships, such as internships, fellowships, and other collaborative ventures;
- Noting staffing shortages at the state hospitals, urge LSH and OSH to establish programs, such as internships, fellowships, and similar initiatives to enhance recruitment measures;
- KDADS develop a comprehensive salary and benefits schedule to enhance recruitment; and
- Noting the destructive nature of bullying in the workplace and condemning it at all employment levels in state hospitals, KDADS investigate incidents of employee bullying and develop policies to curtail such behavior.

Report of the Special Committee on Organization of Public Health Boards to the 2017 Kansas Legislature

CHAIRPERSON: Representative Daniel Hawkins

VICE-CHAIRPERSON: Senator Elaine Bowers

OTHER MEMBERS: Senators Steve Fitzgerald, David Haley, and Michael O'Donnell; and Representatives John Barker, Gail Finney, Kyle Hoffman, and John Whitmer

STUDY TOPIC

Combining Certain Health Boards

- Consider the combination of the Board of Nursing and the State Board of Healing Arts under one administrative entity for the purpose of potential reduction of administrative costs and increased efficiency over time.

Special Committee on Organization of Public Health Boards

REPORT

Conclusions and Recommendations

The Committee makes the following recommendations:

- The Board of Nursing and the State Board of Healing Arts not be consolidated at this time; and
- The House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare review and consider combining the Board of Examiners in Fitting and Dispensing of Hearing Instruments with the Kansas Department for Aging and Disability Services.

Proposed Legislation: None.

BACKGROUND

The Legislative Coordinating Council (LCC) in 2016 appointed a Special Committee on the Organization of Public Health Boards, composed of nine members. The LCC tasked the Committee with considering the combination of the Board of Nursing (KSNB) and the State Board of Healing Arts (BHA) under one administrative entity for the purpose of potential reduction of administrative costs and increased efficiency over time.

Interest in considering the combination of public health boards arose from one of the numerous recommendations made in the *Kansas Statewide Efficiency Review* commissioned by the Legislature and conducted by Alvarez & Marsal (A&M Study). The A&M Study recommended creating an umbrella board, the Public Health Board, with the following boards consolidated under this umbrella board: Behavioral Sciences Regulatory Board (BSRB), Kansas Dental Board (KDB), BHA, Board of Examiners in Fitting and Dispensing of Hearing Instruments (KBHAE), KSNB, and the State Board of Pharmacy (KBP). The A&M Study noted other states (such as Utah,

Iowa, and Virginia) align boards and commissions thematically in order to optimize resources and prevent needless redundancies in services. This consideration provided a starting point for the Committee discussion.

The Chairperson indicated one consideration for the consolidation that has been discussed would create an umbrella board with 12 to 14 public health boards under the umbrella board. Fees still would be submitted to the individual boards, which would operate much as they do currently. However, employees would perform cross-functions for each of the boards, such as licensing teams, legal teams, and others. An executive director would manage all the shared services for all the boards, such as personnel functions.

As a result of the A&M Study recommendation, other public health boards contacted the Chairperson inquiring about the charge of the Committee. The Chairperson invited the additional health boards to present testimony to the Committee on how each board operates and their views on the key aspects for a successful reorganization of public health boards.

The Committee was granted two meeting days by the LCC and met on December 6 and 14, 2016, at the Statehouse.

COMMITTEE ACTIVITIES

The Committee held all-day meetings on December 6 and 14, 2016, at the Statehouse. In addition to the KSBN and the BHA, the Committee received testimony from additional public health boards.

December 6, 2016, Committee Meeting

Presentation from Governor's Office

The Policy Director from the Office of the Governor discussed the role of the Governor, as tasked by the Legislature, in appointing some members of public health boards and councils across state government. An appointments director, two support staff, and, occasionally, interns from universities focus primarily on the appointments. The Policy Director's testimony contained information on the state public health boards in existence, including the boards' authorizing statutes, the activities regulated, the fee schedules, and the licensing requirements. He stated the Administration believes these boards serve a dual purpose of public safety and health and create an economic benefit, making access to the professions easier for Kansans.

Public Health Boards' Presentations

Board of Examiners in Optometry. The Vice President of the Board of Examiners in Optometry (Optometry Board), stated the activities of the Optometry Board to protect the public included annually reviewing and updating the licensing examination (Kansas is one of ten states that administers a test), reviewing all continuing education classes, and acknowledging complaints by the public within one week.

The Vice President of the Optometry Board stated the most important aspect of an umbrella board structure is that the same level of service is maintained. He noted the Optometry Board feels it provides a high level of service, and the umbrella

structure may make it difficult to maintain current standards, as each board has its own volume of rules and regulations. He said the public, licensees, and companies seeking to do business in Kansas rely on the Optometry Board for answers.

In response to questions, the Vice President of the Optometry Board noted the Optometry Board has only one employee and gave an example of increased efficiency gained by changing from annual licensing and auditing to biennial. In 2017, staff will propose going to an online program for continuing education classes.

Emergency Medical Services Board. The Executive Director of the Emergency Medical Services (EMS) Board testified the EMS Board oversees all aspects of EMS services in Kansas. Its purpose is public safety first, to protect and promote the welfare of Kansans through efficient and effective regulation of EMS, and to ensure quality out-of-hospital care is available statewide. The activities of the EMS Board include certifying EMS providers, licensing ambulances, permitting entities to provide ambulance service, and approving EMS education. EMS providers include all who respond to a 911 call; some are full-time EMS employees and others are volunteers.

The Executive Director noted the EMS Board sets the standards for EMS education and the EMS communication system. Two grants are offered for assistance to local EMS services. The EMS Board also researches, develops, and maintains a database on pre-hospital patient care, which is used to make recommendations on clinical guidelines for patient care specific to different entities.

With regard to the A&M Study recommendation, the Executive Director stated the EMS Board supports efforts to improve efficiency. However, the EMS Board strongly believes a specialized agency to administer EMS as an industry is beneficial to and necessary for the protection of Kansans. He stated employees wear many hats within the agency, with 14 employees already sharing services. The EMS Board believes it has already created an umbrella organization structure within the agency.

In response to questions, the Executive Director noted funding for the EMS Board is through a percentage of fire insurance premiums submitted to the State and not from the State General Fund (SGF). The current agency budget is \$2.1 million with a grant fund of \$900,000.

Board of Nursing. The Executive Administrator of KSBN stated the agency was developed by legislative action in 1913. The agency's mission is to assure Kansans receive safe and competent care by nurses and mental health technicians through licensure and regulations. The KSBN meets 4 times a year, and all 11 board members are appointed by the Governor. Six committees assist the workings of the KSBN. The agency is fee funded and receives no SGF moneys. Ten percent of fees, up to \$100,000, and all fines go to the SGF. In FY 2015 and FY 2016, the KSBN transferred \$100,000 each year from the Nursing Fee Fund to the SGF.

The Executive Administrator stated the KSBN is the largest health care fee-funded board with approximately 72,000 active licensees (at a cost of \$33 per year) and only 26 staff. Seven investigators have an average of 321 complaints per year to investigate, and 421 of 2,248 were assigned to the Assistant Attorney General for possible discipline. The agency's budget in FY 2015 was \$2.2 million, compared to the BHA with 27,480 licensees, 58 staff, and a budget slightly over \$5.0 million. The KSBN reduced its fees in 2014 from \$60 to \$55 for every two years due to agency efficiencies that were implemented.

The Executive Administrator said the KSBN was the first health care regulatory board to have real-time online renewals, which were launched in 2001 and won a national award. The online renewals are three to five times faster, and thousands of dollars were saved with paperless renewal cards. She noted the numerous agency efficiencies accomplished.

The Executive Administrator stated the KSBN has participated in Commitment to Ongoing Regulatory Excellence (CORE) since 2000, which benchmarks performance to other boards of nursing with umbrella boards, independent boards, and boards similar to the size of the KSBN. Kansas processes initial exam applications is an

average of 1.6 days compared to other independent boards at 6.2 days, with umbrella boards at 9.1 days and boards of similar size at 3.0 days. She said the CORE report indicates an umbrella board arrangement is not as efficient. The complete report was attached to her testimony.

In summary, the Executive Administrator stated combining the fee-funded boards might negatively impact consumer safety; decrease efficiency in nursing due to loss of the current level of service, allowing unsafe nurses to continue to practice; separate discipline processes would consume staff time and decrease consumer safety; and conflicts of interest between boards could arise. She stated the KSBN has had positive outcomes and is willing to continue to share agency efficiencies and assist other agencies, and that can be done without consolidation. KSBN supports the continuation of an independent agency.

In response to questions, the Executive Administrator stated, of the seven investigators, six are registered nurses and one is a licensed practical nurse. She noted the investigations are timely because the seven investigators know the scope of the nursing practice. An Assistant Attorney General and a Special Assistant Attorney General are housed in the KSBN office, and their salaries are paid by the KSBN.

State Board of Healing Arts. The Executive Director of the BHA gave a presentation of the work of the agency. The BHA's mission is public protection and strengthening through education those who practice medical professions under the BHA. The Executive Director noted public protection and economic benefit are key facets of professional regulation. She stated there is a shortage of health care providers, so it is incumbent upon the BHA to license qualified medical professionals efficiently to meet patient needs, without creating overly burdensome regulations that inhibit the practice.

The Executive Director discussed the differences between the BHA and KSBN with regard to agency size, licensing population, budget, and the public protection and safety requirements for the different professions. She noted, as one moves up the continuum of health

care complexity, there is a vast difference on what is necessary and appropriate to ensure the basic mission of public protection. The requirements for licensing and regulating the professions vary significantly.

The Executive Director responded to questions regarding the differences between an umbrella board and an independent board. She stated there are several different regulatory agency structures nationwide. She noted Oklahoma has separate regulatory boards for medical doctors and doctors of osteopathic medicine, each of which have a couple of allied professions. She said Missouri has a regulatory commission with a wide range of professions. The Executive Director noted the agency's experience, from a regulatory perspective with the licensing of multiple professions and some states that have the global regulatory agencies, is that these states struggle with efficiencies, bureaucracy, and "red tape." She stated the BHA has struggled to get verification for someone previously licensed in Illinois or in other states with large regulatory agencies.

The Executive Director provided a brief history of the Kansas Healing Arts Act (Act), noting the Act itself is specific to three professions, but each profession has its own practice act that governs and regulates it. She stated this requires the agency staff to work together to provide a multitude of functions for the different professions, such as processing applications and online renewals, performing intake and reviews, and investigating complaints. The staff perform all these functions for all professions, which vary significantly by profession.

According to the Executive Director, approximately 3,000 new licenses were issued for FY 2016. The agency processes license applications on average within three days, including weekends and holidays, and typically the same day or the next. She noted 95 percent of the renewals are completed online, and the agency has become more efficient in the last few years with the use of technology. The BHA website contains information from 1997 forward on all public documents for licensee actions, and licenses may be verified online.

In regard to the disciplinary investigations, the Executive Director stated individuals investigate their own profession because they best know the standard for their profession. Review committees for specific professions make decisions based on the standards for that profession, and experts in the same field are used to provide an appropriate review. Part of the peer review process is the disciplinary panel, which is a subgroup of board members that reviews cases where standard of care is not met or there is a serious concern. Experts, who may come from out of state, must be hired by the hour to review the complex medical complaints, making these complaints resource intensive. She noted the importance of autonomy in the BHA's multi-professional regulatory environment.

The Executive Director responded to questions regarding software use, stating the BHA has the same software as KSBN. When asked about the potential to use this software for all health agencies, she stated KSBN, BHA, the Board of Technical Professions, the Kansas State Board of Cosmetology (KSBOC), and the Real Estate Board use the same database and platform. The Office of Information Technology Services (OITS) approached BHA because of agency in-house expertise of the software and it was a challenge for OITS to host and maintain for the agencies.

In response to a question about the reason for the disparity between KSBN and BHA with regard to the number of licenses, employees, and other areas, the Executive Director replied it hinges on the complexity of the licensed professions.

State Board of Pharmacy. The Executive Secretary of the KBP stated KBP's mission is to ensure all persons and entities conducting business relating to the practice of pharmacy in the state are properly licensed and registered. The KBP also strives to assure compliance with pharmacy standards regarding the compounding, manufacturing, and dispensing of prescription drugs, eliminating unlicensed and unqualified practice in Kansas, educating licensees, and setting very high standards for examination and qualification for licensure.

The Executive Secretary stated the KBP licenses qualified individuals to be pharmacists,

students or interns, or technicians, and also evaluates competency and character at the time of licensure and throughout licensure or registration. The agency also registers resident and non-resident pharmacies dispensing drugs to Kansans, as well as durable medical equipment providers, pharmacy drug manufacturers, wholesale distributors, labs, ambulances, research institutions, and clinics. The agency also provides regulatory oversight for canine units required to practice and train with both legal and illegal substances for which KBP monitors compliance.

The Executive Secretary stated the agency regulates the profession by conducting inspections of all registered facilities on an annual basis, audits continuing education compliance, and conducts investigations on all complaints or other suspicious activities reported to the KBP. The KBP manages the unused medication donation program that allows pharmacies to donate unused medications to clinics which then provide them to indigent patients. To date, the program has seen more than \$18.0 million in donated medications in the past five or six years.

The KBP membership, meetings, and terms were described by the Executive Secretary. The KBP has seven members: six are licensed pharmacists from various practices and one is a public member. KBP meetings are held quarterly; however, meetings usually occur five to six times a year, with some meetings by phone conference. The agency has been working to have virtual meetings to decrease costs. The agency is a fee-funded agency, so expenditures are based on grant funding or licensure and registration fees. The KBP appoints an executive secretary and employs five inspectors, three of whom are licensed actively practicing pharmacists and two are pharmacy inspectors. Licensing staff are also employed. The KBP utilizes outside counsel for legal work; however, there is access to several lawyers in the firm who provide counsel to other public health agencies. To decrease costs, the KBP has hired two part-time law students to help facilitate legal matters.

The Executive Secretary stated the KBP licenses just under 6,000 pharmacists and approximately 8,000 technicians and registers 5,600 different kinds of facilities. About one-sixth of registered facilities are pharmacies in Kansas.

KBP also inspects ambulances only to assure proper storage and handling of pharmaceuticals. The agency currently prints licenses, but will stop that process soon and move toward the in-house online verification process.

The Executive Secretary discussed the agency's search for a database to replace an old system. Staff reviewed software used by other agencies, but the KBP needed additional enhancements that would have been costly. The KBP executed a contract with eSoftware Solutions and has been customizing the database system since May 2016. Under the new system, applications are online and licensees are able to print their own renewals. The database will include continuing education. It directly links an internal case management system and has a staff audit monitoring feature that electronically logs all activity.

In reviewing other state reorganization models, the Executive Secretary stated, with the one-size-fits-most models, agencies might be required to use shared resources that fit the needs of most participants, but not all. She noted, although the agencies may perform the same functions, each license type and law is different and unique and requires some specialized knowledge and understanding of the specific profession.

The Executive Secretary answered questions regarding the transferability of functions and whether there are important distinctions requiring preservation of independent boards. She stated specialized knowledge is needed because it is important to have people trained in the profession who can do the job with the necessary skills and ensure compliance. She stated agencies need to know when to waive a rule or make an exception; if they are not familiar with the profession, it is very difficult to know when to make those allowances.

According to the Executive Secretary, consolidation often results in automated services, increased response time, decreased quality, and decreased disciplinary actions. She stated the consolidation process being discussed will not be as efficient as the structure currently in place.

The Executive Secretary added she would like to see more data about the A&M Study analysis to better understand the recommendation. She stated to operate the higher level board like in Texas, most smaller groups under it are contributing money to the upper group to function, and this is costing more money. She stated Texas is several years into its consolidation and has seen some struggles and some benefits, but the consolidation was not as expected. She noted KBP was part of the Kansas Department of Health and Environment (KDHE) and migrated out. She asked the KBP not be placed under an umbrella organization again.

In terms of a cost-benefit analysis of consolidation, the Executive Secretary indicated KBP staff provided the following concerns: increased middle management for additional staff, slow processing time, inconsistency in message with more staff, license verification goes down dramatically, and less training and education for staff. Consideration should be given to multi-lingual services, information technology, human resources, legal support, shared meeting spaces, and collaboration of staff. The Executive Secretary stated the KBP already shares resources. She said when the KBP has needed additional support, KSBN and BHA sent staff to assist. In terms of office space and meeting space, it is difficult for larger departments to locate the entire department in one building.

The Executive Secretary said efficiencies could be realized, and KBP would be willing to review and would want to be a part of the recommendation if the change would work for all agencies involved.

In response to a question, the Executive Secretary reported the agency has 12 employees and 1 part-time pharmacy student. The KBP budget is \$2.4 million. The agency has, in the past, received grant funding upwards of \$300,000 per year. The operating budget for K-TRACS (the prescription monitoring program in Kansas) is \$208,000.

Behavioral Sciences Regulatory Board. The Executive Director of the BSRB stated he had an opportunity to review the A&M Study recommendations with the BSRB and provided

background information about the agency to explain in detail its opposition to the recommendations.

The Executive Director said the BSRB is the state licensing agency for the mental health professions and traces its roots back to 1980 when the Social Work Board and the Board of Psychology were combined to form the BSRB. The BSRB licenses the following mental health professionals: licensed psychologists; master level psychologists; clinical psychotherapists; bachelor, master, and specialist clinical level social workers; master and clinical level professional counselors; master and clinical level marriage and family therapists; bachelor, master, and clinical level addiction counselors; and assistant behavior analysts and behavior analysts.

The Executive Director stated there are 12 members on the BSRB, 4 of whom are members of the public. The BSRB meets every other month, and teleconferences are scheduled if a special activity needs to be discussed. During the months the BSRB does not meet, the Complaint Review Committee meets and determines if the activity in question violates the law. The BSRB can revoke, suspend, limit, condition, refuse to license or refuse to renew a license, assess a penalty up to \$1,000, and can take further disciplinary action if the activity is criminal in nature. There also is an advisory committee for each profession that is chaired by a member of that profession who serves on the BSRB and provides input to the BSRB from each profession's perspective.

The Executive Director noted the total number of licenses effective June 1, 2016, was 12,630; a breakdown by licensed professional was provided in the testimony. Examinations to meet licensure requirements are given through the national associations as part of the membership fee.

According to the Executive Director, the budget for FY 2017 is \$734,909 and \$754,454 for FY 2018. About 74 percent of the budget is for personnel. The agency is exclusively funded with licensure fees, and receives no SGF, federal funds, or grants. Ten percent of the fees collected is deposited into the SGF before the agency receives the remaining 90 percent.

The Executive Director stated the BSRB is one of the largest consolidated mental health regulatory boards in North America. The BSRB strives for efficiency by cross-training the other eight staff members to enable them to perform multiple jobs and to have the needed expertise to license many different mental health professionals.

The Executive Director stated representation from all professions would be a key consideration if the health boards were to consolidate. Increased managerial layers could potentially decrease efficiency. Managerial expertise is needed to monitor and assist the staff, and this could add an additional layer of managers of the umbrella agency. He noted the more layers that exist, the more removed the board is from constituents. He said it is difficult to obtain information on licensure by reciprocity from the State of Illinois, which is one example of a consolidated system.

In considering administrative costs such as fiscal services, human resources, information technology, and legal services, the Executive Director stated the agency does not have specific employees in the agency to perform those tasks. Legal representation is provided by two attorneys from the Kansas Attorney General's Office (AG's Office) who handle all legal matters. The BSRB contracts with the Division of Personnel Services for \$1,200 a year for all Human Resources matters. The BSRB utilizes OITS for all technology services and the Small Agency Accounting Center for fiscal work.

In response to questions from the Committee regarding the BSRB funding and expenditures, the Executive Director stated the cost for personnel services is \$100 a month. There is no payment made directly to the AG's Office or the Small Agency Accounting Center. If additional information technology expertise is required from OITS, there is an hourly rate charge.

The Executive Director asked whether additional human relations and legal staff would need to be hired in a larger consolidated agency, thus adding to the budget, to replace the cost-effective shared services now used by the BSRB and other agencies. He also stated the investigations are becoming more complex and time consuming. He said the BSRB expects fiscal

oversight by the Legislature, but there will be no savings to the SGF if consolidation of regulatory boards occurs.

The Executive Director said regardless of the Committee's decision, the BSRB would work with the Legislature and stand ready to assist in any way.

State Board of Mortuary Arts. The Chairperson noted it was uncertain if the State Board of Mortuary Arts (SBMA) would be included should the Committee recommend consolidation, but believed the Executive Secretary of the SBMA should be invited to present to the Committee. The Executive Secretary stated the SBMA does not believe it needs to be merged with other agencies to become more efficient, although the agency understands the charge of the Committee.

The Executive Secretary stated the mission of the SBMA is to ensure licensees perform their professional services in a manner providing maximum protection for the health, safety, and welfare of Kansans; inform the public of the laws available to them when using the services of a licensed funeral professional; and provide additional support whenever possible.

The Executive Secretary said the SBMA and staff believe consumers and licensees deserve knowledgeable representatives who can be contacted about situations occurring within the funeral profession and the area of licensure and regulation. He stated this is a most vulnerable time for their consumers and they need to be able to timely speak to a professional who can guide them when dealing with the loss of a loved one.

The Executive Secretary stated there are three full-time staff consisting of an inspector, an office manager, and an executive secretary. The agency licenses embalmers, funeral directors, assistant funeral directors, crematories, crematory operators, funeral establishments, and branch establishments. The agency also pre-registers and registers students in mortuary college and registers both apprentice embalmers and apprentice funeral directors. Quarterly examinations are administered to funeral directors and monthly examinations are administered to assistant funeral directors. The

SBMA works with approximately 1,000 non-licensee contacts annually, and more than twice that many contacts on subjects dealing with the funeral profession.

The Executive Secretary explained OITS provides technology services for a fee when it cannot be handled in-house. The AG's Office provides legal services of two attorneys. The agency functions on licensee fees, and 90 percent of the fees go to the Mortuary Arts Fee Fund and 10 percent goes to the SGF.

The Executive Secretary concluded by saying the SBMA and staff believe the current system is working and excels, and the agency should be allowed to continue performing its mission in its current manner.

Kansas Dental Board. The Executive Director of the KDB stated the KDB has nine members consisting of six dentists, two hygienists, and one public member. The KDB has three staff members consisting of an executive director, paralegal, and a licensing specialist. The chief role of the KDB is to license and regulate dentists and dental hygienists across the state, which number 2,200 and 3,000 respectively. He explained the KDB also performs disciplinary investigations, on which it spends most of its time and resources.

The Executive Director explained the KDB's budget is \$400,000 each fiscal year. Unlike all of the other state agencies, the agency hires independent contractors. One licensed dentist is hired who performs 360 annual inspections of dental offices across the state. He noted there is tremendous value in having a dentist perform the inspection of a dental office. This dentist also serves as an expert witness in trials and works through an in-depth quantity contract. An attorney also is contracted on an in-depth quantity contract. If additional funds are needed, they are requested through the permission of the Budget Director through an investigation reserve fund. The agency receives no SGF moneys, but exists on licensee fees; 90 percent of those fees are deposited in the agency fee fund, while 10 percent is paid to the SGF. He stated the fee split is more valuable to the KDB than a sweep of its funds because it is faster and a guaranteed income. The 10 percent fee split

is intended for accounting, budgeting, payroll, and any incidental costs.

The Executive Director stated the KDB will do what is necessary to move the state forward if the Committee decides consolidation is the best route.

In response to a Committee question regarding the KDB complaint caseload, the Executive Director noted the caseload is variable, averaging 125 complaints the last couple of years. Previously, the average was 150. He noted, although the number of cases has diminished, the complexity has increased tremendously.

Kansas State Board of Cosmetology. The Chairperson noted the Executive Director of KSBOC was invited to provide a presentation, but the agency probably fits in an area other than under an umbrella public health board. The Executive Director clarified there is some separation between the public health boards and the KSBOC, but the latter includes aspects with regulations and operations that cross over into the health industry. The KSBOC's main focus is the beauty industry, regulating the multiple beauty industry professions that provide hair, skin, and nail services, as well as body art (tattooing, piercing, and permanent cosmetics) and tanning facilities.

The Executive Director stated the KSBOC has an eight-member board. The agency regulates, licenses, and also provides information to the professions to help them comply with the law. The agency can take disciplinary action on those in violation of rules and regulations. The goal has been to work the agency out of the revenue arising from disciplinary measures through the use of the education process. About four years ago, the agency began with a \$130,000 revenue stream from disciplinary actions taken and were down to \$59,000 last year from revenue for fines.

The Executive Director explained there are 14 full-time staff members and 1 part-time person. The KSBOC budget is just under \$1 million. The agency is comprised of three sub-programs: administration, licensing, and enforcement. The enforcement program does a good job of inspecting 4,000 facilities statewide. The facility

inspections are completed annually, but the statutory requirement is every two years. An effort is made to inspect every facility at least once a year. There are approximately 30,000 to 32,000 licensees including schools, facilities, and licensees. The number of schools has become very fluid, as many corporate-owned schools have closed nationwide.

The Executive Director noted centralization of board regulatory agencies is not something new. Many states have umbrella agencies. However, all of the agencies presenting before the Committee are fee funded, do not draw from the SGF, and all contribute 10 percent of their revenue stream to the SGF. The KSBOD also utilizes those services paid through the contribution to the SGF for technology through OITS. The agency also contracts with the Department of Personnel Services for \$100 a month.

A question was raised about a previous hearing that included much debate about folding the Kansas Board of Barbering into the KSBOD. The Executive Director noted barbers want to maintain autonomy.

Kansas Board of Examiners in Fitting and Dispensing of Hearing Instruments. The Executive Officer of the KBHAE provided testimony to the Committee. He noted the mission of the KBHAE is to establish and enforce standards to ensure Kansans receive competent and ethical hearing aid care. The agency regulates hearing instrument specialists and audiologists.

The Executive Officer stated the KBHAE is a fee-funded agency consisting of one part-time executive officer. Statutorily, there are five board members. Two licensure exams are administered annually, and some of the examiners are also board members. There are two KBHAE meetings annually, and teleconference calls are held as needed. He noted, although this agency is smaller, it is of great importance to Kansas consumers. Like other agencies, 90 percent of the revenue is deposited in the fee fund and the remaining 10 percent goes to the SGF. Revenue is generated through licensure, application, exam, and other regulated fees. In addition, the KBHAE processes consumer and provider complaints.

The Executive Officer stated the opinion of the KBHAE is the State will not benefit from placing the KBHAE under the umbrella board of the public health agencies. The KBHAE is not funded by the State, and all revenue is from licensing fees. The main concern is that the KBHAE retain authority over the licensure and examination process and the discipline of those licensed by the KBHAE. Being self-sustaining, it does not appear there would be a benefit in making administrative changes to a board that has competently and efficiently served Kansans with hearing impairments for nearly 50 years.

December 14, 2016, Committee Meeting

Kansas Board of Veterinary Examiners. The Executive Director of Kansas Board of Veterinary Examiners (KBVE) provided testimony to the Committee. He discussed the development and mission of the KBVE, the composition of membership and staff, and meetings of the KBVE.

The Executive Director stated the agency recently completed a two-year trial merger with the Kansas Department of Agriculture that had negative outcomes, including non-communication, disruption and downgrade of services, loss of control, overturning of decisions, dilution of authority, undermining of mission, potential legal liabilities, disorganization of meetings, and lack of needed board member orientation and training.

The Executive Director stated the American Association of Veterinary State Boards surveys veterinary state boards and holds national meetings where information and ideas are exchanged with other states, and has not found any benchmark lines indicating the larger merged agencies are any more efficient than the stand-alone agencies.

The Executive Director added the KBVE is very efficient. The annual fee for licensure for veterinarians is \$95; however, the average across the nation is \$140. In theory, he added, there might be some positives for forming a multi-agency group, but the agencies must be like-minded. In consolidating, some services might be viewed as redundant, but should be reviewed carefully. He noted the fee fund balance changed dramatically from the time of the merger until July 1, 2016. The

KBVE began FY 2017 as a stand-alone regulatory agency.

In response to a question from the Committee, the Executive Director stated he works an average of 16 hours a week, which currently serves the public well, but strategic planning needs to happen going forward that will require more hours.

A Committee member stated he believed the merger between the Kansas Department of Agriculture and the KBVE is not a good example of the potential with mergers.

Kansas Board of Barbering. The Kansas Board of Barbering (KBB) submitted written-only testimony for the December 6, 2016, meeting. Members of the KBB presented testimony at the December 14, 2016, meeting on behalf of the KBB and for the Kansas Barbers for Legislative Action (KBLA). One member stated he understands there is significant pressure to reduce state spending and lessen the current deficit, but KBLA is opposed to the changes recommended by the A&M Study. He indicated the changes recommended would be of little benefit to Kansas consumers.

The KBB member stated the KBB consists of five members, four of whom are barbers and one public member-at-large. Three board members have an instructor's license to give exams. The KBB is responsible for testing on live models, including the straight edge shave. He said some of this testing is done inside a maximum security facility, and such exams could not be effectively tasked to another entity.

One KBB member also noted consideration is being given to the KBB administrator being a part-time position, with the office run by one person. He added KBB contributes to the State as a fee-funded agency. He stated barbers are a small group and fear their identity will be lost if merged with the KSBOC. He said a study was conducted of barbers, and about 98 percent do not want to consolidate with the KSBOC. Some respondents said they would drop their license if KSBOC and KBB were consolidated.

The other KBB member added there is also the aspect of public health, and fairly significant diseases can spread in the practice of barbering.

The second KBB member commented the A&M Study gave boards and commissions only two pages in the Study, less than 1 percent of the entire A&M Study. She added Missouri has combined boards and, if you were to call Missouri, the response time and expertise is reduced by the watering down of process resulting from any sort of merger. She stated when she calls the KBB, the staff is attuned to her questions and the applicable statutes. The staff is more efficient and effective and is not overpaid, and no one on the board or its agency is overpaid.

In response to a question, one KBB member indicated there are about 1,600 licensed barbers. When asked whether barbers would lose autonomy and the art of barbering if placed under a bigger agency that handles barbers, cosmetologists, body art licensees, and others, one KBB member noted so many different professions would be handled under one agency. The second KBB member added it is believed the KSBOC is assembled differently than the KBB, and its administrator is appointed by the Governor. The KBB administrator is hired by the KBB.

In response to why the KBB and the KSBOC could not easily be consolidated given their close office locations in Topeka and similar board size, the second KBB member noted the KBB is a fee-funded agency. She said there is no redundancy because the professions are different. Additionally, if licensees are willing to pay to fund their own separate licensing agency, they should have that option.

Stakeholders' Presentations

Nursing Professions. The President of the KBSN gave a presentation on behalf of the KBSN in opposition to the proposal to combine the KBSN and the BHA or any other board. She cited several reasons for opposing consolidation. Nursing is a stand-alone profession, with its own legal standing, own body of knowledge, own professional standards, and own areas of specialization. There are times when nurses work synchronously with other health professions to provide health care to patients, and there are times nursing profession priorities may be in conflict with other health care professionals. She said nurses are the only health care professionals who

provide sustained continual contact and care to patients. Nurses are the coordinators and managers of direct care. She said because nursing is so pervasive and provides such critical care to citizens of Kansas, safety is paramount.

The KBSN President stated, by combining the boards, nursing could potentially become subservient to other boards. She said it is imperative the KBSN continue to be autonomous and oversee the nurses in Kansas to keep the public safe and, to date, KBSN has done that effectively.

The KBSN President stated two factors enable KBSN to deliver services the way it does: a detailed strategic plan and being able to leverage its expertise and experience within the profession to drive its decision making.

With regard to the strategic plan, the KBSN President stated, unlike the other boards in Kansas, KBSN has had a detailed strategic plan for 15 years. It prioritizes KBSN's initiatives and allows for the direction of personnel, board members, and resources to achieve these initiatives. If KBSN were combined with other boards, including BHA, KBSN's ability to strategically plan would be substantially impaired. She asked who would establish priorities among several boards and how resources and personnel would be given to carry out KBSN's initiatives when other boards would have priority.

With regard to the other factor involving the ability to be able to leverage KBSN's expertise and experience within the profession to drive its decision-making, the KBSN President noted, unlike many other boards, the KBSN requires its executive administrator to have both nursing and administrative experience, and that is reflected in how the KBSN is managed and operated.

As an example, the KBSN President noted, at the December 6, 2016, meeting, the Executive Director of BHA said she considers BHA to be a mini-umbrella board. The BHA has number of health care professions under its umbrella. If BHA plans to conduct an investigation, it requires multiple committees, levels of committees, and hiring an expert. The process is long and costly. The BHA processes 700 cases a year. By contrast,

KBSN has expert nurse investigators and expert nurses sitting on one committee. It is a one-step process. KBSN investigators bring data and the committee makes disciplinary decisions because it has expertise in its profession to do so. She said KBSN opens and processes around 2,000 cases a year and does so very cost effectively. By placing KBSN under an umbrella where there are multiple ongoing processes, KBSN's ability to be efficient and effective could be significantly impaired and cost more. In addition, by slowing down those processes, the public is not kept safe, because inferior or unfit nurses would be working for months longer, when KBSN could ordinarily stop licensees from practicing sooner.

The KBSN President noted, at the December 6, 2016, meeting, the Committee heard from many other boards on how they are working independently to streamline processes, handle matters efficiently, and cut costs. Many of the boards collaborate to share innovations and systems or operational perspectives. One example is the KBSN working in collaboration with the KBP and the BHA to develop policy for chronic pain management. These boards work more efficiently and cost effectively together. She said the point is the boards made the decision about priority collaborations, unlike an umbrella board that pits boards against each other in competition for resources, personnel, and priorities. When expert boards driven internally collaborate, they do so in a way that makes sense. She stated the boards show they collaborate and are committed to continuing to do so.

The KBSN President concluded by saying the KBSN has demonstrated its critical need for oversight, demonstrated it has done its job well, and shown it collaborates with other major boards. She respectfully requested the Committee reject the proposal to combine the KBSN with the BHA or any other board.

A representative of the National Council of State Boards of Nursing (NCSBN) also provided testimony. She noted the national organization provides data, service, and resources to the state boards of nursing to assist in their functions and to help in their role of public protection. A great deal of research is conducted through Project CORE, which gathers data every other year from the boards of nursing to help establish their

performance measurement. The boards can see from the data how their own board is doing in relation to other boards, especially in regard to efficiency. She added her testimony reflected not only that the KSBN is efficient, but it is one of the most efficient boards in the country.

The NCSBN representative presented data comparing KSBN with umbrella boards, independent boards, and three boards with the same number of nurses as Kansas. The data indicated KSBN processes licenses and resolves complaints faster and has the lowest licensure fee per year.

As an example of the complexity of the work by the KSBN staff, the NCBSN representative stated Advanced Practice Registered Nurses (APRNs) have 4 distinct roles and 32 certification exams, but staff needs to know the other exams that exist to ensure they are not approving an exam that is unqualified. Not only does staff need to know Kansas' licensure requirements, but also those across the nation. This does not include the work dealing with licensed mental health technicians the KSBN also oversees.

The NCBSN representative said, from a national perspective, the KSBN is an exemplary board and has the respect of other state boards because of its quality and its dedication to public protection.

The Chairperson of the Legislative Committee of the Kansas State Nurses Association (KSNA) also provided testimony stating KSNA members object to the consolidation of boards because the responsiveness of the KSBN is valued in order to facilitate changes that enhance the ability to be current in practice and education.

The Chairperson said the KSNA Legislative Committee members telephoned states where the board of nursing was in an umbrella structure. KSNA members were unable to speak to someone who could answer questions, and were often transferred numerous times to voice mail. Several times they were on hold for 15 minutes or no one answered the telephone. The Chairperson said Kansas nurses appreciate the respect, consideration, and efficiencies received from the KSBN and the responsiveness to questions and

concerns. She added KSNA is unable to identify any advantages of placing KSBN in a potentially competitive relationship with another agency or having an executive director in a position of possible biases and conflicts of interest. There is concern such an umbrella arrangement would undermine the efficiencies KSBN has established. Additionally, she noted every health board should be concerned that no fiscal analysis supporting an umbrella structure in Kansas has been provided.

Social Work Profession. The Executive Director of the Kansas Chapter National Association of Social Workers (KNASW) presented testimony. She noted there are over 7,000 social workers licensed and regulated in Kansas by the BSRB. She stated the BSRB is a consolidated agency and a consolidated regulatory board because they regulate seven different professions.

The Executive Director said KNASW does not believe a consolidated board is efficient for public protection and would promote an independent board for social work if such would be considered in the state. She stated the BSRB, by licensing many different professions, loses the identity of the profession. She also noted social work is grossly under-represented on the BSRB, with only 2 social workers representing 7,400 licensed social workers. There are 2 psychologists representing 900 psychologists.

The Executive Director stated 38 other states have independent boards for social work. The three states mentioned in the A&M Study have independent licensing and regulatory boards for social work, even though they are in an umbrella administrative agency. She noted, if there is an opportunity to make some change, KNASW would strongly advocate for an independent regulatory board for social work.

Health Care Professions. A health care consultant presented testimony in which she noted the December 6, 2016, testimony was a loud and clear message there is no real support for consolidation of regulatory boards under an umbrella board, but state agencies would be willing to cooperate if that was the action taken by the Legislature. The common theme was to protect the public. She noted the testimony also identified

complexity and autonomy in doing this work all funded by fees from those they license. No SGF is being expended, unless a task related to their regulatory role has been added to the agency's work, such as tracking prescription orders for scheduled drugs assigned to the KBP. She added she does not support an umbrella board for public health fee-funded agencies in Kansas.

Speech Language Pathology and Audiology Professions. The Executive Director of the Kansas Speech-Language-Hearing Association (KSHA) gave a presentation. The KSHA has 1,000 members in the state representing speech language pathologists and audiologists. Audiologists are required to hold a license through the Kansas Department for Aging and Disability Services (KDADS) to practice in the state. Audiologists who also wish to sell hearing aids must have another state license through the KBHAE.

The Executive Director stated KSHA proposes to consolidate the KBHAE with KDADS. The reasons for the proposal include that KDADS is an existing board that already regulates most of the speech and hearing professionals in the state. This would eliminate unnecessary duplication and redundancy. The second reason for this consolidation is consumer protection. At this time, it is very difficult to determine who to file a complaint with if a consumer is dissatisfied with the fit of hearing aids. She stated, by moving the KBHAE under KDADS, it would be much easier for Kansas consumers to determine where the complaints should be filed. She noted KDADS is fully staffed with full-time employees, so complaints will be handled efficiently and promptly. The third reason she cited to advocate for the consolidation of KBHAE with KDADS is professional access. She said she hears from KSHA members that they are unable to get the information they need from the KBHAE or have a difficult time contacting KBHAE. She also received calls from numerous outside agencies wanting to hire a hearing aid professional that ask her for license verification because KBHAE has no website. She indicated KDADS already has an online license verification tool, and there is no reason to build another website.

In summary, the Executive Director stated KSHA supports the idea of streamlining, consolidating, and simplifying the licensing

process, and placing audiologists under one agency, preferably KDADS, because KDADS already licenses audiologists.

A practicing audiologist also gave a presentation. He stated KDADS is a logical agency to regulate hearing aid dispensing because it has licensed audiologists since 2012, and about half of the licensees under the KBHAE are already licensed under KDADS. Consolidation would allow for the efficient licensing of hearing aid specialists in the state and also provide state oversight over KBHAE by being located in Topeka. He noted KDADS can offer services now provided by the KBHAE and do so at a lower cost. KDADS also has a website consumers and professionals can access. The KBHAE does not have a website to assist a consumer with an issue relating to hearing aids or dispensing in Kansas. He also stated KDADS is cost efficient. The cost of a license for an audiologist is \$135 every two years. The KBHAE charges \$100 per year, and has proposed a 25 percent increase in fees beginning in 2017. He asked the Committee to act to move KBHAE to KDADS.

Dental Profession. The Executive Director of the Kansas Dental Association (KDA) presented testimony, noting Kansas dentists have a very good relationship with the KDB. He stated the KDA and KDB work together on peer review and the well being program. He said KDA believes the KDB is very efficient.

The Executive Director stated, because of economies of scale, the KDA understands why the A&M Study suggested placing public health boards under one umbrella agency. However, there is a point where efficiencies actually decrease. He stated perhaps consolidating smaller boards would make more sense as the Committee moves forward.

Funeral Services Profession. The Executive Director of the Kansas Funeral Directors Association (KFDA) provided testimony. The KFDA represents approximately 300 funeral homes across Kansas. She said KFDA is opposed to placing the SBMA under an umbrella agency. KFDA is supportive of finding efficiencies within SBMA and in doing so, keeping licensing fees paid by members in check. She noted the SBMA is

extremely streamlined and makes a conscious effort to work with the minimal amount of funding necessary to run operations since it is a fee-funded agency. If more efficiencies are found, there is no fiscal impact to the State, and it only affects licensees.

The Executive Director stated funeral service is a very specialized field and somewhat different from other health-related professions that could be placed in an umbrella agency. She noted it is important to KFSA members that the staff of the agency has funeral service experience, while the staff of an umbrella agency would likely lack expertise in the area of funeral service, which the Executive Director of KFSA believes the member licensees and the public deserve.

The Executive Director noted when contacting other states' consolidated agencies, there is frustration that answers to questions cannot be received because the staff does not have the same level of expertise. Calls are transferred many times, and no one has an answer. In Kansas, a person can always reach someone with expertise, and that holds true for the public and licensees. She said the current method of regulation is working extremely well. A structural change in the regulatory system of fee-funded agencies will likely lower the level of service and regulation provided for the benefit of the public and to licensees.

APRN Profession. A representative of the Kansas Advanced Practice Nurses Association (KAPN) provided testimony. In Kansas, there are almost 5,000 advanced practice registered nurses, certified nurse midwives, clinical nurse specialists, and nurse practitioners.

The representative stated the idea to merge public health boards, particularly the KSBN and the BHA, is a proposal to solve a problem that does not exist. The KSBN and the BHA both operate efficiently. There is no data or report that finds such a change to be more efficient. No fiscal note is attached to this proposal and making a change of this magnitude would be costly. She stated there is uncertainty as to how this proposal would be more efficient.

The representative said the KSBN and BHA both operate on the fees generated from licensing professions in the state, and both operate within their own budgets and are financially responsible to maintain those budgets. She added the KSBN has demonstrated efficiency of operations and processes handling 72,000 licensees. Kansas staff have been responsive to questions and concerns. It has also implemented technology for streamlining processes.

The representative stated KSBN has sufficiently demonstrated the value of its work and the efficiency of its staff, and firmly believes governance of nursing belongs with nursing. She stated the KAPN does not support the consolidation proposal.

Practical Nurse Educators. The President of the Kansas Council of Practical Nurse Educators (KCPNE) gave testimony on behalf of the Kansas Council of Associate Degree Nurse Educators (KCADNE) and KCPNE. She stated these organizations are concerned consolidation would diminish access and quality of services. She added KCPNE and KCADNE acknowledge the effort to promote cost savings and efficiency to the State; however, including KSBN in this consolidation could result in loss of proficiency, creating more expense, and increase risk of public safety. She stated some boards might benefit from the process, but consolidation would not be an advantage to the KSBN. Consolidation would bring a loss of true peer review to all disciplines involved.

Statutory Overview and Research

At the December 6, 2016, meeting, Kansas Legislative Research Department (KLRD) staff provided the Committee with information regarding public health boards in other states, which was to be reviewed by Committee members prior to the December 14, 2016, meeting.

An Office of Revisor of Statutes staff member, in response to questions that arose at the December 6, 2016, meeting, shared the history of the services provided and the 10 percent fee fund credit statutes. The public health agencies operate on the fees they receive for licensing. He referred to KSA 2015 Supp. 75-3170a (use and purpose of 10 percent charge to fee agencies and when charge

not applicable). The statute provides this credit is to reimburse the SGF for accounting, auditing, budgeting, legal, payroll, personnel, purchasing, and any other government services provided by the State to the fee agencies. The information provided by Revisor staff includes pages relating to a number of health-related fee agencies from the *2016-2017 Kansas Legislature Appropriations Report* prepared by KLRD staff. The information shows expenditures and FTE positions authorized, whether filled or not, and indicates no money is paid to the agencies from the SGF.

The Revisor staff member said a limit of \$100,000 per fiscal year for transfer to SGF was established for the fee-funded agencies. Although originally enacted in 1973, the credit was 20 percent and did not have a cap. In 1975, the Legislature created a \$200,000 cap. This was changed to the current law by the 2011 Legislature with a fee credit of 10 percent and a cap of \$100,000.

There are a number of agencies that transferred \$100,000 per agency to the SGF in FY 2015 and FY 2016: KSBN, BHA, KBP, BSRB, and the EMS Board. KSBOC transferred \$100,000 of fee fund revenue to SGF in FY 2016. All boards

contribute to the SGF as reimbursement for services received from the State.

In response to requests made at the December 6, 2016, meeting, KLRD staff prepared a listing by health agency that includes the number of FTEs and executives, budget, expenditures, amount paid to SGF per statute, and litigation costs. KLRD staff also provided a spreadsheet containing agency board information, including number of board members, frequency of meetings, facility location, and facility space by square footage.

CONCLUSIONS AND RECOMMENDATIONS

The Committee recommends:

- The KSBN and the BHA not be consolidated at this time; and
- The House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare review and consider combining KBHAE with KDADS.

Report of the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight to the 2017 Kansas Legislature

CHAIRPERSON: Representative Daniel Hawkins

VICE-CHAIRPERSON: Senator Michael O'Donnell

OTHER MEMBERS: Senators Jim Denning, Laura Kelly, Forrest Knox (substitute for Senator Love at November 18, 2016, meeting), Jacob LaTurner, Garrett Love, and Mary Pilcher-Cook (January meeting only and served as Vice-chairperson); and Representatives Barbara Ballard, Will Carpenter, Willie Dove, John Edmonds, and Jim Ward

CHARGE

Oversee Long-Term Care Services and Medicaid Programs

KSA 2016 Supp. 39-7,160 directs the Committee to oversee long-term care services, including home and community based services (HCBS). 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 successful transfer be applied to the provision of services for long-term care. Further, the Committee is to oversee the Children's Health Insurance Program, the Program for All-Inclusive Care for the Elderly, and the state Medicaid programs (KanCare), and to monitor and study the implementation and operations of these programs including, but not limited to, 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

The Committee makes the following conclusions and recommendations:

Managed Care Organization (MCO) Operations

The Committee made the following recommendations regarding MCO operations:

- The Secretary of Health and Environment shall develop standards to be utilized uniformly by each MCO serving the State of Kansas pursuant to a contract with the Kansas medical assistance program for each of the following:
 - Documentation to be provided to a health care provider by any MCO when it denies a claim for reimbursement submitted by such provider. Denial reason codes must be compliant with the Health Insurance Portability and Accountability Act, and MCOs must consistently apply denial reason codes in the same manner to ensure accurate reporting to the State; and
 - Documentation to be provided to a health care provider by any MCO when recoupments are made pursuant to a post pay audit of such provider to include transparency of methodology used in the audit and a specific explanation of the reason for recoupment. MCOs may not arbitrarily remove codes (such as ICD-10, CPT, and DRG) submitted by the provider or change the level of care provided to reduce payment without using the proper appeal protections in place;
- The Secretary of Health and Environment shall complete a quarterly review of claims denials and appeals to determine:
 - Whether a high percentage of denials are overturned on appeal and, if so, address the issue with the MCO(s); and
 - If a certain procedure or codes are denied more often than others, whether those denials are appropriate, and address the issue with the MCO(s);
- A notice of a right to appeal, including the details and specific action required, be sent to individuals who were assessed under the Capable Person Policy, as it is written in the current Waiver and implemented by the MCOs, and as a result had their plans of care adversely affected. The notice is to be sent no later than December 15, 2016;
- MCOs report to the Committee on the first pass denial rate;

- All MCOs shall work together to develop one standardized credentialing application. MCOs will respond to all submissions within 15 working days. MCOs should use a Council for Affordable Quality Healthcare portal for processing credentialing applications;
- MCOs standardize the under- and over-payment process; and
- Require notices of changes to a Plan of Care be provided to both individuals and providers.

Mental Health

The Committee made the following recommendation regarding mental health:

- Legislation be introduced by the House and Senate health committees to work on the Mental Health 2020 Initiative plan from the Community Mental Health Centers.

Medicaid Clearinghouse Operations

The Committee made the following recommendation regarding Clearinghouse operations:

- Eligibility applications over 45 days aging be sent to a team formed exclusively to get applications through the process and finished. The Kansas Department of Health and Environment (KDHE) should set a goal that 75 percent of long-term care applications be cleared in the first 45 days.

Administration of KanCare

The Committee made the following recommendations regarding the administration of KanCare:

- Extend the current 1115 Waiver for one year and delay the request for proposal until the State clearly understands federal changes to the Affordable Care Act and Medicaid; and
- The Kansas Eligibility and Enforcement System (KEES) not be expanded to Phase 3 until there has been a clear demonstration of system functionality and operational integrity is determined and all problems have been resolved. Request the Legislative Division of Post Audit update the Information Technology audit on KEES published in December 2015 and report satisfactory performance before Phase 3 expansion can occur.

KanCare Reporting and Rates

The Committee made the following recommendations regarding KanCare reporting and rates:

- All uncompensated care numbers presented to the Committee be based on 100 percent of Medicare allowable; and
- The 4 percent Medicaid reimbursement cut and corresponding policies be reversed.

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 2016 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 (KanCare).

The 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 for two consecutive days 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 2016 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 access 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 before 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 2016 Session (January 22 and April 18) and twice for two days each during the interim (August 4 and 5 and November 17 and 18). The Committee members toured Family Service & Guidance Center, in Topeka, and the Medicaid Eligibility

Clearinghouse on August 4. In accordance with its statutory charge, the Committee's work focused on the specific topics described in the following sections.

KanCare overview and update. *KanCare enrollment.* Updates on Medicaid and CHIP member eligibility and expenditure information; KanCare financial summaries; provider networks; claim processing and denials; utilization summary; value-added services and in-lieu-of services; and member grievances, appeals, and hearings were provided to the Committee at all four meetings.

At the January meeting, the Division of Health Care Finance (DHCF) Director, KDHE, reported January–February 2016 average annual membership was 396,842. At the fourth quarter meeting, the Director reported January–September 2016 average annual membership was 451,068.

Eligibility application backlog. The Legislative Division of Post Audit (LPA) conducted an audit to review the timeliness of Medicaid eligibility determinations. The audit report states there was an application backlog of 14,000 as of June 2016. The report states the following as possible factors contributing to the backlog:

- Technical glitches when the Kansas Eligibility Enforcement System (KEES) was implemented in 2015;
- An underestimation by KDHE of how many people would apply for Medicaid as a result of the Affordable Care Act (ACA); and
- Transition of all Medicaid eligibility determination responsibilities from the Department for Children and Families (DCF) to KDHE in January 2016.

The audit report states KDHE has made the following changes in an effort to eliminate or reduce the backlog:

- Increased the number of staff to process the applications;

- Stopped reviewing renewal applications; and
- Worked to improve KEES.

At the April meeting, several Committee members reported hearing complaints about long wait times when individuals call the Clearinghouse and asked KDHE officials to consider implementing goals for answering the phones and wait times. A representative from KDHE agreed to discuss the issue with the Clearinghouse contractor.

At the August meeting, the Secretary of Health and Environment reported the backlog of 3,587 unprocessed applications should be eliminated by September 2016. Committee members expressed frustration with the ongoing delays in processing applications.

At the November meeting, Committee members again expressed concern with the fact the backlog had not yet been eliminated. The Secretary of Health and Environment provided information to the Committee indicating the backlog had decreased to 1,970 unprocessed applications and would never be eliminated completely due to gaps in time when individuals are asked to provide additional information to make an application complete.

The audit report states the Centers for Medicare and Medicaid Services (CMS) has been tracking the backlog since February 2016 and plans no further action once the backlog is resolved.

KanCare request for proposal (RFP). The RFP for Medicaid MCOs was originally scheduled to be released at the end of 2016 for a June 2017 award; however, the DHCF Director indicated KDHE intends to wait to release the RFP until a clear direction regarding the future of the ACA is determined.

CMS review. In October 2016, CMS conducted a review of KanCare focusing on 2013 to the present. An exit review between KDHE and CMS occurred on November 16, 2016. KDHE stated CMS will prepare a final report regarding

the review. As of December 22, 2016, KDHE had not received the report from CMS.

Reimbursement rate cuts. Effective July 1, 2016, the Medicaid reimbursement rate to providers was cut 4.00 percent and the rate to nursing home providers was cut 4.47 percent. Multiple stakeholders provided comments to the Committee regarding the rate cut, explaining the financial strain the cut has placed on providers, and requested the rate cuts to be reversed.

The Chairperson stated it is his intention to introduce legislation during the 2017 Session to reverse the cuts.

Dental service providers. Several dental providers provided oral and written testimony to the Committee about the financial hardship created by the low reimbursement rates. One dental provider indicated she loses money each time she provides services to a Medicaid consumer.

Long-term care facility providers. At the November meeting, nursing home provider stakeholders stated the rate cuts, combined with the 150 percent higher provider assessment and the application backlog, put an unsustainable burden on long-term care services for senior Kansans. Stakeholders also stated some progress on application determinations is being realized; however, some long-term facilities still are reporting between \$1.0 million and \$2.0 million in pending Medicaid claims.

In mid-2016, KDHE announced an advanced payment program for long-term care facilities. This program allowed long-term care providers to request advanced payments, half of the payment for which the individual was eligible, from KDHE while the Medicaid applications of their residents were pending. Several facilities attempted to participate in the program. When requests for advanced payment were received by KDHE, advanced payments were not granted; rather, the applications of the residents at the requesting facilities were prioritized for eligibility determination.

Pharmacy providers. The DHCF Director reviewed Medicaid provider pharmacy rates. He reported the dispensing fee for large chain

pharmacies, defined as those companies with 30 or more locations within the state of Kansas, were reduced from \$10.50 to \$4.50. All other pharmacies' dispensing fees were reduced from \$10.50 to \$9.25. The rate cuts were implemented July 1, 2016.

KEES update. The Secretary of Health and Environment reported throughout calendar year (CY) 2016 KDHE was working to update and improve KEES. Since KEES was implemented in 2015, the Secretary stated, KDHE and the KEES vendor have implemented 17 major enhancements to improve system operations in eligibility, customer service, imaging, data entry, and registration.

Capable Person Policy. In May, the State announced a Capable Person Policy change as part of the \$56.0 million in budget-balancing Medicaid cuts. At the August meeting, a representative of KDADS indicated there would be rigorous enforcement of the Capable Person Policy, which limits reimbursements for routine daily tasks completed for individuals with disabilities if a household member is capable of performing the tasks. In a letter to KDHE dated October 12, 2016, CMS officials stated they found a number of inconsistencies between Kansas' approved waivers and the Capable Person Policy. CMS also stated when the Capable Person Policy disagrees with an approved waiver, the waiver is the authority regarding the services and providers for which Federal Financial Participation matching funds can be claimed. In the letter, CMS explained that correcting these inconsistencies will require amendment of either the policy or the waivers and advised that, until the waiver amendments are approved by CMS, KDADS must halt implementation of the Capable Person Policy as written. Several stakeholders addressed the change and expressed concern a change to the waiver would adversely affect individuals with disabilities receiving Medicaid benefits under one of the waivers.

Health Homes. The DHCF Director reported at the April meeting that the Health Homes program was ending, members and partners had been notified, and the MCOs were working on transition plans. A representative of KDHE stated the Health Homes Learning Collaborative activities were focused on helping Health Home

providers transition their members to other forms of care coordination.

MCOs financial update. A representative of KDHE provided information to the Committee at the fourth quarter meeting indicating the MCOs had a total adjusted net income difference between the first quarter of 2015 and the first quarter of 2016 of \$7,512,146. The information also stated the total adjusted net income as of June 30, 2015, for the MCOs was \$6,814,818.

KanCare Ombudsman. The KanCare Ombudsman provided information to the Committee at all four meetings.

January meeting. The KanCare Ombudsman is available to members and potential members of KanCare through phone, e-mail, and letters and in person. During the fourth quarter of 2015, there were 524 contacts through these various means, 139 of which were related to an MCO issue (26.5 percent). Review of the past two years by quarter showed the number of contacts during the quarters are very similar with the exception of the second quarters in 2014 and 2015, which seem to typically have a decrease.

April meeting. During the first quarter of 2016, there were 1,130 contacts. This was a 117 percent increase over the average number of contacts for the past quarters. The top two categories resulting in contacts are Medicaid eligibility and "other." The "other" contacts were often Clearinghouse concerns not connected to eligibility, such as change of address, disenrollment from KanCare, and spend-down questions.

In regard to outreach, the Ombudsman's office has created a flow chart for the KanCare application process and revised the information for KanCare members on grievances, appeals, and state fair hearings.

The average number of days to resolve issues during the first quarter of 2016 was seven. The percentage of files resolved in one day or less was 49.6 percent. The percentage of files closed during the first quarter was 76.5 percent.

August meeting. The number of contacts for the second quarter was 846. That is a 63 percent

increase over the 2014-2015 average. It is also down from the first quarter increase of 117 percent. The change seems to be fewer people calling confused about the change with the Clearinghouse and just wanting to know their Medicaid status.

November meeting. The number of contacts for third quarter was 687. That is a 32 percent increase over the 2014-2015 average.

Step therapy. In its 2015 Annual Report, the Committee recommended KDHE adopt a policy allowing MCOs and providers to use step therapy for the non-waiver population. Step therapy is a tiered system in which a patient must try a drug from Tier 1 before trying a drug from Tier 2, unless there is a clinical reason why a Tier 1 medication is not appropriate for a particular patient. The Deputy Secretary of Health and Environment reported step therapy ensures the use of proven and clinically effective drugs prior to use of more costly or riskier options for the same medical condition. SB 402 (2016) went into effect on July 1, 2016, authorizing KDHE to implement step therapy. KDHE began implementing a step therapy policy as it relates to specific drugs in July 2016 and will continue to phase in implementation through January 1, 2017.

Mental health issues. The Committee heard from the following organizations regarding mental health issues: Association of Community Mental Health Centers of Kansas, COMCARE, and Family Service and Guidance Center.

Representatives from the above organizations expressed concern about the following:

- Four percent rate reduction in Medicaid reimbursement;
- Discontinuance of the Health Homes program;
- Decertification of Osawatomie State Hospital (OSH); and
- Change in KDADS policy regarding mental health screenings.

The representatives indicated these changes have created unprecedented waiting lists for psychiatric residential treatment facilities for youth and adolescent patients, financial stress for community mental health centers (CMHCs), and mental health patient capacity problems in the state.

At the August meeting, the Deputy Secretary for Aging and Disability Services responded, stating KDADS received information from CMS indicating KDADS' screening policy is a parity violation and KDADS will work to determine the best way to perform the screening function. The then-Interim Secretary for Aging and Disability Services indicated KDADS' goal was to have OSH re-certified by August 2016.

Medicaid claims. Representatives from Lawrence Memorial Hospital (LMH) and the three MCOs addressed claims processing and Medicaid as it relates to hospitals and medical centers.

The Health Plan Chief Executive Officer (CEO), UnitedHealthcare Community Plan (UnitedHealthcare), stated the claims data are relatively stable. LMH is specifically concerned with the clinical processes. During a meeting with LMH, UnitedHealthcare walked through its process, and LMH walked through its process. The focus of UnitedHealthcare is where and when a change is needed to the communication process. The UnitedHealthcare CEO stated UnitedHealthcare's goal is to maintain dialogue and discussion, and regarding inpatient stays, UnitedHealthcare wants complete transparency in making determinations, and, regarding claims, UnitedHealthcare hopes to clarify the clinical processes disconnect throughout the hospital system.

The CEO and President, Sunflower State Health Plan (Sunflower), stated when Sunflower looked at the yearly averages for claims payments and prior authorization processing times from year to year, there were variances of no more than 10 to 13 percent. The CEO further stated Sunflower responds in a reasonable range of time, from six to eight days on the average, for denial cases. Sunflower looked at its rates as being consistent over the course of three years.

The CEO, Amerigroup Kansas Plan (Amerigroup), reviewed Amerigroup's operational points looking for outliers from any previous activity. Amerigroup has a denial rate of 7 percent. Of its prior authorization claims, only 4 percent were denied. The CEO for Amerigroup stated Amerigroup's operation techniques were good, but LMH may have perceived it otherwise and there are issues on both sides that could be improved with communication regarding billing and payment. The CEO stated Amerigroup is interested in improving the relationship and service process with all the hospitals it serves. The CEO noted Amerigroup meets with its providers on an as-needed basis regarding billing concerns.

The Director of Compliance Management, LMH, spoke to the Committee regarding LMH's investigative findings. The Director explained specific examples of the claims process problems and the appeal process and how long it took to get a denial overturned and asked for some consideration that correctly submitted claims not get caught up in the claims department. The Director stated LMH staff want to improve the efficiency of the process and make it better for the patients. LMH is using three different sets of billing and denial processes to process claims, a different process for each MCO. The Director asked for a set of systematically similar processes to reach conclusions on unresolved claims issues and that each MCO offer regular update classes to providers, so collaboration happens in problem solving for LMH and other providers across the state. The Director noted the new privatized system is more complicated than when the State handled the claims. The Director of Care Coordination, LMH, noted LMH's inpatient denial rate has probably quadrupled since the State contracted with the MCOs.

Presumptive eligibility for pregnant women.

The DHCF Director stated a pregnant woman is presumed eligible for prenatal services and receives a reduced level of the benefit package. Once presumed eligible, she could apply for full benefits under Medicaid, as presumed eligibility does not exist for full benefits. The DHCF Director stated, even with the backlog in the processing of Medicaid eligibility applications, applications for pregnant women are given priority.

Age requirement for personal care service workers. In 2015, KDADS implemented a policy changing the minimum age of personal care workers from 16 to 18 and submitted waiver amendments that would be impacted. During the January meeting, the DHCF Director informed the Committee KDADS would be working with CMS to expeditiously reverse the policy to reinstate 16 as the minimum age.

Non-payment of services provided when people are receiving in-home health care. The DHCF Director stated a policy effective since November 5, 2015, states if proper and timely notification was not provided to a targeted case manager (TCM) of a member being opted-in to a Health Home and the TCM provided TCM services, then the TCM would be held harmless financially.

KanCare Waiver Integration project. At the August meeting, the Secretary of Health and Environment stated KDHE continued to examine how to best combine the current seven waivers into two waiver categories: children and adults. The Secretary stated the project would be coordinated with projects affecting the HCBS program. Committee members indicated there is no legislative interest for KDHE to continue to pursue the Waiver Integration project. Further, a Committee member explained the Waiver Integration Subcommittee formed during the 2016 Legislative Session recommended a bill be considered by the House Committee on Health and Human Services requiring legislative approval of waiver integration and prohibiting implementation of waiver integration prior to January 1, 2018.

At the November meeting, the DHCF Director stated KDHE then was not pursuing Waiver Integration.

Osawatomie State Hospital (OSH). In January 2016, CMS decertified OSH, citing reasons such as patient and staff safety concerns and appropriate facility concerns. At the April meeting, the then-Interim Secretary for Aging and Disability Services indicated a recertification specialist had been hired and he expected OSH to be recertified within a couple of months. At the November meeting, the Acting Secretary for Aging and Disabilities stated OSH was not yet

recertified but was ready for CMS to perform the required recertification inspections. (As of December 22, 2016, OSH had not been recertified.)

Larned State Hospital (LSH). At the April meeting, the Executive Director of the Kansas Organization of State Employees spoke to the Committee regarding staffing issues at LSH and the recent shift of mental health inmates from the State Security Hospital to correctional facilities. The Executive Director reported LSH was significantly understaffed with a vacancy rate just under 40 percent. She stated the high vacancy rate required several employees to work mandated overtime and made it difficult for employees to be granted vacation time. The Executive Director further reported the classified employees at LSH have not received an across-the-board cost-of-living pay increase since 2009, and the pay and working conditions both contribute to high turnover.

The Executive Director stated, in an effort to address the mandatory overtime at LSH, KDADS closed two units that house correctional inmates in need of psychiatric care and moved several inmates to Lansing Correctional Facility, which is not equipped to handle the inmates with psychiatric conditions.

The then-Interim Secretary for KDADS acknowledged staffing is an issue at both LSH and OSH. He provided documentation to the Committee to show recruitment efforts and vacancy rates. The then-Interim Secretary further stated he expects employees to be treated with respect and dignity.

In a follow up to questions by Committee members, KDADS officials provided information about overtime expenditures at both OSH and LSH.

Presentations on KanCare from individuals, providers, and organizations. Written and oral testimony was presented at each quarterly meeting. Some individuals and organizations stated appreciation for the help and services provided by the MCOs and relationships developed with the MCOs that have allowed problematic issues to be addressed and resolved

quickly. The following is a summary of the concerns and suggested solutions.

Concerns. The various areas of concern and need expressed by providers, organizations, and individuals included the complexity of the documentation process for care services provided by in-home caregivers; lack of coordination of services; implementation of Waiver Integration before a final policy and procedure manual was published and training and education were standardized; inclusion of seniors in Waiver Integration; delays in KanCare coverage for pregnant women and infants; Traumatic Brain Injury (TBI) waiver not being used to its full potential; KanCare failing older adults as is illustrated by the automation of the application process, application backlog, budget cuts, lack of oversight, and enforcement; applicants not notified of their right to appeal when their eligibility determinations exceed 45 days; lack of reliability of KEES; the Kansas Medical Assistance Program system frequently unable to be accessed so that TCMs can enter billing information; for-profit MCOs are not person-centered; a policy restricting payments to providers unless there is a face-to-face visit could negatively impact individuals who live semi-independently; implementation of the Capable Person Policy could negatively affect services individuals receive; the detrimental affect of the 4.47 percent cut to reimbursement rates nursing homes received combined with the higher provider assessment; 4.00 percent reimbursement rate cut for providers; lack of adequate payment for emergency room services necessary to treat a patient as required under the Emergency Medical Treatment and Active Labor Act; transparency of quality metrics used by MCOs to report statistics to KDHE; lack of standardization of provider credentialing requirements; lack of standardization of prior authorization requirements; delay in prior authorization for services; continual billing issues; ineffective MCO representatives who do not answer phone messages or e-mails in a timely manner; lack of rate increase for intellectual/developmental disabilities (I/DD) HCBS providers; funding cut to the Senior Care Act program; increase in I/DD waiting list; the difficult process to become a Medicaid provider and be paid for claims is limiting the number of providers; and the treatment of patients at the state and private psychiatric hospitals.

Recommended solutions. Various solutions to issues with KanCare expressed by providers, organizations, and individuals included repeal of the 4.00 percent reimbursement reduction; providers be part of MCO RFP development process; the I/DD population be carved out of KanCare; not implement Waiver Integration; eliminate the Medicaid eligibility application backlog; move the Office of the Inspector General to the Insurance Commissioner's Office or other neutral office and require the position to be filled by a non-partisan individual; move the Ombudsman's Office to an outside organization that is qualified to inform and assist people in their legal rights; build a presumptive eligibility system for every category of KanCare and demonstrate it is operational; require standardized notification to consumers regarding right to appeal and changes in their care coordinator; collect data on the adequacy of KanCare; increase the pay scale for providers; have agencies vet policies with CMS prior to implementation; Medicaid expansion be considered by the 2017 Legislature; agencies allow at least a six-month comment period when new policies are proposed; agencies shift from a provider-centric model of service delivery to a person-centered model of services; and provide more funding to the Supported Employment Program.

Representatives of the following organizations and providers testified or provided written testimony before the Committee: Anderson County Hospital; Case Management Services; Community Living Opportunities; Communityworks, Inc.; Equi-Venture Farms, LLC; Flint Hills Community Health Center; Genesis Family Health; Genoa; GraceMed Health Clinic; Hutchinson Clinic, P.A.; InterHab; Jenian, Inc.; KanCare Advocates Network; Kansas Action for Children; Kansas Adult Care Executives; Kansas Advocates for Better Care; Kansas Association of Area Agencies on Aging and Disabilities; Kansas Association of Centers for Independent Living and the Self-Direction Care Providers of Kansas; Kansas Association of Pediatric Dentists; Kansas Council on Developmental Disabilities; Kansas Health Care Association and Kansas Center for Assisted Living; Kansas Dental Association; Kansas Home Care Association; Kansas Hospital Association; KVC Health Systems; LeadingAge Kansas; Life Centers Family Support Organization;

MidAmerica Alliance for Access; National Association of Social Workers, Kansas Chapter; Oral Health Kansas; Residential Treatment Services of Southeast Kansas; Riverfront Senior Residence; and Wyandotte County Fetal and Infant Mortality Review Board.

Agency responses to presentations by individuals, organizations, and providers. KDHE and KDADS officials responded to various concerns during the course of testimony; however, when provided a specific opportunity during the April, August, and November meetings to respond to stakeholders' concerns, KDHE and KDADS representatives did not provide additional comments.

MCO Testimony and Responses to Presentations By Individuals, Organizations, and Providers. *April meeting.* All three MCOs provided oral-only comments about the situation with LMH and Newman Medical Center. Each MCO expressed concern over the conflict and indicated either the issues had been resolved or they were working to resolve the issues.

August meeting. Representatives from Amerigroup and Sunflower responded to specific comments made by stakeholders. A representative from UnitedHealthcare indicated he had no response.

November meeting. The CEO for Amerigroup, responding to concerns, stated HCBS providers should be receiving Notices of Action and Changes in Service Plans and she would like to be notified if that is not happening. Amerigroup stated it is engaged in value-based purchasing and, if a facility changes ownership and subsequently becomes out-of-network, Amerigroup still pays 100 percent of the Medicaid-approved claims.

The CEO for Sunflower, responding to concerns, stated there had been improvement in the approval rate and timeliness of claims and Sunflower is interested in standardizing procedures and credentialing.

The CEO for UnitedHealthcare, responding to concerns, stated UnitedHealthcare has nurses, care coordinators, and social workers performing assessments in nursing facilities to assure

members are receiving quality care and UnitedHealthcare utilizes value-based contracting and customer satisfaction surveys.

Human Services Consensus Caseload. Staff from the Division of the Budget, DCF, KDHE, KDADS, Kansas Department of Corrections, and KLRD met April 12, 2016, to revise the estimates on caseload expenditures for FY 2016 and FY 2017 and on October 28, 2016, to revise estimates on caseload expenditures for FY 2017 and develop estimates on caseload expenditures for FY 2018 and FY 2019. The caseload estimates include expenditures for KanCare medical programs, non-KanCare programs, including Nursing Facilities for Mental Health (state only) and Frail Elderly (FE)/Physical Disability (PD) Waiver Assessments, Temporary Assistance to Families, the Reintegration/Foster Care Contracts, and Out-of-Home Placements.

Spring estimates. At the April meeting, a KLRD staff member reviewed the estimates and provided the following information. As the starting point for the spring estimate, the group used the approved budget in 2016 House Sub. for SB 161. A chart summarizing the estimates for FY 2016 and FY 2017 was provided to the Committee. The new estimate for FY 2016 is an increase of \$100.2 million from all funding sources, including an increase of \$3.3 million from the State General Fund (SGF). The estimate for FY 2017 is an increase of \$2.1 million from the SGF and \$91.9 million from all funding sources. The combined estimate for FY 2016 and FY 2017 is an all funds increase of \$192.1 million, including \$5.4 million from the SGF.

Fall estimates. At the November meeting, a KLRD staff member reviewed the estimates and provided the following information. The estimate for FY 2017 is an increase of \$147.0 million from all funding sources and \$1.9 million from the SGF as compared to the budget approved by the 2016 Legislature. (The approved amount reflects the Governor's May 2016 allotments.) The estimate for FY 2018 is a decrease of \$120.4 million from all funding sources and an increase of \$35.3 million from the SGF above the FY 2017 revised estimate. The estimate for FY 2019 is an increase of \$48.4 million from all funding sources and \$165.8 million from the SGF above the FY 2018 estimate. The combined estimate for FY 2017, FY

2018, and FY 2019 is an all funds increase of \$75.0 million and an increase in SGF expenditures of \$203.0 million.

Quarterly HCBS report. At each Committee meeting, the Interim or Acting Secretary for Aging and Disability Services provided information on average monthly caseloads and average census for state institutions and long-term care facilities. The Secretary also provided information on savings on transfers to HCBS waivers and the HCBS Savings Fund balance. (See Addendum A.)

Update on renewal of waivers. At the November meeting, KDADS officials provided information stating the Autism Waiver renewal application had been submitted and, if the Waiver is approved, three behavioral services will be transferred from the Waiver to the State Plan, and more children will receive early intervention autism services.

As of November 2016, the Serious Emotional Disturbance Waiver renewal had not been submitted, but CMS approved a 90-day extension. CMS indicated to KDADS that CMHCs can no longer provide all eligibility determinations, plan of care development, and provision of services. KDADS is working with CMS to address this potential conflict of interest.

Update on amendments to renewed HCBS waivers. At the April meeting, KDADS officials reported CMS approved the following HCBS Waiver amendments in February 2016: TBI; PD; FE; Technology Assisted; and I/DD.

Waiting lists update. At the April meeting, KDADS officials reported 8,772 individuals were receiving services on the HCBS I/DD program and 3,481 individuals were on the waiting list; 5,686 individuals were receiving services on the HCBS PD program and 475 individuals were on the waiting list.

At the August meeting, KDADS officials reported 8,896 individuals were receiving services on the HCBS I/DD program and 3,387 individuals were on the waiting list, and 5,975 individuals were receiving services on the HCBS PD program and 438 individuals were on the waiting list.

As of November 2016, KDADS officials reported 8,936 individuals were receiving services on the HCBS I/DD program and 3,533 individuals were on the waiting list, and there were 6,204 individuals receiving services on the HCBS PD program and 505 individuals on the waiting list. The information provided by KDADS indicated every individual on the PD waiting list had been contacted; however, KDADS had received information that some individuals had not been contacted. KDADS was working to resolve this issue.

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 made the following conclusions and recommendations.

The Committee made the following recommendations regarding MCO operations:

- The Secretary of Health and Environment shall develop standards to be utilized uniformly by each MCO serving the State of Kansas pursuant to a contract with the Kansas medical assistance program for each of the following:
 - Documentation to be provided to a health care provider by any MCO when it denies a claim for reimbursement submitted by such provider. Denial reason codes must be compliant with the Health Insurance Portability and Accountability Act, and MCOs must consistently apply denial reason codes in the same manner to ensure accurate reporting to the State; and
 - Documentation to be provided to a health care provider by any MCO when recoupments are made pursuant to a post pay audit of such provider, to include transparency of methodology used in the audit and a specific explanation of the reason for recoupment. MCOs may not

arbitrarily remove codes (such as ICD-10, CPT, and DRG) submitted by the provider or change the level of care provided to reduce payment without using the proper appeal protections in place;

- The Secretary of Health and Environment shall complete a quarterly review of claims denials and appeals to determine:
 - Whether a high percentage of denials are overturned on appeal and, if so, address the issue with the MCO(s); and
 - If a certain procedure or codes are denied more often than others, whether those denials are appropriate, and address the issue with the MCO(s);
- A notice of a right to appeal, including the details and specific action required, be sent to individuals who were assessed under the Capable Person Policy, as it is written in the current Waiver and implemented by the MCOs, and as a result had their plans of care adversely affected. The notice is to be sent no later than December 15, 2016;
- MCOs report to the Committee on the first pass denial rate;
- All MCOs shall work together to develop one standardized credentialing application. MCOs will respond to all submissions within 15 working days. MCOs should use a Council for Affordable Quality Healthcare portal for processing credentialing applications;
- MCOs standardize the under- and over-payment process; and
- Require notices of changes to a plan of care be provided to both individuals and providers.

The Committee made the following recommendation regarding mental health:

- Legislation be introduced by the House and Senate health committees to work on the Mental Health 2020 Initiative plan from the CMHCs.

The Committee made the following recommendation regarding Medicaid Clearinghouse operations:

- Eligibility applications over 45 days aging be sent to a team formed exclusively to get applications through the process and finished. KDHE should set a goal that 75 percent of long-term care applications be cleared in the first 45 days.

The Committee made the following recommendations regarding the administration of KanCare:

- Extend the current 1115 Waiver for one year and delay the RFP until the State

clearly understands federal changes to the ACA and Medicaid; and

- KEES not be expanded to Phase 3 until there has been a clear demonstration of system functionality, operational integrity is determined, and all problems have been resolved. Request LPA update the information technology audit on KEES published in December 2015 and report satisfactory performance before Phase 3 expansion can occur.

The Committee made the following recommendations regarding KanCare reporting and rates:

- All uncompensated care numbers presented to the Committee be based on 100 percent of Medicare allowable; and
- The 4 percent Medicaid reimbursement cut and corresponding policies be reversed.

ADDENDUM A

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

ANNUAL REPORT FOR THE 2016 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 2016 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 2016, 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 2016. 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

DD INSTITUTIONAL SETTINGS AND WAIVER SERVICES*	
Private ICFs/MR: Avg. Mo. Caseload SFY 2016	137
State DD Hospitals – SMRH: Avg. Mo. Caseload SFY 2016	305
MFP: Number discharged into MFP program – DD SFY 2016	33
I/DD Waiver Community Services: Avg. Mo. Caseload SFY 2016	8,802
*Monthly averages are based upon program eligibility.	
Sources: SFY 2016—Medicaid eligibility data as of November 30, 2016. The data include 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 2016. These additional abbreviations are used in the chart:

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

FE / PD / TBI INSTITUTIONAL SETTINGS AND WAIVER SERVICES*	
Nursing Homes-Avg. Mo. Caseload SFY 2016	10,235
MFP FE: Number discharged into MFP program receiving FE Services	49
MFP PD: Number discharged into MFP program receiving PD Services	148
MFP TBI: Number discharged into MFP program receiving TBI Services	10
Head Injury Rehabilitation Facility	29
FE Waiver: Avg. Mo. Caseload SFY 2016	5,049
PD Waiver: Avg. Mo. Caseload SFY 2016	5,647
TBI Waiver: Avg. Mo. Caseload SFY 2016	486
*Monthly averages are based upon program eligibility.	
Sources: SFY 2016—Medicaid eligibility data as of November 10, 2016. The data include people coded as eligible for services or temporarily eligible.	

**AVERAGE DAILY CENSUS IN STATE INSTITUTIONS AND
LONG-TERM CARE FACILITIES**

Kansas Neurological Institute: Avg. Daily Census

FY 2010 – 157
FY 2011 – 153
FY 2012 – 152
FY 2013 – 145
FY 2014 – 143
FY 2015 – 144
FY 2016 – 141

Parsons State Hospital: Avg. Daily Census

FY 2010 – 186
FY 2011 – 186
FY 2012 – 175
FY 2013 – 176
FY 2014 – 174
FY 2015 – 173
FY 2016 – 164

Private ICFs/MR: Monthly Avg.

FY 2010 – 194
FY 2011 – 188
FY 2012 – 166
FY 2013 – 155
FY 2014 – 143
FY 2015 – 140
FY 2016 – 137

Nursing Facilities: Monthly Avg.

FY 2010 – 10,844
FY 2011 – 10,789
FY 2012 – 10,761
FY 2013 – 10,788
FY 2014 – 10,783
FY 2015 – 10,491
FY 2016 – 10,235

*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 that does have the effect of cost avoidance, the savings resulting from moving the individuals to home and community based services, as of December 31, 2016, was \$0.

Balance in the KDADS Home and Community Based Services Savings Fund

The balance in the Kansas Department for Aging and Disability Services Home and Community Based Services Savings Fund as of December 31, 2016, was \$0.