

Report of the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight to the 2018 Kansas Legislature

CHAIRPERSON: Senator Vicki Schmidt

VICE-CHAIRPERSON: Representative Daniel Hawkins

RANKING MINORITY MEMBER: Senator Laura Kelly

OTHER MEMBERS: Senators Barbara Bollier, Bud Estes, Richard Hilderbrand (August and November meetings), and Jacob LaTurner (February and April); and Representatives Barbara Ballard, Susan Concannon, John Eplee, Jim Ward (February, August, and November), Chuck Weber, and John Wilson (April)

CHARGE

KSA 2017 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 system for the provision of services for long-term care system. 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 program, and 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 expresses the following concerns and adopts the following recommendations:

- KanCare 2.0 proceed as scheduled;
- The Kansas Department of Health and Environment (KDHE) include comprehensive dental benefits for adults in the KanCare 2.0 request for proposal;
- KanCare 2.0 include measures to reduce the waiting lists;
 - The Committee is concerned about the increase in Home and Community Based Services waiting lists;
- A comprehensive master plan addressing mental health be developed, including corrections;
- KDHE provide to the Senate Committee on Public Health and Welfare and the House Committee on Health and Human Services, by February 22, 2018, effective criteria and performance measures for the KanCare Clearinghouse and call center;
- The Kansas Department for Aging and Disability Services develop policies and practices for surveying long-term care facilities that will give surveyors latitude in interpreting deficiencies, provide adequate salaries and thorough training to enhance the work of surveyors, and monitor inspections and provide reports to the Committee regarding citations and fines;
- A letter from the Committee be sent to the Centers for Medicare and Medicaid Services requesting Kansas representation on a stakeholder group reviewing the nursing home survey process and a copy of the letter be sent to the Kansas congressional delegation. (*Staff note:* After further investigation, it was determined that such stakeholder group does not exist; therefore, no action will be initiated by the Committee regarding this recommendation at this time. The Chairperson has directed staff to advise Committee members of this development at the January 2018 meeting.);
- KDHE clarify the language regarding power of attorney (POA) documents to distinguish between POA for health care and POA for finances; and
- The Child Welfare System Task Force review and clarify Medicaid eligibility for children in foster care and consider streamlining eligibility to make the transition out of foster care more consistent and efficient.

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 2017 Supp. 39-7,159, *et seq.* The previous Joint Committee on HCBS Oversight was created by the 2008 Legislature in House Sub. for SB 365. In HB 2025, the 2013 Legislature renamed and expanded the scope of the Joint Committee on HCBS Oversight to add the oversight of KanCare (the State's Medicaid managed care program). The Committee oversees long-term care services, including HCBS, which are to be provided through a comprehensive and coordinated system throughout the state. The system, in part, is designed to emphasize a delivery concept of self-direction, individual choice, services in home and community settings, and privacy. The Committee also oversees the Children's Health Insurance Program (CHIP), the Program for All-Inclusive Care for the Elderly (PACE), and the state Medicaid programs.

The Committee is comprised 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 Appendix A for the 2017 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 is also 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 2017 Session (February 24 and April 19) and twice for two days each during the interim (August 22 and 23 and November 28 and 29). In accordance with its statutory charge, the Committee's work focused on the specific topics described in the following sections.

KanCare Overview and Update

The Secretary of Health and Environment reported KDHE submitted a request for a one-year extension of the current (1115) Medicaid waiver (1115 Waiver). The Centers for Medicare and Medicaid Services (CMS) approved the request in November 2017; therefore, the current KanCare program will continue until December 31, 2018.

KanCare Cost Comparison

At the February meeting, KDHE submitted testimony stating KanCare had produced more than \$1.4 billion in savings to the State and a portion of those savings were used to eliminate (as of August 2016) the physical disability (PD) waiver and reduce the intellectual and developmental disability (I/DD) waiver waiting lists. Upon discussion with the Committee, the Secretary of Health and Environment indicated the \$1.4 billion could also be classified as "cost avoidance." At the November meeting, the Interim Medicaid Director provided information indicating that actual expenditures in 2017 (through September) were about \$400,000 less than the 2012 projection for KanCare expenditures and about \$600,000 less than was estimated for Medicaid expenditures without KanCare.

Medicaid Eligibility Backlog

At the February meeting, the Secretary of Health and Environment informed the Committee the number of unprocessed Medicaid applications was 1,680 and it was anticipated the backlog would be cleared by April 2017. At the April meeting, the Secretary reported the number of unprocessed applications was 325. At the November meeting, the Interim Medicaid Director reported, as of November 15, 2017, 2,799 unprocessed applications were past the 45-day requirement for an application to be processed. The Interim Medicaid Director also provided a chart to the Committee showing the numbers of unprocessed applications past 45 days, by month, from August 2015 to November 15, 2017.

Long-term Care Facilities

Backlog reduction. At the February meeting, the Secretary of Health and Environment informed the Committee that KDHE had a five-point plan to

reduce the long-term care (LTC) facility application backlog. The plan included 90.0 percent advance payment for any LTC application pending more than 45 days, a webinar for LTC staff working on eligibility, and an established hotline for LTC facilities and staff. At the August meeting, the Secretary indicated advanced payments were not made to LTC facilities; rather, LTC facilities that applied for advanced payments had their applications expedited for processing.

Pilot project. At the February meeting, the Secretary of Health and Environment also informed the Committee that KDHE had launched a KanCare Clearinghouse Liaison pilot project. The Secretary stated KDHE initiated the pilot project to help skilled nursing centers resolve Medicaid eligibility and claims issues. The Secretary also indicated the goal was to have a statewide rollout.

The project was praised by conferees and appreciation was expressed regarding the increased communication between nursing homes and the Clearinghouse, which processed Medicaid eligibility applications. However, it was noted by conferees that pilot project participants experienced accelerated eligibility determinations but the improvement was limited to those participating in the project and was not experienced systemwide.

The Interim Medicaid Director indicated at the November meeting that KDHE would be expanding the pilot project to include all 330 nursing homes by April 2018.

KanCare 2.0

In 2017, KDHE began the process of renewing the KanCare program and the renewal program is referred to as “KanCare 2.0.” KDHE is required to obtain approval from CMS prior to making changes to the current KanCare program. The requested changes are incorporated into the 1115 Waiver renewal application. The contract with MCOs to administer the current KanCare program expires December 31, 2018; therefore, KDHE is required to go through the request for proposal (RFP) process to facilitate new MCO contracts.

Request for proposal. The KanCare 2.0 RFP was posted in November 2017. The RFP indicates KanCare 2.0 contracts will take effect January 1, 2019. Several conferees recommended changes not be allowed to the KanCare system without legislative approval. (For additional stakeholder comments, see Presentations on KanCare from Individuals, Providers, and Organizations on the following page).

Office of Revisor of Statutes and KLRD staff provided information to the Committee regarding the KanCare 2.0 RFP, as follows: the five-year term of the 2.0 contract will begin January 1, 2019, and end December 31, 2023; the RFP does not present a conflict with the statutory requirement for an independent third-party review and is silent on the issue of an external entity or policy; the RFP includes significant liquidated damages, not in the current KanCare contract, for MCOs and subcontractors; the liquidated damages are assessed at the sole discretion of the State; and the RFP requires MCO staff receive training to apprise eligible Medicaid recipients of Kansas’ program for work opportunities.

1115 Waiver renewal application. In June, KDHE held public meetings to collect stakeholder input. The stakeholders were asked to provide input on areas in which KDHE was proposing changes for KanCare 2.0. In November, after the renewal application was posted, KDHE held additional stakeholder public meetings.

At the November meeting, the Interim Medicaid Director indicated the 1115 Waiver renewal application would be submitted to CMS by December 31, 2017.

KLRD staff stated the 1115 Waiver renewal application includes a work requirement and a 36-month lifetime cap for certain Medicaid recipients. Neither of these provisions is in the current KanCare program.

KanCare Process Improvement Working Group

A written-only update was provided to the Committee from the Working Group at the February meeting. At the August meeting, the Kansas Medicaid Director provided an update on

the Working Group's progress. The Chairperson of the Committee asked that parallel provider credentialing be placed back on the Working Group's agenda for further review. Representatives from all three MCOs provided information on various difficulties with standardization for provider credentialing across the MCOs.

Reports: Kansas Foundation for Medical Care, Inc.

At the April meeting, a representative from the Kansas Foundation for Medical Care (KFMC) explained that KFMC is an independent quality review organization and has been evaluating Medicaid services since 1995. The KFMC representative stated reviews are driven by CMS standards and assess MCO compliance and validate an MCO's performance, performance improvements, and information systems. The representative provided performance measures for each of the MCOs, including the results of consumer and mental health perception surveys.

Managed Care Organizations' Financial Update

KDHE provided testimony indicating the adjusted net income (loss) of the MCOs through June 2017 was as follows: Sunflower, \$2,492,255; Amerigroup, \$11,092,619; and UnitedHealthcare, \$1,026,800.

Kansas Eligibility Enforcement System

The Interim Medicaid Director stated the Kansas Eligibility Enforcement System (KEES) Phase III became fully operational in September 2017. The Interim Medicaid Director further stated KEES integrates eligibility to streamline the application process, standardizes use of data and creates a single source of truth for all eligibility data, and provides a platform for beneficiaries to access information about medical and non-medical services in one location.

Osawatomie State Hospital

The Secretary for Aging and Disability Services provided an update on Osawatomie State Hospital (OSH), as follows: in preparation for recertification from CMS, OSH increased the beds

available from 120 to 158; the waiting list has been reduced; and only one bid was received for the RFP regarding building and operating OSH. The Secretary stated the sole bid was received from CorrectCare, which is involved in a number of lawsuits. However, the Secretary has visited five facilities operated by CorrectCare and was impressed. The Secretary stated that before signing a contract with a vendor, the information would be provided to the 2018 Legislature for approval.

Larned State Hospital

A representative from KDADS provided information to the Committee regarding a complaint survey conducted at Larned State Hospital by CMS and KDADS August 21-24, 2017. The KDADS representative stated a corrective action plan and updates to the plan were submitted to CMS on November 21 and 27, respectively. The plan and updates addressed ligature points and insufficient purchase orders.

KanCare Ombudsman

The KanCare Ombudsman provided information to the Committee at each meeting. In February, the Ombudsman reported the Office has a new website and would be starting a three-hour training program for community organizations that would like to learn more about Medicaid.

The number of contacts for the fourth quarter of 2016 was 523. The number of 2017 first-quarter contacts was 825 and the number during the second quarter was 835. In the third quarter of 2017, there were 970 contacts, which is up 41.0 percent from 2016. The third quarter of 2017 had the second-most contacts ever recorded by the Ombudsman's Office. Issues are not being resolved as quickly as in 2016. The Ombudsman reported the higher number of contacts and the slower resolution is likely due to increased outreach efforts and more complicated issues, respectively.

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 presented by conferees.

Concerns

CHIP. The possibility of Congress failing to reauthorize CHIP. (*Staff note:* In December 2017, Congress granted a short-term extension of federal funding for CHIP.)

Claims. Dilatory processing of claims, and coding problems; increasing time required to process Medicaid claims; and the inconsistencies in processing claims among MCOs.

Clearinghouse. Ongoing poor communication with the Clearinghouse and erratic responses from the Clearinghouse.

Documentation. Inadequate or incomplete documentation making it difficult to evaluate the effectiveness of KanCare programs and the strength of the long-term services and supports provider network under the seven HCBS waivers.

Waiting lists. The growing waiting list for the PD Waiver and the waiting list for all HCBS Waivers; concern for the 3,000 individuals remaining on the HCBS waiting lists, some of whom have waited 7 years for services; and the waiting lists have not been reduced since KanCare was implemented.

Application backlog. The backlog and the uncompensated care resulting from the mishandling of nursing home eligibility applications.

Crisis funding. The ten-day delay for crisis funding is too long and the process is complex.

Eligibility. Difficulty navigating the Medicaid eligibility process, and the eligibility backlog.

LTC facilities. Deficiencies in KanCare service delivery have created problems for nursing homes and assisted living facilities, and care assessments have created a delay in Medicaid

applications resulting in facilities not being reimbursed in a timely manner.

Children. Children’s mental health services: families are not able to access the level of care they need in a timely manner, and residential facilities have more than 300 youth and children on waiting lists; the number of children served by KanCare has dropped.

MCOs. Medicaid payments exclude “natural supports” from family or friends; however, MCOs are not properly following the rule by coercing volunteers to provide services that would qualify for Medicaid payments; and MCOs are not following the agency mandate regarding premature placement of individuals diagnosed with Alzheimer’s disease.

Providers. Medical providers have incurred financial loss as Medicaid reimbursement rates have dropped; financial hardship from the 4.4 percent Medicaid reimbursement cut to providers; and workforce background checks still taking too long.

KanCare 2.0. The work requirement and the 36-month lifetime limit for certain Medicaid recipients included in the request to CMS for approval of KanCare 2.0; decrease in time to file an appeal; sleep-cycle support (enhanced care services) policy changes initiated by KDADS are not being corrected; does not address self-directed care; does not address systemic problems, such as backlogs in the current system; does not address mental health concerns; will restrict due process; the service coordination process needs to be clarified: MCOs should be required to use only oversight personnel who are medically licensed; and the current system of mental health service be retained.

Other. Inconsistent VoiceCare service; failure to notify providers when a patient loses Medicaid; time and the high number of services that require pre-authorization; no expedited eligibility process for those near the end of life; contractual obligations for services to individuals with Alzheimer’s disease under KanCare have not been met; and lack of providers for autism services.

Recommended solutions

KFMC review its annual evaluations of the KanCare program; expanding Medicaid would be beneficial to Kansas; the Legislature monitor the KanCare 2.0 MCO RFP as KDHE requests renewal of the 1115 Waiver with CMS; integrating targeted case management with care coordination to provide more comprehensive service for seniors; recommended home care providers receive a pay increase and benefits, as an increase would afford dignity to these caregivers; additional funding to address the HCBS waiting lists; carve out I/DD Waiver services from the managed care system; provide dental service for adults in KanCare 2.0; increase the reimbursement rate for dental providers; suspend KanCare 2.0 and allow the next governor's administration to develop a better system; more State oversight of the MCOs; increase Medicaid rates for autism services; and streamline credentialing process for applied behavioral analysis providers.

Conferees. Private citizens and representatives of the following organizations and providers testified or provided written-only testimony before the Committee: AARP Kansas; Alliance for a Healthy Kansas; Alzheimer's Association; Association of Community Mental Health Centers of Kansas; Case Management Services; Central Kansas Foundation; Children's Alliance of Kansas; Community Health Council, Wyandotte County; Community Living Opportunities; Communityworks, Inc.; Disability Rights Center of Kansas; Equi-Venture Farms, LLC; Family Service and Guidance Center; Flint Hills Community Health Center; Genesis Family Heartland Community Health Center; GraceMed Health Clinic; Integrated Behavioral Technologies, InterHab; Jenian, Inc.; Johnson County Area Agency on Aging; KanCare Advocates Network; Kansas Action for Children; Kansas Adult Care Executives; Kansas Advocates for Better Care (KABC); Kansas Appleseed Center for Law and Justice; Kansas Association for the Medically Underserved; 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 Community Action Programs; 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; Mother and Child Health Coalition; National Association of Social Workers, Kansas Chapter; Oral Health Kansas; Pathways Alternative Center for Education; Residential Treatment Services of Southeast Kansas; Riverfront Senior Residence; Sisters of Charity of Leavenworth; Southeast Kansas Independent Living Resource Center; Stormont Vail Health; United Community Services of Johnson County; and Wyandotte County Fetal and Infant Mortality Review Board.

Managed Care Organization Testimony

Representatives of all three MCOs provided testimony and responses to presentations by individuals, organizations, and providers at each meeting.

A representative from Amerigroup provided information regarding Amerigroup's involvement with communities, strategies for dealing with the opioid crisis, and improved sleep-cycle support. The Amerigroup representative also stated 19.0 percent of Amerigroup's services are self-directed and 81.0 percent are agency-directed; Amerigroup uses only licensed providers, whether in- or out-of-state; and Amerigroup's 2016 profit was 0.2 percent and, as of November 2017, a 0.2 percent loss for 2017.

Representatives from UnitedHealthcare Community Plan provided information regarding sleep-cycle support, a multi-tiered pharmacy plan for opioid management, and information on sequential care for youth in foster care. A UnitedHealthcare representative also stated all physicians employed by UnitedHealthcare are licensed in Kansas and UnitedHealthcare's profit margin for 2016 was 0.3 percent and was the same for the first two quarters of 2017.

Representatives from Sunflower discussed the organization's approach for sleep-cycle support and the initiatives Sunflower has in place to address opioid addiction. A representative from Sunflower also stated Sunflower's 2016 profit margin is 0.004 percent.

Representatives from each MCO discussed how their respective organizations address health care effectiveness data and information set requirements.

Managed Care Organization Incentives

The Interim Medicaid Director explained 14 pay-for-performance measures serve as incentives for the MCOs. The Director stated that in calendar year 2015, UnitedHealthcare met 63.6 percent of the measures; Sunflower, 53.0 percent; and Amerigroup, 59.0 percent. Under the current KanCare contract, MCOs are being paid and then must reimburse KDHE for areas where they did not meet the measures. Beginning in 2019, KDHE will shift to paying incentives based on what measures have been met.

Medicaid Managed Care Study

In late 2017, Leavitt Partners began conducting a study reviewing KanCare's costs and utilization, quality of care, and program initiatives. A representative from Leavitt Partners presented information to the Committee about the first of three topics: cost and utilization. The Leavitt Partners representative stated that under KanCare, Medicaid spent about \$1.7 billion less than the projected trend and, during the first year of KanCare, expenditures shifted from hospital settings to HCBS settings. The remainder of the study is projected to be completed in 2018.

Clearinghouse

KDHE contracts with Maximus to operate the Clearinghouse. A representative of Maximus outlined steps being taken to correct errors and backlog issues at the Clearinghouse.

Human Services Consensus Caseload

Staff from the Division of the Budget, Kansas Department for Children and Families (DCF), KDHE, KDADS, Kansas Department of Corrections, and KLRD met April 18, 2017, to revise the estimates on caseload expenditures for FY 2017 and FY 2018, and October 31, 2017, to revise 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); PD Waiver Assessments; Temporary Assistance to Needy Families, the Reintegration and Foster Care contracts, and Out-of-Home Placements.

Spring

The estimate for FY 2017 is an increase of \$25.1 million from all funding sources and \$14.2 million from the State General Fund (SGF) as compared to the budget recommended by the Governor and adjusted by 2017 Senate Sub. for Sub. for HB 2052, the current year rescission bill.

Since an appropriations bill for FY 2018 and FY 2019 had not yet been passed, the starting point for the April estimates was the Governor's recommendations for FY 2018 and FY 2019. The estimate for FY 2018 is an increase of \$19.6 million from all funding sources and a SGF decrease of \$3.0 million compared to the FY 2018 Governor's recommendation. The estimate for FY 2019 is an increase of \$4.1 million from all funding sources and a SGF increase of \$6.4 million above the FY 2019 Governor's recommendation. The combined estimate for FY 2017, FY 2018, and FY 2019 is an all funds increase of \$48.8 million and a SGF increase of \$17.6 million.

Fall

The estimate for FY 2018 is a decrease of \$4.6 million from all funds and an increase of \$16.4 million from the SGF when compared with the budget approved by the 2017 Legislature. The estimate for FY 2019 is an increase of \$259.1 million from all funds, including \$50.0 million from the SGF above the approved amount; a combined estimate for FY 2018 and FY 2019 results in an all funds increase of \$254.5 million and a SGF increase of \$66.4 million.

Quarterly Home and Community Based Services Report

At each Committee meeting, written testimony was provided by KDADS on the average monthly caseloads and average census for state institutions and LTC facilities. A representative from KDADS provided information on savings on transfers to

HCBS waivers and the HCBS Savings Fund balance. (See Addendum A.)

Update on Renewal of Waivers

KDADS received CMS approval for the Serious Emotional Disturbance Waiver on April 28, 2017. At the August meeting, a representative of KDADS reported that community mental health centers (CMHCs) provide eligibility determinations, plans of care, and service provisions. CMS has informed KDADS that CMHCs cannot continue to perform all three duties due to an inherent conflict of interest. KDADS is pursuing a contract with third-party assessors to provide side-by-side assessments.

KDADS received CMS approval for the Autism Waiver on June 14, 2017. Three behavioral services moved from the Waiver to the State Plan.

Waiting Lists Update

At the November meeting, the KDADS Commissioner for Community Services and Program Commission reported as of November 14, 2017, the HCBS I/DD waiting list had 3,603 individuals and 8,963 individuals were receiving services, and 1,318 individuals were on the HCBS PD waiting list and 5,953 individuals were receiving services.

Program for All-inclusive Care for the Elderly

At the November meeting, the KDADS Commissioner for Community Services and Program Commission provided the following information regarding PACE: Midland, Via Christi Hope (VCH), and Bluestem are PACE sites and had a combined enrollment of 556 individuals; KDADS was reviewing proposals for a new PACE site to be located in eastern Kansas; and an audit was performed by the State and CMS of VCH's program after concerns were reported. The Commissioner indicated CMS, KDHE, and KDADS were monitoring VCH's plan of correction.

Anti-psychotic Drugs for Dementia Patients

At the November meeting, the Interim Medicaid Director discussed the the recent goals published by CMS regarding reducing anti-psychotic drugs for dementia patients. A representative of KDHE stated the agency is reviewing best practices and will provide guidance for state policies and policies for MCOs. A representative from KABC stated the State is not providing leadership in reducing the use of anti-psychotic drugs and is not educating MCOs regarding state policies. The KABC representative recommended verifiable informed consent be provided prior to administering anti-psychotic drugs, KDADS provide better training for staff, and KDHE improve oversight of the MCOs.

Foster Care and Medicaid

A representative of DCF provided information about issues related to Medicaid services for children in foster care. The representative stated DCF created a Medicaid liaison to coordinate Medicaid services for foster children.

Oversight of Long-term Care Facilities

A representative of a LTC facility stated response by CMS and KDADS to deficiencies is excessive and punitive. The representative asked that the Committee encourage surveyors to write deficiencies commensurate with the level of harm the deficiency poses and to give an agency discretion to prevent G-level (actual harm that is not immediate jeopardy) deficiencies from triggering a ban on admissions.

A representative from LeadingAge Kansas stated, in the past two years, citations for "immediate jeopardy" have increased exponentially and these citations have an immediate and negative effect on person-centered care and can be financially devastating to high-quality facilities.

The KDADS Commissioner for Survey, Certification and Credentialing responded to questions from Committee members. The Commissioner reported KDADS has 20 vacant survey positions, and in August 2017, new regulations regarding immediate jeopardy were

issued by CMS, which has resulted in a drop in reporting.

CONCLUSIONS AND RECOMMENDATIONS

The Committee adopted the following recommendations:

- KanCare 2.0 proceed as scheduled;
- KDHE include comprehensive dental benefits for adults in the KanCare 2.0 RFP;
- KanCare 2.0 include measures to reduce the waiting lists; the Committee is concerned about the increase in HCBS waiting lists;
- A comprehensive master plan addressing mental health be developed, including corrections;
- KDHE provide to the Senate Committee on Public Health and Welfare and the House Committee on Health and Human Services, by February 22, 2018, effective criteria and performance measures for the KanCare Clearinghouse and call center;
- KDADS develop policies and practices for surveying LTC facilities that will give

surveyors latitude in interpreting deficiencies, provide adequate salaries and thorough training to enhance the work of surveyors, and monitor inspections and provide reports to the Committee regarding citations and fines;

- A letter from the Committee be sent to CMS requesting Kansas representation on a stakeholder group reviewing the nursing home survey process and a copy of the letter be sent to the Kansas congressional delegation. (*Staff note:* After further investigation, it was determined that such stakeholder group does not exist; therefore, no action will be initiated by the Committee regarding this recommendation. The Chairperson directed staff to advise Committee members of this development at the January 2018 meeting.);
- KDHE clarify the language regarding power of attorney (POA) documents to distinguish between POA for health care and POA for finances; and
- The Child Welfare System Task Force review and clarify Medicaid eligibility for children in foster care and consider streamlining eligibility to make the transition out of foster care more consistent and efficient.

APPENDIX A

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

ANNUAL REPORT FOR THE 2017 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 statute (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 tables and accompanying explanations are provided in response to the Committee's statutory charge.

Number of Individuals Transferred from State or Private Institutions to HCBS, 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 HCBS during state fiscal year 2017, 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 2017. 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: Average Monthly Caseload SFY 2017	133
State DD Hospitals – SMRH: Average Monthly Caseload SFY 2017	300
MFP: Number discharged into MFP program – DD SFY 2017	30
I/DD Waiver Community Services: Average Monthly Caseload SFY 2017	8,926
*Monthly averages are based upon program eligibility.	
Sources: SFY 2017—Medicaid eligibility data as of November 28, 2017. 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 HCBS during SFY 2017. These additional abbreviations are used in the table:

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

FE / PD / TBI INSTITUTIONAL SETTINGS AND WAIVER SERVICES*	
Nursing Homes-Average Monthly Caseload SFY 2017	10,047
MFP FE: Number discharged into MFP program receiving FE Services	54
MFP PD: Number discharged into MFP program receiving PD Services	102
MFP TBI: Number discharged into MFP program receiving TBI Services	4
Head Injury Rehabilitation Facility	28
FE Waiver: Average Monthly Caseload SFY 2017	4,863
PD Waiver: Average Monthly Caseload SFY 2017	6,071
TBI Waiver: Average Monthly Caseload SFY 2017	453
*Monthly averages are based upon program eligibility.	
Sources: SFY 2017—Medicaid eligibility data as of November 28, 2017. 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: Average Daily Census

FY 2011 – 153
FY 2012 – 152
FY 2013 – 145
FY 2014 – 143
FY 2015 – 144
FY 2016 – 141
FY 2017 – 142

Parsons State Hospital: Average Daily Census

FY 2011 – 186
FY 2012 – 175
FY 2013 – 176
FY 2014 – 174
FY 2015 – 173
FY 2016 – 163
FY 2017 – 160

Private ICFs/MR: Monthly Average*

FY 2011 – 188
FY 2012 – 166
FY 2013 – 155
FY 2014 – 143
FY 2015 – 140
FY 2016 – 137
FY 2017 – 133

Nursing Facilities: Monthly Average*

FY 2011 – 10,789
FY 2012 – 10,761
FY 2013 – 10,788
FY 2014 – 10,783
FY 2015 – 10,491
FY 2016 – 10,235
FY 2017 – 10,047

*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, 2017, 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, 2017, was \$0.

Minority Report to the 2018 Legislature

January 2018

From: Senator Laura Kelly

To: 2017 Member of the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight

Re: KanCare 2.0

The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight voted to recommend that the 2018 Legislature proceed with the KanCare 2.0 request for proposal (RFP) and the 1115 Waiver renewal application. I strongly disagree with this recommendation.

I submit to the 2018 Legislature that proceeding with the RFP and application, as written, is not in the best interest of Medicaid recipients or the State of Kansas. Since its inception, KanCare has been plagued with problems, most of which have not yet been resolved. The Committee still routinely hears complaints about many aspects of the KanCare system almost five years after it was implemented. This continues to trouble me and many of our colleagues.

Some of the ongoing complaints presented to the Committee include inconsistent processing of claims by the managed care organizations (MCOs); the backlog of applications which negatively impacts individual applicants and nursing facilities; the inability of the Clearinghouse to process applications in an efficient manner; and the lack of standardized credentialing for providers by MCOs.

Additionally, the current RFP requires a five-year contract with the MCOs, beginning January 1, 2019. Therefore, the 2019 Administration will not have any opportunity to provide input regarding the operation of this important and troubled program.

It is my recommendation that the 2018 Legislature require the Kansas Department of Health and Environment to halt KanCare 2.0 and request another one year extension of the current KanCare program. This will allow time to fix ongoing problems and allow the new administration to provide input into a system for which it will ultimately be responsible.

Note: Senator Barbara Bollier and Representative Barbara Ballard concur with the above report.

MINORITY REPORT
REP. JIM WARD
KANCARE OVERSIGHT COMMITTEE

Conclusions:

1. KDHE is the single state Medicaid agency and solely responsible for the Medicaid program in Kansas.
2. There are consistent and serious problems with the Kansas Medicaid program as operated under KanCare and its three Managed Care Organizations. (MCOs)
3. Hospitals, nursing homes and other health providers have had great difficulty getting timely payments for services.
4. Eligible Kansans needing health care have faced long waiting lists.
5. KanCare has presented eligible people needing health care unclear and difficult application procedures.
6. The restricted ombudsman currently in place provides little real help to Kansans trying to navigate the various challenges presented by KanCare.
7. In a letter dated January 13, 2017 from the Center for Medicare and Medicaid Services (CMS) numerous problems in the KanCare program were set out. Attached hereto as Exhibit #1. Based on a significant number of complaints regarding the KanCare program from beneficiaries, providers and advocates CMS took a series of steps to investigate the Kansas program including an on-site review. CMS concluded that Kansas was substantially out of compliance with Federal statutes and regulations as well as its Medicaid State Plan.

8. There were several specific findings:

- a. Kansas failed to establish clear roles and responsibilities for State employees who administer and operate KanCare program.
- b. There was limited coordination between KDHE and KDADS which posed a risk to health and safety of Managed Long Term Services and Supports participants. CMS pointed out a lack of communication and collaboration between the state agencies.
- c. Kansas did not engage in sufficient oversight of the activities of the MCOs. (private insurance companies)
- d. CMS found the State's oversight of the MCOs has diminished over the 4 years that KanCare had been in operation.
- e. Public feedback consistently describes a lack of engagement and adversarial communication from the State. Stakeholders overwhelmingly report an inability to get clear and consistent information from the State and MCOs, making it difficult for KanCare enrollees to navigate their benefits.
- f. Stakeholders also note the State often does not respond to public comments or include changes in final policy documents to address public comments.
- g. MCOs requesting participants to sign incomplete forms without specific hours of services. MCOs revising care plans without participant input.
- h. Individualized care plans taking months to complete.
- i. No MCOs require the signature of providers responsible for plan implementation.
- j. Lack of oversight and reliable data makes it difficult to determine whether sufficient providers are in the networks to serve the enrolled beneficiaries.
- k. MCO's network data contained incorrect and inconsistent information.

9. 2017 Kansas legislature passed Senate Sub. For HB 2026 which attempted to address the concerns raised by CMS and others.
10. Insufficient time has passed to evaluate the effects of Senate Sub. For HB 2026.
11. KDHE has failed to show steps required by Senate Sub. For HB 2026 have been implemented.
12. The state continues to have difficulties with safety at Osawatomie and Larned State Hospitals.

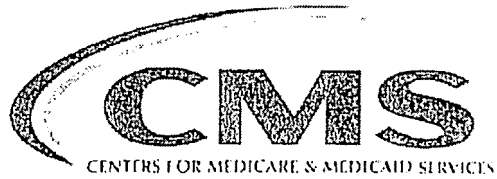
Recommendations:

1. KDHE shall postpone its request for proposals from potential insurance providers and a 1115 waiver necessary to implement KanCare 2.0. The agency may renew its request for new 1115 waiver and request for proposals from insurance providers in one year after demonstrating the problems outlined above have been resolved.
2. KDHE shall prepare a report on the implementation of each provision of Senate Sub. For HB 2026 and present it to the next meeting of the KanCare Oversight Committee.
3. Lifetime caps are inconsistent with quality health care and should not be part of the Kansas Medicaid program.
4. Lifetime caps are a barrier to health care access and will result in a deterioration of health outcomes.
5. The administration shall remove lifetime caps from any 1115 waiver application.

6. Work requirements for recipients of Medicaid in Kansas shall not be requested by any 1115 waiver until Medicaid expansion has passed into law and is fully implemented.
7. The limited ombudsman program currently in place for KanCare shall be enhanced to include the authority of the office of ombudsman to investigate complaints against KDHE, KDADS and any of the 3 MCOs. The results of said investigations shall be reported to the MCO in question and KDHE. An annual report of investigations and results be provided to KanCare Oversight Committee at each quarterly meeting.
8. The Attorney General or his designee shall appear and report progress on the hiring of an Inspector General to the KanCare Oversight Committee. The Attorney General or his designee shall report difficulties in hiring an Inspector General and make recommendations.
9. The legislature should carve out the Intellectual and Developmental Disability participants of Medicaid in Kansas from KanCare and KanCare 2.0. This community of patients shall be served under the traditional Medicaid program.

Exhibit # 1

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106



Division of Medicaid and Children's Health Operations

January 13, 2017

Susan Mosier, M.D.
Secretary and State Health Officer
Kansas Department of Health and Environment
Curtis State Office Building
1000 SW Jackson Street, Suite 340
Topeka, KS 66612

Dear Dr. Mosier:

This letter addresses the Kansas Department of Health and Environment's (KDHE) noncompliance with the requirements of the KanCare program, authorized under Section 1115 of the Social Security Act (the Act), provisions of Kansas' Home and Community-Based Services (HCBS) waivers, and Federal Medicaid statute and regulations. This noncompliance, which is detailed in the enclosed KanCare Findings and Recommendations Report, places the health, welfare, and safety of KanCare beneficiaries at risk and requires immediate action.

The KanCare program establishes a managed care delivery system through a combination 1115/1915(c) waiver for nearly all of the 425,564 Medicaid and Children's Health Insurance Program (CHIP) beneficiaries in Kansas. KanCare's average annual costs total \$3.4 billion.¹ The combined nature of the program means that some of the State's most vulnerable and medically complex individuals are enrolled in managed care, such as those living in nursing facilities or enrolled in HCBS waivers.

Throughout 2016, CMS received a significant number of complaints and concerns regarding the KanCare program from beneficiaries, providers, and advocates. In response, CMS reviewed information concerning the reported issues, discussed systemic concerns with State staff, and engaged State representatives to remediate individual cases as appropriate. Ultimately, CMS conducted an on-site visit from October 24, 2016 to October 27, 2016. The on-site review consisted of interviews with State agencies responsible for the KanCare program; interviews with staff of Amerigroup Kansas, Inc., Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas, the three KanCare managed care organizations (MCOs); and three stakeholder listening sessions with KanCare beneficiaries and families, providers, and advocacy groups. Additionally, CMS requested documentation both prior to and after the onsite. Our review of the provided documentation substantiated concerns

¹ Kansas Department of Health and Environment. *State Fiscal Year 2016. Kansas Medical Assistance Report (MARR)*. Retrieved from: <http://www.kancare.ks.gov/policies-and-reports/medical-assistance-report>

regarding administrative oversight of the program. In addition, the on-site discussions and documentation review revealed a number of concerns regarding the operation of KanCare.

The results of our on-site review confirm that Kansas is substantively out of compliance with Federal statutes and regulations, as well as its Medicaid State Plan. Kansas has failed to administer the KanCare program as required by section 1902(a)(4) of the Act and 42 C.F.R. § 431.15. The results of CMS' onsite review outlined in this letter and the accompanying report are particularly concerning given the large role KanCare plays in delivering care to Medicaid beneficiaries in Kansas. We have detailed some of the key findings of the review below, but want to underscore the serious nature of these concerns and the risks it poses to beneficiaries. These concerns affect beneficiaries' receipt of services necessary to stay in the community, beneficiaries' ability to access needed care, and the State's ability to ensure the health and welfare of beneficiaries.

Administrative Authority: 42 C.F.R § 431.10(b); 42 C.F.R. § 441.745

CMS regulations require States to establish a Single State Medicaid Agency with ultimate administrative authority over the Medicaid program. The Single State Medicaid Agency is responsible for the administration and supervision of the Medicaid State Plan, as well as any State operating agencies and/or contractors that perform functions on the State Medicaid Agency's behalf.

- The State has failed to establish clear roles and responsibilities for State employees who administer and operate the KanCare program. The State relied on a memorandum of understanding between KDHE and the Kansas Department of Aging and Disability Services (KDADS) that was last updated in 2010, prior to the implementation of KanCare. The memorandum references State departments that no longer exist and lacks criteria for KDHE to evaluate performance of KDADS.
- Limited coordination between KDHE and KDADS poses a risk to the health and safety of Managed Long Term Services and Supports (MLTSS) participants, who may experience difficulty managing their benefits. Review of MCO oversight and performance reports is divided between KDHE and KDADS and the lack of communication and collaboration creates a knowledge gap between the agency that operates the HCBS waivers (KDADS) and the agency responsible for managed care contract implementation (KDHE). This lack of communication also reduces the State's ability to identify problems, determine whether identified problems are improving in any systemic way, and initiate necessary changes at the MCO level.
- Kansas did not engage in sufficient oversight of the activities of the MCOs. While the State receives many reports from the MCOs, there is no evidence of significant analysis or subsequent program changes based on those reports. For example, recent MCO reports indicate that a low percentage of required health screenings were completed, but there is no evidence that the State provided feedback to the MCOs regarding completion of health screenings. The MCOs reported receiving little feedback on submitted reports, and the feedback that is provided is verbal rather than written. Further, reporting is inconsistent among the MCOs, which limits the State's ability to track issues and identify trends

- across the program. For example, the levels used by each of the three MCOs to categorize critical incidents vary, resulting in inconsistent reporting to the State.
- The State's oversight of the MCOs has diminished over the four years of KanCare operation, as evidenced by its annual onsite reviews of the MCOs and subsequent reports. The 2013 annual report was a comprehensive document, and corrective action plans were issued to the MCOs regarding identified issues. The 2014 and 2015 annual reports were each two pages long, with little content of substance.
 - Public feedback consistently describes a lack of engagement and adversarial communication from the State. Comments from KanCare stakeholders at multiple stakeholder sessions overwhelmingly reflect an inability to obtain clear and consistent information from the State and MCOs, making it difficult for KanCare enrollees to navigate their benefits.
 - Stakeholders further noted that the State often does not respond to public comments or include changes in final policy documents to address public comments. The State maintains the KanCare Advisory Committee, and the MCOs each maintain an advisory board, but these committees do not meet all applicable requirements. Furthermore, committee members indicated that the committee meetings did not provide opportunities for meaningful public input.

Person-Centered Planning Process: 42 C.F.R § 441.301(c); 42 C.F.R § 441.725(b)

CMS requires that service plans for each participant in Medicaid HCBS programs be developed through a person-centered planning process that reflects the beneficiary's individual preferences and goals. The rules require that the person-centered planning process is directed by the participant, and may include other individuals as chosen by the participant. This planning process, and the resulting person-centered service plan, assist the participant in achieving personal outcomes in the most integrated community setting, ensure delivery of services that reflect personal preferences and choices, and help assure the participant's health and welfare.

- CMS uncovered significant compliance deficiencies with the person-centered planning process, which included: MCOs requesting participants sign incomplete forms without the number of hours or types of services they would receive; MCOs revising person-centered plans without the participant's input; and MCOs failing to ensure provider signatures on person-centered plans as required.
- One MCO indicated that while a service plan is developed for each waiver participant within 14 days of entering the waiver, the required person-centered plan is not developed until 3 to 6 months after services are authorized. The delayed completion of the person-centered plans compromises safeguards meant to ensure that waiver services and supports reflect participants' individual preferences and goals.
- None of the MCOs have processes in place that ensure all final service plans are signed and agreed to by the participant or that the participant receives a copy of the final plan. All three MCOs described processes that required participants to sign "interim" or "proposed" plans that were then reviewed and possibly revised by a utilization review committee within the MCO. If changes were made, MCOs attempted to obtain participant signatures on the final plans; but MCO staff stated they are not always successful in obtaining those signatures.

- None of the three MCOs currently require the signature of providers responsible for plan implementation, as required by 42 C.F.R. § 441.725(b)(9). The lack of member and provider signatures jeopardizes waiver participants' understanding of the services they should be receiving, and delivery of those services by providers.

Provider Access and Network Adequacy: 42 C.F.R § 441.730; 42 C.F.R. § 438.206

CMS requires States to ensure that each MCO maintains a network of providers that is sufficient to provide adequate and timely access to Medicaid services covered under the contract between the State and the MCO.

- The State's approach to tracking, monitoring, and overseeing provider network adequacy and access to care for KanCare consumers is limited. Given that KanCare serves nearly all Medicaid and CHIP beneficiaries, many of whom live in rural and frontier areas known to be underserved, CMS would expect a more robust oversight process including proactive monitoring of the number of providers enrolled in each MCO's network in regions with known access issues.
- MCOs must submit multiple reports to the State regarding access to care. However, there seemed to be little analysis or trending based on these reports at the State level. CMS staff have asked KDHE staff multiple times in late 2016 for the State's analysis of network adequacy. Although KDHE provided MCO provider network reports in response to these requests, CMS has never received any evidence of the State's analysis of network adequacy.
- The provider network data produced by the MCOs for much of 2015 contained incorrect and inconsistent information on provider specialties related to HCBS, making the data not useful for analyzing trends in HCBS provider network adequacy. The MCOs report that the data now being reported is correct, after a data clean-up effort in 2015.
- This lack of oversight and reliable data makes it difficult to determine whether sufficient providers are in the networks to serve enrolled beneficiaries, and to effectively track the impact of policy changes on provider networks.

Participant Protections: 42 C.F.R. § 438.100; 42 C.F.R. § 441.301(c)(2)(xiii); 42 C.F.R. § 441.302; 42 C.F.R. § 438.440

States are required to ensure that managed care enrollees are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. To obtain HCBS waivers, States must assure CMS that necessary safeguards are in place to protect the health and welfare of beneficiaries and that any modification to an individual's freedoms meets specific requirements and is fully documented in the person-centered service plan. Finally, CMS requires that States and MCOs provide information to enrollees regarding grievance, appeal, and fair hearing procedures and timeframes, using a State-developed or State-approved description.

- Staff of one MCO mistakenly believed that use of restrictive interventions were not permitted in any of Kansas' HCBS waivers. However, two waivers allow for restraints, restrictions, and/or seclusion in certain circumstances. Because this MCO did not correctly understand the rules around restrictive interventions, they did not document rights restrictions in the person-centered plans as required.

Therefore, safeguards to protect beneficiaries' health and welfare with regard to restrictive interventions could not be carried out.

- The State does not have a comprehensive system for reporting, tracking, and trending critical incidents. MCO staff indicated that there was no formal, systematic process for them to report critical incidents, or resolution of critical incidents, for their members to the State; rather, they would call or email State staff to report such incidents. Recent HCBS reports provided no data to demonstrate that unexpected deaths were investigated within required timeframes; that reviews of critical incidents were initiated and reviewed within required timeframes; that the use of restraints, seclusion, or other restrictive interventions followed procedures as specified in the approved waivers; or that the unauthorized use of restrictive interventions was detected. The lack of oversight of critical incidents increases the risk that waiver recipients' rights, health, and safety could be in jeopardy.
- During the implementation of KanCare, the State permitted the MCOs to develop their own provider appeal processes. However, according to Federal rules, those processes should have been developed or approved by the State. The State recognized that difficulties resulted from the differing provider appeal processes, and asked the MCOs to develop one standardized process in late 2015. Until the new process is implemented, the MCOs continue to use differing provider appeal processes, creating administrative burden for providers who must navigate three different appeal processes.

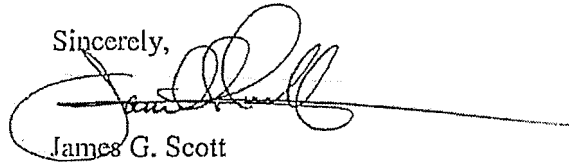
Due to the severe and pervasive nature of the on-site review findings and the resulting impacts this has on the beneficiaries and providers, CMS is requiring Kansas to develop a Corrective Action Plan (CAP) describing the actions it will take to correct the identified noncompliance. KDHE must submit the CAP to CMS as soon as possible, and no later than February 17, 2017. The CAP must include a detailed plan addressing each of the findings identified in the attached report. The CAP must also include the milestones and dates specifying when the actions will be fully implemented; their impact on the health, welfare, and safety of waiver participants; and a strategy for ongoing review and monitoring of the KanCare program. CMS expects the State agencies responsible for the KanCare program to implement the CAP in an expeditious and transparent manner which includes engaging stakeholders on changes and planned changes. Implementation of the CAP, once approved, will be monitored by CMS.

Federal regulations at 42 C.F.R. § 430.35 allow CMS to withhold Federal Financial Participation payments from a State after a finding that the State's plan fails to comply, or to substantially comply, with the provisions of section 1902 of the Act. In the event that Kansas fails to: 1) submit the required CAP in the indicated timeframe, 2) submit a CAP that is sufficient to mitigate the issues, or 3) implement and monitor the CAP as approved by CMS, we plan to initiate formal compliance action as described in 42 C.F.R. § 430.35, including financial sanctions of State administrative funds. Kansas' execution of the CAP and measured performance improvement will ultimately inform the extension of Kansas' 1115 demonstration program, as well as future managed care contracts and 1915(c) waiver actions. KDHE is entitled to appeal the findings of noncompliance pursuant to the procedures set forth at 42 C.F.R. Part 430, Subpart D.

Page 6 – Dr. Susan Mosier

If you have any questions regarding this matter, please contact me at (816) 426-5925 or via email at James.Scott1@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink, appearing to read "James G. Scott", with a long horizontal line extending to the right.

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

cc:

Vikki Wachino
Mike Nardone
Eliot Fishman
Mike Randol
Christiane Swartz
Tim Keck
Codi Thumess
Brandt Hahn
Brad Ridley
Susan Fout