

**Report of the
Robert G. (Bob) Bethell Joint Committee on
Home and Community Based Services and
KanCare Oversight
to the
2020 Kansas Legislature**

CHAIRPERSON: Senator Gene Suellentrop

VICE-CHAIRPERSON: Representative Brenda Landwehr

RANKING MINORITY MEMBER: Senator Barbara Bollier

OTHER MEMBERS: Senators Ed Berger, Bud Estes, and Mary Pilcher-Cook; and Representatives Barbara Ballard, John Barker, Will Carpenter, Susan Concannon, and Monica Murnan

CHARGE

KSA 2019 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 any proceeds resulting from the successful transfer be applied to the system for 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 program (KanCare), 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.

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

ANNUAL REPORT

Conclusions and Recommendations

The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services (HCBS) and KanCare Oversight adopts the following recommendations:

- The managed care organizations (MCOs) develop and define a more comprehensive pediatric case management infrastructure;
- The Legislature allocate funding to the Kansas Department for Aging and Disability Services (KDADS) to address the current crisis in accessing psychiatric residential treatment facility services by providing a tiered approach to psychiatric services for children in all Kansas counties;
- A stakeholder group be formed to review alternative or creative ways for applied behavior analysis licensure to address the state's lack of capacity or lack of network adequacy for applied behavioral supports for children currently qualifying under KanCare;
- A KanCare outreach worker be located at each Kansas Department for Children and Families site to assist with the completion of KanCare applications and answering questions regarding KanCare eligibility and the eligibility process;
- KDADS report back to the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight how the state administers its Olmstead plan;
- The Kansas Department of Health and Environment (KDHE) continue to monitor the MCOs and verify claims are paid in a timely manner;
- KDHE and KDADS continue to address reducing the use of anti-psychotic drugs on older adults in long-term care settings;
- KDADS work to provide more surveyors and ensure effective training of survey staff to identify and cite potential abuse and neglect in long-term care settings;
- KDADS continue to develop a multi-year plan to eliminate the Intellectual/Developmental Disability HCBS waiver waiting list;
- The Protected Income Limit be permanently changed in statute at 150 percent of Supplemental Security Income;

- KDHE and KDADS research innovative ways to address the issue of the temporary staffing agencies and their negative impact on rural long-term facilities;
- The Legislature consider an increase in nursing reimbursements for the Technology Assisted HCBS waiver to a level closer to the national average; and
- KDHE, KDADS, and the MCOs look at how to streamline the credentialing process for KanCare providers.

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 2019 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 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. The Committee is not to exceed six total meetings in a calendar year; however, additional meetings may be held at the call of the chairperson when urgent circumstances 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 2019 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 through 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 2019 Session (February 15 and April 29) and twice for two days each during the 2019 Interim (August 26 and 27 and November 18 and 19). In accordance with its statutory charge, the Committee's work focused on the specific topics described in the following sections.

KDHE KanCare Overview and Update

KDHE staff provided information on the following topics at the Committee meetings: KanCare program updates, including the continuity of care policy, a corrective action plan (CAP) update; the MCOs' financial status, the status of the State's Section 1115 waiver application, KanCare utilization and cost comparison data, provider panels, OneCare Kansas, and KanCare data and analytics; updates on the Medicaid eligibility application backlog, the status of the KanCare Clearinghouse contract, and the KDHE Clearinghouse staffing; stakeholder and legislative engagement efforts; and a KanCare Executive Summary containing data on eligibility and expenditures, financial summaries, the provider network, medical loss ratio, claims, value-added and in-lieu-of services, and grievances, appeals, and fair hearings received and resolved.

At the February 15 meeting, the then-Acting Secretary of Health and Environment outlined his priorities for KDHE as follows: improve Medicaid eligibility processes, provide focused care for individuals who are elderly and disabled, provide extensive training for staff to mitigate turnover,

address key vacancies in leadership, and reduce HCBS waiting lists.

At the April 29 meeting, the Secretary of Health and Environment stated recommendations had been made to the Governor to fill key leadership vacancies in the Health Care Finance Division, specifically the Deputy Secretary of Health Care Finance and the Medicaid Director, and the appointments would be announced soon. The position of Medicaid Medical Director, then held by the Secretary, would be filled in the near future. The Secretary noted areas of accountability to be addressed. He stated, where practical, KDHE would consider the decentralization of services to bring more personalized attention to clients. He added KDHE would pursue innovation to achieve access to primary health care services in all communities. The Secretary stated KDHE would continue to work with the Kansas Health Institute on improving available data, with the goal of turning data into programs and solutions for improved health care services.

The KDHE leadership team was introduced at the August 27 meeting, noting the agency has a 10.0 percent staff vacancy rate within the Division of Health Care Finance. Efforts being made to improve KanCare customer services and reduce response times to fewer than 45 days per application were discussed. A KDHE representative discussed how helpful the protected income level (PIL) increase had been to KanCare members. An explanation was provided of the process used to monitor the MCOs to ensure quality performance through a third-party contract and a variety of other quality review measures. MCOs are rewarded for plan performance, and 3 percent is withheld from capitation payment if the Pay for Performance quality measures are not met at the end of the year. With regard to the increase in PIL being authorized only for one year through a legislative proviso, a KDHE representative noted the PIL change could be made in administrative rules and regulations, which would require less legislative intervention.

At the November 18-19 meeting, the Secretary of Health and Environment outlined the agency's efforts to respond to provider complaints and improve the claims management process. The Secretary stated the Centers for Medicare and Medicaid Services (CMS) had approved raising

the PIL from \$747 per month to \$1,177 per month. The change would exclude 92 percent of those formerly required to pay the client obligation.

KanCare Contracts with MCOs

At the February 15 meeting, a KDHE representative stated KDHE implemented the new KanCare contracts with Aetna Better Health of Kansas (Aetna), Sunflower Health Plan (Sunflower), and UnitedHealthcare Community Plan (United) on January 1, 2019. KDHE conducted extensive readiness reviews of the MCOs to ensure the organizations were prepared to begin the new contracts. KDHE also provided educational sessions in six locations across the state for providers and beneficiaries to explain changes in the new contracts.

A KDHE representative reported KDHE was working with the MCOs to transition from Amerigroup to Aetna in order to facilitate beneficiary changes.

Continuity of care policy; contracting providers. At the February 15 meeting, a KDHE representative stated KDHE implemented its Continuity of Care Policy to ensure a smooth transition as members move between MCOs and to ensure a smooth transition for on-boarding Aetna and off-boarding Amerigroup. A KDHE representative stated, per the policy, any beneficiary who moved to a different MCO was guaranteed no changes to the beneficiary's plan-of-care or prior authorizations for 90 days. Additionally, the policy provided that a contracting Medicaid provider with an existing MCO be treated as a contracting provider by a new MCO for the first 90 days of the plan year to allow additional time for a new MCO to enter into contracts with such provider. This allowed the provider to receive 100.0 percent of the Medicaid fee-for-service (FFS) rate or the contracted rate for the 90 days and not be treated as an out-of-network provider eligible for only 90.0 percent of the Medicaid FFS rate. The 90-day timeline was the minimum time frame and could be extended as needed should, for example, the MCO need additional time to review and assess the plans-of-care and prior authorizations or to finalize contracts with providers.

A KDHE representative stated at the April 29 meeting that Aetna extended the Continuity of Care Policy timeline beyond the required 90 days.

Aetna Corrective Action Plan

A KDHE representative reviewed the notification on July 24, 2019, of Aetna's non-compliance with the terms and conditions of the KanCare request for proposal (RFP). Aetna's CAP submitted on August 6, 2019, was rejected; KDHE had anticipated a more detailed CAP. A request was made for a review of the MCO contract with Aetna regarding the steps KDHE could take regarding assignment of new members during a period of noncompliance and a date certain on when KDHE would take such action.

At the November 18-19 meeting, a KDHE representative noted the updated CAP from Aetna had been accepted and stated KDHE continued to enforce high standards while Aetna worked to achieve full compliance.

MCO Financial Update

A KDHE representative reviewed MCO financial data (profit and loss) for calendar year (CY) 2018 at the April 29 meeting. The KDHE representative commented the MCOs' total gross profits of 1.2 percent based on the CY 2018 National Association of Insurance Commissioners filings were in line with program targets, and plans showed an increase in net profit of \$1.9 million when comparing the fourth quarter of 2017 to the fourth quarter of 2018, an increase that was driven by a \$500.0 million increase in revenues. The process used to determine MCO profit using medical loss ratio was explained.

At the August 27 meeting, Committee members discussed the profit/loss ratio of the MCOs. A KDHE representative noted, system-wide, the capitation-rate profit stays about 1.0 percent. Typically, a first-year MCO receives a profit of approximately negative 4.0 percent, as was the case with Aetna. A review of the MCOs' profit/loss ratio was provided at the November 18-19 meeting.

Section 1115 Waiver Extension

At the February 15 meeting, a KDHE representative stated the Section 1115 Waiver was

approved in December 2018, and the extension is valid until December 31, 2023. KDHE is required to provide quarterly and annual reports to CMS. A KDHE representative updated the Committee on the Section 1115 Waiver at the April 29 meeting, noting the MCOs had completed the first quarter of operations. The KDHE representative stated KDHE conducted training for all staff on the standard terms and conditions (STCs), the rules under which the Medicaid program operated. Responsibilities for each STC were assigned to a staff member to maintain compliance with STC requirements and to avoid financial penalties of up to \$5.0 million in lost Federal Financial Participation funding that may be imposed on new waivers for non-compliance with STCs. The first quarterly report to CMS was due within 60 days after the end of the first quarter.

Health Care Access Improvement Panel Provider Assessment

As directed by the 2019 Legislature, KDHE reported it was increasing the Health Care Access Improvement Panel provider assessment from 1.83 percent of net inpatient revenues to 3.0 percent of net inpatient and outpatient revenues and changing the base year to 2016. A KDHE representative noted this increase in program funds will require amending the Section 1115 waiver to account for new moneys in the waiver's budget neutrality. CMS approval of the Section 1115 waiver amendment is required to implement the Health Care Access Improvement Program (HCAIP) provider assessment changes. Target implementation is July 1, 2020, pending CMS approval. The KDHE representative indicated the HCAIP increase to 3.0 percent was modest and only half of the 6.0 percent cap.

OneCare Kansas

A KDHE representative described the OneCare Kansas program at the February 15 meeting. OneCare Kansas is a wrap-around "whole-person" approach based on a medical home. The program is a redesigned health homes program for a limited population to stay within the eligible funding and with the only changes to the previous program being an opt-in provision and a limit on the MCOs administrative cost of 10.0 percent. It includes six core services, in addition to the standard Medicaid services. A funding cap of

\$2.5 million from the State General Fund (SGF) was established.

A KDHE representative noted OneCare Kansas was scheduled to begin in state fiscal year (FY) 2019; however, KDHE may request an extension to a start date of January 1, 2020, because additional time may be needed to finalize the program design in order to submit a Medicaid state plan amendment specific to the program design. When the program design is finalized, a Medicaid state plan amendment was to be submitted to CMS.

A KDHE representative provided an update of OneCare Kansas at the April 29 meeting, stating the program would coordinate physical and behavioral health care with long-term services and supports (LTSS) for persons with chronic conditions. [Note: The scheduled implementation date remained as January 1, 2020.] The KDHE representative stated KDHE has a contract with the University of Kansas to assist in defining the population and narrowing the criteria for those eligible to participate in OneCare Kansas. The reimbursement rate, scope, or identification of the target populations had not been established but would be provided to the Committee when available. A newsletter was created to keep interested groups apprised of the program's progress.

At the August 27 meeting, a representative of KDHE stated the new OneCare Kansas initiative was completing data analysis to identify the target population, after which capitation rates would be developed for the MCOs; the target implementation date was set for January 1, 2020.

At the November 18-19 meeting, a KDHE representative noted the target population had been determined for the OneCare Kansas: children and adults with asthma who are at risk for a variety of other chronic conditions, including diabetes, chronic obstructive pulmonary disease, mental illness, and substance use disorder; and those with severe bipolar disorder or paranoid schizophrenia. It was determined this combination offers the highest savings and the best health outcome improvements. By setting the implementation date as April 1, 2020, to coincide with the beginning of a quarter, KDHE would receive enhanced federal match funds for the entire quarter. The enhanced

federal match will continue for eight quarters, after which cost savings should fill the federal funding gap. Outcomes data should be available in three quarters, when additional data would be available.

KanCare Utilization and Data Analytics

A KDHE representative outlined the three pillars of KDHE's strategic vision related to data: analytical, which was reviewed during the February 15 Committee meeting; operational; and public health, to be reviewed at a future meeting. The operational pillar focuses on measuring effectiveness and impacts of policy changes. KDHE is working to improve standardized reporting on Medicaid data. It was reported the MCOs submit reports to KDHE, and KDHE wanted to receive the raw data behind the reports from the MCOs so KDHE can make better comparisons across MCOs.

An update on the timeline for the Kansas Eligibility and Enforcement System (KEES) upgrade, for which approval for state funding was received earlier in 2019, was provided at the April 29 meeting. The Finance and Analytics Director stated the upgrade is a joint venture by KDHE and the Department for Children and Families (DCF). CMS approved the advance planning document on April 1, 2019, to use the funds for the KEES upgrade at an enhanced federal match rate. The anticipated launch date for the ten-month upgrade process would be mid to late March 2020.

A variety of performance metrics were provided at the November 18-19 meeting. The data indicated approximately 13 million claims had been processed during the first three quarters of CY 2019.

KanCare Meaningful Measures Collaborative (KMMC). At the February 15 meeting, a representative of the Kansas Pharmacists Association reported on the progress of the KMMC, which is an initiative to increase the validity and usefulness of data broadly available about KanCare, as well as to establish a transparent process that “transcends administrations and individuals.” The representative reported the 75 KMMC members had been divided into 3 groups: the Executive Committee, the Stakeholder Working Group, and the Data Resources Working Group. He identified

the function of each group, stating their work would result in precise, clear decisions. A representative of the Kansas Association of Centers for Independent Living and chairperson of the Stakeholders Working Group outlined the work of the group: determine the data measures, establish criteria, and provide a consumer engagement pilot. A KDADS representative reported data mapping and a methodology template would enable the Data Resources Working Group to finalize analytics and develop a work plan for the remaining measures.

A first report from the KMMC was provided at the August 26 Committee meeting. KMMC members were building consensus through stakeholder and consumer engagement and initiating a pilot to establish priorities. In addition to reports to the Committee with supporting data, KMMC reports were also to be provided to the Senate Committee on Ways and Means, House Committee on Appropriations, House and Senate budget committees, House Committee on Health and Human Services, and Senate Committee on Public Health and Welfare. A representative of the KMMC Stakeholder Working Group discussed the stakeholder engagement and consumer engagement pilot projects and the process undertaken to identify areas of interest and key themes. The priorities measures pilot group reviewed the state-reported measures and selected three pilot measures for which additional clarity was needed: health care utilization, eligibility determination, and network adequacy. Those were being winnowed into groups or themes in order to establish priorities. The next steps would involve identifying and assessing potential meaningful measures from the Stakeholders Working Group priority areas, developing a data map, and prioritizing the selected meaningful measures. The KMMC Data Resource Working Group was compiling the stakeholder information and developing measurable data. The Secretary of Health and Environment noted quality information is needed to design the KanCare plan properly. A written-only update on the KMMC's progress was provided at the November 18-19 meeting.

KanCare Clearinghouse

Medicaid Eligibility Backlog

A KDHE representative provided specific details at the February 15 meeting on KDHE's

efforts to reduce the backlog on the applications for family medical assistance (Family Medical), elderly and disabled medical programs (Elderly and Disabled), and long-term care (LTC Medical) medical services. She stated the application backlog at that time was 235, broken down as follows: 78 applications for Elderly and Disabled, 115 applications for LTC Medical, and 42 applications for Family Medical.

At the April 29 meeting, a KDHE representative reviewed the status of Medicaid eligibility applications. She identified applications over the 45-day limit for processing applications (Family Medical, 36 applications, or less than 1.0 percent; Elderly and Disabled, 86 applications, or 3.0 percent; and LTC Medical, 93 applications, or 9.0 percent) and pending applications waiting for additional information (Family Medical, 150 applications, or 3.0 percent; Elderly and Disabled, 314 applications, or 12.0 percent; and LTC Medical, 153 applications, or 14.0 percent). The KDHE representative noted a downward trend on the number of applications exceeding 45 days and explained staff are receiving more extensive training.

With regard to the number of Elderly and Disabled applications not processed within 45 days, a KDHE representative indicated a notice of non-compliance was sent to Maximus, the eligibility processing contractor, on January 30, 2018, requiring improvement in the numbers by June or July 2018. The KDHE representative noted improvement as a result of measures undertaken by Maximus. She stated, although the number of Elderly and Disabled applications not processed within 45 days was down, the goal of bringing the LTC Medical applications in-house to KDHE was to enhance customer service. The enhanced customer service would include calling individuals to obtain outstanding information rather than denying applications for failure to provide the requested information.

A KDHE representative indicated the base contract with Maximus was amended to address the cost of additional staff to handle applications not processed within 45 days. In addressing the possibility of additional cost to the State if Maximus were again to fall behind in processing applications and need additional staffing, the KDHE representative stated Maximus could

always request additional staff, but KDHE would determine whether the staffing increase was necessary to keep the application and review process moving appropriately.

At the November 18-19 meeting, a KDHE representative reviewed the Medicaid eligibility processing status for applications over 45 days for applications in active and pending status and for the following eligibility categories: Family Medical, Elderly and Disabled, and LTC Medical. She noted during the open enrollment period for the Patient Protection and Affordable Care Act Health Insurance Marketplace (Marketplace) (November 1 through December 14), the agency would receive between 10,000 and 15,000 applications for individuals potentially eligible for Medicaid or CHIP. The KDHE representative provided a staffing and workload update for the transition of KanCare Clearinghouse services to KDHE staff and noted KDHE's efforts to communicate with stakeholders and providers through the KanCare newsletters, rapid response calls, monthly meetings with nursing facility associations, and surveys of providers and eligibility staff. The KDHE representative noted the positive feedback from stakeholders and the improvement in customer service. With the exception of a few nursing facilities that were to transition in December 2019, Frail Elderly (FE) and LTC Medical applications were being processed by KDHE staff. The KDHE representative stated the Upload Document Portal, used by all nursing facilities to submit information that automatically links to an applicant's case, had been helpful in reducing the backlog in application processing. Maximus still answers calls at the call center, but any questions regarding eligibility, including spend downs, are routed to KDHE staff.

With regard to the eligibility process for restrictive settings, the interface with Appriss provides daily information on who enters and exits county jails. All eligibility processes for restrictive settings are handled by a dedicated unit of State staff who work to reinstate KanCare benefits for individuals upon release from these settings. The state prison information is provided by the Kansas Department of Corrections, not Appriss.

Oversight of Maximus

Employee training. A KDHE representative addressed issues with Maximus at the February 15

meeting. Complaints about the timeliness of eligibility determinations had been received by KDHE from providers and beneficiaries over the past several years. KDHE moved responsibility for employee training and quality of work from Maximus to KDHE, effective January 1, 2019. The new approach provides training to certify the qualification of each employee. A review coach is also available to employees.

Maximus contract and RFP. At the February 15 meeting, a KDHE representative stated Maximus' contract had been temporarily extended so KDHE could incrementally bring the application process for Elderly and Disabled and LTC Medical services in house. She stated KDHE would issue a RFP for processing the Family Medical applications.

KDHE's plan, pending negotiations on the contract extension options with Maximus, was to transition away from contractor Maximus for the processing of applications for Elderly and Disabled and LTC Medical services by January 1, 2020, with Maximus continuing to process Family Medical applications through June 30, 2020.

A Committee member requested KDHE provide information about how the move of application processing for LTC Medical and Elderly and Disabled services to KDHE would affect any existing KDHE contracts and the number of employees and the space needed to accomplish the change.

In compliance with a budget bill proviso requiring an update on the KanCare Clearinghouse contract be provided to the Committee should an agreement be reached with Maximus, a KDHE representative reported at the April 29 meeting that an agreement was reached with Maximus to extend the contract for 18 months, through the end of CY 2020. The contract terms would allow KDHE to assume the processing of the more complex applications for Elderly and Disabled and LTC Medical services by January 1, 2020. In CY 2020, KDHE would also continue the training and quality responsibilities assumed in CY 2019. Maximus would continue processing all applications through CY 2019, with one caveat, and continue processing applications for Family Medical services for CY 2020. In preparation for the assumption of responsibilities on January 1,

2020, KDHE would process applications that come through the Marketplace and some cost-of-living adjustments for Elderly and Disabled and LTC Medical services during the last half of CY 2019. Later in CY 2019, KDHE would issue a RFP for a new contract to begin January 1, 2021, to process only the Family Medical applications; KDHE would continue to process the Elderly and Disabled and LTC Medical applications. The KDHE representative noted KDHE would expect bids from three, four, or five Maximus-type providers for the new KanCare Clearinghouse contract to begin in CY 2021. The bidding process would be open to all entities, including Maximus.

A KDHE representative stated at the April 29 meeting KDHE would request Committee support for the restoration of the \$5.0 million funding removed from the KDHE budget, pending review following release of revised human services caseload estimates, in order to assist in the negotiating of the Maximus contract. The representative noted restoration of the funding would allow the contract to be funded in full and enable a smooth transition in KDHE application processing responsibilities beginning January 1, 2020. Without the \$5.0 million, KDHE would have to find a way to self-fund the Maximus operation or the in-house operation.

At the April 29 meeting, a KDHE representative stated a contract was signed to lease a building at Forbes Field in Topeka near the KanCare Clearinghouse location to house the KDHE staff who will be processing the Elderly and Disabled and LTC Medical applications. KDHE reviewed available state offices, but none were found to meet the program's needs. The proximity of the contracted building to the KanCare Clearinghouse location would facilitate on-site training, quality operations, and face-to-face interactions between KanCare Clearinghouse and KDHE staff.

A KDHE representative stated at the August 27 meeting that Maximus would continue processing Family Medical applications through all of CY 2020, but KDHE released a RFP for a new contract to handle the Family Medical portion to begin at the end of the Maximus contract. The RFP was sent to six prospective contractors.

An update was provided at the November 18-19 meeting regarding the Maximus contract, the transition to KDHE, and the RFP for Family Medical applications processing. Maximus will continue processing Family Medical applications through the end of the contract period, December 31, 2020. The transition of responsibility for Elderly and Disabled and LTC Medical application processing to KDHE staff will be completed one month ahead of schedule (December 1, 2019). KDHE was reviewing the bids received on a RFP for a new contract for processing of Family Medical effective January 1, 2021. The Medicare Savings Program (MSP) is completely handled by KDHE staff, and pending MSP applications that Maximus began are all in-house and caught up. Some Maximus staff were hired by KDHE.

Medicaid Expansion

The Secretary of Health and Environment stated at the April 29 meeting KDHE would be prepared to meet the required timeline for implementation should the Legislature approve Medicaid expansion. In considering the State's move toward Medicaid expansion, the Secretary addressed the cost of "churning"—members moving back and forth between eligibility and non-eligibility—at the November 18-19 meeting. If there are work requirements, drug testing, premiums, or lockouts connected with Medicaid expansion, the Secretary stated, churning will be much more prevalent. If that happens, KDHE will need more staff to deal with it.

A KDHE representative provided a cost estimate for 2019 HB 2066 (Medicaid expansion) based on certain assumptions, including a straight Medicaid expansion. With offsets, the effective match rate for Kansas would be approximately 97 percent federal/3 percent state. Requests were made for multiple follow-up information to be provided at the next meeting.

Asset Recoupment

The State can use a complex process to attach assets, such as a house, after a Medicaid recipient (and, if applicable, the spouse) dies. These assets produce \$10 million to \$12 million annually, according to the KDHE General Counsel at the February 15 meeting.

Telemedicine

At the February 15 meeting, a KDHE representative addressed the Kansas Telemedicine Act enacted in 2018 (Senate Sub. for HB 2028). He stated the bill purported to allow coverage for thousands more types of telemedicine services than are allowed by CMS. Effective January 1, 2019, KDHE implemented a policy to cover the specific services allowed by CMS. KDHE was working with advocate groups to identify additional services that may be covered if the State were to contribute a portion of the funding. A Committee member requested KDHE contact Kansas' federal delegation for help at the federal level to expand the scope of Medicaid coverage of telemedicine. The Committee member mentioned other states were also having this issue.

KDADS Overview and Update

At the February 15 meeting, the then-Acting Secretary for Aging and Disability Services noted her previous experience with the forerunner to KanCare and the Kansas Department of Social and Rehabilitation Services. The Secretary stated she planned to enhance collaboration across agencies as Secretary for Aging and Disability Services.

A KDADS representative stated KDADS was hopeful a HCBS provider rate increase scheduled to go into effect April 1, 2019, and increased training would help address the provider shortage. The KDADS representative noted the CAP initiated by CMS and explained both KDADS and KDHE had completed the operational items of the CAP. After eight quarters of monitoring for compliance, the plan will be considered successful.

At the August 27 meeting, the Secretary for Aging and Disability Services highlighted several changes being made: slowing down the HCBS waiver renewals to allow for additional input from stakeholders, placing eligibility workers at local DCF offices to assist with eligibility applications, and creating a State Hospital Commission. The Secretary introduced a KanCare Strategic Planning Document to illustrate the agency's long-term goals (2020-2024) to modernize the continuum of care through technology, collaboration, and innovation; revitalize self-direction offerings and support self-direction and self-determination through programming and policies; improve

consumer-driven decision making and program design; improve workforce development across the state; increase meaningful and community-integrated employment opportunities for populations served by KDADS; implement comprehensive approaches to link target populations to accessible community-based housing; adopt a strategic prevention framework; and have movement toward data-informed continuous quality improvement. A request was made for KDADS agency staffing plans and the required funding for staffing the agency.

At the November 18-19 meeting, the Secretary for Aging and Disability Services provided the KDADS Strategic Planning Document and provided an update on multiple topics within the agency's purview. The Secretary reported work with the Kansas Department of Labor to identify direct care workers and provisional licensed staff workforce issues and determine the possible use of individuals outside the health care labor market who might be able to fill openings if additional pay and training was provided. The Secretary referenced two workforce programs in place to fill critical health positions: the Kansas Health Professions Opportunity Project and the State Board of Nursing-approved licensed mental health technician training program in place at Osawatomie State Hospital (OSH), which received approval in September 2019 to expand to Larned State Hospital (LSH) as a pilot project.

The Secretary noted no systemic issue was found on the issue of individuals with disabilities losing access or receiving a reduction in food assistance benefits, and the issue has been resolved. The Secretary also provided an update on the Family First Prevention Services Act and the process for the accreditation of beds in a qualified residential treatment program. The Secretary noted the KDADS budget needs to address staffing and program services within the agency.

Meetings Facilitated by Wichita State University

At the April 29 meeting, a KDADS representative highlighted a plan to change the focus of monthly meetings facilitated by Wichita State University to begin brainstorming ways to address social determinants, such as housing, transportation, caregiver support, and nutrition. The goal will be to discuss with MCOs how

quality of life, medical, and behavioral health needs can best be met for the HCBS waiver population and to provide this information to the Legislature.

Cost of Specialized Medical Care Rate Increase

A KDADS representative stated the estimated cost of increasing the specialized medical care (SMC) rate for Intellectual and Developmental Disability (I/DD) and Technology Assisted (TA) HCBS waivers to \$47 per hour would be \$9.6 million from the SGF (\$2.3 million for the I/DD waiver and \$7.3 million for the TA waiver) based on current utilization and potential increases in utilization at current caseload.

PACE

A KDADS representative commented at the February 15 meeting on the PACE initiative designed for comprehensive care for elderly people. The KDADS representative stated the PACE program serves about 555 individuals in 23 counties per year. Because of legislation enacted in 2018, funds were available for administrative case management to expand PACE and improve other HCBS waiver programs. KDADS issued a RFP for a contract that would expand these services by Spring 2019. The RFP bids were submitted in January 2019, and KDADS was in the process of reviewing the technical proposals. Administrative case management would be providing assistance with completing Medicaid applications to individuals who were functionally eligible for PACE or for Traumatic Brain Injury (TBI), FE, or Physical Disability (PD) waivers. The KDADS representative noted PACE operates separately and apart from the MCOs.

When a Medicaid-eligible person comes to an Aging and Disability Resource Center (ADRC), the individual is given the option of PACE if all the criteria are met. PACE participants are subject to a PIL. A KDADS representative stated there are plans to expand PACE into additional rural areas as interest increases. KDADS also planned to issue a RFP for ADRC contracts. The then-existing ADRC contract ended in March 2019.

At the April 29 meeting, the Midland Care Connection Chief Executive Officer provided detailed information regarding PACE services and

noted the program is more individualized and less expensive than Medicaid and Medicare.

Quarterly HCBS Report

Written testimony was regularly provided by KDADS on the average monthly caseloads for HCBS waivers, Money Follows the Person, LTC facilities, and state institutions; average census for state institutions and LTC facilities; and average length of stay for psychiatric residential treatment facilities (PRTFs). A KDADS representative provided information on savings on transfers to HCBS waivers and the HCBS Savings Fund balance. (See Appendix A for the 2019 report.)

At the April 29 meeting, a KDADS representative provided the I/DD waiver participation by MCOs.

HCBS Waiver Renewals

At the February 15 meeting, a KDADS representative listed four HCBS waivers—I/DD, TBI, FE, and PD—scheduled to be renewed in 2019. The KDADS representative provided an update at the April 29 meeting, stating I/DD and TBI draft waiver renewals had been submitted to CMS for review. Initial submissions for the FE and PD waiver renewals would be due to CMS by July 1, 2019. Information was provided on the public comment period and stakeholder engagement for the FE and PD waiver renewals and efforts made to improve public access and involvement in the stakeholder engagement process, including live streaming, recording, and captioning of the sessions.

At the November 18-19 Committee meeting, a KDADS representative provided information on the 13 waiver renewal listening sessions KDADS initiated over the prior three months for stakeholder input on the FE, I/DD, and PD waivers that were up for renewal. A list of common themes from the listening sessions was included in the testimony; services, transportation, employment, and workforce issues were the top themes. She noted the stakeholder concerns expressed indicated the agency had more work to do on the renewals. With regard to the 12-hour limit for specialized medical care for individuals on the TA and I/DD waivers, amending the waivers to make the 12-hour cap a soft cap or eliminating the cap altogether was at the top of the KDADS list.

KDADS initiated TA, Brain Injury (BI), and Autism work groups to identify barriers and services that need enhancing. A Serious Emotional Disturbance (SED) waiver work group was also being initiated.

BI Waiver Delays

A KDADS representative updated Committee members at the August 26-27 meeting regarding the BI waiver implementation. Prompted by a 2018 legislative proviso, the TBI waiver was transitioned into the BI waiver. The steps necessary to accomplish the transition and the plans for including children in the BI waiver were explained. New functional assessment tools for adults with TBI and acquired BI had to be created and tested, with approval by CMS for the BI waiver for the adult population occurring August 5, 2019. KDHE could not apply for the inclusion of children on the BI waiver until a functional assessment tool for BI youth was developed and tested, and training on the tool was provided. These requirements had an October 28, 2019, target completion date, at which time KDHE would be able to apply to CMS for a waiver amendment to add the youth population to the BI waiver. The completed BI waiver would add individuals from birth to age 16.

An amendment to expand the BI waiver to include youth ages birth through 15 years was submitted by KDHE to CMS for review and approval on November 6, 2019. A KDADS representative noted development of the functional assessment tool for youth ages 4 through 15 years was completed and trainings for assessors continue. For children from birth through three years of age, the waiver would be accessed through a physician order.

Assessment and Person-Centered Service Plan Development for HCBS Waiver Services and CMS Conflict of Interest Ruling

At the August 26-27 meeting, a KDADS representative explained the CMS Conflict of Interest Final Rule (42 CFR 441.301(c)(1)(vi)): an individual may not receive both direct waiver services and case management from the same organization. KDADS was implementing a Statewide Transition Plan to comply with the Final Rule by making adjustments to the delivery system.

Final Settings Rule

At the August 26-27 meeting, a KDADS representative briefly discussed the status of the Statewide Transition Plan for the final HCBS Settings Rule (42 CFR 441.301(c)(4)-(5)), which received initial approval from CMS on May 21, 2019. KDADS launched Community Connections as it began the process of coming into compliance with the rule. Site-specific assessments were expected to begin in September 2019 with providers. The representative stated a Community Connections website would be launched containing tools and resources for use by providers and interested parties to obtain information and guidance through the process.

HCBS Waiting Lists Update

HCBS waiting list updates were provided at each Committee meeting. At the February 15 meeting, a KDADS representative stated there was an eight-year waiting list for services on the I/DD waiver and a high response rate when services were presented to an individual on the list. The KDADS representative reported at the February 15 meeting the HCBS I/DD waiting list had 3,911 individuals and 9,076 individuals were receiving services, and 1,527 individuals were on the HCBS PD waiting list and 5,800 individuals were receiving services.

At the April 29 meeting, a KDADS representative stated the maximum number of individuals that could be served through available appropriations were being served. She noted, without additional appropriations, individuals would come off the waiting list only if someone else no longer received services or if a crisis or exception request was made for services. Due to CMS regulations, the waiting list could not be reduced by offering limited services to more individuals. The KDADS representative confirmed KDADS could evaluate a crisis exception request made by a community developmental disability organization (CDDO) and make a determination to prioritize the individual for services regardless of where the individual is on the waiting list.

At the August 26-27 meeting, a KDADS representative explained the federal parameters of the HCBS waiver programs to allow each state flexibility to tailor services to the needs of the individuals, so long as the costs of the services are

less than the costs for parallel services in an institution. The KDADS representative provided updated waiting list numbers. At the November 18-19 meeting, a KDADS representative reported as of November 7, 2019, the HCBS I/DD waiting list had 4,021 individuals and 9,019 individuals were receiving services, and 1,576 individuals were on the HCBS PD waiting list and 5,872 individuals were receiving services. As of the November meeting date, in CY 2019, 257 offers for HCBS services were made to individuals on the I/DD waiting list and 1,394 offers were made to individuals on the PD waiting list.

A KDADS representative provided an estimate of the cost to eliminate the I/DD and PD waiting lists at the November 18-19 meeting. Based on current costs and utilization, it would cost \$78,585,260 from the SGF to eliminate the I/DD waiting list and \$414,046,420 from the SGF to eliminate the PD waiting list. The estimates do not include potential costs to increase the network of available providers. Being on the waiting list does not mean the individual is not receiving services and stated some CDDOs and I/DD systems provide some services that are not dependent on HCBS waivers. To obtain a breakdown of the needs of the waiting list population, KDADS would have to engage all partners at the CDDOs to obtain the information. Although not impossible, the process would be difficult and take some time and would require additional funding for the CDDOs to accomplish.

It was reported at the November 18-19 meeting that KDADS and KDHE were collaborating on a Disability and Behavioral Health Employment Support pilot program to address the waiting lists by helping 500 members obtain and maintain employment. The pilot would be voluntary for eligible KanCare members.

Louisiana system to eliminate I/DD waiting list. In response to a request made at the August 26-27 meeting, a KDADS representative described how Louisiana eliminated its I/DD waiting list as of April 2018. She noted Louisiana has five I/DD waiver programs (three for children, one for adults, and one for adults and children) with a different menu of services for each program; Kansas has one program and one menu of services. The Louisiana system allows a member to receive only the services needed, but Kansas is

required to provide all individuals on the I/DD waiting list the full menu of services, if needed. Kansas would need to apply to CMS to establish a tiered waiver program. Potential concerns were expressed about making the tiered model fit Kansas because Kansas has more progressive services and stakeholders would have reservations with Louisiana's approach.

Oversight of LTC Facilities

Use of Anti-psychotic Drugs in Nursing Facilities

At the February 15 meeting, a KDADS representative reported the agency is making progress in reducing the use of anti-psychotic drugs in nursing facilities. Kansas ranks 42nd in the nation in the use of anti-psychotic drugs in nursing facilities, and KDADS expects to continue to show improvement. At the April 29, August 26-27, and November 18-19 meetings, a KDADS representative announced progress in reducing the use of anti-psychotic drugs in nursing homes.

Nursing Facility Surveys

A KDADS representative stated at the February 15 meeting that the salary increase for LTC certified surveyors has increased the number of staff; therefore, the time gap between surveys has been reduced. It has also increased the number of complaints investigated, lowered the vacancy rate, and increased the total number of criminal record background checks. A minor complaint follow-up is conducted with a phone call; more serious issues always result in an on-site visit. Additional outside contractors conducted nursing facility surveys only temporarily, and none would be used going forward.

At the April 29 meeting, a KDADS representative stated, as of the meeting date, no nursing facility surveys were more than 12 months past due, and surveys were occurring every 11 to 11.5 months in compliance with the CMS requirements. The salary increase for certified registered nurse surveyors made possible through budget enhancements in FY 2018 had improved retention and recruitment. Changes in CMS and state processes and available online training had allowed the certification of surveyors to often take 6 months instead of 12 months. The number of vacant health facility surveyor positions as of the

meeting date was 10 full-time equivalent (FTE). The KDADS representative noted changes in CMS interpretations had significantly reduced immediate jeopardy citations.

A KDADS representative stated nursing facility survey data did not include data on assisted living facilities. A different survey process based only on state regulations and not federal regulation was required for assisted living facilities. At the time of the April 29 meeting, 10 assisted living facilities had surveys completed more than 16 months previously and the surveys of 50 facilities had been completed between 12 to 15 months previously. There were 7 surveyors to complete surveys in 450 assisted living facilities across the state, 7 being the total number of surveyors for assisted living facilities funded, and additional funding would be required to improve the frequency of the assisted living surveys.

At the August 26-27 meeting, a KDADS representative noted the LTC facility survey backlog had been reduced, and all state-only surveyor positions had been filled, but 17 certified health facilities surveyor positions remained open, most of which were in the northeast region of the state where the wages paid are not competitive with those paid by hospitals and other providers.

Adult Care Home Receiverships

A KDADS representative provided an update at the February 15 meeting on the receivership actions taken to address Skyline, Pinnacle, Fort Scott, Great Bend, Franklin Peabody, and Westview of Derby nursing facility bankruptcies. She explained KSA 2019 Supp. 39-954 allows the Secretary for Aging and Disability Services to file an application for an order appointing the Secretary as the receiver to operate an adult care home when certain conditions occur. The Secretary for Aging and Disability Services, using resources from the Civil Monetary Penalty (CMP) Fund, had stabilized the operation of each home; none had closed. She reported the Secretary for Aging and Disability Services was working to find new operators and to date had returned \$2.8 million to the CMP Fund.

At the April 29 meeting, a KDADS representative reviewed the status of LTC facilities' receiverships. From March 2018 until

that meeting, KDADS was involved in 22 receivership actions and two of those receiverships had been transferred to private receivership. Of the \$4.6 million borrowed from the CMP Fund for the Skyline receivership, \$4.0 million had been returned to the State. The Secretary for Aging and Disability Services continued to meet with landlords and prospective buyers to discuss efforts to locate new operators for the 15 Skyline facilities. The remainder of the receiverships were being marketed for sale or efforts are being made to locate new operators. The KDADS representative expressed gratitude for 2019 SB 15 that amended receivership statutes, including increasing the financial scrutiny of new applicants and, in the case of change of ownership, defining "insolvent," and allowing a receiver immediate access to accounts receivable instead of state CMP funds. These changes would obviate facility mismanagement, provide more oversight, and ensure similar receivership situations do not recur. The KDADS representative noted only one facility under receivership was closed; due to the low number of residents, it made more sense to move the individuals. The process of choosing a new operator was explained.

At the August 26-27 meeting, a KDADS representative reported a potential operator had been identified for the 15 Skyline facilities and \$4.6 million had been returned to the CMP Fund. The KDADS representative noted the Pinnacle facilities were being marketed for sale.

At the November 18-19 meeting, a KDADS representative noted the 15 Skyline facilities were sold October 1, 2019; the two Pinnacle facilities were being marketed and one sold November 1, 2019; and the Secretary for Aging and Disability Services been appointed receiver for the Great Bend and Peabody facilities. The CMP Fund balance as of October 31, 2019, was \$5,039,123. No facilities were closed in the most recent year, avoiding transfer trauma for residents.

Behavioral Health

Psychiatric Residential Treatment Facilities

A KDADS representative, commenting on behavioral health, reported at the February 15 meeting on the requirement of "medical necessity" before admitting youth to a PRTF. The agency employed the Kansas Foundation for Medical Care

(KFMC) to audit the finding of medical necessity; KFMC determined 100 percent of the medical necessity placements were appropriate.

At the April 29 meeting, a KDADS representative stated the number of children on the PRTF waiting list remained steady, with a total of 150 children on the MCOs' waiting lists. He also noted an interagency collaboration among DCF, KDHE, and the Kansas Department of Corrections about the Children's System of Care for Behavioral Health Services based on 2018 House Sub. for SB 179 to seek proposals through a competitive process for juvenile crisis intervention centers.

A KDADS representative reported at the August 26-27 meeting on the recommendations in a study by the National Association of State Mental Health Program Directors Research Institute regarding the use of PRTFs in Kansas to evaluate wrap-around services for those on the PRTF waiting list and to identify barriers to reimbursement for services. The KDADS representative reported 155 individuals on the PRTF waiting list, 49 of whom were in foster care. Additional relief for the waiting list was anticipated with the launch of qualified residential treatment facilities by DCF in October 2019. There are 318 beds statewide for PRTF individuals. The study was initiated to determine how to better address the waiting list. A workforce shortage also affects the waiting list. Each MCO determines PRTF medical necessity. At the November 18-19 meeting, a KDADS representative reported a PRTF waiting list of 159 individuals as of November 4, 2019, 35 of whom were in foster care. Information was provided regarding the redesignation of a hospital in Hays that provided PRTF services. The children's acute care services were moved to Wichita, which resulted in no children's psychiatric hospital in the western side of the state. The hospital in Hays was expected to open 38 new PRTF beds by the end of CY 2019. An update is to be provided at the next meeting on what is being done to address PRTF capacity and the need for children's psychiatric hospitals in western Kansas.

State Hospitals

At the February 15 meeting, a KDADS representative briefed the Committee on the state hospitals. At each meeting, KDADS staff

referenced data regarding weekly vacancy rates and overtime trends at OSH and LSH.

At the April 29 meeting, a KDADS representative announced the Commissions on Aging and Community Based Services would combine into one, and a new State Hospitals Commission would be established. The new initiative would allow the four state hospital superintendents to begin collaborating regularly to develop a more coordinated plan for the state hospitals and to allow input from the Behavioral Health Commission.

At the August 26-27 meeting, a KDADS representative highlighted three notable services at the state hospitals: the mobile on-site forensic evaluations at LSH, the exceptional adaptive and assistive technology offered at Kansas Neurological Institute (KNI), and the outreach services provided at Parsons State Hospital and Training Center (PSHTC).

At the November 18-19 meeting, comprehensive statistics regarding the state hospitals' vacancy rates and overtime trends were provided.

Osawatomie State Hospital

A KDADS representative stated at the April 29 meeting that the waiting list at OSH had no more than one or two individuals in the previous several weeks and had consistently been below the 20 or so individuals at the first of the year. The KDADS representative credited new triage efforts to ensure care was provided with the reduction in the waiting list and expressed hope the efforts would lead to eventually lifting the OSH moratorium. The KDADS representative stated no plan for OSH had been formulated to rebuild or remodel; a plan would be proposed for the 2020 Legislative Session. At the August 26-27 meeting, a KDADS representative discussed a proposed plan to be completed and presented to the Legislature by January 2020 to lift the moratorium of admissions at OSH. At the November 18-19 meeting, a KDADS representative stated eight step-down beds, used as a last step before transitioning into the community, would be added at OSH between November 1, 2019, and December 31, 2019, increasing total bed capacity from 166 to 174 using existing funding; the additional eight beds

are not Medicaid beds. Additionally, OSH has been chosen as a Trauma-Informed Care Pilot site.

Larned State Hospital

At the November 18-19 meeting, a KDADS representative noted LSH was continuing to reach out to Kansas counties, courts, and licensed clinical staff to complete forensic evaluations in secured confinement settings where the individual is located.

Parsons State Hospital and Treatment Center

A KDADS representative reported at the November 18-19 meeting PSHTC was moving forward with an equine support program to promote emotional well-being and recreational benefits for residents.

Kansas Neurological Institute

At the November 18-19 Committee meeting, a KDADS representative stated KNI is finding creative solutions to its nursing shortage by using special training for certified medication aides to qualify for licensed practical nurse duties.

Kansas Personal Care Directory

A Committee member introduced the rollout of the Kansas Personal Care Directory, which is an online matching service registry to enable providers and families to more easily obtain direct care services. Appreciation was expressed for the investment by community partners in a solution to the direct care workforce shortage. Plans for expansion of the program include collaboration with multiple entities to provide training and college credit to expand the direct care workforce. The three MCOs provided funding to keep the website going and to kick start the project.

Medicaid Inspector General

At the February 15 meeting, the Medicaid Inspector General provided a history of the function of an inspector general and explained the nonpartisan office would evaluate the efficiency and transparency of the KanCare MCOs. Two or three staff would serve with her.

The Medicaid Inspector General reported at the April 29 meeting the office receives an average of one or two fraud reports each day, primarily

alleging eligibility fraud. She noted her office was not assigned prosecutorial duties; evidence of fraud is turned over to the pertinent agencies that can prosecute. A review of reports of suspected fraud sent to the KDHE Medicaid Inspector General e-mail address after the Medicaid Inspector General function was transferred from KDHE to the Office of the Attorney General and, pending her confirmation, was under way to determine whether any substantiated reports of fraud were inadvertently missed during the transition between agencies. An eligibility fraud investigation related to misreporting income, marriage, and dependents that was referred by DCF was near completion. Two audits were being prepared by the Office of Medicaid Inspector General (OMIG) to examine provider credentialing processes and pharmacy contract requirements.

The new Assistant Medicaid Inspector General was introduced at the August 26 meeting and the first OIMG report was presented. The unmonitored KDHE e-mail address contained 42 complaints alleging eligibility fraud, which were transferred to the OMIG and investigated. All such e-mails are now automatically transferred to the OMIG.

The Medicaid Inspector General noted, as of the November 18-19 meeting date, the OMIG had received about 100 complaints regarding fraud, waste, abuse, and illegal acts. Each complaint is screened for jurisdiction; those outside the authority of the Medicaid Inspector General are forwarded to the appropriate agencies.

The Medicaid Inspector General provided an update on OMIG Report No. 19-01. The OMIG forwarded 26 complaints alleging a beneficiary was or beneficiaries were not eligible for Medicaid benefits to the KanCare Clearinghouse for follow-up. As of the November 18-19 meeting date, 25 of the complaints had been resolved, and one remained pending.

The Medicaid Inspector General presented two recent OMIG reports at the November 18-19 meeting. The first, Report No. 20-01, was a performance audit of KDHE examining whether the agency has efficient systems in place to timely and appropriately discontinue Medicaid eligibility when a Medicaid beneficiary enters a state prison,

and whether the State made capitation payments on behalf of inmates during FY 2019 and, if made, whether the payments were recouped upon termination of eligibility. The scope of the audit included all admissions to the Topeka Correctional Facility in FY 2019. The Medicaid Inspector General reported 77 percent of the cases were handled appropriately; 23 percent were not and resulted in \$184,997.43 in monthly KanCare capitation payments. She noted, in August 2019, KDHE implemented a new data exchange with Appriss to provide real-time notification when an adult Medicaid beneficiary enters a jail or detention center, a service that should help obviate most overpayments. She presented four findings, which included the previous Kansas Department of Corrections-Medicaid data-matching process resulted in errors, and KDHE's policy of requiring at least ten days' written notice prior to terminating eligibility for inmates is inconsistent with federal and state regulations and results in extra months of eligibility for incarcerated beneficiaries who are categorically ineligible for Medicaid. KDHE agreed with five recommendations and was taking an additional recommendation under consideration. The state contract with the MCOs allow the State to recover monthly capitation payments if a beneficiary is subsequently determined to be ineligible. A review of CMS reports for other states from past years indicates such overpayments are not unique to Kansas. The OMIG has not tracked the money recouped or saved through its investigate efforts. To the Medicaid Inspector General's knowledge, the approximately \$185,000 in capitation payments made by the State for inmates had not been collected.

The Medicaid Inspector General stated an exception to the ten-day notice requirement prior to termination of Medicaid eligibility in state and federal law applies when a beneficiary is incarcerated; the exception requires notice be given no later than the effective date of termination. KDHE Division of Health Care Finance Policy No. 2019-08-01 requires more notice to inmates before terminating eligibility than required under state and federal regulations, resulting in extra months of eligibility for incarcerated beneficiaries.

The second recent OMIG report presented, Report No. 20-02, addressed cases of Medicaid

fraud. The report provided Kansas' current options for dealing with suspected eligibility fraud. The Medicaid Inspector General, while acknowledging there is no uniform standard by which to determine fraud, said the primary determinant is that the act is intentional. She commented on applicable criminal statutes and administrative options and offered some practical considerations that could impact how a Medicaid eligibility fraud case is handled. Among the considerations noted were KDHE's limited investigative resources. KDHE does not have a Fraud Investigations Unit and does not have authority to prosecute cases of eligibility fraud. KDHE would be required to refer a potential fraud case to local prosecutors, who have discretion on whether to pursue a criminal case for eligibility fraud. The Medicaid Inspector General commented, in terms of time and cost, the most efficient means for terminating Medicaid eligibility is through the redetermination process. With regard to collecting from individuals for eligibility fraud, in most cases it is counterproductive to try to recoup payments because Medicaid participants lack liquid assets.

KanCare Ombudsman

The KanCare Ombudsman provided updates at each of the Committee meetings on the services provided by the Office of the KanCare Ombudsman.

At the February 15 meeting, the KanCare Ombudsman highlighted portions of the 2018 KanCare Ombudsman's annual report. She noted the KanCare Ombudsman's Office (three full-time employees, one part-time employee, and volunteers) received an average of 1,000 calls per quarter. Adding a toll-free number increased capacity without increasing the budget, and staff resolve nearly all calls within two days. She identified trends over the previous four years: transition to another MCO spiked concerns, grievances and appeals remained steady, and spend-down issues significantly increased. She added an appendix to the annual report.

The KanCare Ombudsman reported the number of contacts with the KanCare Ombudsman's Office for the fourth quarter of 2018 was 1,124. The number of 2019 first-quarter contacts was 1,060 and the number during the second quarter was 1,097. In the third quarter of

2019, there were 1,071 contacts. New data were available in the third quarter of 2019 in the form of the tracking of five new program types, seven new Medicaid Issues, and six new “Other Issues”; the division of the “Issues Category” into three sections (Medicaid Issues, HCBS/Long Term Services, and Other Issues); and the tracking of cases by priority codes (HCBS, LTC, urgent medical needs, urgent, and life threatening).

At the August 26 meeting, the KanCare Ombudsman noted two satellite offices were staffed by volunteers Monday through Friday. At the November 18-19 meeting, the KanCare Ombudsman noted the KanCare Ombudsman Office had mailed 24,000 brochures advertising its services and had contracted with Language Lines through KDADS to accommodate the multiple language needs of individuals who contact the office.

Presentations on KanCare from Individuals, Providers, and Organizations

Written and oral testimony was presented at each quarterly Committee meeting. Some individuals and organizations stated appreciation for the increased dental benefits offered by the three MCOs and the addition of \$3.0 million, including \$1.3 million from the SGF, reflected in the proposed FY 2020 budget to increase the Medicaid dental reimbursement rate; the Governor’s \$8.1 million allocation to bring KanCare eligibility processing back under KDHE; the additional funds to reduce the gap in nursing facility inspections; the enacted PIL increase; the HCBS provider rate increase; the change in definition for the TBI waiver (now the BI waiver) to include children and adults with acquired brain injury; United’s and Sunflower’s cooperation in accepting single-case agreements for potential assisted living residents; the innovative Employment First legislation; the State’s leadership in dealing with LTC facilities that are emerging from bankruptcy; and KDADS support for state institutions.

Concerns and suggested solutions presented by conferees are summarized in the following paragraphs.

Concerns

Adult Disabled Child Criteria. The Adult Disabled Child Criteria form discriminates against adoptive children, making it difficult to qualify for adult Medicaid services.

KanCare Clearinghouse. Failure of the KanCare Clearinghouse to provide an effective Medicaid eligibility process; costs to nursing facility providers caused by delays in determining Medicaid eligibility; eligibility processing delays have caused senior citizens to be denied access to services and even lose services they have; and given problems experienced by individuals with I/DD with the KanCare Clearinghouse, the Clearinghouse may not be the best model to handle Medicaid applications.

Eligibility application process and backlog. The eligibility application process is more complex and creates untenable delays, financially crippling many service providers; there are long delays in LTC application approvals.

Supplemental Nutrition Assistance Program benefits. Individuals with I/DD continue to lose food assistance.

Targeted case management (TCM). There is difficulty in receiving TCM prior authorization for additional TCM units.

Claims. Coding mistakes at the KanCare Clearinghouse continue to cause unnecessary delays in claims payments. Delays in reimbursements and low rates limit providers in offering high-quality health care.

Amerigroup. Concerns were expressed about the nonpayment of claims by former MCO Amerigroup, with outstanding Amerigroup claims totaling \$14.3 million in charges reported by one organization.

Aetna. Problems with this MCO include unpaid claims and delays in receipt of signed provider contracts, billing and credentialing problems for providers, financial hardships and lack of consumer choice created when Aetna refused to accept single-case agreements for potential assisted living facility residents, incorrectly processed claims erratic overpayments

and underpayments, and continued uncertainty regarding provider contracting status.

Client obligation errors. Coding errors in the client obligation process cause significant financial problems for clients.

Assisted living and nursing facility surveys. Deficiencies in some of the surveys do not show up on reports. Surveys for assisted living facilities are not completed as timely as those for nursing facilities.

Elder care reimbursement rates. Reimbursement rates for elder care are inadequate.

Nursing facility staffing. Nursing facilities cannot compete with local providers, resulting in staff leaving for higher paying jobs in the community; funding barriers and workforce shortages make staffing a constant struggle, which is further compounded by temporary staffing agencies recruiting staff away from one provider and selling them back to the provider at inflated fees; and the increased use of staffing agencies is a trend that not only increases staffing costs, but requires facility staff to spend additional time training the temporary staff to reduce liability risk because the staffing agencies do not provide properly trained individuals.

Medicaid institutional bias. Medicaid is biased toward institutional care; barriers that increase the bias against community supports and services include care coordinators failing to offer community services as an option, long waiting lists for community-based services, and failing to address direct-care staff recruitment; and the current attitudes toward the I/DD population seems to be biased against institutional care, although CMS requirements, Medicaid law, and *Olmstead* state both community and institutional services must be offered. [Note: The U.S. Supreme Court ruling in *Olmstead v. L.C. (Olmstead)* requires states to eliminate unnecessary segregation of persons with disabilities and ensure persons with disabilities receive services in the most integrated setting appropriate to their needs.]

Receiverships. Having 22 nursing homes in receivership does not bode well for the future of LTC.

Anti-psychotic drugs. Kansas continues to rank among the worst of states for inappropriate use of anti-psychotic drugs to control dementia patients.

HCBS. Concerns about HCBS include the growing length of the waiting list for I/DD individuals; individuals in crisis are often ignored while on the I/DD waiver; the HCBS workforce crisis of low wages has resulted in a shortage of caregivers and the need for training for caregivers, which have limited individuals with disabilities from obtaining in-home personal care services; and chronic underfunding has not kept the pace with the rising costs for serving individuals with I/DD, with underfunding resulting in an increase in the HCBS waiting lists and a decrease in workforce capacity that has exacerbated this population's diverse and complex service needs.

Direct care workforce. The challenge in employing personal care attendants has been augmented by the background check requirements; the shortage in the direct care workforce has reached crisis levels; and diminished workforce capacity creates systemic barriers and gaps for providing effective services for diagnosis, behavioral health treatment, medication management, and crisis support.

Specialized medical care. Concerns related to specialized medical care include SMC T1000 rates are inadequate; providers struggle to hire nursing staff to cover the authorized hours of SMC for the TA and I/DD waiver participants, especially in rural Kansas areas; there is a shortage of highly skilled private duty nurses to help support families of children who are tracheostomy dependent in the home and increased reimbursement rates for specialized staff caring for these medically complex children are needed; increased training and pay for SMC professionals are needed; the cost of hospital care for these individuals far exceeds the cost for comparable care in the home; and the SMC services limit of 12 hours per day needs to be increased to 24 hours per day.

PIL. The \$747 per month PIL places burdens on Medicaid recipients and discourages seeking gainful employment; and the \$747 PIL does not offer sufficient income for living expenses for those under the HCBS waivers. [Note: CMS had

approved raising the PIL from \$747 per month to \$1,177 per month.]

TBI waiver. “Critical need” language in a recent rule change denies those on the TBI waiver access to assistive technology, and there is a need for increased Medicaid reimbursement rates for TBI services.

Waiver transition delays. Individuals dropped from the SED waiver will not receive services through the I/DD waiver for years, unless it is through a crisis process that is difficult to obtain.

Financial management services. Financial management services providers are receiving monthly fees when no billing services are provided.

Fingerprint-based background check. The requirement for fingerprint-based background checks for personal care attendants adds a complexity to self-directed care because the State determines whether an applicant can be hired, increasing the difficulty in finding care attendants given the workforce shortage.

MCOs. Work with the MCOs is complex and often counterproductive; MCO care coordinators often tell a client who is self-directing who the healthcare provider must be, rather than providing the client a list of providers from which to choose; there is a conflict of interest when care coordinators, who work for an MCO, determine medically necessary services; and there is increased denial of necessary services and the increased number of appeals needed to acquire medical supplies and services for medically fragile children and individuals with I/DD and mental health needs.

“Just cause” for changing MCOs. The rights of individuals sometimes take second place to the interests of the MCOs with regard to what constitutes “just cause” for individuals to change their choice of MCOs.

CDDOs. CDDOs need oversight.

Pregnancy and birth service delivery. KanCare needs an effective pregnancy and birth

service delivery, with provider payments connected to value-based outcomes, rather than FFS.

Recommended Solutions

Conferees offered comments on potential solutions in the categories below.

Eligibility. Change in vendor to give providers better tools by restructuring the eligibility process; move LTC application processing back to KDHE; continued reporting by KDHE to the Committee on progress and performance as elderly and disabled eligibility processing transitions back to KDHE.

Funding. Continue financing the Kansas Personal Care Directory and launch a coordinated effort to recruit direct care professionals; appropriate funds in the KDADS budget to eliminate the client obligation for persons on the HCBS waivers and within PACE; ensure an appropriate level of funding that supports capacity in response to demand for services; and funds allocated to the Promoting Excellent Alternatives in Kansas program be redirected to quality measures and rate increases.

I/DD. Need for system-wide competency-based training that would result in the ability to implement cross-system crisis prevention and intervention plans for the individuals served and wider access to emergency services for behavioral health for those under the I/DD waiver; the need to develop models for intensive community support as an alternative to incarceration for Kansans with I/DD accused of a crime or discharged from a state psychiatric hospital following a civil commitment; re-prioritize funding to change the current disincentives for employing I/DD individuals so service providers are empowered to enable disabled citizens’ access to competitive, integrated employment; rebalance the day services rate provided in a congregate setting and the supported-employment rate for I/DD individuals to incentivize competitive, integrated employment; increase funding for benefit planners who help individuals with disabilities understand the impact of working on their benefits; prioritize a pilot program to offer comprehensive services to enable I/DD individuals to gain and maintain employment; a multi-year plan be created to

address the lack of I/DD provider capacity and eliminate the I/DD waiting list; and build increased capacity for behavioral health services in the I/DD waiver system.

MCOs. Pay claims in a timely manner; credential providers in a timely manner.

PIL. Enactment of one of the bills considered by the Kansas Legislature (2019 SB 10 and HB 2205) to address the burden created by the PIL; approval of pending legislation raising the PIL to \$1,177; continuation of the one-time increase in the PIL enacted during the 2019 Legislative Session, with an increase to 300 percent of Supplemental Security Income (SSI); and make the PIL increase permanent.

Service delivery. Reinstating local case management; separate case management from care coordination; use of telehealth and remote monitoring can lower costs and improve outcomes across the healthcare system and lower percentages of those needing to move to nursing facilities; the State develop specialized service-delivery programs modeled after evidence-based practices in other states; Medicaid savings would be realized by using midwives for most births; increased reimbursement rates for dental providers; and reintroduction of legislation to create dental therapists in Kansas.

Service settings. Community service care coordination; re-commitment to the Money Follows the Person program; create a special Money Follows the Person program targeted to nursing facilities for mental health; creating an Olmstead plan to help reduce the I/DD waiting list; develop a comprehensive Olmstead plan; focus on community services rather than institutional solutions; ensure an individual's personal choices are integrated with LTSS; use value-added or in-lieu-of services or benefits to improve beneficiaries' lives relevant to their needs; need to increase funding and capacity for community-based services to address the increased desire of individuals over age 65 to remain in their homes; and address the decline in self-direction.

Workforce. Increase the wages and benefits for the HCBS workforce; a 15 percent to 20 percent reimbursement rate increase would assist in resolving the nursing facility staffing problem;

request a line-item budget increase to raise SMC T1000 provider reimbursement rates for in-home care for TA and I/DD waiver individuals to \$47 per hour (another suggested \$48 per hour); allocate funding for additional KDADS in-house staff to coordinate, facilitate, and oversee stakeholder engagement; move the KanCare Ombudsman program outside state government; need oversight of temporary staffing agencies to hold them accountable; and need additional funding to increase the number of surveyors providing oversight for LTC facilities and the number of Adult Protective Services (APS) workers to timely address complaints of abuse, neglect, and exploitation made to the APS.

Other solutions. Expand Medicaid, which would benefit most personal care attendants and other direct service and support workers; enactment of 2019 HB 2404 to create the Kansas Senior Services Task Force; changes in the Adult Disabled Child Criteria rule and form; use of a screening tool implemented in Louisiana to eliminate the HCBS waiting lists; eliminate waiting lists for individuals needing LTSS to fully participate in their communities; use a single form of utilization review to identify service or payment outliers; pursue active engagement with older adults and members of the Area Agencies on Aging for a broad perspective on LTSS; increase the SMC services limit of 12 hours per day to 24 hours; and the need to implement a policy to address chemical restraint of and misuse of anti-psychotic drugs on older adults in all LTC settings.

Conferees

Private citizens and representatives of the following organizations and providers testified or provided written-only testimony before the Committee: Advocacy Services of Western Kansas; Anthony Community Care Center; Ascension Via Christi Health; Association of Community Mental Health Centers of Kansas; Attica Long Term Care; Case Management Services, Inc.; Children's Alliance of Kansas; Children's Mercy Hospital; Community HealthCare System; Cornerstone Clinic; Country Club Estates; Craig HomeCare; Disability Rights Center of Kansas; InterHab; KanCare Advocates Network; Kansas Adult Care Executives Association; Kansas Advocates for Better Care; Kansas Association of Area Agencies on Aging and Disabilities; Kansas Association of Centers for

Independent Living; Kansas Council on Developmental Disabilities; Kansas Health Care Association and Kansas Center for Assisted Living; Kansas Home Care and Hospice Association; Kansas Hospital Association; Kansas Lifespan Respite Coalition; Kansas Pharmacists Association; LeadingAge Kansas; Lakeview Village; Locust Grove Village; Memorial Health System; Midland Care Connection; Minds Matter, LLC; New Birth Company; Oak Creek Senior Living; Options Services; Oral Health Kansas; Solomon Valley Manor; Southeast Kansas Independent Living Resource Center; Thrive Skilled Pediatric Care; TILRC; Villa St. Francis; and Windsor Place.

Responses from Agencies and MCOs

Representatives of KDHE, KDADS, and the MCOs provided responses to concerns expressed by individuals, stakeholders, and organizations at each Committee meeting. At the April 29 meeting, Committee staff were asked to prepare a form to follow up on issues presented to the Committee and the resolution of those concerns. The spreadsheet created to track outstanding issues was used by the state agencies and MCOs to address the concerns. At the August 26 meeting, KDHE, KDADS, and the MCOs addressed 58 unresolved issues from previous meetings that were included in the tracking spreadsheet. The list included recurring themes: the PIL, the HCBS waiting list, eligibility issues, self-direction, and mental-health questions. KDADS was asked to look into how Louisiana was able to reduce its I/DD waiting list and report back to the Committee. The Committee members also requested additional details on the cost of increasing the reimbursement rates for the SMC T1000 service code and the cost to Medicaid and HCBS if the State chooses to expand Medicaid. Representatives of KDHE addressed questions regarding unpaid claims from Amerigroup, stating providers need to go through the appeals process before KDHE can intervene.

At the November 18-19 meeting, a KDHE representative traced the responses of the agency regarding unresolved Medicaid issues (both general issues and specific issues) identified by conferees at the August 26-27 meeting. With regard to the PIL, KDHE understood the Legislature's intent was to make the increase in the PIL permanent and included the increase in the base budget for KDHE for FY 2021. KDHE is

proceeding through the rules and regulations process to revise the PIL to \$1,177 because the PIL is addressed in current rules and regulations and not in statute. Due to the fiscal implication of an increase in the PIL, KDHE would not make another change in the PIL without appropriation from the Legislature. KDHE agreed to recalculate and provide the Committee with the cost of increasing the PIL to 300 percent of the federal poverty level. KDHE also agreed to provide a broad-brush fiscal note on the cost of raising the SMC T1000 rates that would include the potential cost savings of the rate increase as compared to the cost of hospitalization.

A KDHE representative addressed questions regarding the differences between provider enrollment and credentialing. The Medicaid Program is responsible for the enrollment process, which requires a core set of information to be provided to each MCO. Credentialing looks at additional information, including the provider's professional history and malpractice history, to enroll with an MCO.

At the November 18-19 meeting, a KDADS representative provided responses to unresolved issues within KDADS's authority. The KDADS representative provided her recollection of the programs Kansas put in place instead of an Olmstead plan. She recalled state agency efforts to identify individuals in nursing facilities who would be good candidates for transferring to a community setting, including the Resident Status Review. KDADS planned to contract with an individual to document the history since 1999 of efforts instituted by the State, in lieu of an Olmstead plan, to provide services to assist with transitions into the community; however, the document might not be available until late January 2020.

In a similar manner, representatives of each of the MCOs provided responses to unresolved issues. All three MCOs addressed the approval of additional TCM units of I/DD services and noted each negotiates single case agreements at higher rates that depend on varying factors. With regard to the lack of a stable workforce and the inability to achieve a full care plan for individuals on the TA waiver, the Sunflower representative noted providers have indicated the State's low reimbursement rate for SMC is a factor in

maintaining a stable workforce. The rate increase being requested is in line with what neighboring states are paying.

Managed Care Organization Testimony

Representatives of all three MCOs provided testimony highlighting their programs at each Committee meeting.

UnitedHealthcare Community Plan of Kansas

At the February 15 meeting, a United representative noted it was operating under KanCare 2.0. A United representative commented on the 360 readiness documents reviewed by the State; noted the agency's 6.0 percent increase in membership, which included 6,648 new members transitioned from Amerigroup; and cited 27 issues that had been addressed and resolved. The value-added benefits included in the 2019 contract, such as dental benefits, assistance with transportation, and vision coverage, were identified.

At the April 29 meeting, a United representative explained United had created a team of 27 staff to assist all providers in navigating the healthcare system, including a team of business analysts who study claims data looking for trends in claim denials to determine whether an internal problem exists or whether additional provider training is needed to address the issue. The new system also included an Associate Director of KanCare Networks and Contracts responsible for looking at network adequacy, especially with regard to the needs of HCBS waiver individuals, and to identify critical areas and gaps in services. The Associate Director had been meeting with non-participating HCBS providers to identify and remove barriers and open the door for possible recruitment. Barriers to participation as a Medicaid provider were identified and solutions to address identified problems were presented.

At the August 26-27 meeting, a United representative noted United's value-added services to veterans. Some benefits were for a selected population and other benefits were provided for all members. The enhanced dental care included restorative services. New benefits for CY 2020 included a \$1,000 debit card to assist an individual transitioning from an institution to a community setting.

At the November 18-19 meeting, a United representative noted an infant's placement in a neonatal intensive care unit (NICU) automatically triggers case management. United is working on a predictive model to prevent the need for NICU care. Information was provided on the MCO's services with focus on three initiatives to support employment and education for Kansans. The United representative noted broadening the capacity for applied behavior analysis (ABA) service is challenging because private insurance pays more for those services than KanCare. An explanation of the provider credentialing process was provided.

Sunflower Health Plan

A Sunflower representative reviewed the agency's core beliefs at the February 15 meeting: focus on individuals, address whole-person health issues, and be actively involved in the communities. The representative described ways in which Sunflower has provided in-lieu-of services, value-added benefits, and sponsorship and grants beyond Medicaid, and he commented on a dual-special-needs Medicare Advantage plan recently initiated in selected counties. The Sunflower representative discussed mental health services and telemedicine that have involved 1,000 individuals not previously participating in health care. He also referenced a project to improve health in rural counties.

At the April 29 meeting, a Sunflower representative indicated the improvement in the satisfaction score on the third-party LTSS member satisfaction survey was linked to transition coordination and the creation of a LTSS Advisory Committee and a LTSS Quality Assurance Subcommittee to address the unique nature of the services needed by the population group. The Start Smart for Your Baby initiative that incorporates care management, care coordination, and disease management to improve the health of mothers and their newborns was explained. A Medicare Advantage Dual Special Needs Plan (overseen by CMS, KDHE, and the Kansas Insurance Department) to provide comprehensive benefits for a targeted population eligible for both Medicare and Medicaid was outlined. An intensive parent-training pilot program focused on foster care children that uses the Parent Management Training Oregon Model was implemented to address the needs of foster care children and avoid

PRTFs where possible. Four foster care children have been part of the pilot. The Provider Accessibility Initiative grant program was explained.

A Sunflower representative provided information on value-added benefits at the August 26-27 meeting. A leadership update was also provided for the positions of Chief Medical Director and Behavioral Health Medical Director. A new initiative, Project ECHO, was introduced as a means to offer increased effectiveness for providers through additional best-practices training and additional programs to treat opioid use. A partnership with the National Council for Independent Living to offer grants to improve accessibility and quality of life for disabled individuals was outlined. The Sunflower representative provided an update on members' experiences with PRTFs and noted reasons for denial of service.

Regarding value-added benefits, the Sunflower representative presented a tally to show how individual members were provided extra services and the total dollar value year-to-date of each. New benefits for 2019 were identified, such as the Parent Management Training–Oregon Model for foster parents (a \$24,000 value per child) and transportation services for employment, the frail elderly, and those who are physically disabled.

At the November 18-19 meeting, a Sunflower representative outlined the MCO's quarterly activities, provided an update on various educational services, provided information on nursing facility initiatives to reduce the use of anti-psychotic drugs, and noted the agency's use of a dedicated team focused on transitioning members from a nursing facility to the community. A total of 58 members have been approved and were on the PRTF waiting list as of November 15, 2019. Information was also provided on the conditions that automatically trigger the use of case management. Sunflower is working on ABA workforce capacity using a subject-matter expert to assist with contracting ABA providers.

Aetna Better Health of Kansas

At the February 15 meeting, an Aetna representative reviewed the history of Aetna

services and experience in 16 states with varied populations. The implementation review process, the network being built in the state, and the clinical and care coordination efforts were outlined. Committee members were assured Aetna would honor prior authorizations and had almost 14,000 contract providers in its managed care system. Details were provided on the agency's integrated system of care. The agency's approach is a non-medical model that partners with stakeholders to reach a spectrum of populations, including care for the elderly and individuals with disability. Value-added benefits for each of these disparate populations were identified and advantages associated with Aetna, such as budget stability, state investment, and resolving health disparities, were listed.

At the April 29 meeting, an Aetna representative reviewed Aetna's activities during the previous quarter to build its network of providers, including 173 of 193 hospitals in Kansas, federally qualified health centers, and community mental health centers, with the gap being specialty hospitals, and 15,580 contracted providers. Aetna was also paying claims from non-contracted providers at Medicaid rates through May 31, as provided by the Transition of Care policy. It was noted 96.7 percent of claims were paid within 30 days during the first quarter. The clinical and outreach metrics were outlined and Aetna's system of care was described. With regard to children on the PRTF waiting list, the following was noted: each of the 55 children on the PRTF waiting list is assigned a case manager to find needed services pending PRTF admission; the shortest wait for PRTF admission was 2 days and the longest was 51 days; members were waiting 21 days on average before placement in a PRTF and spend an average of 49 days in a PRTF; and 12 applicants were denied PRTF admission. Approximately 13,000 pending claims were noted. The issue with providers not receiving information on their credentialing because some welcome packets were sent to provider groups without a roster of those credentialed was being addressed. Aetna anticipated one-third of the member volume when the KanCare contract was bid, but its member makeup had not reached that level.

At the August 26-27 meeting, a representative of Aetna Medicaid noted Aetna's 430 employees in Kansas; by the end of 2019, Aetna would have

invested \$200,000 in Kansas community organizations. Two examples of Aetna's commitment to Kansas were noted: expanding a Dual-Eligible Special Needs Medicare Plan into 15 counties for 2020 and implementing a value-based contract with Children's Mercy Primary Care Network in 6 counties. The Aetna Medicaid representative sought to assure members Aetna would fulfill its responsibilities. A new Aetna leadership team was introduced. The team worked closely with KDHE to complete and execute the revised CAP that was submitted. The Aetna Medicaid representative referenced clinical and outreach metrics and service enhancements to illustrate Aetna's commitment to Kansas.

An Aetna representative outlined Aetna's actions in addressing deficiencies: rewriting management plans, streamlining the applications process and claims resolution, and contributing to critical state projects such as OneCare Kansas. Details regarding Aetna members' experiences with the PRTF waiting list and length of treatment were provided. Two innovations were presented: an intervention initiative called the Guardian Angel Program and an opioid prescriber education program. Aetna's value-added services were discussed, including vision and dental care, GED assistance, pre- and post-natal visits for pregnancies, and gift cards for children who complete healthy activities.

At the November 18-19 meeting, an Aetna Medicaid representative reported Aetna's top priority is to execute the CAP approved by KDHE; a list of the meetings was provided to illustrate the responsiveness of the MCO toward issue resolution. An Aetna representative further addressed the CAP remediation indicating the intent was to close out all areas of the CAP by the end of CY 2019. A Provider Advisory Council had been created to offer continuing accountability. Information was provided regarding Aetna's investment in community organizations and support for members moving into the community. Several person-centered programs were illustrated. The Aetna representative noted 50 members were on the PRTF waiting list as of October 31, 2019, and the average wait time on the list was 64 days. Information was provided on Aetna's value-added services. The Aetna representative noted a case manager is automatically assigned to a member being released from a hospital, and 120 hours of

respite care per year is provided for family caregivers. Aetna has the same issues with ABA services experienced by the other MCOs.

Human Services Consensus Caseload

Staff from the Division of the Budget, DCF, KDHE, KDADS, and KLRD met April 12, 2019, to revise the estimates on human services caseload expenditures for FY 2019 and FY 2020, and on October 24, 2019, to revise estimates on caseload expenditures for FY 2020 and to develop estimates for FY 2021. The estimates include expenditures for Temporary Assistance for Needy Families, the Reintegration/Foster Care contracts, and KanCare Regular Medical Assistance and KDADS Non-KanCare.

Spring Estimate

The combined estimate for FY 2019 and FY 2020 was an all funds decrease of \$10.4 million and a SGF decrease of \$8.0 million below the Governor's recommended budget. The FY 2019 revised estimate for all human service caseloads was \$3.5 billion from all funding sources, including \$1.3 billion from the SGF. The FY 2020 revised estimate was \$4.1 billion from all funding sources, including \$1.3 billion from the SGF.

Fall Estimate

The estimate for FY 2020 was a decrease of \$24.7 million from all funding sources and \$15.3 from the SGF when compared with the budget approved by the 2019 Legislature. The estimate for FY 2021 was an increase of \$482.7 million from all funds, and a SGF increase of \$80.5 million, from the FY 2020 revised estimate. For FY 2021, the estimate for all human service caseloads is \$4.2 billion from all funding sources, including \$1.4 billion from the SGF. The combined estimate for FY 2020 and FY 2021 was an all funds increase of \$458.0 million and a SGF increase of \$65.2 million.

CONCLUSIONS AND RECOMMENDATIONS

The Committee adopted the following recommendations:

- The MCOs develop and define a more comprehensive pediatric case management infrastructure;

- The Legislature allocate funding to KDADS to address the current crisis in accessing PRTF services by providing a tiered approach to psychiatric services for children in all Kansas counties;
- A stakeholder group be formed to review alternative or creative ways for ABA licensure to address the state's lack of capacity or lack of network adequacy for applied behavioral supports for children currently qualifying under KanCare;
- A KanCare outreach worker be located at each DCF site to assist with the completion of KanCare applications and answering questions regarding KanCare eligibility and the eligibility process;
- KDADS report back to the Committee on how the state administers its Olmstead plan;
- KDHE continue to monitor the MCOs and verify claims are paid in a timely manner;
- KDHE and KDADS continue to address reducing the use of anti-psychotic drugs on older adults in LTC settings;
- KDADS work to provide more surveyors and ensure effective training of survey staff to identify and cite potential abuse and neglect in long-term care settings;
- KDADS continue to develop a multi-year plan to eliminate the I/DD HCBS waiver waiting list;
- The PIL be permanently changed in statute at 150 percent of SSI;
- KDHE and KDADS research innovative ways to address the issue of the temporary staffing agencies and their negative impact on rural long-term facilities;
- The Legislature consider an increase in nursing reimbursements for the TA HCBS waiver to a level closer to the national average; and
- KDHE, KDADS, and the MCOs look at how to streamline the credentialing process for KanCare providers.

APPENDIX A

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

ANNUAL REPORT FOR THE 2019 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 2018 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 provides a summary of the number of individuals transferred from intellectual/developmental disability (I/DD) institutional settings into HCBS during state fiscal year (SFY) 2019, together with the number of individuals added to HCBS due to crisis or other eligible program movement during SFY 2019. The following abbreviations are used in the table:

- ICF/IDD — Intermediate Care Facility for Individuals with Developmental Disabilities
- MFP — Money Follows the Person program
- SFY — State Fiscal Year

FE / PD / TBI INSTITUTIONAL SETTINGS AND WAIVER SERVICES*	
Nursing Homes-Average Monthly Caseload SFY 2019	10,226
MFP FE: Number discharged into MFP program receiving FE Services: SFY 2019 Q1 and Q2	5
MFP PD: Number discharged into MFP program receiving PD Services: SFY 2019 Q1 and Q2	9
MFP TBI: Number discharged into MFP program receiving TBI Services: SFY 2019 Q1 and Q2	0
Head Injury Rehabilitation Facility	33
FE Waiver: Average Monthly Caseload SFY 2019	4,545
PD Waiver: Average Monthly Caseload SFY 2019	5,790
TBI Waiver: Average Monthly Caseload SFY 2019	390
*Monthly averages are based upon program eligibility.	
Sources: SFY 2019—Medicaid eligibility data as of January 15, 2020. The data include people coded as eligible for services or temporarily eligible.	

The following provides a summary of the number of individuals transferred from nursing facility institutional settings into HCBS during SFY 2019. The caseload has been decreasing in SFY 2019 as the MFP federal grant wound down. Kansas stopped MFP transitions in July 2017; individuals transitioning by that time had 365 days of MFP, after which they were transitioned to the appropriate HCBS program. 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 2019	10,226
MFP FE: Number discharged into MFP program receiving FE Services: SFY 2019 Q1 and Q2	5
MFP PD: Number discharged into MFP program receiving PD Services: SFY 2019 Q1 and Q2	9
MFP TBI: Number discharged into MFP program receiving TBI Services: SFY 2019 Q1 and Q2	0
Head Injury Rehabilitation Facility	33
FE Waiver: Average Monthly Caseload SFY 2019	4,545
PD Waiver: Average Monthly Caseload SFY 2019	5,790
TBI Waiver: Average Monthly Caseload SFY 2019	390
*Monthly averages are based upon program eligibility.	
Sources: SFY 2019—Medicaid eligibility data as of January 15, 2020. 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 2012 – 152

FY 2014 – 143
FY 2015 – 144
FY 2016 – 141
FY 2017 – 142
FY 2018 – 140
FY 2019 – 138

PARSONS STATE HOSPITAL AND TRAINING CENTER: AVERAGE DAILY CENSUS

FY 2013 – 176
FY 2014 – 174
FY 2015 – 173
FY 2016 – 163
FY 2017 – 160
FY 2018 – 160
FY 2019 – 162

PRIVATE ICFS/MR: MONTHLY AVERAGE*

FY 2013 – 155
FY 2014 – 143
FY 2015 – 140
FY 2016 – 137
FY 2017 – 133
FY 2018 – 137
FY 2019 – 119

NURSING FACILITIES: MONTHLY AVERAGE*

FY 2013 – 10,788
FY 2014 – 10,783
FY 2015 – 10,491
FY 2016 – 10,235
FY 2017 – 10,047
FY 2018 – 10,049
FY 2019 – 10,226

*Monthly averages are based upon Medicaid eligibility data.

Savings Resulting from the Transfer of Individuals to HCBS

The “savings” 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/IDD and an increase in the I/DD (HCBS I/DD) Waiver budget as a result of the transfers.

For nursing facilities and state ICFs/IDD, 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/IDD, 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, 2019, 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, 2019, was \$0.