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

CHAIRPERSON: Representative Daniel Hawkins

VICE-CHAIRPESON: Senator Michael O'Donnell

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

CHARGE

Oversee Long-Term Care Services and Medicaid Programs

KSA 2016 Supp. 39-7,160 directs the Committee to oversee long-term care services, including home and community based services (HCBS). The Committee is to oversee the savings resulting from the transfer of individuals from state or private institutions to HCBS and to ensure that any proceeds resulting from the successful transfer be applied to the provision of services for long-term care. Further, the Committee is to oversee the Children's Health Insurance Program, the Program for All-Inclusive Care for the Elderly, and the state Medicaid programs (KanCare), and to monitor and study the implementation and operations of these programs including, but not limited to, access to and quality of services provided and any financial information and budgetary issues.

January 2017

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

Annual Report

Conclusions and Recommendations

The Committee makes the following conclusions and recommendations:

Managed Care Organization (MCO) Operations

The Committee made the following recommendations regarding MCO operations:

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

- All MCOs shall work together to develop one standardized credentialing application. MCOs will respond to all submissions within 15 working days. MCOs should use a Council for Affordable Quality Healthcare portal for processing credentialing applications;

- MCOs standardize the under- and over-payment process; and

- Require notices of changes to a Plan of Care be provided to both individuals and providers.

Mental Health

The Committee made the following recommendation regarding mental health:

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

Medicaid Clearinghouse Operations

The Committee made the following recommendation regarding Clearinghouse operations:

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

Administration of KanCare

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

- Extend the current 1115 Waiver for one year and delay the request for proposal until the State clearly understands federal changes to the Affordable Care Act and Medicaid; and

- The Kansas Eligibility and Enforcement System (KEES) not be expanded to Phase 3 until there has been a clear demonstration of system functionality and operational integrity is determined and all problems have been resolved. Request the Legislative Division of Post Audit update the Information Technology audit on KEES published in December 2015 and report satisfactory performance before Phase 3 expansion can occur.

KanCare Reporting and Rates

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

- All uncompensated care numbers presented to the Committee be based on 100 percent of Medicare allowable; and

- The 4 percent Medicaid reimbursement cut and corresponding policies be reversed.

Proposed Legislation: None.

Background

The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services (HCBS) and KanCare Oversight operates pursuant to KSA 2016 Supp. 39-7,159, *et seq.* The previous Joint Committee on HCBS Oversight was created by the 2008 Legislature in House Sub. for SB 365. In HB 2025, the 2013 Legislature renamed and expanded the scope of the Joint Committee on HCBS Oversight to add the oversight of KanCare (the state's Medicaid managed care program). The Committee oversees long-term care services, including HCBS, which are to be provided through a comprehensive and coordinated system throughout the state. The system, in part, is designed to emphasize a delivery concept of self-direction, individual choice, services in home and community settings, and privacy. The Committee also oversees the Children's Health Insurance Program (CHIP), the Program for All-Inclusive Care for the Elderly (PACE), and the state Medicaid programs (KanCare).

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

As required by statute, at the beginning of each regular session, the Committee is to submit a written report to the President of the Senate, the Speaker of the House of Representatives, the House Committee on Health and Human Services, and the Senate Committee on Public Health and Welfare. The report is to include the number of individuals transferred from state or private institutions to HCBS, as certified by the Secretary for Aging and Disability Services, and the current balance in the HCBS Savings Fund. (See Addendum A for the 2016 Report.) The report also is to include information on the KanCare Program as follows:

- Quality of care and health outcomes of individuals receiving state Medicaid services under KanCare, as compared to outcomes from the provision of state Medicaid services prior to January 1, 2013;

- Integration and coordination of health care procedures for individuals receiving state Medicaid Services under KanCare;

- Availability of information to the public about the provision of state Medicaid services under KanCare, including access to health services, expenditures for health services, extent of consumer satisfaction with health services provided, and grievance procedures, including quantitative case data and summaries of case resolution by the KanCare Ombudsman;

- Provisions for community outreach and efforts to promote public understanding of KanCare;

- Comparison of caseload information for individuals receiving state Medicaid services prior to January 1, 2013, to the caseload information for individuals receiving state Medicaid services under KanCare after January 1, 2013;

- Comparison of the actual Medicaid costs expended in providing state Medicaid

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

- Comparison of the estimated costs expended in a managed care system of providing state Medicaid services before January 1, 2013, to the actual costs expended under KanCare after January 1, 2013; and

- All written testimony provided to the Committee regarding the impact of the provision of state Medicaid services under KanCare upon residents of adult care homes.

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

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

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

Committee Activities

The Committee met twice during the 2016 Session (January 22 and April 18) and twice for two days each during the interim (August 4 and 5 and November 17 and 18). The Committee members toured Family Service & Guidance Center, in Topeka, and the Medicaid Eligibility Clearinghouse on August 4. In accordance with its statutory charge, the Committee's work focused on the specific topics described in the following sections.

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

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

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

- Technical glitches when the Kansas Eligibility Enforcement System (KEES) was implemented in 2015;

- An underestimation by KDHE of how many people would apply for Medicaid as a result of the Affordable Care Act (ACA); and

- Transition of all Medicaid eligibility determination responsibilities from the Department for Children and Families (DCF) to KDHE in January 2016.

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

- Increased the number of staff to process the applications;

- Stopped reviewing renewal applications; and

- Worked to improve KEES.

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

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

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

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

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

CMS review. In October 2016, CMS conducted a review of KanCare focusing on 2013 to the present. An exit review between KDHE and CMS occurred on November 16, 2016. KDHE stated CMS will prepare a final report regarding the review. As of December 22, 2016, KDHE had not received the report from CMS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Representatives from the above organizations expressed concern about the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Fall estimates. At the November meeting, a KLRD staff member reviewed the estimates and provided the following information. The estimate for FY 2017 is an increase of $147.0 million from all funding sources and $1.9 million from the SGF as compared to the budget approved by the 2016 Legislature. (The approved amount reflects the Governor's May 2016 allotments.) The estimate for FY 2018 is a decrease of $120.4 million from all funding sources and an increase of $35.3 million from the SGF above the FY 2017 revised estimate. The estimate for FY 2019 is an increase of $48.4 million from all funding sources and $165.8 million from the SGF above the FY 2018 estimate. The combined estimate for FY 2017, FY 2018, and FY 2019 is an all funds increase of $75.0 million and an increase in SGF expenditures of $203.0 million.

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

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

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

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

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

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

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

Conclusions and Recommendations

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

The Committee made the following recommendations regarding MCO operations:

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

The Committee made the following recommendation regarding mental health:

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

The Committee made the following recommendation regarding Medicaid Clearinghouse operations:

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

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

- Extend the current 1115 Waiver for one year and delay the RFP until the State clearly understands federal changes to the ACA and Medicaid; and

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

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

- All uncompensated care numbers presented to the Committee be based on 100 percent of Medicare allowable; and

- The 4 percent Medicaid reimbursement cut and corresponding policies be reversed.

ADDENDUM A

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

ANNUAL REPORT FOR THE 2016 LEGISLATIVE SESSION

The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight is charged by statute to submit an annual written report on the statewide system for long-term care services to the President of the Senate and the Speaker of the House of Representatives at the start of each regular legislative session. The authorizing legislation (KSA 2016 Supp. 39-7,159) creating a comprehensive and coordinated statewide system for long-term care services became effective July 1, 2008.

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

- The number of individuals transferred from state or private institutions to home and community based services (HCBS), including the average daily census in state institutions and long-term care facilities;

- The savings resulting from the transfer of individuals to HCBS as certified by the Secretary for Aging and Disability Services; and

- The current balance in the Home and Community Based Services Savings Fund.

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

Number of Individuals Transferred from State or Private Institutions to Home and Community Based Services, Including the Average Daily Census in State Institutions and Long-term Care Facilities

Number of Individuals Transferred—The following table provides a summary of the number of individuals transferred from developmental disability (DD) institutional settings into home and community based services during state fiscal year 2016, together with the number of individuals added to home and community based services due to crisis or other eligible program movement during state fiscal year 2016. The following abbreviations are used in the table:

- ICF/MR — Intermediate Care Facility for the Mentally Retarded

- SMRH — State Mental Retardation Hospital

- MFP — Money Follows the Person program

- SFY — State Fiscal Year

DD INSTITUTIONAL SETTINGS AND WAIVER SERVICES*	
Private ICFs/MR: Avg. Mo. Caseload SFY 2016	137
State DD Hospitals – SMRH: Avg. Mo. Caseload SFY 2016	305
MFP: Number discharged into MFP program – DD SFY 2016	33
I/DD Waiver Community Services: Avg. Mo. Caseload SFY 2016	8,802
*Monthly averages are based upon program eligibility.	
Sources: SFY 2016—Medicaid eligibility data as of November 30, 2016. The data include people coded as eligible for services or temporarily eligible.	

The following table provides a summary of the number of individuals transferred from nursing facility institutional settings into home and community based services during state fiscal year 2016. These additional abbreviations are used in the chart:

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

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

Average Daily Census in State Institutions and Long-Term Care Facilities

Kansas Neurological Institute: Avg. Daily Census

FY 2010 – 157

FY 2011 – 153

FY 2012 – 152

FY 2013 – 145

FY 2014 – 143

FY 2015 – 144

FY 2016 – 141

Parsons State Hospital: Avg. Daily Census

FY 2010 – 186

FY 2011 – 186

FY 2012 – 175

FY 2013 – 176

FY 2014 – 174

FY 2015 – 173

FY 2016 – 164

Private ICFs/MR: Monthly Avg.

FY 2010 – 194

FY 2011 – 188

FY 2012 – 166

FY 2013 – 155

FY 2014 – 143

FY 2015 – 140

FY 2016 – 137

Nursing Facilities: Monthly Avg.

FY 2010 – 10,844

FY 2011 – 10,789

FY 2012 – 10,761

FY 2013 – 10,788

FY 2014 – 10,783

FY 2015 – 10,491

FY 2016 – 10,235

*Monthly Averages are based upon Medicaid eligibility data.

Savings Resulting from the Transfer of Individuals to HCBS

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

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

As certified by the Secretary for Aging and Disability Services, despite individuals moving into community settings that does have the effect of cost avoidance, the savings resulting from moving the individuals to home and community based services, as of December 31, 2016, was $0.

Balance in the KDADS Home and Community Based Services Savings Fund

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