Report of the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight to the 2021 Kansas Legislature

CHAIRPERSON: Representative Brenda Landwehr

VICE-CHAIRPERSON: Senator Gene Suellentrop

OTHER MEMBERS: Senators Ed Berger, Bud Estes, Richard Hilderbrand, and Pat Pettey; Representatives Barbara Ballard, John Barker, Will Carpenter, Susan Concannon, and Monica Murnan

CHARGE

- KSA 2020 Supp. 39-7,160 directs the Committee to oversee long-term care services, including home and community based services (HCBS). The Committee is to oversee the savings resulting from the transfer of individuals from state or private institutions to HCBS and to ensure that any proceeds resulting from the successful transfer be applied to the system for the provision of services for long-term care. Further, the Committee is to oversee the Children's Health Insurance Program (CHIP), the Program for All-Inclusive Care for the Elderly (PACE), 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.

February 2021

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 and KanCare Oversight recommends:

- The House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare hold informational hearings within the first 60 days of the 2021 Legislative Session on the 340B Drug Pricing Program;

- The House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare hold informational hearings within the first 60 days of the 2021 Legislative Session regarding the efforts of Oral Health Kansas;

- The Legislature review how other states estimate human services consensus caseloads;

- The K-TRACS prescription drug monitoring program be funded through the State General Fund;

- Nursing facilities be given the same immunity from civil liability provided to health care providers in 2020 Special Session HB 2016;

- The Legislature address the systemwide health care workforce issues, such as: safety, shortages, pay, education, licensure, and training (*e.g.*, virtual training of certified nurse aides by nursing facilities);

- The Legislature work on integrated care and coordinating general and behavioral health, which includes mental health, substance abuse, and primary care;

- The Legislature monitor the financial stability of long-term care facilities in Kansas;

- The Legislature monitor and report the increase in Home and Community Based Services (HCBS) waiver services provided to school-aged children in remote settings;

- The Legislature support expansion of the federal Excellence in Mental Health Act and then pursue participation. If participation in the Excellence in Mental Health Act is not possible, pursue a state plan amendment or change to the Section 1115 Waiver to allow interested providers to gain access to the Certified Community Behavioral Health Clinic (CCBHC) model. [*Note:* This recommendation mirrors Recommendation 2.1 of the Special Committee on Mental Health Modernization and Reform working groups' report to the Special Committee, *Strategic Framework for Modernizing the Kansas Behavioral Health System.*];

- The Legislature consider adding the Program of All-Inclusive Care for the Elderly (PACE) to the consensus caseload process;

- Regarding telehealth, the Legislature should:

    - Develop standards to ensure high-quality telehealth services are provided. This includes: establishing consistent guidelines and measures for telehealth in collaboration with licensing and regulatory agencies, requiring standard provider education and training, ensuring patient privacy, educating patients on privacy-related issues, allowing telehealth supervision hours to be consistently counted toward licensure requirements, and allowing services to be provided flexibly when broadband access is limited;

    - Maintain reimbursement codes added during the COVID-19 public health emergency for behavioral telehealth services and consider options to prevent loss of facility fees so that providers are not losing revenue by delivering telehealth services;

    - Establish coverage of telehealth for crisis services to allow for the use of telehealth with law enforcement and mobile crisis services and explore virtual co-responder models for law enforcement to aid police departments and other law enforcement agencies as they respond to mental health crises in rural and frontier communities;

    - Address the following items to ensure individuals receive, and providers offer, telehealth in the most appropriate locations: adopt a broad definition of originating site, consistent with the Kansas Telemedicine Act; allow staff to provide services from homes or other non-clinical sites, if patient privacy and safety standards can be met; and examine issues related to providers practicing, and patients receiving, services across state lines, such as by exploring participation in interstate licensure compacts; and

    - Utilize telehealth to maintain service and provider continuity as children, particularly foster children, move around the state and consider how the unique needs of parents of children in the child welfare system can be met *via* telehealth. [*Note:* The telehealth recommendations mirror Recommendations 10.1 through 10.5 of the Special Committee on Mental Health Modernization and Reform working groups' report to the Special Committee, *Strategic Framework for Modernizing the Kansas Behavioral Health System.*]; and

- The Legislature study and consider adjusting PACE rates annually, similar to the KanCare managed care organizations.

The Committee expresses concern and suggests the Legislature look at the charges nursing facilities incur when temporary staff must be used to meet workforce needs.

Proposed Legislation: The Committee requests a Committee bill be introduced containing the language of 2020 HB 2550, as amended by the House Committee on Social Services Budget, to increase reimbursement rates for providers of HCBS under the Intellectual and Developmental Disability waiver.

Background

The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services (HCBS) and KanCare Oversight operates pursuant to KSA 2020 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 2020 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 once during the 2020 Session (February 28) and four times during the 2020 Interim (June 22–23, September 28, December 9, and December 15). 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 Aetna Better Health of Kansas (Aetna) corrective action plan; the status of the Section 1115 waiver amendment on the Health Care Access Improvement Program (HCAIP); the status of amendments to the administrative rules and regulations on the protected income limit (PIL); OneCare Kansas; Technology Assisted (TA) waiver rates; the Disability and Behavioral Health Employment Support Pilot program; updates on the status of Medicaid eligibility applications and the transition of the application processing; KDHE Clearinghouse staffing and the Clearinghouse request for proposal (RFP) for processing Family Medical applications; KanCare COVID-19 update on special authorities and changes to the program; financial review of MCOs; KanCare analytics and performance metrics; 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 28, 2020, meeting, the Secretary of Health and Environment stated according to the America's Health Rankings, Kansas has had the greatest decline in health rankings of all states in the past 30 years. The decline is not limited to the Medicaid population. He stated the goal is to reverse the this trend and noted several key areas of concern.

At the June 22–23, 2020, meeting, the Secretary of Health and Environment provided a KDHE update, including personnel changes resulting from the departure of the Medicaid Director. The Secretary discussed COVID-19, the continuity of operations within KDHE, the impact on KanCare from the emergency declarations, and the response plan. The Secretary praised the work of the MCOs during the pandemic. He presented a review of purchases and disbursements of personal protective equipment (PPE), the daily rate trend of positive COVID-19 cases, and the reopening plan in regard to the COVID-19 pandemic.

At the September 28, 2020, meeting, the Secretary of Health and Environment noted the hiring of a new Medicaid Director. The Secretary stated KDHE implemented mobile COVID-19 testing in areas with limited capabilities to deal with the disease. The Secretary discussed the expansion of Medicaid codes for telehealth and virtual visits and said they had been extremely important for Kansans to access care during the pandemic. The Secretary stated an additional

major change at KDHE would be hiring a new Medicaid Medical Director, a position that is difficult to fill because the compensation is one-third of that offered by a normal medical practice. He noted after the contractor Conduent assumes operations currently performed by Maximus, the agency would be in standard operation mode.

At the December 9, 2020, meeting, the Secretary of Health and Environment provided an agency update and reviewed the COVID-19 vaccine delivery plan. He said KDHE was using Coronavirus Aid, Relief, and Economic Security (CARES) Act money through the Strengthening People and Revitalizing Kansas (SPARK) Taskforce to expand testing. Information on the collection sites and an overview of the novel therapeutics being used to treat COVID-19 was provided. The Secretary noted there is concern regarding hospital capacity. He then reviewed the Mission Control application used to assist hospitals with patient referral and transfer. He noted the program was particularly useful for rural and critical care hospitals needing to transfer a patient who needs more intensive care than what is available in those settings. The hospital staff can call Mission Control, which then locates a bed to meet the patient's needs and arranges for transportation using local transport options. Mission Control is also being used to repatriate patients to their home hospitals or skilled facilities after completion of the more intensive treatment. A copy of the KanCare Executive Summary was provided.

In response to questions at the December 9, 2020, meeting, the Secretary provided clarification of "pooled" and "un-pooled" COVID-19 testing. With pooled testing, multiple saliva samples are pooled together and tested. If the results come back negative, then all pooled samples are considered negative. Pooled testing makes it easier to test a large number of persons and is more cost effective. If symptoms are present or there might be infected individuals present, individual tests would be conducted instead of pooled tests. The Secretary stated individuals could test positive up to 30 to 60 days after recovering from COVID-19, but would not be infectious. He said it is recommended the previously infected individual not be tested again because of the possibility that residual particles might still be present. Reinfections have occurred, but normally after a period of some number of months following recovery from the first infection.

Aetna Corrective Action Plan

A KDHE representative reviewed the status of the Corrective Action Plan (CAP) for Aetna at the February 28, 2020, meeting. He said the goal was to partner with Aetna to have the MCO work back into compliance. As of this meeting, KDHE had closed 10 of the 12 CAP items and 2 unofficial items. The representative said Aetna and KDHE remained in constant contact to work through the remaining CAP items quickly. He stated Aetna's responsiveness and communication with the provider community had improved, and KDHE hoped to lift the CAP during fiscal year (FY) 2020 if progress continued and ongoing monitoring would continue. A list of the CAP items was provided.

At the June 22–23, 2020, meeting, a KDHE representative noted Aetna was back in compliance, and the CAP was closed on June 12, 2020. Monitoring and oversight would continue for all MCOs.

HCAIP Provider Assessment

At the February 28, 2020, meeting, a KDHE representative reviewed the proposed changes to the HCAIP. An increase in program funds necessitated amending the Section 1115 waiver to account for the new moneys with regard to budget neutrality. KDHE was working with the federal Centers for Medicare and Medicaid Services (CMS) to gain approval. The new program could not be implemented without CMS approval. The targeted date for implementation was July 1, 2020, pending CMS approval. SB 225 (2020), which would make the changes permanent, remained in committee at the time of this meeting. A proviso in the FY 2020 budget bill granted KDHE authority to continue operating the current program at the current funding levels through the end of FY 2020. The Kansas Hospital Association made a request to add the proviso to the FY 2021 budget bill, similar to the proviso in the FY 2020 budget bill.

At the June 22–23, 2020, meeting, a KDHE representative stated CMS indicated the proposed amendment to the State's Section 1115 waiver to address changes in the HCAIP would be denied.

KDHE would be partnering with the Kansas Hospital Association to arrive at an alternate solution to meet the budget neutrality requirements.

A KDHE representative provided an update on the HCAIP at the September 28, 2020, meeting. She noted during the examination of next steps after CMS indicated it would deny the State's Section 1115 waiver amendment, KDHE identified a technical error in the original CMS budget neutrality calculations and was finalizing a proposal to correct the error. She said KDHE believes CMS made an error by omitting some expenditures the State incurred between 2012 and 2017 when figuring the cost for the State without the expenditure waiver, which resulted in an artificially low budget neutrality cap. She said the error would amount to an additional $395.0 million increase to the state budget neutrality cap, which is the total amount of federal and state money the State can spend over five years through the Section 1115 waiver. The representative clarified there was no state funding for HCAIP, rather the reference to state money pertained to the amount the State can afford to stay within the budget neutrality cap under the Section 1115 waiver. The State is limited in the total amount it can spend under the waiver and, if the total exceeds the budget neutrality cap, the State must reimburse the federal government from the State General Fund (SGF). The representative noted there was no certainty CMS would approve the request to correct the budget neutrality error, as this decision was within the discretion of CMS.

At the December 9, 2020, meeting, a KDHE representative stated the technical correction on the budget neutrality cap was submitted on September 30, 2020, and KDHE had been notified CMS was reviewing the proposal. If CMS approves the proposal, KDHE would work with the Kansas Hospital Association to determine the provider assessment percentage increase the State could afford while staying within the budget neutrality cap.

Protected Income Limit

At the February 28, 2020, meeting, a KDHE representative discussed the PIL, which increased from $747 per month to $1,177 per month on September 1, 2019. This increase allowed 92.0 percent of HCBS members to have no client obligation, with 2.0 percent to have an obligation of less than $100. The PIL was increased through a proviso in the 2019 budget bill during the 2019 Legislative Session. HB 2549 (2020) would make the PIL change permanent, but the bill remained in the House Committee on Social Services Budget at the time of the meeting. In the House Committee, a motion was made to increase the PIL to 300.0 percent of Supplemental Security Income (SSI), at a cost of $11.4 million, all funds, and $4.4 million SGF, but it failed for lack of a second.

At the June 22–23, 2020, meeting, a KDHE representative stated approval was received from CMS for the six amended waivers impacted by the PIL increase. The representative provided the estimated cost of increasing the PIL to 300 percent of SSI. KDHE was preparing amendments to the rules and regulations addressing the PIL.

A KDHE representative provided an update on regulations for the HCBS PIL at the September 28, 2020, meeting. An overview of the regulatory process was also provided. KDHE was on track to publish notice of the public hearing on proposed regulations in early October 2020, with the hearing set for early December 2020. The representative stated after the hearing, assuming no changes were made, the regulation would take effect 15 days after publication in the *Kansas Register*.

At the December 9, 2020, meeting a KDHE representative stated a public hearing was held on December 3, 2020, on proposed amendments to the KDHE administrative rules and regulations to reflect the PIL increase to $1,177 per month. No changes were made to the proposed amendments. Confirmation was received from the Office of the Secretary of State the regulation would be published in the *Kansas Register* on December 17, 2020, which would set the effective date as January 1, 2021.

OneCare Kansas

A KDHE representative stated at the February 28, 2020, meeting that OneCare Kansas was set to launch on April 1, 2020. As of the meeting date, of the 34 providers who had applied to be OneCare providers, 27 were fully contracted. KDHE staff conducted provider training during February 2020. Seven locations around the state were used to

conduct member education meetings to help members understand the benefits of the program. The representative said the program is intended to coordinate physical and behavioral health care with long-term services and supports for persons with certain chronic conditions. A chart was provided to illustrate medication management for persons with a history of asthma.

At the June 22–23, 2020, meeting, the KDHE representative stated OneCare Kansas was launched on April 1, 2020, with membership education meetings in March 2020.

At the September 28, 2020, meeting, the KDHE representative stated that to date, 37 providers had applied for OneCare Kansas, and 33 had been approved. One additional provider was expected to be fully contracted by October 1, 2020. To date, 412 members were enrolled in the asthma population, and 293 members were enrolled in the Serious Mental Illness population. The representative said KDHE was working with the MCOs to develop and finalize a single, standard audit tool for review of the OneCare providers.

A KDHE representative stated at the December 9, 2020, meeting that as of December 1, 2020, there were almost 900 members enrolled, with 581 members enrolled as part of the asthma population and a little more than 300 members as part of the Serious Mental Illness population. Six-month audits were underway to measure outcomes and effectiveness, as required by 2020 SB 66. The link to the audit tool was provided. The representative said efforts to explore options to increase participation continue.

Disability and Behavioral Health Employment Support Pilot

At the June 22–23, 2020, meeting, a KDHE representative stated the Disability and Behavioral Health Employment Support Pilot (Employment Support Pilot) program, a voluntary program for up to 500 eligible KanCare members, would be operated by KDHE through a Section 1115 demonstration waiver. The program was being designed with guidance from an advisory board and had a proposed implementation date of July 2021.

A KDHE representative provided an update on the Employment Support Pilot program at the September 28, 2020, meeting, stating it would operate during the waiver period of 2019 through 2023, with the possibility of renewal if effective. KDHE received estimates from a contractor to design and build pilot-specific fields and functions; however, the bid was declined due to cost. The plan was to retain a contractor to expedite the implementation plan and to launch the program in July 2021. The representative stated specific reports were mandated to track the health care costs in the Employment Support Pilot program. SGF funding was provided to the Employment Support Pilot program in FY 2020 and FY 2021.

At the December 9, 2020, meeting, a KDHE representative stated KDHE had begun the recruiting process for two benefit specialists and a program manager to support the Employment Support Pilot program. KDHE executed a contract with an expert to provide technical implementation assistance and to write the program manual. The contractor began work in November 2020. The representative said the targeted start date for the program is July 2021.

TA Waiver Rates for Specialized Medical Care

Follow-up information regarding raising private duty nurse Specialized Medical Care (SMC) rates under the TA waiver was provided by a KDHE representative at the February 28, 2020, meeting. Assumptions were provided, and the potential cost offsets were listed. The KDHE representative noted two weeks of care in a person's home must be guaranteed before a patient would be released from the hospital. He noted other considerations, including uncertain provider capacity and the timing of offsets that could be delayed.

At the June 22–23, 2020, meeting, a KDHE representative discussed the fiscal impact of increasing the SMC code rates and the potential offsets associated with the rate increase, noting calculation of the offsets was difficult.

COVID-19-Related Activities

With regard to KDHE's ability to handle any future outbreaks, the Secretary of Health and

Environment stated at the June 22–23, 2020, meeting the key is to rapidly respond with testing to determine whether an individual is positive for COVID-19, identifying individuals who have been exposed through case investigation and contact tracing, and isolating or quarantining accordingly. He said to be prepared for any future outbreak, the State needs enough testing equipment and a PPE pipeline sufficient to keep up with the usage rate throughout the state. The PPE policy has always been to prioritize the allocation of PPE to direct care personnel, emergency providers, and hospitals. An example was provided of the process followed when an individual tested positive for COVID-19 at a correctional facility. The Secretary said the best way for nursing facilities to request PPE was to contact the county emergency managers and work through them. The Secretary stated he was confident in the number of COVID-19 deaths reported, as the information came from death certificates. If a death certificate was received that did not make sense, it was sent back to the attending physician or medical examiner for clarification. He stated he did not believe there was an advantage to listing the cause of death as COVID-19, since such a listing did not increase the payment to the doctor. If a hospital intentionally codes a cause of death incorrectly, it is considered fraud.

At the June 22–23, 2020, meeting, a KDHE representative outlined the special authorities exercised and some of the changes to KanCare to address the COVID-19 pandemic. A COVID-19 Kansas Medical Assistance Program (KMAP) provider information page containing links to a variety of resources was included in the KDHE testimony.

A KDHE representative stated at the September 28, 2020, meeting that partnerships with the MCOs and other agencies had enabled a consistent flow of information during the COVID-19 pandemic. The Secretary of Health and Environment explained the contact tracing and quarantine process when someone tests positive for COVID-19. Responding to the difference between the less strict quarantine process at hospitals as compared to the process KDHE follows, the Secretary stated hospital employees wear medical-grade PPE, but the PPE used in the community is not medical grade. He explained if an individual wearing an N-95 or surgical mask, a face shield, and eye protection tested positive for COVID-19, no one around that individual would be considered a close contact if they were also wearing medical-grade PPE.

A KDHE representative stated at the September 28, 2020, meeting that on July 30, 2020, the public health emergency was extended through October 22, 2020. The representative reviewed the special authorities exercised across the KanCare program during the COVID-19 pandemic. She reviewed some of the changes to KanCare, such as the delay of annual eligibility reviews, which results in no one being removed from KanCare unless they move out of state or voluntarily withdraw. In response to whether CMS covered the cost due to temporary discontinuance of annual reviews and suspension of terminations in Medicaid, the KDHE representative stated CMS covered the cost at the regular rate, plus an additional 6.2 percent paid on all claims to cover the SGF cost for coverage, not just for those individuals who were ineligible, but the entire Medicaid population. The representative stated the additional 6.2 percent in federal financial participation (FFP) should allow the State to break even on SGF costs.

The KDHE Director of Program Finance and Informatics provided further information at the September 28, 2020, meeting regarding the additional Medicaid federal funds received due to the 6.2 percent FFP increase. He noted approximately $55.0 million was received for each of the first and second quarters of calendar year 2020. Actual totals would be provided at a later time. A KDHE representative said an additional $100.0 million total would be received for the last two quarters of calendar year 2020, since the federal emergency declaration was extended into the fourth quarter of calendar year 2020, allowing the State to receive the 6.2 percent FFP rate increase through the fourth calendar quarter.

At the September 28, 2020, meeting, a KDHE representative discussed updates made to the KMAP website to help providers identify important information regarding changes pertaining to COVID-19 that were being implemented by KMAP. Links to COVID-19-related bulletins and online resources were added to the COVID-19 KMAP Providers Information web page.

A KDHE representative stated at the September 28, 2020, meeting that KDHE was seeing about $40.0 million in SGF savings per quarter as a result of the 6.2 percent increase in the FFP due to the COVID-19 pandemic.

At the December 9, 2020, meeting, a KDHE representative noted KDHE received approval to use SPARK funding to continue providing coverage for CHIP and M-CHIP (for beneficiaries 6 to 18 years of age with a poverty level between 113 percent and 133 percent of the federal poverty level) who age out of the program during the COVID-19 pandemic. She stated COVID-19 testing is covered by Medicaid with an order from a qualified provider, and COVID-19 vaccines will be covered by Medicaid. Kansas will continue to receive the 6.2 percent increased FFP for Medicaid and the 4.3 percent increased FFP for CHIP through March 31, 2021. If the public health emergency is extended, the increased federal participation could continue beyond March 2021.

Special Authorities

At the September 28, 2020, meeting, a KDHE representative discussed the different policy flexibilities allowed for telehealth services. She provided an overview of the 1915(c) HCBS Waiver Appendix K: Emergency Preparedness and Response (Appendix K) and the application KDHE submitted to CMS in June 2020 to access different flexibilities due to the COVID-19 pandemic. In regard to the application to CMS for Additive Appendix K#4 regarding Individual Education Plans (IEPs) and the services proposed to be offered through this waiver, the KDHE representative explained the waiver was envisioned as providing personal care services for individuals who already receive KanCare services and who required this assistance in their IEPs but may not be able to access it due to remote learning during the pandemic.

At the December 9, 2020, meeting, a KDHE representative provided a review of the special authorities that have been exercised across the KanCare program, including approval of the Section 1135 waiver, Appendix K flexibilities, CMS concurrence for eligibility adjustments, disaster relief state plan amendments, and policy flexibility for telehealth. Additional details regarding Appendix K flexibilities were provided by KDADS and appear in the KDADS section of this report. Presentations specifically addressing the Additive Appendix K#4 flexibility were made by KDADS and Kansas State Department of Education (KSDE) representatives and are summarized later in this report.

KanCare Utilization and Data Analytics

At each meeting, a KDHE representative provided information on analytics and performance metrics. A review of the MCO percent of population and an update of KanCare claims data was provided, including claim totals and claim denials. Charts were provided reflecting the timeliness of claims processed, member grievances, and the appeals process and resolution. A review of the customer service center, including charts comparing the number of calls, the speed of answer, and the call abandonment rate for both members and providers, was presented. Information on the MCOs' profit and loss and a KanCare Executive Summary containing program data was provided at each meeting. The MCOs' profits and losses for the quarter ending June 30, 2020, was included in KDHE's September 28, 2020, testimony.

Telemedicine

At the June 22–23, 2020, meeting, a KDHE representative stated KDHE could extend telemedicine codes approved by CMS to allow coverage for services during the COVID-19 pandemic from June 30, 2020, until the end of the public health emergency or until rescinded. When the public health emergency ends, a formal process will be followed to determine whether to extend or rescind the codes. The CMS decision on telemedicine codes it would continue to allow would determine the codes KDHE could extend.

KanCare Clearinghouse

Medicaid Eligibility

At the February 28, 2020, meeting, a KDHE representative provided information on KanCare eligibility and its status. As of February 18, 2020, there were 8,471 applications in-house. The KDHE representative provided breakdowns on the number of applications over 45 days in active and pending status and the number of applications received by KDHE during the November through

December 2019 federally facilitated marketplace (FFM) open enrollment. There was a 22 percent increase in applications received over the 2018 volume. The increase resulted in a temporary increase in the number of applications over 45 days, including many applications received from the marketplace that were aged by the time KDHE received them. An update on the status of Medicaid eligibility processing at the KDHE Clearinghouse was provided.

At the December 9, 2020, meeting, a KDHE representative reviewed the status of Medicaid eligibility applications. Of 4,546 total Medicaid applications in-house, 89 applications were over the 45-day processing time requirement. Of these 89 applications, 31 applications were in active status and ready to be processed, and 58 applications were in pending status awaiting information from the applicant, a provider, or a financial institution. A review of the applications received during the FFM open enrollment period of November 1 through December 15, 2020, was presented; 9,730 applications were received from the FFM.

Workload Transition from Maximus to KDHE

Information regarding the transition of workload for KanCare programs from Maximus to KDHE was provided at the February 28, 2020, meeting. The transition was completed one month early on December 1, 2019. Communication with stakeholders remained in place. A list of the various programs and the date of transition to KDHE responsibility was provided. An update was provided regarding the release of an RFP for a new KDHE Clearinghouse contract for processing Family Medical applications, with a start date of January 1, 2021. An update on the workload transition was provided at the June 22–23, 2020, meeting.

At the September 28, 2020, meeting, a KDHE representative noted Maximus would continue to process Family Medical applications through the end of the contract period, December 31, 2020. A new KDHE Clearinghouse contract was completed and awarded to Conduent in August 2020, and the company would begin processing Family Medical applications on January 1, 2021. The Conduent contract is for up to six years; it begins with a base three years, and then three optional one-year terms may be added. The cost of the contract is $136 million over 6 years. Clawback provisions for poor performance are in place in the Conduent contract. Conduent is required to use the Kansas Eligibility Enforcement System (KEES).

At the December 9, 2020, meeting, a KDHE representative provided an update on the transition of workload from Maximus and confirmed Conduent would begin processing Family Medical applications on January 1, 2021. The KDHE representative stated she had been working with Conduent since September and had confidence it would do a good job. There are performance measures in the contract, with metrics to measure its performance.

KDHE Clearinghouse Staffing

At the February 28, 2020, meeting, the status of the KDHE Clearinghouse staffing was reviewed by a KDHE representative, noting the majority of the positions had been filled. Recruiting and training for eligibility staff would continue. An update was provided at the June 22–23, September 28, and December 9, 2020, meetings on the status of the KDHE Clearinghouse staffing.

MCO Credentialing and Contracting Process

A representative of the Kansas Association of Medicaid Health Plans provided testimony at the February 28, 2020, meeting on KanCare credentialing and contracting. A new portal was launched by KDHE to assist in KanCare credentialing. The representative said the portal addressed many of the needs of the providers and significantly improved the process. A description of the processes related to enrollment, credentialing, and contracting was provided. The representative made suggestions to make the process more expedient and efficient.

Discussion of Impact of COVID-19 on KanCare Programs and Populations

KDHE

The KDHE State Epidemiologist provided an update on the COVID-19 pandemic situation at the June 22–23, 2020, meeting. A review of KDHE's statutory authority and regulations related to disease reporting was provided. All diseases on the statutory list must be reported within four hours

once suspected or confirmed. The processes for case notification and investigation were given. The following information was provided: charts regarding disease spread, hospitalizations, and deaths; county total case rates, cases by age and sex groupings, hospitalized and non-hospitalized cases by county, and testing rates; and the number of long-term care (LTC) facilities with outbreaks, the affected counties, and the total number of cases and deaths. The State Epidemiologist described the steps taken by KDHE and the technical supports provided to address an LTC center outbreak.

The National Healthcare Safety Network (NHSN) Long-Term Care Facility COVID-19 Report for Kansas was provided at the June 22–23, 2020, meeting. The State Epidemiologist provided information as to the KDHE response to the report. LTC facilities were required to report cases to the NHSN. She said testing was a major component of the response. A review of reopening requirements for nursing facilities was presented.

KDADS

At the June 22–23, 2020, meeting, the Secretary for Children and Families and Secretary for Aging and Disability Services discussed the impact of COVID-19 on KanCare programs and populations. A total of 53 guidance documents were created and posted on the KDADS COVID-19 Resource Center web page. The need for nutrition and supportive services was addressed, including plans to convert congregate meals to alternative service delivery meals. A list of Appendix K flexibilities for HCBS approved by CMS was provided. With regard to behavioral health, she stated there had been an expansion of telehealth authorities in concert with KDHE. KDADS received $2.0 million in federal grant funding to support additional behavioral health services to individuals impacted by COVID-19. The Secretary stated KDADS was working with the Kansas Division of Emergency Management (KDEM) on its crisis counseling program and applied to the federal Substance Abuse and Mental Health Services Administration for a suicide prevention and domestic violence COVID-19 response grant. With regard to surveys, certification and credentialing guidance documents were created and, in spite of survey activities initially limited by CMS, numerous surveys had been conducted. A list of lessons learned to help prepare for the next wave was given, including the hiring of a COVID-19 LTC liaison to work across systems to support facility and community-based LTC.

Department for Children and Families Presentation on Families First

At the February 28, 2020, meeting, a Department for Children and Families (DCF) representative provided information on Families First Prevention Services (Families First). Eligibility for the program is limited to families with children at imminent risk of removal to foster care, and services are limited to 12 months. The program received 55 proposals, and 17 grants were awarded over 4 categories: kinship navigation, mental health, substance use disorder, and parent skill building. All programs must be evidence based. A list of the grantees, the evidence-based practice, the amount awarded, the proposed number of families served, whether the program was new or existing, and a snapshot of the program enhancements was given. DCF is required to evaluate the Families First programs. DCF awarded a RFP to the University of Kansas to perform the robust evaluation required. The University of Kansas School of Social Welfare and the Center for Public Partnership and Research will collaborate to look at specific data indicators, outcomes, and the readiness and reach of providers. The short-term outcomes are well-being and family functioning. The long-term outcome is whether entry into foster care is being prevented. A statewide advisory group and a regional advisory group have been created. DCF hoped to have enough data in summer 2020 to look at outcomes to see whether families whose children started receiving services in November 2019 had come back into care. By November 2020, DCF anticipates some useable data from the Families First programs should be available to shed light on what is happening.

KDADS Overview and Update

A KDADS representative provided information at the February 28, 2020, meeting regarding HCBS, including a summary of the waiver enrollment as of January 2020, Physical Disability (PD) and Frail Elderly (FE) waiver renewals, stakeholder engagement on proposed amendments to current waivers, and work groups

created to evaluate the needs of participants receiving waiver services under the TA, Serious Emotional Disturbance (SED), and Autism waivers. Plans were being made to schedule a day-long meeting to identify key values, purpose, and future direction of Intellectual and Developmental Disability (I/DD) targeted case management (TCM). The KDADS representative noted the new Brain Injury (BI) waiver initially approved by CMS on August 5, 2019, for the adult population was fully expanded to include youth ages birth to 15 years old on December 1, 2019. Activity on the new BI waiver since its approval was provided.

A KDADS document reviewing the history of HCBS and providing an overview of the *Olmstead* decision was presented at the February 28, 2020, meeting. A KDADS representative presented the history and overview at the June 22–23, 2020, meeting.

At the September 28, 2020, meeting, the Secretary for Aging and Disability Services provided a KDADS update. She discussed the issue of visitation in nursing facilities, noting depression and mental health issues were an increasing concern for residents, and family visitation would mitigate the effects of those conditions. She noted CMS issued recommendations for outdoor visitation plans and other options, and facilities had also been directed to develop plans for indoor visits. She indicated the federal regulations for compassionate care visits were being interpreted broadly and not just for end-of-life situations.

At the December 9, 2020, meeting, the Secretary for Aging and Disability Services complimented the KDADS staff for the manner in which they had balanced the management of the COVID-19 pandemic and the ongoing responsibilities of the agency.

Targeted Case Management

At the September 28, 2020, meeting, a KDADS representative stated KDADS had created a TCM work group to establish a common vision for TCM services in the future and to address issues such as conflicts of interest. The 40-member work group met for the first time on September 15 and 16, 2020, and concentrated on goals, core values, practices, and the vision for the service going forward. The representative stated TCM was a very prescriptive set of services individuals were allowed to receive. She noted TCM could include help with advocacy for the individual's care planning, and KDADS was looking into the sustainability of the TCM service and wanted to save what was best from the system.

Administrative Case Management

At the February 28, 2020, meeting, a KDADS representative provided a brief review of administrative case management (ACM) for the BI, PD, and FE waivers, and PACE. The ACM contract was awarded to the Northwest Kansas Area Agency on Aging (AAA), which would be subcontracting with the other ten AAAs to provide these services.

A review of ACM, a service launched on May 1, 2020, was presented by a KDADS representative at the June 22–23, 2020, meeting. Approximately 101 individuals receive these services. ACM assists individuals who have been found functionally eligible for the BI, PD, or FE waivers and PACE with the completion of the Medicaid enrollment form and helps with the collection of information to be submitted with the application. A chart reflecting ACM activity was provided at the September 28, 2020, meeting. At the December 9, 2020, meeting, a chart of ACM services provided from its launch on May 1, 2020, through October 2020, including the number of people served and the units and hours of service, was outlined.

Disability and Behavioral Health Employment Support Pilot

Information on the Employment Support Pilot program to be operated by KDHE and collaboratively worked on by KDHE and KDADS was provided by a KDADS representative at the February 28, 2020, meeting. The pilot is designed to assist 500 members in obtaining and maintaining employment. Eligibility requirements for the pilot were provided.

PACE

A KDADS representative provided information at the February 28, 2020, meeting on PACE enrollment, counties served, and providers providing services in those counties. Updated

information was provided at the June 22–23, 2020, meeting. A PACE update was provided at the September 28, 2020, meeting, indicating 689 individuals are enrolled in the program. An update was provided at the December 9, 2020, meeting, indicating a total of 696 individuals were enrolled in PACE as of December 1, 2020.

A representative of Midland Care Connection, Inc., provided testimony regarding PACE at the December 15, 2020, meeting. He provided a brief overview of Midland Care Connection. PACE serves individuals ages 55 and older, certified by the State to need nursing home care, be able to live safely in the community at the time of enrollment, and live in a PACE service area. After being admitted to the program, if a PACE enrollee needs nursing home care, PACE pays for it and continues to coordinate the enrollee's care. A list of the available PACE services was provided, including adult day care and clinic services, primary care, hospital and nursing home care when necessary, social services, all necessary prescription drugs, home health and personal care, and medical specialties. The representative stated the cost of care in PACE is 10 to 15 percent less than the cost of caring for a comparable population through Medicaid, including HCBS waiver programs, by providing preventive care. The representative provided the 2021 PACE public policy priorities for Kansas: increasing the PIL to 300 percent of SSI, adjusting PACE rates annually comparable to the annual update and adjustments for KanCare MCOs, and reinserting PACE in the Consensus Caseload estimating process.

The Midland Care Connection representative responded to questions and provided subsequent information regarding the breakdown of the savings under PACE when compared to the state Medicaid program. He described the difficulty in expanding PACE to other areas of the state due to a lack of PACE-eligible persons to allow the program to be viable. He noted there was a cap on PACE enrollment that was lifted when KanCare started. PACE has since grown from 120 to 150 participants to 750. The representative noted 90 percent of PACE participants are dual eligible, 9 percent are Medicaid only, and 1 percent are private pay. PACE participants are not on KanCare.

Quarterly HCBS Report

Written testimony was regularly provided by KDADS on savings on transfers to HCBS; the average monthly caseloads for private intermediate care facilities (ICFs), state I/DD hospitals, and head injury facilities; the number of persons transitioned on the Money Follows the Person program; average monthly caseload for HCBS I/DD, PD, FE, and BI services; monthly average eligibility caseload for nursing facilities; and the daily census for the Kansas Neurological Institute and Parsons State Hospital and Treatment Center. [*Note*: See Appendix A for the 2020 report.]

HCBS Waiver Renewals and Amendments

A KDADS representative provided information regarding the PD and FE waivers in the renewal process at the time of the June 22–23, 2020, meeting. Once those waivers were approved, KDADS would shift focus to a number of listed amendments to multiple waivers.

At the June 22–23, 2020, meeting, in response to a question regarding the proposed amendment to allow additional telehealth services within the waivers, a KDADS representative stated the additional telehealth services were different than those put in place as a result of the COVID-19 pandemic. Telehealth services are available only on the FE waiver. The KDADS representative noted the similarity in the FE and PD waivers and the interest among stakeholders to allow telehealth services under the PD waiver. The representative stated KDADS believes consideration of adding telehealth to the PD waiver is warranted.

A KDADS representative reviewed the HCBS waiver renewals and proposed amendments at the September 28, 2020, meeting. The PD and FE waivers remain in the CMS waiver renewal process. Once the waivers are approved, the focus would be on a number of amendments to multiple waivers, including unbundling the assistive services, per CMS request. Another proposed amendment was to move the cap on SMC services from a hard cap to a soft cap. A review was also in process to unbundle the I/DD day services and I/DD prevocational employment services, per CMS request. With regard to plans to review the SED waiver, the representative responded KDADS

would be updating the performance measures and revisions to include a plan of care process.

At the December 9, 2020, meeting, a KDADS representative stated the PD and FE waiver renewals were approved by CMS on October 26, 2020. Each is authorized for five years with a retroactive effective date of January 1, 2020. A list of proposed amendments to multiple waivers was provided. The public comment period for proposed amendments, which are described in the September 28, 2020, summary above, ran from October 15 through November 30, 2020.

HCBS Waiting Lists Update

HCBS waiting list updates were provided at each Committee meeting. At the June 22–23, 2020, meeting, a KDADS representative provided a review of the HCBS waiver enrollment as of April 2020. A breakdown by HCBS waiver program of the number of individuals eligible to receive services, on a waiting list, and proposed recipients was presented. There were 4,203 individuals on the I/DD waiting list and 1,298 on the PD waiting list at the time of the meeting.

At the September 28, 2020, meeting, a KDADS representative noted almost half of the I/DD individuals eligible to receive services were on the waiting list. The representative said there had not been much movement on the waiting list. KDADS received 124 requests for crisis services and approved 106 year to date.

A KDADS representative noted at the December 9, 2020, meeting that 6,266 individuals were on the waiting lists, with 4,394 on the I/DD waiting list and 1,972 on the PD waiting list.

HCBS Appendix K Flexibilities

A KDADS representative provided a description of the Appendix K flexibilities for the HCBS waivers at the June 22–23, 2020, meeting. Appendix K includes actions that states can take under existing 1915(c) HCBS waiver authority to respond to an emergency. A list of CMS-approved flexibilities was provided. The items in Appendix K were authorized until January 26, 2021, and are valid for one year. The items do not have to be used, but they are options.

A KDHE representative noted at the June 22–23, 2020, meeting that KDADS had requested approval from CMS for provider retainer payments for habilitation services and personal care services, and work was underway on internal policies to move this option forward. The primary focus of the discussion revolved around the provider retainer payments to maintain the provider network during the COVID-19 pandemic. The representative stated the retainer payments would come from the capitation payments already being paid to the MCOs. The authority KDADS had received from CMS limited the number of days that could be paid to 30 service days. An explanation was provided on how the 30 service days were counted. The retainer payments can be used only for I/DD day and residential services and personal care services that are provided under multiple waivers. The representative stated the initial calculations showed, due to fewer or less costly services being provided in other areas of the KanCare program, any costs of the retainer payments would be offset. The representative said checks and balances were put in place by KDADS to ensure only providers providing services during this time period would be eligible for payments. That determination was based on plans of care and person-centered plans that were in effect on March 1, 2020. Providers who received payments for alternate services provided during this time period would not be eligible for retainer payments. The number of providers that completely closed during this time frame was under 25. The day services were the most impacted. In response to whether the retainer payments could come out of COVID-19-related funds instead of the MCO capitation payments, the representative stated CMS made it clear the direct care payments or retainer payments must go through the MCOs.

At the September 28, 2020, meeting, a KDADS representative provided additional information on the Appendix K flexibilities. CMS-approved flexibilities include expanding telehealth opportunities, permitting provisional employment pending background checks, and providing retainer payments for habilitation services and personal care services. The representative responded to several questions about the Additive Appendix K#4 flexibility for IEP services, stating the flexibility would provide medically necessary support for students doing remote learning. The school districts were accustomed to providing

these services in their buildings, but the services were not available in student homes during remote learning. KDADS was waiting for guidance from CMS. In the meantime, KDADS was allowing students with an IEP indicating the need for medically necessary services and who were in a remote learning setting to receive support. Under normal circumstances, the school districts would pay for these services. Home-based services were paid out of the KDADS budget. The representative explained the only children who would receive these services through this waiver flexibility were ones already being provided HCBS services, and these services were deemed a requirement in their IEPs. Services through the waiver flexibility would only apply to students in remote settings and not when students were present in physical school buildings. The representative stated this waiver had not been approved and was part of a set of waivers applied for in Appendix K. The representative said KDADS was committed to working with KSDE on this issue.

Presentations were made by KDADS and KSDE representatives at the December 9, 2020, meeting to specifically address the Additive Appendix K#4 flexibility. Details on those presentations are outlined later in this report.

HCBS Settings Final Rule

At the June 22–23, 2020, meeting, a KDADS representative reviewed the timeline for the HCBS Settings Final Rule, involving self-assessment of sites, desk review of self-assessments and evidence submitted, remediation in areas of non-compliance, and heightened scrutiny for sites with features that institutionalize or isolate HCBS participants and offered feedback to bring the sites into compliance with the Settings Final Rule. KDADS would work with KDHE and the MCOs to transition individuals receiving services from providers that were noncompliant with the Settings Final Rule by March 2022 to other providers that were compliant.

A KDADS representative provided an overview of the HCBS Settings Final Rule process and where Kansas was in the process at the September 28, 2020, meeting. The representative noted 2,813 HCBS sites had submitted self-assessments and evidence for review for the Settings Final Rule. As of September 25, 2020, all but one site had been reviewed. At the December 9, 2020, meeting, a review of the timeline for the Settings Final Rule was presented.

Oversight of Long-Term Care Facilities

COVID-19-related Activities

A review of the COVID-19-related actions for nursing facilities and adult care homes implemented by KDADS was provided by a KDADS representative at the June 22–23, 2020, meeting. A timetable of the steps taken was provided. On June 1, 2020, CMS required infection control surveys in all nursing facilities by July 31, 2020, with follow-up surveys within three to five days of a report of a positive COVID-19 test. KDADS issued guidance on June 12, 2020, to allow nursing facilities to reopen to visitors and outside services in cooperation with local health departments. To reopen, nursing facilities were required to have a plan to respond to positive COVID-19 cases. The KDADS testimony included information on the results of on-site investigations, civil monetary penalty grants used for technology devices for the adult care home residents to remain in contact with their relatives, and adult care-related temporary licenses granted due to the COVID-19 pandemic.

At the September 28, 2020, meeting, the Secretary for Aging and Disability Services discussed the usage of the $10.0 million from the SPARK Taskforce to purchase PPE and presented a review of the COVID-19 status in the four state hospitals. In response to a question regarding the lack of PPE for nursing facilities, the Secretary stated inconsistencies in supply availability and issues with the quality of PPE had contributed to this situation. She stated PPE being provided by the federal government was not medical grade, and KDADS was using SPARK money to eliminate the PPE shortage. The agency was negotiating a contract with a vendor to supply PPE. The Secretary noted at times, KDADS itself had experienced shortages for its hospitals and staff.

In response to a question at the September 28, 2020, meeting about whether surveyors were tested prior to entering nursing facilities or other adult care facilities, the Secretary said KDADS did not have a testing procedure for surveyors. Surveyors were required to wear PPE and were

subjected to the same temperature checks and other safety procedures at facilities. She did not know whether surveyors had to be up-to-date on immunizations and boosters, but would follow-up on this information. With regard to the COVID-19 Adult Care Home Infection Control Survey, a KDADS representative stated 100 percent of the surveys had been completed, 25 immediate jeopardy citations had been issued, and 75 infection control citations had been issued.

A KDADS representative testified at the September 28, 2020, meeting about the guidelines for COVID-19 testing in nursing homes as guided by the Centers for Disease Control and Prevention (CDC), CMS, and KDHE. The frequency of testing depends on the prevalence of COVID-19 in the county, as measured by the positivity rate of testing. State policy allows nursing facilities to use the KDHE state-reported positivity rate. If a nursing facility had exhausted all options in testing efforts, it would not be held accountable for meeting the testing requirements. The U.S. Department of Health and Human Services (HHS) sent testing machines to all nursing homes with a current Clinical Laboratory Improvement Amendment certificate of waiver, and one round of testing kits was included. Additional testing kits needed to be purchased from the manufacturer, but a backlog of testing kits prevented the use of the testing machines. HHS began shipping testing kits to nursing homes in zones with the higher degrees of positivity to support testing of staff. Facilities were to be supplied for several months. A review of KDADS's role in COVID-19 testing was provided. After a positive test result in a nursing facility, KDHE would step in and complete a second test and conduct contact tracing to determine who additionally needed to be tested. Follow-up tests would be conducted two weeks later.

At the September 28, 2020, meeting, a KDADS representative stated new guidelines for visitation in nursing homes were issued September 17, 2020, to improve person-centered needs of residents. Visitation was to be allowed if the community spread was low, and outdoor visitation was highly encouraged. States were authorized to provide $3,000 grants from the Civil Monetary Penalty (CMP) funds for facilities to purchase equipment to facilitate visitation. CMS visitation guidelines were provided. A chart of the funding adult care homes have received from the SPARK Taskforce and the federal government was provided.

A KDADS representative stated at the December 9, 2020, meeting that KDADS is performing required on-site surveys of adult care homes when three or more new COVID-19 suspected and confirmed cases occur at a facility or when there is one confirmed resident case in a previously COVID-19-free facility. As of September 23, 2020, all adult care homes had been surveyed for infection control policies, procedures, and practices. He outlined the plan for the return to regular survey activity for nursing facilities and state-licensed-only adult care homes.

With regard to testing supplies, a KDADS representative stated at the December 9, 2020, meeting that, as of November 19, 2020, 319 facilities in Kansas received testing instruments in three waves between July 20 and November 6. The federal government is also providing BinaxNOW rapid tests to nursing homes in counties with the two highest levels of positivity to serve vulnerable populations, including nursing home residents and staff, assisted living facility residents and staff, and home health agency workers. These tests will be supplied to the facilities for several months to address the shortage of supplies for point-of-care testing instruments in nursing facilities. Responding to a question about the reliability of the binary tests, the representative stated a positive rapid test should be confirmed with a polymerase chain reaction (PCR) test. Seven labs across the state are available to LTC facilities to confirm positive results, and lab testing is paid for directly by KDHE.

At the December 9, 2020, meeting, a KDADS representative stated KDADS also used CARES Act funding to purchase telecommunication devices for residents to use to communicate with family. The CMS-issued nursing facility visitation guidance also expanded the definition of compassionate care. On October 19, 2020, KDADS issued visitation guidance for LTC settings indicating adult care homes should allow visitors if the community spread was low, adequate infection control and social distancing guidelines were in place, and visitors followed facility guidelines on visitation. Information on the amount and source of funding (CMP, CARES, and

SPARK) to support visitation in LTC settings was provided for nursing facilities and state-licensed-only facilities. The CMP funds cannot be used for the state-licensed-only facilities.

At the December 9, 2020, meeting, the Adjutant General's Department provided written responses to questions asked at the September 28, 2020, meeting regarding the distribution of PPE. The Department was unable to answer some of the questions due to the sensitive nature of the information. KDEM instituted a stopgap measure while KDADS implemented its plan to provide PPE. KDEM received 297 resource requests from LTC and adult care home facilities because of an outbreak or as a stopgap measure. KDEM delivered 7,604 cases of PPE to these facilities.

At the December 9, 2020, meeting, KDADS provided written responses to questions posed at the September 28, 2020, meeting regarding PPE, including the exact accounting of PPE, sanitation equipment, and testing supplies; supplies the state had not distributed; the recipients of PPE, sanitation equipment, and testing kits KDADS was required to provide per 2020 Special Session HB 2016; those facilities that had and had not received PPE, testing kits, and sanitation equipment; and the timeframe for abiding with 2020 Special Session HB 2016 requirements regarding the provision of PPE, sanitation equipment, and testing kits. Additionally, KDADS provided a report reflecting the distribution of product and funding to address COVID-19, as required by 2020 Special Session HB 2016, to adult day care facilities, assisted living facilities, boarding care homes, health care facilities, home plus facilities, hospital LTC units, ICFs for individuals with developmental disabilities, nursing facilities, nursing facilities for mental health, and residential psychiatric facilities.

At the December 15, 2020, meeting, a KDADS representative and associations and providers representing LTC facilities provided an update on the requirements and impact of COVID-19 on LTC facilities. These presentations are outlined near the end of the report under the heading of "COVID-19 and LTC Facilities."

Use of Antipsychotic Drugs in Nursing Facilities

At the February 28, 2020, meeting, a KDADS representative provided data reflecting Kansas has had a reduction in the use of antipsychotic drugs in nursing homes, to 37th in the nation in the use of antipsychotic drugs from 51st in the nation in 2011 and 42nd in 2018. As of the second quarter of 2019, the quarterly percent of long-term stay nursing home residents receiving antipsychotic medications was 16.1 percent. The national prevalence is 14.3 percent. The representative said KDADS anticipated continued improvement on the rankings. KDADS is recording and reporting antipsychotic drug usage, and there is an interest in facilities to reduce usage. He stated the use of antipsychotic medication is more prevalent with dementia, and the State needs to be sure it is addressing psychotropic drug use across the care continuum.

At the June 22–23,2020, meeting, a KDADS representative stated continued improvement in reducing the use of antipsychotic drugs in nursing homes was expected based on the activities undertaken.

A KDADS representative stated at the September 28, 2020, meeting the MCOs created pay-for-performance measures tied to reducing inappropriate antipsychotic drug use in the nursing homes. A list of the initiatives implemented by each MCO was included in the testimony. No new information was provided at the December 9, 2020, meeting.

Adult Care Home Receiverships

A KDADS representative provided an update at the February 28, 2020, meeting on the status of adult care home receiverships. At the June 22–23, 2020, meeting, a KDADS representative provided a review of the 22 adult care homes KDADS took into receivership, noting only 2 remained on the market to be sold. Of the remaining 20, 18 were sold and 2 have been or will be closed.

At the September 28, 2020, meeting, a KDADS representative provided an update on the adult care homes in receivership. Two remain on the market for sale: one in Topeka and one in Great Bend, which has a potential buyer.

A KDADS representative reported at the December 9, 2020, meeting that only one of the facilities in receivership remains on the market, with a sale possible.

Behavioral Health

A KDADS representative provided testimony at the February 28, 2020, meeting regarding behavioral health issues. He provided information on the use of community mental health centers (CMHCs) for diversion and to address the need for children's psychiatric hospitals in western Kansas. It was noted CMHCs were already evaluating youth for acute psychiatric hospital admissions, which allows them to divert youth to outpatient services or other levels of care when the necessity for hospitalization is not met. KDADS is working with the MCOs and CMHCs to connect children and families with SED waiver services before and after hospitalizations or residential treatments. KDADS is also working with stakeholders to develop recommendations for pursuing innovative and integrated solutions to deal with the situation. An update was provided on the United Methodist Health Ministry Fund project to find locations and partnerships in western Kansas for acute psychiatric care for children.

At the June 22–23, 2020, meeting, a KDADS representative noted KDADS had been working closely with KDHE to respond to COVID-19 issues in behavioral health services. KDADS issued guidance to providers to allow expansion of telehealth and verbal consent to facilitate social distancing during treatment service delivery in outpatient settings. Additional infection control measures were implemented to reduce positive COVID-19 cases in residential treatment facilities. The representative stated KDADS had been working at the federal level to advocate for continued telehealth flexibility in CMS regulations for the telehealth delivery of behavioral health services in Medicaid and Medicare. The representative gave an update on the plan for a children's psychiatric hospital in western Kansas and indicated issues were being worked through. KDADS had been working with KDHE on the State Institutional Alternatives (SIA) policies for KanCare and had submitted a State Plan Amendment to CMS for approval.

A KDADS representative stated at the September 28, 2020, meeting that KDADS worked with KDHE on new telehealth policies for KanCare and would continue to work with the federal government for continued flexibility. The representative stated an RFP was being created to open and operate a SIA children's psychiatric hospital in Hays, Kansas. This process would use funds allocated in the FY 2020 budget. The KanCare SIA policies were published by KDHE in summer 2020, and the application forms for hospitals interested in applying for this status were available on the KDADS website. The SIA policy would allow hospitals around the state to serve Kansans closer to home and increase capacity in the system of care to allow for voluntary admissions at Osawatomie State Hospital (OSH).

A KDADS representative discussed the behavioral health COVID-19 response at the December 9, 2020, meeting. He noted KDADS had worked closely with KDHE in establishing telehealth policies for KanCare providers and MCOs that helped mitigate some of the negative financial impact on providers and allowed essential services to continue during the pandemic. KDADS was still working on the RFP for the Hays psychiatric facility for adolescents and hoped to have the RFP review process completed within two weeks and to award a contract in March 2021.

Psychiatric Residential Treatment Facilities

At the February 28, 2020, meeting, a KDADS representative provided a review of psychiatric residential treatment facilities (PRTFs). The PRTF waiting list as of February 24, 2020, was 124, down from 159 individuals in November 2019. Information was provided on the steps being taken to address the waiting list. Twenty additional beds had been added to the KVC Health Systems (KVC) facility in western Kansas since November 2019, for a total of 32 licensed beds. KDADS is trying to get the remaining beds licensed. The KDADS representative noted the KVC facility was relicensed from a combined acute psychiatric hospital and PRTF to solely a PRTF. The number of PRTF beds needed were close to being met, but western Kansas was still missing acute psychiatric care hospitalization beds.

A review of the PRTFs was provided by a KDADS representative at the June 22–23, 2020,

meeting. As of June 1, 2020, the PRTF waiting list had reduced from 124 individuals in February 2020 to 112 individuals. There were 336 licensed PRTF beds in the system of care. The new PRTF beds were in three locations: 25 beds in Olathe, 25 beds in Kansas City, and 16 beds in Newton. KDADS was meeting weekly with the MCOs and DCF to review individual cases on the waiting list. Updated PRTF regulations had been drafted and would soon be available for public comment.

A question was posed at the September 28, 2020, meeting regarding whether the State could offer presumptive eligibility for PRTF services for juveniles on the SED waiver without amending the waiver. A KDADS representative responded she would discuss this question with her counterparts at KDHE.

At the September 28, 2020, meeting, a KDADS representative noted the MCO PRTF waiting list as of September 18, 2020, had 90 individuals listed, down from 112 individuals in June 2020. The representative said meetings continue weekly with the MCOs and DCF to discuss cases involving PRTFs.

A KDADS representative noted at the December 9, 2020, meeting the PRTF waiting list had dropped from 112 in June 2020 to 108. Of those 108 individuals, 14 were in foster care, which was down from 24 in June 2020. An additional 50 PRTF beds were in the system, increasing the total number of PRTF beds from 336 in June 2020 to 386. KDADS hoped the increase in beds would further reduce the PRTF waiting list in a few weeks. The additional 50 PRTF beds are located in the Kansas City area, specifically in Prairie Village in Johnson County; 30 of the 50 additional beds were being utilized by KVC.

State Hospitals

A KDADS representative provided an overview of state hospitals at each Committee meeting. At the December 9, 2020, meeting, a KDADS representative stated there had been active COVID-19 cases among staff and residents at all state hospitals. Larned State Hospital (LSH) lost one staff member to COVID-19, but there were no other deaths. He complimented the state hospital staff on a "monumental" effort to contain the virus.

Larned State Hospital

A KDADS representative stated at the February 28, 2020, meeting that the high vacancy rates in direct care nursing positions at LSH continue. Efforts being made by the LSH Superintendent to recruit and retain staff were listed. These efforts included providing training for existing LSH staff to allow them to become licensed mental health technicians. This option is available through approval from the Board of Nursing to make LSH an outreach site for the OSH Mental Health Technician Program. The training program would allow LSH to develop its own licensed staff to fill licensed mental health technician positions in the future. A review of the Governor's Executive Directive 19-510 to raise direct care and nursing staff wages at LSH effective December 1, 2019, was provided. In response to a question regarding salary disparity between the corrections and medical staff at LSH, the representative stated, to avoid salary compression and retain safety and security staff, KDADS used internal resources to fund additional increases for those staff members.

At the June 22–23, 2020, meeting, a KDADS representative provided an update on recruiting and retention at LSH, noting there was overall improvement in both areas. The steps being taken to improve recruitment and retention were provided. The representative noted the number of employees mandated to work a double shift at LSH had been declining in spite of the pandemic.

A KDADS representative stated at the September 28, 2020, meeting that improvement in the overall job vacancy rate at LSH continued, as did the concerted effort to recruit and retain staff. Improvement in the nursing department holdover rate continued.

At the December 9, 2020, meeting, a KDADS representative stated the staffing vacancies continued to decline at LSH. Efforts to recruit and retain staff were presented. The mandatory holdover for the direct care nursing staff had continued a downward trend since March 2020.

Osawatomie State Hospital

A KDADS representative provided information at the February 28, 2020, meeting on the proposed plan to lift the moratorium on voluntary admissions at OSH. A copy of the KDADS testimony before the House Committee on Health and Human Services, the House Committee on Social Services Budget, and the Senate Committee on Public Health and Welfare on February 3, 2020, in response to proviso section 85(r) of House Sub. for SB 25 regarding the plan to lift the moratorium on voluntary admissions at OSH was provided. The representative outlined the FY 2021 Governor's Budget recommendations for KDADS that would expand the number of regional psychiatric hospital beds to serve individuals with mental illness meeting the criteria for state hospital admission, expand the number and scope of community crisis stabilization programs and crisis intervention centers, increase licensed beds at the Adair Building, and renovate the Biddle Building to become a CMS-certified space. KDADS was working on a Census Plan to address the need for services until the planned lifting of the moratorium in May 2021.

In response to questions at the February 28, 2020, meeting regarding the proposed plan to lift the moratorium at OSH, the KDADS representative stated the existing, usable buildings at OSH could be renovated for use effectively, and the proposed plan gets the State to the right place. After a review of capacity, KDADS did not think the State needed a new hospital. The representative said instead, the State needed community beds and crisis intervention centers to fill gaps geographically. These other options would slow the entry into state hospitals by intervening at crisis level in the community, as opposed to increasing state hospital capacity for treatment and then trying to find a way to move the individual out of the state hospital and into community-based services. The representative stated he was not sure the proposed plan was a long-term solution, but it was a reasonable solution to enable voluntary admissions at OSH to resume, which was the goal set. The razing of buildings at OSH would begin in year two of the proposed plan. Although some Committee members agreed KDADS had complied with the request of the Legislature to propose a plan to reopen OSH for voluntary admissions, there was still a need for a long-term plan. The waiting list for admissions at OSH had ten persons at the time of the February meeting.

An update on the lifting of the moratorium on voluntary admissions at OSH was provided by a KDADS representative at the June 22–23, 2020, meeting. A breakdown of the various activities that would lead to increased bed capacity at OSH and increased community-based capacity for inpatient treatment was given. The representative noted, with additional space at OSH and in communities, KDADS planned to lift the moratorium in May 2021. A review of the repurposing of various units at OSH to respond to COVID-19 was provided. In response to questions, the representative explained the State can collect funds from CMS only for certified beds, not licensed beds. As remodeling occurs, the plan was to certify the beds to allow for the collection of Medicaid and Medicare funds. The representative stated the funding for the remodel of OSH was still on track.

With regard to positive COVID-19 cases at OSH, the KDADS representative stated one staff member tested positive the week before the June 22–23, 2020, meeting. This was the first positive case. No positive cases had occurred among patients. Educational processes used at OSH to ensure patients are informed on COVID-19 were outlined. Acute care patients were moved from double-occupancy rooms to single rooms to create isolation in light of the COVID-19 pandemic. This action used an additional 15 beds and limited admissions, resulting in the OSH waiting list reaching 30 individuals. Due to concerns about the increased number of individuals needing services who were on the waiting list, the use of double-occupancy rooms resumed, and OSH reopened 15 beds. The waiting list as of the meeting day was 16 individuals.

At the September 28, 2020, meeting, a KDADS representative stated KDADS had started interviewing contractors to begin construction projects at OSH related to the approved budget. KDADS continued to plan to lift the moratorium in May 2021.

A KDADS representative stated at the December 9, 2020, meeting that efforts to lift the

moratorium on admissions at OSH continued. The KDADS FY 2021 approved budget includes $5.0 million to create additional regional beds to be located throughout the state; this funding was not allotted. The date to lift the moratorium remains in May 2021. A review was provided of the repurposing of several buildings at OSH since the end of the 2020 Legislative Session to respond to COVID-19. KDADS was looking at restructuring the direct care duties in the units to better retain and attract new employees to those positions.

Medicaid Inspector General

At the February 28, 2020, meeting, the Medicaid Inspector General provided an update on the Office of the Medicaid Inspector General (OMIG) and summarized the highlights of the 2019 OMIG Annual Report. She stated 2019 was primarily spent rebuilding the OMIG. Three reports were issued in 2019: a review of e-mails sent to an unmonitored KDHE OMIG address to check for missed fraud reports, KDHE's procedures for discontinuing Medicaid eligibility when a Medicaid beneficiary entered prison, and the resources available to fight Medicaid eligibility fraud. In 2019, the OMIG referred nine providers to the Office of the Attorney General's Medicaid Fraud and Abuse Division for possible prosecution, with ongoing criminal investigations opened for two of the nine providers.

The OMIG expanded to three staff members with the addition of a data analyst to assist in the review of Medicaid, CHIP, and MediKan data. From the November 19, 2019, Committee meeting to the February 28, 2020, meeting, the OMIG received 110 complaints, with the majority alleging Medicaid eligibility fraud.

At the February 28, 2020, meeting, the Medicaid Inspector General summarized a review completed of a major KanCare member grievance against the MCOs during the third quarter of 2019, which involved non-emergency medical transportation grievances filed. She also provided a brief primer on the Medicaid Fraud and Abuse Division of the Office of the Attorney General, which is the Medicaid Fraud Control Unit, noting the differences between the Medicaid Fraud Control Unit and the OMIG.

At the June 22–23, 2020, meeting, the Medicaid Inspector General provided the Committee with Report No. 20-03, which compared the HHS Office of Inspector General's List of Excluded Individuals/Entities with the list of personal care attendants classified as active in the State's billing system. Four personal care attendants considered active on the State's list were listed as excluded on the List of Excluded Individuals/Entities. She said this is one of the fundamental criteria that must be met to provide services in the Medicaid system. The HHS Office of Inspector General exclusion database lists specific reasons for exclusions, and exclusions are enumerated in federal statute. She said tracking the federal statute to identify the reasons for exclusion in the database could be difficult for individuals.

The Medicaid Inspector General stated at the June 22–23, 2020, meeting the OMIG was monitoring KDHE's compliance with the Medicaid eligibility provisions of the Families First Coronavirus Response Act and, based on reviews to date, KDHE was in compliance. The OMIG was also monitoring encounter data for COVID-19 testing for any activity suggestive of fraud or a consumer protection violation. The OMIG also received concerns regarding the potential incentive for fraud due to KDADS' temporary suspension of rules prohibiting parents and spouses from being paid personal care attendants and had taken the concerns under advisement. The Medicaid Inspector General reported 112 complaints alleging Medicaid eligibility fraud had been received by the OMIG since the Committee's February meeting.

At the June 22–23, 2020, meeting, the Medicaid Inspector General provided a brief summary of an ongoing investigation by the OMIG regarding the extent to which TA waiver recipients were receiving authorized SMC services and whether there were any trends among the beneficiaries who had difficulty in accessing these services. No standout trends had been identified as of the meeting date.

With the resignation of the Medicaid Inspector General, the Deputy Attorney General and Chief Information Security Officer for the Office of the Attorney General was serving as administrator for the OMIG. He provided testimony regarding the OMIG at the September 28, 2020, meeting. The

administrator stated a recruiting process was in place to find a candidate to fill the Medicaid Inspector General position. Since the Committee's June meeting, the OMIG had received 242 complaints, and the majority alleged beneficiary fraud. Personal care services continue to be a high-risk area for fraud, waste, abuse, and illegal acts regarding Medicaid. In a recent 6-month study by the OMIG, $49,294.67 was identified in possible improper payments claimed by 30 different personal care attendants while the beneficiary was hospitalized. The cases were referred to the Medicaid Fraud and Abuse Division.

The administrator stated at the September 28, 2020, meeting the OMIG conducted a performance audit on KDHE's processes for discontinuing Medicaid eligibility when a beneficiary enters a state prison and conducted a follow-up review because deficiencies were found. This resulted in the issuance of capitation payments to KanCare MCOs for $184,997.43 for ineligible persons. The follow-up was to determine if the Appriss notification system was working as intended and if the KDHE Clearinghouse staff was taking appropriate action based on notifications. The follow-up testing revealed KDHE received timely notices of each inmate's incarceration, and the KDHE Clearinghouse staff took prompt action to either sustain or discontinue Medicaid coverage as appropriate based on individual circumstances.

The administrator stated a report regarding TA waiver issues was not completed for the September 28, 2020, meeting due to COVID-19 quarantine issues, but the OMIG hoped to have the report for the December 2020 meeting.

At the December 9, 2020, meeting, the administrator reported the Office of the Attorney General is still in the process of recruiting a Medicaid Inspector General. The initial round of interviews was held the week of November 22, 2020, with the second round to be conducted the week of December 7, 2020. Since the September 2020 meeting, 136 complaints have been received. The OMIG is partnering with KDHE on a process improvement plan to provide more insight to policymakers about the types, amounts, and outcomes of eligibility fraud referrals received. The OMIG continued to monitor encounter data related to COVID-19 testing to identify improper activity. A summary report of the numbers of tests and the costs per test was provided. A review of monthly capitation payments made after beneficiaries' deaths was provided, with the OMIG having identified approximately $1.3 million in such capitation payments made on behalf of 25 beneficiaries. The OMIG believed these improper payments were due to delays with the implementation of the KEES. After corrections were made, the improper payments were automatically offset from the three MCOs' monthly capitation payments. The exception was payments made to Amerigroup, whose contract expired at the end of 2018.

KanCare Ombudsman

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

At the February 28, 2020, meeting, the KanCare Ombudsman provided highlights from the 2019 KanCare Ombudsman Annual Report. She noted outreach and education were trending down due to decreased staff and staff turnover. The Wichita satellite office was trending down due to staff shortages and extra calls being sent to the Topeka office to handle. There was an increase in renewal issues in the HCBS TA waiver, and KDHE researched the issue and corrected it. Medicaid eligibility issues and related categories were trending down. KDHE implemented several strategies due to an upward trend in Medicaid renewal issue contacts, which resulted in a significant decrease in these contacts in the fourth quarter. She also noted the Wichita State University Community Engagement Institute and Ombudsman staff created a brief survey to track satisfaction with the services provided by the Office in the Wichita area, and additional surveys are planned for the Topeka and Olathe offices.

At the June 22–23, 2020, meeting, the KanCare Ombudsman provided an update on the Office, noting all offices have been closed since the second week of March 2020 due to COVID-19. A majority of Office volunteers are over the age of 65 and may have underlying conditions. Individuals working remotely began answering calls on March 30, 2020. The tentative plan was to reopen the Johnson County office in July 2020 and the Wichita Office in late August 2020, depending

on local phasing plans. No face-to-face KanCare application assistance will occur until a vaccine for COVID-19 is available, but application assistance was being provided by phone. The KanCare Ombudsman noted less than five percent of all persons requesting assistance need assistance face-to-face. The Office is limiting face-to-face assistance for the volunteers' protection from COVID-19.

A copy of the first quarter 2020 KanCare Ombudsman Report was provided at the June 22–23, 2020, meeting. The KanCare Ombudsman noted appeals and hearings had doubled during the first quarter and, as requested, would inform the Committee on the cause. With regard to funding for the Office, KDADS assumed the funding for the Ombudsman position when it was one person. As the Office has grown, KDADS continues to fund the Office out of its agency budget. Because the Office addresses only Medicaid, it is partially funded by the federal government; KDADS is able to pull down federal funds. A grant with Wichita State University provides funding for a staff person who helps with the volunteer program.

At the September 28, 2020, meeting, the KanCare Ombudsman stated the Wichita satellite office remained closed, and employees were working remotely. In the Johnson County satellite office, one volunteer had returned to work in person, and the rest of the staff were waiting to return in person due to health concerns. The Office noted a 47 percent decrease in contacts in the second quarter of 2020 compared to the first quarter of 2020. The Office was participating in the Integrated Referral and Intake System to help community-based organizations connect families with community resources.

The KanCare Ombudsman reported at the December 9, 2020, meeting that two volunteers were back in the Johnson County satellite office. Three volunteers in training have begun mentoring training. Staff are still working remotely, except when working with volunteers for training and mentoring purposes. The Office is actively recruiting for a Volunteer Coordinator and two volunteers in Service to America positions. Initial contacts in the third quarter were up from the second quarter, but still lower than the first quarter. The KanCare Ombudsman said she believed the increases may be due to a social media boost in July and participation in the Integrated Referral Intake System. The Third Quarter report was provided.

Report on Provider Survey on Telemedicine

A United Methodist Health Ministry Fund representative noted at the December 9, 2020, meeting that, due to the COVID-19 pandemic, the federal government and the State of Kansas issued emergency telehealth policy changes to improve access to telehealth and preserve access to care during the pandemic. The United Methodist Health Ministry Fund partnered with provider groups to survey members about their experiences with the delivery of telehealth services. The representative said research from the University of Kansas School of Medicine showed both providers and members benefited from the expanded use of telehealth services during the pandemic. It was stated telehealth is not intended to replace in-person care. The United Methodist Health Ministry Fund representative stated the Legislature needed to explore options to expand telehealth services and set appropriate reimbursement rates that move toward parity in payment.

An Associate Professor at the University of Kansas School of Medicine presented an overview of the telehealth provider survey. She stated "telehealth" is considered more broad than "telemedicine." The overview included a list of the key takeaways, a review of the geographic distribution of the respondents, a breakdown of the respondents by organization and the types of providers represented, the modalities used to deliver telehealth, and a list of the services provided *via* telehealth. A comparison of pre-COVID-19 and potential post-COVID-19 reimbursement for services was provided. Charts were provided noting the results regarding the overall telehealth experience. The Associate Professor provided a review of the upcoming Phase 2 of the research and responded to questions regarding the details of the survey. With regard to payment parity, the Associate Professor responded that no definition was provided to those participating in the survey. She noted a question needs to be asked about any difference in the cost of one modality over the other and how it effects what is billed.

KanCare Meaningful Measures Collaborative

At the February 28, 2020, meeting, a representative of the KanCare Meaningful Measures Collaborate (KMMC) Executive Committee provided written-only testimony to update the Committee on recent work by the KMMC prior to its March 2, 2020, meeting.

At the June 22–23, 2020, meeting, a UnitedHealthcare Community Plan (UHC) representative reported on KMMC's organization structure, purpose, and the priority areas at the time of the meeting, with pregnancy outcomes being an area of focus. It was noted the Kansas Health Institute facilitates the collaborative. A Kansas Health Institute representative discussed care coordination and provided examples of meaningful measures. Network adequacy is an additional area of focus, and steps are being taken to develop meaningful measures.

At the December 9, 2020, meeting, a University of Kansas School of Social Welfare project manager stated the purpose of the KMMC is to establish consensus around which data and metrics are most needed to better understand the program. The current priority areas of care coordination, network adequacy, pregnancy outcomes, and social determinants of health were noted. The meaningful measures and metrics for each priority were reviewed. Highlights of the reports created for each priority were provided, except for social determinants of health.

A Kansas Health Institute representative discussed consumer engagement at the December 9, 2020, meeting. A survey was conducted as a snapshot of how approximately 700 KanCare consumers who received behavioral health services *via* telehealth felt about the service. There were high levels of satisfaction and a preference for some form of telehealth to continue following the COVID-19 pandemic. There will be continued analysis of telehealth consumer engagement survey results. Potential new priority areas for consideration include behavioral health (mental health and substance abuse), communication, quality assurance, and telehealth.

Presentations on KanCare from Individuals, Providers, and Organizations

Written and oral testimony was presented at each quarterly Committee meeting from individuals, providers, and organizations. Some individuals and organizations provided praise for the following: improvement in the LTC Medicaid application process since it was transferred back to KDHE in December 2019, the increase in the PIL for persons on the HCBS waivers, improved communication due to monthly standing calls between provider associations and MCOs to discuss issues, an increase in Medicaid dental rates in 2019, the increase in the SMC rate (later eliminated under the allotment plan), more transparent information regarding COVID-19 clusters, the SPARK Taskforce providing PPE for adult care homes, the PPE portal, and the unified testing strategy.

Concerns and suggested solutions presented by conferees are summarized below.

Concerns

Waiting list. Many individuals have been on the I/DD waiting list of more than 4,000 adults and children for almost a decade. There is insufficient capacity in the community even if the waiting lists is eliminated.

I/DD. The growing population of older individuals with I/DD faces additional chronic age-related conditions that increase their medical needs and the complexity of such needs. A data system is needed to ensure a less costly and more efficient way to meet the needs of individuals with I/DD. Training is needed for behavioral health providers to address the needs of the I/DD population. Increasing crisis exceptions indicate Adult Protective Services involvement because the needs of the I/DD and autism populations are not being met, placing them at risk of involvement with law enforcement. Incarceration due to behaviors instead of treatment in an ICF or state institution needs to be addressed.

The I/DD population does not fit the MCO medical model. Incarcerated individuals with I/DD do not receive all of the prescribed psychotropic medications needed, even when the individual is awaiting state hospital admission. The push for

development of an *Olmstead* plan could have a goal to further downsize and close ICF/IDD homes, which are the best settings for some of the I/DD population. There is a lack of ICF facilities. States are moving in the direction of forcing residents needing an ICF level of care into community-based care homes that do not provide the types of services and skilled staff needed. Families in crisis are not permitted to access the ICF care option under KDADS gatekeeping policies. Serious financial impacts have been suffered by I/DD providers due to the COVID-19 pandemic, and no relief has been provided by the State to help offset the impact. The level of need of the individuals on the waiting list should be known.

KDHE Clearinghouse. Discriminatory practices exist due to the inaccessibility of the KDHE Clearinghouse to individuals with disabilities and the wait times. There are long delays for approval of crisis exceptions. There are delays in the HCBS application and renewal process.

Targeted Case Management (TCM). Duplication of services exists because MCO care coordinators provide the same services as TCMs. There is a lack of notification by care coordinators to TCMs when individuals are moved from one HCBS waiver to another.

Protected Income Limit (PIL). The current PIL cap creates an obstacle for individuals looking for employment and can be a deterrent to looking for a job or striving for a better one.

Workforce. There is a need for competitive reimbursement rates to attract and maintain a trained workforce. There is a staffing crisis in LTC facilities. Staffing agencies are charging rates for temporary nurses and nurse aides that LTC facilities cannot sustain.

Prompt payment. Prompt payment loopholes for MCOs need to be closed. Submitting claims to the KDHE Clearinghouse prevents clean claims from being date stamped as received because of errors in the State's claims system; this is resulting in uncompensated care.

LTC. Legislation allowing edited tapes to be admissible in a court of law should not be enacted. There is a staffing shortage in LTC. Pay differentials between adult care home staff and staff provided by temporary staffing agencies, which charge twice the pay for their temporary staff, need to be addressed. Regulatory change is needed to allow certified medication aides to administer insulin to insulin-dependent residents. Survey oversight by KDADS has not improved for state-only licensed facilities. There is a need to address the increased use of antipsychotic drugs, high turnover rates among facility staff, and scarce evidence of quality improvement. The State still has an institutional bias that needs to change. Quarantine protocols also add to the workforce problem. Nonstop testing is a massive undertaking logistically and financially. PPE costs are rising and shortages continue.

Behavioral Health. It is difficult to find an adequate provider for a child in psychiatric distress in Kansas.

COVID-19. The State has left LTC providers without COVID-19-related liability protection given to other providers in 2020 Special Session HB 2016, only providing an affirmative defense. Liability insurance rates for LTC facilities have increased even without lawsuits against them. LTC facilities are faced with a lack of funding, workforce shortages, and a lack of PPE. The PPE received by LTC providers was inadequate to protect the individuals providing care. There is a need for fully funded access to rapid-results testing for older residents and care providers.

Without additional funding, most LTC facilities will likely close in the next 6 to 12 months. The cost of mandatory nursing home staff testing, additional PPE, sanitation supplies, and other COVID-19-related budget increases are placing a financial burden on LTC facilities. If the proper PPE is used in LTC facilities, the cost of per resident need is astronomical. The protocol for LTC facilities to request PPE is a complicated multi-step process, with no guarantee the materials will be made available. LTC facilities are walking a fine line between following rules and regulations and doing what is right for residents dealing with the effects of isolation, while not allowing potentially asymptomatic COVID-19-positive visitors into the facility to the detriment of

residents. It was difficult for LTC facilities to find labs to process the tests collected and testing results were delayed. There is confusion within temporary agencies providing staff to LTC facilities about which staff members need to be tested and when the testing should happen. State guidance is needed to protect older Kansans' lives. Some LTC facilities may not need SPARK funding until 2021, but SPARK funding has stipulations on how the funds may be used, and they can only be used until the end of 2020.

State and local officials need to make COVID-19-related data transparent and timely. Older adults living in nursing homes are being isolated with no recourse. There is a lack of federal oversight requiring public health reporting that identifies nursing homes with COVID-19 cases, which is information older adults and their families deserve.

PPE for direct care workers is in short supply. Individuals with disabilities are struggling to have their daily needs met. I/DD service providers are having difficulty accessing COVID-19-related items such as PPE and virus testing equipment and supplies. COVID-19 testing has become a challenge, especially in rural areas of the state. The I/DD population should be prioritized in the distribution of PPE and testing supplies due to having a higher susceptibility to complications from COVID-19.

PPE costs, increased wages and overtime, service interruptions, and COVID-19 relief funding have impacted SMC providers.

Specialized Medical Care (SMC). Grossly inadequate SMC rates are causing staffing shortages that cover less than 60.0 percent of medically necessary authorized hours and that result in delayed hospital discharges, unnecessary rehospitalizations, and compromised health outcomes. Even with the increase in SMC rates, nurses providing SMC level of care remain severely underpaid. There is difficulty in recruiting, training, and retaining SMC nurses in a field that is in high demand.

Money Follows the Person (MFP). Kansas has not taken the opportunity to gain supplemental funding from CMS for the MFP program. Kansas needs to reinstate the MFP program.

Home modifications. MCOs are requiring individuals to seek other funding options for home modifications and provide documentation of the outreach and responses, although the service is covered by Medicaid.

Oral health. There is a need to improve the Medicaid dental provider network and to provide oral health benefits to adults in the Medicaid program. Several dental codes were omitted from the state plan amendment to increase Medicaid dental reimbursement rates.

Employment. The State needs to break barriers to help individuals with disabilities find employment in competitive integrated settings. Planning services need to be expanded. There are shortfalls in the Work Opportunities Reward Kansans program.

Prescription medications. Tresiba needs to be included in the KanCare preferred drug list to allow ease of access.

Recommended Solutions

Conferees offered comments on potential solutions in the categories below.

I/DD. A statewide crisis support program should be created to address systemic barriers and developing statewide solutions for effective services for diagnosis, behavioral health treatment, medication management, and crisis support. Community-based care management should be used to integrate all services into one plan. An intensive community support model for Kansans with I/DD and autism who are caught in the criminal justice system, the Sequential Intercept Model, should be used to identify those individuals who need preventive services. The State needs to ensure any *Olmstead* plan submitted or under consideration will honor guardian choice and protect individual, human, and civil rights. The unnecessary care coordinators and MCOs for the I/DD population should be eliminated. The State needs to develop mechanisms to preserve I/DD provider capacity, including retainer payments and enhanced provider rates that have been used in other states. The $22.1 million,

including $8.9 million SGF, for I/DD service providers, which had been removed from the FY 2021 budget by the Governor's July allotment, must be restored. Cross System Crisis Prevention and Intervention Plans should be implemented to improve the I/DD system, as they would provide tools to support an individual through a crisis. Mobile Crisis Support programs should be considered, and community-based care management should be considered as an alternative to traditional TCM. A study of Kansans on the waiting list should be conducted to answer questions about their needs and to build a tool to make this information easier to access and update. A tool to predict the needs over a three- to five-year period for individuals on the waiting lists is needed to better equip the Legislature and KDADS to make funding decisions and to benefit providers in making strategic plans.

Waiting lists. The State should review the current I/DD waiting list for the actual level of need and review how other states have dealt with their waiting lists. A strategic plan for the elimination of the I/DD waiting list should be created. The Legislature should pass legislation with provisions of 2020 HB 2550, which would direct this Committee to study the rates for services provided under the I/DD waiver and their impact on the I/DD waiting list and expand the study to included providers serving persons on all waiting lists.

Provider tax. The Legislature should extend the provider tax for another five years at the current rate, with a review again in the future.

PIL. The PIL should be increased to 300 percent of SSI, which is $2,369 per month, to break down employment barriers for individuals with disabilities and help elders needing community-based services remain in their homes.

LTC. Stronger oversight of temporary staffing agencies is needed. Adoption of an insulin administration training program for certified medication aides working in skilled nursing facilities, assisted living facilities, residential health care facilities, or home plus facilities should be considered. There is a need to support funding for home-based care. Increased funding should be provided to KDADS to fulfill its federally and state-mandated oversight functions and inspection time frames for adult care facilities to interrupt and prevent abuse and neglect of elders living in nursing facilities. A five-year sunset to the Quality Improvement Provider Assessment (nursing facility bed tax) should be set to allow for adequate review, and Medicaid funding should be tied to address specific improvement outcomes for elders residing in nursing facilities, such as workforce understaffing. The Committee should consider amending the Senior Care Act to include individuals under 60 years of age who have been diagnosed with younger-onset Alzheimer's or other forms of dementia, and funding should be added to cover the additional individuals.

Funding is needed for additional KDADS survey staff responsible for inspecting nursing facilities and adult care facilities. Enhanced state funding should be used to fund improvement outcomes that are specific and measurable. Efforts should continue on legislation to deal with the rates charged by staffing agencies. LTC facilities need to be provided liability protection for health care activities related to the COVID-19 public health emergency. A pathway for temporary nurse aides to become certified nurse aides should be created.

Prompt payment. There are mechanisms in place to address unusual claims. There are contract provisions between KDHE and the MCOs that require the MCOs to make payment when the State directs or instructs such payment in special claims. There is a mechanism through KDHE to instruct the MCOs to make payment timely when due with interest in unusual cases, including those that involve timely filing.

HCBS. There is need to fund community-based initiatives to allow older adults and persons with disabilities to remain in the community. Specific infrastructure is needed for current HCBS participants and to shift away from institutional care to home-based services; this includes strong case management, PPE, and testing. The State should create an *Olmstead* plan.

Workforce. Solutions for addressing the workforce shortage could include future COVID-19 relief funding tied directly to increasing staff wages, state "wage pass-through dollars," support

from the National Guard, extension of the temporary aide position, holding virtual clinics for certified nurse aide courses, and state agency support for collection of testing samples.

COVID-19. Federal funds being held by the State need to be released without delay to assist LTC providers. State guidance must be accompanied by tangible resources and hands-on help. Funding is needed to allow individuals to transition back into their communities. The focus should be on marshaling and distributing resources to stop the spread of the virus, assuring adequate oversight of adult care facilities, ensuring transparency of public COVID-19 information, and public reporting of federal and state COVID-19 funding.

SMC. The State should increase the provider reimbursement rate for SMC to $47 or $48 per hour to attract nurses with the skill level to care for medically fragile children. The State should implement the recommendations of the TA waiver work group. Money should be transferred from the KDHE hospital caseload budget to KDADS to fund the SMC rate increase. The rate increase could be budget neutral or a potential cost savings.

Behavioral Health. Expanding Medicaid, increasing the Medicaid reimbursement rate, continuing telemedicine treatment parity by the federal government, and allowing therapy to be billed in Medicaid without the patient being present would assist CMHCs during and after the COVID-19 pandemic. The mental health system in Kansas needs an overhaul, as it is extremely difficult to navigate.

TCM. The State should restore TCM services to support people in home settings of their choice, which is more cost effective and safer during times of emergency, such as the COVID-19 pandemic. The State should reinstate the MFP program to support persons moving out of nursing homes.

Oral health. The inclusion of an additional increase of $3.0 million, all funds, for dental reimbursement rates in the FY 2021 KDHE budget is needed. The Dental Practices Act should be amended to authorize teledentistry, as teledentistry has been an important asset to triage needs during the COVID-19 pandemic.

Employment in integrated settings. Increased access to benefit planners at KDHE to help individuals with disabilities work and to navigate the complex systems is needed.

Conferees

Private citizens and representatives of the following organizations and providers testified or provided written-only testimony before the Committee: AARP Kansas; Americare Systems; Association of Community Mental Health Centers of Kansas, Inc.; Brewster Place; Case Management Services, Inc.; Craig HomeCare; Disability Rights Center of Kansas; GrassRoots Advocates for Independent Living; InterHab; Jenian, Inc.; KanCare Advocates for Better Care; KanCare Advocates Network; Kansas Adult Care Executives Association; Kansas Association of Area Agencies on Aging and Disabilities; Kansas Association of Centers for Independent Living; Kansas Developmental Disability Coalition; Kansas Health Care Association/Kansas Center for Assisted Living (KHCA/KCAL); Kansas Hospital Association; LeadingAge Kansas; Logan Manor Community Health Services, Maxim Healthcare Services; Morningstar Care Homes; Oral Health Kansas; Recover-Care Healthcare; Self Advocacy Coalition of Kansas; Southeast Kansas Independent Living Resource Center; Sunshine Meadows Retirement Community; Thrive Skilled Pediatric Care; and Topeka Independent Living Resource Center.

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. A representative of the Department for Children and Families (DCF) addressed one issue at the June 22–23, 2020, meeting. A spreadsheet prepared and updated after each meeting by KLRD staff was used to track issues presented to the Committee and the resolution of those concerns. The state agencies and MCOs used the spreadsheet to respond to the concerns. Each conferee concern was identified by name, the issue was noted, and the agency response or resolution was provided. Issues determined by the Committee to have been addressed were noted as closed and removed from future tracking spreadsheets.

The list included recurring topics: the PIL, the HCBS waiting list, eligibility issues, the impact of COVID-19, and mental health questions.

KDHE Responses

At the February 28, 2020, meeting, a KDHE representative reviewed the responses of the agency regarding unresolved Medicaid issues (both general issues and specific issues) identified by conferees at previous Committee meetings. With regard to outstanding claims owed by the prior MCO, Amerigroup, the KDHE representative stated timelines in the appeals process are dependent on when the adverse action occurred and when the provider was notified the claim was denied. Each provider would have had a contract with Amerigroup containing specific language as to the time frames for appeals and a date of no further action. The contract provides the bulk of information on the appeal process and the communication must start with the provider and Amerigroup. The State can step in only at a certain point in time. If there is no response from Amerigroup, KDHE would step in. One large payment is due to Amerigroup, but the release of those funds is not entirely tied to the settlement of claims being appealed by providers. The federal government places restraints on the holding of payments to the MCOs. There are federal timely filing requirements for federal matching dollars KDHE must meet that are different from those for the filing of claims. If KDHE fails to meet the timely filing requirements, it runs the risk of not receiving the federal matching dollars.

At the February 28, 2020, meeting, the KDHE representative stated KDHE does not plan to expand its definition of a "good cause" reason for a beneficiary to change MCOs. A change would be made if good cause is present, and consumers have an opportunity on an annual basis to change MCOs. The representative also stated the rules and regulations process to update the regulation on the PIL increase to 150 percent of SSI was underway.

Other topics addressed by the KDHE representative at the February 28, 2020, meeting included: how Medicaid expansion would provide access to affordable health care for the direct care workforce whose low wages place health care out of reach, the insufficient reimbursement rates contributing to the workforce shortage in adult care homes, and complaints of delays in the credentialing process.

At the June 22–23, 2020, meeting, a KDHE representative presented the status of unresolved KanCare issues. Regarding a deadline when providers would no longer receive payment for claims from Amerigroup, the deadlines are established based on the negative actions taken by Amerigroup, on which appeal may be taken. The representative did not have a dollar amount of claims still outstanding for Amerigroup because she did not know the nature of the dispute.

At the June 22–23, 2020, meeting, the KDHE representative addressed the reason the implementation date for the CMS-approved supported employment pilot for persons on the HCBS waiting lists who have behavioral health needs was not to begin until 2021. She noted the design of the program is complex, and KDHE had to work on policies and benefits for the persons participating. Both KDADS and KDHE are responsible for parts of the project due to the population involved. She also addressed the hold on the community service coordination project to assist KanCare beneficiaries, stating it was due to the current COVID-19 public health emergency, but KDHE was trying to restart the project.

The KDHE representative stated at the June 22–23, 2020, meeting that KDHE assumed processing of eligibility for the elderly, disabled, and LTC programs in January 2020, and processing was in compliance. Because of noncompliance by Maximus, there was a reduction in the contract, and KDHE assumed some of the work under the contract. There were no damages assessed to Maximus for noncompliance.

After providing responses at the September 28, 2020, meeting on unresolved issues included in the spreadsheet that pertained to KDHE, a KDHE representative responded to several Committee member questions. The representative noted KDHE and KDADS do not have a target completion date for the KDHE project related to community service coordination. The KDHE representative stated the KDHE Clearinghouse was accessible to the public, but access was available by appointment.

At the December 9, 2020, meeting, a KDHE representative provided responses to unresolved issues and responded to questions. Regarding the administrative regulation reflecting an increase in the PIL, the regulation would go into effect 15 days after publication and carries the same weight as a statute. A Committee member stated a bill to codify the PIL would be introduced during the 2021 Legislative Session.

KDADS Responses

At the February 28, 2020, meeting, a KDADS representative provided responses to unresolved issues within KDADS' authority and addressed questions posed by Committee members regarding the issue of turnover of MCO care coordinators, indicating KDADS is monitoring the issue. The KDADS representative indicated KDADS would make it a priority to meet with TCMs for the I/DD population to discuss concerns that managed care does not fit the needs of the I/DD population and that a conflict of interest exists with those determining the needed services also being the provider of services. KDADS has had extensive conversation on the conflict of interest issue with CMS and needs to have conversations with the TCMs. The representative noted having both TCMs and care coordinators employed by an MCO is doable.

Regarding the posting the results of federal surveys conducted by KDADS and sent to CMS, a KDADS representative stated at the February 28, 2020, meeting the State is not required to post the results on a state website. The federal survey results are posted on the CMS website. The KDADS survey results website is used to post state-only licensed facility surveys, and KDADS tries to post the federal surveys for the other facilities on the KDADS website, as staffing allows.

At the June 22–23, 2020, meeting, KDADS representatives addressed unresolved issues. KDADS was making progress on the I/DD waiting list and made a request in its budget for FY 2021 for some additional funding to reduce the waiting list. Regarding not meeting the statutory funding for nursing homes, a representative stated KDADS had tried to adjust the rebasing process based on the statutory language. KLRD staff was asked to provide the Committee with statutory funding requirements the Legislature was not meeting. A list of any unmet health-related funding requirements is to be provided to the Committee and all unmet statutory funding requirements are to be provided to the House Committee on Appropriations.

A KDADS representative was asked at the June 22–23, 2020, meeting to provide a response on how to close the issue of dual-diagnosed individuals being dropped from the SED waiver and having to wait years to receive I/DD services.

At the June 22–23, 2020, meeting, a KDADS representative responded to a question regarding nursing students being unable to complete their training. The representative stated because of COVID-19, KDADS allowed some flexibilities. Students must complete a clinical component for the academic program before they can be licensed, and part of that component needs to be done in a clinical setting. KDADS allowed the students to work as certified nurse aides or work in a simulated lab for the clinical part of their curriculum. If students were already working in a nursing setting, the work was counted as part of the clinical requirement.

Regarding receiverships, a KDADS representative stated at the June 22–23, 2020, meeting that two receiverships remain, one in Great Bend and the other in Topeka.

At the September 28, 2020, meeting, a KDADS representative reviewed the status of unresolved issues and responded to Committee members' questions. Regarding the reasons a provider might not want to accept federal dollars provided by the CARES Act, the representative stated some providers may not have incurred significant costs to support accepting the funding and would have to attest for any dollars received. The representative states CARES Act dollars could not be used to replace revenue for government entities, including county facilities.

At the September 28, 2020, meeting, a KDADS representative provided a breakdown of the funding made available to nursing facilities. She noted the $10.0 million in SPARK Taskforce funds was for state-licensed facilities only and to

purchase PPE and cleaning supplies. This funding was approved on September 18, 2020.

A KDADS representative provided the agency's responses to unresolved issues and responded to questions. The representative stated the reason the State would not want to move a child who no longer qualifies for the SED waiver and put them immediately on the I/DD waiver would be the child would be placed at the top of the I/DD waiting list and drop someone on the list further down; a fiscal note will be provided on the impact of such a move. With regard to receiverships, there were no new nursing homes in receivership. Some facilities had temporary management and were trying to avoid receivership.

The process for approval of funds for communication devices for LTC facilities was explained by a KDADS representative at the September 28, 2020, meeting. As part of the application process, each facility signed off that the devices were for resident and not staff use. A 2020 Special Session HB 2016 COVID Allocation – Facility List, which captures the funds provided or available to adult care homes and LTC facilities across Kansas in response to the COVID-19 pandemic, was provided. The PPE listed on the allocations spreadsheet was for PPE that had been shipped and was being received by facilities. The following responses were provided: KDADS was paying for the PPE ordered through the portal; the formula for PPE allotment was based on the number of beds, which is about 40,000; the deadline for requesting the funds was December 30, 2020, and orders need to be placed and shipped prior to the deadline to qualify; the PPE does not have to be used by the deadline but cannot be stockpiled; and there should not be more then a 30-day supply of PPE available at a LTC facility. The reporting period for CARES Act moneys was March 1 to December 30, 2020. That is the period for which businesses need to report all costs related to business interruptions, expenses, and increased staffing.

DCF Responses

The Secretary for Children and Families provided testimony at the June 22–23, 2020, meeting in response to concerns with staffing of Adult Protective Services (APS) that were included in the unresolved issues spreadsheet. The Secretary noted 63 of the 65 positions were filled. She stated while APS caseloads were higher than she would prefer, the response rate had not been negatively affected. A breakdown of APS staffing ratios by region was provided.

MCO Responses

The representatives of each of the MCOs provided responses to unresolved issues. Responses to specific Committee questions are provided below. At the June 22–23, 2020, meeting, a representative of the Kansas Association of Medicaid Health Plans provided written-only testimony regarding MCO payments of the KAN Be Healthy program and vaccination charges.

Aetna. At the February 28, 2020, meeting, an Aetna representative provided responses to outstanding issues identified in the spreadsheet, noting all specific issues pertaining to Aetna had been resolved. With regard to a high turnover of care coordinators, the Aetna representative stated Aetna had 159 care coordinator positions, with 2 vacancies. At the September 28, 2020, meeting, the Aetna representative stated Aetna continues to follow the required state credentialing process. The Aetna representative provided updates at the December 9, 2020, meeting.

Sunflower Health Plan (Sunflower). The Sunflower representative responded at the February 28, 2020, meeting to issues identified in the outstanding issues spreadsheet. With regard to the cap on SMC, the representative said the State Plan indicates there is a limit of 12 hours per day. KDADS has provided new direction that the cap is a soft limit and, if there is a documented need for additional hours, the MCO should be able to fill it. The representative expressed concern about the ability to fill the SMC hours approved due to lack of staff and the gap between the state rate and the market rate. He stated Sunflower would approve special case agreements on a case-by-case basis to meet the SMC needs. The KanCare contract describes the SMC covered benefit as 1 unit of 15 minutes. At the September 28, 2020, meeting, the representative stated no new updates on the unresolved issues spreadsheet were available.

UHC. At the February 28, 2020, meeting, the UHC representative provided responses to

unresolved issues only for those issues with responses that differed from responses provided at the November 2019 meeting. With regard to a high turnover of care coordinators, the UHC representative stated there are only 2 care coordinator openings out of 167. UHC's annualized care coordinator turnover is between 4 percent and 9.5 percent, which is reasonable for UHC. The representative also noted the following: UHC is working with the New Birth Company on an arrangement of value-based outcomes for birth services under KanCare, turnaround for functional credentialing for UHC is 11 days and contracting to participate in the program takes 18-20 days, and no routine denial of services by UHC was identified. At the September 28, 2020, and December 9, 3030, meetings, the UHC representative provided responses and updates regarding unresolved issues related to UHC.

MCO Presentations

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

Aetna Better Health of Kansas

At the February 28, 2020, meeting, an Aetna representative provided an update on the major accomplishments since the November 2019 Committee meeting, including the filling of key leadership positions. A review of the CAP remediation was included in the testimony. A review of the Aetna action plan moving forward was provided. An Aetna representative noted the steps the company was taking to proactively communicate with providers, including the formation of a provider advisory council scheduled to meet on March 31, 2020.

An Aetna representative stated at the June 22–23, 2020, meeting that Aetna had successfully met all the requirements of the CAP. A list of Aetna's areas of future focus was given. The representative described an enhanced provider model focusing on building relationships, which included increased provider communications and relations resources. A review of services Aetna had provided during the COVID-19 pandemic was presented. The representative described the Family Finding Initiative, noting it has a goal of connecting each child with a family so that every child may benefit from the lifelong connections only a family can provide. The core beliefs and six essential components of the initiative were outlined, along with the plan for implementation.

At the September 28, 2020, meeting, an Aetna representative stated Aetna adapted to different care delivery and communication models to better serve its members during the pandemic. Aetna provided over 5,300 COVID-19 tests to its members. Regarding whether Aetna agreed with having one MCO oversee foster care members in KanCare, the Aetna representative said there were pros and cons to doing it that way.

An Aetna representative stated at the December 15, 2020, meeting that Aetna had maintained a high level of service throughout the pandemic utilizing modern care delivery and communication models, such as telehealth. Because of telehealth, there had been increased utilization of the Brain Injury (BI) waiver therapies and an increase in the utilization of remote patient monitoring. Aetna also completed the External Quality Review Organization Audit. The representative noted the number of COVID-19 tests given to members, the instances of care related to COVID-19 that was provided, and the number of COVID-19 outreach calls made to support members. Aetna also provided HCBS services to students receiving remote learning, primarily focusing on attendant care.

Sunflower Health Plan

A Sunflower representative provided health plan highlights at the February 28, 2020, meeting. Value-added benefits had increased in the past year. The vaccination program, Fluvention, generated a 2.76 percent increase in flu vaccine claims over the same time the previous year. The representative provided a summary of Healthcare Effectiveness Data and Information Set rates, which are federal government measures used to track improvement. There was improvement in childhood and adolescent Healthcare Effectiveness Data and Information Set measures. A Sunflower Long-term Services and Supports Treatment Satisfaction Survey conducted for the third year showed 95.0 percent of Sunflower members were satisfied with the quality of services received. An overview was provided for the No One Eats Alone program in five Kansas middle schools and Project

Echo, a lifelong learning and guided practice model. The number of admissions to PRTFs, average lengths of stay, current number of members in a PRTF, and the number of members approved and on the PRTF waiting list as of February 21, 2020, were also provided.

At the June 22–23, 2020, meeting, a Sunflower representative testified as to Sunflower's response to the COVID-19 pandemic. A list of programs and projects to address care management was provided, including approving temporary long-term services and supports for children out of school who received these services in a school setting prior to the COVID-19 pandemic and persons no longer using I/DD day services. The representative provided Sunflower's responses related to social determinants of health, such as broadband connectivity with providers, grants for provider telehealth equipment, and financial support to food pantries. Sunflower was able to maintain claim processing levels during the COVID-19 pandemic, exceeded goals in customer service calls by transitioning to work-from-home plans, and maintained a commendable accreditation level and achieved long-term services and supports distinction from the National Committee for Quality Assurance. Information Healthcare Effectiveness Data and Information Set measures improvements for 2019 and 2020 and PRTF data on average length of stay, admissions, and waiting list were provided. A request was made to report future claims processing data without pharmacy claims, which were believed to skew the data because of the instantaneous response.

A Sunflower representative stated at the September 28, 2020, meeting the MCO had provided face masks to 15 Northwest Kansas Area Agency on Aging community developmental disability organizations and multiple CMHCs. Food and educational supplies and grocery delivery services were provided to Sunflower members. A Sunflower representative stated there were pros and cons to having one MCO oversee all foster care members; a benefit would be having one MCO with a concentrated area of expertise; however, members sometimes criticized not being allowed a choice for their MCO.

At the December 15, 2020, meeting, a Sunflower representative provided an update on Sunflower's efforts during the pandemic. Sunflower distributed tablets to long-term services and supports and aging providers to support individuals with social isolation. Cloth face masks were distributed to educational agencies, foster care contractors, other partners, and members designated at high risk for COVID-19. Through Appendix K, over 1,000 school-age students with disabilities who are receiving remote education are being provided HCBS services. The representative also provided responses to questions from the September 29, 2020, meeting regarding the lower percentage of Sunflower pharmacy appeals resolved during the second quarter of 2020 as compared to the other MCOs, the pros and cons of a single MCO providing coverage for foster care children, and admissions and average length of stay in PRTFs.

UnitedHealthcare Community Plan of Kansas

At the February 28, 2020, meeting, a UHC staff member provided testimony regarding a bridge housing pilot project being launched in Kansas in 2020, named Housing First. Housing First is an approach to connect individuals and families experiencing homelessness to housing without preconditions and barriers to entry. The Housing First program is focused on individuals who are medically complex, with high dollar claims, and who are also homeless. The high volume areas for homelessness are Sedgwick County and the Kansas City area. UHC providers are expected to focus on providing housing and care management in the units for a duration of one year. It is expected Kansas providers will focus on multi-site or single-site settings that are low barrier or no barrier, with a goal of having the individual transition in place. The programs provided must be evidence-based for trauma-informed care. Information was provided on the impact of these types of programs in other states. UHC was in negotiations with the project bidders and anticipated having a contract with providers by March 2020, with the program starting in April or May 2020. The representative said the settings are existing structures the providers already have ready, are a good fit, and are Americans with Disabilities Act-accessible units. Information about the PRTF waiting list and admissions also was provided.

A UHC representative described UHC's response during the pandemic at the June 22–23, 2020, meeting. A list of temporary services provided to UHC members was given. A list of programs provided as part of the COVID-19 relief efforts totaling nearly $1.0 million was given. A description was provided of the federally qualified health center (FQHC) Transformation Pathways, which have a goal to deploy a targeted incentive model that supports providers' needs to address the impact of COVID-19 while investing in transformation efforts targeting access to care and improved outcomes. The transformation pathways included addressing the COVID-19 pandemic, Healthy Children, Healthy Pregnancy, Integrating Behavioral and Physical Health, and Living with Chronic Conditions, and additional projects related to housing and food access also were undertaken. One project described was a housing pilot in Sedgwick County, the Housing First model, which would provide housing for UHC members. UHC's COVID-19-related provider outreach efforts to help meet supply needs were noted. With regard to the impact of COVID-19 on UHC's day-to-day management, issuance of provider payments, and similar operations, the representative noted UHC tried to lower the payment time frames to get payments to providers since utilization had declined. UHC also worked with the other MCOs to streamline the process. Overall, UHC made a total investment in Kansas of over $2.0 million above the KanCare contract requirements. Data regarding the UHC PRTF waiting list was provided.

At the September 28, 2020, meeting, a UHC representative provided a list of Empowering Health Grants that were provided. Examples of the partnering in Kansas between FQHCs and UHC, such as the FQHC Transformation Pathways, were provided. This included implementing telehealth solutions for pediatric patients, focusing on well child visits and addressable social barriers. A chart reflecting UHC's efforts related to food and housing services provided to its members and COVID-19 provider outreach efforts were also discussed. The UHC presenter agreed with the other MCOs that there were advantages and disadvantages with having one MCO oversee foster care members in KanCare.

A UHC representative stated at the December 15, 2020, meeting that there had been no reductions in existing services during the COVID-19 pandemic. Temporary services were authorized to include telehealth, personal care services, and home-delivered meals. UHC provided long-term services and supports members and skilled nursing facilities with COVID-19 testing kits. The Safety, Testing, Overall, Partnership (STOP) initiative was created to address the health disparities of disadvantaged communities. UHC donated surgical masks to each FQHC partner. Meals were distributed through the Mom's Meals program. The testimony included responses to questions posed at the September 28, 2020, meeting related to foster care, managed care, Appendix K flexibilities of IEPs, the PRTF waiting list, and COVID provider outreach efforts.

Human Services Consensus Caseload

Staff from the Division of the Budget, DCF, KDHE, KDADS, and KLRD met April 16, 2020, to revise the estimates on human services caseload expenditures for FY 2020 and FY 2021, and on October 28, 2020, to revise estimates on caseload expenditures for FY 2021 and to develop estimates for FY 2022. 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 2020 and FY 2021 was an all funds decrease of $9.4 million and an SGF decrease of $40.9 million below the amount approved by the 2020 Legislature for FY 2020 and FY 2021. In response to a question regarding funds set aside in the budget for Medicaid expansion, the KLRD fiscal analyst stated there were funds in the budget for Medicaid expansion, but because no expansion legislation was passed by the Legislature, the funds went in the COVID-19 relief fund.

Fall Estimate

The estimate for FY 2021 was a decrease of $20.3 million from all funding sources, including a decrease of $166.5 million SGF, below the budget approved by the 2020 Legislature, adjusted for reappropriation of money not expended in FY 2020 and for funds allotted by the Governor in FY 2021. The estimate for FY 2022 is an increase of

$184.2 million from all funding sources, including an SGF increase of $204.8 million, above the FY 2021 revised estimate.

340B Drug Pricing Program

A representative of Community Care Network of Kansas provided testimony at the December 9, 2020, meeting regarding a threat to the 340B drug pricing program. The 340B drug pricing program was passed by Congress in 1992 to provide equitable access to medications. The program allows nonprofit providers to stretch federal resources and works by drug manufacturers selling drugs at discounted prices to community health centers, hospitals, and other eligible providers. The representative stated the threat is from pharmacy benefit managers (PBMs) attempting to force health centers into contracts that treat them differently because they are a 340B program. She stated this was an attempt by pharmaceutical companies to increase their revenues by limiting or eliminating the 340B program. To date, seven states prohibit PBMs from treating community health centers, hospitals, and other 340B providers differently simply because they participate in the 340B program. She requested full support from the Legislature to ban such activity.

A representative of the Health Ministries Clinic also presented at the December 9, 2020, meeting, stating the relief being sought was legislation that would prohibit PBMs from engaging in actions that reduce funding for Kansans' health care while increasing the PBMs' profits. He noted the remedy required no additional spending by the State, while providing substantial benefits to its residents. The 340B program gives community health centers a mechanism to ensure their patients, who are disproportionately uninsured or under-insured, have the ability to obtain prescribed medications.

At the December 9, 2020, meeting, a representative of Salina Family Healthcare Center provided an overview of the actions taken by PBMs requiring the Center to sign three contracts that have reduced its pharmacy reimbursement rate solely based on its eligibility to participate in the 340B program. He described how the PBMs' actions have impacted his facility. He also provided a 340B program savings impact statement, noting the critical programs and health care services supported by his facility's 340B program savings.

Presentations on HCBS Appendix K Flexibility for IEP Services

KDADS Presentation

A KDADS representative provided testimony at the December 9, 2020, meeting regarding Appendix K, which can be utilized by states during emergency situations to request amendment to approved Section 1915(c) waivers. A list of the CMS-approved Appendix K flexibilities for Kansas was provided. After receiving questions and concerns from parents, providers, and educators about how the needs of school-age waiver participants would be supported during remote learning, KDADS drafted an amendment to the State's existing approved Appendix K (Additive Appendix K#4) and submitted it to CMS for approval. Additive Appendix K#4 proposed to allow medically necessary personal care services and SMC services to be provided during remote school hours as a flexibility afforded during the COVID-19 pandemic. During discussion with CMS, it was determined the amendment was unnecessary, as the State could utilize Early and Periodic Screening, Diagnosis, and Treatment to deliver the medically necessary services. Since the Additive Appendix K#4 amendment was submitted to CMS in draft form, no formal action was necessary to abandon the amendment.

The KDADS reviewed the process to request Appendix K flexibilities at the December 9, 2020, meeting. A list of the waivers to which Appendix K applies was provided. The representative noted the current Appendix K is time-limited and expires January 26, 2021. Services for these students pivot from fee-for-service to managed care delivery. Local education authorities (LEAs) bill KDHE directly for Medicaid services paid as fees for services. MCOs authorize medically necessary Early and Periodic Screening, Diagnosis, and Treatment services through managed care. The LEAs and Medicaid service providers bill only for services actually provided, and there is no duplication of payment for services. The children receiving the attendant care and nursing services are the same children who already receive HCBS waiver services during the summer and school breaks and are now being provided services in the home due to a remote learning situation. Not all

special education children with IEPs receive these services; only those children currently receiving HCBS services would qualify.

Kansas State Department of Education Presentation

A KSDE representative testified regarding the interplay between the federal Individuals with Disabilities Education Act (IDEA) and the Kansas Special Education for Exceptional Children Act. He explained the complexity of services that are not educational in purpose but are necessary for a child to access a free appropriate public education (FAPE), as required by IDEA. The school assumes these services when the school is in session. When the school is not in session, these services are provided in-home through HCBS. The Individual Education Plan (IEP) team determines what it means to receive FAPE for each student, based upon the specific circumstances and context of a given child. If non-educational in-home services are required for a student to receive FAPE and are provided by the LEA, the district may be able to submit a claim for state special education categorical aid or federal Medicaid to subsidize the cost. If the services are found to be unnecessary for FAPE and not provided, the LEA receives no additional state or federal aid.

Integrated Care Presentations

Several individuals provided testimony on the topic of integrated care at the December 15, 2020, meeting. A Kansas Health Institute representative presented a review of the recommendation related to integrated care developed by the System Capacity and Transformation Working Group of the Special Committee on Mental Health Modernization and Reform that met during the 2020 Interim. The introduction to this working group's report stated an important strategy for system transformation would be to "address the continuum of care to ensure an integrated and coordinated approach to care delivery," and the working group designated the recommendation for immediate action (within two years). A second working group, the Finance and Sustainability Working Group, included a recommendation also for action within the next two years, related to the Certified Community Behavioral Health Clinic (CCBHC) Model.

A federal Substance Abuse and Mental Health Services Administration representative provided testimony on integrated care. She noted primary care settings have become a gateway to the behavioral health system, and its providers need support and resources to screen and treat individuals with behavioral and general health care needs. She stated the solution lies in primary and behavioral health care integration. The representative discussed the enactment of the federal Protecting Access to Medicare Act of 2014, which contains a section requiring HHS to establish a process for the certification of CCBHCs as part of a two-year demonstration project under Medicaid. She described the CCBHC model and its benefits and provided a timeline of the CCBHC preparation, planning, and demonstration phases and the awarding of the CCBHC expansion grants, some of which went to southeast Kansas. The required quality measures and reports to Congress were outlined. Information on some of the outcomes of Missouri's CCBHC program were provided, including a 25 percent increase in veteran participation, a 20 percent increase in access to care, and decreasing emergency room visits and hospitalizations.

Several individuals representing the Washington State Health Care Authority (HCA) provided testimony regarding a range of HCA activities with "social determinants of health" (SDOH), integrated care, and the Collaborative Care Management (CoCM) model. The SDOH activities noted included: the Medical Transformation Project (MTP) waiver; examining opportunities to link SDOH with Medicaid managed care purchasing and employee benefit purchasing, which is still in research and development; and MTP Foundational Community Supports, which targeted federal funding to provide supportive housing and supported employment to high needs Medicaid clients. One presentation focused on the MTP Foundational Community Supports program, which is based on the idea that stable employment leads to healthier lives, and addressing housing concerns can result in reduced health care costs. Outcomes data from a preliminary report on this program was provided. The presentation on integrated care included information on legislation enacted in Washington in 2014 to change the way the state purchased mental health and substance use disorder services

in the Medicaid program. The state was directed to fully integrate the financing and delivery of physical health, mental health, and substance use disorder services in the Medicaid program *via* managed care by 2020. Information was provided on how this integration was to be carried out and successes in those regions adopting the program early. The CoCM model was implemented in 2018 and was based on Medicaid rates. The CoCM required, in order to receive payment, the group must have a team trained to deliver care that included a psychiatric consultant, a primary care provider champion, staff with training in aspects of behavioral health, and a registry for tracking progress and interaction with patients.

A Community Health Center of Southeast Kansas (CHCSEK) representative provided information on the integrated care model currently being used at CHCSEK. She noted the various services provided by the Community Health Action Team and CHCSEK's OneCare program. The representative stated CHCSEK cannot bill for TCM with all KanCare members, because they are not a CMHC, but a FQHC. She recommended the Committee explore more opportunities for all providers to bill for services like TCM that support and promote integrated care models.

MCOs' Collaborative Testimony on Integrated Care

Sunflower and UHC representatives provided collaborative testimony on behalf of Sunflower, UHC, and Aetna on integrated care. Multiple representatives for each of the MCOs also were available for questions from the Committee members. A UHC representative listed the impacts of behavioral health issues on Americans. The impact and benefits integrated care can have on individuals was discussed. She noted system barriers include communication and collaboration, infrastructure and investments, and incentives and performance. The representative stated the goal of integrated care was "achieving the triple aim": cost of utilization, population health, and experience of care. The testimony included a handout, "Integrated Care and State Policy in Kansas: Case Study of Community Health Center of Southeast Kansas." The Sunflower representative noted the importance of working internally to remove communication barriers and working outside the MCOs' comfort zones.

In response to questions, the UHC representative stated there are rehabilitative codes that only CMHCs can use. The codes are not only TCM rehabilitative health services, but other rehabilitative services as well. Although codes play a large part in the move to integration, there is still the need for specialists to focus on the areas they do best. The Sunflower representative also noted some of the codes are high cost. The representative said consideration should be given to the overall effect on the system of opening the codes to more providers and the need to proceed with caution so as not to devastate part of the health care system. The Sunflower representative noted there were creative ways to incentivize providers to work together without opening codes and to look at barriers in place to prevent integration.

COVID-19 and LTC Facilities

At the December 15, 2020, meeting, representatives of KDADS, LeadingAge Kansas and two of its members, and the KHCA/KCAL and two of its members presented testimony on COVID-19 testing strategies and the challenges being faced by LTC facilities due to COVID-19.

KDADS

A KDADS representative provided an update on KDADS testing strategies. He noted the federal government shipped point of care testing machines to 319 nursing facilities with a current Clinical Laboratory Improvement Amendment certificate of waiver in three waves of delivery between July 20 and November 6, 2020. The facilities received enough tests and kits for one round of tests. The facilities were directed to buy additional tests from the manufacturer to continue using the testing machines to meet the staff testing requirements set by CMS. Nursing facilities reported a backlog from the manufacturer to obtain more test kits. The facilities were required to have positive tests confirmed with a polymerase chain reaction (PCR) test, which tests for genetic material from the virus. Through Operation Warp Speed, HHS had distributed or was slated to distribute Abbott BinaxNOW rapid test cards to 106 assisted living facilities and 264 nursing facilities in Kansas. These rapid result tests are used in detecting COVID-19 antigens. The tests would be free of charge and would be prioritized to serve vulnerable populations including nursing homes,

assisted living facilities, and home health agency workers to address the shortage of supplies for the point of care testing machines in nursing facilities. When a positive antigen test occurred, facilities could use the KDHE lab or access the SPARK Taskforce-funded regional labs to confirm a positive result from their point of care testing machine. The frequency of the required testing in nursing facilities is dependent on the COVID-19 positivity rate. CMS authorized the use of the KDHE positivity rates to determine the required testing frequency. A summary of all allocations by nursing facilities by funding type was provided.

The KDADS representative reviewed the principle of the Governor's unified testing strategy, with a goal of controlling community spread by expanding statewide testing beyond those with symptoms and cluster investigations, coordinating public and private testing efforts across the state, and communicating testing goals and objectives. The representative discussed the application process for SPARK Taskforce funds, including the goal and who was eligible, and outlined the populations to prioritize and the scalability. The distribution of SPARK Taskforce funds and their use were as follows: $10.0 million in round 1 allocated to counties, $24.0 million in round 2 to increase lab capacity, and $52.0 million in round 3 to implement a unified testing strategy. The SPARK funding process for round 3 was presented. The representative provided a summary of the three sections of the round 3 testing RFP: laboratory testing solutions, high-risk populations, and innovative strategic solutions. A summary of the proposals received from qualified bidders was provided. Some labs were given money up front to allow for setting up the labs. Payments to the labs were made on the number of tests run. A list of the nine labs contracted out for statewide COVID-19 testing and a map showing the counties covered by each lab and the testing services provided was presented. The KDADS representative stated the testing began mid-November and may be able to continue into 2021 if funding continued. The representative said the State was well short of the $52.0 million set aside for testing because the average number of tests per day had not hit the threshold. KDHE will be asked to provide the Committee with the status of the spending by contracted lab.

In response to questions, the KDADS representative stated a survey of LTC facilities licensed by KDADS was conducted prior to rolling out the regional labs. The survey indicated the vast majority of the LTC facilities had the resources to test (700 facilities said they were able to comply with testing, approximately 100 said they were not testing, and 120 to 130 did not respond). The representative said requirements were not placed on LTC facilities that they could not meet. If a facility was unable to comply with testing requirements due to lack of testing supplies or the inability to afford the supplies, they could make their best effort and document the reason to avoid being penalized.

The KDADS representative responded that early in the pandemic, COVID-19 testing was not being done at all nursing facilities. Facilities licensed by CMS were mandated to start testing on August 25, 2020. KDADS had concerns the availability of supplies and testing results could not be guaranteed to state-licensed facilities to meet a testing requirement. With the availability of SPARK Taskforce funding for testing, the State was more comfortable with setting a testing requirement for state-licensed facilities through Executive Order Number 20-69, effective December 14, 2020.

Concern was expressed by a Committee member regarding the position nursing facilities were being placed in if they were relying on a false negative test result. The KDADS representative stated the facilities could use the rapid test for one required test and the PCR test for the second test, so a false negative could be caught in the second test. KDHE would provide further clarification on this topic.

LTC Associations and Members

A LeadingAge Kansas representative discussed two major issues its LTC facility members are facing during the COVID-19 pandemic: the lack of liability protection and staffing shortages.

The LeadingAge Kansas representative stated LTC providers were the only health care providers excluded from full COVID-19 liability protection. She noted for all other health care providers, the protections given were narrowed to only health

care activities related to the COVID-19 emergency and do not apply to acts, omissions, or decisions that result in gross negligence or willful or reckless conduct. She said these liability protections preserve the right to go after the "bad apples." LTC facilities are asking the Legislature for the same liability protections granted to other health care providers. She said singling out the LTC facilities for personal injury class action lawsuits during the pandemic threatens the existence of the senior care system in Kansas, and it has also sparked a crisis in the liability insurance markets and may ultimately threaten the State's Health Care Stabilization Fund.

The LeadingAge representative stated the COVID-19 pandemic has caused a shortage in the nursing home workforce. Staffing agencies are short on workers, and their charges for nurses and nurse aides have quadrupled. The 10- to 14-day quarantining requirements before placing a new agency nurse or aide into a nursing facility delays the placement of temporary staff in nursing facilities. Staff are working 80- to 100-hour work weeks. The following were among the possible solutions to reduce the workforce shortage: using the National Guard to assist with specific tasks, continuing the use of temporary nurse aides and a pathway to certified status after the emergency order has ended, and limiting staffing agency charges. Information regarding testing was included in the testimony but was not presented.

A Logan Manor Community Health Services (Logan Manor) representative testified as to her facility's challenges with COVID-19. She expressed concern over an increase in sadness and depression resulting from the residents' inability to see friends and relative other than through closed windows or communication devices. The residents' health is declining due to isolation and an inability to leave the facility. The rates of depression have increased, and residents have decreased appetites resulting from eating alone in their rooms. The representative provided a review of the first and subsequent round of cases of residents and staff contracting COVID-19.

The Logan Manor representative discussed the staffing issues the facility encountered, with staff working over 80 hours per week and some staffing agencies not willing to send temporary staff to the facility or staffing not being available for three to four weeks. She stated testing has been a problem because results are not available in a timely manner, taking ten or more days to get the results. A change in the lab used has reduced the test result time to two days. She said although the facility was able to order the PPE needed, the cost was high. The facility experienced difficulty in obtaining testing kits for a few weeks. HHS is sending weekly Abbott rapid testing cards to the facility.

A Brewster Place representative stated PPE has been an issue for his facility, at times requiring the use of handmade face coverings for staff and residents. Staffing has been a major concern, with caregiver applications dropping from 30 per month to 3 per month. The promised direct caregiver time per resident per week has been cut by 500 hours at the facility due to staffing issues. He said testing is a daunting task. The inability to take patients for rehabilitation, which is a major part of the facility's revenue stream, due to staffing shortages has caused difficulties for the facility and hardship for patients who need a family member to be released from the hospitals but who have nowhere to go. He noted nursing homes need additional funding not tied to difficult to adhere to mandates and a solution to the staffing shortage.

A KHCA/KCAL representative stated she believed the federal and state governments have failed the nursing home residents and the people who care for them during the COVID-19 pandemic. She stated workforce instability is the most difficult to deal with. Wage pass through legislation and funding and helping to transition temporary nurse aides to certified nurse aides could help address the workforce needs. KHCA is working with Health Care Occupations Credentialing and KDADS to allow training online and clinicals at the facilities where the temporary nurse aides are employed. Providing a waiver to nursing facilities banned from providing nurse aid training due to survey results would also assist with the workforce instability. She noted the Legislature needed to revisit funding for front-line workers.

The KHCA/KCAL representative stated another issue is the rapidly increasing insurance rate. She said nursing facilities need liability protection like that of other health care providers.

The third issue addressed by the KHCA/KCAL representative was the risk of insolvency and closure. Noting the $1.9 billion total economic impact LTC facilities have on the State, she said the State needed to provide stable and sustainable funding for LTC facilities. The representative noted the industry is in crisis.

A representative of Recover-Care Healthcare stated concerns related to COVID-19 management and prevention, noting the virus has exposed the weaknesses across all sectors, and there is no playbook to fall back on. He said providers have been left to innovate and apply protocols to prevent the spread, and there have been inconsistent and inaccurate guidelines from public health officials. He said there had been a large misuse of people and resources in performing a large number of surveys across his 22 facilities, with only 2 deficiencies issued. He stated PPE and staffing have been major concerns. The COVID-19 pandemic has made recruiting, which was already difficult, even more difficult. Wages are low and working in clinics and hospitals was a preferable environment. He stated staffing agencies are recruiting caregivers by offering high wages and passing along the cost to the nursing facilities.

An Americare Systems representative cited two primary issues that have had a significant impact on her organization during the pandemic. The first issue is staffing. She noted eight Directors of Nursing in the skilled division have left due to regulations, liability concerns, the difficulty of the job, and a lack of staff. She stated in her organization with almost 800 employees, there were 80 open positions at the time of the December 15, 2020, meeting. Proper funding for Medicaid would be a solution to the staffing issue. Her second concern was the difficulty in navigating through the process because each county had different reporting requirements, as do multiple local entities within the counties. She asked the Legislature to look at improving the Medicaid reimbursement for LTC facilities. The representative stated in her organization's current situation, there is the possibility of 1 or 2 facilities closing in the state, affecting 100 employees and 80 residents.

Written testimony on the impact of COVID-19 was provided by representatives of the Kansas Adult Care Executives Association and Kansas Advocates for Better Care.

Conclusions and Recommendations

The Committee recommends:

- The House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare hold informational hearings within the first 60 days of the 2021 Legislative Session on the 340B Drug Pricing Program;

- The House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare hold informational hearings within the first 60 days of the 2021 Legislative Session regarding the efforts of Oral Health Kansas;

- The Legislature review how other states estimate caseloads;

- The K-TRACS prescription drug monitoring program be funded through the State General Fund;

- Nursing facilities be given the same immunity from civil liability provided to healthcare providers in 2020 Special Session HB 2016;

- The Legislature address the systemwide health care workforce issues, for example: safety, shortages, pay, education, licensure, and training (such as virtual training of certified nurse aides by nursing facilities);

- The Legislature work on integrated care and coordinating general and behavioral health, which includes mental health, substance abuse, and primary care;

- The Legislature monitor the financial stability of long-term care facilities in Kansas;

- The Legislature monitor and report the increase in HCBS waiver services provided to school-aged children in remote settings;

- The Legislature support expansion of the federal Excellence in Mental Health Act and then pursue participation. If participation in the Excellence in Mental Health Act is not possible, pursue a state plan amendment or change to the Section 1115 Waiver to allow interested providers to gain access to the Certified Community Behavioral Health Clinic (CCBHC) model. [*Note:* This recommendation mirrors Recommendation 2.1 of the Special Committee on Mental Health Modernization and Reform working groups' report to the Special Committee, *Strategic Framework for Modernizing the Kansas Behavioral Health System*.];

- The Legislature consider adding PACE to the consensus caseload process;

- Regarding telehealth, the Legislature should:

    - Develop standards to ensure high-quality telehealth services are provided. This includes: establishing consistent guidelines and measures for telehealth in collaboration with licensing and regulatory agencies, requiring standard provider education and training, ensuring patient privacy, educating patients on privacy-related issues, allowing telehealth supervision hours to be consistently counted toward licensure requirements, and allowing services to be provided flexibly when broadband access is limited;
    - Maintain reimbursement codes added during the public health emergency for behavioral telehealth services and consider options to prevent loss of facility fees so that providers are not losing revenue by delivering telehealth services;
    - Establish coverage of telehealth for crisis services to allow for the use of telehealth with law enforcement and mobile crisis services and explore virtual co-responder models for law enforcement to aid police departments and other law enforcement agencies as they respond to mental health crises in rural and frontier communities;
    - Address the following items to ensure that individuals receive, and providers offer, telehealth in the most appropriate locations: adopt a broad definition of originating site, consistent with the Kansas Telemedicine Act; allow staff to provide services from homes or other non-clinical sites, if patient privacy and safety standards can be met; and examine issues related to providers practicing, and patients receiving, services across state lines, such as by exploring participation in interstate licensure compacts; and
    - Utilize telehealth to maintain service and provider continuity as children, particularly foster children, move around the state and consider how the unique needs of parents of children in the child welfare system can be met *via* telehealth. [*Note:* The telehealth recommendations mirror Recommendations 10.1 through 10.5 of the Special Committee on Mental Health Modernization and Reform working groups' report to the Special Committee, *Strategic Framework for Modernizing the Kansas Behavioral Health System*.]; and

- Study and consider adjusting PACE rates annually, similar to the KanCare managed care organizations.

The Committee expressed concern and suggested the Legislature look at the charges nursing facilities incur when temporary staff must be used to meet workforce needs.

The Committee proposed a Committee bill be introduced containing the language of 2020 HB 2550, as amended by the House Committee on Social Services Budget, to increase reimbursement rates for providers of HCBS under the Intellectual and Developmental Disability waiver.

APPENDIX A

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

ANNUAL REPORT FOR THE 2020 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 2020 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) 2020, together with the number of individuals added to HCBS due to crisis or other eligible program movement during SFY 2020. The following abbreviations are used in the table:

- ICF/IDD — Intermediate Care Facility for Individuals with Developmental Disabilities
- SFY — State Fiscal Year

I/DD INSTITUTIONAL SETTINGS AND WAIVER SERVICES*	
Private ICFs/IDD: Average Monthly Caseload SFY 2020	110
State I/DD Hospitals – SMRH: Average Monthly Caseload SFY 2020	288
I/DD Waiver Community Services: Average Monthly Caseload SFY 2020	9,106
*Monthly averages are based upon program eligibility. Sources: SFY 2020—Medicaid eligibility data as of October 31, 2020. The data include people coded as eligible for services or temporarily eligible.	

The following provides a summary of the average monthly caseload. The caseload had 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. The MFP program has ended. 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 Facilities-Average Monthly Caseload SFY 2020	10,500
Head Injury Rehabilitation Facility	31
FE Waiver: Average Monthly Caseload SFY 2020	4,834
PD Waiver: Average Monthly Caseload SFY 2020	6,014
TBI Waiver: Average Monthly Caseload SFY 2020	461
*Monthly averages are based upon program eligibility. Sources: SFY 2019—Medicaid eligibility data as of October 31, 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 2014 – 143
FY 2015 – 144
FY 2016 – 141
FY 2017 – 142
FY 2018 – 140
FY 2019 – 138
FY 2020 – 132

PARSONS STATE HOSPITAL AND TRAINING CENTER: AVERAGE DAILY CENSUS

FY 2014 – 174
FY 2015 – 173
FY 2016 – 163
FY 2017 – 160
FY 2018 – 160
FY 2019 – 162
FY 2020 – 157

PRIVATE ICF/IDD: MONTHLY AVERAGE*

FY 2014 – 143
FY 2015 – 140
FY 2016 – 137
FY 2017 – 133
FY 2018 – 137
FY 2019 – 119
FY 2020 – 110

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
FY 2020 – 10,500

*Monthly averages are based upon Medicaid eligibility data.

Savings Resulting from the Transfer of Individuals to HCBS

In most, but not all cases, services provided in the community do cost less than those provided in an institutional setting, such as an ICF/IDD or a nursing facility. However, “savings” are only realized if a bed is closed behind the person transferring to HCBS. Due to demand, beds are typically refilled by individuals requiring the level of care provided by the facilities, therefore, the beds are not 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 October 31, 2020, 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 October 31, 2020, was $0.