MINUTES

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

April 29, 2019
Room 548-S—Statehouse

Members Present

Senator Gene Suellentrop, Chairperson
Representative Brenda Landwehr, Vice-chairperson
Senator Barbara Bollier, Ranking Minority Member
Senator Ed Berger
Senator Bud Estes
Senator Mary Pilcher-Cook
Representative Will Carpenter
Representative Susan Concannon
Representative Nancy Lusk, appointed substitute for Representative Barbara Ballard
Representative Monica Murnan

Members Absent

Representative Barbara Ballard
Representative John Barker

Staff Present

Iraida Orr, Kansas Legislative Research Department
David Fye, Kansas Legislative Research Department
Melissa Renick, Kansas Legislative Research Department
Ben Baumann, Kansas Legislative Research Department
Scott Abbott, Office of Revisor of Statutes
Eileen Ma, Office of Revisor of Statutes
Gary Deeter, Committee Assistant

Conferees

Roxanne Hidaka, Co-owner, Case Management Services
Haely Ordoyne, Legislative Committee Co-chair, Kansas Adult Care Executives Association
Karren Weichert, Chief Executive Officer (CEO), Midland Care Connection
Rachel Monger, Vice President of Government Affairs, LeadingAge Kansas
Sean Gatewood, Co-administrator, KanCare Advocates Network
Mike Oxford, Executive Director for Policy and Advocacy, Topeka Independent Living Resource Center
Lou Ann Kibbee, Systems Advocacy Manager, Southeast Kansas Independent Living Resource Center
Christi Nance, Policy Director, Oral Health Kansas

Mike Burgess, Director of Policy and Outreach, Disability Rights Center of Kansas
Dr. Lee Norman, Secretary of Health and Environment, Kansas Department of Health and Environment (KDHE)
Christiane Swartz, Deputy Medicaid Director, KDHE
Adam Proffitt, Finance and Informatics Director, KDHE
Kim Burnam, Eligibility Director, KDHE
Janis DeBoer, Deputy Secretary, Kansas Department for Aging and Disability Services (KDADS)
Amy Penrod, Commissioner, Community Services and Programs, KDADS
Patty Brown, Interim Commissioner, Survey, Certification, and Credentialing, KDADS
Kim Lynch, Chief Counsel, KDADS
Andrew Brown, Interim Commissioner, Behavioral Health Services, KDADS
Kerrie Bacon, KanCare Ombudsman
Amy Deckard, Assistant Director for Information Management, Kansas Legislative Research Department
Sarah Fertig, Medicaid Inspector General
Keith Wisdom, President and CEO, Aetna Better Health of Kansas
Michael Stephens, Plan President and CEO, Sunflower Health Plan
Kevin Sparks, CEO, UnitedHealthcare Community Plan
Carrie Kimes, Director of Provider Relations and Network Strategy, UnitedHealthcare Community Plan
Sandra Berg, Director of Behavioral Health, UnitedHealthcare Community Plan

Others Attending

See Attached List.

Morning Session

Welcome

The Chairperson called the meeting to order at 9:05 a.m. and outlined the schedule for the day.

Presentations on KanCare from Individuals, Providers, and Organizations

The Chairperson welcomed those providing testimony and recognized Roxanne Hidaka, Co-owner, Case Management Services, who outlined issues of concern regarding KanCare including:

- Individuals with intellectual and developmental disabilities continue to lose food assistance on a daily basis;

- The KanCare Clearinghouse (Clearinghouse) problems have improved, but coding mistakes continue to cause unnecessary delays;

- Individuals in crisis are often ignored while on the Intellectual/Developmental Disabilities (I/DD) waiting list;

- Work with the managed care organizations (MCOs) is complex and often counter-productive; and

- The community developmental disability organizations (CDDOs) need oversight (Attachment 1).

Haely Ordoyne, Legislative Committee Co-chair, Kansas Adult Care Executives Association (KACE), focused on issues creating unnecessary problems for those in KACE. She noted the eligibility application process is now more complex and creates untenable delays, which are financially crippling many service providers. Further, low reimbursement rates and difficulties with timely reimbursements limit providers in offering high-quality health care (Attachment 2). She also noted, in 2018, there were 22 nursing homes that went into receivership, a fact that does not bode well for the future of long-term care (LTC) in Kansas. Ms. Ordoyne expressed support for 2019 HB 2404, which would create the Kansas Senior Services Task Force and would allow KACE a seat at the table to address key senior services concerns.

Karren Weichert, Chief Executive Officer (CEO), Midland Care Connection, explained the Program of All-Inclusive Care for the Elderly (PACE) as an alternative to Medicaid services through MCOs or Home and Community Based Services (HCBS) (Attachment 3). She said the program provides wrap-around medical and personal care services that enable a Medicaid-eligible, functionally frail person to remain at home, rather than being admitted to a nursing facility. PACE provides intermittent personal care services in the home; adult day health care at the PACE center; transportation for medical care; simple home modifications to assure a safe home environment; physicians and nurses on call 24/7 to respond to participant needs and make home visits as needed; and medical care for PACE participants, including LTC placement expenses and hospitalizations. Additionally, PACE directly provides physicians and advanced practice registered nurses to serve as the primary care providers to PACE participants and employs a full interdisciplinary team to coordinate care for participants. She reported the program is more individualized and less expensive than Medicaid and Medicare.

Rachel Monger, Vice President of Government Affairs, LeadingAge Kansas, said she echoed the concerns of previous conferees. She likewise noted the inadequacies of the current eligibility processing system and recommended returning the elderly and disabled application processing to the previous system under the Kansas Department of Health and Environment (KDHE). Ms. Monger stated support for requiring continued reporting by KDHE to the Committee on progress and performance as elderly and disabled eligibility processing transitions back to KDHE (Attachment 4).

Sean Gatewood, Co-administrator, KanCare Advocates Network, identified the protected income level (PIL) of $747 as a barrier that does not offer sufficient income for living expenses for those under the HCBS waiver. He cited examples of those individuals facing hardships created by the PIL and expressed hope that pending legislation raising the PIL to $1,177 will be approved. Responding to a question, Mr. Gatewood said his understanding is Medicaid expansion would not cause Medicaid reimbursement rates to increase (Attachment 5).

Mike Oxford, Executive Director for Policy and Advocacy, Topeka Independent Living Resource Center, expressed gratitude for agency staff over past years, as well as for the

pending PIL increase and the provider rate increase. He noted, in 1989, Kansas was the first state in the nation to enact legislation allowing self-directed care for individuals with disabilities, and Kansas continues to be the only state with detailed law giving such rights to individuals with disabilities. However, he requested Committee members address the HCBS workforce crisis of low wages resulting in a shortage of caregivers and the need for training for caregivers, which have limited individuals with disabilities from obtaining in-home personal care services. He recommended Kansas expand Medicaid, which would benefit most personal care attendants and other direct service and support workers, and expressed support for community service care coordination (Attachment 6).

The Chairperson noted Mr. Oxford's impending retirement and extended his appreciation for Mr. Oxford's advocacy for over 30 years.

Lou Ann Kibbee, Systems Advocacy Manager, Southeast Kansas Independent Living Resource Center, expressing gratitude for the pending PIL increase, noted her agency must absorb the client obligation if the client is unable to pay it. She stated the care attendant workforce shortage is the worst she has seen in over 42 years and expanding Medicaid would provide personal care attendants with health care coverage. Responding to a question, Ms. Kibbee replied the background check requirement for personal care attendants adds a complexity to self-directed care because the State determines whether an applicant can be hired, increasing the difficulty in finding care attendants given the workforce shortage. She also noted the MCOs' care coordinators often tell the client who is self-directing who the healthcare provider must be, rather than providing the client with a list of providers from which to choose (Attachment 7).

A Committee member stated, at this time, Senate and House conferees in the budget conference committee have agreed to increase the PIL to $1,147 per month at a cost of $5.3 million SGF to the State for fiscal year (FY) 2020. The PIL amount is not tied to 150.0 percent of Supplemental Security Income, rather it is a flat fee.

In response to a Committee member question regarding self-direction, Ms. Kibbee stated several concerns. With the care attendant background check requirement, the State is limiting who a provider may hire and determining individuals who can work for them, resulting in an increase in the workforce shortage. Additionally, instead of providing a list of providers to those individuals who self-direct care to allow a provider choice in accordance with law, the MCOs' care coordinators are telling these individuals who the provider will be.

Christi Nance, Policy Director, Oral Health Kansas, reviewed the results of recent studies indicating an increase in Medicaid dental rates in other states resulted in an expanded dental provider network and improved access to dental care. She cited reasons noted in one study for the low participation of dentists in Medicaid in the six states examined: low reimbursement rates, onerous administrative requirements, and unreliable patient participation. She expressed gratitude for the addition of $3.0 million, including $1.3 million from the State General Fund (SGF), reflected in the proposed FY 2020 budget to increase the Medicaid dental reimbursement rate. She stated Oral Health Kansas would work with the Division of Health Care Finance, KDHE, to determine how best to allocate the increased rates, if approved. Oral Health Kansas would also monitor the dental provider network to identify any increase in the network resulting from the increased rates. Responding to a question, she replied the proposed $3.0 million in additional funds for reimbursement still do not bring the Medicaid dental rates above 50.0 percent of the commercial rates (Attachment 8).

Mike Burgess, Director of Policy and Outreach, Disability Rights Center of Kansas, expressed gratitude for the proposed increase in the PIL and observed the increase will be life-changing for clients. He stated coding errors in the client obligation process cause significant financial problems for clients. He shared an example of an individual assessed with a client obligation since 1987 who, under federal law, should not have been required to pay. Mr. Burgess stated there likely are other individuals in the same federal child disability benefit category who had client obligations improperly withheld by the State. He asked the Committee to follow up with KDHE on the scope of the issue and the agency's plan to address it. He noted changing federal regulations and workforce shortages complicate many clients' lives (Attachment 9). In response to a Committee member's question, Mr. Burgess stated information from background checks goes to the State, which determines if the applicant may be employed, a fact that complicates the process for self-directed individuals who are attempting to employ personal care attendants.

Patty Brown, Interim Commissioner, Survey, Certification, and Credentialing Commission, Kansas Department for Aging and Disability Services (KDADS), responded to a Committee member question stating the background check information is provided to KDADS, and the statutorily prohibited offenses described in KSA 2018 Supp. 39-200 that disallow an individual from providing care are substantial offenses, primarily crimes against persons. Ms. Brown will provide information on the number per 100 applicants who are declined based on the results of background checks.

Another Committee member noted a previous conferee referenced 2019 HB 2404, which would establish the Kansas Senior Services Task Force to address many areas of concern for seniors. The Committee member noted the bill was passed out as amended by the House Committee for Children and Seniors, but remained below the line of General Orders in the House. The Committee member stressed the need for this task force, which would address many of the issues that have been expressed before the Committee. The Committee member expressed concern with waiting until the 2020 Legislative Session to pass this legislation to address the senior issues expressed.

The following individuals submitted written-only testimony:

- Kari Howell, Private Citizen (Attachment 10);
- Matt Fletcher, Executive Director, InterHab (Attachment 11); and
- Cindy Luxem, CEO and President, Kansas Health Care Association/Kansas Center for Assisted Living (Attachment 12).

Kansas Department of Health and Environment

Dr. Lee Norman, Secretary of Health and Environment (Secretary), KDHE, commented on several general issues:

- An agreement has been reached with Maximus, the contractor responsible for Clearinghouse eligibility application processing services, to extend the contract

and address the services to remain with Maximus and those that will be taken back in-house at KDHE;

- KDHE will be prepared to meet the required timeline for implementation should the Legislature approve Medicaid expansion;

- Recommendations have been made to the Governor to fill key leadership vacancies in the Health Care Finance Division, specifically the Deputy Secretary of Health Care Finance and the Medicaid Director, and appointments will be announced soon. The position of Medicaid Medical Director, currently held by the Secretary, will also be filled in the near future;

- The focus at the Clearinghouse is on improved customer service with a goal of processing the eligibility application correctly the first time;

- The Kansas Eligibility and Enforcement System (KEES) upgrade is on schedule;

- KDHE shares accountability with the MCOs for KanCare. A few areas for improved accountability to be addressed are:

    - Expanding the agency website to make performance measures available to the public;
    - Developing a dashboard around timeliness and efficiency; and
    - Ensuring adequate network capacity, especially the build up of Traumatic Brain Injury (TBI) services available in Sedgwick County;

- Where practical, KDHE will consider the decentralization of services to bring more personalized attention to clients;

- KDHE will pursue innovation to achieve access to primary health care services in all communities; and

- KDHE will continue to work with the Kansas Health Institute on improving the data available, with the goal of turning data into programs and solutions for improved health care services (Attachment 13) (Attachment 14).

The Secretary also referenced the Maximus application process chart (Attachment 15).

Christiane Swartz, Deputy Medicaid Director, KDHE, updated Committee members on the new MCO contracts and the continuity of care policy, the latter ensuring a smooth MCO transition for beneficiaries and providers. The open enrollment period available to all KanCare beneficiaries ended on April 3, 2019. The rapid response calls to address provider, association, and beneficiary questions will continue through the end of April 2019. With regard to the continuity of care policy, Ms. Swartz noted Aetna extended the policy timeline beyond the required 90 days. She also gave a progress report on the Section 1115 waiver approved by the Centers for Medicare and Medicaid Services (CMS) on December 18, 2018. The MCOs have completed the first quarter of operations. KDHE conducted training for all staff on the Standards Terms and Conditions (STCs), the rules under which the Medicaid program operates.

Responsibility for each STC was assigned to a staff member to maintain compliance with STC requirements and to avoid financial penalties that may be imposed on new waivers for non-compliance with STCs. Penalties of up to $5.0 million in lost Federal Financial Participation funding to KDHE may be imposed for non-compliance with STC requirements. The first quarterly report is due to CMS within 60 days of the end of the first quarter.

Ms. Swartz commented on the OneCare Kansas program, a new Medicaid medical health homes program that would provide the limited population of beneficiaries enrolled in the program with six additional core services not available under the standard Medicaid program. The program would coordinate physical and behavioral health care with long-term services and supports (LTSS) for people with chronic conditions. The scheduled implementation date is January 1, 2020. Ms. Swartz noted KDHE has a contract with the University of Kansas to assist in defining the target population and narrowing the criteria for those eligible to participate in OneCare Kansas.

Ms. Swartz responded to Committee members' questions:

- The OneCare Kansas program has yet to establish a reimbursement rate, scope, or identify the target populations; a newsletter has been created to keep interested groups apprised of the program's progress. Committee members requested inclusion on the newsletter subscription list;

- Information on whether a target number of individuals for OneCare Kansas has been identified or the number has been narrowed pending further determination of qualifying criteria will be provided to the Committee by KDHE. Additionally, KDHE will provide information on the department at the University of Kansas with which it is contracting to identify the OneCare Kansas population, the statement of work, and the progress under the contract; and

- With regard to the coding concerns expressed by another conferee, HCBS waiver services are provided in addition to Medicaid services. Each waiver uses a different code for services that, if not correctly applied, could cause problems with regard to the waiver services but not the Medicaid services.

Adam Proffitt, Finance and Informatics Director, KDHE, reviewed MCO financial data (profit and loss) for calendar year 2018 and the membership distribution across each MCO with the recent change in MCOs. He commented the MCOs' total gross profits of 1.2 percent based on the calendar year 2018 National Association of Insurance Commissioners filings were in line with program targets, and plans showed an increase in net profit of $1.9 million when comparing the fourth quarter of 2017 to the fourth quarter of 2018, an increase that was driven by a $500.0 million increase in revenues.

In compliance with a budget bill proviso requiring an update on the Clearinghouse contract be provided to the Committee should an agreement be reached with Maximus prior to this Committee meeting, Mr. Proffitt reported an agreement was reached with Maximus to extend the contract for 18 months, through the end of calendar year 2020. The contract terms will allow KDHE to assume the processing of the more complex Elderly and Disabled and LTC applications by January 1, 2020. In calendar year 2020, KDHE will also continue the training and quality responsibilities assumed in calendar year 2019. Maximus will continue processing all applications through calendar year 2019, with one caveat, and continue processing Family

Medical applications for calendar year 2020. In preparation for the assumption of responsibilities on January 1, 2020, KDHE will process applications that come through the Federally Facilitated Marketplace and some cost of living adjustments for Elderly and Disabled and LTC during the last half of calendar year 2019. Later in calendar year 2019, KDHE will issue a request for proposal for a new contract to begin on January 1, 2021, to process only the Family Medical applications; KDHE will continue to process the Elderly and Disabled and LTC applications.

Mr. Proffitt stated KDHE is asking for Committee support for the restoration of the $5.0 million funding removed from the KDHE budget, pending review at omnibus, in order to assist in the negotiating of the Maximus contract. He noted restoration of the funding would allow the contract to be funded in full and enable a smooth transition in KDHE application processing responsibilities beginning January 1, 2020. He stated, without the $5.0 million, KDHE would have to find a way to self-fund the Maximus operation or the in-house operation.

Mr. Proffitt answered Committee members' questions:

- As anticipated, there were many questions from members and providers about the new MCO, Aetna Better Health of Kansas (Aetna). Aetna provider negotiations, network adequacy, and claims processing are improving. KDHE is tracking the transition to Aetna and assisting as needed;

- KDHE spent equal time in the negotiations with Maximus dealing with the quality of services and finances to ensure the quality of services to be provided met the expected levels;

- A contract was signed to lease a building at Forbes Field in Topeka near the Clearinghouse location to house the KDHE staff who will be processing the Elderly and Disabled and LTC applications. KDHE reviewed available state offices, but none were found to meet the program's needs. The close proximity of the contracted building to the Clearinghouse, although not required, will facilitate on-site training, quality operations, and face-to-face interactions between the Clearinghouse and KDHE staff;

- Regarding the timeline for the KEES upgrade, approval for state funding for the upgrade was received earlier in 2019. The KEES upgrade is a joint venture by KDHE and the Department for Children and Families (DCF). An advance planning document was submitted to CMS, and approval was received on April 1, 2019, to use those funds for the KEES upgrade at an enhanced federal match rate. The upgrade will be a ten month process, with an anticipated launch date of mid to late March 2020, and time for testing is advised;

- Each MCO varies in the proportion of beneficiaries provided medical services versus non-medical services. Amerigroup had a higher number of the TBI and Technical Assistance waiver populations than other MCOs. KDHE will provide information comparing proportionate level of HCBS I/DD waiver services provided by each MCO;

- KDHE will provide further information comparing the profit and loss ratio in KanCare with other states' Medicaid programs, especially other Midwest states.

In terms of total profits and percentage, the KanCare MCOs on average make the $10.0 million profit level, which is approximately a 1.0 percent profit across the board. Kansas uses medical loss ratio (MLR) to determine MCO profit; the current MLR is 91.5 percent, which allows 7.5 percent for administrative costs and a 1.0 percent profit margin. A recent CMS final rule set a nationwide MLR cap of 85.0 percent. Kansas does not have a natural built-in profit margin for the MCOs. KanCare MCOs may request a risk corridor, which establishes an equal range on either side of the profit target. The risk corridor would allow the State to recoup funds when the MCO profit is too high and require the State to provide additional funds when the MCO profit falls below a certain level; however, the State's actuaries have estimated the profit margin well. With regard to the number of MCOs, Kansas is in line with surrounding states that have managed care; and

- KDHE would expect bids from three to five Maximus-type providers for the new Clearinghouse contract to begin in calendar year 2021. The bidding process is open to all entities, including Maximus.

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

With regard to the graph on the number of Elderly and Disabled Medical applications over 45 days, Ms. Burnam indicated a notice of non-compliance was sent to Maximus on January 30, 2018, requiring improvement in the numbers by June or July 2018. The graph reflects the improvement as a result of measures undertaken by Maximus. In response to a question on the percentage of total applications represented by each of the graphs, Ms. Burnam stated approximately 11,000 applications are received per month. She noted approximately 73.0 percent of the applications received are Family Medical, 20.0 percent are Elderly and Disabled Medical, and 7.0 percent are LTC Medical (includes nursing facilities, HCBS, and PACE). Ms. Burnam stated, although the number of Elderly and Disabled Medical applications over 45 days is down, the goal of bringing the LTC Medical applications in-house to KDHE is to enhance customer service. The enhanced customer service will include calling individuals to obtain outstanding information rather than denying applications for failure to provide the requested information.

Responding to a Committee member question, Ms. Burnam referenced the KDHE staffing update showing the staffing shift from Maximus to KDHE. With regard to the increased cost to the State to add staff to process applications that were over 45 days, Ms. Burnam indicated the base contract with Maximus was amended to address the cost of additional staff. In addressing the possibility of additional cost to the State if Maximus were again to fall behind in processing applications and need additional staffing, she stated Maximus could always request additional staff, but KDHE would determine if the staffing increase was necessary to keep the application and review process moving appropriately.

In response to questions regarding KDHE efforts to address repeated requests for information from applicants that had previously been provided or requests for one piece of information at a time resulting in delays in processing LTC applications, Ms. Burnam stated there has been improvement in these areas as a result of extended staff training, the nursing facility liaison program, and weekly meetings with Maximus on applications over 90 days. With regard to applications pending after an individual has died, Ms. Burnam indicated she has not seen many of those lately but asked she be contacted to work through any such pending applications.

Ms. Burnam responded to questions regarding whether spikes in the number of applications were seasonal in nature by stating there is an increase in Family Medical applications in November and December of every year during the marketplace open enrollment period, but no large seasonal spikes have occurred in Elderly and Disabled Medical and LTC Medical applications.

Dr. Norman summarized the reports and commented a higher MLR is a reflection of more medical care being provided and should not viewed as negative. The amounts remaining after the MLR are used for low administrative costs and for a reasonable profit.

Ms. Swartz responded to questions about the delay in implementing OneCare Kansas, stating the program was to start in July 2019, but there have been issues in designing the limited population to ensure a representative sample and in retaining interested providers. Fifty-four providers have expressed an interest in the program. KDHE will provide additional information about OneCare Kansas at future Committee meetings.

Kansas Department for Aging and Disability Services

Janis DeBoer, Deputy Secretary, KDADS, outlined the agency's reports and expressed appreciation for legislative action taken in the 2018 and 2019 Legislative Sessions that will positively impact individuals on HCBS waivers. She noted the HCBS waivers are not a medical model, but rather focus on quality of life and activities of daily living for the approximately 25,000 individuals on the waivers who use about $1.0 billion in KanCare medical services.

Ms. DeBoer highlighted a plan to change the focus of monthly meetings facilitated by Wichita State University to begin brainstorming ways to address social determinants, such as housing, transportation, caregiver support, and nutrition. The goal will be to discuss with MCOs how quality of life, medical, and behavioral health needs can best be met for the HCBS waiver population and to provide this information to the Legislature (Attachment 16).

Amy Penrod, Commissioner, Community Services and Programs, KDADS, reviewed HCBS waiver enrollment and the number of individuals on the various waiver waiting lists; she commented the I/DD waiting list totaled 4,033. Of the 1,590 on the Physical Disability (PD) waiting list, 100 have been offered services year-to-date in 2019. She also noted 555 individuals are enrolled in PACE in FY 2019 and provided a list of the service counties.

In response to a question on the I/DD waiver participation by MCO, Ms. Penrod indicated, of the 9,042 individuals on the I/DD waiver, Aetna has 17.0 percent of the population, Sunflower Health Plan (Sunflower) has 53.0 percent, and UnitedHealthcare Community Plan (UnitedHealthcare) has 30.0 percent.

Ms. Penrod stated the four waivers scheduled to be renewed in 2019 are I/DD, TBI, Frail Elderly (FE), and PD. I/DD and TBI draft waiver renewals have been submitted to CMS for review. Initial submissions for the FE and PD waiver renewals are due to CMS by July 1, 2019. She provided information on the public comment period and stakeholder engagement for the FE and PD waiver renewals and efforts made to improve public access and involvement in the stakeholder engagement process, including live-streaming, recording, and captioning of the sessions.

With regard to the length of time and the number of individuals on the waiting lists, Ms. Penrod indicated some individuals are approaching eight years on the waiting list, and the maximum number of individuals that can be served through available appropriations are being served. She noted, without additional appropriations, individuals will come off the waiting list only if someone else comes off of services or if a crisis or exception request is made for services. A Committee member noted eliminating the waiting list would cost $100 million in state funds and $317 million in federal funds over 5 years. Ms. Penrod explained to Committee members' queries, due to CMS regulations, the waiting list could not be reduced by offering limited services to more individuals.

A Committee member requested KDADS provide a thorough explanation at a future meeting of how the waiver services work, including how an individual is placed on a waiver, the State's flexibility in providing services, and the constraints placed by CMS on the State.

In response to questions, Ms. Penrod stated CDDOs are associated with governmental entities and the State contracts with the CDDOs for services. Concerns with CDDOs are to be reported to KDADS to be addressed. She explained, under managed care, the State pays a capitated rate per KanCare member per month, thereby limiting its financial exposure. Ms. Penrod confirmed KDADS can evaluate a crisis exception request made by a CDDO and make a determination to prioritize the individual for services regardless of where the individual is on the waiting list.

Ms. Brown provided data on the average census for state institutions and LTC facilities through the first quarter of FY 2019. She announced progress in reducing the use of anti-psychotic drugs in nursing homes. She stated, as of the meeting date, no nursing facility surveys are over 12 months past due, and surveys are occurring every 11 to 11.5 months in compliance with the CMS requirements. The salary increase for certified registered nurse surveyors made possible through budget enhancements in FY 2018 has improved retention and recruitment. Changes in CMS and state processes and available online training have allowed the certification of surveyors to often take 6 months instead of 12 months. The number of vacant health facility surveyors as of the meeting date is 10 full-time equivalent (FTE). She noted changes in CMS interpretations have significantly reduced immediate jeopardy citations.

Ms. Brown stated the number of national fingerprint-based background checks have increased since the 2018 enactment of Senate Sub. for HB 2386 requiring completion of those checks for HCBS and behavioral health. She responded to an earlier question by noting, of the 69,222 applicants on whom criminal record checks were conducted in 2018, only 319 were denied.

Responding to questions, Ms. Brown replied the nursing facility survey data does not include assisted living facilities. A different survey process based only on state regulations and not federal regulation is required for assisted living facilities. She stated, at present, 10 assisted living facilities have surveys over 16 months and 50 facilities are between 12 to 15 months.

There are 7 surveyors to complete surveys in 450 assisted living facilities across the state. She replied only 7 surveyors for assisted living facilities were funded, and additional funding would be required to improve the frequency of the assisted living surveys. She responded that the last one or two surveys by contract surveyors occurred in January 2019, and contract surveyors are no longer being used. She noted, to the best of her recollection, there were no significant differences in the violations found by the contract surveyors as compared to the state surveyors; both types of surveyors follow the same process and set of regulations and are subject to the same follow-behind surveys required by CMS.

Kim Lynch, Chief Counsel, KDADS, reviewed the status of LTC facilities' receiverships. She reported, from March 2018 to the present, KDADS was involved in 22 receivership actions and two of those receiverships have been transferred to private receivership. Of the $4.6 million borrowed from the Civil Monetary Penalty (CMP) Fund for the Skyline receivership, $4.0 million has been returned to the State. The Secretary for Aging and Disability Services continues to meet with landlords and prospective buyers to discuss efforts to locate new operators for the 15 Skyline facilities. Ms. Lynch commented the remainder of the receiverships are being marketed for sale or efforts are being made to locate new operators. She expressed gratitude for 2019 SB 15 that amended receivership statutes, including increasing the financial scrutiny of new applicants and in the case of change of ownership, defining "insolvent," and allowing a receiver immediate access to accounts receivable instead of state CMP funds; these changes will obviate facility mismanagement, provide more oversight, and assure similar receivership situations do not recur. Ms. Lynch responded only one facility under receivership was closed; due to the low number of residents, it made more sense to move the individuals. The closed facility is now under private receivership and could apply with KDADS to open. She noted the process of choosing a new operator involves the bank that owns the structure or the landlord selecting a new operator through a bidding process, with KDADS vetting the operator upon selection. Any new bidder will face the same financial scrutiny and due diligence required by the enacted legislation and will not be selected based on the highest bid.

Deputy Secretary DeBoer was asked to provide a progress report at the upcoming Committee meetings on the monthly brainstorming sessions that will focus on addressing the social determinants of the HCBS population. She referenced the printed information regarding state hospitals' weekly vacancy rates and overtime trends and announced the Commissions on Aging and Community Based Services will combine into one, and a new State Hospitals Commission will be established. The new initiative will allow the four state hospital superintendents to begin collaborating regularly to develop a more coordinated plan for the state hospitals and to allow input from the Behavioral Health Commission. Responding to questions about a plan for Osawatomie State Hospital (OSH), Deputy Secretary DeBoer stated no plan has been formulated to rebuild or remodel; a plan will be proposed for the 2020 Legislative Session. KDADS anticipates the appointment of a Commissioner of State Hospitals by the third quarter Committee meeting and further reports will be provided at that time. With regard to problems at Larned State Hospital (LSH) and the vacancy rates, she mentioned a recent visit to LSH and a website created by community leaders in support of LSH.

In response to a question regarding the waiting list at OSH, Andrew Brown, Interim Commissioner, Behavioral Health Services, KDADS, replied the waiting list has had no more than one or two individuals in the last several weeks and has consistently been below the 20 or so individuals at the first of the year. He credited new triage efforts to ensure care is provided with the reduction in the waiting list and expressed hope the efforts will lead to eventually lifting the OSH moratorium.

Mr. Brown indicated there has not been much difference in the number of children on the Psychiatric Residential Treatment Facilities (PRTF) waiting list, with a total of 150 children on the MCOs' waiting lists. He also noted an interagency collaboration with DCF, KDHE, and the Kansas Department of Corrections about the Children's System of Care for Behavioral Health Services based on 2018 House Sub. for SB 179 to seek proposals through a competitive process for juvenile crisis intervention centers. Mr. Brown responded the differences other states' PRTF systems and the fluctuating number of available beds make it difficult to compare PRTF waiting lists. He noted approximately 17 states have no PRTF system in place. Mr. Brown stated a preliminary report by the National Association of State Mental Health Program Directors Research Institute (NRI) on PRTFs is available, and he hoped the report will be ready to discuss at the third quarter Committee meeting. He noted KVC Health Systems has a plan for additional PRTF beds for higher acuity children to potentially open as soon as July 1, 2019.

The Committee recessed for lunch from 12:10 to 1:30 p.m.

Afternoon Session

KanCare Ombudsman Report

Kerrie Bacon, KanCare Ombudsman, referenced her written testimony and responded to Committee members' questions. She replied the Office of the KanCare Ombudsman includes herself and two other FTEs, as well as a number of volunteers; there are satellite offices in Olathe and Wichita. She said the offices field a wide variety of questions; the total number of calls usually range above 1,000 per quarter, with application assistance and questions about HCBS ranking as the top two issues. Individuals needing application assistance may go to local satellite offices for help in contacting the Clearinghouse. In responding to questions about changes made or improvements that could be made, Ms. Bacon indicated issues expressed during conversations with individuals are passed on to KDHE. She also attends monthly MCO meetings, the KanCare Advisory Committee, and the LTC Advisory Committee. She stated she is open to suggestions for improvement and is following up on the process to address autism services capacity being worked on by the MCOs. She indicated the large number of contacts received are not a concern because more individuals know about the Office of the KanCare Ombudsman (Attachment 17).

Human Consensus Caseload Spring Estimates

Amy Deckard, Kansas Legislative Research Department, outlined the Spring 2019 Human Services Consensus Caseload Estimates for FY 2019 and FY 2020 (Attachment 18). She noted, because an appropriations bill for FY 2019 and FY 2020 has yet to be passed by the Legislature, the starting point for the April 2019 estimates are drawn from the Governor's budget recommendations for FY 2019 and FY 2020. She summarized the estimates: FY 2019 is a decrease of $15.9 million from all funding sources and a decrease in the SGF of $12.3 million compared to the FY 2019 Governor's recommendation. The FY 2020 estimate shows an increase of $5.4 million from all funding sources and a SGF increase of $4.2 million above the FY 2020 Governor's recommendation. The combined estimate for FY 2019 and FY 2020 is an all funds decrease of $10.4 million and a SGF decrease of $8.0 million below the Governor's recommended budget.

Ms. Deckard gave specific numbers detailing each program, such as Temporary Assistance for Needy Families, Foster Care, KanCare Medical, and other services of KDADS, KDHE, and DCF.

Presentation by Medicaid Inspector General

Sarah Fertig, Medicaid Inspector General, updated the Committee on the progress of forming a new office for oversight of KanCare, the hiring of qualified staff, and the training she has received (Attachment 19). She highlighted recent activities, such as meeting with various agency staff and reviewing reports of suspected fraud related to Medicaid, the Children's Health Insurance Program, and MediKan. She reported the office receives an average of one to two fraud reports each day, primarily alleging eligibility fraud. She noted her office is not assigned prosecutorial duties; evidence of fraud is turned over to the pertinent agencies that can prosecute. Ms. Fertig noted a review is underway of reports of suspected fraud sent to the KDHE Medicaid Inspector General e-mail address after the Medicaid Inspector General function was transferred from KDHE to the Attorney General's Office and pending her confirmation. The review is to determine if any substantiated reports of fraud were inadvertently missed during the transition between agencies. An eligibility fraud investigation related to misreporting income, marriage, and dependents that was referred by DCF is near completion. She also noted two audits are being prepared to examine provider credentialing processes and pharmacy contract requirements.

Responses from Agencies and MCOs

Committee members discussed the agenda for the third quarter Committee meeting. A member requested a form be prepared with the help of Committee staff to follow-up on issues presented to the Committee and the resolution of those concerns. One example given was testimony provided regarding back-pay owed to the Anthony Community Care Center. Another member requested testimony from dental providers who do not provide Medicaid services to understand why they do not accept Medicaid patients. Other requests were made for further information on PRTF issues and autism waiver services and the difficulties of accessing those services.

MCO Presentations

The Chairperson invited testimony from the three MCOs.

Keith Wisdom, President and CEO, Aetna, reviewed Aetna's activities during the past quarter (Attachment 20). He reported Aetna is building a network of providers that includes 173 of 193 hospitals in Kansas, federally qualified health centers, and community mental health centers, with the gap being specialty hospitals and 15,580 contracted providers. Aetna is also paying claims from non-contracted providers at Medicaid rates through May 31, as provided by the Transition of Care policy. He noted 96.7 percent of claims were paid within 30 days during the first quarter (Attachment 21). He outlined the clinical and outreach metrics and described Aetna's system of care. Mr. Wisdom stated each of the 55 children on the PRTF waiting list is assigned a case manager to find needed services pending PRTF admission; the shortest wait for PRTF admission was 2 days, the longest was 51 days. Members are waiting 21 days on

average before placement in a PRTF and spend an average of 49 days in a PRTF. Twelve applicants were denied PRTF admission (denial reasons included not meeting the standards of medical necessity, the symptoms could be treated in an outpatient setting, or the members were no longer a danger to themselves or others). Mr. Wisdom concluded with a story of a member's success through the assistance of a service coordinator. He stated he will provide the number of claims denied at the third quarter Committee meeting, but responded to a question on pending claims, stating the number fluctuates daily and the last number he recalled was approximately 13,000. In response to questions regarding providers not receiving information on their credentialing, he stated some welcome packets were sent to provider groups without a roster of those credentialed, but that issue was being addressed. Mr. Wisdom responded to questions on what constitutes a good PRTF outcome and confirmed case managers are automatically assigned to children on a PRTF waiting list. He also indicated Aetna anticipated one-third of the member volume when the KanCare contract was bid, but their member makeup has not reached that level.

Michael Stephens, Plan President and CEO, Sunflower, commented on the results of a third-party LTSS member satisfaction survey (98.3 percent satisfaction). He indicated the improvement in the satisfaction score was linked to transition coordination and the creation of a LTSS Advisory Committee and a LTSS Quality Assurance Subcommittee to address the unique nature of the services needed by the population group. He explained an innovative initiative, Start Smart for Your Baby, that incorporates care management, care coordination, and disease management to improve the health of mothers and their newborns. He also outlined a Medicare Advantage Dual Special Needs Plan (overseen by CMS, KDHE, and the Kansas Insurance Department) to provide comprehensive benefits for a targeted population eligible for both Medicare and Medicaid. Mr. Stephens noted Sunflower has implemented an intensive parent-training pilot program focused on foster care children that uses the Parent Management Training Oregon Model; the pilot program is intended to address the needs of foster care children and avoid PRTFs where possible. Four foster care children have been part of the pilot. He commented on the Provider Accessibility Initiative, a grant program to address accessibility issues; 50 providers submitted grant applications for the $100,000 pool of grant funding. The National Council for Independent Living will select the grant recipients on Sunflower's behalf (Attachment 22).

Kevin Sparks, CEO, UnitedHealthcare, introduced Carrie Kimes, Director of Provider Relations and Network Strategy, UnitedHealthcare. Ms. Kimes explained UnitedHealthcare has created a team of 27 staff to assist all providers in navigating the healthcare system, including a team of business analysts who study claims data looking for trends in claim denials to determine if an internal problem exists or if additional provider training is needed to address the issue (Attachment 23). She noted the new system also includes an Associate Director of KanCare Networks and Contracts who is responsible for looking at network adequacy, especially with regard to the needs of HCBS waiver individuals, and to identify critical areas and gaps in services. The Associate Director has been meeting with non-participating HCBS providers to identify and remove barriers and open the door for possible recruitment. Ms. Kimes identified the following barriers to participation as a Medicaid provider: lower Medicaid rates as compared to commercial rates; difficult and time consuming enrollment and credentialing process; provider enrollment fee of $586 to process the provider application; additional training requirements resulting in additional time and financial investment to qualify for provider enrollment; lack of a sustained volume of members to support a full-time business model; and a potential cost of upwards of $10,000 for the entire application process and training expenses to possibly serve a very limited number of members. In identifying barriers to service, Ms. Kimes offered the following solutions to address identified problems: provide competitive rates, reimburse for

travel time and mileage between appointments, waive or reduce the application fee, reevaluate the appropriate level of training required, and explore "hold days" for HCBS workers when members are in an acute stay for an extended period to protect the worker from loss of income during a member's acute stay.

Questions from Committee members were addressed as follows:

- Regarding tools that can be offered to parents following a child's release from a PRTF, Sandra Berg, Director of Behavioral Health, UnitedHealthcare, said, depending on the provider network, each MCO will provide specific tools to address each need; and

- Jonalan Smith, Chief Operating Officer, Sunflower, replied many members with behavioral health disorders also have co-occurring substance use disorders. Tobacco use is prevalent among Sunflower members with behavioral health diagnoses, and alcohol and drug use hinder healthy outcomes for clients. He stated the biggest hurdle is the lack of providers of addiction services.

A Committee member asked Mr. Smith about work in other states that has been effective in reducing the rate of addiction, tobacco use, and substance abuse that could be considered in Kansas. Information will be provided at the third quarter Committee meeting. Mr. Smith mentioned KDHE has begun to address this issue with a liaison between the Public Health and the Medicaid sides of KDHE.

Approval of February 15, 2019, Minutes; Adjourn

The Chairperson noted conferee Karren Weichert, Midland Care Connection, provided additional information about PACE services (Attachment 24) (Attachment 25).

By motion of Senator Bollier and seconded by Representative Landwehr, the minutes for February 15, 2019, were unanimously approved.

A Committee member requested follow-up information regarding the systematic client obligation errors identified by the conferee for the Disability Rights Center of Kansas at the meeting and the concerns identified by other conferees at the February 2019 Committee meeting. The Committee member would like know if these issues have been resolved.

The meeting was adjourned at 3:16 p.m. The Chairperson announced the third quarter Committee meeting would occur in August or September.

Prepared by Gary Deeter

Edited by Iraida Orr

Approved by the Committee on:

August 26, 2019
(Date)