MINUTES

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

August 20-21, 2018
Room 112-N—Statehouse

Members Present

Representative Daniel Hawkins, Chairperson
Senator Vicki Schmidt, Vice-chairperson (August 20)
Senator Bud Estes
Senator Richard Hilderbrand
Senator Laura Kelly
Senator Ty Masterson
Representative Barbara Ballard
Representative Susan Concannon
Representative John Eplee
Representative Kyle Hoffman
Representative Nancy Lusk, appointed substitute for Representative Ward

Members Absent

Senator Vicki Schmidt, Vice-chairperson (August 21)
Representative Jim Ward

Staff Present

Erica Haas, Kansas Legislative Research Department
Iraida Orr, Kansas Legislative Research Department
David Fye, Kansas Legislative Research Department
Scott Abbott, Office of Revisor of Statutes
Eileen Ma, Office of Revisor of Statutes
Jarod Regier, Office of Revisor of Statutes (August 21)
Gary Deeter, Committee Assistant

Conferees—August 20

Robert St. Peter, MD, President and Chief Executive Officer (CEO), Kansas Health Institute
Stephanie Sanford, Self Advocate Coalition of Kansas
Jon Rosell, PhD, Executive Director, Kansas Medical Society
Jonathan Hamdorf, Director, Division of Health Care Finance, and Medicaid Director, Kansas Department of Health and Environment
Jeff Andersen, Secretary of Health and Environment
Adam Proffitt, Director, Program Finance and Informatics, Division of Health Care Finance, Kansas Department of Health and Environment
Sarah Irsik-Good, President and CEO, Kansas Foundation for Medical Care

Janis DeBoer, Executive Director, Kansas Association of Area Agencies on Aging and Disabilities
Jean Hall, Ph.D., Director of Life Span Institute, Institute for Health and Disability Policy Studies, University of Kansas; Professor and Researcher, University of Kansas and Kansas University Medical Center
Mitzi McFatrich, Executive Director, Kansas Advocates for Better Care
Cindy Luxem, President and CEO, Kansas Health Care Association/Kansas Center for Assisted Living
Kari Bruffett, Director of Policy, Kansas Health Institute
Sean Gatewood, Co-administrator, KanCare Advocates Network
Tish Hollingsworth, Vice President, Reimbursement, Kansas Hospital Association
Steve Gieber, Executive Director, Kansas Council on Developmental Disabilities
Audrey Schremmer, Secretary, Kansas Association of Centers for Independent Living
Stuart Little, Little Government Relations, LLC,representing the Behavioral Health Association of Kansas
Matt Etzel, Principal Auditor, Legislative Division of Post Audit
Tim Keck, Secretary for Aging and Disability Services
Sarah Shipman, Secretary of Administration

Conferees—August 21

Katrina Ostmeyer, PhD, former Associate Executive Director, Integrated Behavioral Technologies, Inc.
Jane Kelly, Executive Director, Kansas Home Care and Hospice Association
Debbie Thuston, Director, Neosho Memorial Regional Medical Center Home Health Agency; District 3 Co-Representative, Kansas Home Care and Hospice Association
Mike Oxford, Executive Director for Policy and Advocacy, Topeka Independent Living Resource Center
Marilyn Kubler, Director, Jenian, Inc., Targeted Case Management
Sean Gatewood, Co-administrator, KanCare Advocates Network
Joan Kelley, Private Citizen and Independent Advocate
Janet Williams, President, Minds Matter, LLC
Richelle Marting, JD, on behalf of Dr. Kathy Cain, Topeka Pediatrics and Kids First Urgent Care
Bob Mikesic, Co-executive Director, Independence, Inc., for Kansas Association of Centers for Independent Living
Christi Nance, Policy Director, Oral Health Kansas
Mike Burgess, Director of Policy and Outreach, Disability Rights Center of Kansas
Rachel Monger, Vice President, Government Affairs, LeadingAge Kansas
Timothy Graham, Interim Executive Director, InterHab
Ron Fugate, Private Citizen
Jonathan Hamdorf, Director, Division of Health Care Finance, and Medicaid Director, Kansas Department of Health and Environment
Jeff Andersen, Secretary of Health and Environment
Dr. Greg Lakin, State Health Officer and Medicaid Medical Director, Kansas Department of Health and Environment
Tim Keck, Secretary for Aging and Disability Services
Amy Penrod, Commissioner of Community Services and Programs, Kansas Department for Aging and Disability Services
Susan Fout, Commissioner of Behavioral Health Services, Kansas Department for Aging and Disability Services
Dr. Mike Dixon, Superintendent, Parsons State Hospital and Training Center

Camille Dobson, Deputy Executive Director, National Association of States United for Aging and Disabilities
Kevin Sparks, CEO, UnitedHealthcare Community Plan
Dale Marsico, Business Consultant, UnitedHealthcare Community Plan
Tanner Fortney, Director of Operations, Johnson County Mental Health Center
Frank Clepper, CEO, Amerigroup Kansas Plan
Deborah Stewart, President and CEO, Finity
Matthew Onstott, Vice President, Government Solutions, Finity
Michael Stephens, President and CEO, Sunflower Health Plan

Others Attending

See Attached List.

Monday, August 20
All Day Session

Welcome

The Chairperson opened the meeting at 9:00 a.m. and welcomed members, conferees, and guests.

Roundtable Discussion of KanCare Meaningful Measures Collaborative

The Chairperson opened a roundtable discussion regarding a new data initiative, KanCare Meaningful Measures Collaborative. The discussion was led by Robert St. Peter, MD, President and Chief Executive Officer (CEO), Kansas Health Institute (KHI). Dr. St. Peter explained the initiative includes 40 diverse groups, all of whom have an interest in the success of KanCare. He stated the endeavor will, from the data available, develop a data network that includes transparency, performance measures, and other metrics that will increase the usefulness of the broad spectrum of information. He noted the diverse membership is willing to collaborate and stated the members will avoid evaluating present policies; the purpose of the group is to create a data repository to make information more readily available and useful (Attachment 1 and Attachment 2). He laid out the scope of the project, and explained the group includes consumers, stakeholders, state agencies, and the research community.

Dr. St. Peter explained, for the group to function efficiently, an Executive Committee was established, which, besides Dr. St. Peter, includes: Jon Rosell, Ph.D., Executive Director, Kansas Medical Society; Jonathan Hamdorf, Director, Division of Health Care Finance, and Medicaid Director, Kansas Department of Health and Environment (KDHE); Tim Keck, Secretary for Aging and Disabilities Services (Attachment 3); and Stephanie Sanford, Self Advocate Coalition of Kansas. Ms. Sanford said she appreciated the decision to include those directly affected by the program. Dr. Rosell stated in order to provide effective services, providers must be able to analyze data and ask the right questions. Mr. Hamdorf, acknowledging agencies are not using resources as well as they could, said the group goal is to deliver programs that are effective and provide continuity.

Meaningful Measures Collaborative Executive Committee members responded to Committee members' questions:

- The plan is to upgrade the technology and increase training in order to accomplish the goals (Mr. Hamdorf); and

- The plan is to build a process that is sustainable, then standardize the data (Dr. St. Peter).

Members expressed appreciation for the project.

Executive Committee members made further comments. Secretary Andersen stated KDHE was in full support of the initiative, and the Executive Committee played an important role in balancing the desires of stakeholders and providing focus for the group. Secretary Keck echoed those statements. Ms. Sanford commented that including her organization in the Executive Committee ensures consumers will have a voice in the process. As a consumer, Jason Barrett encouraged the group not to tamper with what is working well, but to address what needs improving.

Additionally, two work groups were formed, the Data Resource Work Group and the Stakeholder Work Group, to provide an opportunity for additional focused input in the work of the Meaningful Measures Collaborative.

Members of the Data Resource Work Group: Adam Proffitt, Director, Program Finance and Informatics, Division of Health Care Finance, KDHE; Sarah Irsik-Good, President and CEO, Kansas Foundation for Medical Care; Janis DeBoer, Executive Director, Kansas Association of Area Agencies on Aging and Disabilities; Jean Hall, Director of Life Span Institute, Institute for Health and Disability Policy Studies, University of Kansas, and professor and researcher at the University of Kansas and the Kansas University Medical Center; Mitzi McFatrich, Executive Director, Kansas Advocates for Better Care; and Cindy Luxem, President and CEO, Kansas Health Care Association/Kansas Center for Assisted Living.

Mr. Proffitt observed that the charter statement (Attachment 2) highlights the sustainable structure and collaborative effort that will produce transparent information and provide context for information, as well as fill in the data gaps by centralizing information. Ms. Irsik-Good noted several aspects of the proposed system include providing an evaluation process for data, building leverage from existing data, and more accurately measuring successes and failures. Ms. DeBoer, noting the 10,000 individuals currently in nursing homes under Medicaid, said the proposed system will help identify those who truly belong in nursing homes and those who could be served by community resources. Ms. Hall observed the initiative will enable researchers to better utilize and analyze data (Attachment 4). Ms. McFatrich said she is passionate about outcomes, the key to which is utilizing data to develop effective policies that promote better outcomes for consumers as well as for providers. Ms. Luxem noted the importance of fostering effective relationships between stakeholders and state and federal agencies.

A Committee member noted the importance of being able to disaggregate data in order to identify different racial groups.

Members of the Stakeholders Work Group: Kari Bruffett, Director of Policy, KHI; Sean Gatewood, Co-administrator, KanCare Advocates Network; Tish Hollingsworth, Vice President,

Reimbursement, Kansas Hospital Association; Steve Gieber, Executive Director, Kansas Council on Developmental Disabilities; Audrey Schremmer, Secretary, Kansas Association of Centers for Independent Living; and Stuart Little, representing the Behavioral Health Association of Kansas.

Ms. Bruffett, referencing the charter statement, stated the goal of the collaborative is for stakeholders and beneficiaries to work together to identify gaps in the data and, through inclusive collaboration, have appropriate outcomes. Mr. Gatewood commented on the challenge of building the right framework to ensure such things as individual differences and quality of life are included in the measurements. Ms. Hollingsworth, noting hospitals have a significant stake in KanCare, stated the initiative will give new direction to data so it can be utilized on different levels. Mr. Gieber expressed a desire to develop data that will enhance policies to assist those with intellectual or developmental disabilities. Ms. Schremmer expressed appreciation for the collaborative approach. Mr. Little hoped the antiquated data systems would be updated and the proposed system would identify gaps in services.

Dr. St. Peter summarized the presentations by noting the importance of proceeding in a timely manner, and he expressed the desire to build a system that will be a model for the country. He commented funding sources had yet to be established, but the system should not require expensive maintenance. He said access to state infrastructure will be important, and he suggested a public/private partnership. Chairperson Hawkins requested regular reports to the Committee. Responding to questions, Dr. St. Peter replied the group will maintain an arms-length process with state agencies. Dr. St. Peter said no budget has been proposed yet for the group; a Committee member commented costs related to the project may affect agency budgets more than the State General Fund. Dr. St. Peter said further meetings of the group are planned and the group will make an official presentation to the Legislature and will update the Committee at the beginning of 2019.

Afternoon Session

Presentation of KanCare Audit Report (Medicaid: Evaluating KanCare's Effect on the State's Medicaid Program)

Matt Etzel, Principal Auditor, Legislative Division of Post Audit (LPA), reviewed a recent audit of KanCare, including the highlights (Attachment 5) and the complete audit report (Attachment 6). The audit addressed a single question: "What effect did transitioning to KanCare have on the State's Medicaid costs, the services provided, and client health outcomes?" He stated, during the first year of KanCare (2013), state payments to the three managed care organizations (MCOs) were about $400 million less than what the MCOs paid in provider claims; however, by 2015, state payments to the MCOs exceeded what the MCOs paid in provider claims by about $400 million. State payments to the MCOs grew from $2.1 billion in 2013 to $3.0 billion in 2016. In regard to Medicaid services during the same period, KanCare increased the use of primary care, dental care, behavioral health, and nursing facility care, but had little to no effect on inpatient care. Mr. Etzel noted that because of insufficient data, KanCare's effect on Medicaid health outcomes was inconclusive. He said eligibility requirements for Medicaid were not changed by implementation of KanCare. Mr. Etzel stated services offered were not significantly affected by KanCare but who provided the case management services changed, with most case management services moving from targeted case managers to MCO managed care coordinators. Mr. Etzel also noted ancillary findings, citing the issue of timeliness and

accuracy of claim payments. The audit offered one recommendation: KDHE should take steps to insure accurate claims data. To accomplish this, the audit recommended KDHE sample Medicaid claims to determine if interest penalties are inflated and require reimbursement. Committee members requested follow-up information regarding health outcomes.

Agency Response to KanCare Audit Report

Jonathan Hamdorf, KDHE, responded to the LPA audit (Attachment 7). He noted capitation payments include more than the cost of services; for example, a seven percent administrative allowance and a one percent profit allowance are added to the cost of services, as are Supplementary Medical Education and Health Care Access Improvement Program costs required by the Centers for Medicare and Medicaid Services (CMS) based upon utilization. In addressing the approximately $400 million less in payments to the MCOs in 2013 than were paid by the MCOs in provider claims, Mr. Hamdorf stated risk corridors had to be paid because the capitation rates were not set up appropriately at the onset of KanCare. With regard to the approximately $400 million more in state payments to the MCOs in excess of claims paid to providers by the MCOs, Mr. Hamdorf explained the excess in state payments was actually about $80 million when the required portions that make up the capitation payments, other than the cost of services, are taken into account. Additionally, the failure to process Medicaid eligibility renewals added $60.4 million in 2015 to the cost. The additional $60.4 million in state costs may be attributed to ineligible individuals remaining on KanCare because a Medicaid eligibility redetermination was not completed. Mr. Hamdorf stated capitation payments are required to be made for individuals on KanCare even if provider services are not used, and some individuals for whom a redetermination was not processed may not have known they could access provider services. The end result is $19.6 million in excess of claims paid, which is reasonable if the MCOs are managing the KanCare population well.

Mr. Hamdorf also noted, beyond the demographics of the Medicaid population, factors such as changes in CMS incentives and regulations, legislative action, and fee schedule increases could also drive the expenditures of a program. In order to definitively say the program itself was what increased the cost, if there was a cost increase, these other factors would have to be tracked and controlled. This type of data would provide a basis for action to be taken on those factors that impacted cost.

In addressing the audit report with regard to service use, Mr. Hamdorf agreed with the report, except for the data related to inpatient use.

Mr. Hamdorf noted there are data issues with Medicaid. He provided two examples, one from the Governmental Accountability Office and another from the Office of the Inspector General, that state the data CMS receives indicates CMS cannot manage the program and outcomes either. He noted CMS has said most Medicaid data across the states is not very good. He stated KDHE has processes in place to ensure quality data.

Another issue Mr. Hamdorf mentioned was the difficulty of working with encounter data because of the reprocessing of claims. Mr. Hamdorf provided the example of the four percent increase to hospitals in the Governor's budget that was enacted. He said claims for July and August 2018 were processed once and will need to be reprocessed to reflect that increase, resulting in multiple incidents of claims with different values.

In addition, Mr. Hamdorf noted there have been system and personnel changes since the audit was performed. He stated the system from which LPA was given data is not the same as that currently used. KDHE has moved to a new data warehouse system. He commented he could not speak to whether there were issues with the previous data system.

To ensure quality data, Mr. Hamdorf said there are pay-for-performance measures in place for MCOs. He stated there is a one percent per calendar quarter risk for encounter accuracy and timeliness that accounted for $22.5 million per year available per MCO in 2016 and that incentive should result in cleaner data and claims. He described the process used by the MCOs and the external audit organization KDHE contracts with to ensure clean claims.

Secretary Andersen stated the timing of the audit was unfortunate, as most of the current KDHE leadership team was not in place. He said, with the current leadership team in place, many of the audit recommendations were underway before the audit report was available. When the audit was completed, the Secretary noted there was conversation between him, Mr. Hamdorf, and the LPA audit team during which KDHE indicated some of the conclusions reached by the audit may or may not have been correct due to other factors that may not have been considered. He noted KDHE expressed concern over the possible impact of releasing an audit with conclusions that were in question. When the audit was published, the lead articles in the leading health care news periodical for two days stated the Kansas Medicaid information was not credible. These articles were published at the same time KDHE was negotiating with Maximus about contract non-performance. KDHE determined that suing Maximus would come to state data versus Maximus data and, with the reliability of the state data publicly in question, the State would have difficulty proving its case in court. He said this is only part of the reason the decision was made not to sue Maximus.

Update on KanCare 1.x Request for Proposal

Sarah Shipman, Secretary of Administration, reported on the status of the request for proposal (RFP) for the KanCare contract. The process, which started and went out for bid in November 2017, went through June 2018. During this time period, there were multiple legislative hearings, discussions with the vendors, and meetings with the agencies. In June 2018, contracts were awarded to three of the six vendors after evaluation of the submitted bids. She said, following the award of the contracts, all three unsuccessful bidders protested, which is not unusual for a contract of this magnitude. The Department of Administration, Office of Procurement and Contracts, responded to and denied the bid protests. The State is into a judicial review process as a result of a lawsuit filed by Amerigroup against the State (Attachment 8). There were hearings in early August 2018 about whether the State could go forward with the contracts while the rest of the litigation was ongoing. Secretary Shipman stated the State was successful in arguing it would be detrimental to the State to stop the process at that time. The State is moving forward under the terms of the contracts while the remaining issues are litigated. She stated the subject of the litigation is whether the process was fair to all six bidders and whether the decisions made by the state agencies and the Department of Administration were arbitrary or based on the documentation and facts available. The case is on an expedited schedule and hearings in September 2018 are anticipated. She said the new MCO contracts will go into effect on schedule, January 1, 2019. Responding to a question, Secretary Shipman replied the three-year contract provides an option to renew. Mr. Hamdorf added all KDHE contracts have a termination clause, but do not typically impose penalties for termination.

Compliance with KanCare Proviso

Members expressed concern KDHE was not following a legislative budget proviso (2018 House Sub. for SB 109, Sec. 118) that required a hiatus in the changes proposed by the KanCare 2.0 1115 waiver application (Attachment 9). Mr. Hamdorf stated there is ongoing litigation on this issue, with dozens of attorneys involved. He said there are changes KDHE would like to consider to improve the system: improvement of network adequacy to ensure persons are receiving needed services; implementation of required CMS regulations; removal of the requirement that people with disabilities have to request a continuation of services after ten days; and changes to eligibility, such as Protected Income Limits (PILs). However, he stated these would be changes to the program as it existed on January 1, 2018, and would be prohibited by the proviso.

Mr. Hamdorf responded to a question saying there is open enrollment for all KanCare members, not just those currently enrolled with Amerigroup. If those currently enrolled with Amerigroup do not make an MCO choice at open enrollment, they will be enrolled with Aetna.

Addressing concerns with the process of changing MCOs, Mr. Hamdorf noted there is flexibility in the process to alter the program so as not to bind the next Administration. The contracts with the MCOs and the 1115 waiver being negotiated with CMS are for three years with two one-year extensions, with the option to terminate or amend. With regard to concerns that the process will be too expensive, he stated all the programs that were identified as cost drivers (*i.e.* community service coordination, work requirements, MediKan initiative, and work opportunities for people with disabilities) have been moved to an implementation date of July 1, 2019, or later, to allow for legislative input during the 2019 Legislative Session. In addressing the third concern of implementation of work requirements, Mr. Hamdorf noted the State is not moving forward with the work requirements at this time. He added the State would need to determine what the program would look like, and CMS would need to determine their national position on work requirements. Although these items are being discussed, he stated they will not go live on January 1, 2019.

Mr. Hamdorf stated the waiver hypotheses with the 1115 waiver have been adjusted to reflect those items on which favorable input was received at the November 2017 meeting of this Committee. The four new assumptions are: value-based reimbursement models will fully integrate physical and behavioral health care; increasing employment independent living supports will help people become more independent; the use of telehealth will enhance access to care in rural, semi-rural, and underserved areas; and removing payment barriers to services provided at institutes for mental diseases (IMDs) will result in improved access to service and better health outcomes.

Assistant Revisor Scott Abbott provided a brief of the proviso included in the 2018 Omnibus Budget bill that applies to state fiscal years 2018 and 2019. He read the language of the proviso, including the requirement legislative prior authorization would be required for any changes in the manner in which KanCare managed care services are provided that are "substantially different" than the manner in which those services were provided on January 1, 2018, including changes to the eligibility requirements. He explained, although a few changes in KanCare were allowed in the proviso, most features of KanCare 2.0 were restricted from implementation by state agencies.

Responding to Committee members' concerns about the proviso was being ignored, Mr. Hamdorf assured Committee members KDHE has not implemented any changes included in

KanCare 2.0 and will follow the directives of the proviso. The agency is moving forward with readiness reviews to ensure the MCOs can operate the requirements of managed care in the state. Responding to a question, he confirmed the proviso is in place until July 1, 2019, and KanCare 1.0 will be in place in 2018 and 2019 until the Legislature has an opportunity to consider the changes desired.

In response to a question about the status of the work requirement included in the 1115 waiver currently with CMS, Mr. Hamdorf replied the agency has told CMS that it will not move forward with the work requirements at this time. He noted, should the Legislature choose to include the work requirements during the 2019 Session, KDHE would have to amend the waiver application to include the work requirements. Mr. Hamdorf agreed with a Committee member who expressed the work requirements would not be a cost reduction measure.

Approval of April 23, 2018, Minutes; Adjourn

By motion of Senator Estes, seconded by Representative Ballard, and unanimous vote of the Committee, the Committee minutes for the April 23, 2018, meeting were approved.

Tuesday, August 21
Morning Session

Welcome

The Chairperson called the meeting to order at 9:01 a.m. He explained, because of the number of conferees, each would be allotted three minutes to present information.

Presentations on KanCare from Individuals, Providers, and Organizations

Katrina Ostmeyer, PhD, former Associate Executive Director, Integrated Behavioral Technologies (IBT), thanked the Legislature, state staff, and the MCOs for their assistance in resolving the issue IBT was having with the provision of Applied Behavioral Analysis (ABA) services. She noted there continues to be a significant shortage of ABA service providers in the state and even fewer providers who are able or willing to work with KanCare due to ongoing issues and low reimbursement rates. Dr. Ostmeyer said IBT has a waiting list of 130 children and families with primary and secondary funding through the KanCare program. She asked the Committee for support in addressing the fundamental flaws in how ABA services are structured under KanCare, which she has been told would require a State Plan Amendment (Attachment 10).

Jane Kelly, Executive Director, Kansas Home Care and Hospice Association, expressed concern over the lack of access to home health and hospice care. She cited low reimbursement rates and burdensome paperwork requirements for both KanCare and Medicare has resulted in some home health and hospice providers closing their doors and has frequently jeopardized patient care for a number of service providers (Attachment 11).

Debbie Thuston, Director, Neosho Memorial Regional Medical Center Home Health Agency, related problems her mid-sized company has had in providing home health and hospice services to the rural community. She noted difficulty in obtaining durable medical equipment for individuals, Medicaid denials for inaccurate reasons, an inability for providers to speak with MCO case managers to provide communication of care updates for home health patients, reimbursement rates for home health services that are below the cost of providing care, and delays in obtaining authorization for home care from the MCOs (Attachment 12).

Mike Oxford, Executive Director for Policy and Advocacy, Topeka Independent Living Resource Center, expressed gratitude for the seven percent rate increase for Home and Community Based Services (HCBS) waiver programs, administrative case management, and for support from KDHE and KDADS for local community based services and supports coordination and the state agencies' leadership in the development of quality measures and metrics for KanCare. However, he said the following recurring problems need to be addressed: Medicaid's institutional bias; low wages, inadequate access to training, and a workforce shortage crisis; restoration of local case management for HCBS beneficiaries; and the inadequacies of the PIL requirements. He also thanked KDHE and KDADS for their work with researchers, MCOs, provider groups, and consumer advocates to develop the quality measures and metrics needed to objectively evaluate how HCBS is performing (Attachment 13).

Marilyn Kubler, Director, Targeted Case Management, Jenian, Inc., noted the HCBS waiting list is approaching eight years. She expressed concern the proposed KanCare 2.0 separates targeted case management from day and residential services (Attachment 14).

Sean Gatewood, noting the crucial role of accurate data, expressed gratitude for the opportunity to work with KDADS on identifying the data specific to Long Term Services and Supports (LTSS) to measure consumer satisfaction and quality of life, the project initiated by KHI to convene stakeholders around the issue of performance and quality measures, and the Committee's focus on performance and quality measures. He expressed concern for the weakening of the KanCare provider network, especially the shortage of health care workers providing individual home care and the adequacy of state resources, both staff and funding, to provide oversight and guide policy for KanCare (Attachment 15).

Joan Kelly, private citizen, independent advocate, and co-guardian of her 27-year-old grandson, recounted the story of one mother's challenge in finding direct support staff care for her adult son who functions at a toddler level and exhibits multiple maladaptive behaviors requiring 24/7 care. She also urged members to address the low wages for direct support staff (Attachment 16).

Janet Williams, PhD, President, Minds Matter, LLC, expressed gratitude to Secretary Keck and Mr. Hamdorf for their assistance in resolving a crisis with an MCO regarding a cut in services for 141 persons with brain injuries. She cited successes of the Traumatic Brain Injury (TBI) waiver and praised the change in the TBI definition of brain injury to include those with acquired brain injury and children. She recommended the MCOs fully support the provision of therapy services to individuals on the TBI waiver, expand the TBI provider network (36 individuals on the TBI waiver in Wichita are not receiving rehabilitation therapy services because no providers are available), and increase Medicaid base rates for TBI services (Attachment 17).

Richelle Marting, JD, on behalf of Dr. Kathy Cain, Topeka pediatrician, related a four-year payment dispute with Amerigroup that created an administrative burden forcing Dr. Cain to

terminate the agreement with the MCO to provide KanCare services. She stated, after an audit of a sample of patient charts, Amerigroup identified an alleged overpayment and, without advance notice, extrapolated an error rate within the sample to the larger universe of claims requiring a large repayment within 30 days. In addition, Ms. Marting noted Amerigroup placed Dr. Cain on a 100 percent prepayment audit of the claim code being reviewed by the MCO and a large number of claims remain unpaid to date (Attachment 18).

Bob Makesic, Co-executive Director, Independence, Inc., on behalf of the Kansas Association of Centers for Independent Living, commented on changes that violate a consumer's choice and self-direction for medical services. He stated, previously, a person or other provider could refer an individual to the Aging and Disability Resource Center (ADRC) for initial assessment to determine eligibility for HCBS services, but now only an MCO can make such a referral. He also noted the MCOs are denying some consumers the option to move from a nursing facility back into the community without a third party, such as a nurse from the MCO, approving the transition. Additionally, he noted the new requirement for fingerprint-based background checks requirement eliminates a consumer's ability to make a final decision whether or not to hire someone and causes delays in hiring service workers. Mr. Makesic asked the Administration to consider an exception to the fingerprinting requirement when writing the waiver renewals in 2019 for persons self-directing services on the Physical Disability (PD), Frail Elderly (FE), and TBI waivers. Mr. Makesic expressed concern about the scarcity of doctors who accept Medicaid. He commented the PIL is inadequate to meet a consumer's living expenses and suggested options implemented by other states to address this concern (Attachment 19).

Christi Nance, Policy Director, Oral Health Kansas, recounted "one story of many" regarding an individual's difficulty in finding a dental provider who accepts Medicaid. The private citizen's letter describing her experience is attached as part of the Oral Health Kansas testimony. Ms. Nance stated the primary reason for the lack of dental providers, particularly oral surgeons, is the inadequate reimbursement rate (Attachment 20).

Mike Burgess, Director of Policy and Outreach, Disability Rights Center of Kansas, offered thanks for the expanded definition of TBI and commented on work of the Employment System Change Coalition dedicated to expanding employment opportunities for those with disabilities. He outlined two concerns: the need to develop programs to assist individuals with disabilities to transition from school to community and the problems that fingerprint-based background checks create in self-directed health care. Mr. Burgess mentioned the Chairman of the State Board of Education is convening a Transition Workgroup to develop resources for students with disabilities, their parents, and their teachers to help them be better informed about what can be done to have a successful transition. He also noted a newly developed tool, LifeCourse Framework, assists individuals to develop a better vision for their future (Attachment 21).

Rachel Monger, Vice President of Government Affairs, LeadingAge Kansas, stated the dysfunctional Medicaid eligibility processing system results in long delays in processing and approving applications for seniors. The failure of the eligibility system is causing severe financial stress for providers of elder services across the state, resulting in payroll delays, staffing cuts, and the refusal of admission to elders in need of care, which in turn continues to harm the availability and quality of care for seniors (Attachment 22).

Timothy Graham, Interim Executive Director, InterHab, commented the promises to slow down and stabilize KanCare by requiring legislative approval before any changes could be made to the existing KanCare system offered by the legislative proviso have not been kept.

Case managers are being separated from those receiving services and providers have not been given clarification from the State or from MCOs on the contracts and the effect they will have on Kansans across the state. He expressed concern about the future of targeted case management within the managed care structure. He urged immediate attention to rectify this lapse (Attachment 23).

Ron Fugate, private citizen, expressed concern the insurance company care coordinators are removed from personal knowledge of what is required to provide LTSS to intellectually or developmentally disabled individuals; this shift from targeted case management has resulted in reduced services for consumers. He also recommended LTSS be excluded from the medical model for health services (Attachment 24).

Conferees responded to Committee members' questions:

- MCOs do not provide rehabilitation services for those on the TBI waiver due to network inadequacy, although those services are required in their contract (Ms. Williams);

- The present lawsuit involving Dr. Cain is in the appeals process. If Dr. Cain files and wins a lawsuit, the MCO would have pay the costs incurred (Mr. Hamdorf);

- Children reaching the age of three, the age at which Technology Assistance (TA) waiver services end, can transition from the TA waiver to the Intellectual and Developmental Disability (I/DD) waiver and bypass the waiting list (Amy Penrod, KDADS);

- Mr. Graham stated he has a letter from CMS indicating it does not require changes in the conflict-of-interest rule that has been interpreted as separating case management from services;

- A provider involved in both targeted case management and direct services has been interpreted as creating a conflict of interest (Mr. Hamdorf);

- A Committee member assured Ms. Kubler that, at the present time, KanCare 2.0 has been suspended;

- If the policy change separating targeted case management from direct services goes through, it will be devastating to targeted case management services provided by Jenian, Inc. (Ms. Kubler);

- Lawsuits like Dr. Cain's occur, sometimes frequently, other times not (Mr. Hamdorf);

- A Committee member suggested the need to look at how other states handle the provider appeals process; and

- There is not enough data to determine if the lack of dental care has geographical ramifications, but there is certainly a decrease in dental providers (Ms. Nance).

The following individuals submitted written-only testimony:

- Haely Ordoyne, Co-chairperson, Legislative Committee, Kansas Adult Care Executives Association (Attachment 25);
- Lou Ann Kibbee, Systems Advocacy Manager, Southeast Kansas Independent Living Resource Center, representing GrassRoots Advocates for Independent Living (Attachment 26);
- Sheldon Weisgrau, Director, Health Reform Resource Project (Attachment 27);
- Rodney Whittington, CEO, Villa St. Francis (Attachment 28);
- Chris Osborn, CEO, Evergreen Community of Johnson County (Attachment 29);
- Amanda Atkisson, Administrator, Solomon Valley Manor (Attachment 30);
- Karen Sturchio, CEO, Kansas Christian Home (Attachment 31);
- Chad Austin, Senior Vice President, Government Relations, Kansas Hospital Association (Attachment 32);
- Dana Bacon, Regional Director, Government Affairs, Central Region, Leukemia and Lymphoma Society, Office of Public Policy (Attachment 33); and
- Courtney Eiterich, Government Relations Advisory Committee members, National Multiple Sclerosis (MS) Society, presenting for Kari Rinker, Senior Advocacy Manager, National MS Society (Attachment 34).

KanCare Update

Secretary Andersen, along with KDHE staff, provided a KanCare update (Attachment 35) and an executive summary (Attachment 36). He noted that a 2018 CMS scorecard ranked Kansas in the top ten states reporting information on strengthening engagement in care.

Regarding the backlog and inefficiencies encountered with vendor Maximus and the eligibility Clearinghouse, Secretary Anderson reported the contract agreed to with Maximus, which is not yet signed, would extended the partnership through 2019. Under the terms of the contract, KDHE would assume responsibility for training and quality beginning January 1, 2019. KDHE will consider directly managing other aspects of application processing in 2019. The contract agreed to with Maximus will cost the agency an additional $2.0 million in State General Funds, but KDHE has no budget authority for the increased cost of the Maximus contract. The Finance Council will have to agree to fund the $2.0 million.

Committee members questioned this report extensively; Secretary Andersen offered the following replies:

- Going forward, Maximus will be accountable for fewer metrics, even though costs to KDHE will not be reduced;

- In the short term, it does not appear possible to make the Maximus decision cost-neutral; it did not make sense to bring in a third party to assume Medicaid application processing, and the State is not in a position to take on the task;

- As part of negotiations with Maximus, the partnership will continue through 2019 and up to $10.0 million in concessions received; KDHE will be holding Maximus accountable to improve operations. Maximus applied staff beyond the requirement in the prior contract;. Because of the time constraints, KDHE will be paying more for less; however, beyond 2019, KDHE will consider a new contract with a different vendor; and

- The $2.0 million increase in the Maximus contract for State FY 2019 includes funds for KDHE to prepare for its additional responsibilities and payment to Maximus.

Secretary Andersen recognized three additional staff: Kolloh Nimley, Public Health/Medicaid Liaison, who will build synergy between Public Health and the Medicaid program; Kim Burnam, Eligibility Director, Division of Health Care Finance, who will be responsible for eligibility and the related staffing migration; and Adam Proffitt, who heads the Data/Analytics team. He commented that the Health Care Access Improvement Program (HCAIP) Fund had been overspent, but the overage was being rectified, and he praised the collaboration of KDHE and KDADS on the Communications Work Group for the new enterprise data warehouse that will provide better insights into the Medicaid program.

Dr. Greg Lakin, State Health Officer and Medicaid Medical Director, KDHE, commented on the overuse of antipsychotic drugs for dementia patients. He stated the off-label use of antipsychotic drugs in the Medicaid long term care population for the non-dual eligibility group 65 years of age and older has dropped by 28.0 percent. A new Drug Utilization Review Board-approved criteria to address antipsychotic drug use for dementia patients will require a diagnosis for approval of antipsychotics in patients 65 years of age and older in the long-term care (LTC) non-dual eligibility group setting. A Medicaid opioid strategy for pain management was developed, and a Substance Use Disorder Task Force was created and met five times since April 2018. Dr. Lakin provided details regarding the pain management program, indicating a new push is in place to make the individual more functional, but not necessarily pain free.

Mr. Hamdorf reviewed other aspects of Medicaid services under KDHE's purview. Weekly meetings with CMS are finalizing an extension of the 1115 waiver; approval is anticipated in November 2018. The work opportunities for persons with disabilities program is included, but cannot be implemented until July 1, 2019, to allow for legislative input. The work requirement will not be implemented without legislative approval. The legislative-funded telehealth initiative is nearing readiness to go live January 1, 2019. He stated the IMD substance use disorder exclusion is under behavioral health, and the agency can move forward with the exclusion, which will allow federal reimbursement for substance use disorder treatment provided in an IMD.

Mr. Hamdorf described the readiness review process under way to ensure the three MCOs under the new KanCare contract will be ready to process claims and enroll providers by

January 1, 2019. Upcoming public meetings for providers and members are scheduled for the first week of September to communicate the changes beginning January 1, 2019, and what changes may occur in the future. He reported a Kansas Medical Assistance Program identification will be federally required for all Medicaid providers by January 1, 2019, to receive payment on claims. The second iteration of the provider module for integrated credentialing will go live on January 1, 2019, creating a single access point for providers to receive credentialing with the State and all three MCOs at one time; the credentialing will follow the three-year intervals for MCO credentialing. He noted the status of other legislative-funded programs (health homes, Medicaid reinstatement post incarceration, mid-year rate adjustment, and tobacco cessation), reviewed data on the status of KanCare applications and reviews that have been pending more than 45 days, provided an update on the April results of the Nursing Facility Questionnaire, shared utilization information comparing 2017 to 2012 and 2017 to 2016, provided MCO profit and loss information showing all three MCOs were profitable (as of March 31, 2018) at a level allowed in the built-in rates, and provided program updates for the spectrum of KanCare services. He concluded by announcing the corrective action plans listed have all been completed; KDHE is waiting for the system to be implemented for the adverse interactions.

KDHE staff responded to Committee members' questions:

- The increased provider rates will go into effect on September 1, 2018, and claims paid in June and July 2018 will be reprocessed at the higher rate;

- A Committee member requested input from KDHE on what can be done to improve dental care;

- LTC application processing can be improved by improving nursing facility staff training and sending KDHE staff to assist the LTC facilities in submitting complete applications and to mitigate errors; and

- If an elderly person is admitted to a LTC facility with the expectation of Medicaid covering the costs, and if the person's application is not approved because he or she is over resources, the facility is put in a position to cover the cost from other resources; and

- A Committee member expressed the need to address what can be done to assist individuals denied admission to a LTC facility pending approval of their Medicaid applications and who have no where to go for needed services.

KanCare and HCBS Update by KDADS

HCBS Update

Secretary Keck introduced Amy Penrod, Commissioner of Community Services and Programs, KDADS, who outlined HCBS information (Attachment 37). She reported 3,719 individuals remain on the I/DD waiting list and 1,581 on the PD waiting list (150 offers were made on the I/DD list in CY 2018; 750 offers were made on the PD list). Four waivers that expire in 2019 are scheduled for renewal: the I/DD, TBI, FE, and PD. She noted changes in the TBI waiver to include acquired brain injury as part of the waiver renewal process, the development

of KanCare proposed HCBS and behavioral health network adequacy standards, the data from the National Core Indicator survey, and the implementation and training on the Person-Centered Service Plan policy. She provided the timeline for consideration and implementation of proposed metrics for HCBS quality measurement, which will be incorporated into the KanCare Meaningful Measures Collaborative. In response to new budget parameters passed by the 2018 Legislature, two RFPs will be issued for administrative case management and for the ADRC. The current ADRC contracts end in March 2019. In response to a legislative request, KDADS will send a survey to providers in late August 2018 to understand how the HCBS provider rate increase for FY 2018 and FY 2019 affected direct service workers; survey results will be available in the Fall of 2018.

Long-Term Care Update

Secretary Keck reviewed the average daily census and the monthly average eligibility caseload data for state institutions and LTC facilities and shared results from the resident satisfaction survey for Kansas nursing homes and data indicating progress in reducing the use of antipsychotics in nursing homes. He reported that vendor HMS is assisting with surveys and provided data updates on the annual and complaint surveys and the status of current surveyor positions. Secretary Keck stated the recent pay increases have been helpful in recruiting and retaining survey staff. He also noted the increase in the number of criminal record background checks since 2015, a recent requirement for HCBS and behavioral health. Responding to a question, Mr. Keck replied he believes the current policy at the Kansas Neurological Institute (KNI) is the dentist treats only KNI residents and does not provide dental services to individuals on I/DD waiver residing in the community; he will verify that information. He provided details on the RFP to build up regional beds and the input being received from the Mental Health Task Force on the RFP and the regionalization process moving forward; the hope is to have the RFP out in September, bids back by the end of 2018, and to the legislature in 2019. Answering another question, Susan Fout, Commissioner for Behavioral Health Services, KDADS, replied when complaints about LTC facilities are received, they are prioritized by severity with responses within the time frames required by CMS criteria. The immediate jeopardy complaints and other more serious ones are responded to immediately. Separate staff is responsible for the complaint surveys, so response to those does not take staff away from the annual surveys.

Behavioral Health Update

Ms. Fout addressed several topics regarding behavioral health. She said KDADS and KDHE clinical staff have recently initiated audits of “medical necessity” and denials being completed in response to concerns regarding inconsistent admissions at Psychiatric Residential Treatment Facilities (PRTFs). She noted the PRTF pilot ended in April 2018. There are questions on how well the pilot worked; if continue with the pilot, changes will need to be made. Ms. Fout mentioned a national study on PRTFs being conducted by the National Association of State Mental Health Program Directors Research Institute. She commented on a System of Care grant to better serve children with serious emotional disturbances and stated an RFP is out for mobile response and stabilization services, as well as for a crisis hotline. She also noted four Kansas sites were selected to participate in a Housing First Bridge Pilot Program, a pilot project to provide safe housing for individuals with co-occurring behavioral health issues who will be connected to Housing and Urban Development entry sites upon completion of detox and residential substance abuse programming.

Receiverships

Secretary Keck returned to provide an update on the Skyline receivership involving 15 adult care homes in Kansas for which the court has appointed the Secretary for Aging and Disability Services as receiver to operate the adult care homes. He noted the difficulty in finding new operators for the facilities in receivership. He commented that, of the $4.5 million from the Civil Monetary Penalties Fund (Fund) used initially to fund Skyline, $1 million has been returned and another $1 million will be returned to the Fund soon. He noted two other receiverships, Fort Scott and Great Bend, have been added.

State Hospitals

Secretary Keck reported on Osawatomie State Hospital (OSH) and Larned State Hospital (LSH), noting staffing changes, weekly staffing vacancy rates, and overtime trends. He commented on a new contract with vendor Navigant Consulting to evaluate the disparate billing and electronic medical records systems in place at each of the four state hospitals. Regarding the Parsons State Hospital and Training Center (PSH) being out of CMS compliance with regard to facility staffing related to physical therapy during the May 2018 annual survey, he stated corrective action plans were already in place to bring the hospital into compliance. Dr. Mike Dixon, Superintendent, PSH, discussed the corrective action plans for the annual and complaint surveys. He noted an Administrative Executive Committee has been added to assist with the corrective action plans, as well as evaluate other areas for possible noncompliance. Regarding the July 2018 PSH complaint survey related to nursing and which resulted in an immediate jeopardy finding, Dr. Dixon said a new policy is being implemented to assist with documentation. The final survey reports for the annual and complaint surveys could be available within the week.

Secretary Keck noted the appendix to his written testimony containing the standard HCBS waiver reports and average monthly caseloads for HCBS and HCBS Money Follows the Person through the third quarter of SFY 2018.

Afternoon Session

National Association of States United for Aging and Disabilities (NASUAD) Presentation

Camille Dobson, Deputy Executive Director, NASUAD, presented information about NASUAD and a national perspective on Managed Long-Term Services and Supports (MLTSS) (Attachment 38). She also provided supplemental information showing the strategies for success in MLTSS (Attachment 39) and demonstrating the value of MLTSS (Attachment 40). She said the NASUAD mission is to design, improve, and sustain state systems delivering home and community based service and supports for people who are older or have a disability; such support includes their caregivers. She outlined ways the association can facilitate the delivery of LTSS through capitated Medicaid managed care plans. She noted NASUAD has expanded its services from a few states in 2010 to nearly 50.0 percent of the states in 2018. Ms. Dobson identified several reasons for the growth of MLTSS: accountability rests with a single entity, administrative simplification, innovation, quality, budget predictability, and person-centered community-based services focus. She listed key elements of a successful MLTSS program and cited evidence from states that have followed the MLTSS program. She noted states examples

of how the MLTSS program has rebalanced spending, improved health outcomes, reduced waiting lists, increased budget predictability, and managed costs. She also discussed the MLTSS program lifecycle, program design, state infrastructure, and quality improvement.

Update: KanCare Ombudsman

As an update on the work of the KanCare Ombudsman, Kerrie Bacon provided written testimony (Attachment 41).

Responses from Agencies and Managed Care Organizations (MCOs)

MCO Presentations

Kevin Sparks, CEO, with Dale Marsico, Business Consultant, UnitedHealthcare Community Plan, and Tanner Fortney, Director of Operations, Johnson County Mental Health Center, outlined how transportation services can improve health outcomes. A pilot partnership between Johnson County Mental Health Center (MHC) and UnitedHealthcare links peer drivers with behavioral health patients. The majority of transportation services provided has been focused on travel to and from employment related destinations, such as trips for job interviews, job training, try-out employment, and work for those who are employed. They reported the program has improved quality of life outcomes, as well as lowering overall healthcare expenditures (Attachment 42). Mr. Fortney expressed gratitude for the financial involvement of UnitedHealthcare. Responding to questions, Mr. Fortney replied that vehicles used for transportation are leased, participants in the program are Medicaid patients, and case managers assure the drivers are qualified. Mr. Marsico commented that the cost per trip is $19.02, which includes the cost of the trip and driver assistance. Patients are charged $3.00 one way, but the remainder is covered by the MHC; however, UnitedHealthcare patients do not pay, as the cost is covered by the MCO.

Frank Clepper, CEO, Amerigroup Kansas Plan, explained the Amerigroup position regarding the lawsuit with Dr. Cain. Noting the medical field is a highly regulated industry, he said Dr. Cain did not exercise adequate precision in her billing practices. In a discussion with the Program Integrity Unit of the state, it was identified there were concerns with Dr. Cain's billing practices that merited an investigation. Based on the Program Integrity Unit's concerns, the Medicaid Special Investigations Unit completed an investigation on a statistical sample of Dr. Cain's claims. The code reviewed comprised 81.0 percent of Dr. Cain's annual billing. As a result of the investigation, Amerigroup reviewed a statistically valid sample of 571 claims and found some anomalies in the data. Amerigroup requested Dr. Cain provide 30 paper records that supported the billing as submitted on those claims. A review of the 30 claims showed an error rate of 67.0 percent in inappropriately billed claims by upcharging or upcoding of claims or misidentifying the billing provider. Applying an algorithm resulted in about $12,000 in overpayments, for which Dr. Cain was billed. Due to the statistical significance of 67.0 percent of claims inappropriately billed, Amerigroup placed Dr. Cain on prepaid review for the code in question and continued to monitor her practice. He said the monitoring has not shown a continuation of that billing error.

Mr. Clepper noted information about the services provided by Amerigroup (Attachment 43) and introduced Deborah Stewart, President and CEO, Finity, and Matthew Onstott, Vice

President, Government Solutions, Finity. Ms. Stewart and Mr. Onstott explained Amerigroup's Health Intelligence Program, an incentive program to tie members into responsible health care. The program consists of: the right activity (Lifetracks), the right engagement (multimedia), the right reward (catalog incentives), and the right reporting (profiles). Ms. Stewart commented 71.0 percent of the information is communicated *via* cell phones, and most catalog listings are healthful items. Mr. Onstott noted 90.0 percent of those using the system expressed satisfaction. Responding to a question, Mr. Onstott replied catalogs were both printed and offered online.

Michael Stephens, President and CEO, Sunflower Health Plan, responding to an earlier question, commented that providing oral health care is a unique challenge because of geography, non-acceptance of Medicaid by many dental providers, and the more difficult treatment options presented by those with disabilities. In presenting the MCO health plan, he noted Sunflower is the first KanCare MCO to reach "Commendable" accreditation status with the National Committee for Quality Assurance. He provided updated information regarding operational metrics (medical and pharmacy claims paid or denied), and he listed value-added benefits available to consumers in 2019. He noted innovative strategies that foster integration, including telehealth and introduction of MLTSS as effective ways to expand services (Attachment 44).

Next Meeting; Adjourn

The Chairperson announced the next Committee meeting is tentatively scheduled for November 8 and 9, 2018, with alternative dates of December 3 and 4.

Responding to a question, the Chairperson stated the individual nominated for the Medicaid Inspector General position has not yet been confirmed by the Senate.

The meeting was adjourned at 3:41 p.m.

Prepared by Gary Deeter

Edited by Iraida Orr

Approved by the Committee on:

November 8, 2018
(Date)