# MINUTES

## JOINT COMMITTEE ON HOME AND COMMUNITY BASED SERVICES OVERSIGHT

September 26, 2012
Room 548-S—Statehouse

### Members Present

Representative David Crum, Chairperson
Senator Carolyn McGinn, Vice-chairperson
Senator Laura Kelly
Senator Kelly Kultala
Senator Dwayne Umbarger
Representative Barbara Ballard
Representative Jerry Henry
Representative Peggy Mast

### Members Absent

Representative Brenda Landwehr

### Staff Present

Iraida Orr, Kansas Legislative Research Department
Martha Dorsey, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Renae Jefferies, Office of the Revisor of Statutes
Katherine McBride, Office of the Revisor of Statutes
Jan Lunn, Committee Secretary

### Conferees

Kari Bruffett, Director, Division of Health Care Finance, Kansas Department of Health and Environment
Shawn Sullivan, Secretary, Kansas Department for Aging and Disability Services
Gary Haulmark, Commissioner of Community Services and Programs, Kansas Department for Aging and Disability Services

### Morning Session

Chairperson Crum called the meeting to order and reviewed the Committee's charge, which is: to oversee the savings resulting from the transfer of individuals from state or private institutions to home and community based services (HCBS); to ensure any proceeds resulting from the successful transfer are applied to the provision of services for long-term care and

HCBS; and to review and study other components of the state's long-term care system (Attachment 1).

**Overview of KanCare and Community Developmental Disability Pilots**

Kari Bruffett, Director of the Division of Health Care Finance, Kansas Department of Health and Environment (KDHE), provided testimony concerning the KanCare implementation process, educational tours, the status of the federal Centers for Medicare and Medicaid Services (CMS) 1115 waiver application, the Kansas Department for Aging and Disability Services (KDADS) educational tour, managed care organizations (MCOs) awarded contractual agreements and their readiness reviews, and other important implementation milestones (Attachment 2).

Ms. Bruffett stated the educational tours throughout the state were well attended and yielded valuable feedback from stakeholders. One suggestion was the development of a standardized provider credentialing form for use by all three MCOs (Amerigroup of Kansas, Inc. (Amerigroup), United Healthcare of the Midwest (United), and Sunflower State Health Plan or (Sunflower)).

On August 6, 2012, the state submitted its formal KanCare Section 1115 waiver to CMS. CMS notified the state on August 21, 2012, the application met all requirements for completeness. CMS began its official comment period on August 21. Comments were accepted through September 20, 2012. Continued discussion with CMS officials is on a weekly basis. Ms. Bruffett noted the earliest date the 1115 waiver application could be approved by CMS would be 45 days after August 21.

Ms. Bruffett discussed the KanCare website (*www.kancare.ks.gov/*), which includes all questions from educational tours and is organized for providers, consumers, and others. The website will serve as KanCare's launching pad and contains information concerning the Governor's KanCare Advisory Council, policies and reports, plan information and application, current news, and the status of the 1115 waiver application and comments.

Ms. Bruffett stated the state had engaged Mercer, a global consulting firm, to assist with education, MCO readiness reviews, CMS interaction, and staff training. She indicated four external stakeholder workgroups were created to ensure a smooth transition to KanCare: Providers, MCOs, Member Involvement and Protection, and Specialized Healthcare and Network Issues. There also is one internal work group consisting of intra-agency (KDADS and KDHE) representatives, and a Governor's Advisory Council, which is charged with providing the Administration with ongoing insight and recommendations on the implementation of KanCare.

To evaluate the MCOs readiness for the January 1, 2013, implementation date, the state began initial readiness reviews on September 5. Completion of readiness reviews will occur prior to the state's "Go/No-Go" decision date of October 19, 2012. Ms. Bruffett stated the Go/No-Go decision relates specifically to a "beneficiary assignment" algorithm file, which will populate the beneficiaries' initial enrollment assignments to each MCO, and is not a decision date on KanCare implementation. The target date to populate this file is October 24, 2012. A determination will be made on the Go/No Go decision date as to whether the algorithm file will be ready to run MCO beneficiary assignments on October 24. The file is necessary in order to send beneficiaries their letters of assignment by November. Following the beneficiary assignment notices, opportunities will be provided for members and MCOs to interact through

"open-enrollment" type meetings. At that time, beneficiaries can choose an MCO other than the one to which they were automatically assigned.

As part of the readiness evaluation, MCOs are required to demonstrate 90 percent of their network providers are in place by October 12 and 100 percent are in place by November 16, 2012. Ms. Bruffett indicated MCOs are encouraged to include every current Medicaid provider in Kansas in their networks. Further, for areas with access issues, the state has encouraged MCOs to sign additional network Medicaid providers. Providers are encouraged, but not required, to enroll in all three MCO provider networks in order to provide beneficiaries more flexibility in choosing service plans. Though the three MCO basic plans are the same, the provider network and value-added services offered could vary from one MCO to another. Value-added services are previously non-covered services to beneficiaries provided at no cost to the state and include adult preventive dental benefits, rewards programs for healthy behaviors, respite care, and other health care services.

Discussions with providers resulted in the conclusion that a single, front-door Medicaid Management Information System (MMIS) billing interface would be available but not mandatory. Providers may send all claims to MMIS, which would then forward the billing to the appropriate MCO. In addition, providers also may bill through their own clearinghouses or directly bill the MCOs. Ms. Bruffett reported, regardless of how a provider bills (MMIS, commercial clearinghouse, or directly to the MCO), the state would possess real-time access to the claims data for the purpose of validating timely claims payments, monitoring health data, and making data-based decisions concerning the KanCare delivery system.

In response to Committee questions, Ms. Bruffett indicated:

- The Section 1115 CMS waiver process in which the state is involved is typical; the state foresees formal 1115 waiver acceptance by CMS.

- MCOs are in the process of hiring their staffing complement (case managers), which could be employees of current providers; the state is working with MCOs to ensure neither interruption of service nor negative impact results from staff being hired away from current providers.

- The January 1, 2013, KanCare implementation date was selected (even though it falls on a holiday) to ensure similar enrollment processes occur annually and to provide outcomes measurement information for a calendar-year period.

- Providers are encouraged to contract with all three MCOs; currently, MCOs are contacting Medicaid providers to proactively engage in contract dialogue. There are links to each MCO on the KanCare website, should providers want to contact an MCO directly.

- Each MCO will offer a full network of provider services. In some cases, out-of-network providers can be accessed, which provides a baseline reimbursement of 90 percent of fee-for-service Medicaid rates.

- Concerning reimbursement rates, CMS updates its diagnosis-related group (DRG) codes, current procedural terminology (CPT) codes, and ambulatory payment classification (APC) codes annually. These codes comprise the

prospective payment system (PPS) rate, which is a means of determining insurance payments based on predetermined prices (from Medicare); a federal requirement exists that mandates primary care rates be paid at 100 percent of Medicare. To date, CMS has not released which codes have been updated and would be paid at 100 percent of Medicare; therefore, providers currently could be verbalizing concerns related to payment rates. The state will make appropriate rate adjustments based on CMS-released information. Under KanCare, there will be no change in Medicaid eligibility requirements.

- The Kansas Eligibility Enforcement System (KEES) is "live" and an online customer portal exists for benefits applications; however, the KEES link is not yet "live" on the KanCare website.

- A side-by-side comparison for each MCO's plan will be available for beneficiaries in a "member packet" as well as on-line when the enrollment period begins. Ms. Bruffett provided Committee members with a matrix listing value-added services for each of the three MCOs (Attachment 3).

- Each MCO's provider manual will be available on-line only since information can change rapidly.

- Contingency plans are being developed should CMS 1115 waiver approval be delayed. The primary issues requiring waiver approval are to: (1) move nearly all Medicaid populations into managed care; (2) cover all services, including long term services and supports (LTSS), through managed care; (3) establish safety net care pools to reimburse hospitals for uncompensated care costs; and (4) create pilot projects to serve as alternatives to Medicaid.

- On a weekly basis, various state representatives communicate with CMS representatives *via* telephone regarding the Section 1115 waiver. State representatives include Cabinet secretaries; key agency representatives (KDADS and KDHE); consultants, such as the state's actuarial firm (Optumas Consulting), and the law firm of Covington and Burling, LLP. Discussion topics include: primary requirements for waiver approval, budget neutrality, and other pertinent topics.

- To ensure a viable network of providers (90 percent by October 12, 2012), the state receives network spreadsheets, which detail providers by specialty, ancillary services, provider geographic information by zip code, and mileage requirements for access to providers.

- There are three MCOs under contract; all services covered by Medicaid are included in each MCO's individual plan. The differences which exist are in each MCO's provider network and the value-added services offered. The state plans to provide beneficiaries with information regarding how each MCO met the established benchmarks during the first plan year to allow for enhanced MCO comparison for the 2014 enrollment period.

- The state, in its overall communication plan, has worked to build successful relationships with providers and advocacy groups, has collaborated with MCOs

to offer beneficiary and provider educational meetings, and has continued to foster communication among all stakeholders. Much communication has been general in nature; however, communication will become more targeted as soon as initial beneficiary assignments to an MCO are made and as the Aging and Disability Resource Centers (ADRCs) counsel beneficiaries concerning available options within the MCOs' plans. In response to a Committee request, Ms. Bruffett provided the Committee with a KanCare brochure containing contact information for consumers (Attachment 4).

Secretary Shawn Sullivan, KDADS, provided a brief overview concerning the KanCare MCO assignment process. He indicated the automatic assignment is based on several formulas and algorithms; a beneficiary's primary care provider is one such formula. For example, if the beneficiary's primary care provider has contracted with Amerigroup, then the beneficiary would be assigned to Amerigroup. It is projected that the initial assignment process will generate equality in the number of total Medicaid beneficiaries assigned to each MCO. From that point, the beneficiary will consult with ADRCs to choose the optimal MCO based on value-added services and in-network providers. Following the first year of implementation, performance standards and matrices could become part of the choice process in addition to the competitiveness created by value-added services and each MCO's provider network.

**Overview of Developmental Disability HCBS Waiver Pilots**

Secretary Sullivan provided testimony concerning the HCBS Waiver for individuals with developmental disabilities (HCBS/DD) pilot program (Attachment 5). He stated the 2012 Legislature included a phased-in approach for services under the HCBS/DD waiver program. This approach did not include technical assistance (TA) waiver beneficiaries or beneficiaries receiving behavioral health services, who also use the HCBD/DD waiver program. The phased-in approach mandates HCBS/DD beneficiaries be excluded from the KanCare program until one year following its implementation date. In addition, HCBS/DD beneficiaries can participate in a pilot project on a voluntary basis.

Secretary Sullivan stated an HCBS/DD Pilot Project Advisory Committee was created in collaboration with the state's 27 Community Developmental Disability Organizations (CDDOs). The Advisory Committee is responsible to develop and provide recommendations related to the: HCBS/DD pilot project design, outcomes and customer satisfaction measures, processes to track and measure outcomes of the pilot, and other related issues. A Request for Information (RFI) was created and distributed to CDDOs throughout the state; ten CDDOs responded to the RFI and expressed interest in pilot program participation.

Secretary Sullivan discussed the "next steps" to implementing the pilot program, which include finalization of operational guidelines and outcome measurements by September 28, 2012. In early October, an invitation to participate will be distributed to HCBS/DD system stakeholders, and volunteers for pilot project participation will be gathered. Providers will be selected and general engagement will begin. As the pilot project is implemented, the outcomes measurements will be put in place and results will be tracked and measured. The HCBS/DD Pilot Project Advisory Committee will assist KDADS in managing the pilot.

Secretary Sullivan responded to questions from Committee members as follows:

- In Kansas, 27 CDDOs serve as gatekeepers to the HCBS/DD system, with each CDDO responsible for a defined market area. There are 230 community service

providers (including the 27 CDDOs) throughout the state. The list of providers can be found on the KDADS website: http://csp.kdads.ks.gov/services/Pages/MapCDDO.aspx

- The pilot program selection process will include evaluation of CDDOs' geographic locations to ensure broad representation of rural and urban providers, a reasonable mix of different-sized agencies, as well as CDDOs that provide targeted case management services. The pilot program is voluntary; those providers who do not participate in the pilot will be serving HCBS/DD waiver beneficiaries according to the current processes, procedures, and regulatory requirements.

- At this time, no decisions have been made to expand the pilot project beyond the current project design.

- MCOs will be part of the pilot program, though they have not been actively involved in the design phase of the project. MCOs have been engaged in weekly dialogue with KDADS. KDADS staff has participated in focused sessions with HCBS/DD providers, MCO representatives, and other interested groups. On October 12, 2012, KDADS has scheduled a separate session with InterHab representatives and other interested groups to review and collaborate on issues related to care coordination and case management.

- Secretary Sullivan was unable to predict or provide a specific answer when asked concerning the possibility of skewed pilot program results if one MCO were to sign a greater number of HCBS/DD waiver beneficiaries.

- Since only ten HCBS/DD service providers expressed interest in the pilot program, Secretary Sullivan indicated it can be assumed there is some resistance to change within the DD community. It is unknown whether those ten service providers which expressed interest in the pilot program are CDDOs.

- Section 1115 waiver approval is required in order for the pilot program to progress.

- To date, there have been no CDDOs or DD community service providers (CSPs) involved in a state-operated managed care plan. All three MCOs will participate in the HCBS/DD pilot program.

**Overview of Reorganization of KDADS and Update on Transition of Services and Waivers**

Secretary Sullivan provided a summary of the reorganization of KDADS, which resulted from Executive Reorganization Order 41 (see Attachment 5, pages 6 and 7). He indicated KDADS had assumed responsibility from the previous Department of Social and Rehabilitation Services (now the Department for Children and Families), for Medicaid waivers and state hospitals and institutions. KDADS also assumed responsibility for some health occupations credentialing from KDHE. Secretary Sullivan noted an error in his written testimony (page 6, Attachment 5) and indicated **KDADS did not assume accountability for KanCare Finance and KanCare Oversight. Those programs remain with KDHE. He also indicated the speech language pathologist and audiologist credentialing program inadvertently was**

**omitted in his written testimony from the list of credentialing programs transferred from KDHE to KDADS.**

With regard to a question concerning the elimination of positions due to the reorganization of agency functions, Secretary Sullivan will provide additional information related to positions eliminated resulting from agency downsizing occurring in Spring of 2011, the voluntary retirement incentive program (VRIP) in Fall of 2011, and as a result of agency reorganization in 2012. He indicated there may be further changes in agency staffing as MCOs assume some functions, and these changes would be resolved through attrition; information on any such staffing changes may not be available until the 2013 Legislative Session, but will be provided as changes are made.

The meeting was recessed at 11:50 a.m.

**Afternoon Session**

The meeting reconvened at 1:43 p.m.

**Quarterly Reports on Average Daily Census for State Institutions and Long-Term Care (LTC) Facilities, Savings on Transfers to HCBS Waiver, and HCBS Savings Fund Balance**

Gary Haulmark, Commissioner of Community Services and Programs, KDADS, reviewed information contained in Attachment 6 related to average daily census in state hospitals and institutions and intermediate care facilities for the mentally retarded (ICFs/MR). In addition, the number of individuals transferred to HCBS from developmental disability institutional settings and nursing facility institutional settings through the Money Follows the Person (MFP) program were reviewed. Commissioner Haulmark defined "savings" through the MFP program as real dollars only when individuals move into a community setting from an institutional setting and the bed is closed behind the individual.

With regard to nursing facilities and state ICFs/MR, Commissioner Haulmark stated savings are only seen if the bed is closed. In nursing facilities and state ICFs/MRs, the bed may be refilled when there is a request by an individual for admission who requires the level of care provided by that facility, and therefore, the bed is not closed. Even when a bed is closed, only incremental savings are realized until an entire unit or wing of a facility can be closed. Any savings realized are considered "cost avoidance" because an individual transferring from an institution into a community setting generates smaller growth in institutional utilization, not pure cost savings.

Commissioner Haulmark reported, as certified by the KDADS Secretary, there are no savings resulting from individuals transitioning to HCBS waiver programs as of September 21, 2012. The current balance in the KDADS HCBS Savings Fund is zero as of September 21, 2012.

The Commissioner responded to questions by Committee members as follows:

- The MFP program is 100 percent federally funded; the state has used this funding source since July 2008.

- The state has not met the goal related to closing a bed when a transition to community services is achieved. Beds are back-filled by individuals requiring services through waiting lists, crisis situations or other causes, which results in the inability to predict actual cost reductions within these programs.

- A Committee member requested a copy of the state's MFP report to the federal government. Commissioner Haulmark indicated the federal government continues to fund the project even though there is no actual cost savings reported.

- According to Commissioner Haulmark, under KanCare, the MCOs would provide support for the MFP project to ensure appropriate transitions into community environments.

- Committee members and Commissioner Haulmark discussed the state's responsibility for the population being served at the Kansas Neurological Institute (KNI) or Parsons State Hospital (PSH). Although CDDOs are the gatekeepers for entrance into institutional settings, the choice of where service is provided is determined by the beneficiary, family or guardian, as per a CMS regulatory requirement. Commissioner Haulmark reported the KNI census is slowly decreasing due to its aging population.

**Update on HCBS Waiting Lists and Steps Taken by KDADS to Reduce Waiting Lists**

Secretary Sullivan referred to his earlier testimony (Attachment 5, pages 11, 12, and 13) and reviewed the HCBS waiting list information.

**HCBS/DD Waiver Waiting List:** 8,298 individuals currently receive HCBS/DD waiver services. There are currently 2,796 who are waiting for services; another 1,247 receive some waiver services but are waiting for additional services (considered "underserved"). Individuals enter the HCBS/DD waiver program through general access to services from the waiting list, through the MFP project, by crisis exception, and by needs-based transfer from other waiver programs. As a result of additional appropriation by the 2012 Legislature, an additional 100 people on the waiting list will be served through the HCBS/DD waiver program.

**HCBS/PD Waiver Waiting List:** Secretary Sullivan discussed the agency's efforts to better manage the HCBS/PD program and its utilization and growth. He described a process begun to audit and verify waiting list information, which consisted of contracting with a third-party call center to contact each of the 3,462 individuals on the waiting list. The call center was able to contact only 377 people (11 percent of the waiting list). Therefore, KDADS concluded the waiting list lacked the integrity on which to base policy decisions and has required the Independent Living Centers (ICLs) responsible for consumers entering HCBS/PD program to review, correct, and update waiting list information submitted by their agency. Each ICL has been asked to certify the accuracy of the waiting list information. Once the process has been completed, KDADS will review and analyze results to better utilize funds dedicated to this waiver program. Secretary Sullivan reported that to better control the HCBS/PD waiting list, ADRCs and the state will play a greater role in the management of the HCBS/PD waiver program.

Responses to HCBS/PD and HCBS/DD waiver services questions follow:

- From the third party call center survey results, it appears there is little, if any, onus on the beneficiary to report any changes in status, address, or telephone numbers. It was suggested that consideration be given to establishing a requirement of mutuality or understanding concerning accuracy of current information.

- The third-party call center, AnswerNet, was paid $4,999 to contact (or attempt to contact) individuals on the HCBS/PD waiting list. Contracts over $5,000 are awarded through a competitive bid process.

- Secretary Sullivan confirmed 100 individuals on the HCBS/PD waiting list will gain access to services by the end of the year.

General discussion and questions regarding HCBS waivers were heard, with Secretary Sullivan responding as follows:

- KDHE is in the process of conducting nursing home Medicaid Recovery Audits; this process does not affect HCBS Frail Elderly (HCBS/FE) waiver recipients.

- At a recent KanCare Advisory Council meeting, Secretary Sullivan clarified that Kansas (according to recent statistics) has the sixth highest nursing facility utilization rate in the country for HCBS/FE and HCBS/PD waiver beneficiaries and the fourth highest in the country per capita. He stated this could indicate the state possesses an opportunity to improve its management of higher-acuity waiver services.

**Targeted Case Management in Programs Administered by KDADS**

As the state prepares for its KanCare transition, Secretary Sullivan discussed the agency's efforts to address key issues, specifically "targeted case management (TCM)." TCM is a service to assist HCBS waiver services beneficiaries with enhanced integration of care and improved outcomes, while preserving program integrity within the KanCare model (Attachment 5, page 13). He stated that KDADS considers TCM a care management service, not the actual provision of care. Secretary Sullivan provided an overview of TCM, requirements within the RFP and contract, recent decisions, and how TCM will be operationalized within the KanCare model.

Secretary Sullivan noted the operational criteria include:

- TCM for individuals with serious and persistent mental illness (adults) or severe emotional disturbance (youth) will continue to be assessed through Community Mental Health Centers (CMHCs) throughout the state.

- TCM for individuals who use HCBS/DD waiver services will continue to be assessed through CDDOs.

- All other TCM services will become the direct or indirect (through subcontractors) responsibility of the three MCOs within the KanCare model.

Specific discussions and questions related to TCM were addressed by Secretary Sullivan as follow:

- The Secretary indicated the Program of All-Inclusive Care for the Elderly (PACE) is excluded from KanCare. PACE is a dual-enrollment option to KanCare and is available to seniors, ages 55 and older, who also are eligible for nursing home care. Secretary Sullivan announced the program is expanding to other market areas in the state: Wyandotte, Johnson, North Central counties, and Southeast counties, while Midland and Via Christi will be expanding their catchment areas. It is anticipated PACE capped slots will be lifted and eligible individuals will be able to choose between PACE and KanCare plans.

- The state is working with current HCBS waiver service providers to ensure non-interrupted TCM services during the transition to KanCare.

- Additional guidelines and expectations were sent September 26, 2012, to all TCM providers concerning core competencies, contingency plans, and transition plans.

- For the FE, PD, and Traumatic Brain Injury (TBI) HCBS waivers and nursing homes, the organizations currently providing functional assessments will no longer provide "front-end" services. ADRCs will perform the functions of assessment and options counseling for these HCBS waiver services. Secretary Sullivan announced a vendor had been selected and an ADRC contract forwarded; however, since an executed contract had not been received by the state, Secretary Sullivan declined to announce the name of the selected vendor.

- Each MCO is expected to hire 125-150 care coordinators who are responsible to coordinate each member's needs through all systems; case managers (different from care coordinators) are responsible to focus on waiver services and develop the beneficiaries' plans of care. The expected number of care coordinators to be hired by each MCO is based on equal enrollment among all three MCOs.

- For FE, PD, and TBI HCBS waiver beneficiaries, care coordinators would be hired by each MCO within the KanCare model. In the event there is unequal beneficiary distribution among the three MCOs, the staffing complement would require adjustment by the MCOs.

- A Committee member requested definition of the statement, ". . . no community service system is destabilized by this transition." Secretary Sullivan indicated TCM functions will continue through the transition to KanCare, under which MCOs will provide case management and care coordination and contract out the provision of services.

The Secretary addressed additional questions and concerns presented by Committee members regarding areas under the purview of KDADS as follow:

- MCOs will administer case management and care coordination; existing organizations will continue to provide actual services.

- Concern was expressed regarding the cyclical readmission of eligible beneficiaries to state hospitals and institutions following release from the Department of Corrections system. Secretary Sullivan acknowledged the issue and supported the provision of services at the community level. A Committee member noted costs have shifted to many community health centers, which are required to bear additional costs due to decreases in mental health services funding at the state level.

- A Committee member inquired how the implementation of KanCare will change or shorten the length of time eligible individuals are waiting for HCBS waiver services. Secretary Sullivan responded that other than additional appropriations to reduce the waiting list, the growth of Medicaid must be curbed. The projection of $1 billion in Medicaid growth reduction would make funds more globally available to reduce waiting lists.

- Through CMS approval of the Section 1115 waiver, additional employment-related pilots would be possible, which could positively impact waiting lists.

- Secretary Sullivan suggested a presentation by KDHE on the employment-related pilot contained in the 1115 waiver application could be made to Committee members.

- Secretary Sullivan stated, at the current time, there was no formal investigation by the Department of Justice related to the *Olmstead* decision. Beyond the statement he offered, he declined to answer further questions and referred Committee members to previous Committee meeting discussions.

- With regard to a question related to checks and balances for the prevention of fraud, Secretary Sullivan indicated other than the transfer of eligibility determination to ADRCs and case management transferred to MCOs, fraud detection and reporting continues through the same avenues as defined in current processes and procedures (Attorney General, Medicaid Fraud Unit, KDADS, and other agencies).

- ILCs will continue to provide HCBS/PD waiver services under KanCare. Secretary Sullivan elaborated that independent audits of ILCs have been completed, which resulted in collaborative efforts to revise standardized documentation, independent financial audits, forms, additional governance and training at the provider level, and expectations. He expressed the auditing process and collaboration had resulted in the improvement of integrity, service provision, and oversight.

- ADRCs will serve as MCO options counselors to assist in beneficiaries' eligibility determination, as well as aiding beneficiaries in the selection of an optimal MCO or PACE plan. A Committee member requested a copy of the ADRC Request for Proposal (RFP) issued in March 2011 for potential vendors and information regarding the awarding of the ADRC contract; Secretary Sullivan indicated he would send Committee members the appropriate electronic link. He indicated Wisconsin, as well as other states, have utilized a statewide ADRC network.

There are currently two pilot ADRC sites in the state: Hays and Wichita. Information regarding ADRCs may be accessed at www.ksadrc.org.

- The current process for accessing services is: for HCBS/FE waiver services and nursing homes, the local Area Agency on Aging (AAA) performs assessments; HCBS/PD waiver services are assessed by CILs; and for the TBI waiver, 16-17 private providers perform assessments. In the new KanCare model, ADRCs will assess and provide options counseling; they will not provide services or be included in the network.

**Possible Agenda Items for the October 30, 2012, Meeting**

The Chairperson requested topics for discussion at the next meeting. The following topics were recommended by Committee members for consideration:

- Overview from KDHE on KanCare Employment-Related Pilots;
- Revisit discussion of a KanCare Oversight Committee;
- KanCare updates from Secretary Sullivan (ADRC, KanCare CDDO Pilot, MCO);
- Provider timelines, and status of Section 1115 Waiver and date waiver must be approved to continue with KanCare implementation on January 1, 2013; and
- Updated testimony from conferees testifying before the Legislative Budget Committee who expressed concerns regarding KanCare implementation.

The meeting was adjourned at 3:50 p.m.

Prepared by Jan Lunn
Edited by Iraida Orr

Approved by Committee on:

November 8, 2012
(Date)