MINUTES

LEGISLATIVE BUDGET COMMITTEE

September 12-13, 2012
Room 548-S—Statehouse

Members Present

Senator Carolyn McGinn, Chairperson
Representative Marc Rhoades, Vice-Chairperson
Representative Jim Denning
Representative Bill Feuerborn
Representative Kasha Kelley
Senator Laura Kelly
Senator John Vratil

Staff Present

J. G. Scott, Kansas Legislative Research Department
Leah Robinson, Kansas Legislative Research Department
Audrey Dunkel, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Bobbi Mariani, Kansas Legislative Research Department
Shirley Morrow, Kansas Legislative Research Department
Michael Steiner, Kansas Legislative Research Department
Dylan Dear, Kansas Legislative Research Department
Iraida Orr, Kansas Legislative Research Department
Jill Wolters, Office of the Revisor of Statutes
Nobuko Folmsbee, Office of the Revisor of Statutes
Daniel Yoza, Office of the Revisor of Statutes
Jan Lunn, Committee Secretary

Conferees Present

Gary Haulmark, Commissioner of Community Service and Programs, Department for Aging and Disability Services
Amy Campbell, Kansas Mental Health Coalition
Denise German, RN, Senior Vice President, Skilled Health Care, Assisted Living Communities
Tom Laing, Executive Director, InterHab
Ami Hyten, Assistant Executive Director, Topeka Independent Living Resource Center, Inc.
Nick Jordan, Secretary, Department of Revenue
Mike Taylor, Public Relations Director, Wyandotte County Treasurer's Office
Thomas G. Franzen, Finance Director and Johnson County Treasurer
John Waltner, Harvey County Administrator, County Treasurer's Office
Shawn Sullivan, Secretary, Kansas Department for Aging and Disability Services
Pam Perry, Vice President, Government Relations, Amerigroup

Nan Kartsonis, Director of Governmental Affairs, United Healthcare
Holly Benson, Director of Governmental Affairs, Sunflower State Health Plan
Chad Austin, Vice President, Government Affairs, Kansas Hospital Association
Debra Zehr, President and CEO, LeadingAge Kansas
Cindy Luxem, President and CEO, Kansas Health Care Association
Matt Fletcher, Associate Executive Director, InterHab
Maury Thompson, Executive Director, Johnson County Developmental Supports

Tuesday, September 12
Morning Session

Chairperson McGinn called the meeting to order at 10:05 a.m.

The Committee's membership, charge, and assigned topics were distributed by the Kansas Legislative Research Department to Committee members (Attachment 1).

State General Fund Receipts

J. G. Scott, Chief Fiscal Analyst, Kansas Legislative Research Department (KLRD), reported State General Fund (SGF) Receipts (July and August) were $13.7 million or 1.7 percent above the estimate. The component of total SGF receipts from taxes only was $10.5 million or 1.2 percent below the estimate (Attachment 2). Mr. Scott reminded Committee members the new income tax legislation becomes effective January 1, 2013; therefore, receipts discussed during the meeting represent those receipts under current law. He indicated the main concern was the shortfall of year-to-date individual income tax receipts, which was approximately $19 million below expectations. Mr. Scott reported receipts are adjusted for fund transfers (school districts, various agencies, Department of Administration, Children's Fund agencies, and others); expected transfers were $91 million, actual transfers were $69 million due to the reduction in the Kansas Bioscience Authority transfer in August 2012. The consensus estimates projected the $35 million transfer to the Kansas Bioscience Authority to be fully paid in August. Historically, these payments have been made in August and November. A total of $12.3 million was transferred in August, with the remainder scheduled to be transferred in November 2012.

In response to a question concerning how the consensus revenue estimating group would create estimates based on the new tax structure, Mr. Scott indicated the group will evaluate projections based on current law, evaluate impact of tax rates and exemptions, and generate an appropriate estimate by November 6, 2012.

State Hospitals Census Update, Hospital Staffing, and Salary Issues

Gary Haulmark, Commissioner of Community Services and Programs, Kansas Department for Aging and Disability Services (KDADS), reviewed census, recruitment and retention issues, staffing to patient ratios, salary issues and pay raises, and quality outcome measurements for Kansas Neurological Institute (KNI), Larned State Hospital (LSH), Parsons State Hospital and Treatment Center (PSHTC), Osawatomie State Hospital (OSH), and Rainbow Mental Health Facility (RMHF). In addition, he reviewed community mental health centers contracts, ComCare Crisis Stabilization Beds, Sedgwick Policy Academy, Census Management Initiative, and the Intensive Case Management Program (Attachment 3).

In response to questions, Mr. Haulmark indicated:

- KNI has experienced licensed practical nurse (LPN) recruitment challenges, which resulted in above-step hiring authority to pay LPN recruits a more competitive wage. A Committee member requested additional information that reflects above-step hiring rates before and after implementation of under-market pay increases for all KNI staff to ensure salary compression issues for long-term employees are not created as a result of the above-step hiring authority.

- Concerning PSHTC and KNI, the budgeted average daily census for FY 2014 will be based on the same figures used to budget for 2013.

- In review of the quality outcomes measurements provided for PSHTC, a Committee member inquired how savings for the elimination of psychotropic medications were calculated. Mr. Haulmark reported the savings were furnished by the facility; however, he assumed the calculation reflected projected savings had expenditures actually been made for these drugs. Commissioner Haulmark added that elimination of psychotropic medications is a medical decision based on each individual's needs and requirements.

- In FY 2013, PSHTC will open a "transition house" in January 2013 that will serve eight Sexual Predator Treatment Program (SPTP) individuals from LSH. A "transition house" was defined as an area to house SPTP individuals in levels 6 and 7 of the treatment phase, which focuses on re-entry into the public sector. The percentage of those individuals reintegrating into the public sector is approximately 2-3 percent. The total average yearly cost for the phases 1 through 7 (at LSH) is approximately $68,000 per year per person. Mr. Haulmark indicated he would provide additional information concerning the cost of Levels 1 through 5 separate from Levels 6 and 7 for the SPTP. He also reported that a study is being conducted at Wichita State University concerning SPTP programs in other states (populations, costs, and other factors), which will be reported during the 2013 Legislative Session.

- Individuals in the SPTP are required to pay for treatment when individual income and ability to pay exists. A Committee member requested additional information concerning efforts to generate payments by SPTP participants.

- Once a SPTP participant is transferred into a transition residence, he is required to reimburse the State for a portion of room and board expenses. Sexual predators are not required to enter the SPTP and can "opt out" of treatment; in Kansas, approximately 53 percent of sexual predators "opt out" of treatment. Kansas maintains a full array of therapeutic services and staff in order to meet constitutional requirements even though offenders may not choose therapy. A Committee member asked whether an individual who opts out of treatment violates a condition of probation upon release; Mr. Haulmark indicated staff is currently reviewing this issue to ascertain what leverage exists to potentially move offenders back into the Department of Corrections system due to a technical parole violation.

- Of the sexual predators completing the program, one was released directly to a nursing home and two were reintegrated into the public.

- For OSH and RMHF, work continues to eliminate management layers. During the 2013 Legislative Session, a request will be made to license both facilities under one hospital in order to increase efficiency and generate savings.

- Mr. Haulmark described the process for accessing private sector hospital beds due to census capacity. He indicated that OSH was over its licensed capacity 48 percent of the time during FY 2012 prompting an "above- step" hiring authority request. Mr. Haulmark will provide the hourly wage for an LPN at OSH at the request of a Committee member; however, he indicated he thought it was approximately $16-18. It is hoped that with under-market pay adjustments, aggressive recruiting, and an enhanced pool of potential employees in Johnson County some relief for these staffing challenges can be realized.

In response to questions regarding a hiring freeze and what plans the State has to address vacancy rates in state hospitals, Mr. Haulmark indicated there is never a hiring freeze for direct care staff and those positions are automatically posted following a weekly review conducted by Commissioner Haulmark and Secretary Sullivan. Non-direct care staff positions are reviewed and approved individually (by position) for posting at the weekly review meeting.

Concerning prior issues regarding reimbursement rates to Via Christi Hospital for census management issues at OSH, Mr. Haulmark indicated a more equitable rate was negotiated, and the State is no longer paying for emergency room visits. With the addition of the ComCare Crisis Stabilization Beds contractual agreement, the State could significantly reduce short-term stays at Via Christi and Prairie View facilities. Mr. Haulmark will furnish the reimbursement rates for Via Christi compared to Prairie View and other facilities providing the same services.

A Committee member requested additional information concerning the overtime paid at each state facility.

Chairperson McGinn requested the information prior to adjourning the meeting on September 13; if information is unavailable by that time, Senator McGinn asked Mr. Haulmark to notify Committee members of when requested information could be expected.

Amy Campbell, Kansas Mental Health Coalition, appeared to discuss the progress being seen for improving state mental health hospitals and strategic planning for the mental health system (Attachment 4). She commended KDADS for enhancing communication with stakeholders and the renewed focus on staffing deficiencies. Ms. Campbell reported a work group, Hospital to Home Project, was created to evaluate needed services for persons with mental illness to avoid hospitalization and to ensure effective post-hospitalization transitions. She noted that concerns still exist:

- Accreditation issues are serious;

- Staffing is a continuing concern. She suggested the Legislature request a report including a breakdown of numbers of patients compared to numbers of direct care staff by level of credentialing over a period of five to ten years;

- Protection of hospitals' budgets could ease concerns related to consistent, quality care in a safe environment;

- Consideration of mental health hospital issues separately from other institutional programs, specifically the SPTP;

- Encourage Legislative review and focus on children's inpatient private residential psychiatric facilities/programs (PRTF) to promote effective mental health systems and the role of private/public partnerships.

A Committee member requested additional information related to Ms. Campbell's staffing concern. Ms. Campbell responded the issue relates to the skill mix currently used to provide care compared to the skill mix five years earlier and ten years earlier. She emphasized that without reports containing the number of overall staff, by skill, compared to inpatient numbers, a thorough analysis of improvement opportunities is limited. Services and treatment provided during an inpatient stay impacts the statistics related to readmissions and the costs related to those readmissions.

Ms. Campbell noted the reopening of RMHF is delayed by six months due to the expanded scope of renovation at that facility and encouraged review of RMHF's budgeted appropriation. An initial plan called for a 36-bed unit and subsequently, was expanded to a 50-bed unit.

Home and Community Based Services (HCBS) Waivers

Amy Deckard, Kansas Legislative Research Department, provided an overview of the HCBS waiver program, which provides the State flexibility to develop and implement alternatives to placing Medicaid-eligible individuals in hospitals, nursing facilities, or intermediate care facilities. The HCBS waiver program recognizes that many individuals at risk of being placed in these facilities can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care. States may also target 1915(c) waivers by specific illness or condition. Waiver services are not required to be made available to all Medicaid recipients, and they can be limited to that specific population for whom the waiver is provided.

A Committee member asked when an eligible HCBS beneficiary is placed on a waiting list whether the individual is entitled to admission to a facility or institution. Ms. Deckard indicated they are and the admission would not have to be a State-operated facility, but the entitlement does provide the beneficiary admission into an institution. The federal statute provides that HCBS waivers are required to be cost neutral to institutional care.

Ms. Deckard continued with her presentation by reviewing available HCBS waivers: Autism, Developmental Disability (DD), Physical Disability (PD), Technology Assisted (TA), Traumatic Brain Injury (TBI), Frail Elderly (FE), Seriously Emotionally Disturbed (SED), and Community Based Alternatives to institutional care. In addition, information was provided listing individuals on each waiver's waiting list, as well as HCBS expenditures from all funding sources (historical comparison FY 2000 to FY 2013 Approved) and HCBS expenditures from the SGF (historical comparison FY 2007 to FY 2013 Approved) (Attachment 5).

A Committee member inquired why the waiting list has quadrupled in a three to four year span. Ms. Deckard stated there has been a concerted state and federal effort to rebalance long-term care systems by transitioning people with Medicaid from institutions to the community through the "Money Follows the Person" program. In addition, various policy changes have impacted the waiting list, how vacant slots are filled, and life-span issues, such as more people coming on the waiver than those going off waiver services and age-eligibility (*i.e.*, Autism and FE waivers). Ms. Deckard could not speak conclusively regarding reasons for waiting list increases.

Ms. Deckard responded to questions as listed:

- Of the services/supports listed on the PD waiver ("Overview of Medicaid HCBS Waivers operated by DBHS/CSS & MH and KDADS"), a Committee member inquired which one or how many comprise 80 percent of the total expenditure. Ms. Deckard indicated she would work with the agency to obtain that information. The referenced "Overview" applies to HCBS waivers as of today's date; when KanCare is implemented in January 2013, the DD waiver has been excluded or "carved out" until January 1, 2014.

- Ms. Deckard could not speak to the stability of the Autism waiver since there are individuals who "age off" the waiver, individuals who are newly diagnosed may backfill those aging off and anecdotal evidence exists indicating large waiting lists may result in individuals declining to apply for HCBS waiver services.

- Prior to 2008, the TA waiver was a private service provided under the Medicaid program. In FY 2009, all expenditures for the Attendant Care for Independent Living Program were shifted to the TA waiver. Since this was not previously a waiver program, an expenditure decrease would have been seen in the Medicaid overall spending, which would account for this shift.

The meeting was recessed at 11:40 a.m.

Afternoon Session

The meeting was reconvened at 1:36 p.m.

Home and Community Based Services (continued)

Gary Haulmark, KDADS, was recognized to present information related to waiver services. Mr. Haulmark informed Committee members that upon advice of general counsel, he would not answer any questions nor provide any information regarding HCBS waiver services or any waiver waiting list.

Committee members continued to ask for reasons behind his refusal to answer any questions; Mr. Haulmark cited potential litigation as a reason not to respond.

Chairperson McGinn requested that Mr. Haulmark communicate with the agency's general counsel and that he be prepared to provide a date certain upon which he could provide

a HCBS update and respond to Committee members' questions. The Committee members requested that the agency's general counsel attend the meeting on September 13.

Denise German, RN, Senior Vice President, Skilled Health Care, Assisted Living Communities, was recognized to discuss issues specific to the FE waiver for clients residing in assisted living facilities. Ms. German provided written testimony concerning issues from a client (Attachment 6), but provided no written testimony relating to her verbal comments. Ms. German indicated concerns exist with the managed care organizations (MCOs) accountable to administer the FE waiver under KanCare, which include the following:

- Concern exists with how each MCO will assess each client's care needs;
- The assisted living industry (AL) industry still has no understanding of how savings would be generated;
- The complexity of assigning "care units," which is the mechanism for AL reimbursement;
- The time frame for KanCare implementation begins January 1, 2013;
- Regarding whether HCBS FE bed capacity will decrease compared to private-pay populations, Ms. German indicated the industry has seen AL facilities decline acceptance of HCBS FE clients already(25 facilities in the last year);
- There is concern regarding reimbursement rates for "care units" and how they are assigned for a social model of care results in reduced revenue for AL facilities, as well as inconsistent approval of care units from MCOs and insurance companies in various geographic areas.

In response to questions, Ms. German responded:

- She would submit her testimony in a written format.
- A client's case manager is accountable to approve care units; care units must be "hands on" and are 15-minute intervals of time. Ms. German reported the agency indicated that the original interpretation of a care unit was incorrect. Reminding a client it is time for dinner or to take medication does not qualify as "hands on," this revised interpretation resulted in an $80,000 monthly revenue reduction for her 16-buildings. Ms. German commented a client should not be subjected to a "hands on" intervention when it is unnecessary and only for the purpose of capturing revenue; many AL residents have mild dementia or cognitive disorders, which may not require "hands on" treatment.
- A Committee member asked KLRD staff to obtain minutes and testimony from Secretary Shawn Sullivan, which occurred during Committee meetings in the last session. The Secretary discussed the goal of integrating AL reimbursement into the waiver services program, which would prevent Kansas residents from moving directly into a skilled facility or would enable residents from a skilled facility to

move into an AL facility. A Committee member asked follow-up questions to Mr. Haulmark; he indicated he had been directed not to answer questions.

- Ms. German could not definitively provide the care unit rate reimbursement; however, she indicated a client is obligated to contribute $746 towards their care. She provided an example in which a client with a total income of $1,746 does not qualify for HCBS FE waiver, but would qualify for a skilled facility.

- Ms. German indicated she would furnish a copy of an educational program concerning the HCBS program to Committee members.

Tom Laing, Executive Director, InterHab, discussed the HCBS waiting lists and supports for persons with intellectual/developmental disabilities (I/DD) (Attachment 7). He stated the waiting lists represent unmet needs and undiminished hopes of families; Mr. Laing urged the Legislature to update the 2005 Legislative Budget Committee Report, which proposed a three-year, phased-in approach to: a) eliminate the I/DD waiting lists; and b) upgrade reimbursement rates for I/DD service providers to meet increased demands. Mr. Laing discussed the status of the waiting list and how the waiting list numbers should be reported. Questions and discussion ensued as listed below:

- In July, the method of reporting individuals on the waiting list changed. Previously the waiting list included those eligible applicants but whose start-date had not yet arrived. KDADS now reports eligible applicants excluding those whose start-date has not yet arrived. Mr. Laing recommended that KDADS restore the previous reporting practice.

- As of July 2012, there are 8,298 I/DD waiver participants. Assessments are performed by Community Developmental Disability Organizations (CDDOs). There is no capitation on the waiver; however the State has employed a capitated, tiered rate based on each client's diagnosed profile. $37,500 is the average expenditure per person per year. Individuals not receiving waiver services could receive federal assistance through a medical card, vocational rehabilitation services, or Social Security Disability Income (SSDI) payments.

- All states have an I/DD waiver services program, though they may be designed differently.

- Underserved clients are qualified as those beneficiaries eligible for full services, but are receiving insufficient services according to their needs.

- In response to a question regarding the average cost per medical card per HCBS waiver services recipient, Mr. Laing indicated KLRD had calculated those figures several years ago, and in spite of the growing numbers of persons served, total medical costs were decreasing.

Ami Hyten, Assistant Executive Director, Topeka Independent Living Resource Center (TILRC), submitted testimony concerning the HCBS PD waiting list (Attachment 8). Ms. Hyten indicated the waiting list is approximately 3,600 Kansas residents. She reported that recently KDADS had requested her agency to contact 177 individuals (originally screened for services by TILRC) and to survey those eligible individuals to determine if services were still needed. The

process has begun and contact has been made with approximately 100 individuals. Of those 100 waiting individuals, 65 indicated services were still needed; one eligible individual has been waiting for services since April 6, 2009. Ms. Hyten provided examples of how eligible individuals cope with day-to-day needs for services and supports. She discussed the importance of community-based resources and the community connection in light of the KanCare implementation, as well as the fact that local CDDOs will no longer provide case management (MCOs will assume that function). Ms. Hyten stressed the importance of an *Olmstead* Plan development to move waiting lists with reasonable speed, to nurture community-based resources, and to ensure resources exist to provide the continuum of care, problem-solving, advocacy, and choice.

Responding to questions, Ms. Hyten indicated the Supreme Court does not define "reasonable speed." There have been several lower court cases and opinions have been expressed indicating the outside length is generally 18 months.

Kathy Lobb, Self-Advocate Coalition of Kansas, reminded Committee members to keep "people first" at the forefront when discussing KanCare and other healthcare initiatives (Attachment 9). She stressed the importance of consumer-friendly language to ensure individuals can make informed decisions concerning services they need.

Jill Wolters, Office of the Revisor of Statutes, discussed recent developments related to the *Olmstead* decision (Attachment 10). Ms. Wolters reported on the court's decision and the requirement to provide community services being based on three conditions being met. Ms. Wolters also distributed a handout from the U.S. Department of Justice for reference (produced on June 22, 2011). This resource (on page 5, question 9 and question 14 on page 7) references questions related to budget cuts and violation of *Olmstead* and the Americans with Disabilities Act (ADA). In response to a question, Ms. Wolters clarified that the 18-month time frame previously discussed by Ms. Hyten refers to a "reasonable promptness" by moving individuals from a waiting list into needed services. Committee members requested Ms. Wolters respond to additional questions as listed:

- Budget cuts can violate ADA and *Olmstead* when significant funding cuts are made to community services (those on waiting lists, as well as those receiving services) creating a risk of institutionalization or segregation.

- A "fundamental alteration" requires the public entity to establish that the modification would fundamentally alter its service system.

- The current federal administration has indicated enforcing *Olmstead* is a top priority. The decision was rendered in 1999; Ms. Wolters could not conclusively respond whether there have been modifications to the interpretation since the original ruling.

- Ms. Wolters was asked to research any updates or modifications and provide that information to the Committee.

- With regard to recent *Olmstead* cases, Ms. Wolters referred Committee members to the Kansas Legislative Research Department's website (Attachment 11).

Financial Management System (FMS) Update

Gary Haulmark, KDADS, provided information concerning the FMS system in Kansas (see Attachment 3). He provided an overview of the system's evolution, reported a FMS work group was created to review rates, practices and improvement opportunities. At the current time, the work group has recommended the evaluation of limiting FMS providers but felt that project should be delayed until the KanCare is implemented.

Ami Hyten, Topeka Independent Living Resource Center, spoke concerning the rapid changes since implementing the Kansas FMS (Attachment 12). She reported on the consequences resulting from the implementation as follows and answered questions:

- Provider agencies have been downsized and satellite offices closed.
- Flexibility was provided to beneficiaries but has been restricted.
- A significant provider has closed and no longer provides services, which included CareLink services. CareLink was a program offering an intermediary to trouble shoot what needs exist prior to calling 911 dispatch. The monthly fee for this service was $35. These types of systems can remind consumers to take medications and sometimes are populated with personal and medical information for specific conditions or illness.
- Fewer providers result in fewer consumer choices; the greatest concern is that consumers are losing critical support systems.
- Ms. Hyten could not speak concerning the overall reduction in providers across the State; she provided anecdotal information from her regional FMS network.
- The gap in providing support to consumers could be filled by case managers assisting consumers in self-directing care or other providers who could pick up those needing support services.
- A Committee member verbalized the importance that legislators fully understand the impact of these consequences. Chairperson McGinn stated Legislative Research could survey Independent Living Centers to ascertain impact or gather other important information.

Off-budget Briefing

J.G. Scott, KLRD, discussed with Committee members off-budget items that contain reportable and non-reportable expenditures. Non-reportable expenditures are excluded from the budget and include such items as documents prepared by the State printing plant, maintenance, information technology and health care. Such items are accounted for in the agency's operating expenditures, but taken off-budget for accounting purposes so as not to double count the funds. Other funds, such as revolving funds and bond proceeds, are off-budget items; also other items are removed for policy reasons. Mr. Scott reviewed non-expense items of which the Kansas Public Employees Retirement System (KPERS) is the largest (Attachment 13).

Responses to questions follow:

- The State Water Plan demand transfer of $6 million was intended to be transferred from SGF; it was changed to a revenue transfer (non-SGF expenditure). However, it has not been made for several years. In order to remove the item from the list, a revision to statute is required.

- The School District Capital Improvement Fund represents the equalization payments; there have been no changes to this item.

- The Kansas Department of Transportation (KDOT) transfer to the Highway Patrol would show as a revenue transfer and a reduction in revenue and with expenses showing in the Highway Patrol budget.

- There are other smaller, similar transfers (KDOT transfer to Highway Patrol) from universities to state agencies, as well as the Highway Patrol revenue from Homeland Security, which are then transferred to other agencies.

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

Wednesday, September 13
Morning Session

The meeting reconvened at 9:05 a.m.

Division of Motor Vehicles (DMV) Update

Secretary Nick Jordan, Kansas Department of Revenue (KDOR), provided information concerning the State's new motor vehicle system (Attachment 14). He reviewed the rationale for a new system, performance of the new system, the process of title and tag renewals and registrations, as well as "next steps" towards improving the system's performance. Title and tag renewal statistics were reviewed. He indicated that at the time of "go-live" there were multiple system technical problems resulting in statewide breakdowns. Secretary Jordan commented that KDOR recognized the hardship placed on counties and began the process to collaborate with stakeholders to improve the system and the performance of 3M, the vendor providing software and integration services.

He reported KDOR continues to track time for various transactions: 10-15 minutes for a title, and 1-4 minutes for renewal. He indicated the Department is committed to build on the progress achieved to date. A voluntary DMV Task Force, with representation from counties, law enforcement, car dealers, bankers, and consumers, will be appointed by the Governor to not only assist in the development of plans and processes to increase efficiency and effectiveness at DMVs in Kansas, but also to assess the current system and its performance.

Secretary Jordan reported the Department has:

- Worked with 3M to resolve issues to result in conformance to contract provisions. The state has withheld $2 million of 3M's payment to ensure problems are corrected.

- Provided and funded temporary assistance at DMV offices.

- Waived the convenience fee for on-line renewals (in August).

- Funded (to the available funding ability) overtime incurred by counties during the initial system implementation phase. $561,000 will be paid to all 105 counties (from KDOT's vehicle fee fund) within the next week.

Discussion followed:

- A Committee member expressed appreciation to the KDOR for the work put into the process and suggested the new system includes a systemic problem, which requires a clerk navigate 19 screens to complete a tag renewal. The previous system contained seven screens. Secretary Jordan could not respond why the software requires twice as many screens; a Committee member suggested counties are now required to manipulate more information than under the old system—information has become the county's responsibility, rather than the State's responsibility. Secretary Jordan indicated this issue would be evaluated when the state "owns" the code from 3M, which will be upon project completion.

- Secretary Jordan expressed confidence that the State's information technology (IT) team will be fully equipped to manage code changes given their experience and involvement in the system's development and implementation.

- A Committee member requested elaboration on system problems experienced at the county level. Secretary Jordan provided examples such as: county loses connection with its internet provider, limited or lack of clerical staff training, varying volumes county-by-county, and other problems. Of the 105 Kansas counties, ten county treasurers were highly engaged and involved with the development, training, and "go-live" process.

- With regard to a question concerning for what purpose KDOT would use its vehicle fees fund (which is now being used to reimburse counties for incurred overtime), Secretary Jordan could not respond. Secretary Jordan did elaborate that the State knows how many hours counties were working in the new system; reimbursement will be at the rate of $15.00 per hour over 40 hours weekly.

- The total cost of the system was $40 million ($22 million for software and the remaining directed to hardware and maintenance). Secretary Jordan reported that ten percent of the contractual cost would be withheld by the State to ensure contract compliance. Since the 2012 Legislature swept the $4 modernization fee from the agency budget, $6.7 million in funding was reduced, which would have been targeted for maintenance. He indicated there could be a request for additional appropriation in the 2013 Session.

- With regard to insurance verification in the new system, Secretary Jordan reported that even though the system contains the capability for real-time database verification, it does not exist at the current time. Therefore, annual insurance verifications at vehicle registration are handled manually. While the

State of Kansas Insurance Commissioner could mandate a real-time verification system through rules and regulations, Secretary Jordan supported legislative action as quickly as possible.

- Secretary Jordan commented it was anticipated that elimination of convenience fees could be presented during the next Session, which would result in a fiscal note.

- With regard to incomplete and inaccurate records (one percent of all Kansas records or 70,000), Secretary Jordan reported records could not be corrected until the consumer presents in twelve months for the next renewal. KDOR is sending lists of these incomplete and inaccurate records on a monthly basis to local DMV offices to assist in planning their staffing complement.

- In response to a question concerning why the new system was not running under a Citrix or terminal service environment, Kevin Cronnister, Chief Information Officer, Department of Revenue, could not respond, but assured Committee members staff is researching the issue, and his office will report back to the Committee at a later time.

- Early during the implementation, a Committee member commented, manual indexing was occurring and asked if that issue had been resolved. Mr. Cronnister responded that manual re-indexing occurs during the evening (when no one is in the system) and that additional information would be provided to Committee members when the issue is resolved through 3M.

- A Committee member suggested, since one percent of the inaccurate or incomplete records are being corrected by local offices, fee funds be redirected to local offices to compensate for this activity. Secretary Jordan responded that as of January 1, 2013, KDOT is the agency targeted to receive the $4 vehicle fee fund and discussions should occur during the next Legislative Session.

Mike Taylor, Public Relations Director, Wyandotte County, provided information to Committee members concerning his County's experience with the implementation of the DMV system, which resulted in significant overtime, maintenance, and security expenditures. In addition, four new employees were added in the County Treasurer's Office resulting in approximately $200,000 in expenses yearly (Attachment 15).

Thomas Franzen, Johnson County Treasurer, spoke concerning the impact of the new motor vehicle system on Johnson County. He provided an overview of his offices logistical and operational processes and discussed current issues, transaction processing times, consumer wait times and behaviors, and the cost impact since implementation (Attachment 16). Mr. Franzen indicated his actual transaction times appear to be different from the averages reported by Secretary Jordan. He stressed that the implementation of the new system has exacerbated the budget deficit in his county and requested that the Legislature increase the County Service Fee from $5 to $7 per transaction.

John Waltner, County Administrator, Harvey County, indicated his issues appear to be related to inconsistency within the DMV operating system. He cited several examples of the system "freezing" or "crashing", system interruption related to a credit on a plate or tag, and other specific issues. In addition, Mr. Waltner reported extreme delays from the State's IT

resource center when technical assistance is requested. Secretary Jordan will follow-up with Mr. Waltner. (No written testimony)

- With regard to a question regarding whether any future costs would be shifted to local governments as a result of the DMV system implementation, Secretary Jordan indicated he would provide information at a later date.

- Currently there is a $5 service fee on titles and renewals in addition to other fees. Secretary Jordan will provide a list of these fees to Committee members.

Written testimony was submitted by Jim Rice, Seward County Commissioner, Liberal, Kansas (Attachment 17).

Home and Community Based Services (HCBS) Waivers (continuation)

Shawn Sullivan, Secretary, KDADS, stated KDADS legal counsel was not in attendance at the meeting. He reported the State had been contacted by the Department of Justice concerning HCBS DD and PD waiting lists; the review is on-going by local agency attorneys and the State Attorney General and is subject to attorney/client privilege. He reported there is no formal investigation by the Department of Justice; the agency is confident the State is in compliance with ADA and *Olmstead*. However, to protect the best interest of the State when there is a potential for litigation, limited HCBS waiver information would be provided (No written testimony). Information provided by Secretary Sullivan follows:

1. DD waiting list:
    - 8,298 receiving DD waiver services;
    - 4,043 on waiting list; 2800 of those are waiting and do not receive services, and 1247 receive services and are underserved;
    - Access to the waiting list is through crisis exceptions and by transfer through federally funded “Money Follows the Person” program;
    - Total amount of funds paid in the last fiscal year was $329 million for the DD HCBS waiver;
    - During 2012 Session, the Legislature appropriated an additional $1.8 million to address DD waiting list reduction; and
    - Processes have been completed to work with CDDOs to bring 100 people off the DD waiting list.
2. PD waiting list:
    - Agency has evaluated a variety of ways to better manage the PD waiver.
    - The integrity of the waiting list was questioned due to the cost per person per month (PPPM) was growing disproportionately to other waivers; number of individuals on the waiting list had grown quickly; average use of service per person per month varied widely and was inconsistent among providers;

- Utilization review occurred using the application of standards similar to other waivers; targeted follow-up on plans of care was conducted; the level of training and case management guidance was increased to providers. Included in the training were specific requirements to evaluate the need for services to bring them within normative ranges and to survey the individuals placed on the waiting list by the providers to ensure persons still required services and that case managers were knowledgeable concerning crisis criteria for access to the waiting list.
- Following review, the agency determined there were inadequate systems in place to complete the service utilization and wait list management processes.
- Corrective action included contracting a third party call center to contact 3,462 individuals on the waiting list (using the contact information from providers and case managers). From that process, 377 people were contacted from the 3,462 on the waiting list; 63 indicated they had moved out of State, no longer needed service, were unaware they were on the waiting list, or had not been contacted by the case manager from 6-12 months. 1,100 on the waiting list had numbers disconnected; a wrong number was reached; or the contact resulted in an operator intercept. Since that time, KDADS sent the list to PD providers with a directive to update the contact information, to certify and attest its accuracy, and to take steps to locate the individual currently on the waiting list. This process is to be completed by the end of September.
- The expectation is that more accurate information concerning the PD waiting list will be available within 6-8 weeks.

Questions and discussion followed:

- In response to a question concerning whether there was evidence to support that people were moving into the State due to the quality of DD services in Kansas, Secretary Sullivan could not speak conclusively but indicated he had heard similar anecdotal comments.

- In response to a question, Secretary Sullivan indicated that a forensic audit is being conducted related to alleged practices by the Statewide Independent Living Council of Kansas (SILCK).

- Secretary Sullivan elaborated the third party call center called each person on the PD waiting list and attempted to update information. The Centers for Independent Living (CIL) are to update information for persons who were not contacted by the call center.

- Secretary Sullivan indicated that once information is updated by the CILs, the plan is to roll out the Aging and Disability Resource Centers (ADRCs) in conjunction with the KanCare implementation. ADRC functions will include eligibility, enrollment, and is intended to offer a full range of long term support options where an individual can access a single entry point to public long term support programs and benefits. The ADRCs will be responsible for the FE, PD,

and TBI waiver services. The procurement process is occurring at the current time, and it is anticipated ADRCs will be operational soon.

- In response as to why questions concerning HCBS waivers were not answered at the meeting on September 12, Secretary Sullivan indicated that was to protect the State's interest. Further dialogue with agency attorneys and the Attorney General yielded the ability to answer some questions. Secretary Sullivan stated there was no formal investigation by the Department of Justice. Committee members expressed surprise and concern that legislators were denied access to information considered to be within their area of responsibility for the State of Kansas and encouraged open and transparent exchanges of information.

- Secretary Sullivan affirmed that 100 people will come off the I/DD waiver list due to additional appropriation authorized by the 2012 Legislature; he was asked to research the call center results and identify how long the 11 percent contacted have been on the waiting list.

- With regard to a question concerning whether ADRCs will assume responsibility for DD waiver services, Secretary Sullivan responded the CDDOs will continue in their role to determine eligibility for HCBS DD waiver services.

- Secretary Sullivan indicated KDADS has had no reason to question the integrity of the DD waiting list.

- Secretary Sullivan indicated that from 2007 to 2011, the PD waiver grew 40 percent compared to 18 percent for the DD waiver and 7-8 percent FE waiver. Attendant care services account for the largest portion of PD waiver expenditures. He will furnish additional information

- Secretary Sullivan was asked to provide a written copy of his testimony.

Chairperson McGinn asked that a draft document, "Recent Activity Alleging *Olmstead* Violations," be distributed by representatives from the Legislative Research Department. This was provided as information to Committee members (Attachment 18).

KanCare Update

Pam Perry, Vice President, Government Relations, Amerigroup, presented testimony related to her organization's structure, key dates for the KanCare implementation, the readiness review concerning eligibility and enrollment, integration, functional areas, and value-added services (Attachment 19). Ms. Perry's answers to questions follow:

- New Jersey and Texas represent the states with the largest Amerigroup membership. Amerigroup no longer has a presence in Illinois, District of Columbia and South Carolina.

- Ms. Perry affirmed the goal is to have 90 percent of providers credentialed one month from today's date.

- With regard to whether Amerigroup has begun the creation of the Medicaid medical home plan, which refers to a new Medicaid option to provide coordination of physical and behavioral health care with long term services and supports for people with chronic conditions. Ms. Perry indicated the medical home portion is due to roll out in late 2013; she will provide requested information at a later time.

- Ms. Perry confirmed that provider incentives are included in the contractual agreement; "gain sharing" is excluded.

- With regard to whether Kansas can initiate its own pilot program for dual eligible beneficiaries, Ms. Perry deferred to Secretary Sullivan, who indicated he would respond later in the discussion.

- Ms. Perry confirmed that Amerigroup has had prior experience with long term services and supports, the firm has had no prior experience with HCBS waivers included as a mandatory service in the managed care environment.

- With regard to incorporating various elements into a plan to make a profit, Ms. Perry indicated it is a matter of coordination and plan of care development, which is customized based on individual needs and result in efficiencies and improved patient outcomes.

- Ms. Perry indicated that while some of the Kansas infrastructure (CDDOs and Program for All-inclusive Care for the Elderly) will remain in place, Amerigroup staff anticipates collaboration with these entities to provide optimal integration and member outcomes.

- Dental benefits for children will not change; adult Medicaid dental services such as cleaning and examinations will be included in Amerigroup's plan.

Nan Thayer Kartsonis, Plan President, United Healthcare Community Plan, provided and update to Committee members on the progress of the KanCare implementation. She described United Healthcare (UHC) membership, staffing, and organizational structure (Attachment 20). Ms. Kartsonis expressed confidence that the goal of 90 percent of providers will be in place in accordance with timelines set. In response to other questions, Ms. Kartsonis indicated:

- Each Medicaid provider must have a contract with each managed care organization (MCO).

- The Medicaid plan design and content is uniform among all contracting MCOs. Value-added services vary by MCO provider.

- To ensure beneficiaries lacking transportation get to appointments, the United Healthcare care coordination team can assist with this issue.

The Committee recessed for lunch.

Afternoon Session

The meeting was reconvened at 1:37 p.m.

KanCare Update

Holly Benson, Director of Governmental Affairs, Sunflower State Health Plan, provided information about the Sunflower State Health Plan, which is a subsidiary of Centene Corporation. She detailed the staffing plan being developed, its contracting process, services, operations, plan readiness, and outreach efforts (Attachment 21). Ms. Benson indicated Centene's sister company, Cenpatico, has been serving the mental health needs of HealthWave children since 2005. Ms. Benson responded to questions as follows:

- With regard to questions whether it was routine for her company to send a remittance with an 834 form when providers bill for service and whether she recognized a form 237, Ms. Benson will provide that information as a later time.

- Ms. Benson defined "weekly assignments" in her testimony as meeting with agency representatives and other MCOs and working with 5 external work groups and 14 internal work groups. Operational details, coding, claims, forms, and various system details are discussed.

Secretary Sullivan provided an overview of the KanCare updated timeline from the initial contractual award to the readiness review of the three contractors beginning September 5 through September 21. The second round of educational tours will begin the third week in September. KanCare MCOs must have 90 percent of their provider networks in place by October 12 and 100 percent by November 16, 2012. A "Go/No go" decision of October 19th was established for the January 1, 2013 KanCare implementation (Attachment 22).

Secretary Sullivan responded to Committee members' questions as follows:

- Secretary Sullivan defined dual-eligible beneficiaries as those individuals as eligible for both Medicaid and Medicare benefits of which there are 67,000 in Kansas. While the State is interested in developing a plan to accommodate dual-eligibles, the State did not meet the submission deadline to the Centers for Medicare and Medicaid Services (CMS). Currently, no formal plan has been drafted or submitted; however, Kansas will proceed to develop a plan with a possible implementation in 2014. He indicated the preferred plan would include that the three MCOs manage the Medicare benefit in addition to the Medicaid program.

- With regard to dual-eligible beneficiaries, a Committee member inquired whether the State had the flexibility to allow Medicare-credentialed physicians to see the dual-eligible beneficiaries (in an out-of-network environment) and bill the secondary MCOs. Secretary Sullivan indicated he would consult with CMS and MCOs to ascertain whether that would be possible.

- The State is in the final procurement process for ADRCs, which will serve as the gatekeeper and provide assessments for the HCBS FE, PD, TBI waiver services and nursing homes. A process has begun to develop and design a DD pilot program and to evaluate responses from Requests for Information (RFI) received the last week in August.

- All MCOs are "on track" to meet to meet deadlines.

- Secretary Sullivan reported when the contractual agreements were signed, the original estimate of greater than $800 million in savings over five years was revised to $1 billion over five years. Further, he commented that rather than the term "savings," the more appropriate term would be "reduction in Medicaid growth," which will be achieved through better coordination of services, fewer hospital admissions and readmissions, and improved integration of benefits. KanCare is a primary care type model, with a care coordinator assigned to assist each Medicaid beneficiary. The projected reduction in Medicaid growth increases SGF approximately $430 million.

- Effie Swanson, Kansas Department of Health and Environment, provided the medical loss ratio for each of the three MCO contracts as: United Healthcare 8.31 percent; Sunflower 9.2 percent, and Amerigroup 8.3 percent.

- Secretary Sullivan will provide the administrative fees paid to each MCO contractor at a later time.

- Secretary Sullivan clarified that the statement "experience with CMS is similar to other states" (in his written testimony) refers to Kansas' 1115 waiver application to CMS is similar to the experience from other states. As implementation dates get closer, dialogue with CMS becomes more frequent. If a "No Go" decision is made on October 19, an alternative plan to KanCare implementation would be necessary. Delay would occur and other contingency plans are in development at the current time. Operational delays would include HealthWave contract extensions, substance and mental health contract extensions. Current contractual agreements are in place through December 31, 2012; the Secretary could not respond if current providers would be willing to extend their contracts.

- In the current environment, Coventry, Children's Mercy Hospital, and UniCare provide coverage to HealthWave beneficiaries; Ms. Swanson indicated that providers submit claims to HP interchange for Medicaid Management Information System (HP MMIS) for processing fee-for-service payments; subsequently, the State's fiscal agent makes the payment. In the new MCO environment, HP MMIS will have a different role in that the State will allow different options for providers' billing by developing a single billing interface (previous MMIS system), which will allow providers to bill to a single location. HP MMIS would then send the claim to the appropriate MCO for payment. The Kansas Medical Assistance Program (KMAP) will remain in place for the purpose of validating Medicaid eligibility.

- Secretary Sullivan was requested to elaborate on the proposed pilot projects for the HCBS DD waiver population. The Secretary indicated that Request for

Proposals (RFIs) were sent to various providers; ten providers expressed interest in participation in a pilot. Secretary Sullivan will provide additional information to the interested Committee member.

Iraida Orr, Kansas Legislative Research Department, provided an overview of the "Recent Activity Alleging *Olmstead* Case Violations, which was distributed earlier. (See Attachment 18). She explained the process as follows (No written testimony):

- A complaint is filed with the federal Health and Human Services (HHS) office;

- The Office of Civil Rights (OCR) within HHS conducts the initial review. If the OCR determines that a voluntary resolution with the State is impossible, the ADA compliance review is forwarded to the Department of Justice for further investigation. Upon this referral, the OCR closes its review and functions in a resource role to the Department of Justice;

- The Department of Justice investigates and based on findings, issues a letter to the State recommending remedial measures the State must implement; and

- The Department of Justice may pursue litigation in District Court against the State with or without a concurrent settlement agreement or they could seek Court approval to intervene in any previously filed actions against the State by other entities as well as file statements of interests in those cases.

Ms. Orr further indicated that in Kansas, complaints have been filed with HHS. She described the sequence of events as:

- Complaints have been filed with HHS.

- Officials within the Department of Social and Rehabilitation Services (SRS) met with HHS officials on February 29, 2012, to discuss the complaints;

- As reported in a Kansas Health Institute (KHI) news article on March 29, 2012, four officials from HHS met privately with Governor Brownback and other State officials to discuss the HCBS waiting lists and the State's policy changes that would result in waiting list reductions. Another KHI article on April 23, 2012, reported that HHS OCR had referred findings to the Department of Justice. Further, a letter dated April 19, 2012, and addressed to the individual filing the HHS complaint, indicated the OCR had consolidated all complaints and was performing a compliance review. The content of the letter indicated that since December 2011, the OCR had been involved in a series of phone calls, meetings, and exchanges of information to discuss the results of the investigation and remedial actions necessary to address issues. The OCR concluded voluntary resolution of issues was impossible and therefore, referred the results of the investigation to the Department of Justice.

- On April 25, 2012, Governor Brownback sent a letter to the Director of HHS OCR in which he expressed regret at HHS' decision to terminate participation in assisting Kansas in finding solutions and instead to make it a matter for litigation. The Governor's letter refers to a May 29 letter received by the State from the

HHS OCR notifying the State that an investigation was being opened on the PD waiver and waiting list. The letter cited no communication with Kansas during the more than two years since the May 29 letter and refers to a April 17 letter from HHS indicating the only solution was to force the State to spend money it does not have by adding enough waiver slots to eliminate the waiting list.

- The Department of Justice has not issued a finding letter to date; no letter has been found indicating that the Department of Justice has filed a formal investigation into the matter.

Ms. Orr indicated that copies of letters were available for Committee members' review. A Committee member requested a copy of Ms. Orr's commentary.

Chad Austin, Vice President of Government Relations, Kansas Hospital Association, was recognized to provide testimony (Attachment 23) concerning the KanCare project which impacts member hospitals. He expressed concerns still exist which include:

- Reimbursement structure for critical access hospitals;
- Availability of MCO provider manuals; and
- Approval of the 1115 waiver to allow implementation to begin January 2013.

He indicated that until these issues are resolved, some hospitals are hesitant in moving forward. In response to a question as to how hospitals are prepared to deal with revenue reductions that may result from reduced hospital admissions, Mr. Austin responded that in the current environment, Medicaid does not cover the cost of services. However, for Medicaid beneficiaries presenting for non-emergent services, he suggested treating those individuals in more efficient locations.

Rachel Monger, representing Debra Zehr from LeadingAge, discussed concerns from the organization's membership, which include not-for-profit nursing homes, retirement communities, hospital long-term care units, assisted living and residential healthcare residences, low income housing, licensed health agencies and other community-based service programs (Attachment 24). Concerns from this industry remain:

- KanCare timeline;

- Lack of operational details such as filling procedures and billing, policy manuals, care coordination, recordkeeping requirements, quality measure tracking, and other items; and

- How projected savings would be used and, in contrast, if savings are not realized, what the State's plan would be.

In response to Committee members' questions, Ms. Monger noted providers need extensive billing training and more detail on care management. The billing concern centers on the universal portal, which has been created. The MCOs want providers to bill separately. Gary Haulmark indicated that the providers choose which billing method to use. He informed the Committee that the portal is not ready, but will be. A Committee member requested he provide the expected date for the portal.

Cindy Luxem, Executive Director of the Kansas Health Care Association and the Kansas Center for Assisted Living, presented testimony listing practical and global issues remaining which include: transparency, projected savings, the impact of KanCare on various segments of the healthcare system, implementation, billing issues, contracts, beneficiary enrollment, lack of systems and how they work (Attachment 25). In the current environment, providers will no longer be paid in a ten-day window for a "clean claim;" that window expands to 20 days (under KanCare). Coupled with the KanCare implementation, the State is beginning Medicare and Medicaid audits for 344 nursing homes in Kansas, which creates additional pressure and anxiety. Ms. Luxem also distributed a New York Times article titled "With Medicaid, Long-Term Care of Elderly Looms as a Rising Cost": http://www.nytimes.com/2012/09/07/health/policy/long-term-care-looms-as-rising-medicaid-cost.html?pagewanted=all&_moc.semityn.www. She recommended delaying KanCare implementation.

In response to questions, Ms. Luxem indicated:

- Transparency issues exist that relate to KanCare program details critical to a provider's operations and are still in the process of development, even though stakeholders (State agencies and MCOs) attempt to provide quality information and education.

- A Committee member expressed concern related to the expansion of the payment-processing window to 20 days, and encouraged the agency to reinstate the previous policy, which was a 10-day window. Gary Haulmark, KDADs, indicated he would verify the reimbursement process; he was led to believe the MCOs would pay twice weekly.

Matt Fletcher, Associate Director, InterHab, provided recommendations that included: creating an oversight body for KanCare; delaying KanCare implementation until July 1, 2013; seeking the advice of the Commissioner of Insurance to best manage MCOs; and passing laws to create an expedited hearing process for beneficiaries who appeal MCO decisions (Attachment 26). In addition, Mr. Fletcher indicated his organization recommends the permanent exclusion of I/DD long-term care services and supports from KanCare. Mr. Fletcher reported the Administration's notification process for beneficiary educational programs was neither comprehensive nor consistent. In follow-up to questions, Mr. Fletcher answered:

- CDDOs attempt to disseminate information to the DD community related to KanCare educational programs; and

- His organization was assured that educational materials and formats were developed that were suitable for the population. Gary Haulmark, KDADs, will confirm and provide information as to what formats (multiple languages, audio, Braille) are being provided.

Maury Thompson, Executive Director, Johnson County Developmental Supports, testified that his organization and 56 other counties advocate that the State permanently exclude I/DD services from KanCare (Attachment 27). He expressed concern on how KanCare savings could be achieved, especially with the inclusion of non-medical supports into a medical model; the differences between the PD (managed by the State) and the I/DD (managed by the CDDOs) waiting lists; the complexity of managing the I/DD population, of which 50 percent are dual-eligible beneficiaries; the concept of ADRCs and their impact; and the development of the I/DD pilot program with assistance from an appointed Advisory Committee, which has failed to

identify substantive or comparative measurements to ensure an effective pilot or experimental test.

Chairperson McGinn noted the next meeting would occur on October 9 and 10. The meeting was adjourned at 3:50 p.m.

Prepared by Jan Lunn
Edited by Leah Robinson

Approved by the Committee on:

January 9, 2013
(Date)