

Report of the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight to the 2016 Kansas Legislature

CHAIRPERSON: Senator Mary Pilcher-Cook

VICE-CHAIRPERSON: Representative Daniel Hawkins

OTHER MEMBERS: Senators Jim Denning, Marci Francisco (January – June), Laura Kelly, Jacob LaTurner (August – December), and Michael O'Donnell; and Representatives Barbara Ballard, Will Carpenter (April – December), Willie Dove, John Edmonds, Sharon Schwartz (January – April), and Jim Ward

CHARGE

The Committee is to oversee long-term care services, including home and community based services (HCBS). In its oversight role, the Committee is to:

- Oversee the savings resulting from the transfer of individuals from state or private institutions to HCBS and to ensure that any proceeds resulting from the successful transfer be applied to the system for the provision of services for long-term care and HCBS;
- Review and study other components of the state's long-term care system; and
- Oversee the Children's Health Insurance Program (CHIP), the Program for All-Inclusive Care for the Elderly (PACE), and the state Medicaid programs (KanCare), and monitor and study the implementation and operations of these programs including, but not limited to, access to and quality of services provided and any financial information and budgetary issues.

January 2016

Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight

REPORT

Conclusions and Recommendations

The Committee makes the following conclusions and recommendations:

Prescription Drugs

The Committee made the following recommendations regarding prescription drugs:

- The Kansas Department of Health and Environment (KDHE) produce a report, collaborating with the Managed Care Organizations (MCOs), to report the geographic location and type of provider over-prescribing anti-depressant and anti-psychotic drugs. The geographic locations would mirror the Program for All-Inclusive Care for the Elderly (PACE) regions;
- The KDHE adopt a policy allowing the MCOs and providers to use step therapy (a.k.a., fail first) on the non-waiver population; and
- The KDHE review the preferred drug list (PDL) rules for the non-waiver population and adopt a policy allowing the MCOs to determine the PDL for the non-waiver population, instead of the State setting the PDL for this population. The review should include a variety of options, including new pricing methodologies, relaxing PDL rules, or allowing network contracting strategies. Decisions would be contingent upon providing a positive dollar impact (savings) to State expenditures of any such change.

Health Homes

The Committee made the following recommendations regarding Health Homes:

- The KDHE continue to evaluate the financial and health outcomes of the existing Health Homes program for individuals with Serious Mental Illness (SMI), including exploring opportunities for simplification of the program;
- The KDHE adopt a policy excluding the Developmental Disability (DD) population from the Health Homes program for individuals with SMI to remove duplication of case management services;
- The KDHE adopt a policy that the automatic opt-in to the Health Homes program for individuals with SMI would not apply until the patient has utilized medical services with

an annual minimum value of \$10,000; and, if a patient does not utilize Health Home services during the first 60 days, the patient would be automatically opted out of the Health Homes program;

- The KDHE adopt a policy requiring medical and surgical services in the Health Homes program for individuals with SMI be provided by the lowest number of primary care providers required to provide the needed services; and
- The KDHE adopt a policy holding any targeted case manager financially harmless for the value of the services provided to an individual in a Health Homes program for individuals with SMI when notification of patient inclusion in the program has not been documented or provided in a timely manner to the targeted case manager. The policy should be budget neutral to the Medicaid program.

Colorado Parent as Caretaker Program

- The Committee requests the Kansas Department for Aging and Disability Services review the Colorado Parent as Caretaker Program and determine the feasibility of introducing a program such as this in the state of Kansas.

Services to Pregnant Women

- The Committee requests KDHE review the actual experience of the presumptive eligibility program for pregnant women to determine whether prenatal services are being delayed due to the presumptive eligibility policy not being appropriately implemented.

Proposed Legislation: None.

BACKGROUND

The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services (HCBS) and KanCare Oversight operates pursuant to KSA 2015 Supp. 39-7,159, *et seq.* The previous Joint Committee on HCBS Oversight was created by the 2008 Legislature in House Sub. for SB 365. In HB 2025, the 2013 Legislature renamed and expanded the scope of the Joint Committee on HCBS Oversight to add the oversight of KanCare (the state's Medicaid managed care program). The Committee oversees long-term care services, including HCBS, which are to be provided through a comprehensive and coordinated system throughout the state. The system, in part, is designed to emphasize a delivery concept of self-direction, individual choice, services in home and community settings, and privacy. The Committee also oversees the Children's Health Insurance Program (CHIP), the

Program for All-Inclusive Care for the Elderly (PACE), and the state Medicaid programs.

The Committee is composed of 11 members, 6 from the House of Representatives and 5 from the Senate. Members are appointed for terms that coincide with their elected or appointed legislative terms. The Committee is statutorily required to meet at least once in January and once in April when the Legislature is in regular session and at least once for two consecutive days during both the third and fourth calendar quarters, at the call of the chairperson. However, the Committee is not to exceed six total meetings in a calendar year, except additional meetings may be held at the call of the chairperson when urgent circumstances exist to require such meetings. In its oversight role, the Committee is to oversee the savings resulting from the transfer of individuals from state or private institutions to HCBS and to ensure proceeds resulting from the successful

transfer be applied to the system for the provision of services for long-term care and HCBS, as well as to review and study other components of the state's long-term care system. Additionally, the Committee is to monitor and study the implementation and operations of the HCBS programs, CHIP, PACE, and the state Medicaid programs including, but not limited to, access to and quality of services provided and financial information and budgetary issues.

As required by statute, at the beginning of each regular session, the Committee is to submit a written report to the President of the Senate, the Speaker of the House of Representatives, the House Committee on Health and Human Services, and the Senate Committee on Public Health and Welfare. The report is to include the number of individuals transferred from state or private institutions to HCBS, as certified by the Secretary for Aging and Disability Services, and the current balance in the HCBS Savings Fund. (See Addendum A for the 2015 Report.) The report also is to include information on the KanCare Program as follows:

- Quality of care and health outcomes of individuals receiving state Medicaid services under KanCare, as compared to outcomes from the provision of state Medicaid services prior to January 1, 2013;
- Integration and coordination of health care procedures for individuals receiving state Medicaid Services under KanCare;
- Availability of information to the public about the provision of state Medicaid services under KanCare including access to health services, expenditures for health services, extent of consumer satisfaction with health services provided, and grievance procedures, including quantitative case data and summaries of case resolution by the KanCare Ombudsman;
- Provisions for community outreach and efforts to promote public understanding of KanCare;

- Comparison of caseload information for individuals receiving state Medicaid services prior to January 1, 2013, to the caseload information for individuals receiving state Medicaid services under KanCare after January 1, 2013;
- Comparison of the actual Medicaid costs expended in providing state Medicaid services under KanCare after January 1, 2013, to the actual costs expended under the provision of state Medicaid services prior to January 1, 2013, including the manner in which such cost expenditures are calculated;
- Comparison of the estimated costs expended in a managed care system of providing state Medicaid services under KanCare before January 1, 2013, to the actual costs expended under KanCare after January 1, 2013; and
- All written testimony provided to the Committee regarding the impact of the provision of state Medicaid services under KanCare upon residents of adult care homes.

All written testimony provided to the Committee is available at Legislative Administrative Services.

In developing the Committee report, the Committee also is required to consider the external quality review reports and quality assessment and performance improvement program plans of each managed care organization (MCO) providing state Medicaid services under KanCare.

The Committee report must be published on the official website of the Kansas Legislative Research Department (KLRD). Additionally, the Kansas Department for Aging and Disability Services (KDADS), in consultation with the Kansas Department of Health and Environment (KDHE), is required to submit an annual report on the long-term care system to the Governor and the Legislature during the first week of each regular session.

COMMITTEE ACTIVITIES

The Committee met twice during the 2015 Legislative Session (January 23 and April 28) and held two days of meetings during the 2015 Interim (August 21 and December 29). In accordance with its statutory charges, the Committee's work focused on the specific topics described in the following sections.

KanCare overview and update. At the January meeting, the Acting Secretary for Health and Environment provided a KanCare cost comparison comparing both pre- and post-KanCare costs. She stated the goals of KanCare were better coordination and integration of care, reducing gaps in care, reducing delays in care, and reducing redundant exams and testing. She reported preventative services such as dental, vision, visits to primary physicians, visits to Federally Qualified Health Centers and Rural Health Centers, and non-emergency transportation utilization had increased, while inpatient stays and emergency room visits had decreased.

A Committee member asked a question about the length of time MCOs are allowed to process prior authorization requests. The Secretary for Aging and Disability Services stated processing of prior authorizations was a contractual requirement for which the state has an enforcement mechanism and the length of time varies depending on the situation.

KanCare enrollment. Updates on Medicaid and CHIP member eligibility and expenditure information; KanCare financial summaries; provider networks; claim processing and denials; utilization summary; value-added services and in-lieu-of services; and member grievances, appeals and hearings were provided at all four meetings. The Division of Health Care Finance (DHCF) Director, KDHE, stated at the April meeting that membership by MCOs remained relatively unchanged at approximately one third of the membership in each MCO with total membership of 406,333 as reported January through March 2015.

In August, the DHCF Director reported the average annual membership from January through June 2015 was 410,180. Responding to an inquiry

from a Committee member, the DHCF Director explained the contractual obligation of the MCOs to safeguard the confidentiality of member and program data.

In December, the DHCF Director reported the average annual membership from January 2015 through November 2015 was 411,805.

Eligibility determinations. During the January meeting, the Acting Secretary for Health and Environment stated Executive Reorganization Order No. 43 would transfer eligibility positions from the Kansas Department for Children and Families (DCF) to the KDHE clearinghouse beginning January 1, 2016. She indicated savings would be created by consolidating the eligibility positions, with a reduction in the administrative burden.

KanCare Inspector General position. An update on the vacant position was provided at all four meetings. Representatives from KDHE stated recruiting for the position has been difficult, and KDHE was reviewing the original 2007 statute to determine whether the program integrity goals were being met with other existing measures. During the 2014 Legislative Session, SB 182 was introduced. The bill would have moved the position from classified to unclassified. The bill became Senate Sub. for SB 182 and would have eliminated the position. The bill was not enacted. At the August meeting, the Secretary for Health and Environment (formerly the Acting Secretary; for the remainder of this report she will be referred to as the Secretary) stated the salary had been increased and the position reposted; at the December meeting, she stated the position is continuously posted.

Kansas Eligibility Enforcement System (KEES) Update. At the January meeting, the KDHE Chief Information Technology Officer (CITO) reported KEES implemented the account transfer component allowing individuals who apply for health insurance coverage on Healthcare.gov and assessed eligible for Medicaid to have their applications automatically transferred for processing by the KanCare Clearinghouse eligibility workforce. The KDHE CITO also reported the enrollment process was in pilot mode

and would be moved to production within two weeks.

During the April meeting, the KDHE CITO reported the Medicaid component of KEES was about 83 percent complete and a production cut-over was targeted to begin in late June 2015. The Deputy Secretary for Health and Environment, responding to a question from a Committee member, stated by the time KEES goes live in July 2015, the amount spent on the KEES project will be close to the original pre-implementation estimate of \$139 million. The Secretary for Health and Environment reported that KEES conversion and implementation for Medicaid eligibility functions began on June 19, 2015, and entered full production on July 13, 2015.

Health Homes implementation. During the January meeting, the Secretary for Health and Environment stated Serious Mental Illness (SMI) Health Homes was launched in July 2014 and as of January 1, 2015, 27,766 individuals were enrolled. She reported there were 80 contracted Health Home Partners (HHPs), with each MCO having at least 56 contracted HHPs. The KDHE DHCF Director reported KDHE would compare the acute care costs of individuals in Health Homes for individuals with SMI to costs for individuals with the same diagnosis codes; however, since the Health Homes was implemented in July 1, 2014, data needed to determine cost savings were not available yet.

During the April meeting, the DHCF Director stated, as of April 2015, more than 33,000 members were eligible for SMI Health Homes and about 28,000 of those members enrolled, which was about a 17 percent opt-out rate. The DHCF Director reminded the Committee the federal financial rate was 90 percent for the first two years of Health Homes, and KDHE would provide information gathered from the HHPs listening tour and survey during the third quarter meeting. In a response to a question by a Committee member, the DHCF Director stated the 17 percent opt-out rate was lower than KDHE had projected in the budget projections for Health Homes. The DHCF Director also stated Medicaid eligibility was not impacted by a person's decision to participate in or opt out of Health Homes.

At the August meeting, the DHCF Director shared the results of the listening survey and tour. The DHCF Director stated many success stories were shared that demonstrated KanCare members are being diverted from using the emergency room as a primary source of medical care, preventing unnecessary inpatient stays, correcting duplicate prescribing problems, teaching each member to help manage his or her chronic conditions, and helping him or her understand more about healthy living. The DHCF Director stated nine themes raised by the HHPs, and that KDHE has taken immediate steps in response to the HHPs input as well as developed a long-term action plan.

Transition of Long-Term Services and Supports for Individuals on HCBS Intellectual / Developmental Disability (I/DD) waivers. The Secretary for Aging and Disability Services provided an update on the transition of I/DD Long-Term Services and Supports into KanCare at all four meetings.

MCOs financial update. A update was not available at the January meeting because the filing deadline for the National Association of Insurance Commissioners Financial Statement was not until February 15, 2015.

At the April meeting, the DHCF Director provided information indicating the MCOs reported about 46 percent reduction in loss in Calendar Year (CY) 2013 as compared to CY 2014. Responding to a question from a Committee member, the DHCF Director stated the net loss reported by MCOs through December 31, 2013, was \$116,208,699 and through December 31, 2014, the net loss was \$52,959,879.

The DHCF Director reported the MCOs had a total adjusted net income January 2015 through September 30, 2015, of \$41,676,498.

KanCare Ombudsman. The KanCare Ombudsman provided an update indicating there were two opportunities for members and providers to meet the Ombudsman, one at a vendor booth at an InterHab Conference and the second at the Brain Injury Conference. The Ombudsman stated the Ombudsman's office mailed information about its services to the 105 targeted case managers. The Ombudsman provided a summary to the

Committee of the 2014 fourth quarter report. She stated the top four issue categories for the fourth quarter were medical services, HCBS general issues, appeals and grievances, and billing. She indicated billing and appeals and grievances were the top two issues that have been consistent across all four quarters.

At the April meeting, the Ombudsman indicated the office received 510 contacts during the first quarter of 2015, with 221 of the contacts related to an MCO issue.

At the August meeting, the Ombudsman indicated the Volunteer Program would begin September 1, 2015; the numbers of contacts to the office were down slightly in the second quarter; a new Ombudsman brochure was developed; and nursing facility issues and pharmacy were new top issues reported by members.

At the December meeting, the Ombudsman reported the Volunteer Program had been implemented in Wichita, and programs were planned for Kansas City and Johnson County in early 2016. The Ombudsman also reported the office received a total of 1,551 contacts during the first, second, and third quarters. Of those contacts, 616 were related to MCO issues.

During CY 2015, the Ombudsman provided Medicaid program outreach at several events including the KanCare (I/DD) Friends and Family Advisory Council, the Conference on Poverty, and the Disability Caucus.

Hospital claims. At the January meeting, a representative from Newman Regional Health expressed concern that some of the claims processing problems expressed to the Committee in 2014 had not been resolved with the MCOs and did not have long-term solutions. At the April meeting, the Chairperson stated the testimony provided by Newman Regional Health at the January meeting was not wholly accurate and the MCOs followed up with Newman Regional Health and the problems were resolved.

At the December meeting, representatives from Lawrence Memorial Hospital (LMH) expressed concerns about the coordination of patient care and utilization review, processing of

claims submitted to KanCare MCOs for payment, and payment denial of claims for services and the appeals process. A representative from LMH stated many claims are denied without a reason being provided. The MCOs provided information indicating denied claims always include a reason for the denial.

The Chairperson invited LMH and the MCOs to provide an update at the January 2016 meeting.

Presentations on KanCare from individuals, providers, and organizations. The Committee heard from multiple KanCare beneficiaries regarding both favorable experiences and difficulties faced in navigating the system.

Positive experiences were described by multiple individuals receiving KanCare services. Among the favorable testimony heard were comments related to the ease of navigating the process, valuable assistance provided by the support teams and case managers, support teams and case managers being responsive and cooperative, MCOs' efforts at keeping members informed, services provided by the MCOs to facilitate the members' ability to remain in their homes, support provided in addressing both physical and mental health problems, and MCOs taking time to assess and then address individual needs.

Various complaints heard by the Committee from individuals included situations where the system's structure caused confusion in which neither the MCO nor the provider would take responsibility, difficulty in navigating the Interactive Voice Response System, frustration with the change in age requirements for personal care service workers, the inability to obtain information regarding the basis for reductions in plans-of-care hours, lack of knowledge and communication regarding the status of individuals on the waiting lists, difficulty navigating the system and administrative burdens, lack of service providers, caseworkers being difficult to work with, and difficulty in understanding and navigating the appeals process.

Representatives of the following organizations and providers testified or provided written testimony before the Committee: Kansas Home Care Association; LeadingAge Kansas; Newman Regional Health; Kansas Hospital Association;

Kansas Action for Children; Kansas Health Consumer Coalition; InterHab; Kansas Advocates for Better Care; Topeka Independent Living Resource Center; Jenian, Inc.; Kansas Neurological Institute Parent Guardian Group; Association of Community Mental Health Centers of Kansas; Community Health Center of Southeast Kansas; COMCARE of Sedgwick County; Advocate Care Services; Life Patterns; Providence Professional Services; Case Management Services, Inc.; HealthCore Clinic; Asbury Park; Kansas Center for Assisted Living; Lawrence Memorial Hospital; Self-Direction Care Providers of Kansas; Health Homes Mirror, Inc.; Wyandot, Inc.; Bert Nash Community Mental Health Center; Cottonwood, Inc.; and Advocacy Services of Western Kansas, Inc.

Some organizations and providers praised KDHE and KDADS for the agencies' willingness to work with them on issues that arose and KDHE for providing leadership on the Health Home initiative. The KDHE also was praised for inviting Kansas providers to provide input regarding the Integrated Waiver project and partnering with Financial Management Services (FMS) providers attempting to comply with the U.S. Department of Labor (DOL) rule. The MCOs also received praise for their cooperative efforts from organizations and providers, though some expressed difficulty with particular MCOs.

Various areas of concern or need expressed by organizations and providers [*responses from agencies provided in brackets*] included the potential loss of needed services to a number of individuals on the physical disability (PD) waiting list because KDADS had been unable to contact them [*A representative from KDADS explained the efforts made by the agency to contact individuals on the PD waiting list and noted the waiting list number actually includes some individuals who have been extended an offer to receive services. The representative also indicated the acceptance rate of services is about 50 percent.*]; the funding mechanism for the Frail Elderly (FE) waiver in assisted living; retaining support staff due in part to low wages; prior authorization particularly in general and as it relates to crisis funding [*A representative from KDHE explained MCOs have about ten days to respond from the time the request is received, and there is no prior authorization required for emergencies.*]; long

I/DD waiting list and low rates for I/DD providers [*A representative from KDADS stated KDADS has had issues with not being able to contact people who have been on the I/DD list for a lengthy time, possibly due to their relocating or having started other services. The representative also indicated KDADS is working closely with the Community Developmental Disability Organizations to identify names that should and should not be on the list.*]; an unfunded mandate for background checks on all personal care service workers [*A KDADS representative stated KDADS is trying to mitigate those costs by working within KDADS and with the Survey Certification Commission.*]; challenges facing FMS providers, such as requests for FMS rate increases and moving from a self-directed model to a vendor fiscal employer model [*A representative from KDADS explained the changes were put in place to ensure consumers could successfully perform the role as employer, and KDADS accepted provider input when developing the FMS manual. The representative also indicated KDADS is not performing a rate study related to FMS providers.*]; the need for management and control of the PD waiting list to be with the Centers for Independent Living; the need for support for older adults; concerns as to the use of anti-psychotic drugs as chemical restraints in the treatment of dementia in the elder population; the change in age requirements for support workers [*A representative from KDADS stated the age requirement for personal care service workers was changed in response to a request for information from CMS and is not a federal requirement.*]; the need for increased reimbursement rates for HCBS professional staff providing services and supports to those with disabilities; concern with the new DOL rules [*A representative from KDADS stated KDADS is preparing to implement the rule according to the Court of Appeals time line which begins enforcement January 1, 2016.*]; members' rights to due process not being protected; individuals with I/DD being opted-in to mental health Health Homes but not being notified [*A representative from KDHE stated effective November 1, 2015, MCOs are required to provide written notice to the TCM of the individual being placed in the Health Home.*]; long-term supports not being understood by MCOs; and long-term supports not belonging in KanCare.

Hepatitis C drug use and Centers for Medicare and Medicaid Services (CMS) ruling.

At the January meeting, the Secretary for Health and Environment discussed the federal requirement to cover new drugs for hepatitis C once approved by the federal Food and Drug Administration. She stated a 12-week course of treatment for hepatitis C is available in a cost range from \$80,000 to \$120,000 for a full course of treatment. A Committee member requested the projection of the cost of the hepatitis C drug be included in the state budget. The DHCF Director indicated KDHE would work with the KDHE actuary and pharmacy team to achieve an accurate projection.

At the April meeting, the Deputy Secretary for Health and Environment reported hepatitis C drug utilization is part of KDHE's monthly financial reports, and KDHE is anticipating spending between \$30 million and \$32 million per year for the drug.

At the August meeting, the DHCF Director reported \$24,789,662 was expended by MCOs from March 2015 through July 2015 on hepatitis C drugs. In response to a concern from a Committee member, the DHCF Director stated the use of hepatitis C drugs is a concern in all states and the issue is being monitored.

At the December meeting, the DHCF Director stated as it related to comments CMS published on November 5, 2015, concerning the state Medicaid coverage of hepatitis C medications, he did not believe there was any impact or additional cost to be borne by Kansas as Kansas was already compliant with CMS' suggestions. It also was reported that \$28,716,966 had been spent by MCOs on hepatitis C medications from January 2014 to December 2015.

Update on the state and expectation of change regarding psychotropic drug use and prescription drug process. At the April meeting, the Deputy Secretary for Health and Environment provided an update on 2015 Senate Sub. for HB 2149 that was pending and was subsequently enacted. The law allows prior authorization or other restrictions on medications used to treat mental illness to be imposed on Medicaid recipients for medications subject to guidelines

developed by the Drug Utilization Review Board (Board) in accordance with provisions of the bill; establishes instances not to be construed as restrictions; provides for the development of guidelines; establishes requirements for Board review of medications used to treat mental illness available for use before and after July 1, 2015; and creates a Mental Health Medication Advisory Committee (MHMAC) outlining Committee membership and appointments, meeting frequency, and member compensation.

At the August meeting, the Secretary for Health and Environment stated the MHMAC would meet in September to review mental health drugs by class. She also indicated the dose optimization and consolidation prescription drug process replaces multiple doses of a medication at a lower strength with a single dose of medication at a higher strength, applies to a state-approved list of 17 mental health drugs, and allows multiple doses of lower strength to be requested *via* the prior authorization process.

At the December meeting, the Secretary for Health and Environment stated the MHMAC had met three times and had reviewed the proposed criteria for approving mental health drugs and discussed processes for MCO prior authorization implementation and review.

KanCare Waiver Integration project. The Secretary for Health and Environment provided an overview of the KanCare Waiver Integration project, stating there are seven HCBS programs under the 1915(c) waiver that cover autism, FE, I/DD, PD, serious emotional disturbance, technology assisted, and traumatic brain injury (TBI), that operate alongside the 1115 waiver. The 1115 waiver includes all Medicaid services in the State plan, the authority to provide all services through managed care to all populations, and HCBS. The integration project would combine all services into two broad categories of adult and children's services. How the funds would be appropriated under the integration is still undecided. At the August meeting, the goal for new service to be available to beneficiaries was July 1, 2016, but at the December meeting the goal was updated to January 2017.

At the December meeting, the Secretary provided an overview on the outreach KDHE and KDADS conducted to stakeholders. KDHE will file a request with CMS for permission to move forward with the project in the spring of 2016.

Responding to questions, the Secretary for Health and Environment provided the following information about the Waiver Integration project: the payment model will not change; the waiting lists will not be affected; and the vast majority of services will continue to be available.

PACE expansion. The Secretary for Aging and Disability Services informed the Committee three locations were in the process of adding a PACE program. All three locations were in the process of completing the State Readiness Review.

Osawatomie State Hospital (OSH). At the April meeting, the Secretary for Aging and Disability Services stated the hospital needed to undergo renovations to continue to be certified, renovations were in progress, and the renovations needed to be completed by October 1, 2015, to meet CMS' deadline. The Secretary also stated OSH's capacity needed to be reduced by 60 to 146 during the renovations.

At the December meeting, the Secretary for Aging and Disability Services provided an update on the CMS termination of federal government reimbursement for Medicare-eligible inpatients admitted to OSH after December 21, 2015. The Secretary stated OSH is still operating, has 146 patients, and is still taking patients.

Tele-monitoring. At the December meeting, the Chief Executive Officer (CEO) of UnitedHealthcare updated the Committee about UnitedHealthcare's tele-monitoring pilot program that began January 1, 2015. The CEO stated the objective of the program is to evaluate quality and cost outcomes resulting from expansion of tele-monitoring services to additional KanCare populations. The expected benefits include cost reduction in emergency room and inpatient utilization, transportation costs, and nursing home admissions and quality improvement in preventative care for members with chronic disease. The CEO reported, since the inception of the program, inpatient admissions per member per

month decreased by 14 percent and total costs declined by 2 percent.

Agency responses to presentations by individuals, organizations, and providers. At the April meeting, a Committee member, referencing written testimony from Kansas Action for Children that stated the enrollment of poor one- to five-year old children in KanCare had been dropping since November 2012, asked if policy changes in DCF regarding Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP) would impact enrollment. The KDHE CITO stated a change in the eligibility policy for SNAP or TANF would not affect the eligibility for the one- to five-year-old group. A Committee member expressed interest in reviewing policy changes made in DCF programs impacting the enrollment of young children in Medicaid.

A Committee member inquired about how applications from pregnant women applying for Medicaid were processed. The KDHE CITO explained those applications were moved to the front of the eligibility queue for processing and, with the implementation of KEES, there would be a presumptive eligibility pool for pregnant women that would grant 60 days of eligibility to allow time to process the applications.

The Secretary for Health and Environment responded to testimony provided by InterHab related to HCBS rate with the I/DD provider rate. The Secretary indicated KDADS staff continue to work with CMS to see if there is going to be a change in the CMS approach to the provider assessments and KDADS was working with a work group of DD providers to identify outcomes that could be tied to an increased rate of reimbursement. The Secretary indicated there could be a higher reimbursement rate tied to improved outcome in HCBS.

MCO testimony and responses to presentations by individuals, organizations, and providers. Representatives of the three MCOs testified at the four committee meetings. The CEO from Amerigroup Kansas Plan provided the Committee an update on Amerigroup 2014 achievement, 2014 provider payments and 2014 provider payment detail, provider servicing,

Health Homes statistics, I/DD program, and 2015 initiatives. In response to questions, the CEO stated Amerigroup continues to meet with its DD and PD waiting list individuals at least once a year assessing for gaps, developing plans of care, and continuing to work with them to help support whatever needs they have until they become eligible to go on the waiver.

The CEO and Plan President from Sunflower State Health Plan provided an overview on the progress made by Sunflower over the past 24 months, and he addressed the prior authorization issue indicating Sunflower is near the required 14-day turnaround time. The CEO also reported Sunflower had about 149,000 members, paid out more than \$1 billion to providers in 2014, and transitioned 170 members in 2014 from nursing facilities into HCBS.

The Health Plan CEO from UnitedHealthcare Community Plan provided information on utilization management, quality outcomes, provider satisfaction, member satisfaction, and prior authorization, including steps UnitedHealthcare had taken to address the prior authorization problem. The CEO also reported UnitedHealthcare's claim denial rate in 2015 has been about 7 percent, with 20 percent of denials due to a prior authorization issue.

Human Services Consensus Caseload Spring Estimates. At the April meeting, a KLRD staff member provided an overview of Human Services Consensus Caseload Estimates for FY 2015, FY 2016, and FY 2017. The staff member stated, as a starting point for the current estimate, the Human Services Consensus Caseload Estimating Group (Group) used the Governor's budget recommendation as adjusted by 2015 House Sub. for SB 4 and appropriation revisions and supplementals for FY 2015 and FY 2016 for various state agencies. The staff member indicated the estimate for all caseloads for FY 2015 was a decrease of \$36.4 million from the State General Fund (SGF) and \$119.3 million from all funding sources from the amount approved in House Sub. for SB 4. The new estimate for FY 2016 was a decrease of \$58.6 million from all funding sources and an increase of \$3.8 million from the SGF. The estimate for FY 2017 was a decrease of \$6.5 million from the SGF and \$71.0 million from all funding sources from the Governor's budget

recommendation. The combined estimate for FY 2015, FY 2016, and FY 2017 was an all-funds decrease of \$248.9 million, including \$39.1 million from the SGF. The staff member next provided details on FY 2015, FY 2016, and FY 2017 human services caseload estimates.

In response to questions, the staff member provided the following information: the Group made increases in the estimates for hepatitis C drugs from the 2014 fall estimates; the Group used not quite a two percent growth in Medicaid membership for each year; regarding the Federal Medical Assistance Percentage change in FY 2017, the Group used a blended rate to account for the fact the federal rate crosses over fiscal years, and the Group knew how the percentages were calculated, but members were not able to look at the actual calculations; and the Group reinserted \$12 million for the DCF settlement. The staff member explained the settlement arose from a past federal audit that determined certain expenditures were not allowable that DCF believed were allowable; therefore, adjustments had to be made.

Human Services Consensus Caseload Fall Estimates. At the December meeting, a staff member from KLRD reviewed the estimates on human services caseload expenditures for FY 2016 and FY 2017. Staff from the Division of the Budget, DCF, KDHE, KDADS, Kansas Department of Corrections (KDOC), and KLRD met on October 28, 2015, to revise the estimates on human services caseload expenditures for FY 2016 and FY 2017. The caseload estimates include expenditures for Temporary Assistance to Families, the reintegration/foster care contracts, out-of-home placements, KanCare regular medical assistance, non-KanCare, and nursing facilities.

The staff member reported the human services caseload expenditures estimate for FY 2016 is \$3.0 billion from all funding sources and \$1.1 billion from the SGF. This represents an increase of \$48.9 million from all funding sources, including \$16.6 million from the SGF as compared to the budget approved by the 2015 Legislature. The estimate for FY 2017 is \$3.0 billion from all funding sources including \$1.1 billion from the SGF and is an increase of \$82.2 million from all funding sources, including \$30.8 million from the SGF from the FY 2017 approved budget. The combined estimate for FY 2016 and FY 2017 is an all-funds

increase of \$131.0 million and a SGF increase of \$47.4 million. The staff member stated the administration of KanCare within the state is accomplished by KDHE maintaining financial management and contract oversight including regular medical services, while KDADS administers the Medicaid Waiver programs for disability services as well as long-term care services, mental health and substance abuse services, and the state hospitals. In addition, KDOC administers the part of KanCare related to youth in custody.

Concerning FY 2016, a Committee member asked the staff member to explain the information concerning the transfer of expenditures for state hospital assessments from the KanCare to non-KanCare portion of caseloads. The staff member explained, effective January 1, 2016, some of the services provided are not paid for under the contract with the MCOs, so these entitlement services are being reallocated to the line item non-KanCare.

Concerning FY 2017, a Committee member asked the staff member to explain the statement concerning the addition of SGF expenditures needed to account for an anticipated federal penalty regarding two-parent work participation rates in those receiving services through the program. The staff member stated a portion of the TANF program at the federal level has a requirement for participation at a certain rate in order to qualify for the block grant funding. It is anticipated Kansas will not meet the required percentage for two parents working for FY 2017; therefore, a penalty is expected, requiring an increase in the funds allocated to the SGF.

Quarterly HCBS report. At each Committee meeting, the Secretary for Aging and Disability Services provided information on average monthly caseloads and average census for state institutions and long-term care facilities. The Secretary also provided information on savings on transfers to HCBS waivers and the HCBS Savings Fund balance.

Financial Management Services (FMS) program update. At the January meeting, the Secretary for Aging and Disability Services stated the changes to the FMS program were put in place

to ensure consumers could successfully perform the role as employer. She also stated the changes would implement a consistent model across the state.

Update on renewal of waivers. At the December meeting, the Secretary for Aging and Disability Services stated the renewal applications for PD, I/DD, FE, and TBI waivers were approved by CMS; CMS approved an extension to March 28, 2016, of the Serious Emotional Disturbance waiver program; and CMS approved an extension of the Autism waiver program to March 30, 2016. The Secretary also stated KDADS submitted amendments to renewed HCBS waivers to modify sleep-cycle support service to comply with the Fair Labor Standards Act and the DOL rule.

Waiting lists reduction. The Secretary for Aging and Disability Services stated at the January meeting that, with the Governor's proposed budget increases, 175 additional individuals would be moved off of the I/DD waiting list and 125 individuals moved off of the PD waiting list.

At the April meeting, the Secretary for Aging and Disability Services stated, as of April 14, 2015, 5,482 individuals were receiving services on the HCBS PD program and 8,724 individuals were receiving services on the I/DD program. The Secretary reported from January 1, 2015, to March 31 2015, 9 individuals from the I/DD waiting list accepted services and 55 individuals from the PD waiting list accepted services. Responding to a question, the Secretary stated \$65 million all funds had been allocated to the waiting lists since 2013.

At the August meeting, the Secretary for Aging and Disability Services reported, as of August 15, 2015, there were 1,721, individuals on the PD waiting list and 3,449 individuals on the I/DD waiting list.

At the December meeting, the Secretary for Aging and Disability Services reported KDADS had extended offers of service to everyone who was placed on the PD waiting list as of June 30, 2015, and earlier, and there were 1,319 individuals on the PD waiting list as of December 2015. The Secretary also reported there were 3,554 individuals on the I/DD waiting list as of

December 2015, and 565 individuals started I/DD services in 2015.

U.S. DOL HCBS settings rule. At the January and April meetings, the Secretary for Aging and Disability Services updated the Committee on the DOL rule regarding whether direct service workers serving HCBS waiver clients would be subject to minimum wage and overtime benefits from which they previously were exempt and indicated there was on-going litigation. During the August meeting, the Secretary stated the U.S. Court of Appeals issued a unanimous opinion affirming the validity of the DOL Final Rule. The ruling requires Kansas to provide an hourly rate instead of a nightly rate for sleep cycle support. The Secretary indicated the plaintiff filed a petition for *writ of certiorari* requesting the U.S. Supreme Court hear an appeal of the case. Kansas coordinated an *amicus* brief filed December 23, 2015, with 12 other states' Attorneys General in support of the plaintiffs. KDADS submitted targeted waiver amendments to CMS to update policies related to personal care and overnight support.

Federal Health Insurance Marketplace update. Information was provided by representatives of the Kansas Insurance Department (KID) at the January, April, and August meetings.

A representative of KID reported at the January meeting that enrollment totaled 54,899 Kansans who completed the eligibility portion of the application process between November 15, 2014, and December 15, 2014, 39,023 of whom selected a Marketplace plan. The representative from KID noted the remainder had either not selected a plan (11,964) or had been determined eligible for Medicaid/CHIP (3,912). The representative also explained the data did not include consumers automatically re-enrolled into coverage.

During the April meeting, the KID representative reported, as of March 10, 2015, Marketplace enrollment was at 96,197, with 80 percent eligible for financial assistance. A Committee member asked the representative if the commercial payers had their financial strength decreased by the Marketplace business and if

those payers would pass costs to the private sector. The representative stated the companies are not in a financial position that causes significant concern.

During the August meeting, a representative from KID reported the following companies were Marketplace insurers and provided a financial review of the companies: Blue Cross and Blue Shield of Kansas, Coventry Health Care of Kansas, Coventry Health and Life Insurance Company, and Blue Cross and Blue Shield of Kansas City.

The KID representative also reported the 2016 Marketplace open enrollment is November 1, 2015 through January 31, 2016.

CONCLUSIONS AND RECOMMENDATIONS

Based on testimony heard and Committee deliberations, the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight makes the following conclusions and recommendations.

The Committee made the following recommendations regarding prescription drugs:

- The KDHE produce a report, collaborating with the MCOs, to report the geographic region and type of provider over-prescribing anti-depressant and anti-psychotic drugs. The geographic locations would mirror the PACE regions;
- The KDHE adopt a policy allowing the MCOs and providers to use step therapy (a.k.a., fail first) on the non-waiver population; and
- The KDHE review the preferred drug list (PDL) rules for the non-waiver population and adopt a policy allowing the MCOs to determine the PDL for the non-waiver population, instead of the State setting the PDL for this population. The review should include a variety of options, including new pricing methodologies, relaxing PDL rules, or allowing network contracting strategies. Decisions would be contingent upon providing a positive dollar impact (savings) to State expenditures of any such change.

The Committee made the following recommendations regarding Health Homes:

- The KDHE continue to evaluate the financial and health outcomes of the existing Health Homes program for individuals with SMI, including exploring opportunities for simplification of the program;
- The KDHE adopt a policy excluding the DD population from the Health Homes program for individuals with SMI to remove duplication of case management services;
- The KDHE adopt a policy that the automatic opt-in to the Health Homes program for individuals with SMI would not apply until the patient has utilized medical services with an annual minimum value of \$10,000; and, if a patient does not utilize Health Home services during the first 60 days, the patient would be automatically opted out of the Health Homes program;
- The KDHE adopt a policy requiring medical and surgical services in the Health Homes program for individuals with SMI be provided by the lowest number of primary care providers required to provide the needed services; and

- The KDHE adopt a policy holding any targeted case manager financially harmless for the value of the services provided to an individual in a Health Homes program for individuals with SMI when notification of patient inclusion in the program has not been documented or provided in a timely manner to the targeted case manager. The policy should be budget neutral to the Medicaid program.

The Committee made the following additional recommendations:

- Request KDADS review the Colorado Parent as Caretaker Program and determine the feasibility of introducing a program such as this in the state of Kansas; and
- Request KDHE review the actual experience of the presumptive eligibility program for pregnant women to determine whether prenatal services are being delayed due to the presumptive eligibility policy not being appropriately implemented.

Proposed Legislation

The Committee did not propose legislation for consideration during the 2016 Legislative Session.

ADDENDUM A

Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight

ANNUAL REPORT FOR THE 2015 LEGISLATIVE SESSION

The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight is charged by statute to submit an annual written report on the statewide system for long-term care services to the President of the Senate and the Speaker of the House of Representatives at the start of each regular legislative session. The authorizing legislation (KSA 2015 Supp. 39-7,159) creating a comprehensive and coordinated statewide system for long-term care services became effective July 1, 2008.

The Committee's Annual Report is to be based on information submitted quarterly to the Committee by the Secretary for Aging and Disability Services. The Annual Report is to provide:

- The number of individuals transferred from state or private institutions to home and community based services (HCBS), including the average daily census in state institutions and long-term care facilities;
- The savings resulting from the transfer of individuals to HCBS as certified by the Secretary for Aging and Disability Services; and
- The current balance in the Home and Community Based Services Savings Fund.

The following table and accompanying explanations are provided in response to the Committee's statutory charge.

Number of individuals transferred from state or private institutions to home and community based services including the average daily census in state institutions and long-term care facilities:

Number of Individuals Transferred—the following table provides a summary of the number of individuals transferred from developmental disability (DD) institutional settings into home and community based services during state fiscal year 2015, together with the number of individuals added to home and community based services due to crisis or other eligible program movement during state fiscal year 2015. The following abbreviations are used in the table:

- ICF/MR – Intermediate Care Facility for the Mentally Retarded
- SMRH – State Mental Retardation Hospital
- MFP – Money Follows the Person program
- SFY – State Fiscal Year

DD INSTITUTIONAL SETTINGS AND WAIVER SERVICES*	
Private ICFs/MR:Avg. Mo. Caseload SFY 2015	140
State DD Hospitals – SMRH: Average Monthly Caseload SFY 2015	317
MFP: Number discharged into MFP program – DD	30
I/DD Waiver Community Services: Average Monthly Caseload SFY 2015	8,740
* Monthly averages are based upon program eligibility.	
Sources: SFY 2015 - Medicaid eligibility data as of November 30, 2015. The data include people coded as eligible for services or temporarily eligible.	

The following table provides a summary of the number of individuals transferred from nursing facility institutional settings into home and community based services during SFY 2015. These additional abbreviations are used in the chart:

- FE – Frail Elderly Waiver
- PD – Physical Disability Waiver
- TBI – Traumatic Brain Injury Waiver

FE/PD/TBI INSTITUTIONAL SETTINGS AND WAIVER SERVICES*	
Nursing Homes -Average Monthly Caseload SFY 2015	10,491
MFP FE: number discharged into MFP program receiving FE Services	54
MFP PD: number discharged into MFP program receiving PD Services	148
MFP TBI: number discharged into MFP program receiving TBI Services	7
Head Injury Rehabilitation Facility	31
FE WAIVER: Average Monthly Caseload SFY 2015	5,159
PD WAIVER: Average Monthly Caseload SFY 2015	5,415
TBI WAIVER: Average Monthly Caseload SFY 2015	516
* Monthly averages are based upon program eligibility.	
Sources: SFY 2015 - Medicaid eligibility data as of November 30, 2015. The data include people coded as eligible for services or temporarily eligible.	

Average Census in State Institutions and Long-Term Care Facilities

Kansas Neurological Institute: Average Daily Census

FY 2010 - 157
FY 2011 - 153
FY 2012 - 152
FY 2013 - 145
FY 2014 - 143
FY 2015 - 144

Parsons State Hospital: Average Daily Census

FY 2010 - 186
FY 2011 - 186
FY 2012 - 175
FY 2013 - 176
FY 2014 - 174
FY 2015 - 173

Private ICFs/MR: Monthly Average

FY 2010 - 194
FY 2011 - 188
FY 2012 - 166
FY 2013 - 155
FY 2014 - 143
FY 2015 - 140

Nursing Facilities: Monthly Average

FY 2010 - 10,844
FY 2011 - 10,789
FY 2012 - 10,761
FY 2013 - 10,788
FY 2014 - 10,783
FY 2015 - 10,491

*Monthly Averages are based upon Medicaid eligibility data.

Savings Resulting from the Transfer of Individuals to HCBS

The “savings” through *Money Follows the Person* translates into real dollars only when an individual moves into a community setting from an institutional setting and the bed is closed behind the individual. This process would result in a decreased budget for private ICFs/MR and an increase in the MR/DD (HCBS/DD) Waiver budget as a result of the transfers.

For nursing facilities and state ICFs/MR, the process is consistent with regard to individuals moving to the community. The difference is seen in “savings.” As previously stated, savings are seen only if the bed is closed. In nursing facilities and state ICFs/MR, the beds may be refilled when there is a request by an individual for admission that requires the level of care provided by that facility. Therefore the beds are not closed. In addition, even when a bed is closed, only incremental savings are realized in the facility until an entire unit or wing of a facility can be closed.

As certified by the Secretary for Aging and Disability Services, the savings resulting from the individuals to home and community based services, as of December 31, 2015, was zero dollars.

Current Balance in the KDADS Home and Community Based Services Savings Fund

The balance in the Kansas Department for Aging and Disability Services (KDADS) Savings Fund as of December 31, 2015, was zero dollars.