MINUTES

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

November 18, 2016
Room 548-S—Statehouse

Members Present

Representative Daniel Hawkins, Chairperson
Senator Michael O'Donnell, Vice-chairperson
Senator Jim Denning
Senator Laura Kelly
Senator Forrest Knox (substitute for Senator Garrett Love)
Senator Jacob LaTurner
Representative Barbara Ballard
Representative Will Carpenter
Representative Willie Dove
Representative Jim Ward

Member Absent

Representative John Edmonds

Staff Present

Jennifer Ouellette, Kansas Legislative Research Department
David Fye, Kansas Legislative Research Department
Erica Haas, Kansas Legislative Research Department
Iraida Orr, Kansas Legislative Research Department
Norm Furse, Office of Revisor of Statutes
Scott Abbott, Office of Revisor of Statutes
Kyle Hamilton, Office of Revisor of Statutes
Debbie Bartuccio, Committee Assistant

Conferees

Jennifer Ouellette, Fiscal Analyst, Kansas Legislative Research Department
Cynthia Gardner, Private Citizen
Kerry Cosgrove, Case Manager, Jenian, Inc.
Linda MowBray, Kansas Health Care Association and Kansas Center for Assisted Living
Rachel Monger, Director of Governmental Affairs, LeadingAge Kansas
Christopher Rea, Board Chairman, Kansas Adult Care Executives
Tanya Dorf Brunner, Executive Director, Oral Health Kansas, Inc.

Terica Gatewood, PharmD, Site Manager, Genoa
Michael Jones, Private Citizen
Phaedra Moll, Private Citizen
Jamie Price, Senior Vice President, Community Living Opportunities
Aldona Carney, Private Citizen
Ben Swinnen, President, Equiventure Farms
Shane Heit, KVC Health Systems
Mike and Sheri Nieder, Private Citizens (Oral Only)
Scott Williamson, M.D., Parent and Advocacy Committee Member, Life Centers Family Support Organization
Phillip Davis, Chief Executive Officer, Flint Hills Community Health Center
Craig Knutson, Public Policy Coordinator, Kansas Council on Developmental Disabilities
Susan Mosier, M.D., Secretary of Health and Environment
Mike Randol, Director, Health Care Finance, Kansas Department of Health and Environment
Aaron Dunkel, Deputy Secretary, Kansas Department of Health and Environment
Tim Keck, Acting Secretary for Aging and Disability Services
Brandt Haehn, Commissioner of Home and Community Based Services, Kansas Department for Aging and Disability Services
Kerrie Bacon, KanCare Ombudsman
David Rossi, Chief Operating Officer and Dr. John Esslinger, Chief Medical Officer, UnitedHealthcare Community Plan
Gerald Snell, Manager of Foster Care Programs, UnitedHealthcare Community Plan
Chris Coffey, Health Plan President and Chief Executive Officer, Sunflower State Health Plan
Laura Hopkins, Chief Executive Officer, Amerigroup Kansas Plan

Others Attending

See Attached List.

Morning Session

Chairperson Hawkins opened the meeting at 9:30 a.m. and welcomed attendees. Due to the number of scheduled presenters, he indicated each person would be limited to four minutes with questions to be held until the completion of the presentations.

Human Services Consensus Caseload Fall Estimates

Chairperson Hawkins recognized Jennifer Ouellette, Fiscal Analyst, Kansas Legislative Research Department (KLRD), who reviewed the Human Services Consensus Caseload Fall Estimates. She stated the caseload estimates include expenditures for Temporary Assistance to Families, the reintegration and foster care contracts, out of home placements, and KanCare regular medical assistance and nursing facilities. A chart summarizing the estimates for Fiscal Year (FY) 2017 through FY 2019 was included at the end of the memorandum (Attachment 1).

Ms. Ouellette said the estimate for FY 2017 is an increase of $147.0 million from all funding sources and $1.9 million from the State General Fund as compared to the budget approved by the 2016 Legislature. (The approved amount reflects the Governor's May 2016 allotments.) The estimate for FY 2018 is a decrease of $120.4 million from all funding sources and an increase of $35.3 million from the State General Fund above the FY 2017 revised

estimate. The estimate for FY 2019 is an increase of $48.4 million from all funding sources and $165.8 million from the State General Fund above the FY 2018 estimate. The combined estimate for FY 2017, FY 2018, and FY 2019 is an all funds increase of $75.0 million and a State General Fund increase of $203.0 million.

The administration of KanCare within the state is accomplished by the Kansas Department of Health and Environment (KDHE) maintaining financial management and contract oversight including regular medical services, while the Kansas Department for Aging and Disability Services (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, the Kansas Department of Corrections (KDOC) administers the part of KanCare related to youth in custody. Throughout the report, KanCare medical estimates include all Medicaid KanCare expenditures for all agencies. Beginning in FY 2018, all KanCare expenditures will be included in the KDHE budget. KDADS and KDOC will maintain responsibility for their program policies and performance.

The report included summary information for FY 2017, FY 2018, and FY 2019.

Ms. Ouellette addressed questions from the Committee concerning the 1.04 percent increase in the Federal Medical Assistance Percentage (FMAP). A Committee member requested additional information concerning how the FMAP is calculated and how the rate for Kansas compares with what other states are experiencing.

Presentations on KanCare from Individuals, Providers, and Organizations

Chairperson Hawkins recognized Cynthia Gardner, private citizen, who requested mental health patients no longer be referred to as “consumers” and that consideration be given to building a new psychiatric hospital closer to Wichita, Kansas. She said many of the patients at Osawatomie State Hospital are poor and uninsured, which means their families and friends have limited financial resources available to make the six-hour round trip from Wichita, Kansas to Osawatomie, Kansas. She also suggested a van or bus be provided for families to make the trip once a week from Wichita to Osawatomie. Ms. Gardner expressed concerns about: patients being transported in restraints; patients signing legal and binding documents while they are incapacitated during the intake process at private and state psychiatric hospitals; the practice of making technology a priority over what is in the best interest of the vulnerable mentally ill population; and billing practices (Attachment 2).

Chairperson Hawkins recognized Kerry Cosgrove, Case Manager, Jenian, Inc., who suggested seven ways to improve the lives of the most vulnerable citizens of Kansas and maintain a consistent business model for the agencies charged with providing quality services (Attachment 3):

- Carve out Home and Community Based Services (HCBS) from KanCare and place the administration of HCBS back with the state;
- Hire a non-partisan Inspector General who is separate from KDADS and KDHE;
- Move the Ombudsman Office to an outside, independent agency that is available to inform individuals of their legal rights;

- Fix the backlog of the Kansas Eligibility Enforcement System (KEES);

- Fix the laborious and time consuming steps to enter a state treatment center when there is a clear crisis. Hire competent staff with ongoing professional training to understand how to work with individuals who have extreme behaviors;

- Revise, with residential provider agency input, the new policy that restricts residential providers from providing maximum care to their individuals; and

- Increase the pay scale for providers so they can hire competent workers and provide benefits.

Chairperson Hawkins recognized Linda MowBray, Kansas Health Care Association and Kansas Center for Assisted Living, representing nursing homes, assisted living, residential health care, home plus, and nursing facilities for mental health (Attachment 4).

Ms. MowBray stated the agency's concerns fall into two categories:

- The continued backlog of Medicaid pending applications; and

- The 4.47 percent cut to Medicaid reimbursement rates for nursing home providers that went into effect on July 1, 2016.

Ms. MowBray stated, while there have been improvements in the backlog issues, the agency's providers report the backlog is still present. For example, one company reports over $1 million in pending Medicaid claims and another has over $2.5 million in pending Medicaid claims. She said another frightening trend, as shown in the 2015 nursing home cost reports, is the reduction of jobs in the workforce. She also stated loss of jobs, decreased revenue, decreased sales, and business leaving the state indicate a critical turning point.

Chairperson Hawkins recognized Rachel Monger, Director of Government Affairs, LeadingAge Kansas, the state association for not-for-profit aging services. Ms. Monger's testimony focused on the effects of the July 1, 2016 cuts for nursing home Medicaid reimbursement rates, as well as the continued backlog of Medicaid eligibility applications. She said the rate cuts, combined with a 150 percent higher provider assessment, and the devastation wrought by a Medicaid eligibility application backlog, is putting an unsustainable burden on long-term care services for senior Kansans.

Ms. Monger stated nursing homes have taken the brunt of the Medicaid eligibility delays over the last year and are faltering, especially in the rural areas where their services are needed the most. She stated in the last 12 months, 4 LeadingAge Kansas members have closed their doors and 2 more were sold to large for-profit nursing home chains. Ms. Monger stated losing 6 members to financial failure in one year is unprecedented.

Ms. Monger stated while the new advanced payment program has been helpful, a backlog still remains and to protect their operations, nursing homes continue to turn away seniors with "Medicaid pending" status. She stated having to wait even the federally allowed 45 days for an eligibility determination before getting care could mean severe disability or even

death for a frail elder. LeadingAge continues to receive reports from members about processing errors and communication problems (Attachment 5).

Chairperson Hawkins recognized Christopher Rea, Board Chairman, Kansas Adult Care Executives (KACE), a non-partisan, non-profit, and professional association serving nursing home administrators and assisted living operators in Kansas.

Mr. Rea stated KACE's members are struggling with two major concerns regarding KanCare: ongoing delays due to the Medicaid eligibility application backlog; and the financial crisis caused by a simultaneous increase in the Kansas Quality Care Assessment ("bed tax") and cuts in Medicaid reimbursement rates to nursing facilities (Attachment 6).

Mr. Rea offered the following two solutions:

- Increasing customer service and improving communication regarding the application process could eliminate many of the current delays by ensuring applications are completed correctly the first time; and

- Reversing the Medicaid nursing home provider rate cut would help stabilize nursing facilities in the state, as Kansas nursing facilities and the businesses that provide their supplies and services are struggling to remain solvent.

Chairperson Hawkins recognized Tanya Dorf Brunner, Executive Director, Oral Health Kansas, Inc., the statewide advocacy organization dedicated to promoting the importance of lifelong dental health by shaping policy and educating the public. Ms. Dorf Brunner urged the Committee to recommend the 2017 Legislature explores the value of including dental benefits for all Kansas Medicaid beneficiaries. She said the costs of not offering restorative dental benefits, such as fillings and crowns, are borne not only by the work-age adults who are not able to take care of their dental health, but by all of us.

Ms. Dorf Brunner stated when the 4 percent KanCare reimbursement rate cut was implemented in July, it impacted a set of services that have been languishing for many years. She stated the Medicaid rates paid to dental providers are around 40 percent of the cost to provide the services; therefore, the additional cut has made it even harder for Medicaid dental providers to continue to provide services. She said it is time to not only reverse the cuts, but consider the effect the historically low rates are having on the scant dental services offered through KanCare. She stated further eroding the KanCare dental provider network will put beneficiaries at risk of serious illness, which will cost not only more money, but even lives (Attachment 7).

Chairperson Hawkins recognized Terica Gatewood, PharmD, Site Manager, Genoa, a healthcare company that builds on-site, closed-door pharmacies inside community mental health centers (CMHCs). She said she was the Site Manager for the Genoa pharmacy located inside Valeo Behavioral Health Care in Topeka.

Ms. Gatewood stated on April 1, 2016, pharmacies' Medicaid reimbursement was changed to the national average drug acquisition cost (NADAC) plus $10.50. This change resulted in a negative financial impact to Genoa of over $750,000. On July 1, 2016, pharmacies' reimbursement was further lowered to NADAC plus $9.25 for companies with less than 30 sites in Kansas, including Genoa. This final rate increased the loss for Genoa to over $1 million. Ms.

Gatewood explained, due to Genoa's model of providing extra services like packaging and personalized refill reminder calls, Genoa's cost to dispense is 50 percent higher than a typical retail pharmacy. Therefore, under the current dispensing fee of $9.25, Genoa is reimbursed below what it costs to dispense every prescription filled.

Ms. Gatewood said research has shown that Genoa's integrated care model produces higher medication adherence rates than the industry standard, reduces rates of hospitalization, and lowers emergency department utilization for the patients who visit Genoa's on-site pharmacies. She urged Committee members to set a Medicaid reimbursement rate that is fair and will allow pharmacies like Genoa to continue to provide a high level of care to their patients (Attachment 8).

Chairperson Hawkins recognized Michael Jones, private citizen, who spoke concerning his son, Trevor Jones, a 22-year-old developmentally disabled individual who has Prader-Willi Syndrome (PWS), a complex genetic disorder affecting appetite, growth, metabolism, cognitive function, and behavior. PWS is characterized by behavioral problems linked to chronic feelings of insatiable hunger and a slowed metabolism that can lead to excessive eating and life-threatening obesity. Mr. Jones shared the issues that have occurred in his family's journey to provide assistance to his son and thanked members of Community Living Opportunities (CLO) and Sunflower for their advocacy on behalf of Trevor (Attachment 9).

Chairperson Hawkins recognized Phaedra Moll, private citizen, who shared her experiences following a vehicular accident, which resulted in a traumatic brain injury (TBI), impacting cognitive functioning and rendering her with severe chronic pain. She received assistance *via* KanCare and a TBI Waiver (Attachment 10).

Chairperson Hawkins recognized Jamie Price, Senior Vice President, CLO, providing supports for HCBS Intellectual/Developmental Disabilities (I/DD) Waiver beneficiaries, immediate care facilities/individuals with intellectual disabilities (ICF/IID) beneficiaries, and targeted case management (TCM).

Ms. Price said throughout the KanCare implementation many of the issues CLO has experienced and heard that other I/DD organizations and members are facing appear to be related to state policy changes and budget decisions rather than to KanCare itself. She stated these decisions are often presented as KanCare or managed care organization (MCO) changes, adding to the confusion, fear, and frustration of the program.

Ms. Price stated KEES is still not fixed and Kansans are coded incorrectly in the system, which further delays important coverage and support. She stated it is extremely important moving forward that the Administration continue to vet policy changes with the Center for Medicare and Medicaid Services (CMS) prior to implementation, so the system does not continue to start and stop policies. Additional services available through KanCare such as adult dental, respite, and hospital companions need to be considered.

Lastly, she requested Medicaid expansion be considered during the 2017 Legislative Session (Attachment 11).

Chairperson Hawkins recognized Aldona Carney, private citizen, and the parent of a young man with severe disabilities who relies upon KDADS programs to make it through the day.

Ms. Carney said many nursing homes report they are not being compensated for services due to the Medicaid eligibility application backlog. She stated between that and declining reimbursement rates, nursing homes fear they may not be able to stay open and adding one more layer of administration with three distinct players has added complexity, aggravation, and expense in communities across the state. She said we all need to work together in caring for citizens with disabilities in Kansas and we can do better, and we must do better for the vulnerable populations in Kansas (Attachment 12).

Chairperson Hawkins recognized Ben Swinnen, President, Equiventure Farms, a licensed day and residential provider in Shawnee County, with facilities in Newton as well as shared living residential supports in Douglas County. He shared three cases which illustrated the type of cooperation and outreach developed between a provider and Amerigroup that bring significant benefits to the members (Attachment 13).

Chairperson Hawkins recognized Shane Heit, KVC Health System, a licensed social worker in the State of Kansas and currently the I/DD Specialist for KVC Behavioral Healthcare. Ms. Heit stated KVC is serving a growing number of children with I/DD within the foster care system. This population continues to increase as communities struggle to provide the unique services needed to stabilize these children.

Ms. Heit stated KVC and Amerigroup have been working diligently to bridge the gap in services for children with I/DD so these children reach permanency and exit the foster care system. She stated these cases are extremely difficult due to the high level of care often needed for this population to remain in their community, and this will continue to be a challenging feat, but KVC and Amerigroup are making a commitment to children with I/DD (Attachment 14).

Chairperson Hawkins recognized Mike and Sheri Nieder who provided testimony concerning services provided for their son. Mr. and Ms. Nieder expressed appreciation for the support provided by KanCare and Amerigroup. There was no written testimony submitted.

Chairperson Hawkins recognized Scott Williamson, MD, Parent and Advocacy Committee Member, Life Centers Family Support Organization, representing more than 100 families, guardians, and caregivers of loved ones served in residential and day services at Life Centers of Kansas located in Overland Park, Kansas. Dr. Williamson stated Life Center's major concern is the enactment of State Policy E2016-082, dated September 1, 2016, and asked that implementation of this policy be halted until further review. He said this State Policy is listed as a residential billing policy change and this is not just a change in how invoices are paid but a change in rate methodology, a type of change requiring a waiver amendment according to the federal rules for the 1915(c) Waiver.

Dr. Williamson said the policy is an attempt to limit community based services and reduce the number of providers in the state. He stated the increased paperwork and documentation, threat of service reductions and reimbursements, and retroactive policy implementation have created a hostile business environment for providers. In light of these concerns, he requested that KDADS allow at least six months of public comment to CMS, the Kansas Legislature, and KDADS from clients throughout the state regarding this new policy (Attachment 15).

Chairperson Hawkins recognized Phillip Davis, Chief Executive Officer, Flint Hills Community Health Center (Flint Hills), an organization providing healthcare services for more than 10,000 residents with a specific focus on providing accessible and affordable care to the

underserved population. He stated, overall, they have shared a very positive relationship with the MCOs, especially UnitedHealthcare, with whom they have established an accountable care organization. He noted challenges have included problems with automatic reassignment of patients from one provider to another and the difficulty experienced by patients when attempting to get approved through KEES.

Mr. Davis said Flint Hills, along with other safety-net clinics, would benefit greatly from centralized credentialing. He stated a centralized system potentially could have prevented the issues Flint Hills and other safety net clinics experienced with the reassignment of patients, reducing the administrative burden for both the State and for Flint Hills. Centralized credentialing also would mean new providers could be credentialed sooner, which would allow patients to be seen by those providers more quickly, and ultimately, to have greater access to care.

In addition, Mr. Davis stated there would be a benefit from a state policy on under- and over-payments because with the standardization of how these issues are handled, legal and accounting issues could be greatly mitigated. He indicated the impact of these under- and over-payments is significant for Flint Hills and other safety net clinics, as the MCOs currently make up 30 percent of their payer mix.

Mr. Davis said despite the challenges, there have been many successes. One successful outcome of Flint Hill's partnership with UnitedHealthcare has been the monitoring of inactive patients who have not been seen by a provider. He stated UnitedHealthcare assigns these patients to one of their providers, which allows them to begin managing the patients' care and following up with the patients to ensure receipt of quality and timely health care (Attachment 16).

Chairperson Hawkins recognized Craig Knutson, Public Policy Coordinator, Kansas Council on Developmental Disabilities (Council). The Council was created by state and federal law with the expressed intent that Council activities would increase self advocacy and leadership efforts of individuals with I/DD, promote systems and systemic change, and enhance capacity building so that people with disabilities could live as independently as possible in the communities of their choice.

Mr. Knutson said Kansas spends roughly $490 million per year on all I/DD services; however, less than one cent of every dollar is spent on the Supported Employment program, and outcomes reflect that investment. Mr. Knutson made the following suggestions:

- Money should be shifted from a provider centric model of service delivery to a person centered model of services. When a person controls the money, providers must compete for that person's services;

- Money should be moved from congregate day facility settings and used to incentivize the Supported Employment program services. Providers must be reimbursed at a reasonable rate and be reimbursed to provide long-term, follow-along services to ensure that people remain employed once they find a job; and

- People need to be educated about the importance and benefits of employing people with disabilities, as all people need to be valued members of the

communities of their choice, and there is no better entrance to community than with competitive, integrated employment.

In conclusion, Mr. Knutson stated there is no reason Kansas has one-third fewer citizens with disabilities working than the average state, as the money is available and significant changes in where and how it is spent are overdue (Attachment 17).

Chairperson Hawkins called the Committee's attention to the written only testimony submitted as follows:

- Dr. Laura Huyett, DDS (Attachment 18);
- Jamie King, PsyD, LP, Director, Residential Treatment Services of Southeast Kansas (Attachment 19);
- Amanda Gress, Director of Governmental Relations, Kansas Action for Children (Attachment 20);
- Dr. Melinda Miner, DDS, Hays, Kansas (Attachment 21);
- Dr. William A. Miller, DDS, Hill City, Kansas (Attachment 22);
- Dr. Nick Rogers, DDS, Arkansas City, Kansas (Attachment 23);
- Dr. John Fales, DDS, MS, President, Kansas Dental Association and President, Kansas Association of Pediatric Dentists (Attachment 24);
- Mitzi McFatrich, Executive Director, Kansas Advocates for Better Care (Attachment 25);
- Garrett Drake, Chief Executive Officer, MidAmerica Alliance for Access (Attachment 26); and
- Roxanne Hidaka, Case Management Services, Inc. (Attachment 27).

Chairperson Hawkins opened the meeting for questions from the Committee members.

A Committee member asked Mr. Rea to review the 45-day eligibility backlog issue and the problem with nursing facility providers not receiving payment. The member said the problem is much greater now than prior to KanCare because providers were more confident with the prior system as to what would be approved or not approved. Mr. Rea said it appeared the people processing the applications do not understand the information needed to get approval, and it is taking an extremely long time to obtain eligibility approvals.

A Committee member asked Ms. Gatewood to review the information provided concerning the $10.50 and $9.25 pharmacy dispensing fees and the special pharmaceutical services provided to patients of CMHCs. Ms. Gatewood explained how the change in

reimbursement rates is negatively effecting pharmacies in Kansas. The Committee member asked Ms. Carney about the example she provided of a mother's son with cerebral palsy and seizure disorder who was denied his life-saving seizure medication by his MCO. The situation was not resolved until the mother's legislators intervened. The mother had paid for the medication out-of-pocket and the Committee member requested follow up on whether she had been reimbursed once approval had been given for the medication.

A Committee member asked Ms. Gatewood how an additional reimbursement rate cut to providers would effect pharmacies. She responded decisions would have to be made concerning what services to cut.

A Committee member asked Ms. Ouellette if she had a cost figure for the statement in the Consensus Caseload Report stating "other increases are due to estimated savings which were not realized for Medicaid Eligibility Payment Error Rate Measurement rates and increases in retroactive fee-for-service payments due to the eligibility determination backlog." Ms. Ouellette said she did not have that information readily available and would report back to the Committee. The Committee member asked Ms. MowBray if there was a structure in place to reinstate the outreach workers who are no longer available to assist clients with their Medicaid eligibility applications. Ms. MowBray said she believed there are still community resources that could be made available if approved to do so. She said the application process is quite lengthy and complicated. The Committee member referred to the testimony by Ms. Heit in which she made reference to positive outcomes in KVC's work with Amerigroup, and asked if KVC was working with the other two MCOs. Ms. Heit responded affirmatively. The Committee member asked Mr. Knutson to discuss employment opportunities available for those with developmental disabilities. As an example, Mr. Knutson referred to the Project Search program and the graph on page four of his testimony concerning job retention. The Committee member requested Dr. Williamson provide an example of how the Residential Policy Change would affect a patient.

KanCare Report on MCOs' Financial Status; Waiver Integration Project; Step Therapy; Medicaid Eligibility Backlog Update; KEES Update

Chairperson Hawkins recognized Susan Mosier, M.D., Secretary of Health and Environment, who presented an overview and update on KanCare. She provided the name and contact information for KDHE's legislative liaison, John Monroe, and stated he was the contact person at KDHE to answer questions and address issues regarding KanCare. She then announced a centralized credentialing system would be available in October 2017 (Attachment 28).

Secretary Mosier stated the goals of KanCare are whole person care coordination, clear accountability, improved health outcomes, and financial sustainability. Graphs were provided that addressed the following topics:

- Improved alcohol and drug treatment;
- Improved well-child visits;
- Improved diabetes care;
- Improved employment status;
- Reduced nursing facility re-admits;
- Decrease in prenatal care; and

- KanCare new services (top five services by expenditures and top five services accessed by members).

Secretary Mosier reported that in 2015, 133,012 members received value added services, which was an increase of 32 percent since 2014. She stated since the beginning of KanCare, members have been provided over $12 million in total services at no cost to the state, and these services were not available to members under the previous Medicaid system.

Secretary Mosier next reviewed KanCare utilization. She reported the following changes in Medicaid membership activity since the implementation of KanCare:

- Members are more likely to attend their appointments;
- Primary care physician utilization increased 24 percent;
- Non-emergency transportation increased 33 percent;
- Costly inpatient hospital stays decreased 23 percent; and
- Emergency room visits decreased 1 percent.

Concerning waiver utilization, Secretary Mosier reported the following changes in waiver membership activity since the implementation of KanCare:

- Members are more likely to attend their appointments;
- Primary care physician utilization increased 80 percent;
- Non-emergency transportation increased 56 percent;
- Costly inpatient hospital stays decreased 29 percent; and
- Emergency room visits decreased 7 percent.

A KanCare Cost Comparison graph was provided for years 2002 through 2019. Secretary Mosier stated KanCare has produced more than $1.4 billion in savings to the State, and a portion of these savings has allowed the State to invest in eliminating the Physical Disability (PD) Waiver waiting list, as of August 2016, and reducing the DD Waiver waiting list.

Secretary Mosier discussed two scenarios if waivers were to be carved out of KanCare. In the first scenario, if the State takes over care coordination services, she indicated over $180 million in additional care and staffing costs would be incurred over five years, and over 400 staff would be needed to perform services and manage recipients. In the second scenario, if care coordination services go back to pre-KanCare levels, over $340 million in additional care and staffing costs would be incurred over five years.

Secretary Mosier addressed the active backlog and stated the active backlog was approximately 800 as of the last CMS report. The report appears to show 1,970 applications are backlogged; however, there were 482 applications pending and awaiting additional information from the applicant. She stated there were approximately 700 applications designated as “information received on denial.” If an individual applies and is denied, then reapplies, the system reports the original application date, not the date of the new application.

Secretary Mosier stated KDHE and the KEES vendor (Accenture) have developed and implemented 17 major system enhancements to KEES to improve system performance across the functional areas of eligibility, customer service, imaging, data entry, and registration.

Secretary Mosier next reported on staffing. She stated the Clearinghouse vendor (Maximus) added 40 temporary staff for calendar year 2016 with an additional 70 staff added in July. Fifty of these staff are specifically trained to process family medical applications. This additional staff will also mitigate federally facilitated marketplace applications (FFM) from creating a backlog.

Secretary Mosier stated the State has augmented staff by 20 temporary workers. Twelve of these staff are registering FFM applications during the Affordable Care Act open enrollment period, and staff are working overtime as needed.

Secretary Mosier explained there have been several internal and external process improvements. Externally, KDHE worked with process experts to assess work flow and identified and implemented a number of short-term and long-term improvements. The Clearinghouse vendor installed a new call management system that better serves beneficiaries. Since February 2016, the overall average speed to answer calls has declined from 27 minutes to about 46 seconds, and the maximum wait time has declined from over 1 hour and 22 minutes to less than 11 minutes. A graph was provided illustrating the number of legislative constituent inquires. It showed the number has decreased.

Graphs were included addressing backlog trends, trends for pregnant women, pregnant women facts, and trends for newborns. Secretary Mosier stated 70 percent of pregnant women cases are processed in less than 10 days, 96 percent of pregnant women cases are processed in less than 30 days, and 4 percent of the cases are on hold waiting for additional information from the applicant.

She said pregnant women who meet the criteria for presumptive eligibility will receive coverage for prenatal and emergency room visits until a final determination has been completed. The hospitals and clinics that have completed or scheduled training for the Presumptive Eligibility System represent 12 percent of Medicaid births in 2015. KDHE is in the process of enrolling and training additional hospitals in the Presumptive Eligibility System.

Secretary Mosier stated 94 percent of all newborn cases are processed within 20 days, 78 percent of those are processed in less than 10 days, and 6 percent are waiting additional information from the applicant.

Secretary Mosier referred Committee members to a number of documents for their review which cover a KanCare eligibility improvement overview, training and system enhancements, and a KanCare Executive Summary (Attachments 29, 30, 31, 32, and 33).

Chairperson Hawkins opened the meeting for questions.

A Committee member asked if additional services are provided to clients *via* KanCare, how does that affect the institutions available to assist these clients. Secretary Mosier responded one of the goals of HCBS and KanCare is to try to keep people in their communities rather than admit them to an institution.

A Committee member, referring to slide 16 of Secretary Mosier's presentation, asked how many applications the Clearinghouse processed in a calendar year. Secretary Mosier responded there were approximately 11,000 to 12,000 per month plus another 14,000 during open enrollment. The Committee member referred to the 482 pending unprocessed applications and asked how long they had been waiting for approval. Secretary Mosier responded she would provide this information to the Committee at a later date. Regarding denials, information is tracked from the original date; however, CMS does not count backlog until the time all of the necessary information has been received. The Committee member stated the information received from the nursing homes does not match with the information provided in the chart concerning backlog and the time frame for receiving eligibility approvals. The Committee member questioned whether future applications scheduled for KEES should be postponed, given the current problems with the system. Secretary Mosier responded a decision to move forward with implementing additional applications (Phase 2 and Phase 3) for KEES will be made only if the analysis indicates the KEES system and staff are ready.

Another Committee member referred to the testimony received from conferees about the long period of time it has been taking to receive eligibility approvals. The Committee member said it would seem from the report provided to the Committee that there is not a backlog problem. Secretary Mosier responded backlogs still exist; however, significant progress has been made in reducing the level of backlogs. The Committee member said this is not what she has been hearing from the constituents so there is a discrepancy in the data. Secretary Mosier requested the Committee member refer problems directly to her so they can be addressed.

Chairperson Hawkins asked if Secretary Mosier would like Committee members to forward all the e-mails to her that Committee members receive concerning problems with the system, and she responded affirmatively. She indicated she is very serious about working together to resolve these issues.

A Committee member referred to the information provided by the Legislative Division of Post Audit (LPA) report and the figures shown on slide 22 of Secretary Mosier's presentation and noted the large discrepancy in the backlog numbers. She requested Deputy Secretary Aaron Dunkel respond to the question. He explained the numbers from the LPA report were from an Operations and Management Report (OMR), while the numbers shown in this presentation were for CMS reporting as was requested by CMS. Some of the items in the OMR numbers are not in the CMS numbers. For example, he said the Supplemental Security Income (SSI) determination applications are not included in the over 45 days number reported to CMS. The Committee member requested information on the SSI numbers and Deputy Secretary Dunkel responded the numbers would be provided to the Committee at a later date. The Committee member expressed frustration in the backlog issue and in receiving accurate information about it.

Chairperson Hawkins said Committee members are trying to get answers so they can respond to inquiries from their constituents regarding the eligibility system and the backlog issues. He indicated prior to the implementation of KEES, Committee members were not being notified of problems, and now they are hearing about massive problems. He questioned whether there would be a long-term structural backlog. Secretary Mosier responded there were problems with the transition to KEES; however, there will always be a certain level of backlog.

Chairperson Hawkins stated his intent to recommend applications over 45 days need to be escalated and worked on until they have been resolved. He suggested a team be

established with the task of resolving this backlog. Secretary Mosier reported that as of August, changes had been made to focus more intently on the resolution of problem applications.

Chairperson Hawkins said he heard some of the Clearinghouse staff are very ingenious on finding work-arounds for KEES; therefore, he questioned the plans to implement Phase 2 of KEES.

Another Committee member questioned why KDHE would move to Phases 2 and 3 of KEES when there are issues with Phase 1 that have not been addressed. Secretary Mosier responded she believed the updates scheduled for April for KEES will only be implemented if there are no significant problems with the current system.

A Committee member asked Secretary Mosier whether KEES would ever work as it was designed and asked what the system had cost. She responded she believes KEES will work as designed, and she will get back to the Committee concerning the cost of the system.

A Committee member, again referring to slide 16 of the presentation, asked Deputy Secretary Dunkel for information concerning the backlog for nursing home applications. Deputy Secretary Dunkel responded this information would be provided to the Committee at a later date.

Referring to slides four through nine, a Committee member requested Secretary Mosier provide the number of people involved in the percentage improvements shown in the report. The Committee member asked how much money would be saved if waivers were carved out of the managed care system. Secretary Mosier stated the answers to these questions would be provided to the Committee at a later date. The Committee member asked how many Department for Children and Families staff were assisting with the backlog, and Secretary Mosier indicated there had been about ten people.

There was discussion concerning the criteria for presumptive eligibility for pregnant women. The Committee member requested a break down of Medicaid births by region in Kansas.

A Committee member expressed concern about what might happen if KDHE is requested to reduce the budget by an additional 5 percent and asked Secretary Mosier to take the initiative to evaluate the budget and provide some examples of what might be cut should the 5 percent reduction be required. Deputy Secretary Dunkel said he could not provide information without further study of the situation.

Chairperson Hawkins indicated he would be in favor of a carve out in which there would be a single source MCO to take care of all of the I/DD community. He also said he would not be in favor of adding a fourth MCO as has been suggested by the Administration and others. However, he said using a fourth MCO for the I/DD community as a single source might be helpful and asked Secretary Mosier if she would be willing to look at this suggestion. She responded she was willing to look at all options that would improve service.

Chairperson Hawkins recognized Mike Randol, Director of Health Care Finance, KDHE, who began his remarks concerning the information provided on page 27 of the presentation regarding an on-site CMS review which was conducted on October 24, 2016. He also reviewed slides relating to: MCO financial status update, nursing facility advanced payments, step

therapy, and KanCare 2.0. Director Randol reported that due to the upcoming transition in administration in Washington D.C., issuance of the the request for proposal for KanCare 2.0 would be delayed to accommodate any changes that may occur due to the transition. He reported there are no plans to move forward with any activity on waiver integration. The focus will be on KanCare 2.0 with a target implementation date of January 1, 2018.

Chairperson Hawkins requested a report on step therapy be provided to the Committee on the first week of January, including information on any challenges that have occurred with the implementation of step therapy.

There was discussion concerning the scope of the information provided concerning nursing facility advanced payments on slide 29. Director Randol indicated he was willing to work with any nursing facility to review and resolve pending applications and payments.

A Committee member requested, in the future, to be provided a list of the reasons for denials of nursing home facility advanced payments.

A Committee member asked the status of receiving another fall risk management (FRM) rate. Director Randol replied another FRM rate would be received in 2017.

There were no other questions.

Chairperson Hawkins recessed the meeting at 1:00 p.m. to be reconvened at 2:15 p.m.

Afternoon Session

Update on Osawatomie and Larned State Hospitals; I/DD HCBS Waiver Update/Long-Term Services and Supports (LTSS); Waiting Lists Updates

Chairperson Hawkins reconvened the meeting at 2:23 p.m. and recognized Tim Keck, Acting Secretary for Aging and Disability Services, who provided an update on the status of various programs at Osawatomie State Hospital (OSH) and Larned State Hospital (LSH). The report included information on state hospital weekly vacancy rates and state hospital bi-weekly hours and cost of overtime (Attachments 34 and 35).

Acting Secretary Keck reported morale at the hospitals has improved. He said they are ready for recertification at OSH and are awaiting CMS to complete the recertification review. He indicated KDADS has been working with Valeo Behavioral Health Care on a patient transition program. He referred to a request for proposal being distributed concerning potential privatization models for operation of the state hospitals.

A Committee member stated it was his opinion privatization might not be beneficial based on the problems experienced with KanCare.

Another Committee member commended Acting Secretary Keck for investigating the privatization model.

A Committee member asked if there was a time line concerning the recertification process for OSH. Acting Secretary Keck responded CMS has not provided a time line for completion.

KDADS Update on State Fiscal Year 2017 First-Quarter Report on Average Daily Census for State Institutions and Long-Term Care Facilities

Chairperson Hawkins recognized Brandt Haehn, Commissioner of HCBS Division, KDADS, who provided information on the following topics:

- I/DD waiting list;
- CMS request for accountability of wait list;
- Autism services;
- Serious emotional disturbance; and
- Average monthly caseload for state institutions and long-term care facilities (Attachment 36).

Several Committee members requested clarification concerning the residential service pay policy.

There were no other questions.

KanCare Ombudsman Update

Chairperson Hawkins recognized Kerrie Bacon, KanCare Ombudsman, who shared information regarding the activities of the Ombudsman Office for the third quarter of 2016 and an update on the Ombudsman Volunteer Program. She referred members to the document outlining the core elements of the KanCare Ombudsman position. She also provided copies of the following documentation for Committee members' reference as they work with their constituents to address issues (Attachments 37, 38, and 39):

- Ombudsman contact information;
- KanCare grievance, appeals, and state fair hearing process;
- Medicaid grievances and Medicaid hearings;
- Spend down fact sheet;
- Estate recovery fact sheet;
- Application packet for elderly and disabled;
- Application packet for children and families; and
- Application for Medicare savings program.

Chairperson Hawkins asked Ms. Bacon to review her staff level. She stated she has one staff person in Topeka, a part-time staff person in Wichita and two satellite offices with ten volunteers.

Chairperson Hawkins asked whether the task of the Ombudsman Office is to resolve problems or to serve as an information resource. Ms. Bacon responded the Office does both. She said she prefers helping people help themselves, by providing them with resource information and letting them proceed forward.

A Committee member asked Ms. Bacon if she was an attorney, and she indicated she was not. He stated a concern that she worked for an agency for which the issues arise and that the ultimate people responsible were the same people who paid her salary. He indicated another criticism was that a true Ombudsman advocates for the clients rather than only providing resource information.

A Committee member said based on feedback she has received, she did not think the Ombudsman Office has at times handled issues aggressively enough.

A Committee member requested a copy of the mission statement and position description for the Ombudsman position. Ms. Bacon responded she would provide the information to the Committee at a later date.

Chairperson Hawkins told Ms. Bacon she was doing what she was assigned to do; however, the Committee members may have some recommendations concerning the duties of the position.

Agencies' and MCOs' Response to Stakeholders' Concerns

Chairperson Hawkins recognized Laura Hopkins, Chief Executive Officer, Amerigroup Kansas Plan, who responded to a concern raised about out-of-network payments if facilities had changed ownership. She stated Amerigroup pays 100 percent of Medicaid, understanding that the change in ownership is out of Amerigroup's control. She said there were some concerns raised by the pharmacists about the availability of medication therapy management, and she confirmed that is a billable service.

Ms. Hopkins said there were concerns about the availability of Amerigroup's Medical Directors. She indicated they spend much of their time on proactive outreach with other physicians, taking calls, etc. She provided their names and phone numbers as follows:

- Dr. Joe Schlageck, Chief Medical Director, 913-563-1637;
- Dr. Rex Joyce, Associate Medical Director, 913-563-1605; and
- Dr. Bill Mack, Psychiatrist, 913-563-1636.

Ms. Hopkins said there were some concerns from HCBS providers about not receiving copies of Notices of Action or changes in Service Plans. She said these should be sent out 100 percent of the time, and she would like to be notified if that is not the case. Her telephone number is 913-563-1604.

Ms. Hopkins said there were concerns about the need for value-based purchasing, and she said Amerigroup is heavily engaging in value-based purchasing.

Chairperson Hawkins recognized Chris Coffey, Health Plan President and Chief Executive Officer, Sunflower State Health Plan, who reported there have been improvements in the approval rate and timeliness of claims. He indicated Sunflower has been averaging about a 15 percent overall claim denial rate. He said Sunflower is open to a higher level of standardization and to methods of reducing the administrative burden. Sunflower is interested in changes in the credentialing process. Mr. Coffey discussed some of the audit methods utilized to oversee the work performed by Sunflower.

Chairperson Hawkins recognized David Rossi, Chief Operating Officer, UnitedHealthcare Community Plan, who reported UnitedHealthcare has nurses, care coordinators, and social workers performing assessments in nursing facilities to assure their members are receiving quality care and to identify any required support needs of the members. He stated UnitedHealthcare utilizes value-based contracting and customer satisfaction surveys.

No state agency responses were offered at this time.

MCO Presentations

Chairperson Hawkins recognized Mr. Rossi, who introduced Dr. John Esslinger, Chief Medical Officer, and Gerald Snell, Manager of Foster Care Programs, UnitedHealthcare Community Plan (Attachments 40, 41, and 42).

Mr. Rossi stated UnitedHealthcare focuses on the whole person needs of individuals, their families, and their care teams. UnitedHealthCare is working toward stronger provider collaboration and administrative simplification, working directly with providers and associations. UnitedHealthcare assists members and their families with options for right time and right place housing and living arrangements, and has continued to focus on transitioning members to community based settings, when appropriate.

Dr. Esslinger stated UnitedHealthcare's focus on collaboration with physicians is key to building a better health care system and better health care outcomes. The focus is on population health management rather than the fee-for-service mentality. He discussed patient-centered incentive programs being utilized by GraceMed and Flint Hills Community Health Center. These incentive programs promote preventative care, increasing healthy behaviors, improving quality outcomes, and decreasing non-emergent emergency room use and unnecessary hospitalizations.

Mr. Snell addressed some of the special needs of foster care members. He discussed the My Journey program, which is a program for transition-aged youth in Wichita designed and built in partnership with Young People in Recovery with a focus on creating positive peer relationships and building life and health management skills. He said UnitedHealthcare also has a specialized service coordination approach in which the team works to ensure the foster care youth are receiving all the primary preventative community based services which they need to be able to remain in their current placement and to avoid unnecessary episodes of in-patient care or residential treatment. Mr. Snell stated UnitedHealthcare has partnered with the National Foster Parent Association to design, develop, and deliver training that will support UnitedHealthcare Community Plan of Kansas staff develop and/or strengthen a basic understanding of the foster and adoptive individual and family experiences. UnitedHealthcare is committed to ensuring the needs of foster care members are met.

The UnitedHealthcare testimony included charts covering the following information:

- Claims processing turnaround time (all providers);
- Claims processing turnaround time (HCBS providers only);
- Prior authorization volume; and
- Claims denials - total volume (all providers).

Chairperson Hawkins opened the meeting for questions.

A Committee member stated her support of the My Journey program.

A Committee member asked how long the foster care programs have been in place. Mr. Snell indicated, while they have provided foster care services in the past, they have increased the level of programs and support over the past year.

Chairperson Hawkins recognized Mr. Coffey, who highlighted that Sunflower achieved "Commendable" accreditation status following final Healthcare Effectiveness Data and Information Set (HEDIS) rates for measurement year 2015. He stated Sunflower Health Plan also was the recipient of the 2016 DisAbility Champion Award for its commitment to employing individuals with disabilities, as well as noteworthy programs and initiatives supporting employment practices (Attachments 43 and 44).

Mr. Coffey's testimony included information concerning:

- Clinical outcomes with LTSS integration;
- HCBS waiver enrollment;
- Member satisfaction;
- Employment; and
- Sunflower Health Plan 2016 report card.

There were no questions for Mr. Coffey.

Chairperson Hawkins recognized Ms. Hopkins, who discussed information on the following topics (Attachments 45 and 46):

- Operational performance;
- Provider engagement;
- Consumer engagement and quality; and
- Community engagement.

Ms. Hopkins and Kyle Kessler, Executive Director of the Association of Community Mental Health Centers of Kansas, discussed Amerigroup's CMHC collaboration model. She said at the end of 2015, Amerigroup began exploring how their organizations could work more effectively together to address the opportunities to improve outcomes for their collective consumers. Ms. Hopkins stated the collaboration has already driven a number of operational improvements including:

- Reduction of prior authorization requirements;

- Development of a daily census report that helps Amerigroup better support KanCare participants experiencing a psychiatric hospitalization;

- Amerigroup is planning to develop additional capabilities that may include;

    - Evolution of the Quality Incentive Program;
    - Enhanced service array achieved through value-added or other services; and
    - Collaborative data modeling to drive future improvements.

A Committee member requested actual numbers be provided where percentage increases were referred to in the testimony.

Chairperson Hawkins recognized Deputy Secretary Dunkel, who addressed questions from Committee members concerning KDHE's earlier testimony. He referred to slide 4 concerning alcohol and drug dependence and said there were 421 people served in 2013 and 613 in 2014. He said the denominator in the equation would be 841 in 2013 to 1202 in 2014. Concerning well child visits, there were 36,523 in 2013 and 39,484 in 2014.

Deputy Secretary Dunkel said KDHE set a number of service goals very aggressively and believes there has been good improvement made on services provided with KanCare.

The Committee received two documents containing information from KDHE and KDADS concerning questions from Committee members (Attachments 47 and 48).

Committee Discussion on Report Recommendations

Chairperson Hawkins asked Committee members for their recommendations for the Committee report. He offered the following recommendation (Attachment 49):

- The Secretary shall develop standards to be utilized uniformly by each MCO serving the state of Kansas pursuant to a contract with the Kansas Medical Assistance Program for each of the following;

    - Documentation to be provided to a health care provider by any MCO when it denies a claim for reimbursement submitted by such provider. Denial reason codes must be Health Insurance Portability and Accountability Act (HIPAA) compliant and MCOs must consistently apply denial reason codes in the same manner to ensure accurate reporting to the state;
    - Documentation to be provided to a health care provider by any MCO when recoupments are made pursuant to a post pay audit of such provider, to include transparency of methodology used in the audit and a specific explanation of the reason for recoupment. MCOs may not

arbitrarily remove codes (*e.g.* ICD-10, CPT, DRG) submitted by the provider or change the level of care provided to reduce payment without using the proper appeal protections in place;

- The Secretary shall complete a quarterly review of claims denials and appeals to determine;
    - If a high percentage of denials are overturned on appeal and if so, address the issue with the MCO(s); and
    - If a certain procedure or codes are denied more often than others, whether or not those denials are appropriate and address the issue with the MCO(s).

A Committee member asked Chairperson Hawkins to explain the proper appeal protections that were in place. Chairperson Hawkins replied he was not familiar with the appeal protections. He said the purpose of the recommendation was to give the providers more protection from things being changed arbitrarily.

Chairperson Hawkins moved, seconded by Senator O'Donnell, to pass the recommendation.

A Committee person asked if this recommendation was addressing the diagnosis related group (DRG) issue. Chairperson Hawkins responded affirmatively.

The motion passed.

Chairperson Hawkins moved, seconded by Senator Kelly, that legislation be introduced by the Health Committees to work on the Mental Health 2020 Initiative plan from the CMHC's. The motion passed.

Chairperson Hawkins moved, seconded by Representative Ballard, that a notice of a right to appeal be sent to individuals who were assessed under the Capable Person Policy, as it is written in the current Waiver and implemented by the MCOs, and as a result had their plan of care adversely affected.

Chairperson Hawkins stated the reason for the recommendation is for the many people who do not understand that they have a right to appeal Capable Person Policy decisions. If a notice is sent providing them an opportunity to learn they have a right to appeal, then they can exercise that right if they choose to do so.

Senator Kelly asked if the recommendation was in the form of legislation. Chairperson Hawkins replied is was in the form of a recommendation to KDADS.

Senator Kelly moved to amend the motion for recommendation regarding the Capable Person Policy to state in addition to notification to request needs assessment, detailed specific action is included for what is needed to make the request. In addition, she requested a date certain be added to assure it is completed in a timely manner.

Chairperson Hawkins said he approved the amendments to his motion. *He stated a substitute motion has been presented by Senator Kelly to add that KDADS provide the details*

and specific action that a person needs to make the request and that the correspondence be sent out no later than December 15, 2016. Chairperson Hawkins and Representative Ballard approved the amendment to the original motion. The substitute motion passed.

Chairperson Hawkins recognized Senator Denning who suggested eight recommendations (Attachment 50).

Senator Denning moved, seconded by Senator Kelly, that eligibility applications over 45 days aging be sent to a team formed exclusively to get applications through the process and finished. KDHE should set a goal that 75 percent of long-term care applications be cleared in the first 45 days. KDHE submit a monthly progress report to the Committee.

Representative Ward asked why the recommendation was limited to only long-term care applications. Senator Denning replied, from the information presented, he was comfortable that at least 90 percent of the medical applications were clearing within 45 days, and the real problem was with the long-term care applications.

Senator Kelly asked if the goal of 75 percent of the applications be cleared within 45 days was an initial goal toward a higher percentage to eventually be cleared within the 45 days. Senator Denning replied it was his understanding that before the implementation of KEES that at least 50 percent were cleared in that time frame, so he chose 75 percent as a goal to strive for.

The motion passed.

Senator Denning moved, seconded by Representative Ballard, that all MCOs should work together to develop one standardized credentialing application. MCOs will respond to all submissions within 15 working days. MCOs should use a Council for Affordable Quality Healthcare (CAQH) portal for processing credentialing applications.

Senator Kelly made a substitute motion to change the word "should" to "shall" concerning MCOs working together to develop one standardized credentialing system. Senator Denning seconded the substitute motion.

Senator Kelly requested clarification from Senator Denning concerning the request for MCOs to respond to all submissions within 15 working days.

The substitute motion passed.

Senator Denning moved, seconded by Representative Ballard, that the 4 percent Medicaid reimbursement cut and corresponding policies be reversed.

Senator Ballard asked whether this would assist the pharmacists and enable them to continue to provide the value added services to their mental health patients. Chairperson Hawkins stated this would roll back the cuts experienced by the pharmacists. He indicated this proposal would roll back all of the Medicaid reimbursement cuts made by the Governor.

Representative Ward expressed his hope that Committee members would vote for what is needed to provide the funds to fix the problem. Chairperson Hawkins stated he was working on legislation to do so.

The motion passed.

Senator Denning moved, seconded by Representative Dove, to extend the current 1115 Waiver for 1 year and delay the RFP until the state clearly understands federal changes to the Affordable Care Act and Medicaid. The motion passed.

Senator Denning moved, seconded by Representative Carpenter, that KEES not be expanded to Phase 3 until there has been a clear demonstration of system functionality and operational integrity is determined and all problems have been resolved. LPA will update the Information Technology (IT) audit on KEES in December 2015 and report satisfactory performance before Phase 3 expansion can occur.

Senator Kelly said she was not sure the Committee could order LPA to perform a function but the Committee could request it. Chairperson Hawkins agreed the Committee could make the request.

Senator Kelly made a substitute motion, seconded by Representative Carpenter, to request LPA update their IT audit on KEES. The substitute motion passed.

Senator Denning moved, seconded by Representative Ballard, that KDADS would investigate the newly published Institution for Mental Disease Policy rules, to enhance the care to Kansas mental health patients.

Senator Kelly asked if this has anything to do with the issue of termination versus suspension of Medicaid benefits. Senator Denning said it did not. He said it has to do with Medicaid patients being able to go into a mental health hospital with more than 16 beds.

The motion passed.

Senator Denning moved, seconded by Senator Kelly, that all uncompensated care numbers presented to the Committee be based on 100 percent of Medicare allowable. The motion passed.

Senator Denning moved, seconded by Senator Kelly, that MCOs report to the Committee on first pass denial rate.

Senator Kelly requested Senator Denning explain the meaning of a first pass denial rate.

The motion passed.

Chairperson Hawkins asked for further recommendations

Representative Ballard asked whether any of the recommendations would benefit rural nursing homes. Senator Denning said he believes the first recommendation he suggested and subsequently passed would be of benefit.

Senator Kelly moved, seconded by Senator LaTurner, to require notices of changes to a Plan of Care be provided to both individuals and providers. The motion passed.

Senator Kelly moved, seconded by Representative Ballard, to standardize the under- and over-payment process. The motion passed.

Senator Kelly moved, seconded by Representative Ballard, that the structure of the Committee revert to the original structure that was put in place when the Committee was changed from the Joint Committee on Home and Community Based Services to the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight.

She explained the difference is that the Committee originally was an eleven member Committee with four democrats (two from the House and two from the Senate) and seven republicans (four from the House and three from the Senate). When the change in Committee structure occurred, the second democrat from the Senate was removed. She said the original structure was put in place to assure there would be representatives from both the Appropriations Committee and the Health Committee from both chambers. She stated she is currently on both committees; however, this may not always be the case.

Senator Denning indicated he would not support the recommendation as he thought the current make up of the Committee has worked well. He suggested a better format for the change might be in a bill format.

Senator Kelly said this would make the Committee more like a standard Committee.

The motion failed.

Senator Kelly moved for the creation, funding, and staffing of an independent office of the Inspector General. There was no second and Senator Kelly withdrew the motion.

Chairperson Hawkins asked if there were any other recommendations and there were none.

Approval of August 4, 2016, and August 5, 2016, Minutes

Senator LaTurner moved, seconded by Senator Kelly, to approve the minutes from August 4, 2016, and August 5, 2016. The motion passed.

Adjourn

Chairperson Hawkins expressed his appreciation to Committee members and meeting attendees. The meeting was adjourned at 5:05 p.m.

Prepared by Debbie Bartuccio
Edited by Erica Haas

Approved by the Committee on:

January 5, 2016