State of Kansas

Jim Ward

House Democratic Leader

February 8, 2018

To: Chairman Hawkins and House Health & Human Services Committee Members

From: Rep. Jim Ward, House Minority Leader

RE: Proponent testimony for HB 2591

Chairman Hawkins and Legislative Colleagues:

Thank you for discussing House Bill 2591. This bill would extend the current Kansas Medical Assistance Program (KanCare 1.0) until January 1, 2022, with no changes in eligibility requirements or limitations to receive State Medicaid Services.

I am requesting this committee make changes to the bill. First, add language prohibiting the inclusion of work requirements; prohibiting any premium requirements for beneficiaries; and prohibiting lifetime caps on services in the Kansas Medicaid program without prior specific legislative approval of these elements. Make the bill effective upon publication in the Register. Finally, make the time of extension for the current Kansas Medical Assistance Program (KanCare 1.0) two (2) years.

The Kansas Medicaid program is in crisis. I have sat on the KanCare Oversight Committee since its inception and heard many, many horror stories. Hospitals, nursing homes and other health providers have great difficulty getting timely payments for services. Eligible Kansans needing health care have faced long waiting lists. KanCare has presented eligible people needing health care unclear and difficult application procedures. There is currently little real help to Kansans trying to navigate the various challenges presented by the different procedures of the Managed Care Organizations. I have also attached a letter sent from CMS sent to the Kansas Secretary of Health and Environment in January 2017 outlining several significant deficiencies in our Medicaid

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program. We passed legislation in 2017 directing KDHE to address concerns raised in the CMS letter.

Extending the current Kansas Medical Assistance Program (KanCare 1.0) for 2 years, prohibiting work requirement, premium requirements or lifetime caps on services are the right steps to fixing Medicaid in Kansas.

I will stand for questions. Thank you for your time today.

Exhibit # 1

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations

January 13, 2017

Susan Mosier, M.D.
Secretary and State Health Officer
Kansas Department of Health and Environment
Curtis State Office Building
1000 SW Jackson Street, Suite 340
Topeka, KS 66612

Dear Dr. Mosier:

This letter addresses the Kansas Department of Health and Environment's (KDHE) noncompliance with the requirements of the KanCare program, authorized under Section 1115 of the Social Security Act (the Act), provisions of Kansas' Home and Community-Based Services (HCBS) waivers, and Federal Medicaid statute and regulations. This noncompliance, which is detailed in the enclosed KanCare Findings and Recommendations Report, places the health, welfare, and safety of KanCare beneficiaries at risk and requires immediate action.

The KanCare program establishes a managed care delivery system through a combination 1115/1915(c) waiver for nearly all of the 425,564 Medicaid and Children's Health Insurance Program (CHIP) beneficiaries in Kansas. KanCare's average annual costs total $3.4 billion.[1] The combined nature of the program means that some of the State's most vulnerable and medically complex individuals are enrolled in managed care, such as those living in nursing facilities or enrolled in HCBS waivers.

Throughout 2016, CMS received a significant number of complaints and concerns regarding the KanCare program from beneficiaries, providers, and advocates. In response, CMS reviewed information concerning the reported issues, discussed systemic concerns with State staff, and engaged State representatives to remediate individual cases as appropriate. Ultimately, CMS conducted an on-site visit from October 24, 2016 to October 27, 2016. The on-site review consisted of interviews with State agencies responsible for the KanCare program; interviews with staff of Amerigroup Kansas, Inc., Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas, the three KanCare managed care organizations (MCOs); and three stakeholder listening sessions with KanCare beneficiaries and families, providers, and advocacy groups. Additionally, CMS requested documentation both prior to and after the onsite. Our review of the provided documentation substantiated concerns

[1] *Kansas Department of Health and Environment. State Fiscal Year 2016. Kansas Medical Assistance Report (KMAR). Retrieved from:* http://www.kancare.ks.gov/policies-and-reports/medical-assistance-report

across the program. For example, the levels used by each of the three MCOs to categorize critical incidents vary, resulting in inconsistent reporting to the State.

- The State's oversight of the MCOs has diminished over the four years of KanCare operation, as evidenced by its annual onsite reviews of the MCOs and subsequent reports. The 2013 annual report was a comprehensive document, and corrective action plans were issued to the MCOs regarding identified issues. The 2014 and 2015 annual reports were each two pages long, with little content of substance.
- Public feedback consistently describes a lack of engagement and adversarial communication from the State. Comments from KanCare stakeholders at multiple stakeholder sessions overwhelmingly reflect an inability to obtain clear and consistent information from the State and MCOs, making it difficult for KanCare enrollees to navigate their benefits.
- Stakeholders further noted that the State often does not respond to public comments or include changes in final policy documents to address public comments. The State maintains the KanCare Advisory Committee, and the MCOs each maintain an advisory board, but these committees do not meet all applicable requirements. Furthermore, committee members indicated that the committee meetings did not provide opportunities for meaningful public input.

Person-Centered Planning Process: 42 C.F.R § 441.301(c); 42 C.F.R § 441.725(b)

CMS requires that service plans for each participant in Medicaid HCBS programs be developed through a person-centered planning process that reflects the beneficiary's individual preferences and goals. The rules require that the person-centered planning process is directed by the participant, and may include other individuals as chosen by the participant. This planning process, and the resulting person-centered service plan, assist the participant in achieving personal outcomes in the most integrated community setting, ensure delivery of services that reflect personal preferences and choices, and help assure the participant's health and welfare.

- CMS uncovered significant compliance deficiencies with the person-centered planning process, which included: MCOs requesting participants sign incomplete forms without the number of hours or types of services they would receive; MCOs revising person-centered plans without the participant's input; and MCOs failing to ensure provider signatures on person-centered plans as required.
- One MCO indicated that while a service plan is developed for each waiver participant within 14 days of entering the waiver, the required person-centered plan is not developed until 3 to 6 months after services are authorized. The delayed completion of the person-centered plans compromises safeguards meant to ensure that waiver services and supports reflect participants' individual preferences and goals.
- None of the MCOs have processes in place that ensure all final service plans are signed and agreed to by the participant or that the participant receives a copy of the final plan. All three MCOs described processes that required participants to sign "interim" or "proposed" plans that were then reviewed and possibly revised by a utilization review committee within the MCO. If changes were made, MCOs attempted to obtain participant signatures on the final plans; but MCO staff stated they are not always successful in obtaining those signatures.

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- None of the three MCOs currently require the signature of providers responsible for plan implementation, as required by 42 C.F.R. § 441.725(b)(9). The lack of member and provider signatures jeopardizes waiver participants' understanding of the services they should be receiving, and delivery of those services by providers.

Provider Access and Network Adequacy: 42 C.F.R § 441.730; 42 C.F.R. § 438.206
CMS requires States to ensure that each MCO maintains a network of providers that is sufficient to provide adequate and timely access to Medicaid services covered under the contract between the State and the MCO.

- The State's approach to tracking, monitoring, and overseeing provider network adequacy and access to care for KanCare consumers is limited. Given that KanCare serves nearly all Medicaid and CHIP beneficiaries, many of whom live in rural and frontier areas known to be underserved, CMS would expect a more robust oversight process including proactive monitoring of the number of providers enrolled in each MCO's network in regions with known access issues.
- MCOs must submit multiple reports to the State regarding access to care. However, there seemed to be little analysis or trending based on these reports at the State level. CMS staff have asked KDHE staff multiple times in late 2016 for the State's analysis of network adequacy. Although KDHE provided MCO provider network reports in response to these requests, CMS has never received any evidence of the State's analysis of network adequacy.
- The provider network data produced by the MCOs for much of 2015 contained incorrect and inconsistent information on provider specialties related to HCBS, making the data not useful for analyzing trends in HCBS provider network adequacy. The MCOs report that the data now being reported is correct, after a data clean-up effort in 2015.
- This lack of oversight and reliable data makes it difficult to determine whether sufficient providers are in the networks to serve enrolled beneficiaries, and to effectively track the impact of policy changes on provider networks.

Participant Protections: 42 C.F.R. § 438.100; 42 C.F.R. § 441.301(c)(2)(xiii); 42 C.F.R. § 441.302; 42 C.F.R. § 438.440
States are required to ensure that managed care enrollees are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. To obtain HCBS waivers, States must assure CMS that necessary safeguards are in place to protect the health and welfare of beneficiaries and that any modification to an individual's freedoms meets specific requirements and is fully documented in the person-centered service plan. Finally, CMS requires that States and MCOs provide information to enrollees regarding grievance, appeal, and fair hearing procedures and timeframes, using a State-developed or State-approved description.

- Staff of one MCO mistakenly believed that use of restrictive interventions were not permitted in any of Kansas' HCBS waivers. However, two waivers allow for restraints, restrictions, and/or seclusion in certain circumstances. Because this MCO did not correctly understand the rules around restrictive interventions, they did not document rights restrictions in the person-centered plans as required.

Therefore, safeguards to protect beneficiaries' health and welfare with regard to restrictive interventions could not be carried out.

- The State does not have a comprehensive system for reporting, tracking, and trending critical incidents. MCO staff indicated that there was no formal, systematic process for them to report critical incidents, or resolution of critical incidents, for their members to the State; rather, they would call or email State staff to report such incidents. Recent HCBS reports provided no data to demonstrate that unexpected deaths were investigated within required timeframes; that reviews of critical incidents were initiated and reviewed within required timeframes; that the use of restraints, seclusion, or other restrictive interventions followed procedures as specified in the approved waivers; or that the unauthorized use of restrictive interventions was detected. The lack of oversight of critical incidents increases the risk that waiver recipients' rights, health, and safety could be in jeopardy.
- During the implementation of KanCare, the State permitted the MCOs to develop their own provider appeal processes. However, according to Federal rules, those processes should have been developed or approved by the State. The State recognized that difficulties resulted from the differing provider appeal processes, and asked the MCOs to develop one standardized process in late 2015. Until the new process is implemented, the MCOs continue to use differing provider appeal processes, creating administrative burden for providers who must navigate three different appeal processes.

Due to the severe and pervasive nature of the on-site review findings and the resulting impacts this has on the beneficiaries and providers, CMS is requiring Kansas to develop a Corrective Action Plan (CAP) describing the actions it will take to correct the identified noncompliance. KDHE must submit the CAP to CMS as soon as possible, and no later than February 17, 2017. The CAP must include a detailed plan addressing each of the findings identified in the attached report. The CAP must also include the milestones and dates specifying when the actions will be fully implemented; their impact on the health, welfare, and safety of waiver participants; and a strategy for ongoing review and monitoring of the KanCare program. CMS expects the State agencies responsible for the KanCare program to implement the CAP in an expeditious and transparent manner which includes engaging stakeholders on changes and planned changes. Implementation of the CAP, once approved, will be monitored by CMS.

Federal regulations at 42 C.F.R. § 430.35 allow CMS to withhold Federal Financial Participation payments from a State after a finding that the State's plan fails to comply, or to substantially comply, with the provisions of section 1902 of the Act. In the event that Kansas fails to: 1) submit the required CAP in the indicated timeframe, 2) submit a CAP that is sufficient to mitigate the issues, or 3) implement and monitor the CAP as approved by CMS, we plan to initiate formal compliance action as described in 42 C.F.R. § 430.35, including financial sanctions of State administrative funds. Kansas' execution of the CAP and measured performance improvement will ultimately inform the extension of Kansas' 1115 demonstration program , as well as future managed care contracts and 1915(c) waiver actions. KDHE is entitled to appeal the findings of noncompliance pursuant to the procedures set forth at 42 C.F.R. Part 430, Subpart D.

If you have any questions regarding this matter, please contact me at (816) 426-5925 or via email at James.Scott1@cms.hhs.gov.

Sincerely,

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

cc:
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