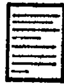
 **DRAFT**

Report of the Joint Committee on Home and Community Based Services Oversight to the 2012 Kansas Legislature

Chairperson: Senator Carolyn McGinn

Vice-chairperson: Representative Bob Bethell

Other Members: Senator Laura Kelly, Kelly Kultala, and Dwayne Umbarger; and Representatives Barbara Ballard, David Crum, Jerry Henry, and Brenda Landwehr

Statutory Charge

- To help ensure long-term care services, including home and community based services, are provided through a comprehensive and coordinated system throughout the state, the Committee is to oversee the savings resulting from the transfer of individuals from state or private institutions to home and community based services 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 home and community based services. Additionally, the Committee is to review and study other components of the state's long-term care system.

December 2011

Senate Ways and Means
Date: 01-20-12
Attachment: #1

Joint Committee on Home and Community Based Services Oversight

Report

Conclusions and Recommendations

Based on the testimony heard and the Committee deliberations, the Home and Community Based Services (HCBS) Oversight Committee reached the following conclusions and made the following recommendations:

- The Committee recommends that all interested parties develop a consensus agreement on the topic of expanded access to dental care for discussion during the 2012 Legislative Session;
- The Committee recommends that the implementation dates for the Financial Management System (FMS) and the Electronic Verification and Monitoring (EV&M) System occur simultaneously on January 1, 2012;
- The Committee recommends that the appropriate State agencies contact the Centers for Medicare and Medicaid Services (CMS) to request a change in the FMS implementation date. It is recognized that CMS is able to grant any extension and that State agencies requested a December 1, 2011, implementation date for the FMS component;
- In the event an FMS implementation date extension is not achieved, the Committee recommends that all current providers' contracts be extended without penalty, and all providers be held harmless;
- The Committee recommends that the Department of Social and Rehabilitation Services (SRS) and the Kansas Department on Aging (KDOA) work with provider organizations to assist in solutions to alleviate the burden associated with the required entry of plans of care into FMS;
- The Committee recommends that the House Appropriations and Senate Ways and Means Committees re-evaluate the FMS provider rate of $115 early in the 2012 Legislative Session;
- The Committee recommends that SRS and the Attorney General's Office continue to explore grant opportunities to address the growing problem of human trafficking in Kansas, but also to search for prevention funding that could decrease this crime and victimization;
- The Committee recommends that the State work with the federal government on further coordination to fight human trafficking and decrease its impact;

- The Committee recommends that the 2012 Legislature authorize an oversight committee specifically focused on the policy and implementation questions connected with the managed care approach to Medicaid programs.

Proposed Legislation: None

Background

The Joint Committee on Home and Community Based Services Oversight operates pursuant to KSA 39-7,159, *et seq*. The Oversight Committee was created by the 2008 Legislature in House Sub. for SB 365. The Committee oversees long-term care services, including home and community based services which are to be provided through a comprehensive and coordinated system throughout the state. The system, in part, is to emphasize a delivery concept of self-direction, individual choice, services in home and community settings, and privacy.

The Oversight Committee is composed of nine members, five from the House of Representatives and four from the Senate. Members are appointed for terms that coincide with their elected or appointed legislative terms. The Committee is to meet at least four times each year at the call of the chairperson. In its oversight role, the Committee is to oversee the savings resulting from the transfer of individuals from state or private institutions to home and community based services 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 home and community based services. Additionally, the Committee is to review and study other components of the state's long-term care system.

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 and the Speaker of the House of Representatives, which includes the number of individuals transferred from state or private institutions to home and community based services, as certified by the Secretary of Social and Rehabilitation Services and the Secretary of Aging, and the current balance in the Home and Community Based Services Savings Fund. (See Addendum A for the 2011 Annual Report.) Additionally, the Kansas Department on Aging (KDOA) and the Kansas Department of Social and Rehabilitation Services (SRS), in consultation with the Kansas Health Policy Authority (KHPA), are 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. The KHPA was abolished effective July 1, 2011, pursuant to Executive Reorganization Order No. 38 (ERO No. 38). The ERO transferred all duties, functions and powers of KHPA to the Division of Health Care Finance within the Kansas Department of Health and Environment (KDHE).

Committee Activities

The Oversight Committee held three days of meetings during the 2011 Interim (August 23; October 11; October 12). In accordance with its statutory charges, the Committee's work focused on the following issues:

- Status of nursing home admissions;
- Impact of budget reductions on the funding, services, and population served by the Home and Community Based Services waivers;
- Long-term care quarterly report;
- Updates on the status of Home and Community Based Services waivers and waiting lists;
- Patient census in state mental health hospitals;

practitioners proposals contained in SB 192 and HB 2280, which were introduced during the 2011 Legislative Session. Both bills reside in each respective chamber's health committees. In addition, the Committee heard information concerning ongoing activities including: the Regents plans to study work force issues, the Medicaid 140 initiative of the Kansas Dental Association, and updates regarding two bills passed during the 2011 Session (the franchise bill and the hospital dental clinic expansion for counties with populations under 50,000). It is anticipated that the subject of expanded dental care will be a topic for continued discussion during the 2012 Session.

A representative of Oral Health Kansas provided information regarding Medicaid coverage for dental services. She noted that although Medicaid and HealthWave provide access to dental services for children, only emergency dental services, such as extraction of infected teeth when conditions exist that threaten the health of the person, are provided for adults. She explained that dental services were available through the HCBS waivers from 2007 to January 1, 2010, with limited access to dental services since January 2010 for persons on the HCBS Frail Elderly waiver through a crisis exception. As of February 2011, 13 crisis exceptions had been granted.

The Oral Health Kansas representative also provided information from a study published in August 2010 which stated "Oral health problems in the ER for the seven states examined cost considerably more than the average cost of dental care."

A representative of Kansas Action for Children spoke at the October 11th Committee meeting concerning the Kansas Dental Project, which creates a mid-level dental provider called a Registered Dental Practitioner (RDP) as a means to address the dental workforce shortage in Kansas, particularly in rural and underserved areas. She outlined the proposed 2012 legislation and described the key elements and goals contained in the proposal.

A representative of the Kansas Association for the Medically Underserved, discussed the impact of creating a mid-level practitioner on safety net clinics in the state. He indicated implementation of the Kansas Dental Project would expand high-quality dental care in Kansas, increase the work force pool, and allow expansion of care within the safety net environment.

The President of Fort Hays State University (FHSU) offered further information concerning the education of registered dental practitioners in Kansas. He explained FHSU intends to offer a baccalaureate program to train RDPs in Kansas. At the current time, dialogue regarding curriculum options is occurring with the Kansas Board of Regents. He clarified that a proposal cannot be submitted to the Board of Regents until the Legislature passes the bill. He envisions private donation funding for initiating the program with tuition funding sustaining it. He also indicated the location of FHSU will assist placement of RDPs in sparsely populated communities in Western Kansas and encouraged support of this proposal which he said would enhance high-quality dental care in rural areas, create strong jobs, and enhance communities.

A dentist in private practice in Pittsburg, Kansas, discussed his practice and reasons for his support of the proposed mid-level practitioner program. He described barriers to dental access and stressed the importance of evaluating new models that will enhance access and provide additional services to the underserved population in Kansas.

The Committee also received testimony in support of the RDP program from various other entities.

A representative of the Kansas Dental Association (KDA), spoke in opposition to the creation of a new licensed non-dentist clinician. He discussed findings from a recent Bureau of Oral Health report that identified four dental deserts in Kansas and projected that 14 strategically placed dentists in Western Kansas could improve that area's access to dental services. The representative discussed the definition of "dental deserts" referenced in his testimony as 20 miles from a dentist. This includes portions or all of Wallace, Logan, Greeley, Lane, Ness, Hodgeman, Haskell, Clark, Kiowa, Comanche,

option. She acknowledged that there were known issues resulting in postponement of the implementation date from September 1 to November 1. In response to the question of whether a contingent plan for expediting contract approvals prior to November 1 existed, the representative responded that the agency was working hard to ensure all contracts are approved.

A representative of SRS provided information regarding the changes made by CMS in the reimbursement system. Each FMS provider contracted by SRS and KDOA provides payroll services to eligible participants or representatives. Prior to the November 1 implementation date, reimbursement made to the beneficiary included funding for both the payroll agent (administrative fees) and the direct care/support provider. CMS suspected there was variation in administrative fees, and mandated the separation of the administrative fee from the provider payment. SRS, through various studies on actual administrative fee costs, set the administrative fee rate at $115 per month per person (PMPP) from $140 PMPP; the direct care/support provider rate was unchanged.

The SRS representative further indicated there are 42 FMS payroll agents across the state; a payroll agent is approved through submitting information to SRS. The applicant also is required to have a Medicaid Management Information System (MMIS) fiscal agent number through which SRS collaborates to build the systems necessary for claims processing.

It was requested that a written (visual) supplement be furnished to Committee members that reflected the direct care/support provider service rate prior to and after FMS implementation, the administrative rate prior to and after FMS implementation, a complete breakdown of activities/areas included in administrative fee (*i.e.*, overhead, rent), and all details relevant to the new method of administering these waivers.

SRS provided the following details with regard to the FMS rates:

- While the pre-FMS rate and the post-FMS rate is the same, $12.24, the post-FMS example for the attendant care class follows: The existing service provider's average hourly rate is $8.98 plus $1.58/hour to cover taxes, FICA, and worker's compensation. An additional $1.68/hour is deducted to create a pool of money to pay the $115 FMS rate.
- When working with an average, some direct care/support providers will get more and some will get less. Concern was expressed by Committee members that the state has set limits on what caregivers can be paid and has limited what consumers can offer to caregivers in terms of benefits and pay increases. Following considerable discussion, it was learned that a letter had been sent to providers earlier in the week. Committee members requested a copy of the letter.
- With regard to the reduction in the FMS payment rate, which resulted from the Myers and Stauffer study, the establishment of the rate took place in the spring between the Secretaries of SRS and KDOA and various staff members. The SRS Secretary confirmed that FMS providers were advised of the FMS rate reduction without participation in the decision-making process. For future decisions such as this, Committee members suggested the legislative intent would be to include stakeholders in the decision-making process.

A representative of KDOA reported that the Myers and Stauffer study began 2-3 years ago and was conducted in phases. Phase Five began in January 2011 and continued through October 2011, and focused on the development of a partnership with the Secretaries of SRS and KDOA to create strategies to implement study recommendations. Implementation was to have taken place in January 2011; it was postponed until September 2011, and further delayed until November 1, 2011.

could be flawed based on parameters submitted by SRS and KDOA. She urged Committee members to consider the delay of FMS implementation until January 9 (to coincide with the EV&M implementation) and to reconsider the new administrative rates.

A representative of InterHab stated that the Community Developmental Disability Organizations (CDDOs) were concerned about the FMS program changes and specifically, the issue concerning the delay in receiving executed contracts. In addition, the rationale for reducing the FMS rate per unit of service from the originally agreed upon rate of $140 to $115 was unclear. Feedback has been received that the new plans of care are below the standard of those being used prior to the program change.

Committee members requested clarification on the variances in attendant care wage rates. The KDOA Secretary was in the audience and responded that there is one pay rate for each waiver. Variability occurs when the direct care/support worker serves clients on different waivers. The Secretary also provided that the greatest impact from the standardization has been on 1,400 clients in assisted living or Home Plus settings. From August 1, 2011, to September 1, 2011, there was an average 13 percent cut for those 1,400 residents without the 900-1,000 additional time requests, which are currently being processed. This evaluation resulted in the 10 percent increase for providers caring for this population. While some providers may have experienced a 20-25 percent reimbursement reduction, the average was 13 percent. The Secretary stated that KDOA staff continues to work with facilities to ensure standards were administered appropriately. In addition, the issue of outstanding time requests could have contributed to the 20-25 percent reductions cited by providers. The Secretary noted that the original HCBS waiver system was not intended for assisted living; it was added several years after the initial implementation. He further noted that standardization changes may reflect HCBS inadequacies. In the long term, additional changes that use a market-by-market approach will be recommended to better serve those in less restricted environments.

Human Trafficking

The Committee recommends that:

- **SRS and the Attorney General's Office continue to explore grant opportunities to address the growing problem of human trafficking in Kansas, but also to search for prevention funding that could decrease this crime and victimization;**

- **The State work with the federal government on further coordination to fight human trafficking and decrease its impact; and**

- **SRS act to secure safe homes or facilities within the state to house victims of human trafficking for the provision of education, therapy, safety, rehabilitation, and other services needed to reintegrate victims into their home communities. The staff of the Attorney General's Office and SRS are to work on statutory language to accomplish this task.**

The Committee heard testimony concerning the increase of human trafficking in Kansas. An Assistant Attorney General with the Kansas Attorney General's Office provided an overview of human trafficking in Kansas, defined the term "human trafficking," discussed the Trafficking Victims Protection Act (TVPA), provided information related to the profitability of human trafficking, cited individual case studies in Kansas, and discussed the key elements and goals in Kansas as being prevention, protection, prosecution, and partnership. Discussion was heard concerning prosecution, penalties, and sentencing guidelines. The Assistant Attorney General provided information related to victims' services programs and discussed the Dallas human trafficking investigation model. She stressed the importance of recognizing the signs of human trafficking and the importance of reporting suspected human trafficking to authorities. Information also was heard about the work and goals of the Attorney General's Human Trafficking Advisory Board.

The SRS Deputy Secretary provided service details for the Developmental Disability (HCBS/DD) waiver which serves individuals with significant developmental disabilities. As of August 5, 2011, the Developmental Disability (HCBS/DD) waiver served 8,065 unduplicated individuals. In FY 2011, 316 individuals left waiver services, and those positions were filled by individuals in crisis situations. As of August 4, 2011, there were 2,478 persons on the HCBS/DD waiting list who currently do not receive any HCBS services and who have a request date of July 31, 2011, or earlier. The Deputy Secretary noted that additional dollars were allocated to the HCBS/DD waiver for FY 2012, and SRS is in the process of working with CDDOs to offer services to individuals on the waiting list. At this time, SRS projects approximately 285 individuals from the waiting list will be served with this funding. The exact number of persons served will be determined by the projected annualized cost to serve each person who is offered and accepts services.

A question arose at the August 23 Committee meeting on SRS's interpretation of the Legislature's intent with regard to the use of the new funding provided for FY 2012 waiver services. The Deputy Secretary stated the new funding would only fund 285 persons who are not receiving services. There are currently 2,478 persons on the waiting list who are not receiving any services, and 1,100 people in the underserved category. He indicated SRS understood the Legislature's intent was to provide for those individuals not receiving services. The Deputy Secretary suggested the Committee make a recommendation to serve both lists (the unserved and the underserved).

Psychiatric Residential Treatment Facilities

The Committee recommends that:

- **SRS, as a matter of record in the *2012 Legislative Report*, provide a report on the children discharged from a Psychiatric Residential Treatment Facility (PRTF), whether the children have been mainstreamed into the public or private education systems, readmitted, and other relevant information. Further, the Committee recommends the SRS report be furnished to the Legislative Budget Committee in preparation for its hearing on November 14, 2011;**

- **The Committee recommends a letter from Rick Shults, Director of the Division of Disability and Behavioral Health Services, SRS (referenced as Attachment 39 in the October 11-12 Committee minutes), be included in the *2012 Legislative Report*; and**

- **The Committee recommends that SRS continue meeting with PRTF providers to compare data and impact, that the providers continue to compile their own data, and that the Legislature revisit the PRTF issue in the appropriate committees during the 2012 Session to hear from SRS, providers, and families concerning PRTF referrals and to address issues of appropriate care and changes in the referral process.**

The Committee heard testimony related to PRTF screenings by SRS and Community Mental Health Centers. The Committee asked SRS to provide a report of children discharged from a PRFT, whether they have been mainstreamed into the public or private education systems, readmitted, and other relevant information.

During testimony by the SRS Secretary, clarification was requested concerning the screening process for potential placement in a PRFT (prior to SRS conducting a secondary screen). The Secretary reported community mental health centers (CMHCs) continue to screen children for placement to or discharge from a PRFT; SRS is performing an additional level of screening following the CMHC recommendation. In a case where the SRS secondary screen does not agree with the findings from the CMHC screen, a Committee member asked if the SRS social worker would possess veto power over the MHC screening team. The Secretary indicated if there was disagreement between the reviewing entities (SRS and CMHC), SRS would work with CMHCs to determine appropriate services.

apprehended and incarcerated 64 felons, identified 4 already incarcerated and receiving food assistance, and terminated the food assistance benefits for those who were identified and remain at large. Program savings of $12,000 are projected.

Considerable discussion was heard concerning the recent Kansas Health Solutions (KHS) alleged fraud and whether the fraud was discovered through an internal KHS audit and its subsequent alert to federal and state agencies or through discovery by SRS in the process of contract negotiation.

Managed Care

The Committee recommended that:

- **Any pending request for proposal (RFP) the State is considering relative to the implementation of a Medicaid managed care program in Kansas exclude HCBS/DD services; and**
- **That the 2012 Legislature impanel an oversight committee specifically focused on the policy and implementation questions connected with the managed care approach to Medicaid programs.**

The Committee heard discussion concerning the possibility of a managed care program being included in Medicaid reform.

A representative of InterHab provided copies of responses to the Administration regarding the effort to broaden the use of so-called managed care contracts to replace current state and local management. He indicated, if a broader use of managed care contracts was adopted, the result would be to allow the State to become a more remotely accountable agent in the delivery of human service programs.

The InterHab representative indicated he understood it was likely the State will release a request for proposal (RFP) to transfer control of the State's Medicaid program to a contractor. He encouraged the Legislature fully examine any such plan, and he recommended that the HCBS/DD program be carved out of any managed care RFP, and further recommended a Legislative special committee address the managed care issue.

DD INSTITUTIONAL SETTINGS	
Private ICFs/MR: number served at start of SFY 2011	165
State DD Hospitals – SMRH: number served at start of SFY 2011	343
MFP : number discharged into MFP program from **Private ICFs/MR**	(8)
MFP : number discharged into MFP program from **Public ICFs/MR SMRH**	(13)
Private ICFs/MR: number not discharged into MFP	(5)
Public ICFs/MR - SMRH: number not discharged into MFP	(4)
Sub-Total - **Private ICFs/MR**	152
Sub-Total - **Public ICFs/MR -SMRH**	326
Private ICFs/MR: New admissions	5
Public ICFs/MR: New admissions	4
Sub-Total - **Private ICFs/MR**	157
Sub-Total - **Public ICFs/MR -SMRH**	330
Private ICFs/MR Total Net Changes	(8)
Public ICFs/MR Total Net Changes	(13)
TOTAL DD Institutional Changes	(21)
DD HCBS WAIVER SERVICES	
DD Waiver Community Services : number served at start of SFY 2011	7,664
MFP : number joining into this program throughout SFY 2011	57
Subtotal	7,721
Net number added to DD HCBS waiver community services due to crisis/other eligible programs	204
Subtotal	7,925
Total Net Changes DD Waiver	261
Total Net Changes DD Waiver and Institutional	240

The following table provides a summary of the number of individuals transferred from nursing facility institutional settings into home and community based services during state fiscal year 2011. These additional abbreviations are used in the chart:

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

Average Daily Census in State Institutions and Long-Term Care Facilities-

Kansas Neurological Institute:	FY 2009 – 158 FY 2010 – 157 FY 2011 – 156
Parsons State Hospital:	FY 2009 – 192 FY 2010 – 186 FY 2011 – 186
Private ICFs/MR:	FY 2009 – 178 FY 2010 – 171 FY 2011 – 162
Nursing Facilities:	FY 2009 – 10,817 FY 2010 – 10,442 FY 2011 – 10,772

Savings Resulting from the Transfer of Individuals to HCBS

The "savings" through *Money Follows the Person* translates into real dollars only when individuals move 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 stated above, savings are only seen 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. Further, 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.

In addition to these considerations, people coming onto the waiver programs for reasons other than transferring from an institution affects what possible savings there are in the respective systems. The savings realized are "cost avoidance" savings, in that individuals transferring from institutional to community services results in a smaller growth in institutional service utilization. This supports an increase in access to community based services, retains all resources within the service system, and results in proportionally slower growth of costs in the system.

ADDENDUM B

DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Sam Brownback, Governor
Robert Siedlecki, Acting Secretary

www.srs.ks.gov

DIVISION OF DISABILITY AND BEHAVIORAL HEALTH SERVICES
MENTAL HEALTH

January 12, 2011

Michael Goldberg, Chief Executive Director
Kansas Health Solutions
534 S. Kansas Avenue, Suite 510
Topeka, Kansas 66603

Dear Michael Goldberg:

Social and Rehabilitation Services established some very specific goals when Mental Health Managed Care was initiated and Kansas Health Solutions (KHS) was engaged to administer and manage the community mental health managed care program. Those goals included:

- Preserving federal Medicaid funding for community mental health services and psychiatric residential treatment facilities (PRTFs);
- Serving more Medicaid eligible people who need mental health services, especially adults with a severe and persistent mental illness (SPMI) and children with a serious emotional disturbance (SED);
- Minimizing disruptions to the existing mental health system and preserving the public mental health system as exemplified by the community mental health centers (CMHCs); and
- Expanding the number of private mental health providers, especially child welfare contractors.

After three and a half years of hard work, these goals have, for the most part, been accomplished. Kansans with mental illness are receiving the critical services they need to assist with their recovery and ensure they live successful, productive lives. KHS was and continues to be a major reason for these successes.

In the last nine months we have worked together to build the ground work for the next priorities for mental health managed care. Mental Health Services and KHS have completed broad practice guidance to improve public mental health services, especially for persons who have extraordinary mental health needs. We have examined and identified concerns regarding community mental health, inpatient, and residential treatment service utilization patterns across the state. KHS, the Association of Community Mental Health Centers of Kansas, and the Kansas Association for the Medically Underserved have implemented pilot projects to improve coordination of physical and mental health treatment. We must now take this ground work and use it to further improve the effectiveness, efficiency, and accountability of the public mental health system.

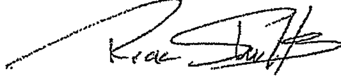
The utilization of inpatient and residential treatment for persons with mental illness varies significantly across the state. The extent of this variation exceeds what would be reasonably expected. One reason may be that people with extraordinary mental health needs are receiving ineffective mental health rehabilitation and support services. Where this is identified to be the case, KHS is expected to improve the effectiveness of the treatment practices especially for those CMHCs who utilize inpatient and residential treatment at higher per capita rates than most other CMHCs. Targeted improvement in community-based services is conservatively expected to result in an overall five percent reduction in admissions to inpatient and residential treatment in the last quarter of FY 2011 and another seven percent in FY 2012. These efforts are intended to avoid future increased costs by avoiding preventable psychiatric inpatient and residential treatment.

Finally, KHS will assist Mental Health Services with identifying the children in state custody or on the SED Waiver who are receiving mental health medications in quantities, doses, or combinations that cause professional clinical concern. KHS will arrange for respected medical professionals to review the prescribing practices for these children and discuss any concerns with the treating physician. This expert consultation is expected to result in either the treating physician making clinically appropriate adjustments in prescribing practices or providing a clinically reasonable explanation for the medication as prescribed. This effort is also expected to improve the lives of children who use these medications and their families.

SRS greatly appreciates KHS' efforts in achieving the original goals of mental health managed care. We look forward to working collaboratively with you and your providers to implement these new priorities.

Please let me know if you have any questions or concerns.

Sincerely,



Rick Shults,
Director

cc: Mike Hammond, Association of Community Mental Health Centers

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