MINUTES

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

December 15, 2020
Room 112-N—Statehouse

Members Present

Representative Brenda Landwehr, Chairperson
Senator Ed Berger
Senator Richard Hilderbrand
Senator Pat Pettey
Representative Barbara Ballard
Representative John Barker
Representative Will Carpenter
Representative Susan Concannon
Representative Monica Murnan

Members Absent

Senator Bud Estes
Senator Gene Suellentrop, Vice-chairperson

Staff Present

Iraida Orr, Kansas Legislative Research Department
Marisa Bayless, Kansas Legislative Research Department
Eileen Ma, Office of Revisor of Statutes
David Long, Committee Assistant

Conferees

Shawn Sullivan, President and Chief Executive Officer (CEO), Midland Care Connection, Inc.
Kari Bruffett, Vice President for Policy, Kansas Health Institute
Kim Nelson, Regional Administrator, Substance Abuse and Mental Health Services Administration
Dr. Sandra Berg, PhD, LCPC, Executive Director, UnitedHealthcare Community Plan (UHC)
Dr. Will Warnes, Medical Director, Behavioral Health, Sunflower State Health Plan (Sunflower)
Melodie Pazolt, Section Manager, Behavioral Health Programs and Recovery Support Services, Washington State Health Care Authority
Mary Fliss, Deputy for Clinical Strategy and Operations, Washington State Heath Care Authority
Alice Lind, BSN, MPH, Washington State Health Care Authority
Leah Gagnon, Community Health Center of Southeast Kansas

Scott Brunner, Deputy Secretary of Hospitals and Facilities, Kansas Department for Aging and Disability Services
Rachel Monger, Vice President of Government Affairs, LeadingAge Kansas
Teresa McComb, Administrator, Logan Manor Community Health Services
David Livingston, CEO, Aetna Better Health of Kansas
Michael Stephens, President and CEO, Sunflower
Joe Ewert, CEO, Brewster Place
Linda MowBray, President and CEO, Kansas Health Care Association and Kansas Center for Assisted Living
Anthony Johnson, Regional Vice President, Recover-Care Healthcare
Della Ribordy, Regional Director of Operations, Americare Systems, Inc.
Audrey Masoner, Chief Fiscal Officer, UHC

Others Attending

See Attached List.

All Day Session

Welcome

The Chairperson welcomed the Committee members and the conferees. It was noted some members and conferees would be participating *via* Zoom.

Overview of Program of All-Inclusive Care for the Elderly

Shawn Sullivan, President and Chief Executive Officer (CEO), Midland Care Connection, Inc., provided testimony regarding the Program of All-Inclusive Care for the Elderly (PACE) in Kansas (Attachment 1). Mr. Sullivan provided a brief overview of Midland Care Connection. PACE is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. PACE serves individuals ages 55 and older, certified by the state to need nursing home care, able to live safely in the community at time of enrollment, and living in a PACE service area. If a PACE enrollee needs nursing home care, PACE pays for it and continues to coordinate the enrollee's care. The program provides the entire continuum of care and services needed while maintaining the participant's independence at home for as long as possible. A list of the PACE services was provided, which included adult day care and clinic services, primary care, hospital and nursing home care when necessary, social services, all necessary prescription drugs, home health and personal care, and medical specialties. A history of the PACE model of care was reviewed. The cost of care in PACE is 10 to 15 percent less than the cost of caring for a comparable population through Medicaid, including home and community-based services (HCBS) waiver programs, by providing preventive care. Only five percent of PACE participants live in nursing homes.

Mr. Sullivan provided the 2021 PACE public policy priorities for Kansas: increase the protected income level (PIL) to 300 percent of Supplemental Security Income, adjust PACE rates annually comparable to the annual update and adjustment for KanCare managed care organizations (MCOs), and reinsert PACE into the Consensus Caseload process.

A fact sheet with frequently asked questions regarding PACE and information on Midland Care program locations and services offered by county were included in the testimony.

Mr. Sullivan responded to questions from the Committee members:

- PACE savings in Northeast Kansas is a 10 percent savings from the Medicaid program for the 750 people who are participating in the program. Information will be provided to the Committee regarding the breakdown of the savings.

- Mr. Sullivan provided clarification as to the difficulty of expanding PACE to other areas of the state by noting the program needs enough PACE-eligible people to allow the program to be viable. It takes between 75 to 100 people in a service area for the program to break even, which is more challenging in rural areas.

- Regarding the reason the state is having difficulty getting traction on PACE, Mr. Sullivan responded there was a cap on PACE enrollment, but it was lifted when KanCare started. PACE has since grown from 120 to 150 participants to 750. Many individuals have the mistaken perception they would no longer be able to see their current physicians. PACE strives to integrate care, so a PACE participant may continue to see their primary care physician.

- Regarding a trend in nursing home residents, Mr. Sullivan said in the past several years, there has been a decline from approximately 11,000 to 10,400 in the number of Medicaid beneficiaries who reside in nursing homes. A request was made for the total number of individuals the State is preventing from entering nursing homes through the PACE program.

- When asked if the PIL was a major factor in the 119 people who declined entering PACE, Mr. Sullivan responded it was the primary reason, but there were other factors that influenced the decision not to participate.

- Kansas had one of the lowest PIL in the country prior to the increase in 2018.

- Regarding how Kansas PACE enrollment compares to enrollment in surrounding states, Mr. Sullivan stated Colorado has a more robust system than Kansas does. Missouri does not have a PACE program since the one in St. Louis closed, but the state is trying to open one in Kansas City. Nebraska has one in Omaha and possibly other sites. He will provide a comparison of enrollment numbers to the Committee.

- Regarding whether allowing PACE services to begin in the middle of the month would save the State money or would be more convenient for the needs of the consumers, Mr. Sullivan responded more discussions are needed with other other state PACE programs on this topic. Some states allow services to begin mid-month, but Kansas allows services to start only on the first day of the month. With the timing of eligibility in Kansas, if an individual's needs change from time of contact and eligibility for services such that the individual is no longer able to live safely at home, then the individual will not be able to enroll in PACE.

- With the COVID-19 pandemic, there has been an increased interest in PACE locally and across the country.

- Approximately five percent of PACE participants reside in nursing homes.

- Nationally, 90 percent of PACE participants are eligible for both PACE and Medicaid ("dual eligible"), 9 percent are Medicaid only, and 1 percent are private pay.

- In Midland Care, 80 percent of PACE participants are dual eligible, 19 percent are Medicaid only, and 1 percent are private pay. The other PACE programs in the state are similar to the national average. The lower number of dual eligible population at Midland Care than other Kansas PACE programs and nationally was primarily due to mental health issues in persons aged 55 to 65.

- Mr. Sullivan said he believed PACE was removed from the Consensus Caseload process because the cap on enrollment was removed, but he was not entirely sure. He responded there was little if any impact in PACE being removed from the Consensus Caseload process. Mr. Sullivan responded the benefit to being a part of the Consensus Caseload process is it would put PACE on the same level as the MCOs. Secondly, if there are budget allotments, caseloads are exempt from that process due to federal statute requiring caseloads be funded.

- Rate rebasing for MCOs is done twice a year, but PACE is done every three years. Mr. Sullivan responded there have been two rate studies over the past 15 years. The first was in 2013 and the second in 2018. There was no federal requirement to look at rates every three years until 2015. He said PACE faces the same financial risk as MCOs and would like to be treated similarly.

- No PACE participants are on a HCBS waiver because they are not in KanCare, Mr. Sullivan responded.

- Regarding the potential for fewer available beds in nursing homes, Mr. Sullivan responded nursing homes are hard to operate financially. When occupancy decreased 10 to 20 percent due to COVID-19, the nursing homes were assisted by federal Coronavirus Aid, Relief, and Economic Security Act (CARES) money. When those funds end next year, a significant number of nursing home operators and facilities may be forced to close. It is not whether closures will happen but when and how many.

- The current percent of Medicaid pay in nursing homes is 60 percent, an increase from the 40 to 50 percent in recent years.

- The average daily Medicaid rate for nursing homes in Kansas is $197 per day. The Kansas Department for Aging and Disability Services (KDADS) will provide the difference between the Medicaid rate and the private pay rate.

Integrated Care Presentations

Kari Bruffett, Vice President for Policy, Kansas Health Institute, presented a review of the recommendation related to integrated care developed by the System Capacity and Transformation Working Group of the Special Committee on Kansas Mental Health Modernization and Reform that met during the 2020 Interim (Attachment 2). Information was provided regarding the three working groups of the Special Committee. The introduction in the System Capacity and Transformation Working Group Report provided the following language for context on recommendations related to system transformation: "An important strategy for system transformation will be addressing the continuum of care to ensure an integrated and coordinated approach to care delivery." The working group's recommendation on integration was designated for immediate action (within two years).

A second working group, the Finance and Sustainability Working Group, included a recommendation also for action in the next two years, related to the Certified Community Behavioral Health Clinic (CCBHC) Model. Kim Nelson, Substance Abuse and Mental Health Services Administration (SAMHSA), provided testimony on integrated care (Attachment 3). Ms. Nelson began her testimony by stating that in 2019, 61.2 million Americans had a mental health or substance use disorder (SUD). She stated these people die decades earlier than the general population mostly from untreated and preventable chronic illnesses. Primary care settings have become a gateway to the behavioral health system, and its providers need support and resources to screen and treat individuals with behavioral and general health care needs. Ms. Nelson stated the solution lies in primary and behavioral health care integration.

Ms. Nelson paused her presentation to allow others with scheduling conflicts to make their presentations.

Melodie Pazolt, Section Manager, Behavioral Health Programs and Recovery Support Services, Washington State Health Care Authority (HCA), provided testimony regarding a range of HCA activities with "social determinants of health" (SDOH) (Attachment 4). These activities include the Medicaid Transformation Project (MTP) waiver; examining opportunities to link SDOH with Medicaid managed care purchasing and employee benefit purchasing, which is still in research and development; and MTP Foundational Community Supports, which targeted federal dollars to provide supportive housing and supported employment to high needs Medicaid clients. Ms. Pazolt focused on MTP Foundational Community Supports in her presentation. She noted stable employment leads to healthier lives. She stated laid-off workers are 54 percent more likely than continuously employed workers to have fair to poor health, and 83 percent more likely to develop a stress-related condition such as heart disease. Unemployment has been linked to loss of health insurance, increased stress and blood pressure, unhealthy coping behaviors such as drinking or drugs, and increased depression. A study has also found that addressing housing concerns can result in reduced health care costs. The program includes specialists that focus on Foundational Community Support (FCS) benefits related to employment and housing. Examples of supported employment and supportive housing benefits were provided. Eligibility requirements for FCS benefits were provided. A preliminary evaluation of FCS containing study measures and a summary of key findings was discussed and outcomes data was provided. Ms. Pazolt noted additional research reporting is available on the HCA website.

Alice Lind, BSN, MPH, Washington State HCA, provided testimony on the efforts of the State of Washington to integrate care (Attachment 5). In 2014, legislation was enacted to change how the state purchases mental health and SUD services in the Medicaid program. The

state was directed to fully integrate the financing and delivery of physical health, mental health, and SUD services in the Medicaid program *via* managed care by 2020. The state was also directed to integrate mental health and SUD services through Behavioral Health Organizations as an interim step to 2020. A pathway was created for regions to fully integrate early, starting in 2016. A chart comparing the benefits of integrated care with the current system of silos was provided. The implementation was phased in over a four-year period. Ms. Lind emphasized the Medicaid benefits stayed the same. Each region was to have a Behavioral Health Administrative Service Organization that would provide crisis services and conduct involuntary treatment investigations. The processes to ensure a successful transition were reviewed. Ms. Lind provided some of the early adopter region successes. In one region, 11 indicators showed favorable change at the 95 percent confidence level, and only 2 indicators showed unfavorable change. Links to resource documents were included in the testimony.

Ms. Lind agreed to provide the following in response to a Committee member's questions: how the new program affected budget neutrality and how to prove it, the difficulty for MCOs to orchestrate the difference in billing, and any data after 2017 showing continued positive outcomes.

Mary Fliss, Deputy for Clinical Strategy and Operations, Washington State HCA, provided testimony on the Collaborative Care Management (CoCM) model (Attachment 6). In July 2017, the Washington State Legislature provided $4.0 million in funding to implement the CoCM. The model was based on Medicare rates and was implemented in 2018. The model required that in order to receive payment, the group must have a team trained to deliver care which included a psychiatric consultant, a primary care provider champion, staff with training in aspects of behavioral health and a registry for tracking progress, and interaction with patients. Reimbursement for CoCM codes is limited to groups that meet all requirements and provide the required certification. Ms. Fliss reviewed the key considerations in implementation noting the Centers for Medicare and Medicaid Services (CMS) does not appear to have a standard "certification" process for use. As of May 2019, 86 providers/groups have submitted attestation forms to HCA for CoCM model delivery. A clarification was made that a board-certified addiction medicine professional or addiction psychiatrist may be a consultant when the diagnosis is SUD.

Leah Gagnon, Community Health Center Southeast Kansas (CHCSEK), provided testimony regarding the integrated care model currently being used at CHCSEK (Attachment 7). Ms. Gagnon noted CHCSEK strives toward an "everything under the roof" approach resulting in a greater ease for community members with care needs. Ms. Gagnon continued by noting the various services offered by the Community Health Action Team, including home visits and blood pressure checks, delivering medications, following up after hospital visits, and SDOHs. CHCSEK also has a OneCare Program. She stated the opportunity lies in care management and care coordination because having the same care manager coordinate both behavioral health and primary care treatment plans leads to better treatment adherence. Ms. Gagnon stated at issue is that CHCSEK cannot bill for targeted case management with all KanCare members because they are not a community mental health center (CMHC) but a federally qualified health center. Ms. Gagnon recommended the Committee explore more opportunities for all providers to bill for services like targeted care management that supports and promotes integrated care models.

Ms. Nelson resumed her presentation by discussing the enactment of the federal Protecting Access to Medicare Act (PAMA) of 2014. Section 223 of PAMA required the U.S. Department of Health and Human Services (HHS) to establish a process for the certification of CCBHCs as part of a two-year demonstration project under Medicaid. She discussed the

benefits of CCBHCs. A time line of the CCBHC preparation, planning, and demonstration phases and the awarding of the CCBHC expansion grants, some of which went to southeast Kansas, was provided. The key provisions of PAMA and the CCBHC certification criteria were discussed. Staffing and care coordination were considered the key linchpins. A list of the required clinic quality measures and state-reported quality measures was provided. A review of the purpose and required services for the CCBHC planning grants was presented. The various reports to Congress that were required and the topics covered were discussed. A comparison of key features of Medicaid Demonstration and SAMHSA Expansion Grants was reviewed. A list of the states with CCBHC-Expansion grantees was provided. A map of Missouri was provided indicating the locations of its certified community behavioral health organizations (CCBHOs) participating in the CCBHO Prospective Payment Demonstration Project. Ms. Nelson noted some of the outcomes of Missouri's program, including a 20 percent increase in access to care, a 25 percent increase in access for veterans, and decreasing emergency room visits and hospitalizations.

Ms. Nelson responded to questions from the Committee members:

- Regarding what was done to increase veteran participation by 25 percent, Ms. Nelson responded it was done through outreach that specifically targeted veterans. Same-day appointments and 24-hour crisis care also contributed.

- Ms. Nelson clarified the statistics provided are site-based.

- Regarding if the time frame for the 36,277 law enforcement referrals increase was over a two-year period, an age breakdown for those referrals, and whether the quality measures were an aggregate or by individual, Ms. Nelson said she would contact the Missouri state agency for responses.

MCOs Collaborative Testimony on Integrated Care

Sunflower State Health Plan (Sunflower), Aetna Better Health of Kansas (Aetna), and UnitedHealthcare Community Plan (UHC) provided collaborative testimony on integrated care.

Dr. Sandra Berg, Ph.D., LCPC, Executive Director, UHC Behavioral Health-KanCare, represented the three MCOs in reviewing the collaborative testimony (Attachment 8). Dr. Berg began her testimony by listing the impacts of behavioral health issues on Americans. These issues include SUD, co-morbid chronic health disorders, early death due to serious mental illness, and lack of care for behavioral health disorders. The benefits of integrated care were discussed and the impact integrated care can have on individuals. Dr. Berg presented a case study of an individual with serious health issues, as well as substance abuse and mental health issues. The study included the steps taken by the case manager to establish an integrated care program that assisted the individual to receive behavioral health and medical help. Additionally, the case manager looked into additional services such as transportation and food banks. As a result, the individual continues to see her primary care physician and adheres to her medication plan. The individual is now sober and even serves as a mentor for others suffering with drug addiction.

Dr. Berg continued with a discussion on system barriers. These include communication and collaboration, infrastructure and investments, and incentives and performance. Examples of

each were provided. Examples of provider barriers in each of the three barrier areas were presented. Recommendations relating to integrated care from the Special Committee on Kansas Mental Health Modernization and Reform working groups were provided to the Committee. The testimony was concluded with a chart that showed the goal of integrated care was "achieving the triple aim." These outcomes include cost of utilization, population health, and experience of care.

The testimony included a handout: "Integrated Care & State Policy in Kansas: Case Study of Community Health Center of Southeast Kansas" (Attachment 9).

Dr. Will Warnes, Medical Director, Behavioral Health, Sunflower, commented that working internally is just as important as what the providers are doing. Sunflower is working to remove the silos and working outside their comfort zone. All administrative meetings include integrated members, and rounds are now also integrated when discussing complex cases.

The following MCO representatives were present to answer questions:

- Maggie Meyers, Manager, Case Management, Sunflower;
- Michael Stephens, President and CEO, Sunflower;
- David Livingston, CEO, Aetna;
- Josh Boynton, Executive Director of Business Development, Aetna, a CVS Health Company;
- Jennifer Pruente, Long Term Services and Support Director, Aetna, a CVS Health Company; and
- Dr. Frank Angotti, Behavioral Health Medical Director, Aetna, a CVS Health Company.

Dr. Berg and Dr. Warnes responded to questions from Committee members as follows:

- Dr. Berg responded, in Kansas, there are rehabilitative codes that only CMHCs can use. These codes are not only targeted case management rehabilitative health services but other rehabilitative services as well. Codes play a large part in the move to integration, but the healthcare system still needs specialists to focus on what they do best. CMHCs provide the best services in the code areas in which they specialize. The question is whether some codes should be spread to other providers.
- Dr. Warnes also responded to the question regarding allowing more providers to provide certain code services and incentivize providers. He stated some codes are high cost. There would be a need to consider the overall affect on the system and proceed with some caution and red alerts. He explained red alerts by stating Kansas is superior in CMHC to Nebraska and Iowa. If a code was opened for the sake of collaboration, there are downstream effects that would have to be

planned for; the CMHC system could be devastated if not careful. He stated there are many creative ways to incentivize providers to work together without opening codes and look at barriers in place that prevent integration.

The Chairperson noted one should always proceed with caution if expanding codes because of the long-term effect that could dismantle the system. She noted there is a large fiscal impact with some codes. If some codes open, it could be the State might not be able to pay them with current financial restraints.

A Committee member asked for the fiscal note if codes were opened for integration and collaboration. Kansas Legislative Research Department staff was asked to gather this data and provide it to the House Committee on Social Services Budget.

Working Lunch

The Chairperson recessed the meeting at 12:02 p.m. The meeting resumed at 12:19 p.m.

COVID-19 and Long-Term Care Facilities

Scott Brunner, Deputy Secretary of Hospitals and Facilities, KDADS, provided an update on KDADS testing strategies (Attachment 10). Mr. Brunner began with a summary on the point-of-care testing machines and associated tests that, as of November 19, 2020, were shipped to 319 Kansas nursing facilities with a current Clinical Laboratory Improvement Amendment Certificate of Waiver. There were three waves of delivery from July 20 to November 6, 2020. The facilities received enough tests and kits for one round of tests. The facilities were directed to buy additional tests from the manufacturer to continue using the testing machines to meet the CMS staff testing requirements. Mr. Brunner stated nursing facilities reported a backlog from the manufacturers to obtain more testing kits. The facilities were required to have positive tests confirmed with a polymerase chain reaction (PCR) test, which tests for genetic material from the virus. Through Operation Warp Speed, HHS has distributed or was slated to distribute Abbott BinaxNOW rapid test cards to 106 assisted living facilities and 264 nursing facilities in Kansas. These tests would be free of charge and would be prioritized to serve vulnerable populations including those in nursing homes and assisted living facilities and home health agency workers to address the shortage of supplies for the point-of-care testing machines in nursing facilities. The test is a rapid result test used in detecting COVID-19 antigens. Mr. Brunner reviewed the role of the Kansas Department of Health and Environment (KDHE) when a positive antigen test result occurred. Facilities could use the KDHE lab or access the Strengthening People and Revitalizing Kansas (SPARK)-funded regional labs to confirm a positive result from their point-of-care testing machine. The frequency of testing in a nursing facility is dependent on the COVID-19 positivity rate. CMS authorized the use of the KDHE positivity rates to determine the required testing frequency.

Mr. Brunner provided a review of the principle of the Governor’s unified testing strategy, with a goal of controlling community spread by expanding statewide testing beyond those with symptoms and cluster investigations, coordinating public and private testing efforts across the state, and communicating testing goals and objectives. The application process for SPARK money, outlining the goal and who was eligible, was discussed. The populations to prioritize and

the scalability were reviewed. In round one, $10.0 million in SPARK funding was allocated to counties. In round two, $24 million was allocated to increase state lab capacity. More than $52.0 million was allocated for round three to implement a unified COVID-19 testing strategy. The SPARK funding process for round three was presented. Mr. Brunner provided a summary of the three sections of the round three testing request for proposal: laboratory testing solutions, high risk populations, and innovative strategic solutions. A summary of the proposals received from qualified bidders was provided. A list of the nine labs contracted out for statewide COVID-19 testing was reviewed, with a map showing the counties covered by each lab and the testing services provided. Mr. Brunner stated testing began mid-November 2020 and may be able to continue into 2021 if funding continues. Contact information for each lab was also provided to the Committee.

A summary of all allocations by nursing facilities by funding type was provided to the Committee for their review (Attachment 11).

Mr. Brunner responded to questions from the Committee members:

- When asked if all of the labs are using the same cycle thresholds, Mr. Brunner responded he would contact KDHE to provide that information.
- Regarding whether the labs were open on weekends, Mr. Brunner responded they were open and running tests. He said he assumed they were receiving tests, but he would verify that information.
- When asked whether all nursing homes have the needed supplies to comply with the testing mandate, Mr. Brunner said that a survey was taken of long-term care facilities licensed by KDADS before rolling out the regional labs. The survey indicated the vast majority of long-term care facilities had the resources to test. Requirements were not placed on facilities that they could not meet. If a facility is unable to comply due to testing supplies or the inability to afford the supplies, for example, they are to make their best efforts and document the reason and will not be penalized.
- When asked to better define “vast” when talking about complying with testing requirements, Mr. Brunner stated the survey indicated 700 adult care facilities said they were able to comply, approximately 100 said they were not testing, and 120 to 130 did not respond to the survey.
- A Committee member expressed concern that early in the pandemic, legislators were unable to inform constituents as to why COVID-19 testing was not being done at certain nursing facilities. Mr. Brunner stated the issue was confusion regarding what facilities were licensed though CMS and those licensed by the State. Facilities licensed by CMS were mandated to start testing on August 25, 2020. KDADS was concerned it could not guarantee the availability of supplies and testing results to state-licensed facilities to meet a testing requirement. He stated the availability of SPARK funds to ramp up testing increased access to testing, making the State more comfortable with setting a testing requirement for state-licensed facilities through Executive Order Number 20-69, effective December 14, 2020.

- A Committee member asked about the accuracy of the rapid test. The member expressed concern with the possibility of a false negative test result and the position in which the nursing facilities were being placed when relying on the negative result. Mr. Brunner stated facilities could use a rapid test for one required test and the PCR test for the second test, so a false negative could be caught in the second test. Mr. Brunner said he would ask KDHE to provide further clarification.

- When asked if all of the money has been distributed to the regional labs as per their contracts, Mr. Brunner stated the payments were made on the number of tests run. Some labs were given money up front to allow for setting up the labs. He will ask KDHE for the status of the spending by contracted lab and provide the information to the Committee. He said the State has used only a percentage of the $52.0 million set aside for testing because the average number of tests per day has not hit the threshold.

- Regarding clarification between sampling and pooling, Mr. Brunner said sampling refers to who administers the test when a facility does not have someone certified to do it. Pooling is when multiple samples are combined and tested as one. If the pooled sample comes back negative, all individuals are considered negative. If the pooled sample comes back positive, then each sample is tested separately to determine who is positive.

A comment was made by a Committee member that, during the special session, it was known there would not be enough testing for all nursing facilities, yet legislation to provide liability protection was not extended to them.

Rachel Monger, Vice President of Government Affairs, LeadingAge Kansas, provided testimony on the challenges its members are facing during the COVID-19 pandemic (Attachment 12). There are two major issues long-term care facilities are facing. The first is the lack of liability protection. Ms. Monger stated long-term care providers are the only health care providers excluded from full COVID-19 liability protection. For all other providers, the protections given are narrowed to only health care activities related to the COVID-19 pandemic and do not apply to acts, omissions, or decisions that result in gross negligence or willful or reckless conduct. These liability protections preserve the right to go after the “bad apples.” Long-term care facilities are not asking for special treatment. She said singling out these facilities for personal injury class action lawsuits during the pandemic threatens the existence of the senior care system in Kansas. It has sparked a crisis in the liability insurance markets and may ultimately threaten the state’s Health Care Stabilization Fund. Ms. Monger asked the State to provide these facilities the same protection as other health providers have. The second issue is staffing shortages. The outbreak has caused a shortage in the nursing home workforce. Staffing agencies are short on workers and their charges for nurses and nurse aides have quadrupled. Requirements to quarantine for 10 to 14 days requirements before placing a new agency nurse or aide into a nursing facility delay the placement of temporary staff in nursing facilities. Hospitals with their staffing shortages are unable to provide support to nursing facilities. Staff have been stressed due to work weeks of 80 to 100 hours. Ms. Monger provided possible solutions to reducing the workforce shortage issues in her testimony, including the use of the National Guard to provide assistance with specific tasks, continuing the use of temporary nurse aides and a pathway to certified status after the emergency order has ended, and limiting staffing agency charges.

Teresa McComb, Administrator, Logan Manor Community Health Services, provided testimony regarding the experiences her facility has endured during the pandemic (Attachment 13). A serious concern is the increase in sadness and depression resulting from the residents' inability to see friends and relatives, other than through closed windows or communication devices. She stated residents could not attend family functions or even dine with other residents. The staff has done their best to fill the gaps by creating activities. A review of the events regarding the first and subsequent round of cases of residents and staff contracting the virus was provided. Ms. McComb continued with a review of the staffing issues the facility has encountered. Staff members were working more than 80 hours a week. Some staffing agencies were not willing to send people to their location. Other agencies could not get someone to the facility for three to four weeks. She stated testing has been a concern. The facility continues to do weekly testing. The issue has been getting the results back in a timely manner. Initially it was taking ten days to get the results. By changing labs, the test result time was reduced to two days. She expressed disappointment that not much support was received from the state representatives, but they had strong community support. Ms. McComb reiterated the residents are declining due to the isolation and inability to leave the facility. The rates of depression and decreased appetites are increasing due to dining in their rooms and not seeing other residents. Ms. McComb concluded her testimony by stating the vaccine can come none too soon.

Ms. McComb responded to questions from the Committee members:

- When asked about the facility's personal protection equipment (PPE) supply, Ms. McComb responded the facility has been able to order PPE and have a supply on hand. The cost is still very high.

- Ms. McComb responded N95 masks are not being reused on a regular basis. They would reuse the masks if they had to place someone in isolation.

- Ms. McComb stated the facility was one of the last ones to receive testing kits. The testing machine was received in August. For a couple of weeks, there was difficulty getting the testing kits. The facility was receiving the kits from its supplier. The facility is also receiving the Abbott rapid testing cards weekly from HHS.

Joe Ewert, CEO, Brewster Place, provided testimony regarding his facility's experience during the COVID-19 pandemic (Attachment 14). Mr. Ewert described Brewster Place as a stand-alone not-for-profit organization. While a significant number of residents are on Medicaid, 85 percent of the revenues are generated directly from residents who pay for their housing and services. PPE has been an issue, at times requiring the use of handmade face coverings for staff and residents. Staffing is a major concern. Caregiver applications have dwindled from 30 per month to 3 per month. There is a commitment to provide 2,600 hours of direct caregiver time a week to the residents, but the time had been cut by 500 hours due to staffing issues. The team has tried its best fill the gaps. Even the Chief Operating Officer, Chief Financial Officer (CFO), and the CEO provide services as needed. Testing is a daunting task. An area of major concern is the facility's current inability to take patients for rehabilitation, which is a large piece of the facility's revenue stream. It also creates hardship for families with family members needing to be released from hospitals but they have nowhere to go. Mr. Ewert recommended the Legislature find a solution to the staffing shortage. He stated nursing homes need additional funding that is not tied to difficult-to-adhere-to mandates.

Mr. Ewert responded to questions from the Committee members:

- In regards to his statement that groups such as the National Guard come in and do testing of residents, Mr. Ewert said this has been discussed in peer circles and has been done in other states. These groups could take the testing samples to free up staff to provide nursing care.

- When asked if the directive that nursing homes must admit COVID-19 positive residents came from KDADS, Mr. Ewert stated it was on the KDHE website.

Linda MowBray, President and CEO, Kansas Health Care Association (KHCA) and Kansas Center for Assisted Living, provided testimony regarding the issues affecting the nursing home industry (Attachment 15). She stated nearly 60 percent of residents in Kansas nursing homes rely on Medicaid. Ms. MowBray stated she believed the federal and state governments have failed these nursing home residents and the people who care for them during the COVID-19 pandemic. Ms. MowBray described the issues faced and possible solutions. The first issue is workforce instability, which is the hardest to deal with. She stated wage pass-through legislation and funding could be a solution. Another option could be to help transition temporary nurse aides into certified nurse aides (CNAs). KHCA is working with health occupations credentialing and KDADS on changes to the CNA training program to allow training online and clinicals at the facility where the temporary aid is employed. She stated many nursing facilities have a ban on nurse aide training because of survey results. She would like the State to provide a waiver so these nursing facilities can train and the temporary aides can work in place. Ms. MowBray also stated the Legislature needs to revisit funding for front-line workers. The second issue is the skyrocketing insurance rate. Liability protection, like that received by all other health providers, is needed for nursing facilities. The third issue is the risk of insolvency and closure. There needs to be stable and sustainable funding from the State for long-term care facilities, which have a $1.9 billion total annual economic impact on the state. Ms. MowBray reiterated the industry is in crisis.

Anthony Johnson, Regional Vice President, Recover-Care Healthcare, provided testimony on the effects of COVID-19 on long-term care facilities (Attachment 16). Mr. Johnson gave a brief overview of the 22 facilities in his company’s Kansas operation. He stated concerns related to COVID-19 management and prevention, noting the virus has exposed the weaknesses across all sectors, and there is no playbook to fall back on. Providers have been left to innovate and apply protocols to prevent the spread. There have also been inconsistent and inaccurate guidelines from public health officials. There has been a large misuse of people and resources in performing a large number of surveys for his company’s facilities, with only two deficiencies issued. He stated surveyors are not being tested. PPE has been a major concern throughout the pandemic. Mr. Johnson provided some potential solutions for these issues in his written testimony.

Mr. Johnson stated staffing continues to be a major concern. Even before the pandemic, recruiting caregivers was difficult. Wages were low and working in hospitals and clinics was preferable. The COVID-19 pandemic has only made it more difficult to recruit and retain staff. Staffing agencies are hijacking caregivers by offering high wages and passing the cost along to the nursing facilities. Possible solutions to address staffing were provided.

Mr. Johnson responded to questions from the Committee members:

- When asked if complaints concerning the facility were a part of the number of surveys that were done, Mr. Johnson responded that a third of the infection control surveys were related to complaints. The remainder were standard surveys.

- Regarding other states that have tried to control the wages being charged by staffing agencies, Mr. Johnson responded, in 2013, Minnesota enacted legislation to put a cap on what providers could be charged.

Della Ribordy, Regional Director of Operations, Americare Systems, provided testimony on the experiences her organization has had during the pandemic (Attachment 17). Ms. Ribordy provided the economic impact her organization has on the communities where its facilities are located: almost 800 employees earning more than $23.6 million. Americare pays almost $500,000 in property tax and $156,000 in Kansas income tax. There are two primary issues that have had a significant impact on the organization during the pandemic. The first issue is staffing. Eight Directors of Nursing in the skilled division have left due to regulations, liability concerns, the difficulty of the job, and not enough staff. At the time of the meeting, there were 80 open positions. The number of vacancies has tripled since the pandemic began. She states a solution would be proper funding from Medicaid. Ms. Ribordy noted being grateful for the CARES Act and SPARK funding received. Secondly, there is the issue of navigating through the process. Each county is different in regards to reporting. There is also the issue of the various local entities within the counties. Ms. Ribordy asked the Legislature look at improving the reimbursement for the long-term care facilities through the Medicaid program. Ms. Ribordy stated, in the organization's current situation, there is the possibility of 1 or 2 facilities closing in the state, affecting 100 employees and 80 residents. While seemingly small in numbers, this would impact families and communities.

Written-only testimony was provided by:

- Haely Ordoyne, Chairwoman, Kansas Adult Care Executives Association (Attachment 18); and

- Mitzi McFatrich, Executive Director, Kansas Advocates for Better Care (Attachment 19).

Managed Care Organizations' KanCare Presentations

Audrey Masoner, CFO, UHC, provided an update on UHC's response to COVID-19 (Attachment 20). Ms. Masoner noted the focus was "Members First," and there had been no reductions in existing services. Temporary services have been authorized to include telehealth, personal care services, and home-delivered meals. UHC has provided approximately 9,000 long-term services and supports (LTSS) members and 275 skilled nurse facilities with COVID-19 test kits. The Safety, Testing, Overall, Partnership initiative was created to address the health disparities of disadvantaged communities. UHC has donated 10,000 surgical masks to each federally qualified health center partner. Through the federal CARES Act Provider Relief Fund, a

total exceeding $1.0 million was paid out to 3,795 Kansas providers. Over 1,000 meals have been distributed through the Mom's Meals program. The testimony included an appendix addressing questions from a previous Committee meeting related to foster care in managed care, Appendix K flexibilities of individualized education plans, psychiatric residential treatment facility (PRTF) wait list, and COVID-19 provider outreach efforts.

David Livingston, CEO, Aetna, provided an update on the efforts of Aetna during the COVID-19 pandemic (Attachment 21). Mr. Livingston provided a personal story regarding the efforts of a Service Coordinator to assist a member who had fallen and broke her ankle, noting the successful resolution was due to the use of telehealth. Aetna has maintained a high level of service throughout the pandemic utilizing modern care delivery and communication models, such as telehealth. Aetna has also completed the External Quality Review Organization Audit. Because of telehealth, there has been increased utilization of the brain injury waiver therapies and an increase in the utilization of remote patient monitoring. More than 11,000 COVID-19 tests have been given to members, 17,000 instances of care related to COVID-19 have been provided to members, and 5,000 COVID-19 outreach calls have been made to support members. Aetna has provided HCBS services to students receiving remote learning, primarily focusing on attendant care.

Michael Stephens, President and CEO, Sunflower, provided an update on Sunflower's efforts during the COVID-19 pandemic (Attachment 22). Mr. Stephens described the efforts of the Care Management Team to resolve a situation being experienced by an individual who had been a member for only one week. The MCO distributed 48 tablet computers to providers of LTSS and services to aging adults to support individuals with social isolation. Cloth face masks were also distributed to educational agencies, foster care contractors, other partners, and members designated at great risk for COVID-19. Through Appendix K, over 1,000 school-aged students with disabilities who are receiving remote education are being provided HCBS services and are being served at a cost between $200,000 and $300,000 per month. Mr. Stephens provided responses to questions posed at the September 28, 2020, meeting regarding the lower percentage of Sunflower pharmacy appeals resolved during the second quarter of 2020 as compared to the rate for other MCOs, the pros and cons of a single MCO providing coverage for foster care children, and admissions and average length of stays in PRTFs.

Mr. Stephens responded to questions from the Committee members:

- Regarding guidance to health care providers on the receipt and distribution of the COVID-19 vaccines and the cost, Mr. Stephens responded the MCOs are still learning about those topics. The MCOs are working with the State to collaborate on a way of receiving and distributing the vaccine and the cost involved. No complete guidance is available to share with providers. Guidance is expected in the coming weeks.

Discussion and Recommendations for Joint Committee's Report to the 2021 Legislature

The Committee adopted the following recommendations:

- The House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare hold hearings within the first 60 days of the 2021 Legislative Session on the 340B Drug Pricing Program;

- The House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare hold informational hearings within the first 60 days of the 2021 Legislative Session regarding the efforts of Oral Health Kansas;

- The Legislature review how other states estimate caseloads;

- The K-TRACS prescription drug monitoring program be funded through the State General Fund;

- Nursing facilities be given the same immunity from civil liability provided to health care providers in 2020 HB 2016;

- The Legislature address the system-wide health care workforce issues, such as safety, shortages, pay, education, licensure, and training (for example: virtual training of CNAs by nursing facilities);

- The Legislature work on integrated care, coordinating general and behavioral health, which includes mental health, substance abuse, and primary care;

- The Legislature monitor the financial stability of long-term care facilities in Kansas;

- The Legislature monitor and report the increase in HCBS waiver services provided to school-aged children in remote settings;

- The Legislature support expansion of the federal Excellence in Mental Health Act and then pursue participation. If participation in the Excellence in Mental Health Act is not possible, pursue a state plan amendment or change to the 1115 Waiver to allow interested providers to gain access to the CCBHC model. [*Note*: This recommendation mirrors Recommendation 2.1 of the Special Committee on Kansas Mental Health Modernization and Reform working groups' report to the Special Committee, the Strategic Framework for Modernizing the Kansas Behavioral Health System.];

- The Legislature consider adding PACE to the consensus caseload process;

- Regarding telehealth, the Legislature:

  - Develop standards to ensure high-quality telehealth services are provided. This includes establishing consistent guidelines and measures for telehealth in collaboration with licensing and regulatory agencies, requiring standard provider education and training, ensuring patient privacy, educating patients on privacy-related issues, allowing telehealth supervision hours to be consistently counted toward licensure requirements, and allowing services to be provided flexibly when broadband access is limited;

- Maintain reimbursement codes added during the public health emergency for tele-behavioral health services and consider options to prevent loss of facility fees so that providers are not losing revenue by delivering telehealth services;
- Establish coverage of telehealth for crisis services to allow for the use of telehealth with law enforcement and mobile crisis services and explore virtual co-responder models for law enforcement to aid police departments and other law enforcement agencies as they respond to mental health crises in rural and frontier communities;
- Address the following items to ensure to ensure that individuals receive, and providers offer, telehealth in the most appropriate locations: adopt a broad definition of "originating site," consistent with the Kansas Telemedicine Act; allow staff to provide services from homes or other non-clinical sites, if patient privacy and safety standards can be met; and examine issues related to providers practicing, and patients receiving, services across state lines, such as by exploring participation in interstate licensure compacts; and
- Utilize telehealth to maintain service and provider continuity as children, particularly foster children, move around the state and consider how the unique needs of parents of children in the child welfare system can be met *via* telehealth. [*Note:* The telehealth recommendations mirror Recommendations 10.1 through 10.5 of the Special Committee on Kansas Mental Health Modernization and Reform working groups' report to the Special Committee, the Strategic Framework for Modernizing the Kansas Behavioral Health System.]; and

- Study and consider adjusting PACE rates annually, similar to the process for KanCare managed care organizations.

The Committee expressed concern and suggested the Legislature look at the charges nursing facilities incur when temporary staff must be used to meet workforce needs.

The Committee proposed a Committee bill be introduced containing the language of 2020 HB 2550, as amended by the House Committee on Social Services Budget, to increase reimbursement rates for providers of HCBS under the Intellectual and Developmental Disability waiver.

Adjourn

The Chairperson thanked the Committee members, staff, and the conferees for all of their work.

The Chairperson adjourned the meeting at 4:06 p.m.

The following are responses to questions from the Committee members that were provided after the meeting adjourned:

- KDADS provided the average monthly Medicaid caseload in nursing facilities for 1998 through 2020. Information was also provided regarding the difference between the Medicaid rate and the private pay rate in nursing facilities (Attachment 23).

- Conferees from the Washington State HCA responded to questions regarding budget neutrality and how it was proved for the 1115 waiver. An answer was also provided regarding how managed care providers orchestrate the difference in billing under integrated care. A response was also included regarding whether numbers after 2017 continue to show positive outcomes. It was also noted that evaluation results from 2020 had not been released but can be provided at a later date (Attachment 24).

- The Washington State HCA provided the "Evaluation of Integrated Manage Care in North Central" Washington for the Committee to review (Attachment 25).

- The Missouri Coalition of Community Behavioral Healthcare provided responses to two questions. It was noted the 38,277 referrals referenced in Ms. Nelson's testimony were for the years 2017-2019 and most were adults. Data reflecting the age breakdown will be sent at a later date. The measures cited in Ms. Nelson's testimony were tracked in aggregate, but can be drilled down for appropriate interventions (Attachment 26).

- KDADS provided responses to various questions posed by Committee members during the December 9 and December 15, 2020, Committee meeting (Attachment 27).

- KDHE provided responses to various questions posed by Committee members during the December 15, 2020, Committee meeting (Attachment 28).

- KDADS provided the 2020 Special Session HB 2016 COVID funding and test allocation list (Attachment 29).

- Mr. Sullivan, Midland Care Connections, Inc., provided responses to questions from Committee members regarding PACE (Attachment 30).

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Approved by the Committee on:

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(Date)