



Landon State Office Building
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Topeka, KS 66612

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www.kdheks.gov/hcf/

Robert Moser, MD, Secretary
Kari Bruffett, Director

Sam Brownback, Governor

**KanCare Advisory Council
Curtis State Office Building, Topeka, Kansas
Minutes of November 13, 2012**

Council Members Present:

Dr. DeDe Behrens
Andy Brown
Dr. Kevin Bryant
Representative Jerry Henry
Walt Hill
Randy Johnson
Steve Kelly
Larry Martin
Steve Ortiz
David Sanford
Senator Allen Schmidt
Audrey Schremmer-Philip

Council Members Absent:

Mary Barba
Dr. John Calbeck
Mike Conlin
Dave Geist
Representative Brenda Landwehr
Barney Mayse
Colin McKenney
Susette Schwartz

Council Members Attending Via Phone:

Dr. Craig Concannon

Other Participants:

Secretary Robert Moser, Kansas Department of Health and Environment
Secretary Shawn Sullivan, Kansas Department on Aging and Disability Services
Kari Bruffett, Director of KDHE Division of Health Care Finance

Welcome- Steve Kelly, KanCare Advisory Council Chair

Chairman Kelly began the meeting and welcomed Council members. The Chairman noted that during this meeting, Council members will hear presentations from each of the three selected KanCare managed care organizations(MCOs), a general KanCare update, an update from the external stakeholder workgroups, and information on the upcoming educational outreach events.

Review and Approval of Minutes from September 17, 2012, Council Meeting

Chairman Kelly asked if there was any discussion on the previous meeting's minutes. Steve Ortiz moved the minutes be approved. Audrey Schremmer-Philip seconded the motion and the minutes were approved by the Council.



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Update from KanCare External Work Groups

Each of the four KanCare external stakeholder work groups provided a brief update for the Council.

Managed Care Organizations-Related Issues- Christiane Swartz

Ms. Christiane Swartz noted that the managed care organizations (MCO) work group handles operational issues. This workgroup has met four times since July, and regularly meets on the third Monday of every month. The first meeting of this work group was used to gather a list of issues and areas of concern from work group members. The following areas were noted:

- Claims processing,
- Prior authorization processes for providers,
- Member enrollment and customer service issues, and
- Transitioning current systems to the new model.

The group's second meeting was devoted to MCO presentations which addressed the issues identified. The presentations were similar to those shared with the Council at the last meeting. Ms. Swartz noted that this work group has had a good deal of interaction with the KanCare health plans and others who were able to answer many of their questions.

The third meeting of the work group was held in September and focused on the readiness reviews, the front-end billing portal, KanCare website and content, and a progress report on the activities of the other work groups.

During the October meeting, the KanCare MCOs gave an update on credentialing, approval of provider manuals, and the contracting process. State officials gave an update on the upcoming enrollment tours. The work group also reviewed materials such as the enrollment packet, and spent time discussing the assignment logic and how the system would make plan assignments. Ms. Swartz noted that the next meeting of this work group will be November 19. This meeting will focus on the enrollment packet mailing, reviewing updates to the enrollment packet, and sharing informational materials and engagement activities targeted to the public. The group will also hear information on the status of any provider manuals that are not yet final, a contracting update, and information on provider and beneficiary training.

Specialized Healthcare and Network Issues- Becky Ross

Ms. Becky Ross updated the Council on the activities of the Specialized Healthcare and Network Issues (SHNI) workgroup. The SHNI workgroup has met five times. The first meeting focused on identifying issues and concerns among members and their constituencies. This group discusses many issue areas, including health homes, behavioral health, home and community based waiver services, nursing facilities, other facility-based services, non-emergency medical transportation, and other issues.

During the first meeting, issues regarding non-emergency medical transportation arose, so the group detailed some further issues in the next meeting and heard from all three KanCare health plans on how the plans would address those issues.

The August meeting was focused on health homes. The State has an interagency project team working on this initiative. The group was asked to review a draft of health homes quality measures, and the group provided feedback on specific measures proposed for inclusion in the health homes State Plan Amendment.

The September meeting focused on hearing from the MCOs regarding their experience in other states with health homes or medical homes. This meeting also included updates on credentialing, contract templates, and readiness reviews. Further, the work group made recommendations regarding education efforts for members and providers that were utilized in the State's written materials and the educational tours. The SHNI group also helped identify existing organizations and other groups that could help providers and others educate members.

The October meeting focused on how the health plans will manage home and community-based services. Members also heard an update on the Aging and Disability Resource Center (ADRC) and how it will work under KanCare.



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The November meeting included an ADRC update, update on the 1115 waiver proposal, and continuing updates on the State's education efforts.

Member Involvement and Protections- Russell Nittler

Mr. Russell Nittler noted that the Member Involvement and Protections work group meets monthly to address issues facing KanCare beneficiaries. During the July meeting participants were asked to note their top two concerns for the transition to the new program. The work group also discussed the KanCare educational tours, member education documents, and the KanCare website. The group also reviewed the KanCare "Quick Facts" brochure and heard information on the assignment process and how beneficiaries can change their MCO assignment outside the enrollment period. Mr. Nittler noted the group's suggestions regarding a KanCare ombudsman, and how Minnesota approached problems with members' MCOs. In the September meeting, the State shared the enrollment packet with the work group and gathered input. The meeting also featured a presentation from Nick Wood of the Disability Rights Center and information about the KanCare State Fair booth.

Mr. Nittler did note that this work group did not meet in October because their regular meeting time conflicted with the first KanCare stakeholder call. The group will meet again November 14th to discuss the final enrollment packet, enrollment tour, and other agenda items.

Provider Issues- Paul Endacott

Mr. Paul Endacott noted that the provider work group also meets monthly. During the first meeting, participants identified provider credentialing and contracting as priority issues to discuss. The group heard information about the standardized credentialing process the KanCare health plans will utilize. The group's second meeting focused on provider payment, including claims processing and billing. The KanCare health plans presented information on how they will configure their billing and claims processing systems, and answered questions from the work group on these issues.

In September the work group discussed timely filing requirements, prior authorization systems, appeals, reporting formats and flexibility. It was noted during the meeting that some providers will need to update the current reporting formats they are utilizing. The group also heard information from KanCare subcontracted organizations regarding their contracting processes. The work group reviewed draft provider manuals and provided helpful feedback to the State.

During the October meeting many State staff were visiting Baltimore to discuss the 1115 waiver proposal, so the group heard some additional information about the status of the waiver discussion. The work group also discussed the October 19th go/no-go decision and its impact on the timing of when the initial assignment algorithm will run. The State's fiscal agent was available to present on the algorithm and how it works.

Mr. Endacott noted that during each of this work group's meetings, providers have given a great deal of input which was helpful to the State, and work group members also send emails and phone calls to staff as issues arise. This information has helped shape discussions between the State and our MCO partners.

David Sanford- I have heard that providers are hesitating to sign contracts with the MCOs until the provider manuals are final. How is this impacting implementation?

Kari Bruffett- Nearly all provider manuals are completed. A few remain outstanding, but we expect them to be completed in the immediate future once the State's requested changes are incorporated.

Steve Kelly- Will providers who are waiting on the information be considered out of network, or will there be a grace period?

Kari Bruffett- All nursing facilities will be considered in-network for 90 days and will be treated as such for the initial assignments to KanCare MCOs. We expect the same kind of treatment for other providers for a period after January 1. That will not be indefinite, but it is our intent that providers who wish to contract will not be penalized for completing the process after January 1.

Tribal Technical Advisory Group- Kari Bruffett



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Ms. Kari Bruffett noted that this group has had a number of meetings to address particular issues, but regular meetings are the first Tuesday of each month. During the initial meetings the work group went over member educational materials with the goal of customizing the content for Native American members who must decide whether or not to opt-out of KanCare. Native Americans and Alaska Natives are unique in their ability to opt out of the KanCare program, so State staff went over the opt-out language in the letter which went out to consumers. The work group also regularly hears from participants about obstacles that might face members after KanCare is implemented, and the group assisted the State in creating options to work through the issues. Ms. Bruffett noted that this month the State began scheduling educational meetings specific to the American Indian population in Kansas. The State is still working to set up those meeting dates and locations.

Audrey Schremmer-Philip- How soon will we know how the opt-out process will work for members, especially those with HCBS services?

Kari Bruffett - All current services will be available through the fee-for-service program, but consumers will not have access to the value-added benefits offered by the KanCare MCOs or the extra care coordination.

Audrey Schremmer-Philip- Who will handle targeted case management, and will consumers still use a medical card?

Kari Bruffett - Yes, they will still use a medical card as will other groups not in KanCare, and targeted case management will be handled through the fee-for-service system when consumers opt-out of KanCare.

Audrey Schremmer-Philip- We need to understand as soon as possible who exactly will handle TCM if a consumer chooses to opt- out.

Steve Ortiz- We are encouraging members not to opt-out.

Kari Bruffett -Thank you. We want to be very clear so that members understand their protections will apply regardless of whether they are in KanCare or not.

Steve Ortiz- One of the issues we dealt with for our tribal members was how to coordinate with the Veteran's Administration. Some tribes have decided to negotiate directly, but others are waiting for a standardized contract. There are a couple of fronts where we need to coordinate.

Presentations by KanCare Managed Care Organizations

Each of the three selected KanCare MCOs was asked to provide a brief presentation and update on their implementation activities.

Amerigroup Kansas

Gary Haulmark, a representative from Amerigroup, noted that the Plan President Laura Hopkins had asked him to present on her behalf. Amerigroup is currently busy with recruiting and training more than 300 new staff for their Kansas plan. Most new staff are native Kansans and the majority are working in the area of care coordination. Mr. Haulmark noted that Amerigroup is holding one of several open house events tonight in Overland Park for new employees who are beginning their employment in December. All of these new positions are offered a full benefit package.

Amerigroup has also successfully processed its enrollment file, and the call center is up and began taking live calls on Friday. Mr. Haulmark noted that Amerigroup has four teams prepared and ready to participate in the State's educational tour later this month. Additionally, Amerigroup will outreach to new members by mailing a pre-welcome flier around November 30 and conducting pre-welcome calls in December. Member ID cards will be sent in December and the official welcome calls will take place in January. Provider training also continues across the state.

Senator Allen Schmidt- When will your provider training begin?

Gary Haulmark- It is ongoing in locations across the state.

Dr. Kevin Bryant- Do you have goals for your ratio of members to case managers?



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Gary Haulmark-That is a complicated question because there are many variables such as case mix. It is our estimate that the ratio will be about 60:1.

Sunflower State Health Plan

Jean Rumbaugh, Plan President for Sunflower State Health Plan provided the Council with a brief update. Sunflower has been working to build our team and be prepared to be operational on January 1st. Eighty-seven percent of Sunflower's projected staff has been hired or offers are pending. Sunflower is also currently completing training and setting up offices across the state. Ms. Rumbaugh noted that during new employee orientations, Sunflower was pleased when they saw the wealth of knowledge the company is building to serve the KanCare membership. We are also building care management teams, with a number of different team members. Staff ratios will depend upon which waiver and specific populations the care management staff will serve. For certain waivers, the ratio could be 80:1, 225:1, or 30:1, depending on care needs.

Additionally, the member support center is currently answering phone calls. The Sunflower State Health Plan website is up and the provider look-up function available, with provider directories available on request. Sunflower is also preparing for the State's educational tours and to send new member outreach, such as the health risk assessment and other tools.

Finally, the health plan is also targeting 100 percent network adequacy by working to get all current providers into network, complete their credentialing, and ensure they are loaded into Sunflower's system. Final provider manuals are all posted online with the exceptions of financial management services (FMS) and behavioral health, which will hopefully be posted soon. Educational meetings are also posted on the website, and provider relations representatives are available by geographic location to assist providers. Sunflower is working to finalize the infrastructure necessary for KanCare, which includes testing, conducting information technology transfers, working through the spenddown process, and any other activities necessary for our January 1st launch.

Senator Allen Schmidt- Could you please repeat the expected care management ratios again?

Jean Rumbaugh- For the autism, developmental disabilities, frail elderly, physical disabilities, and traumatic brain injury waivers, the ratio is about 80:1. For the long-term care population in nursing facilities it is approximately 225:1, and for the technology assistance waiver, it is approximately 30:1.

David Sanford- How many staff members will you have in the State of Kansas?

Jean Rumbaugh – We will hire around 300 new staff. We have more than 200 currently, but we will adjust as needed after we get our membership files.

David Sanford- Will the State automatically assign equally, for example, by county?

Kari Bruffett- The assignment algorithm did not have a geographic component, other than provider relationships. We aimed for equal distribution in numbers and case mix throughout the state. This is one reason we expect plans to sign up more providers than they technically need so they can serve all members who choose them.

Randy Johnson- This is a question for all MCOs—as you build your care coordination teams for mental health, there is value to be gained from people who have actual experience with recovery services. Are you incorporating that into your care coordination programs?

Jean Rumbaugh – We are hiring people with that experience and individuals with disabilities for peer support.

Gary Haulmark- Amerigroup is doing the same.

Nan Thayer Kartsonis- United uses peer programs in our clinical models for care coordination. We also have a peer bridge support program as a value-added service.

Kari Bruffett- The State also asked each of the plans to submit plans for hiring people with disabilities more generally to the State and we will follow-up with them on actual hiring metrics. We will report that as a measure of the success of KanCare.



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Walt Hill- How much time will care managers spend over the phone with patients versus face to face contacts, and do you have any additional ideas for access?

Jean Rumbaugh - It depends upon the individual. Some who are at higher risk will have more one-on-one contact. Providers can also use member connections representatives to identify people who need to come in for appointments. We have telephonic and face-to-face programs, telemonitoring, and other ways to use technology.

Gary Haulmark- The State did a great job to build incentives into the plans' contracts. We have every incentive to take care of our members in the most effective manner, whether that be by phone, face-to-face, or any other way.

Nan Thayer Kartsonis- For pregnant moms and those who have acute conditions, more of our care management will be completed by phone. We also use some more progressive technology to work with those individuals including cell phone programs. The long term care population is more one-on-one due to the risks and disabilities involved. We structure ourselves so that we have back-up for care coordinators doing administrative tasks so our care coordinators can be in the field most of the time.

UnitedHealthcare of the Midwest

Nan Thayer Kartsonis, Plan President for United Healthcare began with an update on United's implementation activities. Ms. Kartsonis noted that United is progressing well in staffing and has currently hired 89 percent of the clinical team, and 100 percent of client services. Many have been hired and in training for a number of weeks. United is having some difficulties hiring a psychologist or additicionologist, but all other positions are in training currently. Ms. Kartsonis told the Council that United will staff more than 300 people in total, and currently has between 220 to 225 people on staff.

United continues to work on network contracting and began meetings with nursing facility providers last week. Ms. Kartsonis noted that United saw tremendous turnout for this initial training and will do more orientations for other provider groups beginning in the upcoming weeks. Provider training opportunities are all posted on the United website and the State's KanCare website.

Additionally, United has begun communicating with members assigned to the plan after the mailings went out last week. Several member orientations are scheduled next week and the information technology and technical teams are working to get those systems up and running. United is also working to ensure a smooth transition of care for all of its members. Finally, Empower Kansans is an initiative to invest in hiring Kansans with disabilities. United will release a request for information in early December for this program.

Dr. Kevin Bryant- What is the ratio of the case managers to members?

Nan Thayer Kartsonis- The ratio depends on the consumer. Excluding the technology assistance waiver, ratios range from 75 to 125 consumers per case manager. Nursing facility caseloads are higher because those folks get 24-hour nursing care. Additionally, all higher-risk patients will generally have a lower ratio.

Update on KanCare- Secretary Sullivan, Ms. Kari Bruffett

Ms. Bruffett noted that the State began mailing the initial assignment mailings on Friday. These will continue to go out over the next few weeks. The Council received a copy of the mailing with the contents of the packets members received. The State will provide copies of these materials on the educational tour. All members also received a separate mailing inviting them to attend the tour. Some of the external work groups made changes to the packet before it was sent, and the State also made changes according to CMS recommendations. One of the major changes made was based on conversations with CMS to allow for the full 90-day choice period after January 1. The State also made it very clear that members can request provider directories in hard copy.

State officials had a very productive meeting with CMS on October 18 in Baltimore. A team traveled to Baltimore to meet with CMS and other review team members to discuss KanCare and the outstanding issues that needed to be resolved to implement the program on January 1. The waiver approval is still not final, but we are very encouraged by our regular conversations with CMS. An additional resolution from that conversation was to revise the structure, but not the intent, of the hospital safety net care pools. The health care access improvement panel will remain focused on uncompensated care.



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Ms. Bruffett noted that the State also continues an ongoing focus on network development. We will post our updated instructions to the plans regarding network adequacy soon, and although we know the higher standard is for the plans to sign up all Medicaid providers, it is important to note what is really required is what's needed to take care of a third of all Medicaid members. Some standards for their networks are mileage/minutes ratios, but other providers have standards based on which communities different providers serve. Since October, we have been getting daily updates on key provider categories. These have been helpful in understanding where the networks are for each of the plans. We were pleased with the assignment results based on both the test and actual operational matching to network providers for each of the health plans. Most members were able to be assigned to current providers if they have one.

Finally, Ms. Bruffett noted that the State continues to work on readiness reviews.

David Sanford- In the member letter, it notes that each of the plans will ask consumers to pick a provider. Will plans know the current providers their consumers are using?

Christiane Swartz- The assignment logic identified the consumer's primary care provider for us. Each person was assigned to a plan based on this and other factors. If a consumer calls the State's fiscal agent or one of the plans, they will have the information about the primary care provider, but the consumer can change that at will. If the consumer does not change, they will remain with their current primary care provider that is listed on their card.

Secretary Shawn Sullivan took the floor and noted that many Council members have asked a few questions about how the home and community based services (HCBS) system will work under KanCare. Secretary Sullivan then went over a list of questions and answers he has received.

Question: What plan does the state have to address ongoing waiting lists for HCBS services?

Answer: The physical disabilities and developmental disabilities waivers have waiting lists. There are a couple of answers to this question. Without KanCare there is very little chance that the lists will be addressed. With KanCare, the State will hopefully reduce the growth of Medicaid per year to a degree which will allow flexibility to reduce the wait lists. KanCare also features a number of benefits for coordinating services for those who are not yet on the waiver. Persons on the waiting list who are currently receiving State plan services will receive care coordination services through KanCare before they begin receiving waiver services. Currently people on the waiting list receive very little contact or assistance from the State. Within KanCare, they will receive frequent coordination from their KanCare health plan. Those not on Medicaid will get at least quarterly contact from the Kansas Department for Aging and Disability Services.

Question: How will the State handle the transition of targeted case management from fee-for-service to KanCare?

Answer: We continue to have regular conference calls and meetings with various case management entities. As consumers of HCBS waivers have notices of action, this will include the program manager's contact information on it to ensure communication. This will allow them to contact the State and get help finding a new agency or case manager as needed. The State is also working with case management entities to start transitioning care plan information to the KanCare health plans. Generally, the State is asking case management entities to transition three pieces of information—the most current Uniform Assessment Instrument, the current or most recent notice of action, and the most current attendant care worksheet that includes the plan of care and number of hours designated for specific tasks. We also ask case management entities to transition any additional information that would benefit consumers.

Question: In our meeting with CMS the State was asked to work on getting the word out for community providers. Providers want to know how the transition will impact HCBS consumers.



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Answer: There are 17 HCBS transition activities that the State has outlined. These activities including the following:

- The State has held extensive educational opportunities for consumers, advocates, and providers (such as town hall meetings).
- Stakeholder engagement occurs through the KanCare Advisory Council and external work groups.
- Managed care organization are accountable to the State through regular meetings with State staff.
- Functional assessments are ongoing, and are to be completed annually for consumers.
- Continuity will exist in consumer plans of care—existing plans must be honored for the first 90 days of KanCare or until a new assessment can be completed by the health plans.
- As assessments are completed, if plans of care are reduced, this must be reviewed by State staff. We do not believe there will be a lot of reductions, but this was a best practice we took from Tennessee and other states.
- State staff will do ride-alongs with care coordination teams from the health plans so the plans understand our instruments and tools.
- Every KanCare consumer will have both the MCO and State grievance and appeal rights before or after an assessment is completed
- Any consumer can begin the State grievance process before the MCO process is exhausted
- A KanCare Ombudsman will be set up for consumers
- Eligibility will be determined by State or contractors, not KanCare MCOs. For many consumers this will be done by the Aging and Disability Resource Centers (ADRCs). ADRCs will serve the traumatic brain injury, physical disability, and frail elderly waiver populations and the nursing facility population. Consumers will be referred by the enrollment center as needed or members can call the ADRC directly.
- A quality assessment and performance improvement team has been set up between KDHE and KDADS. We want clear lines of responsibility for contract and quality monitoring as well as stakeholder engagement.
- The State has delayed the inclusion of waiver services for the intellectually and developmentally disabled (I/DD) consumers for one year.
- A pilot program will occur in the first year of KanCare for I/DD waiver consumers.
- A new front-end billing system will be in place to allow providers options for claims submission.
- We will maintain the 1915 (c) waiver structure and protections for consumers in KanCare even under the 1115 waiver demonstration.
- Technology testing for HCBS and all other provider types will occur prior to launch of KanCare.

Larry Martin - Will you be monitoring data transfers through the KAMIS system?

Secretary Sullivan- That will be an option, we will send relevant data to the MCOs prior to January 1.

Larry Martin - Are monitoring measures going to be available for the Council to use as assessments as well?

Secretary Sullivan- Yes. That will be part of it, in addition to the pay for performance program.

Larry Martin - It will be interesting to see if there is some degree of consistency among the MCOs.

Kari Bruffett- After the first year, we will put together a scorecard on the three plans to help people pick their plans in the future.

Audrey Schremmer-Philip- Did you say that 80 percent of consumers on the wait list will move into KanCare?

Secretary Sullivan - It may depend on the waiver, but that is close for the I/DD waiver. About 80 percent of consumers on the wait list qualify.



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Audrey Schremmer-Philip- Who will help consumers get enrolled? Will that be the ADRCs?
Secretary Sullivan - ADRCs will do the functional assessments and the State will do the financial eligibility determinations.

Upcoming Educational Events- Kari Bruffett

There are a number of educational events scheduled in the coming weeks. The State will hold member and advocate training on November 14th and 30th to help advocates understand what they need to know to assist consumers in choosing a KanCare plan. The fourth KanCare consumer educational tour will be November 26-29 and will feature two meetings per day in 12 Kansas cities. The State will also hold weekly stakeholder status update calls every Wednesday and provider training continues for all three of the MCOs on an ongoing basis.

Next Meeting of KanCare Advisory Council and Final Questions

The next meeting of the KanCare Advisory Council will be Tuesday, January 8, 2013 from 2:00-3:30 p.m. in Topeka at the Curtis State Office Building.

Representative Jerry Henry- When we receive the approval from CMS for the 1115, what will that look like?

Kari Bruffett- It will not just be a signature. There is a set of standard terms and conditions (STCs) that CMS uses for 1115 applications, and that is part of what we are working on with CMS now. We defined much of the STCs based on our application, but we are also including language from other states. It will be a lengthy document. It may include options for subsequent years. For example, we have decided to phase in the employment pilots (but not the developmental disability pilot) in year two. That information on the process for including those pilots later will be in the 1115 STCs. There are also reporting requirements that will change, so the language will address those.

Steve Ortiz- I understood that there were 14 states that opted out of health reform by submitting a waiver. Is that true?

Kari Bruffett - I am not sure what other states have done. The 1115 demonstration application does not impact the Affordable Care Act and is independent of it. We are one of the first states to follow the 1115 waiver process after the new rules and transparency requirements went into effect. The most recent state to have an 1115 waiver application approved was New Jersey and their program has some similarities to KanCare.

Adjournment

Chairman Kelly asked for a motion to adjourn the meeting. Audrey Schremmer-Philip moved that the Council adjourn, and Steve Ortiz seconded the motion. The motion passed and the meeting was adjourned.