Landon State Office Building
900 SW Jackson Street, Room 900-N
Topeka, KS 66612

Kansas Department of Health and Environment
Division of Health Care Finance

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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 March 12, 2013

Council Members Present:
Dr. Kevin Bryant
Dr. DeDe Behrens
Brenda Landwehr
Larry Martin
Colin McKenney
David Sanford
Senator Allen Schmidt
Audrey Schremmer-Philip
Mike Conlin

Council Members Absent:
Mary Barba
Andrew Brown
Dr. John Calbeck
Dr. Craig Concannon
Representative Jerry Henry
Randy Johnson
Steve Ortiz
Susette Schwartz

Council Members Attending Via Phone:
Dave Geist
Walt Hill
Steve Kelley
Barney Mayse

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
Dr. Susan Mosier, Medicaid Director
Lynne Valdivia, Kansas Foundation for Medical Care

Welcome- Dr. Susan Mosier

Dr. Mosier began the meeting and welcomed Council members. Dr. Mosier noted that during the meeting, Council members will hear presentations from Lynne Valdivia of the Kansas Foundation for Medical Care (KFMC), the three KanCare health plans, and Secretary Shawn Sullivan.

Review and Approval of Minutes from January 8, 2013, Council Meeting

Dr. Mosier asked if there was any discussion on the previous meeting's minutes. Dave Sanford moved the minutes be approved. Senator Allen Schmidt seconded the motion and the minutes were approved by the Council.

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Presentation on the Evaluation Plan for KanCare – Lynne Valdivia

Lynne Valdivia of KFMC, the State's external quality review organization, provided an overview of the evaluation plan for the KanCare program. Ms. Valdivia noted that KFMC has a large number of staff members with various skills that will work on the evaluation, and KFMC will hold overall responsibility for the KanCare evaluation plan. The evaluation plan must be submitted and approved by CMS before the actual evaluation activities begin. KFMC will evaluate the extent to which KanCare achieves its overall goals. The evaluation will test the following four hypotheses.

- By holding MCOs to outcomes and performance measures, and tying measures to meaningful financial incentives, the State will improve health care quality and reduce costs;
- The KanCare model will reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired;
- The State will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health, mental health, substance use disorder, and LTSS; and
- KanCare will provide integrated care coordination to individuals with developmental disabilities, which will improve access to health services and improve the health of those individuals.

The evaluation will focus on assessing the impact of KanCare on each population group, the Ombudsman program's assistance, the intellectual and developmental disabilities (I/DD) pilot project, and the impact of the uncompensated care and Delivery System Reform Incentive Payment pools. Specific evaluation elements include outcome measures, comparisons with baseline and control groups, and process and outcome measures. The plan design must be submitted to CMS by April 30, 2012, and CMS will have until June to review the design and provide feedback.

Senator Allen Schmidt- Are the metrics from pre-KanCare the same as we are using now?
Lynne Valdivia- There are many measures that we were using before that will continue under KanCare. We are currently evaluating which measures have data available.
Senator Allen Schmidt- What percentage of the measures for the new evaluation was in place before KanCare?
Lynne Valdivia – Approximately 70 percent due to new coordination of care measures
Kari Bruffett- We have new pay for performance measures as well and we can pull data to produce measures for the baseline in some cases.

Question and Answer Session with KanCare MCOs and the State - Kari Bruffett and MCO Partners

Director Kari Bruffett introduced Nan Kartsonis from United Healthcare, Thomas Killian from Amerigroup of Kansas, and Jean Rumbaugh from Sunflower State Health Plan. Each representative will address the specific issues that Council members provided prior to the meeting. The MCOs will provide an overview and response for each issue area.

Claims processing and payments issues

Ms. Bruffett provided a handout document that compared the payments to providers under KanCare to similar periods prior to KanCare. The document notes that providers were paid $382,834,696 in January and February of 2012, compared to $392, 894,125 in January and February of 2013. This handout includes payments from all payer sources to providers during the given time period. It includes run-out claims information from the previous managed care plans as well.

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The handout shows that there were certain provider groups that had issues known to the State, and these provider groups had lower payments in total for 2013 than in 2012. There are other provider groups where payments were higher due to claims being paid more quickly by the previous HealthWave and other managed care groups. Ms. Bruffett noted that the handout shows only a snapshot, and that the State will have a better idea of the overall picture of claims payments over the entire first quarter. The snapshot does not include non-claims payments made to providers, such as the Health Care Access Improve Program funds. The current handout is based on reported claims from the MCOs, but the State will validate this information with encounter data as soon as that information is available.

Colin McKenney- How do you determine if the MCOs are paying clean claims timely?

Kari Bruffett- We monitor aging claims regularly. To determine if the MCOs have met the pay for performance claims measures we will examine annual data that is validated with encounter data.

Colin McKenney- So if a provider is routinely having difficulty getting payment in 30 days, how would the State intervene?

Kari Bruffett - That depends on how it comes in to the State. If it was through a grievance to the State our contract management staff at the State would escalate the issue to ensure that the providers' issues are resolved. We have found that for many provider groups the issue is getting claims submitted and accepted by the MCOs as a clean claim.

Thomas Killian- Overall, Amerigroup is meeting the turnaround times for clean claims. The biggest challenge is coding or provider type-specific submission issues. We have had issues getting claims through the front-end billing system and our EDI system. For many smaller providers we have providers replicate claims directly through our website to help troubleshoot the issues. We still have a large number of providers coming in through the contracting process so there is some additional work there that will hopefully help with claims submission in the long run. We did have a few systemic issues that we have worked through and we will go back and re-process the claims as needed.

Larry Martin- In Leavenworth, it appears that the communication from the MCOs is what is lacking the most. Providers are having a hard time getting to the person that can help them. I would ask each MCO to provide a roster of who the individuals are on the field such as provider representatives.

NanThayer Kartsonis- What is the best way to communicate that information?

Larry Martin- If a provider liaison will communicate with us, we are happy.

Kari Bruffett - The State could also perhaps help by expanding the call sheet we have developed with provider representative information. That could also help disseminate the information.

Walt Hill- Many of our issues have to do with numerous moving parts not working together properly. Some of our problems involve ensuring the MCO systems are set up correctly. It has been a combination of issues. We have found that the best strategy is to walk through the problem and diagnose where the issues are.

Kari Bruffett - There are various barriers to getting claims submitted correctly. There are other changes that occurred, other than just the change to KanCare, which are impacting claims. Whenever we hear of these issues we try to communicate the systemic problems through provider associations and other groups and form technical work groups to get the issues resolved.

Nan Thayer Kartsonis - It is helpful for providers to provide information about the claims they have tried to submit and what they have been paid. It is always good to get the information.

Kari Bruffett - We also know there are some issues with the Authenticare system where there is a disconnect between what authorizations exist in Authenticare and what providers need to get paid. We have encouraged the MCOs to try and find solutions to pay providers even without the authorizations completed in Authenticare.

Audrey Schremmer-Philip- Everyone has been very responsive, but we need to know who to contact.

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Senator Allen Schmidt- The communication is critical in every aspect. When the communication does not happen it leads to frustrations and delays.

Jean Rumbaugh- If providers have issues we have our representative map on the website, so please contact us. The biggest concern is the issues that we are unaware exist. We encourage all providers to call us with questions or issues.

Provider Contracting and Credentialing

Ms. Bruffett noted that the Geo Access reports on the readiness activities page of the KanCare website will be updated next week. Many large hospital organizations and other large providers have completed contracting recently so we will see those updates soon. KDHE is also publishing a provider bulletin this week which includes the criteria for extending the continuity of care period for providers who are still in the contracting process. This will allow providers to know what to expect at the end of the 90-day original continuity of care period.

Nan Thayer Kartsonis - The Geo Access maps will not include some large hospitals for United because those contracts closed right after we pulled the data for those reports. If you want more information on that please call me for the most updated network picture.

Thomas Killian- Amerigroup has had a similar experience and we are seeing a spike in provider contracts now.

Jean Rumbaugh - Sunflower has also had a few key providers sign contracts recently, but we are happy to provide updated information.

Care coordination process and access to care coordinators

Ms. Bruffett noted that the State has also heard questions from consumers and providers regarding when they will receive their initial assessment and other contact from their care coordinators. The State wanted to ensure that the MCOs made their care coordinators available directly. Secretary Sullivan noted that KDADS will be working with the MCOs to put out some better information regarding contacts and the process for reaching their care coordinators.

Nan Thayer Kartsonis - Our care coordinators are in the field visiting members so we have put a process in place to allow care managers to receive phone messages and contact from their clients.

Dr. Kevin Bryant- Where are the plans at in the process of hiring all of their care coordinators?

Jean Rumbaugh - We are continuing to hire care coordinators and have 10 open positions that we are recruiting. We also have some staff still in training. We are looking at geographic and caseload factors in our hiring decisions.

Thomas Killian - Amerigroup is close to completing the care manager hiring process. We have a couple of positions still open but we will continue to rebalance caseloads to ensure we are responsive to consumers.

Nan Thayer Kartsonis - United has about 4-5 positions open.

Kari Bruffett- The target for completing assessments was to complete as many as possible within the first 90 days. However, in the Special Terms and Conditions of the 1115 Waiver, the MCOs are allowed up to 180 days to complete assessments. If an individual has not received their new assessment and plan of care in the first 90 days they will have up to 90 additional days for continuity of care and the choice period.

Nan Thayer Kartsonis - We did very well on assessments until the snow storm which slowed us down. There is a certain percentage of people that we cannot reach, so please let us know if you have heard from people who have not had contact. We call everyone first then do a clinical triage to ensure the highest risk folks are assessed first. Regarding referrals from the ADRCs, we have a system in place and a seven-day turnaround to complete assessments and pricing.

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Thomas Killian - It is a similar process for working with ADRCs at Amerigroup and we also have a seven-day turnaround. Amerigroup is making good process on completing our assessments and currently have about 70 percent of our total number of assessments complete. We also prioritize assessments and do the most critical members' assessments first.

Jean Rumbaugh - We have a number of assessments still to complete and we are prioritizing members whose plan of care will expire. We may have to do NF POC assessments after the first 90 days. In the meantime we are working with the NFs to ensure they have a contact in place and can reach us if they have a patient who needs a quicker plan of care change. We also have a process to meet the seven-day turnaround for the ADRCs.

Audrey Schremmer-Philip- That may explain some of the confusion for Money Follows the Person (MFP) program members.

Nan Thayer Kartsonis - We had a mechanism to identify those individuals but it may have not worked perfectly. We want to track any members who are on MFP that have not had contact yet, so please let us know as you come across those.

Barney Mayse- When a member comes off the waiting list, how quickly will they be assessed and a plan of care developed for them?

Secretary Sullivan- It would be the same as anyone else, a seven day turnaround for each step.

Crisis Exception/Expedited Services process

Kari noted that the State also heard that there were some issues with crisis exceptions for individuals who did not have a Medicaid ID number. Secretary Sullivan noted that the process in this case is generally that if someone is referred by Adult Protective Services, the program manager at KDADs is notified. They will then complete the exception paperwork and send it to DCF. If the person is already approved for Medicaid, that person quickly goes onto the waiver. Ms. Bruffett noted that the State wants to ensure that there is no delay in consumers receiving services in these situations where the MCO has no knowledge of the member until they become Medicaid eligible. The State is working with CMS to see if we can get federal match for these administrative services.

Audrey Schremmer-Philip- We have done this for many years without reimbursement. We also tried to create programs to fill the need for in-home care before someone becomes eligible. Now we feel as though our hands are tied.
Kari Bruffett- We need to follow-up on how the State can help get community organizations involved to help before someone becomes Medicaid eligible.

Larry Martin- Providers need some details regarding what is required and provided through value-added services. I would like to see the detailed information on value-added services.
Nan Thayer Kartsonis- I have provided a summary.
Audrey Schremmer-Philip- It would be wonderful to provide that information to the ADRCs to use as a resource in helping people choose their plan.

Update on I/DD Pilots – Secretary Shawn Sullivan

Secretary Sullivan of the Kansas Department of Aging and Disability Services updated the Council on the I/DD pilot project. Around 8,000 people are served through the waiver program but waiver services are currently not in KanCare. A pilot program has been established for this population until they transition to KanCare in 2014. The Department (KDADS) has worked with an advisory group to develop the pilot program, which began this month.

The pilot is a voluntary program that allows consumers and providers to sign up and participate. The goals of the program are to help providers acclimate to the new system and to help consumers learn about managed care. The pilot also will help partners at the KanCare health plans better understand the I/DD service system and demonstrate how these services will be integrated with other KanCare services. The pilot will also ensure that plans of care issues are worked out before people transition to KanCare, and help allow a smooth transition of targeted case management with the

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Community Developmental Disability Organizations. Further, the pilot will attempt to address challenges in the current system, including employment support options and helping support people with challenging behaviors.

KDADs released an invitation letter in February. The agency has currently received responses from 19 providers and 500 participants stating that they would like to participate. Next steps will include regular communication between program staff and MCO staff. A letter will go out soon to the 500 participants describing the program and how to opt out and have their questions answered. The advisory committee will continue to meet and focus on how to get billing systems built into the pilot as it moves forward and will work on how to collaborate with mental health system.

Colin McKenney- You mentioned payment and billing pieces coming online in August. Would this test the same issues?
Secretary Sullivan-We would like that but the budget proviso limits what we can do regarding billing. We want the pilot to be as similar as possible to the full implementation in January.
Colin McKenney- Some organizations have all or nearly all of their participants opting in. Is that what you expected?
Secretary Sullivan- Our letter noted the new opportunity, but we expected that as providers signed up they would contact their consumers with information as well. People are more likely to sign up if their local providers contact them.

Upcoming Educational Events – Dr. Susan Mosier

Dr. Susan Mosier noted that the State has rescheduled some of the KanCare educational meetings that were cancelled due to inclement weather. For consumers, the State has rescheduled meetings in Hays on March 18th and in Wichita on March 20th—both from 6-8 p.m. Provider meetings have been rescheduled for March 18th in Hays, March 19th in Dodge City and March 20th in Wichita. More information on these meetings is available on the KanCare website.

Next Meeting of KanCare Advisory Council and Final Questions

The Council then considered the question of whether or not to extend the Advisory Council's role for one or two additional meetings until the KanCare Oversight Committee is in place. Council members were originally asked to serve for one year, but there will be a gap of a few months before the oversight committee will be formed. Colin McKenney moved that the Council be extended for two additional meetings. Larry Martin seconded the motion and the motion passed. Meetings will be scheduled for May and July of 2013.

Adjournment

Dr. Mosier asked for a motion to adjourn the meeting. Audrey Schremmer-Philip moved that the Council adjourn, and Walt Hill seconded the motion. The motion passed and the meeting was adjourned.