

**KanCare Advisory Council
Curtis State Office Building- Room 530, Topeka, Kansas
Minutes of September 25, 2014**

Council Members Present:

Chairman Larry Martin
Representative Jerry Henry
Representative Susan Concannon
Jamie Price
Mark Hinde
Beth Simpson
Edward Nicholas
Lora Key
Njeri Shomari

Council Members Absent:

Senator Mary Pilcher-Cook

Council Members Attending Via Phone:

Dr. Michael Kennedy
Senator Allen Schmidt
Walter Hill

Other Participants:

Aaron Dunkel, Deputy Secretary, Kansas Department of Health and Environment
Susan Mosier, M.D., Director of KDHE Division of Health Care Finance / Medicaid Director
Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services

Welcome – Chairman Larry Martin
Larry Martin opened the meeting.

Review and Approval of Minutes from Council Meeting, June 11, 2014.

The meeting minutes were unanimously approved by the Council as published. Mark Hinde made a motion to approve the meeting minutes and Jamie Price seconded the motion.

One addition was made to the agenda: Pharmaceutical Reimbursements-presented by Kelley Melton.

Pharmaceutical Reimbursement Summary – Kelly Melton

Kelley reported on issues surrounding MAC (maximum allowable cost) pricing.

Pharmaceutical claims are paid the contracting price, (KanCare MCOs are required to pay the equivalent to the contract price), or will pay a MAC price which is highly variable for generic drugs and is based on market trends and fluctuations. Positives to MAC pricing are that there must be an appeals process. Each of the MCOs has a MAC list that is specific to KanCare. Try to develop base rates so they can be better in line with the state contracts. Pharmacy reimbursement has remained stable or done a little better compared to pre-KanCare numbers.

Challenges: Pharmacies need to purchase competitively and wisely. The appeals process is more challenging. We monitor the appeals that are approved and how quickly they are approved. State is working in conjunction with the MCOs to monitor the MAC situation and to keep it up to date and to recognize areas needing improvement. In 2014, we have seen improvement both in MAC rates and the process as a whole. This will be an ongoing discussion as prices are always changing and we will always need to keep up with them.

Questions and Answers:

Beth Simpson – To buy pharmaceuticals competitively, it is often in volume and the buying power of independent pharmacies is not such that we can get the best price if the MAC is really low. The fluctuation in the market makes it difficult and how quickly MACs gets raised. If one MCO takes a long time to update their MAC and the others don't, six months versus one month, there is no recourse for the pharmacy to dispense that. Now more generics and that's when MAC comes into play. It would be nice if there were a set day or looking at market and it's been seven days since the increase on the market that the State will take that into account and have the MCOs update quickly rather than going through a lengthy appeals process that may take six months.

Kelley Melton – When it does get appealed, and when an MCO does adjust that pursuant to an appeal, they are supposed to go retroactive to the date of the claim on the appeal, but this doesn't apply if the pharmacies aren't appealing. If a pharmacy has taken a loss, pharmacy needs to appeal so that is on file so that we can go retro to that. And, we do have timeframes for how quickly MCOs do need to have those MAC appeals turned around. MCOs are required to respond to appeals in 30 days so that hopefully if you are seeing a loss on a specific claim, if you're refiling it, you aren't seeing it twice. We are asking pharmacies to meet us halfway. Part of what drives updates is hearing from providers. We do not know pricing is an issue until a pharmacy tells us because we are not processing claims anymore.

Larry Martin – How long is the appeal process?

Kelley Melton – 30 days from the date that the pharmacy files the claim.

Larry Martin – Will they all have their MACs posted by October 1?

Kelley Melton – Sunflower has real time look up, Sunflower and United both post pdf lists and those changed recently are highlighted. Each of the MCOs keeps a separate rate sheet, but by the end of the year they should have "real-time" online pricing for pharmacists to check when filling prescriptions.

Updates on KanCare with Q & A

United Healthcare Community Plan – Tim Spilker

Tim Spilker provided a brief update on United Healthcare.

Three areas of focus: Member Care, Provider Collaborations, and Operations Consistency.

- Member care: Their main focus is on whole person community based care. Everything starts with the members. a) In the last six months to a year, an interdisciplinary member approach focusing on care coordination has been implemented. b) Now managing two 2-hour sessions a week to review member cases including both waiver and non-waiver members and take into account the whole needs of a person including medical, behavioral, RX, family, and community needs and develop the right care plan. As this has developed, providers have recently been included in those sessions to gain insight on feedback on the program. c) Locally driven care: The Peer Coaching program includes a number of certified staff who has personal experience with and have recovered from their own behavioral health issues. Therefore, members who participate in the program get a different type of support, and it has had a tremendous impact.
- Provider collaborations: a) There are 64 health home providers that are contracted or in the process of being contracted. We are starting to see claims come through for the six core services: health promotion, care management, social support, individual family support, transitional care, and care coordination and so far we haven't seen any operational issues regarding claims. b) We are focusing on our home health partners and are sharing information such as data, insights, training which has been very beneficial.
- Operations Consistency: a) We continue to focus on operational improvements. We have simplified retro eligibility processing that should impact the hospitals by catching denials on the front end. b) We are working with our nursing facilities on retro rate changes and have adopted a policy that we will only recoup those claims if they are over a certain dollar amount. This limited the impact for some providers. c) We are continuing to focus the HCBS and facilities on timeliness and accuracy and our turn-around times are looking good compared to where we have been in the past. DD claims continued strong performance. d) Accounts receivable is working with the hospital association as well as specific providers to address accounts receivable issues.

Questions and Answers:

Jamie Price – Are you working on a process for sedation dentistry?

Tim Spilker – Yes, we are actively working through that with them.

Jamie Price – Do you have an estimated time on when that will be completed?

Tim Spilker – The process will hopefully be completed in the next 30 days. Grace Med has been a great partner and we are taking a holistic approach to this.

Amerigroup Kansas – Laura Hopkins

Laura Hopkins provided a brief update on Amerigroup.

- Continue to improve claims operations with the recent addition of an enhanced automation process that we think will help us auto-adjudicate a higher percentage of claims. Thus, increasing the claim volume that goes through. Current turnaround time is five to seven days. A recent demand caused the turnaround time to increase to seven to ten days with the huge volume of children being screened with the return of the school year. But, this has returned to normalization.
- A joint operational meeting has been added with our large partners to touch base and ensure we are delivering on services and working with individual providers with open accounts. We are working on simplification around CMHC annual off basis for services announced recently at the CMHC board meeting.
- Due to enhanced servicing, we have added persons and we are redrawing territory maps. We have increased our footprint in a couple of areas. One is in extending our integrated rounds.

We have a high focus on employment. We have enhanced our outreach to ensure people are getting the servicing they need.

- We have 7,500 people enrolled in September for SMI health homes. We have fewer than 100 people who have opted out. We are working on re-integration of nursing facilities. We have 56 SMI health homes and about that many for chronic care as well. Continuing to actively recruit chronic care and health homes. Working with hospitals, health homes, and individual partners.

Questions and Answers:

None.

Sunflower State Health Plan – Chris Coffey

Chris Coffey provided a brief update on Sunflower State Health Plan.

Operations: a) Increase in numbers within the claims department staff in all areas, the staff has now been more than doubled. To help minimize claims issues is provider awareness and education as to how to file them; b) Payment accuracy at 98.8%. Conscious of the fact that the remaining 1.2% still translates to 3,000 claims based on average of 290,000 claims filed in a month. Goal is 99.5%; c) Processing time is down to five days. d) DD: Denial rates below 3%, total year to date around 14%.

Relations: The year 2015 will initiate a revamp of provider relations in terms of areas of focus.

Provider Performance Managers are being added to look into how they can fill in care gaps, assisting the providers with finding out where those gaps are and then gauging their performance.

Member Programs: a) CentAccount program – a credit/debit card that goes to members based on healthy living statistics (well-child visits, PCP visits, and the completion of various screenings) a financial incentive can be awarded to them which accumulate per health status. In 2015, we are broadening the scope as to where they can take card that will be allowed to buy diapers, baby wipes, medications, etc. Enhancing the program will hopefully change outcomes in member focus and drive on their health status. b) Start Smart program – Designed to assist pregnant mothers. Program provides information and resources to help pregnant mothers understand what it needed to care for their child and remain healthy.

Health Homes: About 12,000 members today and have received over 500 claims. Have robust network and are starting to reprioritize the shift towards chronic condition. Will be ready by Jan 1.

Questions and Answers:

None.

Update on I/DD Implementation and U.S. Department of Labor Rule – Secretary Kari Bruffett, Kansas Department for Aging and Disability Services

Secretary Bruffett provided an update on DD Long Term services and supports. At this time, it is still being implemented and they are now beyond a resolution of the underserved list. Presently, MCOs have assessed every individual previously on that list. A partnership with CMS resulted in eliminating the list in just six months. 1,700 individuals who were on list included some who had requested to be on list but didn't have an immediate need. Of those 1,700, about 800 consumers requested and received additional services. The cost of those additional services is estimated at \$11.6 million. For persons whose need wasn't immediate, they can be assessed at any time and are urged to contact their targeted case manager which eliminates the need for a waiting list. Persons will have to be assessed because the services are provided as needed. It doesn't always match up one-to-one with the service requested. However, the expectation of the waiver is that the services do match up to the need.

Statistics on provider payment and turnaround time for processing claims: Average time to pay claims is around 6 days and denials rate is 2 to 3% which includes duplicates. Number of edits to the system that were turned off caused some concerns. Asked MCOs to work together to put together a transition plan for edits to be turned back on. This will be done across the system by all three MCOs.

Progress on waiting list for DD and PD waivers: In calendar year 2014, there were over 100 previously unserved persons who were placed into service. And within the last week, another 100 offers for DD services were made. To date, KDADS has offered 500 individuals on the PD waiting list services not including people in crisis. 219 offered in July and another 119 since July 31. Waiting list has over 3,000 people on it. KDADS is working to send out notices to people that they have had difficulty contacting, the process continues to either have them removed from the list or services are rendered. The targeted goal by the end of December 2014 is 6,092.

Update on U.S. Department of Labor Rule

Companionship Exemption: Last fall, the U.S. Department of Labor issued a reinterpretation of their regulations about companionship exemption. For forty years, individuals who are sole employers who employ people in their home for companionship services were exempt from the FLSA requirements including minimum wage, overtime, etc. In Kansas, we are in the 4-6th percentile of home and community-based services for consumers who self-direct their care. For those consumers, they have been able to hire and fire and direct and manage the work of the people that work for them and they can exceed 40 hours. The concern is overtime and how you actually "count time" or most nearly, how we define hours paid would be changed based on new interpretation. The U.S. Department of Labor recently put in a final rule to change from a Common Law test of to the Economic Realities test.

According to the U.S. DOL, how these tests are interpreted will be defined by the courts. With guidance from the Department of Labor, we believe that there is a high likelihood that if not the state of Kansas, at least our Financial Management service would be considered joint employers based upon the model we have in Kansas. However, there are many factors and we are awaiting a definitive response from the Department of Labor on our request to rule that Kansas' self-directed consumers can continue to use the companionship exemption and or to delay the implementation of the rule.

To date, we have had six teleconference calls with the Department of Labor and we continue to be concerned about impact. The concern is the potential cost implications of keeping track of time as required by the new rule. For example, if the State were considered a joint employer and direct service works for both consumers would count in two different services and travel. We don't have system to track hours that way. Currently, direct service workers who work for more than one consumer are taken from a direct data pull.

Half of fiscal note would be tied to sleep cycle support which is currently paid at a unit cost (\$30-35, depending upon the waiver) not an hourly cost. There are some ways to mitigate the cost such as limiting the number of hours or limiting the number of people who receive sleep cycle support. For the approximately 1,400 people who receive the care, it is critical and by eliminating this service, the result would be to place them in a nursing home or an institution. We continue to work with the Department of Labor and are somewhat encouraged about the likelihood of delay. At this time, we do not have an answer from the federal government as to when they will decide. We have been told on several occasions that they have twin goals: a) to protect the interest of direct service workers and b) to ensure that they do not disrupt creative living arrangements. The greatest impact is on self-directed consumers as well as agencies. We know that at the very least capacity would be impacted as well. We will not recommend limiting consumers' plans of care to 40 hours but there are other states that have taken this action. It is a potential outcome, but not a favorable one.

Questions and Answers:

Allen Schmidt – Did you say that travel would be included in that 40-hour calculation?

Kari Bruffett – Right. If the state or FMS agency were considered the joint employers, then travel time between consumers would be equivalent to going between two work sites.

Allen Schmidt – Thank you.

KDHE Update - Susan Mosier, Division Director and Medicaid Director, and Mike Randol, Director of Program Finance and Informatics, Division of Health Care Finance, Kansas Department of Health and Environment

Mike Randol gave a brief update on the finalization of capitated payments made to MCOs. In fiscal year 2014, we are seeing positive trends in what the MCOs have reported as losses when compared to that of the first fiscal year. We are confident that this trend will continue for the remainder of the year.

State's response – a) Mid-year rate adjustment: Currently, finalizing capitated payments made to the MCOs and we are looking at several factors within that increase. Many are familiar with the health insurance tax that came out of the ACA which the MCOs will be a paying tax based on premium revenue earned. We have to reimburse for that tax as it has to be a part of that capitated payment and the midyear rate is to adjust per reimbursement. b) Adjustment for the inclusion of I/DD underserved: Ensuring that cost incorporated in the capitated payment, as well when the I/DD long term support came into KanCare in February it required that we do a mid-year review to account for those costs to ensure those costs were properly accounted for. c) Methodology from a KanCare managed care perspective: How we set and determine a baseline rate. When a managed care program comes into existence, you are utilizing fee for service data. For the first time in the rate adjustment we are looking at year 2013 and use counter data which is the actual experience of the MCOs. We are finalizing CAP payments and working with our actuaries to finalize that and negotiate the new rates with the MCOs.

Questions and Answers:

None.

Dr. Susan Mosier gave a brief overview of the Executive Summary and the Utilization Report for calendar year 2013.

Stated that Kerri Bacon (ombudsman) was unable to attend but she did provide her report. She then directed council to contact Kerri with any questions.

Executive summary: Eligibility composition and expenditure composition reports. Top 2 categories: a) Individuals with disabilities comprise 15 percent of population and about 48 percent of expenditures. b) The children comprise 65 percent of population and 23 percent of expenditures.

Capitated payments by cohort and members by cohort: These remain unchanged. Highest area for capitated payments is: long term care. This includes nursing facilities; money follows the person and the waivers for the physically disabled and frail elderly. Second, is TANF and PLE population and

then depending on MCO it's either individuals on the DD waiver or the SSI dual and non-dual population.

Membership: The highest membership is TANF and PLE (poverty level eligibility) followed by CHIP which has been relatively stable in 56,000-57,000 member range for the past several months.

Capitation payments and average member counts have remained stable with an even distribution by MCO for this calendar year to date. Information on provider networks from the 3rd quarter of last year to this 2nd quarter of this year, we have had an increase in the number of unique providers in all 3 of the MCOs provider networks.

We have specific information on unique providers for persons on IDD waiver including both HCBS and TCM. Customer service reports for both the member and provider. Denial rates have been relatively stable at 15%. In value added services there will be a few changes to some of those services coming up in the next calendar year but adult dental care and member incentive programs continue to be popular.

Correction: Sunflower totals for members should be 1,091. Value of services avoided was a little over 1.4 million. Remainder totals are correct. Grievances and appeals, remains stable with three of top five being the same across all 3 MCOs: Billing and financial losses, attitude of staff and timeliness. Pay for performance measure for year 1 was left for ease of access.

KanCare utilization report – From calendar year 2013, the goals with KanCare and things we are trying to achieve are a) integration and coordination of care across all the spectrum of health. b) We are looking at moving people on the continuum of healthcare from care to health. c) We want to create a greater focus on prevention wellness and early detection and early intervention.

Dental, vision and primary care utilization has gone up. Transportation is expected to go up as well with people going to more of these visits. What we would expect and what we want to achieve is to have the Outpatient ER visits and inpatient days to go down and we do see that those have reduced.

Width Distribution Factor: The information is based on encounters. Encounters are the information that we get back from the MCOs after a claim has been processed and adjudicated. We get 94-98% of encounters back which is relatively high compared to other states where the number is in the low 90 percent. We are doing very well and the MCOs are doing well in getting that information. Yet, there is 2 to 6% that we do not have back and that is the width distribution factor number based on if we had 100% of the encounters to look at.

Annual report – Was not included in the overview for the sake of time but council was advised that it is available on the KanCare website, www.kancare.ks.gov. Also noted were the KanCare Quarterly Reports which can be found on the KanCare website - policies and report section.

A companion report for this comes from EQRO which is the Kansas foundation for medical care. The report includes total annual expenditure and quality strategy and that is available on the KanCare website. We have information on HCBS waiver waitlist and the managed care delivery system. Updates on the utilization data will be in 2014 report. Finalization of 2013 info about quality surveys and HEDIS measures should be coming out in October. Each MCO has a project that they are working on individually and then a comprehensive pre-diabetes care performance improvement projects that they are working on together.

The report ends with the summary plan financial performance which has several attachments including KanCare budget neutrality demonstration year 1. Large table is total expenditures by Medicaid eligibility group comprised of 9 populations divided into “per member, per month” for each group.

Upper right corner is the number of unique enrollees for each of the nine populations and overall unduplicated beneficiaries served for year one was a little over 413,000. This report doesn't include CHIP.

Questions and Answers:
None.

Larry Martin asked if there were any questions, comments or suggestions for the next meeting. Next meeting will be on 12/15 from 2:00-3:30 p.m.

Questions and Answers:

Dr. Mike Kennedy – Suggested that we get handouts out to members that call in.

Dr. Susan Mosier – We will make sure to those items out ahead of time.

Allen Hinde – Would it be possible to get the MCO's slides emailed out to us?

Dr. Susan Mosier – United Health Care had a set and the other two were verbal reports.

Beth Simpson – Is there was any way that we could get the next agenda or an overview for psychiatric treatment facilities for children?

Dr. Susan Mosier – We'll add that.

Edward Nicholas - Asked for clarification on flipping the switch in terms of edits.

Kari Bruffett- In the claims system, there are some automated processes where information is required or if a claim doesn't have certain information then the claims would be automatically denied. MCOs turned off the part that would automatically deny claims. Some of the edits will be turned back on. More so, just insider claims payment information.

Susan Concannon – While in D.C. for a Medicaid policy summit, she learned that other states that have managed care are not finding success with Health Homes. Stated a lot of it was due to the fact that the paperwork involved was difficult for physicians. Without that medical aspect, Health Homes is hurting. What kind of paperwork do we have in KS?

Laura Hopkins – The documentation for the six core services have been put in place by CMS. It is pretty flexible but is up to Health Homes and how they choose to implement the services.

Tim Spilker – All three of us have different technology solutions and some providers have their own. There is a heavier reliance that health home partners are leveraging technology in hopes of member support. Should simplify but they are specific requirements.

Beth Simpson – Is there any sharing of costs? Isn't it about \$5,000?

Tim Spilker – Yes. We have been taking on the cost for our Health Homes partners. Our intent is to share as much information through the population industries.

Laura Hopkins – Briefly discussed protected health information and security risk.

Chairman Larry Martin thanked everyone for attending the meeting and adjourned.

Next Meeting of KanCare Advisory Council – December 15, 2014, 2:00-3:30 p.m., Curtis State Office Building, Room 530