KanCare Update to Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight

December 28, 2015

KanCare Topics

- KanCare Overview and Opportunities
- Inspector General Update
- Waiver Integration Project
- Psychotropic Drug Use, Prescription Drug Process
- Hepatitis C Drug Use
- Health Home Update
- MCO Financial Status
- KanCare Executive Summary
- HCBS Waiting Lists Update
- U.S. Department of Labor Rule
- 1915(c) Waiver Renewals

KanCare Overview

- KanCare 1115 Waiver Project
- Beginning year 4 of 5 year demonstration
- Capitated risk-based managed care model
- 95% of populations and services
- Break down silos of care
- Improve quality/outcomes and bend cost curve down
- Integrated, coordinated care
- Increased emphasis on health, wellness, prevention, early detection and early intervention

KanCare Opportunities

- Continue capitated risk-based managed care
- Further break down silos of care
- With stakeholders, explore and implement alternative payment models tied to quality and outcomes
- Employ advanced data analytics and predictive modeling for program improvement and MCO oversight
- Leverage public health expertise and programs
- Provide opportunities for job training and employment

Inspector General Update

- Have increased salary
- Position is continuously posted
- KDHE continues efforts to find a suitable candidate

Waiver Integration – Purpose

- To create parity for populations served through Home and Community Based Services (HCBS) – services should be based on a personalized plan of care and centered on an individual's needs rather than their disability
- To offer a broader array of services – some individuals have disabilities that qualify them for more than one HCBS program, but they are limited to a single set of services
- Entrance to HCBS will remain the same, but services will fall into two broader categories:
  - Children's Services
  - Adults' Services

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Waiver Integration – Update

- Public information meetings and calls held August 25 – September 2, 2015
- Waiver Integration Stakeholder Engagement (WISE) workgroup convened and met in September and October
- Project implementation date moved to January 2017
- WISE workgroup recommendations posted and shared at public meetings and conference calls held in November

Waiver Integration – Next Steps

- Stakeholder focus groups will provide advice and recommendations on:
  - Defining new services
  - Refining and improving supportive employment
  - Developing a communication and education plan
  - Dealing with waiting lists
- WISE workgroup recommendations, focus group recommendations, public input and MCO recommendations will all inform development of 1115 amendment

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Psychotropic Drug Use

Mental Health Medicaid Advisory Committee (MHMAC)

- Charged with providing recommendations to the Medicaid Drug Utilization Review board to promote better management of behavioral health drugs in the Medicaid program
- 3 meetings have been held (Sept. 1, Oct. 28, & Dec. 9)
- In addition to review of proposed criteria, MHMAC board members have discussed processes for MCO PA implementation and review, including a 'Preferred Prescriber Status'
- Next meeting scheduled for February 9th

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Approved MHMAC Criteria

- Approved MHMAC proposals that will appear before DUR Board on Jan 13th:
  - Antipsychotic Dosing Limits
  - Use of Multiple Concurrent Antipsychotics
  - Antipsychotics for Children Age 13 or Younger
  - Benzodiazepine Dosing Limits
  - Use of Multiple Concurrent SNRIs
  - Use of Multiple Concurrent SSRIs
  - Use of Multiple Concurrent Antidepressants

DUR Board

- Drug Utilization Review (DUR) Board must accept or reject proposals in full
  - If rejected, proposals will return to MHMAC for further development
  - If accepted, state will coordinate implementation (with patient and prescriber education and outreach) with MCOs

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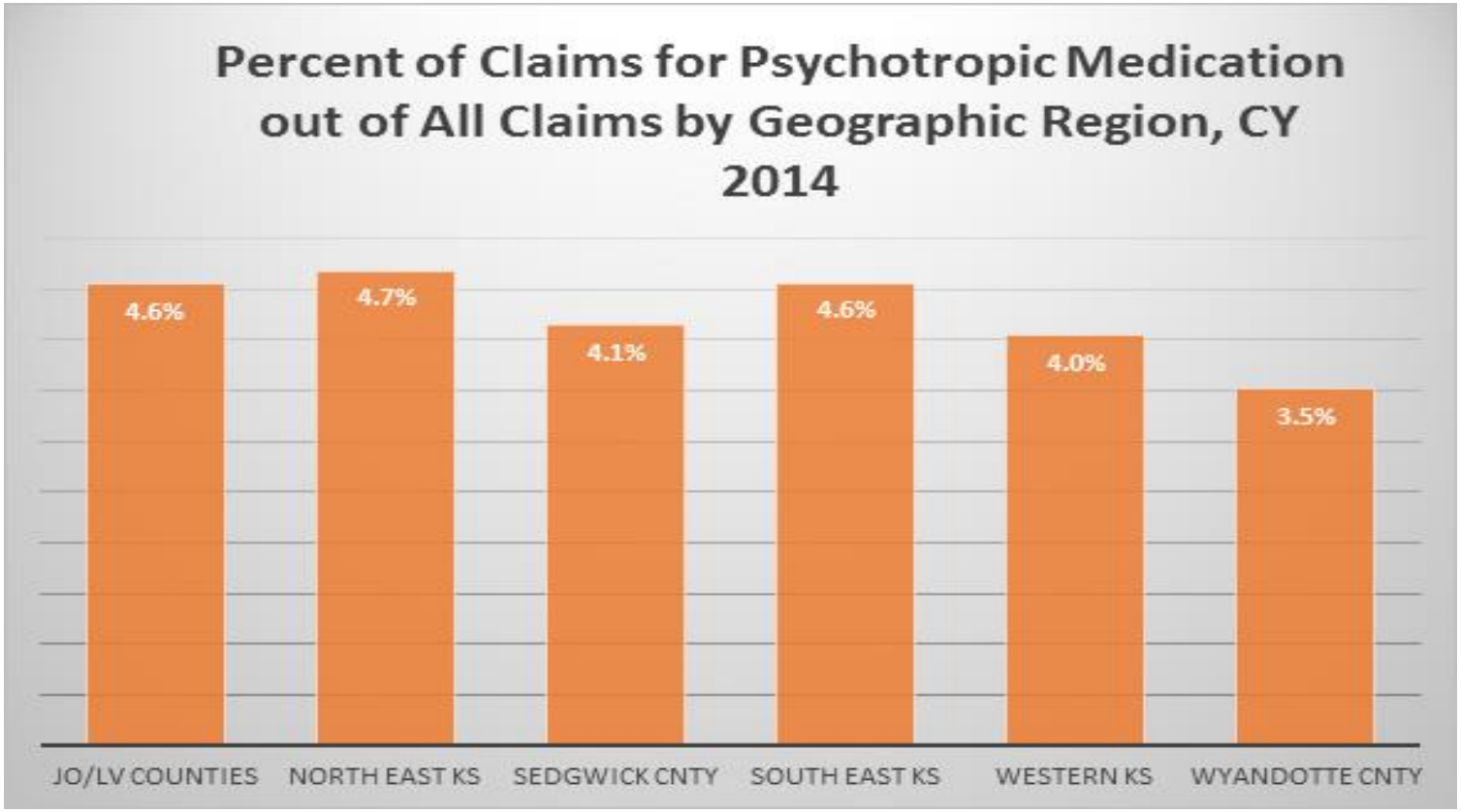
August Follow Up – Psychotropic Use

- Are there certain geographic regions that more heavily utilize psychotropic drugs?



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CMS Hep C State Release

- CMS released comments on Nov. 5th regarding state Medicaid coverage of Hepatitis C medications
- Commentary focused on 2 primary concerns:
  - Criteria Consistency: CMS cites inconsistency between fee-for-service Medicaid and managed Medicaid PA criteria
    - Additionally, inconsistency between criteria utilized by different MCOs in a given state
  - Excessive Barriers: CMS cites ‘arbitrary’ PA criteria pieces that may hinder drug access

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CMS Hep C Concerns Addressed

Addressing CMS' Concerns:

- Criteria Consistency:
  - Kansas is already compliant with CMS' suggestions, as all 3 MCOs plus the state's Fee-For-Service program utilize the same DUR-approved PA criteria for all medications, including Hepatitis C medications
- Excessive Barriers:
  - After discussions with CMS, we believe our criteria is appropriate. CMS' intent was to target states with outlier practices.

Hepatitis C Drug Use

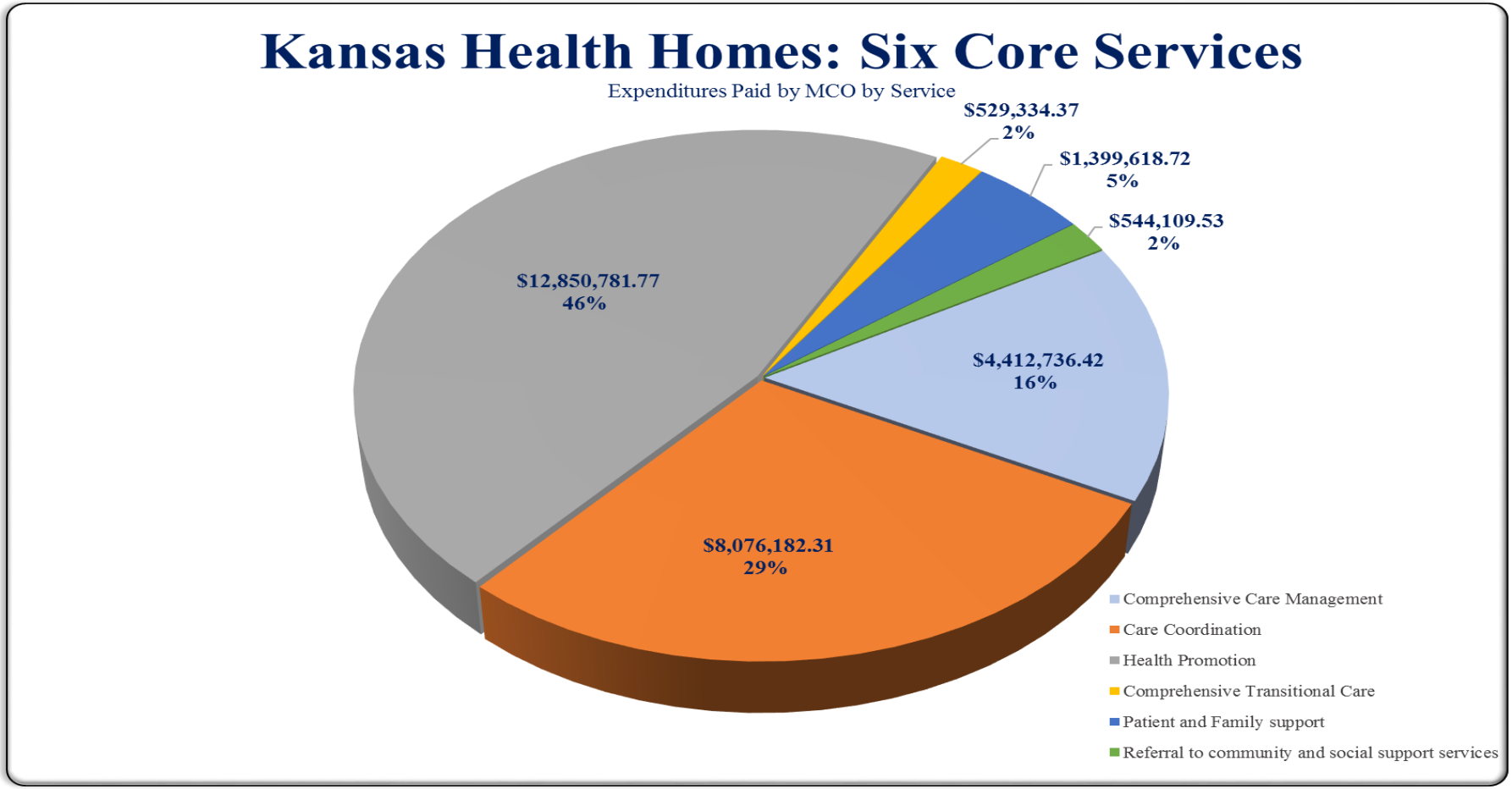
Hepatitis C Case Rate Expenditures by MCO

MCO	CY 2014	YTD 2015	Grand Total
Amerigroup	$6,600,149	$2,654,647	$9,254,796
Sunflower	$6,437,131	$6,251,152	$12,688,283
United	$3,785,401	$2,988,486	$6,773,887
Grand Total	***$16,822,682***	***$11,894,284***	***$28,716,966***

Health Home Status

- Health Homes Conference was held in Wichita August 11 and 12, 2015. About 250 staff from Health Home Partners, state agencies and managed care organizations attended.
- State staff have met onsite with many health home partners at their facilities
- A Health Homes dashboard is on the Health Homes website available at: http://www.kancare.ks.gov/health_home/hh_dashboard.htm

Health Home Core Services



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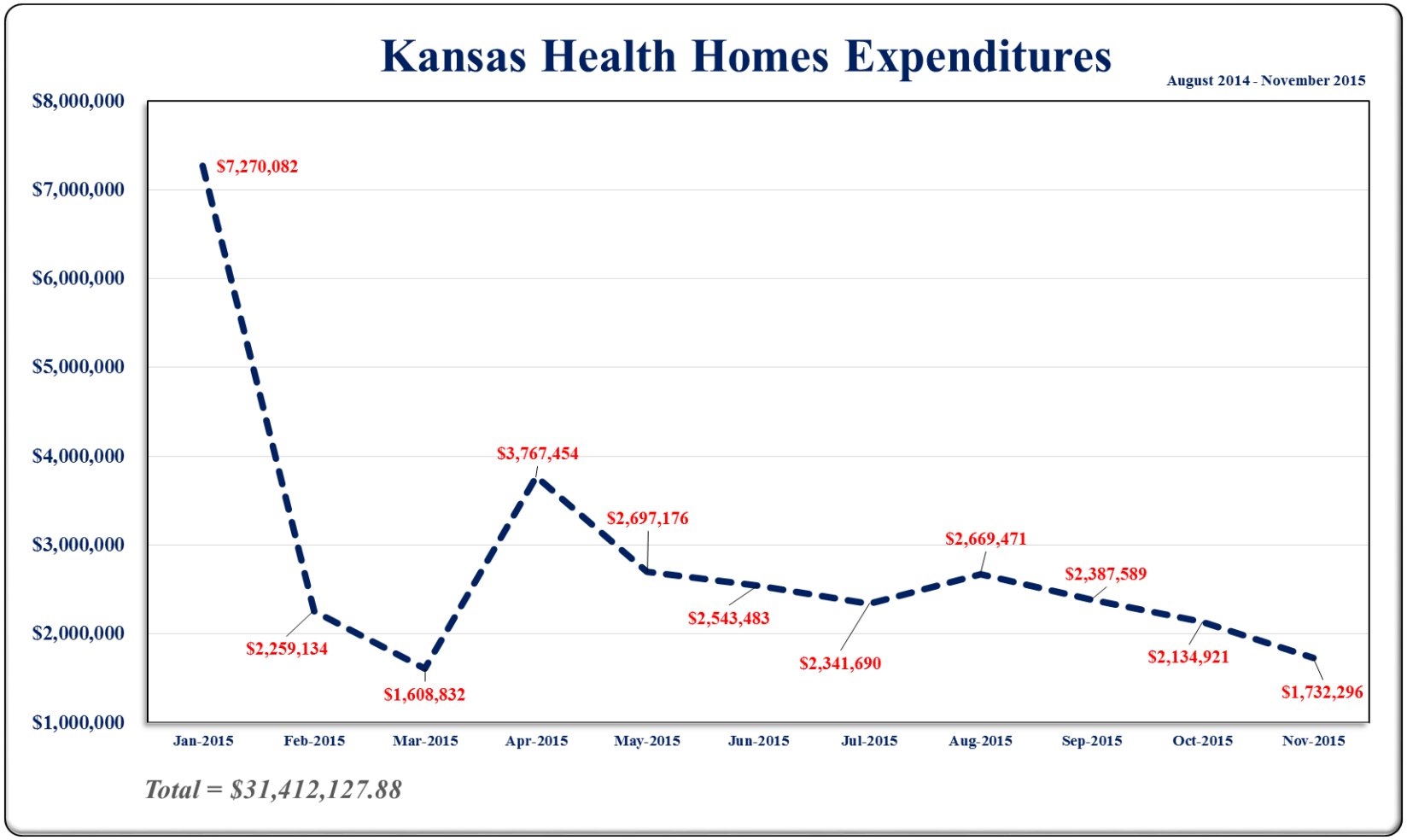
Health Home Expenditures by Month



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August Follow Up – Length of Stay

- Why was the fourth quarter average hospital length of stay so much higher than the previous quarter?
  - Utilization data, including average length of stay, are subject to claims adjustments. A 6 month lag is necessary to allow for provider billing, claims processing and payment; however claims may continue to be adjusted up to a year after first submission.

MCO Financial Status Update

MCO Profit and Loss per NAIC Filings

September 30, 2014 Compared to September 30, 2015

	Amerigroup	Sunflower	United	Total
Total Revenues	$758,089,920	$840,138,616	$669,390,696	$2,267,619,232
Total hospital and medical	$637,609,302	$754,935,171	$554,719,928	$1,947,264,401
Claims adjustments, General Admin., Increase in reserves	$23,430,362	$65,425,709	$85,231,077	$174,087,148
Total underwriting deductions	$661,039,664	$820,360,880	$639,951,005	$2,121,351,549
Net underwriting gain or (loss)	$97,050,256	$19,777,736	$29,439,692	$146,267,684
Net investment gains or (losses)	$1,590,620	$120,803	$0	$1,711,423
Net income or (loss) after capital gains tax and before all other federal income taxes	$98,640,876	$19,898,539	$29,439,692	$147,979,107
Federal and foreign income taxes incurred	$18,918,743	$616,824		$19,535,567
Add Back Change to Reserves	($55,474,368)	($31,292,674)		($86,767,042)
Adjusted Net income (loss) - Through September 30, 2015	$24,247,765	($12,010,959)	$29,439,692	$41,676,498
Add Back Change to Reserves	($3,131,490)	($32,936,087)		($36,067,577)
Net income (loss) - September 30, 2014	($19,594,296)	($14,938,481)	($7,432,779)	($41,965,556)
Adjusted Net income (loss) - September 30, 2014	($22,725,786)	($47,874,568)	($7,432,779)	($78,033,133)
Difference from Q3 2014 to Q3 2015	$46,973,551	$35,863,609	$36,872,471	$119,709,631

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KanCare Executive Summary

- Medicaid Member Eligibility/Expenditure Information
- KanCare Financial Summary CY15/Financial Trends
- Provider Network
- Claim Processing and Denials
- Utilization Summary
- Value Added Services/In Lieu Of Services
- Member Grievances, Appeals and Hearings

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For more information about KanCare

www.KanCare.ks.gov