MINUTES

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

October 7, 2013
Room 548-S—Statehouse

Members Present

Senator Pilcher-Cook, Chairperson
Representative David Crum, Vice Chairperson
Senator Jim Denning
Senator Marci Francisco
Senator Laura Kelly
Senator Michael O'Donnell
Representative Barbara Ballard
Representative Willie Dove
Representative John Edmonds
Representative Ron Ryckman, Jr.
Representative Jim Ward

Staff Present

Melissa Calderwood, Legislative Research Department
Amy Deckard, Legislative Research Department
Iraida Orr, Legislative Research Department
Erica Haas, Legislative Research Department
Nobuko Folmsbee, Office of the Revisor of Statutes
Renae Jefferies, Office of the Revisor of Statutes
Jan Lunn, Committee Secretary

Conferees

Robert Moser, M.D., Secretary, Kansas Department of Health and Environment
Kari Bruffett, Director, Division of Health Care Finance, Kansas Department of Health and Environment
Shawn Sullivan, Secretary, Kansas Department for Aging and Disability Services
James Bart, KanCare Ombudsman
Thomas Bell, President and Chief Executive Officer, Kansas Hospital Association
Lora Key, Chief Executive Officer, Sabetha Community Hospital
John Federico, Federico Consulting, representing the Kansas Health Care Association
Jane Kelly, Executive Director, Kansas Home Care Association
Rachel Monger, Director of Government Affairs, LeadingAge Kansas
Kathy Hunt, Board Member, Oral Health Kansas
Douglas Funk, R.Ph., Immediate Past President of Kansas Pharmacists Association, and Owner of Funk Pharmacy, Concordia, Kansas

Peter Stern, Chief Executive Officer, Kansas Independent Pharmacy Service Corporation
Sky Westerlund, Executive Director, Kansas Chapter of the National Association of Social Workers
Rosie Cooper, Executive Director, Kansas Association of Centers for Independent Living
Marilyn Kubler, Owner, Jenian, Inc., Caseworker
Jerry Slaughter, Director of Government Affairs, Kansas Medical Society (written only)
Anna Lambertson, Executive Director, Kansas Health Consumer Coalition
Mitzi McFatrich, Executive Director, Kansas Advocates for Better Care
Jeremy Whitt, Chief Executive Officer, Delaware Highlands
Rocky Nichols, Big Tent Coalition
Rosie Cooper, Executive Director, Kansas Association of Centers for Independent Living
Kathy Lobb, Self Advocate Coalition
Dulcinea Rakestraw, President, Kansas Association of Addiction Professionals and Kansas Vice President of Preferred Family Healthcare
Tom Laing, Executive Director, InterHab (written only)
Christie Appelhanz, Vice President of Public Affairs, Kansas Action for Children
Barbara Bishop, Executive Director, The Arc of Douglas County
Finn M. Bullers, Private Citizen
Cindy Hermes, Health Care Consumer Ombudsman and Director of Public Outreach, Kansas Insurance Department
Laura Hopkins, Chief Executive Officer, Amerigroup Kansas Plan
Jean Rumbaugh, Chief Executive Officer and Plan President, Sunflower State Health Plan
Tim Spilker, Plan President, UnitedHealthcare
Michael J. Hammond, Executive Director, Association of Community Mental Health Centers of Kansas, Inc. (written only)

Others attending (Attachment Guests).

Morning Session

Chairperson Pilcher-Cook called the meeting to order at 8:01 a.m.

KanCare Update

Dr. Robert Moser, Secretary, Kansas Department of Health and Environment (KDHE), provided an overview of Kansas' Medicaid system prior to the implementation of the State's managed care program, known as KanCare. He noted key concerns and the rationale for the implementation of KanCare. Secretary Moser summarized KanCare's goals and composition and reviewed comparisons in program costs and provider payments (Attachment 1). Secretary Moser explained the statistical comparisons utilize a calendar year, which coincides with the the authority granted the State from the Centers for Medicare and Medicaid Services (CMS) under the State's Section 1115 waiver demonstration proposal. The 1115 waiver operates concurrently with the State's section 1915(c) Home and Community Based Services (HCBS) waivers that require enrollment of the aged, disabled, and some dual-eligible Medicaid beneficiaries into a managed care delivery system.

Kari Bruffett, Director, Division of Health Care Finance, KDHE, discussed aspects of KanCare, including: access to services; KDHE monitoring activities and oversight; quality

measures; membership; capitation payments; provider payments; value-added services; denials; and costs compared to projections. She briefly reviewed the managed care organizations' (MCOs') responses to identified issues or concerns, as well as the State's request to amend the Section 1115 waiver (Attachments 1, pages 7-11, and Attachment 2). Ms. Bruffett reported that the Kansas Foundation for Medical Care, Inc. (KFMC) will complete KanCare's measurement evaluation to ensure the plan's effectiveness and usefulness in complying with federal Medicaid health care delivery systems and policies. KDHE and the Kansas Department for Aging and Disability Services (KDADS) are charged with measuring State contractual, statutory, and regulatory requirements related to how each MCO has implemented KanCare to comply with State standards. A summary of KanCare Quality Measures was discussed. Ms. Bruffett reported data showing the rate of claim denials by MCOs, 16.68 percent (excluding HCBS claim denials), is comparable with denial rates of the state's former HealthWave managed care company and less than the 28.0 percent denial rate when the State handled most of the Medicaid claims.

Discussion was heard relating to a beneficiary's ability to “change for cause” his or her MCO. Ms. Bruffett stated there have been 35 “changes for cause” granted between May and September 2013. The MCO's “pay for performance” measures were reviewed; “pay for performance” enables the MCO's to earn back three percent of capitated payments withheld when the MCOs perform above the contractual standard. A review of common consumer-identified issues and resolutions was provided (Attachment 2, page 14). Ms. Bruffett referred Committee members to the KanCare website, (http://www.kancare.ks.gov/), for a complete list of quality improvement standards and measures.

For clarification, Ms. Bruffett indicated that KanCare capitation payments are paid one month in arrears: for example, payments for January services are paid in February. She also noted dual-eligible beneficiaries (Medicaid and Medicare) are excluded from the tracking statistics. Additionally, HCBS denials are included within the “Denials Summary” table in the KanCare Summary (Attachment 2, page 12). She commented that previous to KanCare implementation, HCBS denials were not tracked separately in the State's tracking system; rather they were tracked in the State system as “Medical.” Insofar as the “Pay for Performance” metrics in the “KanCare Summary (Attachment 2, page 8), Ms. Bruffett indicated there is a 60-day lag time in reporting statistics, since the metric established is “100 percent of all claims are processed within 60 days.”

Ms. Bruffett summarized all KDHE and KDADS inter- and intra-agency oversight activities, as well as those conducted by the MCOs and KFMC, some of which are reported to CMS as required by the demonstration waiver. She acknowledged key issues have arisen, such as:

- Issues with the MCOs' prior authorizations for beneficiary services were identified, which resulted from the AuthentiCare's Electronic Visit Verification (EVV) system. The MCOs and AuthentiCare have enhanced the system to eliminate or reduce identified issues, while allowing for additional oversight activities.

- Providers have expressed concern regarding the untimely adjustment to claims. The MCOs have instituted additional logs, which are submitted to KDHE for resolution monitoring.

- Beneficiaries may experience an issue at a pharmacy due to eligibility confirmation and prior authorization for benefits (due to eligibility being input into the State system and a possible lag in time to migrate information from the State system into the MCO system). The workaround was for the pharmacy to access the Kansas Medical Assistance Program (KMAP) to authenticate and verify eligibility. The MCOs and KDHE have collaborated to ensure prior authorizations for pharmaceuticals match the state's expectations.

- Beneficiaries were concerned that a change in his or her MCO could limit services or providers within the MCO network. MCOs are responsible for ensuring an adequate provider network within the MCO's mileage and distance requirements. When issues exist and a resolution is unachievable, KDHE could grant a “cause for change” to the beneficiary. An MCO's goal is to ensure access to services.

- There is a need for the MCOs and agencies to continue collaborating to ensure the accuracy of information.

- KDHE collaborates with and monitors the MCOs to ensure accurate spenddown and client obligations are applied correctly. Targeted training has occurred to ensure there are no under- or overpayments.

- Critical issues tracking ensures the top ten issues are being reported.

- The State's rapid response call system was eliminated in June 2013. However, the State hosts targeted response calls, such as those related to durable medical equipment (DME), to resolve the providers' and MCOs' outstanding issues. MCOs were asked to enhance their rapid response calls structure in August 2013 to elevate and escalate all issues reported.

Ms. Bruffett reported on 2013 provider payments and non-claim provider payments compared to the same time period in 2012, as well as KanCare costs compared to projections. Total program costs (Medicaid, Children's Health Insurance Program [CHIP] and others) are included in the statistics reported. Cost projections are based on the August 2012 KanCare demonstration application. She indicated that a report could be provided to Committee members concerning KanCare costs per person to ensure costs do not exceed budgetary caps, which were part of the agreement between CMS and the State.

Ms. Bruffett stated two changes to the 1115 demonstration waiver will be requested and one additional change already has been approved. Changes will become effective January 1, 2014, pending CMS approval. The changes are:

- The inclusion of Long-Term Services and Supports (LTSS) for persons with intellectual and developmental disabilities (I/DD) into KanCare;

- The establishment of three pilot programs to support employment and alternatives to Medicaid; and

- The change in the time line for implementing the State's Delivery System Reform Incentive Program (DSRIP) pool already has been approved. The DSRIP pool

involves supplemental payments to the Kansas University Hospital and Children's Mercy Hospital to enhance and support access to care, quality of care, and the health of their patients and families.

In conclusion, Ms. Bruffett indicated that, to date, the federal government shut-down has not affected the progress of the KanCare demonstration through CMS; however, the potential for impact exists should the shut-down be extended.

Ms. Bruffett, also reported that the “health home” model is scheduled to begin in July 2014. The MCOs will integrate this model, which includes targeted case management, into the KanCare program to provide enhanced care for beneficiaries with chronic conditions such as diabetes and severe mental illness. She noted a large group of stakeholders is working to provide input into the model's design and implementation phase.

Shawn Sullivan, Secretary, KDADS, provided an update on the I/DD pilot project (Attachment 1, page 11). He reviewed participant levels, the goals of the pilot program, the project advisory group, and the proposed billing, which began October 1, 2013, for 25 participating pilot providers. Secretary Sullivan noted the advisory group has been engaged and active in the process and education. Education sessions have been held across the state, with national experts brought to Kansas to work with State and MCO employees, the advisory group, pilot providers, and others.

Secretary Sullivan reported on the HCBS Quality Improvement measures submitted to CMS that include additional comprehensive quality measures for HCBS waivers. He indicated that HCBS waivers were created to offer some 20,000 Kansas beneficiaries a community alternative to nursing facilities and other institutional environments. In January 2013, Frail Elderly (FE), Physical Disability (PD), and Traumatic Brain Injury (TBI) HCBS waiver beneficiaries were included in KanCare. With that change, a shift in case management to the MCOs was achieved, as well as the implementation of Aging and Disability Resource Centers (ADRCs) for the purpose of determining an applicant's functional eligibility. ADRCs are not allowed to serve in a provider role within a MCO network. The Southwest Area Agency on Aging was awarded the initial ADRC contract, and it subsequently sub-contracted with ten other state Areas Agencies on Aging to provide ADRC services. With KanCare's implementation, financial mechanisms were put in place to incentivize MCOs to move beneficiaries into community placement under HCBS waivers. Quality measures within KanCare include:

- Amendments to include improvements to statistical analysis and data collection;

- KDADS Quality Management Specialists resuming ride-alongs with MCO care coordinators to observe the care coordinators' interactions with HCBS beneficiaries; and

- The National Indicators Initiative is a collaboration among states and national associations to implement a systematic approach to performance and outcome measurements for HCBS waiver utilization. Through the collaboration, participating States pool their resources and knowledge to create performance monitoring systems, identify common performance indicators, work out comparable data collection strategies, and share results. These developed tools will assist in providing Kansas with more accurate and comparative information on a national level and once completed, the measures will be integrated into KanCare Quality Measures.

Secretary Sullivan concluded his testimony with an update on the Program of All-Inclusive Care for the Elderly (PACE) in Kansas. Currently, there are two programs serving approximately 300 seniors, one in Wichita and one in Topeka. PACE operates similarly to KanCare in that it is a fully at-risk, capitation payment program to care for of all the enrollee's needs. Kansas is in the process of expanding PACE as a dual enrollment option to KanCare. Shortly, an award will be made to the successful bidder or bidders to extend PACE's coverage in 55 counties, which is an expansion in four markets: Johnson and Wyandotte and counties north and south of those areas, Southeast Kansas, and counties surrounding the Manhattan and Junction City area. Following announcement of the bid award, a time line will be generated for the 12-18 month federal approval process. The expanded PACE program is anticipated to begin in 2015.

Chairperson Pilcher-Cook opened the meeting for questions.

A Committee member reported that concerns have been expressed by hospitals around the state relating to MCO claims processing. Many of these hospitals are rural, critical-access facilities with sizable accounts receivable balances from 91 to 241 days old. The Committee member inquired whether this issue was related to a “swing-bed program.” A swing-bed program allows certain small, rural hospitals to use its beds, as needed, to provide either acute or skilled nursing facility care. In some instances, the hospital was asked by the MCO to bill the primary insurance provider (Medicare) prior to billing Medicaid. Ms. Bruffett explained the standard policy requires a denial from the primary insurance provider or an Explanation of Benefit (EOB) prior to billing Medicaid, since it is the payer of last resort. However, Medicaid rules do not require a Medicare EOB for a swing-bed program. She reported one of the MCOs failed to code its system for a blanket denial so that an EOB was not required for a swing-bed program; the issue has been corrected, and the MCO is retroactively processing those claims.

With regard to a question concerning an identified pattern of excessive claims denial to a large, metropolitan hospital that resulted in additional administrative activity to refile claims, Ms. Bruffett indicated the MCOs are concentrating on this issue and targeting work on systemic issues such as retroactive claims processing. Another issue is whether claims were paid appropriately, and the MCOs have been encouraged to address this issue. She commented that the State's expectation is for the MCOs to improve claims processing and “big picture” issues in order to improve provider satisfaction.

A Committee member inquired how and who determines the levels of assistance and hours of service required for a HCBS beneficiary. Ms. Bruffett stated it is the expectation of both the State and CMS that the MCO complete the beneficiary's plan of care within the first six months of KanCare eligibility. Secretary Sullivan responded that the determination of needs is a multi-faceted process involving the MCOs assessing the beneficiary's comprehensive needs, health risks, and reviewing the prior HCBS plan of care. When the MCO determines fewer hours of care are required, the care coordinator begins the plan of care process, which ends with three HCBS review managers (within KDADS) quantitatively reviewing the plan of care and assessing the narrative portion of the tool to determine whether the hours reduction request is approved, approved with recommendation, or denied. State policy is followed with factors such as whether family members can perform certain functions for the beneficiary, changes in family situations, or changes in the beneficiary's functionality being considered. He noted MCOs have requested reduction of plan of care hours in 8.0 percent of all plans. Of that 8.0 percent reduction, 12.0 percent involve individuals on the HCBS/PD waiver and between 6.0 and 7.0 percent involve HCBS/FE beneficiaries; KDADS approves approximately 90.0 to 92.0 percent of reduction requests submitted by the MCOs.

A Committee member asked what process is in place to accommodate an appeal when a reduction request has been approved and the beneficiary desires to appeal that decision. Secretary Sullivan reported there are three channels for a beneficiary to appeal a reduction decision: contact James Bart, KanCare Ombudsman in the KDADS office; enter into a grievance process through the MCO; or go through the State Fair Hearing process. He reported the majority of appeals go through the KanCare Ombudsman or the State Fair Hearing Process.

A question was asked concerning National Core Indicators (NCI) data collection efforts and whether those standards would determine the provision of quality care through KanCare. Secretary Sullivan stated that CMS has 30 to 35 HCBS standards for each of the six waivers that States manage. CMS has revised some of the quality measures; in addition, several States (Kansas is currently in the process of implementing this initiative) utilize NCI measures for their HCBS system to determine performance for ten core outcomes.

A Committee member referred to the "KanCare Summary," which tracks MCO claims processing quality indicators (Attachment 2, page 8), and asked if KDHE intended to create trend analyses for these quality measures. Ms. Bruffett commented the indicators were intended to be above the contractual baseline and to enable MCOs to earn back a portion of capitated payments. The Committee member suggested information could be more meaningful if claims processing percentages were graphically shown by MCO by month.

On the "Denials Summary" table (Attachment 2, page 12), a Committee member noted that "Nursing Facilities" appeared to be the largest outlier when comparing KanCare to KMAP. The question was whether long-term facilities owned by many rural hospitals are being reported under the nursing facility or the hospital category. Ms. Bruffett will provide a more detailed breakdown of the denials summary, pertaining to nursing facilities by type of facility, to differentiate between stand-alone nursing facilities and hospital-based long-term care units.

Referring to the "KanCare Cost Versus Projections" table (Attachment 2, page 12), Ms. Bruffett noted Kansas Medicaid has grown approximately 5.0 percent yearly since 2006. According to the table, the projection without KanCare in August 2012 was projected at 10.0 percent growth; the KanCare Projection in August 2012 was projected at 7.0 percent. The current estimate, which includes legislative appropriations and Spring Consensus Caseloads, is at 4.7 percent. A question was asked as to what factor drives the growth in Medicaid. Ms. Bruffett responded that 2010 provider cuts and programmatic changes in calendar year 2012 reduced growth estimates. Historically, from 2006 to 2011, an actual annual average growth of 7.5 percent can be seen, and current estimates over the same time period are approximately 6.5 percent. She commented the trend analysis is unadjusted for program changes and is based upon utilization and population growth.

Following several questions, Ms. Bruffett indicated that KDHE is satisfied with reimbursement rates to providers, since KanCare reimbursement is at 100 percent of Medicaid. While improvement has been seen with the timeliness of claims processing, Ms. Bruffett stated KDHE is less satisfied with this performance measure. A Committee member expressed concernon the behalf of constituent hospitals who contend that claims processing is more difficult than pre-KanCare. The administrative burden of hiring additional staff to process, reprocess, and appeal denied claims is adversely affecting hospital operations and cash flow. Ms. Bruffett stated tracked data demonstrates that overall percentages of denials within the KanCare program are similar to those of the HealthWave program. The Committee member requested that KDHE furnish dollar amounts of denials by MCOs, as well as information on the number of denials satisfied in favor of the provider and the MCOs. Ms. Bruffett indicated that information could be provided over time; however, KDHE could furnish reasons for denials (for

example, improper bundling) and dollar amounts associated with them. With regard to complaints concerning MCOs' remittance advices and the difficulty providers have in matching the provider's billing to the reimbursement, Ms. Bruffett acknowledged this has been a known issue. MCOs have been requested to resolve this issue.

Ms. Bruffett stated KanCare savings will be used to reduce the HCBS waiting list; savings are attributed to new human services caseload estimates made during Spring 2013, which were projected to be greater than previously budgeted.

With regard to complaints concerning the revenue cycle contained in recent newspaper articles, a Committee member stated without Accounts Receivable Aging Reports for the same time periods in 2013 and 2012, such complaints cannot be confirmed. These reports have been requested but have not been received.

A Committee member expressed appreciation to Secretary Sullivan for his comments and noted that many details he provided in his oral testimony were excluded from his written testimony. Secretary Sullivan was asked to furnish additional written testimony documenting his oral testimony. A request was made that KDADS provide a comparison of HCBS service hours by waiver by plans of care; in addition, that service hours reduction requests and their disposition be furnished. Also, it was requested that KDADS furnish a complete breakdown of performance measures by HCBS waiver. Ms. Bruffett, KDHE, indicated she would furnish Committee members with copies of the HCBS Quality Improvement Strategy document.

James Bart, KanCare Ombudsman, discussed emerging issues, clarified his role, and reviewed case data (Attachment 3). He noted the area of data collection and statistical report preparation has been a recent focus, and the office is in the process of hiring an administrative assistant to aide in reporting functions.

Mr. Bart responded to questions regarding the role of the KanCare Ombudsman as follows:

- The words “independent,” “impartial,” “objective,” and “informal resolution” apply to the KanCare Ombudsman role. The word “advocate” applies to those persons who take an active role in advocacy for the KanCare member and does not apply to the KanCare Ombudsman role. Mr. Bart described the process when a beneficiary contacts his office with a grievance, which includes: interviewing the consumer and the MCO care coordinator; reviewing the plan of care; and assisting the beneficiary in the grievance process through the MCO or the State Fair Hearing process by providing administrative support, furnishing appropriate information, and assuring accommodations are made. He explained his role is one of facilitation, collaboration, communication, and informal dispute resolution.

- A Committee member expressed concern that the Ombudsman’s office had 857 contacts from consumers without a subject or category attached to the contact. Categories for consumer contacts that were identified included pharmacy, transportation, billing, membership, eligibility, and network status. Mr. Bart explained the office practice of contact categorization and indicated that to adequately categorize all resolution statistics was unrealistic. The Committee member suggested a category of “denials” be added to those already created on the contact log. With 20,000 HCBS constituents, additional concern was voiced

by the Committee member that the KanCare Ombudsman's Office lacks the resources to cover the workload.

Presentations from Individuals, Providers, and Organizations on KanCare Reimbursement

Tom Bell, President and Chief Executive Officer (CEO) of the Kansas Hospital Association (KHA), stated KHA's membership has identified the three most common process issues surrounding KanCare as: reimbursement, prior authorization, and credentialing. Additional detail was included in his testimony (Attachment 4). Mr. Bell introduced Ms. Lora Key, CEO, Sabetha Community Hospital, who provided additional information (no written testimony). She commented on her work with the Specialized Healthcare Network Provider Group, the KanCare Tag Group, and the KDHE Provider Workgroup. She explained that her familiarity with implementation workgroups helped her guide her facility through the initial phases of KanCare. However, Ms. Key reported that the level of prior authorizations required and the amount of dollars being held in Sabetha Community Hospital's accounts receivable is problematic. She noted reimbursement problems when rural hospitals own or network with other providers, such as a physician practice, hospice, home health, or a skilled nursing facility.

John Federico, representing Cindy Luxem, CEO of the Kansas Health Care Association and the Kansas Center for Assisted Living, presented testimony, identifying the agencies' concerns (Attachment 5). Mr. Federico stated the biggest impacts on providers are the inability to manage cash flow appropriately, and the increase in administrative costs, including the time required to process, reprocess, and appeal denials, particularly for smaller rural facilities.

Jane Kelly, Executive Director, Kansas Home Care Association (KHCA), furnished Committee members with specific examples of issues, which were identified by KHCA's membership and are included in her testimony (Attachment 6). She indicated home care and hospice providers have seen an increase in denials for patients since KanCare was implemented. She stated her fear is that some of these providers could close or cease to provide services, which would lead to access issues for Kansas citizens.

Rachel Monger, Director of Government Affairs for LeadingAge Kansas, provided information concerning LeadingAge's membership and described the agency's KanCare preparation activities. She echoed concerns voiced by previous conferees and noted the administrative burden to providers is significant. Also, the addition of KanCare's MCO administrative layer increases the burden of claims reimbursement resolution (Attachment 7). According to Ms. Monger, LeadingAge's membership has noted hospice authorizations are of particular concern and encouraged immediate attention to ensure this population is served. She expressed appreciation to KDADS for its responsiveness and assistance in working through issues.

Kathy Hunt, representing Oral Health Kansas, presented testimony relating to the Kansas Cavity Free Kids initiative, which is a grant through the Kansas Head Start Association. She described the program and its pre-KanCare operations and the barriers experienced during the transition to KanCare particularly for Head Start programs (Attachment 8).

Doug Funk, R.Ph., owner of Funk Pharmacy, and immediate past President of the Kansas Pharmacists Association, provided a brief history of the Kansas Pharmacists Association and KDHE's collaborative approach to the creation of a managed-care Medicaid program. He expressed appreciation for KDHE's program oversight and recommended

continuation of that process. He noted there were several concerns surrounding durable medical equipment (DME) and maximum allowable costs (MACs) for prescription drugs, which can be found in his written testimony (Attachment 9).

Peter Stern, CEO, Kansas Independent Pharmacy Service Corporation (KPSC), reported that KPSC's membership has seen timely processing of pharmacy claims; however, there have been problems with MACs being updated in a timely manner, which have produced payment losses for generic products. DME products are processed directly through KanCare, and pharmacies have reported slow payment. Mr. Stern reported medication therapy management, a program for beneficiaries who meet set utilization criteria, is now being expanded into KanCare guidelines. Initial effectiveness reports should be forthcoming in six to nine months (Attachment 10).

Sky Westerlund, LMSW, Kansas Chapter of the National Association of Social Workers, provided testimony concerning KanCare's policy which does not allow licensed social workers to provide substance abuse treatment. She indicated KDADS' policy mandates that licensed social workers must obtain a secondary license in order to provide services to substance abusers. Ms. Westerlund recommended that the KDADS reimbursement policy be revised (Attachment 11).

Rosie Cooper, Executive Director of the Kansas Association of Centers for Independent Living (KACIL), was present to describe a concern related to KanCare reimbursement to a Fiscal Management Service (FMS) provider (Attachment 12). The FMS is accountable to administer payment to a Direct Service Worker (DSW) for KanCare beneficiaries that have chosen to self-direct their services. The problem is created when a DSW fails to submit a time sheet to the FMS provider within 90 days. The DSW is paid, but the FMS provider is out of KanCare compliance and is not reimbursed. Ms. Cooper recommended that an exemption for DSW time records past 90 days be created. Another issue is that third party insurance held by beneficiaries require that a third party liability blanket claim must be filed monthly, which can cause delayed billing past the 90-day claim period. Prior to KanCare, those blanket claims were filed annually. She recommended the third party liability blanket claim be filed by the MCOs rather than by the FMS.

Marilyn Kubler, owner of JENIAN, Inc., a targeted case management agency that provides services to 128 HCBS I/DD waiver clients and seven Working Healthy/WORK program clients, testified before the Committee. Ms. Kubler stated MCOs did not have the WORK procedure code entered into their systems until April or May 2013, which caused a manual work intervention to override denials and delayed payments. Third party liability (TPL) information was not included in at least one MCO's billing system. Therefore, the MCO denied payment because the system did not recognize the insurance as Medicare. For clients whose TPL insurance does not provide a blanket denial letter, JENIAN is required to wait for a denial then resubmit the claim to the MCO, which creates another payment delay. Since JENIAN is a small agency that cannot absorb the delay in payments, she expressed concern the agency will not survive (Attachment 13).

Written testimony was received from Whitney Damron on behalf of the Kansas Psychological Association (Attachment 14) and Jerry Slaughter, Executive Director of the Kansas Medical Society (Attachment 15).

Presentations from Individuals, Providers, and Organizations on Access to and Quality of Services Provided under KanCare

Anna Lambertson, Executive Director, Kansas Health Consumer Coalition, recommended three improvements to ensure consumers' access to services and quality care: provide additional resources and independence to the KanCare Ombudsman, ensure that the Committee reviews summaries and recommendations from the KanCare Workgroup meetings and considers those recommendations, and ensure access to services or pharmaceuticals by closely monitoring the MCOs' pre-authorization requirements (Attachment 16).

Mitzi McFatrich, Executive Director, Kansas Advocates for Better Care, testified concerning observations regarding quality and access issues within the KanCare program. She provided specific examples under the heading of “Home and Community Based Services” in her written testimony (Attachment 17). Ms. McFatrich expressed concern over the lack of a good consumer support and information network, inadequate trending analyses and information from the KanCare Ombudsman's Office, inadequate consumer input, and the lack of program utilization information. Her recommendations included: development of basic program utilization data by care plan, hours and services, and by waiver population groups; development of KanCare Ombudsman program data to identify trends in consumer outcomes and services, as well as provide for consumer input and evaluation of the assistance received; creation of an evaluation database from consumers regarding satisfaction with services and KanCare effectiveness; and strengthening processes for consumer feedback on quality and access.

Jeremy Whitt, Chief Operating Officer, Delaware Highlands Assisted Living in Kansas City, Kansas, discussed the Kansas “gap” in its continuum of care for seniors living in assisted living facilities. He noted many other states have a per diem reimbursement that covers core aspects of assisted living communities. He recommended activation of CMS codes for assisted living care, which would allow MCOs to negotiate per diem rates with providers (Attachment 18).

Rocky Nichols, Big Tent Coalition, distributed testimony concerning the Wisconsin Ombudsman model for comparison with the Kansas KanCare Ombudsman Office. He emphasized the importance of the KanCare Ombudsman's Office and indicated independence, impartiality, and advocacy are critical to its operations (Attachment 19).

Rosie Cooper, Executive Director, KACIL, stressed the need for: MCOs to improve the timeliness of written authorizations for direct service workers to the FMS providers; education and training to assist MCOs in understanding the difference between self-directed and agency-directed care; and improved communication concerning service changes, such as transportation. In addition, she suggested that since many FMS providers are assisting clients with filing appeals and Medicaid reapplication, there should be an increased reimbursement to FMS providers of $140 per member per month (Attachment 20).

Kathy Lobb, Self-Advocate Coalition of Kansas, encouraged Committee members to reinvest KanCare savings into reducing the I/DD waiting list for HCBS services (Attachment 21).

Dulcinea Rakestraw, Vice President of Treatment Services for Preferred Family Healthcare and Chair of the Kansas Association of Addiction Professionals, stated that while the KanCare implementation has worked well for substance abuse treatment consumers, the demand for services exceeds available funding. She encouraged the MCOs to release information regarding utilization, lengths of stay, and denials. In addition, she spoke about the additional administrative burden on providers, which could force providers to cease providing

services. Ms. Rakestraw requested that the Committee and the 2014 Legislature seek a plan to address the increased administrative costs to providers (Attachment 22).

Tom Laing, Executive Director, InterHab, submitted written testimony and recommendations (Attachment 23).

Finn M. Bullers, private citizen, shared his story and KanCare experience, which he stated will result in a reduction in his plan of care from 168 hours weekly to 40 hours weekly, starting November 1, 2013. Mr. Bullers stated his story demonstrates how the implementation of KanCare has failed needy citizens in Kansas (Attachment 24).

Upon request of a Committee member, an information handout, "National Health Care Challenges: Key Environmental Drivers," was distributed to the Committee (Attachment 25).

Chairperson Pilcher-Cook opened the meeting for questions of the previous group of conferees.

Lora Key, CEO, Sabetha Community Hospital, offered two examples of prior authorization issues, as requested by a Committee member. Skilled nursing home facility residents, who are dually eligible for Medicare and Medicaid, must receive a prior authorization for a physician to see the patient in the nursing home environment. A young mother (covered on her Mother's private insurance policy, with Medicaid as the secondary provider) delivered an infant, and Medicaid has denied reimbursement for the infant's delivery because there was no prior authorization. Ms. Key responded to a Committee member that she felt the MCOs' employees had inadequate training, since prior authorizations are taking much longer than under the previous system.

A Committee member requested Secretary Sullivan respond to Jeremy Whitt's testimony concerning Assisted Living (AL) reimbursement for HCBS clients. Secretary Sullivan acknowledged there is a reimbursement gap for AL facilities, which has not been bridged through MCO contracts. He indicated this is a priority, and KanCare could provide the flexibility for MCOs to create AL access and reimbursement. KDADS and the MCOs have scheduled meetings within the next several months to address the issue.

A Committee member noted a recurring issue with providers is the lack of timely payments and questioned the existence of consequences to the MCOs. Ms. Bruffett responded that the pay-for-performance metric is one consequence for untimely payments. There is no metric for claims denial; however, there is a contractual standard, and the State could execute liquidated damages and pursue similar mechanisms.

Secretary Sullivan responded there are three grievance mechanisms to challenge a reduction in plan of care hours for an HCBS waiver recipient: through the MCO, the KanCare Ombudsman, or through the State Fair Hearing Process. The Ombudsman process would offer the most immediate access and resolution. The State Fair Hearing process includes 33 days to file an appeal, with another 30 days before the hearing process begins. Secretary Sullivan indicated he would furnish the MCO grievance time line to members at a later date. He indicated there are no reductions until the grievance and appeal process has been exhausted.

Sky Westerlund, Kansas Chapter of the National Association of Social Workers, confirmed her recommendation that KDADS revise the KanCare reimbursement policy to allow all persons licensed by the Behavioral Sciences Regulatory Board to provide substance abuse services.

Chairperson Pilcher-Cook recessed the meeting at 12:02 p.m.

Afternoon Session

Chairperson Pilcher-Cook reconvened the meeting at 1:32 p.m. and requested Cindy Hermes of the Kansas Insurance Department to update Committee members on the progress of the federal health insurance exchange under the Affordable Care Act (ACA). Ms. Hermes commented the federal exchange system opened on October 1, 2013, and many technical issues have occurred to date, such as logging in errors and slow page loads, which have prevented many consumers from completing the process. Chairperson Pilcher-Cook requested that additional information be provided weekly concerning the number of consumers completing the process of purchasing benefits, the number of consumers receiving subsidies, and other pertinent information if available. Ms. Hermes indicated she would contact CMS to ascertain the availability of the information requested (No Written Testimony).

In response to a question by a Committee member, Ms. Hermes explained that all levels of health insurance plans (Bronze, Gold, Silver, and Platinum) include the essential health benefits. She noted the differences in plans are in the maximum out-of-pocket expenses, deductibles, co-pay, and co-insurance costs. She indicated there also is a catastrophic plan for consumers under age 30.

Quarterly Report on Average Daily Census for State Institutions and Long-Term Care Facilities, Savings on Transfers to HCBS Waivers, and HCBS Savings Fund Balance; Update on Status of Waiting List

Secretary Sullivan, KDADS, provided information on average monthly caseloads and average census for state institutions and long-term care facilities. He explained that HCBS savings are realized when an individual is moved into a community setting from an institutional setting and the bed is closed. There are zero savings resulting from individuals moving to home and community based services, since Kansas does not close a bed in the institutional setting. Last year, Kansas moved 100 people from the PD waiting list, and 2,000 PD waiver-eligible individuals are waiting for services. In addition, 2,997 HCBS I/DD waiver-eligible individuals are waiting for services (Attachment 26).

Written testimony provided by Secretary Sullivan noted that $18.5 million in KanCare savings was released on September 11, 2013, and would go toward waiting list reductions. The funds would bring 418 individuals off the PD waiting list and 235 individuals off the DD waiting list.

Secretary Sullivan discussed two additional issues:

- The first issue is how the FMS role fits within the employer mandate of the ACA requiring the provision of health insurance for employees. In Kansas, 60.0 percent or more of PD waiver recipients self-direct their own care, and the FMS provider serves in an administrative payroll function for direct service workers caring for those beneficiaries. Currently, there are 60 FMS agency providers with more than 50 employees, which fits within the ACA large employer health insurance mandate. KDADS and FMS stakeholders are working to examine

current state policies to ensure compliance with the ACA. KDADS has requested clarification from federal regulatory agencies.

- The second issue surrounds a new Department of Labor mandate, which affects the "companionship rule" in Kansas. For many HCBS waiver recipients, KanCare pays family members to care for their loved one. KDADS is working to determine the potential impact.

In response to Mr. Buller's earlier testimony, Secretary Sullivan indicated that due to privacy standards, specifics could not be discussed. However, he stated that he and five members of his staff had reviewed the plan of care and determined the MCO's action was appropriate.

Secretary Sullivan stated that each HCBS plan of care is unique and depends on the family situation, the family's needs, the beneficiary's circumstances, the required levels of support, and other conditions. He indicated that services stay in place until an appeal process has been exhausted. The Office of Administrative Hearings employs administrative law judges and other support personnel to conduct proceedings for the Kansas Department for Children and Families (DCF), KDHE, KDADS, and other state agencies. Secretary Sullivan offered to distribute guidelines and statutory requirements for the administrative law judges to Committee members following the meeting. Committee members requested additional information including: number of service hours reductions, reasons for reductions, number of reductions approved by waiver, nursing facility utilization, caseload trending information, numbers of service hours reductions compared to increases, and any objective criteria or standards used for decision-making with regard to plans of care reduction requests.

A Committee member expressed concern regarding the earlier testimony from James Bart, KanCare Ombudsman, particularly related to the role of advocacy, which is expected in models from Minnesota, Colorado and Oregon. The suggestion was made to reopen the discussion about the position, its role, job description, and the resources allotted to that Office. Secretary Sullivan suggested the role of protection and advocacy is more appropriate to Aging and Disability Resource Centers (ADRCs). He stated KDADS will continue to monitor the effectiveness of the KanCare Ombudsman Office closely. According to a Committee member, concerns from constituents indicate the KanCare Ombudsman Office has unsuccessfully represented their interests. Secretary Sullivan indicated that while many beneficiaries reported the KanCare Ombudsman has served them well, he is willing to set up consumer surveys or other reporting mechanisms to evaluate satisfaction levels.

In response to questions from the Committee, Ms. Bruffett stated there are approximately 55,000-56,000 members in the Children's Health Insurance Program (CHIP). She clarified that since CHIP was previously included in the HealthWave program, it is excluded from the CMS 1115 demonstration waiver requirements. Therefore, CMS quarterly reports exclude CHIP participants and only reflects Medicaid beneficiaries.

Laura Hopkins, CEO, Amerigroup Kansas Health Plan, addressed the Committee and explained Amerigroup's work with waiver consumers and nursing facility consumers. She reviewed claims payments, claim payment turnaround times, access standards, and proactive improvement opportunities for issues resolution. She indicated Amerigroup's commitment to providers to assist with operational and complex care issues (Attachment 27).

Jean Rumbaugh, CEO,Sunflower State Health Plan, addressed three primary objectives of KanCare: access, quality, and costs. She described some of the earlier issues during

KanCare's implementation phase and directed Committee members' attention to Sunflower's Top Ten System Issues and Status, which are included in her testimony (Attachment 28). She reported that currently 80.0 percent of their claims are auto adjudicated, which represents an improvement from earlier statistics. Ms. Rumbaugh committed to resolving issues in a timely manner to ensure quality care.

Tom Spilker, President, UnitedHealthcare Community Plan of Kansas, discussed the importance of engaging members and providers, communication, operational focus, and coordination of care. He indicated UnitedHealth Care is dedicated to the successful implementation of waiver services for individuals with disabilities, quality, and program innovation (Attachment 29).

Chairperson Pilcher-Cook opened the meeting up for final questions.

A Committee member noted a common theme from providers has been the ability to collaborate with KDHE, KDADS, and MCO staff to reach common goals related to identified KanCare issues. Laura Hopkins, Amerigroup, noted a retraining initiative with customer service representatives had begun. Tom Spilker, UnitedHealth Care commented that as key issues are identified, they are used as training tools. Jean Rumbaugh, Sunflower, also stressed the importance of both MCO retraining and provider training. All MCO representatives expressed commitment to improvement.

Another Committee member asked MCO representatives to identify what is unique in the KanCare process that causes the level of dissatisfaction among providers with claim payments, denials, and administrative overhead. In addition, why is there difficulty in reconciling remittance advices (coding) to payment, compared to the previous system? Jean Rumbaugh, Sunflower, acknowledged her responsibility to ensure support to the front-line provider staff. She indicated working through coding differences and educating providers (and internal MCO staff) to billing and processing issues is of primary importance. Coding is always changing, and she noted the importance of good communication with providers. Laura Hopkins, Amerigroup, stated extenuating circumstances do exist that have caused denials; her organization continues to work towards understanding provider perspectives, identifying root causes, and developing improvement opportunities.

With regard to coding, a Committee member asked what the National Provider Identifier (NPI) number is and how it is used. Laura Hopkins, Amerigroup, explained the National Provider Identifier or NPI is a unique identification number issued to health care providers or organizations by CMS. The NPI follows the practitioner, provider, or organization and is the required identifier for Medicare and Medicaid services; it is also used by other payers, including commercial health care insurers. She noted that some HCBS providers are not required to obtain an NPI number. For Amerigroup, a small, control group is accountable to input NPI information. A Committee member indicated a provider has identified recurring denials related to the NPI number. Ms. Hopkins requested follow-up from the Committee member in order to facilitate a resolution to the issue.

A Committee member asked that information be provided prior to the next meeting to allow an opportunity for members' review. Ms. Bruffett, KDHE, summarized she will furnish:

- Claims processing metrics by month, by MCO;

- A further breakdown of the denials summary pertaining to nursing facilities by type of facility to differentiate between stand-alone nursing facilities and hospital-based long-term care units);

- Additional detail on reasons for denials;

- The Quality Improvement Strategy document, or link to the information; and

- CMS quarterly reports and financial information for each Medicaid eligibility group.

Ms. Bruffett distributed a handout to Committee members, "Update: Modified Adjusted Gross Income (MAGI) Conversion," which is the methodology mandated by the ACA to determine eligibility for specific groups of Medicaid applicants and beneficiaries. Since there was no time to discuss this topic, it will be heard at a later meeting (Attachment 30).

A request was made that, at the next meeting, additional time be allowed for Committee members to converse with providers.

Chairperson Pilcher-Cook adjourned the meeting at 3:00 p.m.

Subsequent to the meeting, a memorandum was mailed to Committee members by Michael J. Hammond, Executive Director, Association of Community Mental Health Centers of Kansas, Inc., regarding testimony received by the Committee at the October 7, 2013, meeting from the Kansas Chapter of the National Association of Social Workers and the Kansas Psychological Association. The memorandum is included (Attachment 31).

Prepared by Jan Lunn
Edited by Iraida Orr

Approved by Committee on:

November 25, 2013
(Date)