MINUTES

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

January 17, 2014
Room 548-S—Statehouse

Members Present

Representative Dave Crum, Chairperson
Senator Mary Pilcher-Cook, 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, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Iraida Orr, Kansas Legislative Research Department
Erica Haas, Kansas Legislative Research Department
Nobuko Folmsbee, Office of the Revisor of Statutes
Renae Jefferies, Office of the Revisor of Statutes
Katherine McBride, Office of the Revisor of Statutes
Nancy Fontaine, Committee Secretary

Conferees

Robert Moser, MD, Secretary, Kansas Department of Health and Environment
Susan Mosier, MD, Kansas Director of Medicaid Services, Kansas Department of Healthand 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
Linda Sheppard, Special Counsel and Director of Health Care Policy and Analysis, Kansas Insurance Department (written only)
Nicholas Taylor, Private Citizen
Jill Bronaugh, Private Citizen
Linda Davis, Private Citizen
Tanya Nelson, Private Citizen (oral only)
Daryl Burger, Private Citizen (oral only)
Wylma Martell, Private Citizen (oral only)

Latricia Caldwell, Amerigroup Case Manager, RN, BSN (presenting testimony of Timothy Esslinger and Julie Rogers)
Danielle Buettner, Private Citizen
Kathy Boutte, Private Citizen (video only)
Jane Kelly, Executive Director, Kansas Home Care Association (written only)
Rosie Cooper, Executive Director, Kansas Association of Centers for Independent Living
Mitzi McFatrich, Executive Director, Kansas Advocates for Better Care
Steve Gieber, Executive Director, Kansas Council on Developmental Disabilities
Rocky Nichols, Executive Director, Disability Rights Center
Tom Laing, Executive Director, InterHab
Rachel Monger, Director of Government Affairs, LeadingAge Kansas (written only)
Chad Austin, Senior Vice President, Government Relations, Kansas Hospital Association (written only)
James Bart, KanCare Ombudsman
Laura Hopkins, Chief Executive Officer and Plan President, Amerigroup Kansas Plan
Jean Rumbaugh, Chief Executive Officer and Plan President, Sunflower State Health Plan
Tim Spilker, Plan President, UnitedHealthcare

Chairperson Crum called the meeting to order at 10:00 a.m.

KanCare Update

Dr. Robert Moser, M.D., Secretary, Kansas Department of Health and Environment (KDHE), provided an update on KanCare. He stated KDHE would host a two-hour stakeholder conference call on January 22, 2014, to provide an update and give stakeholders an opportunity to submit suggestions and advice to help insure a successful implementation (Attachment 1).

Secretary Moser stated KanCare goals remained consistent with integrating public health with primary care efforts across the whole spectrum of health to improve the health of the community. He noted the focus was not just on the medical model of KanCare but an integrated approach using a system of integrated resources. The Secretary explained the State Quality Strategy, which includes the pay-for-performance approach and quality measures. Dr. Moser explained that in 2014, KDHE shifted pay-for-performance measures from operational to outcomes. He explained the outcomes reporting timeline. The reporting timeline included: physical health measure data collected after the first quarter of each subsequent year (2013 complete after March 2014) and reported to the National Committee for Quality Assurance (NCQA) by June, with cumulative national results (establishing percentiles) released by NCQA in July; Spring Consumer Assessment of Healthcare Providers and Systems survey results expected in July or August; behavioral health survey results available in the fall, with pre- and post-KanCare implementation compared; National Outcome Measures measured quarterly; HCBS waiver performance measures measured quarterly and reported annually per the 1915(c) waiver; and new state-developed measures (such as increased employment) generally reported 60 days after each quarter.

Secretary Moser noted, since this was the first year of KanCare, baselines were being established for the Managed Care Organizations (MCOs) with the data currently available. He indicated KDHE would analyze data at the aggregate level and also at the individual level. Secretary Moser stated KDHE also would conduct performance improvement projects in areas such as diabetes management.

Dr. Susan Mosier, M.D., Director of Medicaid Services, KDHE, provided an overview of the new Health Homes program that is to be implemented on July 1, 2014, as a Medicaid State

Plan option. She indicated Health Homes would provide coordination of physical and behavioral health care with long-term services and supports (LTSS) and would be available for those who met the eligibility criteria. She stated there were 12 other states operating Medicaid Health Homes programs, and Kansas was one of three states operating the Health Homes using two State Plan amendments. Dr. Mosier stated the statistics available to date from Health Homes programs were encouraging. She noted there were two primary target populations, with the first being those with serious mental illness and the other being those with asthma or diabetes who also were at risk for another chronic condition (Attachment 1).

Dr. Mosier discussed the process for enrollment in Health Homes, as well as payment and project structures. She updated members on the current status of implementation and resources for staying informed. Dr. Mosier directed the Committee members' attention to a Quick Facts sheet to help answer questions about Health Homes (Attachment 2).

A Committee member asked who provided the communication between the care coordinator and the case manager. Dr. Mosier responded each entity would have staff designated to ensure communication occurred.

A Committee member asked who would pay for items such as environmental assessments to remove asthma triggers. Dr. Mosier indicated these would be paid through per member/per month payments to the MCOs. She noted a contract between the MCO and the Health Homes partner would define the payment structure.

A Committee member asked about the relationship between the MCOs and Community Mental Health Centers, who would assist the individual with details such as obtaining and completing a housing application, and whether there was another partner in the community. Dr. Mosier indicated there could be another partner, as the Health Homes partner can contract out for additional services as well. The Committee member further asked if services required of a Health Homes partner would be in addition to services the Health Homes partner already provided, thus requiring additional payments. Dr. Mosier stated there would be an additional payment and referred to the payment structure in her testimony that provided more information.

A Committee member inquired if there were provisions in place for support services for an individual who was discharged from the hospital with two or more chronic conditions. Dr. Mosier responded the agency was working to smooth out those transitions so care coordination services would be provided.

A Committee member asked what would occur when a primary care provider and a MCO care coordinator did not agree on what should be done for a recipient. Kari Bruffett, Director, Division of Health Care Finance, KDHE, responded one of the purposes of the Health Homes was to empower the providers to lead the care coordination. The Committee member expressed concern the care providers' primary focus was on the care of the patient, while the MCOs wanted to spend as little as possible, concluding there might be conflicts that would need to be resolved. Ms. Bruffett responded this program would encourage partnership and would give little or no incentive to deny services to individuals.

A Committee member asked specifically who would resolve any conflict. Ms. Bruffett responded conflicts would be resolved at the appeals process level through the MCOs.

A Committee member stated Kansas had a grant from the federal government to put Health Homes in place and inquired about the grant amount and if there was an enhanced

federal match. The KDHE staff did not have the exact amount of the grant with them but agreed to provide the information and noted there was an enhanced match.

A Committee member inquired if the Health Homes program was fully funded by the federal government or if State funding was involved. Dr. Mosier believed it was a 90/10 split, but she would have to confirm that. The Committee member expressed concern there was no mention of hospitals and wanted to make sure hospitals were involved, as emergency room care would be a critical part of the Health Homes program. Dr. Mosier agreed.

A Committee member confirmed the 90/10 split between federal and state funding. The member, indicating each member could receive eight quarters of the enhanced match, asked what would happen when the eight quarters had passed. Ms. Bruffett stated the eight quarters would begin from the implementation of the State Plan amendments. If subsequent amendments or additional populations were added, the number of quarters for those populations could be extended. Otherwise the match would revert to the typical match and might become an issue for the state. She noted, however, by then the state would have eight quarters of data to determine if the program reduced emergency department utilization and hospitalizations. At that time, the state could decide if Health Homes was the model desired moving forward.

A Committee member asked if the 90/10 match applied to current Medicaid recipients or just newly added individuals. Ms. Bruffett responded the 90/10 match applied to current recipients and only to Health Homes services.

Ms. Bruffett provided an update on the current status of persons eligible for KanCare and noted a new report providing detailed information by month soon would be available online. Additionally, she stated KDHE received general information ("flat file") from the federal Health Insurance Marketplace on Kansans who might be eligible for services, but the information was not complete enough to determine actual eligibility. Ms. Bruffet indicated KDHE was attempting to contact the individuals regarding potential eligibility and recently sent out approximately 7,000 letters to persons on the flat file list (as of January 14, 2014) for whom contact information was complete. She noted an increasing trend in KanCare applications was likely (Attachment 1).

Ms. Bruffett provided information on the open enrollment process and indicated KDHE had sent out approximately 330,000 packets, and approximately 8,000 recipients had changed plans, to date. She also reviewed the most recent KanCare Executive Summary (Attachment 3).

Secretary Shawn Sullivan, Kansas Department on Aging and Disability Services (KDADS), provided an update on the Home and Community Based Services (HCBS) Intellectual and Developmental Disability (I/DD) waivers and issues with delays in transitioning this population to KanCare, the key reasons for the delays, and remediation efforts. He also discussed the lessons learned from the DD pilot project, which include missing authorizations, date span billing issues, blanket denials for claims involving third-party liability, and accurate assignment of client obligation amounts (Attachment 4).

Secretary Sullivan discussed updates to the KanCare Ombudsman organizational structure. He stated the Ombudsman would continue to be housed in KDADS and would be independent from the MCOs and KDHE. The Secretary noted the accessibility of the Ombudsman would continue to be a point of focus. He stated KDADS also continued to work on the core functions of the Office of the KanCare Ombudsman to make its functions clearer, including serving as an access point for areas of concern, helping consumers understand the

fair hearing process, referring persons to community resources, developing and implementing a program of training and outreach, staffing and training, and being more prescriptive on data collecting and reporting requirements. The Secretary noted KDADS also would be adjusting staff to provide improved responsiveness to issues, including adding a Volunteer Director in the Ombudsman Office to develop a volunteer network across the state.

A Committee member, expressing concern about the cash flow ramifications of the managed care program to providers, wanted to know what the state planned to do in these circumstances. Secretary Sullivan said changes were being made in the billing systems and if those changes failed, funds would be advanced to assist with those issues.

A Committee member asked about an update on the underserved waiting list. Secretary Sullivan indicated great effort had been made toward cleaning up the underserved list and contacting people, but there was not a good response rate.

A Committee member stated there had been problems identified with third-party liability and the MCOs needed to get those issues sorted out soon, as there were some critical issues to address.

A Committee member asked about the status of the Wichita State University survey on the KanCare Ombudsman's Office. Secretary Sullivan stated KDADS contracted with Wichita State University to conduct a survey, but it had not been completed to date. He indicated the results of the survey would be provided when received.

A Committee member asked Ms. Bruffett about the data regarding denied claims and expressed concern one of the MCOs had consistently higher claim denials. The member asked what KDHE was doing about the issue. Ms. Bruffett indicated some variation may be seen if looking by service line, and there may a different experience for different plans based on whether it is for physical health, community health, or other services. She added KDHE would follow up with the MCOs if a trend, such as denials for lack of timely filing, was seen.

Health Insurance Marketplace Update

Linda Sheppard, Special Counsel and Director of Health Care Policy and Analysis, Kansas Insurance Department, provided written testimony to update Committee members on the federal Health Insurance Marketplace (Attachment 5).

Presentations on KanCare from Individuals, Providers, and Organizations

Nicholas Taylor, private citizen, testified he experienced problems with his doctor's office and pharmacy due to issues with KanCare and Amerigroup. He stated his plan of care hours had been cut, and he experienced difficulty in obtaining a copy of his assessment to understand the nature of the reduction. Mr. Taylor also expressed difficulty in obtaining his medical records to review for his appeal. This required him to retain an attorney and spend countless hours trying to resolve the problems (Attachment 6).

Jill Bronaugh, private citizen, testified her son, Nicholas, has cerebral palsy and has received Medicaid benefits since birth. She felt Medicaid was a hard system to navigate, but she thought getting through the paperwork on the front end would be the hardest part. She stated, based on her experience with KanCare, that has not been the case. Ms. Bronaugh noted her

son has had medication denials, provider changes, and multiple supply company changes. She testified the last six months had been the worst of her son's six years with regards to insurance and administrative burdens, and she would like to see the problems resolved (Attachment 7).

Linda Davis, private citizen, testified she and her husband had been caring for their grandson who has major mental health and behavioral problems. She stated her grandson experienced reductions in service and denial of treatment since KanCare began. Ms. Davis said she and her husband had no choice but to give up custody of their grandson to the State to help him get the care he needed. She stated she would like to see her grandson placed in a residential treatment facility, but United Healthcare would not cover it. She also provided ideas to improve the way KanCare works (Attachment 8).

Tanya Nelson, private citizen, provided oral testimony stating KanCare and Amerigroup had changed her life by creating a new support team that has given her hope for the future.

Daryl Burger, private citizen, provided oral testimony stating she felt KanCare had made dramatic changes and things were going much better. She stated, if she needed help, the case managers were always there and willing to provide assistance. She appreciated that her MCO informed her of charges, so she could keep track of things.

Wylma Martell, private citizen, provided oral testimony that she is on a Traumatic Brain Injury waiver and is with Amerigroup. She said Amerigroup had helped her find out what services would be best for her and helped her fix her bathroom to make it more functional. She indicated she had less stress once she knew what to do.

Latricia Caldwell, Amerigroup Case Manager, RN, BSN, testified on behalf of Timothy Esslinger stating Timothy had received help with weight loss and with a move to outpatient physical therapy (Attachment 9).

Latricia Caldwell, Amerigroup Case Manager, RN, BSN, testified on behalf of Julia Rogers, who has cystic fibrosis and with the help of KanCare has been able to have a lung transplant. Ms. Rogers' written testimony noted her case manager helped her make arrangements and prepare for the transplant surgery (Attachment 10).

Danielle Buettner, private citizen, testified KanCare had been a lifesaver for her as she not only needed medical support but mental support due to anorexia nervosa and post-traumatic stress disorder. She felt she would be dead without the support of KanCare and UnitedHealthcare (Attachment 11).

Kathy Boutte, private citizen, provided video testimony stating she was diagnosed in May 2012 with an enlarged heart and was told she needed a heart transplant. She started on medications and was placed on a waiting list but was told she would die within six months. She felt she had two birthdays—her physical birthday and her heart birthday because she was able to have a transplant with the help of Sunflower.

A Committee member asked Linda Davis to clarify what occurred when she felt she had to turn her grandson over to the State for care. Ms. Davis stated her grandson was in a residential treatment facility last spring, but UnitedHealthcare denied an extension of stay and no alternative was given. She stated she wants to see KanCare improved so other families would not be faced with this type of choice.

Linda Davis responded to a Committee member question as to whether she had appealed the decision. Ms. Davis responded they had appealed within the MCO, UnitedHealthcare, but never received a notice of action, and they were not supposed to be able to appeal until the notice was received. She said they did not bother taking it to the state fair hearing that was available because they felt from previous experience, once services were no longer being provided, the state fair hearing officer would find the case moot; so there was no point in appealing.

A Committee member asked Linda Davis for clarification regarding the statement in her testimony where she suggested questions of medical necessity be made by "independent, qualified medical professionals." Ms. Davis responded a doctor reviews whether a case meets medical necessity criteria, and the doctor who reviewed her grandson's case was a UnitedHealthcare doctor. She did not consider him to be independent, and the doctor never even met her grandson. The member asked if she felt anyone who had been involved in the decisions regarding her grandson was not "qualified." Ms. Davis said that was not the case.

In referencing Ms. Davis' suggestion that the Ombudsman position be moved out of the KanCare office, a Committee member asked if she had interaction with the Ombudsman. Ms. Davis responded she had called the Ombudsman several times, and he was very helpful and prompt at the beginning of the process when they were looking for clarification on a few issues. However, when they wanted to dispute the discharge, he could not help very much. She stated when they subsequently engaged an attorney, the Ombudsman said he would not be able to assist them further.

A Committee member asked Linda Davis about her proposal that the state establish a "genuine" appeal process and wanted to know what about the appeal process was not working. Ms. Davis responded the current process was very difficult to figure out, and the majority of families would not be able to work through the procedure. She indicated the appeals process needed to be simple and clear.

A Committee member asked if transplants were covered under Medicaid or if the coverage was now different, and what other services were provided under KanCare that were not provided previously. Dr. Susan Mosier responded that additional coverage was being provided for heart and lung transplants, as well as bariatric surgery, and these were not covered prior to KanCare.

Chairperson Crum recessed the meeting at 1:00 p.m.

Chairperson Crum reconvened the meeting at 1:15 p.m. The Committee members continued their questions of private citizens who had testified earlier in the day.

A Committee member asked Jill Bronaugh to provide more information on the diaper supply issues she experienced. Ms. Bronaugh responded there were no problems with her normal supplier for about the first six months, but then her supplier notified her it would no longer be providing the diapers due to a lack of payment. She worked with her case manager and found a new diaper supplier. She indicated she had issues around this same time with the denial of medications her son had been using for a long time. After six months, she found out the new diaper supplier would no longer be providing supplies due to payment issues. The Committee member asked about her current situation. Ms. Bronaugh responded that after working to get diapers from another supplier, the previous supplier sent a shipment; so she was not sure if the issue was totally resolved yet, but she did have diapers. She said the

Ombudsman had been helpful, but she did not feel it should have taken that level of intervention.

A Committee member asked Nicholas Taylor about the reduction in the number of hours he is allowed for personal assistance and the reason given for the reduced hours. Mr. Taylor responded he had received a notice saying his Instrumental Activities of Daily Living (IADL) hours were being reduced because he had a capable person living in his house. He indicated he did not understand this because he was only authorized 20 hours of IADL, but his hours were reduced by 95. When asked whether he knew of the KanCare Ombudsman, Mr. Taylor indicated he did not know about him until today's meeting.

Jane Kelly, Executive Director, Kansas Home Care Association, provided written testimony (Attachment 12).

Rosie Cooper, Executive Director, Kansas Association of Centers for Independent Living, testified about her concern for the 263 people on the Physical Disability (PD) waiting list who KDADS had been unable to locate. Ms. Cooper noted these persons needed representation. She stated she believed KDADS has worked very hard to contact persons on the PD waiting list, but she was concerned that contact was being lost with these persons who needed services (Attachment 13).

Mitzi McFatrich, Executive Director, Kansas Advocates for Better Care, shared consumer stories about Kansans who needed assistance but were having problems with KanCare. Ms. McFatrich noted the process was confusing, and there was no easy way to seek help. She included in her testimony a position description for an ombudsman position in Wisconsin and noted she would like to see a similar one in Kansas (Attachment 14).

Steve Gieber, Executive Director, Kansas Council on Developmental Disabilities, testified regarding his concerns with the implementation of KanCare and, in particular, the use of PD waiting list funds for the I/DD waiting list. He felt the I/DD pilot was not running well (noting problems with the billing system and its impact on small providers with limited cash flow), and the MCOs were not ready to move forward. Mr. Gieber would like the pilot to continue and to see if it could be made to work (Attachment 15).

Rocky Nichols, Executive Director, Disability Rights Center, testified in opposition to the use of funds designated for the PD and DD waiting lists to be put towards the underserved DD waiting list. He expressed concern about notice and due process problems, including the failure to notify KanCare recipients of reductions in services, and said those who were informed were often misinformed. He felt this discouraged recipients from appealing, due to concerns they would have to pay back the MCOs or the state if they lost the appeal but wanted to retain the services they were receiving, even though KDHE had said that was not the agency's policy (Attachment 16).

Tom Laing, Executive Director, InterHab, encouraged Committee members to consider changes to waiting list protocol and to hold hearings on this issue. He objected to the proposed reallocation of PD waiting list funds to address the I/DD underserved waiting list. He also opposed the carve-in of I/DD LTSS into KanCare because it would cost more, made life more difficult for vulnerable Kansans, and was more complicated and unproven (Attachment 17).

Rachelle Monger, Director of Government Affairs, Leading Age Kansas, provided written testimony (Attachment 18).

Chad Austin, Senior Vice President for Government Relations, Kansas Hospital Association, provided written testimony (Attachment 19).

A Committee member asked Mr. Nichols about the MCO handbooks and if there was any requirement for when notices of action had to be given. Mr. Nichols responded he did not recall there being any requirement. The Committee member followed up by asking if there were any consequences if the MCOs did not provide a notice of action. Mr. Nichols responded there were no consequences to the MCOs. The Committee member asked if Mr. Nichols was aware of many people being successful in the appeals process. Mr. Nichols said he had a few clients who had been successful, but most were not.

SFY 2014 Second Quarter Report on Average Daily Census for State Institutions and Long-Term Care Facilities, Savings on Transfers to HCBS Waiver, HCBS Savings Fund Balance; Waiting List Update

Secretary Sullivan provided an update on the HCBS program, including the average caseload for state institutions and long-term care facilities and updates on the waiting lists. Secretary Sullivan also provided information on the impact of the final rule issued in September 2013 by the Department of Labor regarding the Companionship Exemption for overtime pay under the Fair Labor Standards Act. He stated the categories of workers impacted by the final rule include domestic service employees working in private homes, those providing companionship services hired by third-party employers, and live-in domestic service employees. Secretary Sullivan indicated KDADS was gathering information to determine the fiscal impact these changes would have on the HCBS waivers (Attachment 20).

With regard to the waiting list information provided, a Committee member asked Secretary Sullivan if individuals could wait years before receiving services, and if there was any communication with them while they waited. Secretary Sullivan responded pre-KanCare there had not been any contact until funding was secured; thus the list became unwieldy because of invalid contact information, but KDADS was working to clean up that list. After KanCare implementation, contact information is kept in the MCOs' database, resulting in a better ability to maintain contact with those on the list.

State Agencies' and Managed Care Organizations' Responses to Stakeholder Concerns

Ms. Bruffett provided clarification on the consistency and clarity of access to the MCOs' appeals process. She noted an inter-agency team was working on uniform language for the three MCOs to include in their notices and handbooks. Stakeholder input would be sought to ensure the language was understandable and made sense to consumers. She added there was some confusion regarding the state fair hearing process because there were three ways to access it—in lieu of the MCO appeal process, concurrent with the MCO appeal process, or subsequent to the MCO appeal process. The inter-agency team also intended to clarify other issues that had been raised about the appeals process.

A Committee member asked Ms. Bruffett for clarification on the situation Linda Davis was facing, where her situation was considered moot in the state fair hearing process since her grandson was no longer receiving services. Ms. Bruffett offered to provide a written response but stated a discharge was a clinical decision indicating sufficient progress had been made to return the individual to a less restrictive alternative, and that would not be considered an adverse decision.

Secretary Sullivan stated that when there was a disagreement between the provider and the MCO, KDADS was able to resolve the matter satisfactorily. He noted Complex Case Staffing, consisting of the MCO, the provider, and the caseworker, would meet to resolve the disagreement.

Secretary Sullivan also discussed the Psychiatric Residential Treatment Facilities (PRTFs). A Committee member asked Secretary Sullivan who made the final decision as to when an individual would be moved from in-patient to out-patient treatment. Secretary Sullivan responded a provider would make a decision on when an individual should be discharged.

A Committee member asked Ms. Bruffett, when or if the I/DD population went into managed care for LTSS, if these individuals would then go into a Health Home and if the state would then receive an enhanced federal match. Ms. Bruffett responded that would not necessarily be the case as it was not a health home setting; however, health homes would be available for those with intellectual disabilities. A Committee member asked if data were available on the number on enhanced match and those staying on the current match. Ms. Bruffett indicated she would provide an estimate for those with a serious mental illness and chronic condition.

A Committee member asked Secretary Sullivan what happened when an attorney was involved in the appeals process, particularly with the flow of communication. Secretary Sullivan responded it would become more difficult to communicate and things would become guarded because everything said could become part of the appeal.

KanCare Ombudsman Update

James Bart, KanCare Ombudsman, provided a brief update on the Office of the Ombudsman, including statistics on case data and resolutions. Mr. Bart stated a KanCare customer survey would be completed by Wichita State University and noted some of the proposed questions were included in his testimony (Attachment 21).

MCO Testimony

Laura Hopkins, Chief Executive Officer, Amerigroup Kansas Plan, provided a briefing on Amerigroup's experience since KanCare implementation. She also discussed the MCO's readiness for the I/DD pilot project. In her testimony she included some stories of individuals who had received beneficial services under KanCare. Ms. Hopkins also updated the Committee on how Amerigroup had addressed concerns expressed by the Kansas Hospital Association at a previous Committee meeting by implementing hospital operational enhancements (Attachment 22).

A Committee member asked about the Health Homes concept and, since the persons who would be part of Health Homes would likely deal with emergency rooms, whether the hospitals were supportive with the program. Ms. Hopkins responded the hospitals certainly needed to be involved in Health Homes and noted Amerigroup had worked collaboratively with the state to understand the optimal model for Health Homes and who the partners were who needed to be engaged. The Committee member also expressed concern about the funds required to make Health Homes effective. Ms. Bruffett responded the state still was working on the per member/per month amount to be paid to the MCOs and the amount that would go to providers.

A Committee member asked if it was Amerigroup's policy to pursue consumers who had appealed decisions and lost, in an attempt to obtain return of the funding. Ms. Hopkins responded she would get the information and provide it to the Committee members.

Jean Rumbaugh, Chief Executive Officer and Plan President, Sunflower State Health Plan, provided an update on Sunflower's experience with KanCare. She stated Sunflower was committed to meeting the goals of KanCare and focused on what the MCO was doing for its members. She stated Sunflower had looked into how to improve care to the individuals being served, and one of the areas looked at was diabetic care, including diabetic screenings so outreach could be done. She added Sunflower was engaged in improvement activities for individuals with alcohol and other drug disorders, in order to improve each individual's behavioral and physical health (Attachment 23). She also provided an update on the MCO's preparation for LTSS for the I/DD population, including dividing Care Coordination Teams geographically to provide the best care (Attachment 24). She stated Sunflower had checks and balances in place to ensure no harm is caused to providers due to cash flow. Additional staff had been hired to help address this issue. Ms. Rumbaugh indicated Sunflower was excited about Health Homes and felt it was a great way to partner with the providers to provide better coordination for high-risk individuals.

A Committee member asked if Sunflower had a policy of pursuing refunds from consumers who appealed decisions and maintained services pending the appeal, but ultimately lost the appeal. Ms. Rumbaugh responded she did not believe that was Sunflower's policy but would confirm and provide the information to the Committee members. She also responded she understood the appeals and grievance process could be confusing. Sunflower was looking at ways to make that process clearer.

Tim Spilker, Plan President, UnitedHealthcare, provided an update focused on outcomes, including member programs and engaging members in their own health. He stated some of the steps UnitedHealthcare had taken included: developing a relationship with Sesame Street; using Baby Blocks, an application that encourages pregnant mothers to complete pre-natal exams and adopt healthy habits; and a community-based weight management program. Mr. Spilker noted consumer engagement was critical and agreed the appeals and grievances process was confusing and needed clarification and simplification. Mr. Spilker also discussed UnitedHealthcare's I/DD LTSS implementation readiness, including a three-year $1.5 million commitment focused on finding meaningful employment for the DD population. He recognized the need to get the basics right, so the MCO had to ensure timely and accurate claims payments and fast issue resolution (Attachment 25).

A Committee member referred to earlier testimony from Ms. Davis, where Ms. Davis indicated the UnitedHealthcare care coordinator actually had not met personally with her or her grandson, and the Committee member asked if Mr. Spilker would have expected that to happen. Mr. Spilker provided information on UnitedHealthcare's care coordination policies and indicated the MCO allowed telephonic coordination to occur under certain circumstances. The Committee members asked Mr. Spilker to meet with Ms. Davis following the meeting to discuss her issues.

A Committee member asked if it was UnitedHealthcare's policy to pursue refunds from consumers who appealed and asked for continued services pending appeal, but who subsequently lost the appeal. Mr. Spilker stated UnitedHealthcare did not collect funds from members in those circumstances. The Committee member asked Mr. Spilker to send a letter to that effect. Mr. Spilker added the MCO had language in its handbook that refunds may be collected, but it had not been the MCO's policy to do so.

Senator O'Donnell moved and Senator Pilcher-Cook seconded the motion to approve the minutes from the meeting held on November 25, 2013. The motion carried.

The Chairperson directed the Committee members' attention to the Committee Report and specifically to page 0-27 to the section on Conclusions and Recommendations.

Senator Pilcher-Cook moved and Senator O'Donnell seconded the motion to approve the Committee Report.

A Committee member indicated he intended to vote against the report and submit a minority report, due to concerns with the recommendations.

A Committee member expressed concern about language on page 0-29 in the first sentence of the section regarding the Paperwork Reduction in Application Process. The member asked to strike the word "potential" from that sentence. All members concurred.

A Committee member wanted to verify the information on page 0-27 of the report in the section on Funding the Developmental Disability Waiting List. The member was uncomfortable with the information and was concerned it took money from people who really could use it.

A Committee member suggested, on page 0-27 in the section on Funding the Developmental Disability Waiting List, to insert "Consideration be given to directing" in front of the third bullet point and to strike "should be directed" from the same bullet point. Chairperson Crum indicated this was a recommendation, and the House and Senate still would be making the decision on how the funds would be allocated. He felt this change was not necessary. No Committee action was taken on the suggested change.

Some concern was expressed by a Committee member that, based on previous testimony, taking these funds would essentially leave some people stranded who were in the pipeline, and the funds now would not be available to take care of them. The member wanted to ensure these individuals would not lose funding, but only that available funds were being moved.

Secretary Sullivan responded that while he did not have the actual numbers with him, approximately 43 people were being moved from the PD waiting list to services, and there were an additional approximately 30 to 40 people who had been located but had not responded. He stated no funds would be removed from anyone who had been promised services. The Chairperson stated he was not opposed to looking at this issue further.

The Committee returned to the motion to approve the Committee Report with the concurred changes. *The motion carried*.

Chairperson Crum adjourned the meeting at 3:17 p.m.

Prepared by Nancy Fontaine
Edited by Iraida Orr

Approved by the Committee on:
April 29, 2014
(Date)