MINUTES

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

January 23, 2015
Room 548-S—Statehouse

Members Present

Senator Mary Pilcher-Cook, Chairperson
Representative Dan Hawkins, 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 Jim Ward

Member Absent

Representative Sharon Schwartz—Excused

Staff Present

Iraida Orr, Kansas Legislative Research Department
Erica Haas, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Renae Jefferies, Office of Revisor of Statutes
Nobuko Folmsbee, Office of Revisor of Statutes
Scott Abbott, Office of Revisor of Statutes
Randi Walters, Committee Assistant

Conferees

Ken Selzer, Commissioner of Insurance
Julie Holmes, Director of Accident and Health, Kansas Insurance Department
Audrey Roberts, Case Manager, Amerigroup Kansas Plan (Oral Only)
Rosie Cooper, Executive Director, Kansas Association of Centers for Independent Living
Danica Case, Controller, Newman Regional Health
Karen Hastert, Patient Accounts Supervisor, Newman Regional Health
Mitzi McFatrich, Executive Director, Kansas Advocates for Better Care

Kyle Kessler, Executive Director, Association of Community Mental Health Centers of Kansas
Jeremy Johnson, Health Homes Care Coordinator, Community Health Center of Southeast Kansas
Joan Kelley, Vice President, Kansas Neurological Institute Parent Guardian Group
Marilyn Cook, Executive Director, COMCARE of Sedgwick County
Mike Oxford, Executive Director, Topeka Independent Living Resource Center
Jacque Clifton, Financial Management Services Provider, Guardian, Advocate Care Services
Jon Gerdel, Executive Director, Life Patterns
Doug Gerdel, Chief Executive Officer, Life Patterns
Chad Austin, Senior Vice President, Government Relations, Kansas Hospital Association (Written Only)
Susan Mosier, M.D., Acting Secretary, Kansas Department of Health and Environment
Glen Yancey, Chief Information Technology Officer, KDHE
Mike Randol, Director, Division of Health Care Finance, KDHE
Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services (KDADS)
Kerrie Bacon, KanCare Ombudsman
Laura Hopkins, Chief Executive Officer, Amerigroup Kansas Plan
Michael McKinney, M.D., Chief Executive Officer and Plan President, Sunflower State Health Plan
Tim Spilker, Health Plan Chief Executive Officer, UnitedHealthcare Community Plan

Morning Session

Chairperson Pilcher-Cook called the meeting to order at 9:03 a.m. and provided opening comments.

Health Insurance Marketplace Update

Insurance Commissioner Ken Selzer introduced himself as the newly elected Commissioner of Insurance of the State of Kansas and provided information regarding his background. He stated the Kansas Insurance Department's (KID) mission, as required by Chapter 40 of the Kansas Statutes, is to educate and advocate for consumers, regulate insurance companies, and license insurance agents. He stated the KID would be as innovative, responsive, productive, and efficient as possible with consumers, the insurance industry, and the Legislature (Attachment 1).

Julie Holmes, Director, Accident and Health Division, KID, provided an update on the Health Insurance Marketplace. Ms. Holmes provided statistics regarding the most recent enrollment numbers for Kansas, noting a total of 54,899 Kansans completed the eligibility portion of the application process between November 15, 2014, and December 15, 2014, 39,023 of whom selected a Marketplace plan. She noted the remainder had either not selected a plan (11,964) or had been determined eligible for Medicaid/Children's Heath Insurance Program (3,912). Ms. Holmes explained the data did not include consumers automatically re-enrolled into coverage. She stated the report indicated the demographic characteristics of those selecting 2015 Marketplace plans during the first month of open enrollment were similar to those who selected a Marketplace plan during the early months of the 2014 open enrollment period (Attachment 2).

A Committee member indicated the most recent weekly letter he received from the Centers for Medicare and Medicaid Services (CMS) showed Kansas had 75,800 consumers who selected Marketplace plans, and then he heard on January 22, 2015, that number was over 80,000. He inquired if the full report with the details was being used by Ms. Holmes when reporting 39,000 consumers. Ms. Holmes stated she believed the numbers the legislator saw included automatically enrolled in coverage, and the report she provided did not include those numbers. The Committee member stated there were two silos: new persons signing up for the gold, silver, or bronze health insurance plans in the Marketplace, and persons who signed up during the prior enrollment period who had the option to review their policy and find a better plan, or take no action and be automatically re-enrolled. Ms. Holmes stated that was correct.

A Committee member inquired as to the number of persons automatically re-enrolled who paid their premiums. Ms. Holmes stated, to date, KID did not have information on the number of those who paid their premiums. She indicated the information probably would be available at the end of the open enrollment period.

A Committee member asked for the percentage of persons who paid for the first year of coverage. Ms. Holmes stated she believed there was an article indicating 83 percent had paid for the first year, but she would inquire and provide the information.

A Committee member stated he was interested in Silver Plan data for consumers between 100 and 250 percent of the Federal Poverty Level who enrolled on the federal exchange, when the information was released. Ms. Holmes stated she would provide the information.

Presentations on KanCare from Individuals, Providers, and Organizations

Audrey Roberts, Case Manager, Amerigroup Kansas Plan, testified on behalf of Angela Blea who received KanCare services. Ms. Roberts shared a brief history of how she assisted Angela through a complicated pregnancy. No written testimony was provided.

Rosie Cooper, Executive Director, Kansas Association of Centers for Independent Living (KACIL), addressed concerns with the Physical Disability (PD) waiting list. Ms. Cooper requested the Committee recommend the Kansas Department for Aging and Disability Services (KDADS) enter into a contract with the Centers for Independent Living (CILs) to help KDADS manage the PD waiting list by providing Independent Living Counseling. Ms. Cooper addressed two major issues of concern to Financial Management Services (FMS) providers regarding Home and Community Based Services (HCBS) waiver renewals. The first was the mandatory background checks. She stated KACIL supported the initial safeguards, but asked a plan to reimburse FMS providers be developed. She also expressed concern with the vendor fiscal model, stating there were numerous additional education requirements. Ms. Cooper asked the Committee recommend an FMS rate increase (Attachment 3)

Danica Case, Controller, Newman Regional Health, updated the Committee on the effect the KanCare program's claims processing was having on Newman Regional Health. Ms. Case reminded the Committee of the Newman Regional testimony in April 2014, indicating some of the problems had become apparent again, were not resolved, and did not have long-term solutions. Ms. Case indicated some areas of opportunities for improvement (Attachment 4).

Karen Hastert, Patient Accounts Supervisor, Newman Regional Health, indicated the transition to KanCare with the three managed care organizations (MCOs) and their different requirements had been difficult. Ms. Hastert discussed the hospital's difficulty with claims resolution, payment of claims, and correct claims payments.

Mitzi McFatrich, Executive Director, Kansas Advocates for Better Care (KABC), stated KABC had been working with the National Senior Citizens Law Center to create a new resource for older adults who had questions and concerns about their rights under the KanCare program. Ms. McFatrich stated KABC created the resource because there was a clear surge in the number of questions and concerns after the implementation of KanCare. Ms. McFatrich expressed concerns regarding budgetary issues relating to the Frail Elderly (FE) waiver and reimbursements and the cuts in the 2015 Governor's Budget for senior care. Ms. McFatrich also voiced concern regarding a Kansas Department of Health and Environment (KDHE) report showing, in the first year of KanCare, nursing facility new admissions were up by 7 percent. She expressed concern with the possibility of having a waiting list for the FE waiver, as experienced by individuals on the Physical Disability (PD) and Intellectual and Developmental Disabilities (I/DD) waivers (Attachment 5).

Kyle Kessler, Executive Director, Association of Community Mental Health Centers of Kansas, Inc., stated he believed the role of Health Homes in providing integrative care to bridge behavioral health and primary care needs had achieved improved health care and cost avoidance for vulnerable Kansans statewide. Mr. Kessler stated KDHE deserved credit for providing leadership on the Health Homes initiative. Mr. Kessler indicated this was an important issue to Kansas community mental health centers and to the future of the health care delivery in the state (Attachment 6).

Jeremy Johnson, Health Homes Care Coordinator, Community Health Center of Southeast Kansas, shared a few client histories to illustrate the persons served and the services provided. Mr. Johnson stated these persons, who were representative of the 65 people currently enrolled in their Health Homes Program in community health centers, had experienced improvement. Mr. Johnson indicated the most important improvement experienced by these individuals since joining the program was the hope their lives would one day be better (Attachment 7).

Joan Kelley, Vice President, Kansas Neurological Institute Parent Guardian Group, stated families dedicated to the protection of their loved ones with life-long, severe cognitive-developmental disabilities were struggling. Ms. Kelley stated recruiting and retaining support staff to assist families providing 24/7 care often was an enormous challenge heightened by the disincentive of ever-increasing disparity of the direct support staff wage (Attachment 8).

Marilyn Cook, Executive Director, COMCARE of Sedgwick County, shared a brief history of the COMCARE team's work with a middle-aged man with diabetes who had been hospitalized several times due to his diabetic condition. She stated the team had developed a comprehensive plan, and for the first time in some time, the individual had not been hospitalized in over a month. Ms. Cook indicated the person had taken medications appropriately. Ms. Cook stated the mental health systems had been very responsive to the Health Homes program and were seeing the program work. Ms. Cook stated Health Homes had made a difference in the lives of the persons COMCARE served. Ms. Cook indicated looking forward to the implementation of the second state plan amendment for Health Homes for chronic conditions (Attachment 9).

Mike Oxford, Executive Director, Topeka Independent Living Resource Center (TILRC), updated the Committee regarding the status of the U.S. Department of Labor (DOL) regulations amending the Fair Labor Standards Act's "Companionship Exemption." Mr. Oxford stated he became involved in a federal lawsuit to halt the regulations, and TILRC joined a lawsuit with the National Association of Homecare and Hospice. He helped write affidavits, and Secretary Bruffett wrote an affidavit in support. Mr. Oxford indicated the judge had vacated the entire regulation. He stated the DOL likely would appeal, but there now was time to implement changes to self-direction moving toward increased consumer control over the services through a vendor fiscal model (Attachment 10).

Jacque Clifton, Advocate Care Services, Inc., testified as an FMS provider and also the parent of a 20-year-old man with significant disabilities. Ms. Clifton stated she had been working on the current FMS Provider Workgroup tasked to work with KDADS on issues related to self-direction. She indicated she was a proponent for the change in the current self-direction model to the proposed vendor fiscal employer model, but addressed concerns with the lack of readiness. Ms. Clifton expressed the need to take time to make the right changes, so as not to cause a crisis in self-direction with the other issues being faced (Attachment 11).

Jon Gerdel, Executive Director, Life Patterns, addressed some of the issues experienced by the company regarding prior authorization under the KanCare system. Mr. Gerdel indicated concern with a policy requiring foster children to be agency-directed instead of having self-directed services. Mr. Gerdel believed the policy would limit the choice in services and providers. Mr. Gerdel expressed concern with Crisis Funding and described an experience involving an individual approved for Crisis Funding in July 2014, but for whom notification of approval was not provided until September (Attachment 12).

Doug Gerdel, Chief Executive Officer, Life Patterns, stated he started Life Patterns as an FMS provider in 1993 and also has an adult son with a severe disability. Mr. Gerdel indicated having had no direction from KDADS for the past two years. He expressed difficulty in getting answers or having conversations with the agency, and stated having received vague responses. Mr. Gerdel presented examples of Health Insurance Portability and Accountability Act violations, concerns with the reduction of persons' services by the MCOs, and areas where he believed there were conflicts of interest. Mr. Gerdel indicated he felt long-term supports did not belong in KanCare. Mr. Gerdel stated he believed the MCOs did not understand long-term supports and how they work, and that long-term supports should be excluded from KanCare.

Written testimony was submitted by Chad Austin, Senior Vice President, Government Relations, Kansas Hospital Association (Attachment 13).

In response to Committee questions, Ms. Case and Ms. Hastert, Newman Regional Health, indicated the hospital did not use a commercial clearinghouse or coordinate its error codes for Medicare and Blue Cross Blue Shield. The two conferees stated it was not as difficult to work with one program or two programs, as in the past, but working with the three MCOs was very difficult. Ms. Case stated the hospital resubmitted the prior authorizations,and called to obtain prior authorizations, but if the number did not get to the MCOs, the hospital claim would be submitted and the authorization would not be there. She stated the hospital staff was spending additional time working on connecting and resubmitting the authorizations. The two Newman Regional representatives noted remittance denials were different for each MCO and cumbersome. The conferees stated the hospital's accounts receivable aging was based on the date the claim was sent and agreed to provide the Committee a report on the date of service as compared to the date the claim was sent for primary claims. In addition, the conferees stated the hospital was approved as a critical access hospital retroactively to December 16, 2013,

requiring the hospital to reissue a large number of claims. In that time frame, the hospital re-billed Medicare for those claims, and then had to bill secondary claims. The conferee indicated a large percentage of the hospital's population had Medicare, with an MCO as the secondary. The conferee stated it became apparent, because the hospital was re-billing a mass issue, the MCOs did not understand how to deal with correct denial codes that would allow the hospital to claim those on the Medicare cost report. The conferees agreed with the Committee member that Medicaid paid 20 percent of the Medicare allowable in general, and the hospital needed to work with the MCOs on coding, not on paying the claims. When filing the Medicaid secondary claims, the conferees said the hospital was using the date the claim was sent.

A Committee member stated, in previous meetings, there were issues with funding for community mental health centers (CMHCs) and access particularly for those with no insurance. The Committee member asked if the CMHCs received the money needed to provide the services they were required by law to provide. Marilyn Cook, COMCARE, stated she did not believe the CMHCs have the money needed to provide those services. Mr. Kessler stated that was one of the topics the Governor's Mental Health Task Force addressed in 2014. He stated the Mental Health Task Force wanted to commission a study to discuss the actual cost of providing mental health treatment. Mr. Kessler stated there was more documentation at this time about nonprofit organizations and also stated county government was picking up more of the cost. The Committee member asked if the CMHCs could tabulate the amount of compensation the centers would receive if Medicaid were expanded. Ms. Cook indicated the CMHCs could try to do so. He noted about 25 percent of the Medicaid population lived in Wichita, so COMCARE could probably devise a formula to estimate the compensation. Mr. Kessler indicated the CMHCs probably could make such a calculation. He stated the tabulation would be center by center, because of varying effects on different parts of the state. He also indicated the compensation would vary by population.

A Committee member referred to a statement made that care was better with Health Homes because of increased coordination. The Committee member asked about cost-reduction and whether previous and current expenditures were being tracked. Mr. Kessler indicated there was an on-going pilot study with eight centers, including COMCARE, that would provide some of those analytics. He stated he believed the data would show significant cost savings. Ms. Cook indicated increased access to data would result in greater success. She stated COMCARE was one of the 26 mental health care centers that did not use a national product to keep data; instead, COMCARE modified its own electronic health record. Ms. Cook stated COMCARE had been using the modified health record for only four and a half months, and were near a point of determining the data needed to address the kinds of questions being asked by the Committee. Ms. Cook indicated data windows would then be developed to pull reports for the center.

A Committee member asked Ms. Cooper about her recommendation for increased FMS rates to cover the cost of background checks. Ms. Cooper stated a background check always was available if an individual wanted it; but with the renewal, all waivers would require every new direct care worker to pass a background check prior to being hired. Ms. Cooper stated the background checks were an unfunded mandate being passed on to the FMS providers. She stated support for the background checks, but was asking for another way to reimburse FMS providers for the expense.

A Committee member asked Ms. Cooper if the cost of the background checks and any counseling provided to keep individuals apprised of the waiting list would come from the $115 rate increase for FMS providers. The Committee member also asked if there was a formal proposal. Ms. Cooper indicated the proposal was not formal. She stated KACIL supported

efforts by KDADS to reach these individuals on the PD waiting list, but these individuals did not have the extra support other waivers had. She stated the unintended gap in reaching these individuals was created by the move to KanCare and targeted case management became more care coordination. She stated targeted case management was reduced, creating a hole in the system. She stated she believed these persons were not being reached because they were a difficult population to track.

A Committee member asked Mr. Oxford to comment on the issue of providing services for persons who have been identified on the waiting list but were not receiving services yet. The Committee member also asked if there were ways the TILRC kept in touch with individuals on the waiting list or if having a more formal relationship with KDADS to provide those services would be helpful. Mr. Oxford stated having a more formal relationship with KDADS to keep track of individuals on the waiting lists would be helpful. Mr. Oxford indicated targeted case management was a resource to help stay in touch with individuals on the waiting lists, and TILRC tried to stay in touch. Mr. Oxford stated when there was targeted case management, targeted case management funds could not be used for that service, unless and until the individuals were eligible for Medicaid. Mr. Oxford indicated, even then, those resources could not be used to follow up with persons, resulting in losing track of many individuals on the waiting lists because there never had been a consistent way to stay in touch. Mr. Oxford noted with targeted case management, although the funds could not be used to keep track of individuals on the waiting list, contact information was available and the centers could informally keep up with some of the individuals.

KanCare Update

Dr. Susan Mosier, Acting Secretary of Health and Environment, provided an update on the vacant KanCare Inspector General (IG) position. She indicated the agency was seeking a suitable candidate to fill the role and stated the main issues had been finding a qualified candidate with strong audit and IG background. She stated offers had been made to two candidates with federal IG background, but with the significant difference between federal and state pay scales, the agency had not been able to attract those candidates. Dr. Mosier pointed out the Medicaid program was one of the most highly audited state programs by federal level entities. Dr. Mosier stated the Medicaid program was audited by the Office of the Inspector General, Health and Human Services (HHS), the Government Accountability Office (GAO), the Office of Management and Budget (OMB), and CMS. Dr. Mosier indicated, at any given time, there were probably one or two audits occurring from one or two of those federal agencies (Attachment 14).

Dr. Mosier provided an update on Health Homes, stating Serious Mental Illness (SMI) Health Homes was launched in July 2014. Dr. Mosier noted a booklet, “Health Homes Early Implementation Successes,” included in her testimony described some of the successes heard in previous testimony. Dr. Mosier stated, as of January 1, 2015, 27,766 individuals were enrolled in Health Homes, and 4.9 percent of those enrolled were individuals with intellectual and development disabilities. Dr. Mosier indicated there was a 15 percent opt-out rate, which was less than the 25 percent predicted. Dr. Mosier reported there were 80 contracted Health Home Partners (HHPs), with each MCO having at least 56 contracted HHPs.

Dr. Mosier provided information on the behavioral health drugs statute, KSA 39-7,121b, stating its repeal would enable Kansas Medicaid to manage behavioral health drugs in the same manner as other drug classes. Dr. Mosier presented an overview of recommended changes for the Legislature’s consideration.

Dr. Mosier provided a KanCare cost comparison, comparing both pre- and post-KanCare costs. Dr. Mosier provided a federal effect cost comparison with and without the recently required federal changes. She discussed cost comparison components, including the Health Insurance Provider's Fee, the "woodwork effect," the Federal Medical Assistance Percentage (FMAP), and the federal requirement to cover new drugs for Hepatitis C once approved by the federal Food and Drug Administration. Dr. Mosier stated a 12-week course of treatment for Hepatitis C was available that ranges in cost from $80,000 to $120,000 for a full course of treatment. She indicated one drug released by the federal government in the past month was not on the chart.

Dr. Mosier discussed utilization, stating the goals of KanCare were better coordination and integration of care, reducing gaps in care, reducing delays in care, and reducing redundant or duplicative exams and testing. She stated there also was an emphasis on health wellness, early detection, and early intervention. Dr. Mosier noted the pattern of utilization changes seen were what would be expected with KanCare's emphasis. Therefore, preventive services such as dental, vision, visits to primary physicians, visits to Federally Qualified Health Centers and Rural Health Centers, and non-emergency transportation utilization had increased, while in-patient days stays and emergency room visits had decreased.

Dr. Mosier discussed innovation in service delivery, stating the agency was working on or starting many new projects in 2015. Dr. Mosier provided information on Project ECHO, an Oral Health Initiative, the Collaborative Improvement and Innovation Network, and the Million Hearts Project.

With regard to a question from the Committee concerning the KanCare IG position, Dr. Mosier stated KDHE considered the position important, and the integrity of the program was one of the highest priorities. Dr. Mosier indicated her testimony referenced other audits that put protections in place, including the audits by HHS, OIG, GAO, OMB, and CMS. Dr. Mosier stated the agency also had a well-trained Medicaid Program Integrity Group and participated regularly in the South Carolina Medicaid Integrity Institute. Dr. Mosier stated individuals in the Program Integrity Group continually updated and improved their skills. Dr. Mosier stated the Medicaid Eligibility Quality Control (MEQC) also reviewed KDHE's eligibility and error rates. She stated the MEQC worked with the Kansas Foundation for Medical Care, KDHE's external quality review organization. In addition, KDHE's Program Integrity Group determined, if there was possible fraud, the matter would be sent to the Attorney General's Medicaid Fraud Control Unit. Dr. Mosier stated there were many other areas internal and external to the Medicaid program to help ensure the program's integrity.

A Committee member asked if Dr. Mosier was advocating there was no need for an independent IG. Dr. Mosier stated KDHE was reviewing the original 2007 statute to determine whether the program integrity goals were being met with other existing measures.

Glen Yancey, Chief Information Technology Officer, KDHE, provided an update on developments in the Kansas Eligibility Enforcement System (KEES) since his testimony in November 2014. Mr. Yancey indicated, in October 2014, KEES implemented the account transfer component allowing individuals who apply for health insurance coverage on Healthcare.gov, and assessed eligible for Kansas Medicaid, to have their applications automatically transferred for processing by the KanCare Clearinghouse Eligibility Workforce. Mr. Yancey indicated, to date, over 20,000 applications had been transferred,including a significant backlog since this was the first period transfers were counted that included applicants from the previous season's open enrollment period. Mr. Yancey stated the enrollment process was in pilot mode and would be moved to production within two weeks. Mr. Yancey noted, subsequent

to the Committee's November 2014 meeting, KDHE performed a readiness assessment and identified three major areas requiring remediation and detailed how the issues were being addressed. Mr. Yancey described how KEES would help the state with fraud prevention in the Medicaid program by enhancing automated verifications for applicants and beneficiaries.

In response to Committee questions, Mr. Yancey stated:

- KDHE was working with Accenture to finalize the release plan, which would list all of the defects, the functional system changes being made that would result in the system testing in User Acceptance Testing for an implementation date, and the functions included. Next, KDHE would develop a release plan, showing items not necessary in the scope of the initial release, but that need to be addressed in priority order. Some of those items would be part of the product release schedule. Mr. Yancey indicated, because KEES was an Accenture Commercial-off-the-Shelf product, some of the functionality actually would be delivered by the product group, which was different than the state customization group. Those two groups combined develop the long-term release schedule for KEES. Mr. Yancey stated KEES was in the final stages of development, and KDHE also was working closely with CMS because CMS wanted the same information.

- Mr. Yancey stated some of the medical programs for elderly and disabled people were required to measure or account for the tangible assets a person owned in determining eligibility. Mr. Yancey indicated it was difficult to develop and automate an interface to meet those requirements, so those determinations likely would continue to be accounted for manually.

- Mr. Yancey explained when a paper application and supporting documents was submitted, the paper documents would be sent to the clearinghouse for imaging. The application and imaged documents would become part of the electronic records associated with the particular application and case, allowing a caseworker to view all documents a person submitted.

- Ultimately, the self-service portal would have a feature allowing applicants to upload and attach electronic copies of documents to their applications, eliminating the need for applicants to print and mail paper copies. Mr. Yancey indicated when applications reached the clearinghouse, the applications would be processed in the same manner, but the need for scanning would be eliminated.

- Regarding verification of citizenship, Mr. Yancey indicated a service call could be made to the Federal Data Services Hub to determine citizenship status. KDHE also could access the Kansas Birth Registry electronically to verify whether the consumer had been issued a Kansas birth certificate.

- Currently under CMS rules, data obtained through the Federal Data Services Hub can be used only for Medicaid determination. Mr. Yancey indicated he did not believe the Federal Data Services Hub had a functional structure that would allow access to non-Medicaid agencies, such as the Secretary of State's Office.

Mike Randol, Director, Division of Health Care Finance, KDHE, provided an update on the MCOs' financial status. Mr. Randol stated the filing deadline for the National Association of Insurance Commissioners Financial Statement was not until February 15, 2014, so no update to the financial status of the MCOs was available until that date.

Mr. Randol addressed the Health Home cost savings methodology. He stated one requirement for obtaining CMS approval of the state plan amendment (SPA) was a comprehensive cost savings methodology that would be utilized to determine the effectiveness of Health Homes. The SPA contains a comprehensive cost savings methodology. Mr. Randol stated KDHE would compare the acute care costs of individuals in Health Homes for individuals with SMI to individuals with the same diagnosis codes. Mr. Randol indicated a reduction in in-patient hospital emergency stays would be expected. Mr. Randol stated Health Homes was implemented July 1, 2014, and began in August 2014; therefore, data needed to determine cost savings was not available.

Mr. Randol reviewed the data in the KDHE Executive Summary (Attachment 15).

During a discussion regarding Health Homes, a Committee member stated, after two years of a grant for Health Homes for which Federal dollars have paid most of the cost, the cost of care for the consumers in Health Homes had to be low enough to offset the price when funding reverts to the FMAP. The Committee member indicated, if that was not the case, a new layer of Medicaid expense would be added. The Committee member stated the data had to be tracked closely, so if patients in a Health Home were consuming as much care or more care cost as those not in Health Homes, a decision would need to be made before the funding would shift to the FMAP 60/40 split.

Another Committee member expressed concern regarding an item on the cost comparison component, stating Hepatitis C costs from SFY 2016 to SFY 2017 were almost flat. Mr. Randol indicated the cost was flat because KDHE did not have sufficient data to make the projection. He stated there potentially would be an increase. Mr. Randol indicated data would be analyzed when available and a more accurate projection would be made. The Committee member indicated the Hepatitis C amount could easily double and requested a more accurate number in the budget so the funds would not be spent elsewhere. The Committee member stated a $30 million or $40 million unexpected cost was problematic because the money would be spent if the projection was not included in the budget. Mr. Randol stated KDHE would work with the actuary and the pharmacy team to achieve an accurate projection, at a point in time, and share the information with the member. The Committee member requested the projection be included in the budget.

Dr. Mosier explained prior authorization at the request of a Committee member. A Committee member expressed concern providers were required to get prior authorization for services that have been routinely provided for a long time and with the delays in legitimate requests for prior authorization. The Committee member asked how KDHE was holding the MCOs accountable on this issue, and if standards were built into the contract with MCOs requiring a response within a certain time frame. Dr. Mosier stated prior authorization was not in the contract, but was determined by each MCO. Dr. Mosier stated benefits previously requiring prior authorization had followed that pattern. She stated some benefits previously requiring prior authorization no longer have that requirement. Dr. Mosier indicated KDHE worked with the MCOs on problems through the receipt of a bi-weekly report on provider issues, monthly joint and individual face-to-face meetings, and as needed for individual issues; MCO managers were the point of contact for the state. She stated anyone with a problem could ask these entities,

and they would make sure a resolution was reached. Dr. Mosier noted the KanCare Ombudsman was an additional avenue for resolution.

A Committee member inquired about MCO performance benchmarks in the contract, and whether any sanctions were associated with the benchmarks. Christiane Swartz, Deputy Medicaid Director, Director of Medicaid Operations, Division of Health Care Finance, KDHE, indicated there were benchmarks for the accounting, but the MCOs had a certain amount of time to respond on denials or prior authorizations. She stated KDHE received reports from the MCOs, and the reports do not indicate the MCOs were not meeting the time line. She stated the time line for an MCO to respond to a request for prior authorization was about ten days from the time the prior authorization request was received for a service that could be planned in advance. Ms. Swartz explained there were no prior authorizations required for emergencies. She stated there was a different time line for the MCOs to respond on prior authorizations for a non-emergency situation but when service needed to be rendered sooner, such as a planned surgery in two or three weeks. In these instances, the time line was within 24 to 48 hours. Ms. Swartz stated KDHE completed on-site visits auditing the MCOs on their performance. She stated a similar review process could be performed related to prior authorizations. The Committee member stated prior authorization was a problem that needed to be looked at and tracked, and some sanctions needed to be included so the MCOs were held accountable for delays.

A Committee member asked for a specific dollar amount Health Homes would cost the state annually. Mr. Randol indicated the information was in KDHE's budget projection and would be provided. The Committee member inquired if Health Homes would remove anyone from the Medicaid waiting list. Mr. Randol indicated one of the requirements to be in the Health Homes was current Medicaid eligibility. Mr. Randol stated Health Homes served the current Medicaid population and provided six additional core services. The Committee member asked if the money spent on Health Homes would reduce any waiting lists or serve any more Kansans. Mr. Randol stated, to his knowledge, Health Homes would not reduce any waiting lists and would not add to the Medicaid eligible number.

A Committee member inquired about the proposed change in responsibilities between the Department for Children and Families (DCF) and KDHE. Dr. Mosier stated the Executive Reorganization Order (ERO) would transfer eligibility positions from DCF to the KDHE clearinghouse. Dr. Mosier indicated the new clearinghouse group would assume the eligibility determinations on January 1, 2016, when the transfer would occur. Dr. Mosier stated the transfer was of positions, not actual workers. Dr. Mosier stated eligibility had been performed at the clearinghouse. The eligibility determination that had been performed by DCF was primarily for the elderly and disabled population. Dr. Mosier indicated savings would be created by consolidating the eligibility positions, with a reduction in the administrative burden. There would also be training available in-house for additional eligibility workers. Dr. Mosier stated KDHE wanted to reduce the payment error rate measurement by at least 2 percent in 2016, creating a $26 million reduction, and those were the reasons for the ERO. Dr. Mosier stated KDHE would work out the details with DCF for getting Medicaid applications in over the next few months. DCF would have staff in the locations KDHE staff likely would be located. Dr. Mosier indicated consumers would be able to receive assistance with completing and submitting the paper application through the local offices. The local office workers would not be actual eligibility workers, as the eligibility determinations would be made centrally.

Secretary for Aging and Disability Services Kari Bruffett began her presentation by addressing an issue Ms. McFatrich mentioned regarding a $1 million proposed cut in the Senior Care Act. Secretary Bruffett indicated the reduction was $120,000 and was based on projected

unspent funds. The Secretary stated KDADS was working with some of the associations on the best recommendations for applying the reduction.

Secretary Bruffett also addressed the background checks mentioned by Ms. Cooper. The Secretary stated KDADS was trying to help mitigate those costs by working within KDADS and the Survey Certification Commission, who worked with the Kansas Bureau of Investigation and performed background checks for nursing facilities that were processed at a reduced rate.

Secretary Bruffett next addressed prior authorizations, stating the issues expressed by Jon Gerdel and Doug Gerdel pertained to long-term services and supports, and for the most part go through the AuthentiCare system. She noted something that could be measured and checked was the gap between the time of eligibility determination, the service plan development, and when the authorizations were loaded into the system. The agency could also look for a delay in the time between when an authorization was set to expire and when it was re-loaded. Secretary Bruffett stated the contract with the MCOs required processing the prior authorizations, and while that was not part of pay for performance, the processing of prior authorizations was a contractual requirement for which the state had enforcement mechanisms. She indicated KDADS was encouraging providers to use the KDADS on-line issue logs or the Kansas Medical Assistance Program website and continue to log issues there. Although the log was used by KDADS, KDHE, and the MCOs to help track issues needing work, the log also could be used to track global system issues that might require contract enforcement as well.

Secretary Bruffett provided an update on the transition of I/DD Long-Term Services and Supports into KanCare. Secretary Bruffett also updated Committee members on the current efforts to reduce the PD and I/DD waiting lists and bring more people into services. Secretary Bruffett addressed the DOL rule regarding a change in the definition of the employer of direct support workers who work for self-directing consumers, and what services were included as companionship services and qualified for exemption from the Fair Labor Standards Act. She stated the U.S. District Court in the District of Columbia had issued a couple of rulings having the effect of vacating the entire rule. Secretary Bruffett indicated the DOL appealed on January 22, 2015, which was expected. The judge combined multiple issues to allow the matters to be appealed and litigated at once. Secretary Bruffett stated KDADS was pleased with the DOL case outcome, but knows the case is not over. She stated KDADS would continue to stay engaged and hoped to ensure self-directed consumers continued to be able to operate as employers (Attachment 16).

State FY 2015 First Quarter Reports

Secretary Bruffett updated the Committee on the Financial Management Services (FMS), stating the changes were in large part put in place to ensure consumers could successfully perform the role as employer. She indicated KDADS was working on moving forward with having the contract or agreements signed. The agreements with the FMS providers were still with the state. KDADS also contracted with the MCOs for the services. Secretary Bruffett stated one reason for this change was to have a consistent model across the state that was not necessarily present previously. She stated a memorandum of clarification would be sent on January 23, 2015, for those providers who already had signed the agreement, to ensure the providers know there is a 30-day review period after the FMS policy manual comes out. Secretary Bruffett indicated it was important for KDADS to know who was on board with the model KDADS was moving towards, and that was the reason for requesting the agreements be returned. Secretary Bruffett indicated the signing of the agreements was extended to January 30, 2015 (Attachment 17).

Secretary Bruffett addressed an issue Ms. McFatrich mentioned regarding a 7 percent increase in new admissions to nursing facilities. Secretary Bruffett stated KDHE information indicated a utilization percentage (utilization per thousand consumers) and showed an increase in utilization per thousand Medicaid consumers. Secretary Bruffett stated that was not the same as a 7 percent increase in admissions.

The Secretary presented an update of average monthly caseloads for state institutions and long-term care facilities. She indicated the number from nursing facilities had held fairly consistent over State Fiscal Year (SFY) 2013, SFY 2014, and the first quarter of SFY 2015. Secretary Bruffett stated KDADS' goal was to ensure persons who wanted to be in their homes and communities would be able to live there. Secretary Bruffett indicated KDADS was working on a project to survey hospital discharge planners and other service providers to determine the obstacles and barriers for persons coming from a hospital setting who end on a path to a long-term care facility instead of home.

Secretary Bruffett updated Committee members regarding the average daily census for state institutions and long-term care facilities that were not in-state institutions, the Money Follows the Person program, and waiver renewal updates submitted on December 31, 2014, for Traumatic Brain Injury, PD, FE, and I/DD. Secretary Bruffett stated the Autism and Severe Emotional Disturbance (SED) waivers renewals were due to CMS by September 30, 2015, and additional public information sessions would be held in 2015 regarding those programs.

Secretary Bruffett stated a number of changes had been made to the waiver renewals submitted in December 2014 based upon public comment, including the proposed transition requiring individuals on the PD Waiver to transition to the FE waiver upon turning 65 years of age. She stated KDADS had planned to include some services in the FE waiver that would mimic some of the services that would otherwise be provided by the PD waiver. The Secretary indicated KDHE heard many other concerns, so the transition to the FE waiver from the PD waiver would remain optional. Secretary Bruffett stated KDADS was responding to CMS requests for additional information and informal inquiries. She discussed waiver renewal updates for the statewide transition plan being added to Autism, Technology Assisted, and SED waivers. Secretary Bruffett provided an overview of Phases I, II, and III of the HCBS Transition Plan and information on the FMS hybrid model proposed to CMS that would allow some features of the Agency with Choice and the Vendor Fiscal/Employer agent models. Secretary Bruffett stated one of the main changes impacting consumers required to be part of the transition in this model consistent with an IRS Revenue Procedure, would require a consumer or the consumer's legal representative to obtain a Federal Employer Identification Number (FEIN) for IRS purposes. She indicated if a consumer was unwilling or unable to get an FEIN, one of the options was to change to agency-directed services.

In response to Committee questions, Secretary Bruffett stated the following points.

- Excess funds were wage funds used for worker purposes, such as payroll taxes, that could not be used for administrative purposes. At the end of a fiscal year or some other agreed-upon period, the excess funds would have to be returned to the program, and then the federal share would be returned to the federal government. She noted one of the challenges for some providers in the model the state was moving toward was calculating the excess funds at the client-specific level because the client would be the employer. Secretary Bruffett stated the issue would be clarified in the KDADS policy manual and also in discussions.

- Secretary Bruffet noted one of the challenges for FMS agencies regarding client obligation would be if the client was supposed to pay for some services, but was not paying for the services. The question would be if a consumer was paying the worker, but might not be paying the client obligation and instead would be paying more than the consumer was actually getting paid by the Medicaid program through the MCOs for those services. KDADS calculate client obligation in a manner requiring clients to pay to maintain continued eligibility. She indicated KDADS was working on the issue with KDHE, the MCOs, and FMS agencies. Secretary Bruffett indicated KDADS would like to know whether the reason a Medicaid consumer, who may be self-directing care and moving from one FMS agency to another FMS agency, was changing FMS agencies because of an unpaid client obligation. Secretary Bruffett stated KDADS was trying to determine how the information could be obtained.

- Secretary Bruffett agreed to provide data on the exact number of people on the I/DD and PD waiting lists, along with long-term trend data.

- With the Governor's proposed budget increases, Secretary Bruffett indicated there would be 175 additional individuals moved off of the I/DD waiting list and 125 individuals from the PD waiting list.

- As a result of a conference call on January 22, 2015, and other comments received, KDADS would be issuing a memorandum to extend the signing of the FMS agreements,originally due on January 23, to January 30.

- Upon release of the FMS manual, providers would have a 30-day period to sign the agreement. There would be in-person meetings and teleconference capabilities for questions and answers about the implications of the manual. At the end of the 30-day period or sooner, the providers could decide to terminate the agreement. Secretary Bruffett stated there was provider input on the development of the FMS manual.

- For background checks, KDADS might try to use a system similar to that used by nursing facilities. Secretary Bruffett indicated the way the process works would not change, but the cost would be reduced. The process was still in development. Secretary Bruffett stated she would provide detailed information on the costs.

A Committee member requested the second-year MCO profits and losses. Mr. Randol stated the filings were not due until February 15, 2015. The Committee member requested the information be provided at the next Committee meeting and in a simple format, with a positive or negative number and the amount. Mr. Randol indicated he would provide the information.

Chairperson Pilcher-Cook recessed the meeting at 12:13 p.m.

Afternoon Session

Chairperson Pilcher-Cook reconvened the meeting at 1:30 p.m.

KanCare Ombudsman Update

Kerrie Bacon, KanCare Ombudsman, updated the Committee on the activities of the Ombudsman's office. Ms. Bacon indicated there were two opportunities for members and providers to meet the Ombudsman, one at a vendor booth at an InterHab Conference and the second at the Brain Injury Conference. Ms. Bacon stated the Ombudsman's office mailed information about its services to the 105 targeted case managers. Ms. Bacon provided a summary to the Committee of the 2014 Fourth Quarter Report. She stated the top four issue categories for the fourth quarter were medical services, HCBS general issues, appeals and grievances, and billing. She indicated billing and appeals and grievances were the top two issues that have been consistent across all four quarters. Ms. Bacon provided a summary to the Committee of the 2014 Annual Report. She stated the top call volume months were February, March, July, and October. She stated the call volume in October was the highest due to open enrollment. Ms. Bacon highlighted the appeals and grievances issues for the four quarters of 2014 (Attachment 18).

Secretary Mosier addressed a question from a Committee member regarding why the calls regarding Durable Medical Equipment (DME) had dropped in the fourth quarter. She stated one reason could be related to wheelchair accessories. Dr. Mosier stated there had been a single code for wheelchairs and accessories. Recently, 42 codes were approved, which made it easier for consumers to access a wheelchair and the related accessories.

KanCare MCOs Presentations and Responses to Stakeholder Concerns

Laura Hopkins, Chief Executive Officer, Amerigroup Kansas Plan, provided the Committee an update on Amerigroup 2014 achievements, 2014 provider payments, 2014 provider payment detail, provider servicing, Health Homes statistics, ID/DD program, and 2015 initiatives. Ms. Hopkins stated her written testimony included member success stories for the Committee to review (Attachment 19).

Michael McKinney, MD, Chief Executive Officer and Plan President, Sunflower State Health Plan, referred the Committee to his written testimony and stated it is an overview of where Sunflower is and the progress made over the past 24 months. He addressed the previous DME question and stated, in addition to wheelchair coding, Sunflower was now getting DME through pharmacies instead of a DME provider. Dr. McKinney addressed what Sunflower was doing to improve the prior authorization issue. He indicated they were hovering around the required 14-day turnaround time. Dr. McKinney also addressed retro-eligibility and stated it was a problem in managed care. Dr. McKinney asked permission for Chris Coffey, Chief Operating Officer, Sunflower State Health Plan, to address prior authorizations (Attachment 20).

Mr. Coffey addressed Sunflower's prior authorization list and indicated it was a short list. He stated they were within their contractual window of time to submit prior authorizations. Mr. Coffey indicated as of July 2014, they were paying interest, which had helped Sunflower focus on improving efficiency. Mr. Coffey indicated they had made a conscious effort to meet the 14-day time line.

Tim Spilker, Health Plan Chief Executive Officer, UnitedHealthcare Community Plan, provided the Committee with information on utilization management, quality outcomes, provider satisfaction, and member satisfaction. Mr. Spilker indicated the dialog was starting to change from the focus on operational issues to a focus on collaboration. He indicated some examples

include UnitedHealthcare's tele-monitoring pilot, home modifications, and provider accounts receivable support. Mr. Spilker provided an update on the prior authorization issue and described what that company had done to address the problem. Mr. Spilker indicated they have removed prior authorization requirements for physical therapy, occupational therapy, and speech therapy. Mr. Spilker stated they had made significant progress around the retro-eligibility issue and described what they had done to address the issue. Mr. Spilker updated the Committee on Health Homes enrollment status, operational performance, and member engagement. Mr. Spilker also provided information on a program they were launching in Kansas called Community Health Workers (Attachment 21).

A Committee member asked Mr. Spilker whether UnitedHealthcare implemented the prompt pay bill, the law the 2014 Legislature passed.

Mr. Spilker stated UnitedHealthcare had implemented a similar approach in other markets, but had not executed it because they were working with the state on specific guidelines. He indicated they would be ready and willing to move forward when the design was completed.

A Committee member asked Ms. Hopkins what safety net features would be available to prevent individuals from having their medication changed to a cheaper prescription if the Legislature were to repeal the behavioral health drug statute.

Ms. Hopkins stated there was only a 25 percent chance an individual would be given a different medication. The provider would either provide information that the current medication was appropriate from a medical necessity perspective or that there was something else that might be helpful to the person or another combination of drugs that actually cost more. She also stated there could be another combination of drugs that cost the same or another combination of drugs that cost less. Ms. Hopkins added, if the law were changed, there would be a process to manage the transition in an appropriate and safe way that would not put the provider, the family, or the member at risk.

A Committee member asked Ms. Hopkins whether an MCO or a pharmacist had the authority to intervene if a child was prescribed a behavioral drug at an adult dosage. Ms. Hopkins stated neither an MCO nor a pharmacist had the authority to prevent the prescription from being filled.

A Committee member asked Ms. Hopkins whether an MCO would recommend a generic drug instead of a name brand drug to a first-time psychotropic drug recipient.

Ms. Hopkins stated it would depend on the circumstances of the individual, what the medication is, and what the presenting symptoms are, but typically an MCO would start with the generic version of the medication and then progress to other forms.

A Committee member asked Ms. Hopkins to respond to an issue raised by Jon Gerdel. Mr. Gerdel stated in his testimony there was a big difference between claims being submitted for payment and what had actually been paid.

Ms. Hopkins stated she did not think the issues were current concerning Life Patterns. She stated she checked on the situation while the Committee was on break and found there may have been issues a few months ago, but they had been addressed. She also stated

Amerigroup monitored claims processing on a frequent basis and was open to providers who advise they had a concern or an issue.

A Committee member asked if any organization present wanted to comment on claims not being paid by MCOs. No organization responded to the invitation.

A Committee member asked representatives of each MCO to explain their definition of a "clean claim" and to rate their customer service on a scale from one to ten.

Dr. McKinney stated, based on federal and state definitions, a clean claim is a claim that has all the information necessary to process the claim. He added if the claim includes any incorrect information, it can be considered an "un-clean" claim and unless all the information is correct, the claim will be denied. He stated if a claim has a level of suspicion, then the medical records may need to be reviewed and, in that instance, a claim would be considered "un-clean." He also stated he has inquired into how other states define a clean claim and found most states have a definition similar to Sunflower's definition. Dr. McKinney stated he appreciated being asked about Sunflower's customer service and would rank the company's customer service an eight.

Mr. Spilker stated UnitedHealthcare's definition of "clean claim" was the same as Sunflower's definition. He added about 90 percent of UnitedHealtcare's claims were clean. Mr. Spilker stated UnitedHealthcare had made tremendous progress in operational performance over the past two years, and he ranked the company's customer service an eight. He added UnitedHealthcare was working to be more innovative and collaborative. Finally, he stated UnitedHealthcare was pleased with its member satisfaction scores in the two cap surveys conducted per year, was striving to be "best in class," and was about at the National Committee for Quality Assurance national average for performance.

Ms. Hopkins stated Amerigroup had the same clean claim definition as Sunflower and UnitedHealthcare. Ms. Hopkins stated Amerigroup was doing very well in terms of customer service, was at a four-day turnaround time for non-urgent authorization requests for paying claims, and was averaging about six to seven days from date of receipt. She stated Amerigroup's member satisfaction survey results were above average and she ranked the company's customer service in the eight to nine range. Finally, she stated Amerigroup also was looking at innovative ways to work with providers.

The Committee member thanked the MCO representatives for answering the questions and said she was hearing fewer complaints about KanCare. She also stated the process was improving and would like the MCOs to continue to work hard to ensure Kansans get better treatment.

A Committee member asked Dr. McKinney to respond to Ms. Hastert's testimony. Ms. Hastert testified Newman Regional was experiencing challenges with Sunflower paying claims and paying claims in a timely manner. The Committee member also asked if Sunflower could generate a report that would state the time a claim left the clearinghouse and the time it reached Sunflower, so the delay in processing could be identified.

Dr. McKinney provided a number of possible reasons for the delay in payments to Newman Regional. He explained Sunflower looked at all the claims over $500 that Newman Regional showed as outstanding and of those, Sunflower made errors in the amount of $12,000

and had paid that amount to Newman Regional. Dr. McKinney also stated Sunflower had a visit planned to Newman Regional in the upcoming week to continue to address the concerns.

A Committee member asked Dr. McKinney, if Sunflower were allowed to develop its own Preferred Drug List in return for a $14 reduction in per member per month, whether Sunflower would be willing to consider it.

Dr. McKinney stated Sunflower would consider such an arrangement. Sunflower would grandfather in medications that were already prescribed to members and would automatically enter a prior authorization requirement for members beginning a new drug.

Chairperson Pilcher-Cook adjourned the meeting at 2:38 p.m.

The following information was provided by conferees after adjournment of the January meeting to provide clarification on questions raised:

- Mitzi McFatrich, (KABC): Testimony Correction (Attachment 22);
- Kansas Insurance Department: Percentage of Federally Facilitated Exchange Enrollees Paid First Premium (Attachment 23);
- UnitedHealthcare: January 31, 2015, Follow-up Information and Data on Newman Regional Health (Attachment 24);
- UnitedHealthcare: April 27, 2015, Follow-up Information on Newman Regional Health (Attachment 25);
- Sunflower State Health Plan: April 27, 2015, Follow-up Information on Newman Regional Health (Attachment 26).

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Approved by the Committee on:

April 28, 2015
(Date)