

**KanCare Advisory Council Meeting Minutes
Curtis State Office Building – Room 530, Topeka, KS
Minutes of December 15, 2014**

Council Members Present:

Chairman Larry Martin
Dr. Michael Kennedy
Representative Susan Concannon
Jamie Price
Mark Hinde
Edward Nicholas
Lora Key
Njeri Shomari

Council Members Absent:

Senator Mary Pilcher-Cook
Representative Jerry Henry
Beth Simpson

Council Members Attending Via Phone:

Senator Allen Schmidt
Walter Hill

Other Participants

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

Other Participants Absent:

Lt. Governor Jeff Colyer, M.D.

Welcome – Chairman Larry Martin

Larry Martin opened the meeting. The agenda for the meeting was unanimously approved by the Council as published. Mark Hinde made a motion to approve the meeting agenda and Ed Nicholas seconded the motion.

Review and Approval of Minutes from Council meeting, September 25, 2014

Correction to page seven of September 25, 2014 meeting minutes: “Allen Hinde” should be “Mark Hinde” per Mark Hinde. Beth Simpson also emailed a correction to the minutes. The meeting minutes were approved as amended by the Council.

Larry Martin requested a fiscal snapshot. Asked that there be a quick discussion on fiscal numbers from year one and where we are in year two with fiscal numbers. Michael Randol will provide this information during the KDHE update.

Updates on KanCare with Q&A

Sunflower State Health Plan – Chris Coffey

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

Nearly 300% increase in flu shots this year over last year. This was due to collaboration or an initiative with LifeShare, Sunflower Health Plan and Walgreens. Set up flu clinics in SE Kansas, and Douglas and Johnson counties. LifeShare is focused on serving the I/DD population and with that they have provided almost 600 consults year-to-date, which they plan to exceed by the end of the year, to over 140 members. Many of those consults resulted in a decrease of poly pharmaceuticals, ER visits and overall in-patient admissions. LifeShare has also provided training to 140 I/DD providers and caregivers which touched over 1,400 total participants in training this year.

Chris Coffey gave a brief presentation to the council that included several examples of publications created by Sunflower. The first was on diabetes which is available in both English and Spanish. Other publications include: pregnant mothers, teenage pregnancies and children under the Start Smart program to everything from sickle cell and overall weight loss and wellness. Through the education and materials, we have been able to help and manner such as employment of persons with disabilities and a number of topics including person center of supports, etc.

Chris Coffey shared a recent success story about a 19-year-old I/DD member who by the age of 17 had been in and out of 167 different foster care facilities. When they took over the care for this member through collaboration with KDADS and a number of providers, they were able to find placement for the individual. He is in a community now of three months and is in a setting that is helping him continue to proceed. At the time we received this member, he was incarcerated. Again, he has since been out of incarceration and in care.

Also, this year, we have moved over 130 members out of nursing facility placement and into home and community-based services. We hope that by the end of this year that will exceed about 150.

Sunflower is focused on the resources needed to service the population with a majority of those resources being within: provider relations, quality and the claims department.

Claims: They have increased to processing 300,000 claims per month with an accuracy rate of 98.7% year-to-date. Looking at the I/DD population, they have seven times the number of claims of any other member population. From a care, administrative and claims processing perspective, they consider it to have been a successful year. They are sensitive to the 1.3% they may not have been accurate during the earlier part of the year because that 1.3% does add up to be a large amount of money so, through the all-important resources they have, they have exceeded the 99% mark.

Provider network: Seeing continued growth. Providing in lieu of services, Sunflower has avoided expenditures in excess of \$2 million.

Value Added Services: They include: Personal care assistance over and above waiver limits or orthotics and equipment that the member may need that might prevent issues in the future. About \$1.7 million of value added services were provided this year through disease and healthy living coaching, the Start Smart program, Smoking Cessation, etc.

Lastly, we have a number of initiatives that were focused on throughout the year with everything from NICU Management and re-admissions to in-patient diversion, etc. Those are things that will continue in

2015 with a big focus on working with providers to have upside or gain opportunities contractual so that we can start to move the needle on the quality measures throughout the State.

Quality: Some of the areas that continue to be outstanding are the configuration issues around the coordination of benefits and the third-party liability that they are working through. They have put manual processes in place internally to catch the pre-check run and make sure that providers are paid appropriately, but this still requires more work to be done. Sunflower has continued to fine tune their Home Health partnership in making sure that all of the Home Health partners are meeting the program requirements by conducting a weekly phone call. Doing so has allowed them to identify areas where they can be of assistance. One area has been assisting with finding a PCP to become that PCP consultant and not relying on them just doing it solely by themselves.

Questions and Answers:

Jamie Price – How many members do you have in out-of-state in-patient locations right now?

Chris Coffey – Only 1 or 2, and those 1 to 2 are TBI members. We feel that we have a strong enough network in the state of Kansas with the specialists who can meet the needs of these members. From a medical prudence perspective and a taxpayer dollar perspective, it's more prudent management that those members are within our own state.

Edward Nicholas – In reference to the continuity of care with the TA waiver: Where are you all with it? Stated it has become stressful for many parents of children who are on the TA waiver because of the hours being cut back. Not sure if they have always had the services but the kids need the services. When these members opt to file an appeal, they are “stuck” as a result of no immediate action being taken.

Chris Coffey – I'm not privy of any reduction in hours with the members. Every decision is based on necessity.

Kari Bruffett – When you have any proposed reduction, the reduction should not take effect for at least 33 days so that the folks have time to appeal and then during the time of the appeal. If you or anybody you know find that it is being reduced prior to going through the full appeals process, let us know because we want to be sure that it's being administered appropriately. The services have to go through the review process including the appeal process prior to it being reduced unless it is on an appeal after 33 days.

Edward Nicholas – I'm trying to be an advocate on both sides, for the State and the people. I have two kids on the TA waiver and recently I received a call from someone in western Kansas who asked for my help with this.

UnitedHealthcare Community Plan – David Rossi

David Rossi provided a brief update on UnitedHealthcare.

Key Outcomes: a) Pre-term birth rates - 2012 overall was 11.2% (pre-KanCare data). In 2014, the pre-term birth rate was 8.9%. This results in a 23% decline improvement. b) Inpatient psychiatric services: Measured by admission per 1,000 members - In 2013, UnitedHealthcare was at 3.57%. In 2014, the rate was 3.19%, an approximate 10.5% improvement.

Claims payment turnaround times were a challenge for the MCOs in 2013 even with the implementation and initial struggles overall for the year. As you look at the overall rates in comparison to other states, they were not too bad. In 2014, UnitedHealthcare demonstrated continued improvement over fiscal year 2013. For Clean Claims, the rate of claims paid within 30 days was 99.99%. For Non-Clean claims, claims that require additional data or information from a provider in order to process the claim, there was a 99.91% improvement from 2013. Seeing continued improvement with Claims Denials: Denial rates at 12.55% year-to-date through September 2014.

Empower Kansans: A program that UHC committed to Kansas during the time of KanCare. The goal is to

provide \$1.5 million in grant money over three years for programs that create meaningful employment opportunities for individuals with disabilities. The program really looks at innovative and creative programs to improve opportunities for those with disabilities to gain employment or to have an opportunity for employment.

Round 1 summary: a) \$263,000 awarded to five organizations. b) Key Outcomes: 1) 119 individuals participated in grantee programs; 2) 30+ employers impacted; 3) 34 jobs created. Round 2 summary: a) Approximately \$500,000 awarded to seven organizations; b) Variety of purposes and intentions in mind.

UnitedHealthcare is currently going through the process of reviewing round 3 proposals. There is still approximately \$780,000 available in grants. There are a number of folks on the committee and while UnitedHealthcare does have a place on the committee, they are there primarily for guidance. The other committee members that belong to different disability organizations and various other organizations across the state that have entrust and support in individuals with disabilities are the ones who really talk through and evaluate the programs. They also decide on the ones that have the most merit and are contributing potentially to the charter for the Empower Kansans program.

Health homes: a) 7,554 members engaged enrolled with over 50 providers; b) Currently conducting Joint Operating Committees with all Health Home providers, focused on evaluating member engagement activity; c) Developed Health Home member ID card holder with care coordination contact information which helps to make it easier for the members to get in touch with the people who are most important to helping support them as part of the Health Homes; d) Continue to aggressively monitor claim activity because they understand, as an MCO, how important it is for providers to be paid accurately and timely.

Value added services: (Update: \$946,000 in value added benefits provided thus far in 2014); Key additions for 2015: a) Parks and Recreation activities for individuals with disabilities; b) Home Helper Catalog and Calendar; c) Adult Briefs for PD and FE members

Tele-Health Expansion:

Objective –To improve quality and cost outcomes resulting from expansion of tele-monitoring services to additional KanCare populations (PD and ABD). The goal is also to evaluate and make sure that the services are meeting the conditions in satisfaction for the Tele-Health program.

How it works: UnitedHealthcare identifies and actually enrolls the members. However, members always have a choice; they can choose not to enroll in the program. But generally, most members do opt to take advantage of the benefits of the Tele-Health program. b) Windsor Place, UHC partner, provides the tele-monitoring aspect which includes installing the at-home tele-station that monitors the patient's vital signs and also transmits that information through a series of reports to the RN care coordinator. c) Alerts: There are reports run on a daily basis that will flag members or patients that have some indications that there could be an issue or some sort of healthcare challenge and the care coordinator will reach out right away to the member or patient to make sure there aren't any more significant challenges. There are various reports and information that are available to the provider to make sure the patient is receiving good coordinated care.

Expected benefits: a) Reduction in ER utilization and in-patient utilization trend. b) Improvement in transportation costs and c) nursing home admissions.

Participation: 35 PD waiver members and 45 Age Blind Disabled (ABD) members. UHC is looking to expand and find other innovative Tele-Health programs that they can partner with similar to providers such as, Windsor Place.

Additional Opportunities: Leveraging tele-health to enable transitions from nursing facilities in the community as part of the “money follows the person” program or just continuing to help members who are right for being discharged to a community-based setting. They want to make sure that they are taking full advantage of the opportunities for those where a community-based setting is the right setting for them.

Looking at 2015 and KanCare beyond, they will continue to listen to ideas and thoughts from the Council as well as, consumers and providers across the state and think in terms of ways to innovate and continue to improve the quality, efficiency and overall services as part of KanCare.

Questions and Answers:

Michael Kennedy – In reference to Tele-health: With transmitting vitals, is there an RN in the primary care practice office or is it someone employed by UnitedHealthcare?

David Rossi – It's not UnitedHealthcare, the person is employed by Windsor place. With tele-health, there are many options available in terms of managing the program.

Michael Kennedy – How is the PCP involved?

David Rossi – The primary care physician receives reports on their patients. There are two parts to the process: 1) UHC can provide the information; 2) but, it is important that the physician is aware about the information that is being provided. You can't just send it to them in a vacuum and expect them to look at the data. It helps to have an orientation with their patient so giving them a notification that their patient has been enrolled in the program. Hopefully, that will help in managing the care for their patients.

Jamie Price – How many members do you have in out-of-state in-patient locations right now?

David Rossi – Will have to check on the actual number. Because of the robustness of the network in Kansas, there are very few.

Susan Concannon– What is the primary reason why claims would be denied? And, what steps were taken to improve that from 15% to 12%?

David Rossi – There are a number of reasons why claims deny. One reason would be not having a prior authorization in place. However, that continues to decline as we look to reduce the number of procedures that require prior authorization more and more. UnitedHealthcare has a list online (www.uhc.com) where providers can view which procedures require prior authorization. Another factor resulting in the denial of claims is duplicate claims. But, if you take out duplicate claims, the number is even smaller, as much as dropping the overall rate by 1-2%.

David Rossi – Carrie, can you think of any others that are top reasons for denials?

Carrie Kimes (UHC) – Duplicates are our number one. Other common denials are: Non-covered services, billing codes that are not approved by the health plan, and non-contracted services.

David Rossi – That includes non-covered procedures, as well. A lot of the reason for this has to do with looking at the data and looking for reasons for the denials and then, provider education. That could be provider education through general bulletins and information; the best way to educate is face-to-face and personal contact. We run a lot of reports that give us specific detail on why certain claims deny and why they deny for certain providers. We will actually reach out to the individual providers and spend some time with them to help them understand what the claims denial issue is and then help to educate them.

Sometimes it is a provider education issue and other times it could be a mistake in the configuration. It's generally close monitoring and following up to make sure that we are partnering with the providers to help.

Amerigroup Kansas– Frank Clepper

Frank Clepper provided a brief update on Amerigroup.

Successes: We evangelized our own population and had a perfect score on the NCQA accreditation this year. Had very high member satisfaction scores, as well as good state audit scores. We were also

successful in the implementation of our Developmental Disability Community program and the SMI portion of Health Homes. In 2015, they look forward to adding on the chronic care section of the initiative.

Over 63,000 authorizations generated for services within the Amerigroup system. Over 4,000 members engaged in case management. We made over 13,000 face-to-face visits with our service coordinators and members and, when you think about the amount of miles travelled in rural Kansas that tends to be a pretty big number. It also speaks to the dedication of our service coordinators out in the field to get out there and touch the members that they have a responsibility for.

They also repatriated 119 members out of institutions back into the community. Assisted 598 members with avoid of institutional placement. Again, with the emphasis on managed care and the delivery of services and getting the appropriate outcome for folks, reintegration into communities is a huge success story. Lastly, we also assisted 68 members in gaining employment.

Health Homes initiatives: a) 87% retention rate; b) Delivered over 4,500 Health Homes services to members that were assigned to Amerigroup and stuck with Amerigroup providers; b) Paid \$4.6 million claims year-to-date with an average turnaround time of 6.5 days. Given that claim volume, it is an extremely nice place to be; c) Paid over \$804 million in total claim payments to our providers.

Our member advocates have made more than 4,700 outreach calls to members primarily directing care and making sure appropriate help outcomes to them. Held 580 community events and at those events, touched over 10,000 members directly allowing us the ability to educate our member population on the services available to them.

Understanding the unique nature of the Kansas marketplace, we've also made over 80 onsite visits to Tribal Indian Health Services and Urban Indian Health clinics to make sure that they are totally integrated in the delivery of care.

Had one member in particular who was provided a liver transplant in 2014, a service that took place out-of-state, in Texas. Her transportation and services were coordinated, as well as her reintegration back into the community following the transplant. Her comment to the service coordinator was "thank you so much for connecting directly to me". That says a lot about Amerigroup's dedication and philosophy about delivering services to our members.

Implementation: a) Answered over 155,000 phone calls - about 60% from providers and 40% from members. Average length of call is about six minutes and an average speed to answer is under ten seconds. b) Will continue to focus on the delivery of services in the Kansas marketplace. Earlier, we touched on the 63,000 authorizations that were made and we will continue to look through that data in an effort to make that process easier. Understanding the claim data now over two years, we believe that we can now put some initiatives in place to further ease the authorization requirements within the provider community.

Claims Operations: Looking to reduce rework through our "Drop-to-pay" percentages and also improve audit calculation of member liability across all three forums: patient liability, client obligation, and the spenddown.

Health Homes: Continuing to work with state partners on the implementation for chronic care.

Nursing Homes: Working with state partners on the nursing home facility rate schedules in an effort to reduce the turbulence of rate changes and that population.

We are all leaning forward and looking to the implementation of the Department of Labor rules and their impact on the delivery of care for those affected providers.

We are participating in the Oral Health Initiative and we have an oral health value added benefit that we think will contribute to that providing prophylaxis care to our adult populations. We will continue to look at provider servicing and improving how we do that across the provider community.

Questions and Answers:

Jamie Price - How many members do you have in out-of-state in-patient locations?

Frank Clepper- I will get you an exact number, but I believe the number was three (3) at last count.

Jamie Price – Is it the same population? Traumatic Brain Injury?

Frank Clepper – It is TBI, that’s exactly correct. And, generally for people that are in long-term care situations, the member that I know who we have placed in Florida is because that’s where his family is at, so his familiar support is there.

Mike Kennedy – Why Texas for a liver transplant?

Frank Clepper – It was our understanding that the complexity of that particular transplant could only be done at that facility.

KDADS Update – Secretary Kari Bruffett, Kansas Department for Aging and Disability Services
Secretary Bruffett provided an update on the U.S. Department of Labor Rule and I/DD Implementation. The State of Kansas still considers our self-directed consumers the employers. However, as we discussed at the last Advisory Council meeting and we certainly have discussed broadly more publicly as well, there certainly are concerns about the application of the new U.S. Department of Labor regulation and interpretation of who can serve as sole employer when they’re receiving services from the state. We distributed on Friday a commissioner open letter signed by Commissioner Gina Meier-Hummel to providers and we can get this for the advisory council electronically, as well. It has also been posted on the KDADS website www.kdads.ks.gov for consumers because we knew there were a lot of questions due to the uncertainty of how the DOL will enforce or interpret their regulations as it applies to Kansas. In early October, US Department of Labor published a statement in the Federal Register delaying enforcement of the new regulation on the Companionship Exemption until July 1, 2015.

This allows us to continue our conversations with not only the U.S. Department of Labor but also with CMS and to a certain extent, IRS. This delays enforcement from the Department of Labor’s perspective; it does not necessarily preclude a private cause of actions. We know that is a concern for some providers as it continues. Part of the reason for our statement is to state very clearly what the State’s position is at this point. If anything were to change in the state’s interpretation, we will share that and make changes to the program accordingly.

Just today, the U.S. Department of Labor and the Department of Justice put out a “Dear Colleague” letter. It is a general letter on the implications of the different ways that states might deal with the Department of Labor Rule if it does in fact impact self-directed consumers in that state. Certainly warning against fraud and policy changes that states might consider that might lead to increases in institutionalization which has been our greatest concern.

We will continue to provide information; we have a provider call scheduled for tomorrow and we will have a Financial Management Services (FMS) provider call specific on this issue this Friday to answer questions.

We have shared with the U.S. Department of Labor the waiver renewal information. Included in our waiver renewals is what we believe strengthens the ability of consumers to serve as the true employer. Not only can they hire and fire, but really strengthening the policy that allows the consumers to set the wage from

within the range that can be set by the reimbursement rate. Any funds that wouldn't be fully expended would stay in an account the consumer would use to either pay a bonus at the end of the year to a worker or to pay different workers, different wage rates. This would either depend upon experience, performance or the specific duty that they might perform.

We know that there are still concerns about this moving forward. We anticipate a pretty good conversation in the legislature about if for example, despite some of these changes that we get a more definitive answer from the Department of Labor saying despite this we still think it's likely that the state and/or FMS agency might be considered a joint employer. This would trigger not only the overtime requirements and travel time but, the implications for sleep-cycle also which is the primary concern for most consumers. There have been lots of questions about what the implications are. The new rule has been scheduled to go into effect January 1, 2015.

The way the state is interpreting and using not only the delay in enforcement but our understanding of our consumer status as an employer is that sleep-cycle will continue to be offered as it has been offered. There is nothing in our waiver renewals at this time that changed that definition at all.

We know that there is still uncertainty and there is information available on the website. The information will hopefully include the state's position. Persons can also be added to the LISTSERV if they are interested in that issue by contacting hcbs-ks@kdads.ks.gov and including "LISTSERV Addition" in the subject line.

Waiver renewals: The public comment period for the four waiver renewals that are out pending which include: Intellectually and Developmentally Disabled (I/DD) waiver, Traumatic Brain Injury (TBI) waiver, Frail Elderly (FE) waiver and the Physical Disability (PD) waiver.

Those waivers have all been extended through the end of March 2015, though the TBI waiver confirmation hasn't come through yet but we know it's coming through. This will allow the continued collection of public comment on the waiver renewals and any changes the state might have to make. However, this is more so driven by the HCBS settings rule and the opportunity to make changes to comply with the CMS final rule.

There are a number of documents on the KDADS website including this one. It is found under "Proposed Changes to the HCBS Program posted for Public Comment" and is a waiver-by-waiver summary roughly about ten pages long that contains the major changes in the waiver. The waivers are also available to view in their entirety in PDF format. Lastly, this comment period ends December 20, 2015.

The state is also drafting some frequently asked questions that will be added to the website and shared on the LISTSERV. We know there are a lot of questions about what we have published and what that means as well, including the impact on case management with the conflict-free provisions of the CMS rule and what the implications are particularly for I/DD and conflict-free case management. It's not a simple answer and it's certainly a matter intended. Some of the concerns are that for so many of the consumers who receive case management from a provider that also has ties to providing the services directly. However, we have providers that have implemented, in Kansas, different strategies to ensure that that conflict of interest is protected and we have others that are looking at other options as well. As well as independent case management agencies and individuals who provide those services.

At this point, we do not have feedback from CMS on the content of our waiver renewals in order to determine if the language we included, largely the CMS regulation itself, is sufficient or if we need to be more detailed. If we

do, we definitely will continue collaborative work with not just providers but also consumers about the impact of that.

The main concern that we have heard about has been case management. Certainly, there are other concerns and questions about the waivers as well. For instance, the change in the Physically Disability waiver is a requirement upon aging. After turning 65, folks on the PD waiver would move to the Frail Elderly (FE) waiver.

We have received a number of comments and we look forward to that conversation. Part of the way we dealt with some of the concerns originally, as this proposal came earlier in the year, was to try to change some of the benefits or services described in the FE waiver so that some of the services they provided here would be lost whereas in FE, it would not be.

In the vision of KanCare overall, the MCOs talked about their value added services or more specifically, their in lieu of services; while these waiver definitions are very important, they are not the sole definitions of the services that people can receive. Certainly, the managed care organizations can provide services from one waiver to another waiver, although you have to go through some justifications for that with the State as well as providing those services to individuals who are not on the waiver yet.

However, we know that those definitions matter because not everybody goes through the in lieu of services and not all three of the MCOs look at those quite the same way. We are still looking for the responses on those kinds of changes as well. We do have an HCBS Provider forum that will be held December 16, 2014 from 10:00-11:00 a.m. and at the conclusion of the comment period we will be placing a summary of all the comments received onto the website. It will be similar to the 1115 waiver process where we posted comments and included a summary in the waiver renewals whether we did or did not make changes based upon those considerations.

Update on Waiting List: Making efforts to continue to provide or offer services to individuals on the Physical Disabilities (PD) waiver waiting list. We still have 2,159 individuals on that waiting list; however, some of those individuals have subsequently received offers to receive services within the last few months. It will be difficult to hit this number actually in services but, our goal is to have 6,092 individuals receiving PD services at the end of this month.

KDADS sent 400 offers the week of Thanksgiving to individuals and have received about 150 responses back so far. Persons do not necessarily go back into service so if it has been a while since they have received services or been assessed, they will have to go through an assessment and complete an application. If they aren't currently Medicaid eligible then they have to go through that process. In December, we expect another 900 offers because we are still at about 5,300 individuals who are currently being served despite now about 1,600 offers that have gone out this year. We now know that since we are getting much more current in our offers as far as the individuals who are being offered services in the waiting list; those individuals have now been on the waiting list a much shorter length of time. The fiscal year 2013 additions to the waiting list are now listing these offers of services. More of those are more likely to both be successfully reached and those still in need of services that have not have found other alternatives in the meantime.

The response rate on the original 400 offers is much better than what we had seen before for the previous several hundred before that. On the I/DD numbers served, we still have 8,725 including a handful who are on the MFP Program. The waiting list for I/DD is 3,134. That number was included at the end of the legislative session and is expected to increase within the next month or two.

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

Susan Mosier reviewed the KanCare Executive Summary dated 12.15.14.

Eligibility and expenditure compositions: Children make up 65% of the population and comprise about 27% of expenditures. Individuals with disabilities and the Frail Elderly comprise 65% of expenditures and account for 24% of the population. Expenditures are at \$2.56 billion and the count of individuals receiving services is a little over \$424,000 as of November 30, 2014.

Capitation payments: These remain stable with the greatest amount of capitation payments going out for long term care (LTC). Long term care includes: a) nursing facilities; b) money follows the person; c) waivers for individuals with physical disabilities and the frail elderly. The second largest capitation payment is the TANF and PLE population. And, depending on the MCO, the third largest is individuals with developmental disabilities or the SSI dual and non-dual population.

Members by cohort: TANF and PLE are the largest population at 240,000 members followed by our children on the CHIP program that is staying relatively stable in the 55-57k member range. Lastly, the third largest population is the SSI dual and non-dual.

Our capitation payments and average member counts by MCO have stayed stable for several months now and our provider network have continued to grow for Sunflower and UnitedHealthcare and have gone up a little from June to September for Amerigroup. And, then we also have the number of unique providers for individuals on HCBS and targeted case managers by MCO as of May 20, 2014 and October 31, 2014.

Denied claims: Remains in the 15-16.5% range in September and we will have some updated information at the next meeting for the year in total. The 2014 denied claims by service type by MCO that is in the range of 14.5%-16%.

Value added services: The total number of members served year to date is 203,000 and total dollar value of services provided is \$3.3 million.

The total members that have received in lieu of services have been about 5,500 and with a value of services also at \$3.3 million.

The breakdown between additional Medicaid covered services those are services that we provide on Medicaid and we have existing limitations. The services are provided above and beyond those limitations. Also, non-covered services like TeleHealth and private nursing are things in this category that we do not cover but, that are provided as in lieu of services.

Member Grievances and Appeals: Of the top five reasons for appeals, the three that were consistent for all MCOs were: Billing and financial issues, service and attitude of staff and timeliness and they have continued to work in those areas toward improvement.

Update on Financial Performance – Mike Randol

Mike Randol provided an overview of the KanCare Cost Comparison handout and an update on profit and loss. Chairman Larry Martin requested a profit and loss report from the first and second years of operation. Currently, we have not completed the second year of operation. But, what we have done is, the MCOs are responsible and required to submit a quarterly financial report to the National Association of Insurance Commissioners through the Kansas Insurance Department and we get copies of that information.

Relative to the first year performance compared to the second year performance is that we took a look at the first three quarters of this year in comparison to the first three quarters of 2013. The reported losses for all three

MCOs combined are about 41% of what they were in 2013. We have seen significant improvement in the reported financial situation through the third quarter of this year.

Projection: We continue to see a positive movement toward financial solvency with respect to reporting the financials from a profit perspective and what we look at. I would anticipate that at the end of this year when we look at those quarterly financials in January that we will have seen that improvement continue.

Does the state reimburse the MCOs for any initial operating losses in the way that ACA does at a national level? We don't really reimburse what we call operating losses for the MCOs but what we did put in place for 2013 is what we call "risk corridor". We only utilize that risk corridor for medical expenses so we do not account for their admin cost with respect to that risk corridor. At a high level what that risk corridor is we will take a look at their medical loss ratio and if that ratio is above a certain percentage we will share in that profit and/or loss with you for that first year. We just finalized that analysis with our actuary who will be forwarding that information out to the MCOs.

Cost growth: KanCare cost comparison sheet - According to the legend, "blue" represents actual costs. In 2014, it turns to "red" and the red signifies our current cost and current estimate. In 2012, we did a projection and the "purple" trend line symbolizes a projection without KanCare. The "green" line represents what we believe our KanCare projection to be. The "blue" and "red" are the actual costs we see. There is a definite gap in between if we had not gone to KanCare versus what our current estimate is. This illustrates that as we move into KanCare what we proposed and thought would happen is indeed happening not just from a cost perspective; but also, integration of care for the beneficiaries. The benefit and main reason for going to managed care was to see this reduction in that annual trend cost.

Future reimbursement status: Is there any plan to raise reimbursement rates? Provider rates versus rates paid to the MCOs.

With respect to the rates, the capitated payments, that we pay MCOs we look at those capitated payments with our actuaries on an annual basis. We adjust those rates based on expenditures and analysis that we do with our actuary based on costs that are submitted from the MCOs. We just allowed some of those costs but, we work with our actuary to adjust those cap rates.

Provider rates: At this time, there are no plans to adjust specific provider-type rates in the upcoming calendar year.

Next meeting is set for April 2015, date to be determined.

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

Next Meeting of KanCare Advisory Council – April 2015, to be determined