



Landon State Office Building
900 SW Jackson Street, Room 900-N
Topeka, KS 66612

Department of Health
and Environment
Division of Health Care Finance

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www.kdheks.gov/hcf/

Robert Moser, MD, Secretary
Kari Bruffett, Director

Sam Brownback, Governor

**KanCare Advisory Council
Curtis State Office Building, Topeka, Kansas
Minutes of May 14, 2013**

Council Members Present:

Steve Ortiz
Dave Sanford
Mike Conlin
Audrey Schremmer-Philip

Council Members Attending Via Phone:

Steve Kelly
Barney Mayse
Larry Martin
Allen Schmidt

Council Members Absent:

Mary Barba
Dr. DeDe Behrens
Andrew Brown
Dr. Kevin Bryant
Dr. John Calbeck
Dr. Craig Concannon
Dave Geist
Representative Jerry Henry
Walter Hill
Randy Johnson
Brenda Landwehr
Larry Martin
Colin McKenney

Other Participants:

Secretary Robert Moser, M.D., Kansas Department of Health and Environment
Secretary Shawn Sullivan, Kansas Department on Aging and Disability Services
Kari Bruffett, Director of KDHE Division of Health Care Finance
James Bart, KanCare Ombudsman

Other Participants Absent:

Dr. Susan Mosier, Medicaid Director

Welcome- Secretary Robert Moser, M.D.

Secretary Robert Moser began the meeting and welcomed Council members and others in attendance. Dr. Moser asked everyone in the room to introduce themselves.

Review and Approval of Minutes from March 12, 2013, Council Meeting



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Steve Kelly asked if there was any discussion on the previous meeting minutes. The March 12, 2013, meeting minutes will be changed to indicate Mike Conlin was a council member present at the meeting. Dave Sanford moved the minutes to be approved. Steve Ortiz seconded the motion and the minutes were approved by the Council.

Update on KanCare – Director Kari Bruffett, Division of Health Care Finance, Kansas Department of Health and Environment

Kari Bruffett provided a handout for Provider Payments Quarterly Comparison. The document notes that providers were paid \$628,262,405 in January – March 2012 compared to \$599,341,123 in January – March 2013. This includes run-out claims information from previous managed care plans as well. The document shows 5% below on claims-related payment for the first quarter. The second page provided information on Non-Claims Provider Payments. This document notes that providers were paid \$37,684,363 in January – March 2012 compared to \$63,342,441 in January – March 2013. The large increase is primarily from provider assessment payments. Ms. Bruffett noted that the handouts show only a snapshot and the State will have a better idea of the overall picture of claims payments after the first year. These sheets will be sent electronically after the meeting. The first quarterly 1115 report to CMS will be available on the KanCare website end of May. Currently, the draft evaluation design of the 1115 is available on the KanCare website. A public comment meeting is scheduled in June for the special terms and conditions of 1115. Ms. Bruffett commented we are looking forward to the process to amend the 1115 to include long term services and supports for individuals with developmental disabilities and also implementing the employment pilot projects.

David Sanford – The added benefit of dental care for Medicaid patients, expenditures are \$800,000 above last year. Could you confirm if this service is identified on the website for adult care?

Kari Bruffett – No, I don't believe they are reporting the spending on the value add services in this report. We will confirm and verify.

Update from KanCare Ombudsman – James Bart

James Bart reported the office of Ombudsman has maintained a consistent and manageable workload. Receive approximately 70 contacts per week with an average response time of 4 hours. A web based application has been developed. The Ombudsman log indicates 632 calls during the first quarter and 489 consumer e-mails. Of the 1,100 contacts received, 957 have been resolved with an 86% resolution rate. The information in this contact log will be used for constructing reports and monitoring activity and trends via this application. In general terms, most inquiries are consumer requests for information, assistance in resolving eligibility choice and benefit concerns. Most inquiries require contacting the plans, state agencies and the providers. Once the request information is obtained the answer can be provided by the relevant party or submitted back to Mr. Bart for contacting the consumer. The unresolved concerns are matters that have been pending by Mr. Bart for follow up. Specific concerns that have emerged in the first quarter are:

1. Eligibility for KanCare and choice of plan
2. Status of plan provider networks and choice of primary providers
3. Establishing a relationship and communication with the plans
4. Pharmacy prior authorizations and denials
5. Transportation concerns and scheduling
6. Claims denials

Mr. Bart opened the floor for questions after providing the brief overall update for his office.

Michael Conlin – Is the service as Ombudsman for consumers only or for providers as well?



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James Bart – The service is primarily for consumers, but serves as a liaison for provider concerns, especially as they affect consumers. As provider concerns are received, I usually refer them to the provider relations folks, the plan manager or the appropriate representative within the state.

Michael Conlin – Do you service all concerns for providers directly? Normally we have very unique circumstances that we could just contact directly.

James Bart – The basic resource for providers is largely the provider representative (the initial point of contact for any of the providers) and the second resource is the rapid response call. As KanCare has evolved, there are more specific groups such as HCBS providers. There is a venue for the HCBS providers to call in weekly and address concerns and work through issues as they occur.

Secretary Sullivan – Additionally, the program experts for you would be Kelley Melton at KDHE or Dave Halferty at KDADS depending on population and provider group.

Michael Conlin – I can speak for my colleagues in both industries, for a lot of disappointment in the inability to communicate or receive return phone calls.

Kari Bruffett – From the state?

Michael Conlin – The MCOs would be the short answer.

Kari Bruffett – Please keep us posted on this because it is certainly one of the things we monitor and have oversight on the managed care organizations. Rapid response calls are also where an issue can be raised and ask the MCOs to follow up with folks as needed. This is one of the issues we are currently monitoring carefully. Please feel free to provide examples as needed.

Michael Conlin – Would these come directly to you?

Kari Bruffett – Yes or Dr. Susan Mosier.

Steve Ortiz – I have a quick question on the 1115 Waiver so we can keep this moving smoothly. Will there be a meeting with the 4 tribes?

Kari Bruffett – Yes, we discussed this meeting during the TTAG last week. We discussed if this meeting would occur as before, or use the TTAG structure and go on site to the Nations. If you have thoughts on this, please let me know.

Steve Ortiz – I can host the meeting. Please give me a date and I can put something together.

Mr. Bart advised if no further questions from the phone that his report was concluded.

Question and Answer Session with KanCare MCOs and the State– Director Kari Bruffett

Director Kari Bruffett introduced Randy Smith from UnitedHealthcare, Jean Rumbaugh from Sunflower State Health Plan and Gary Haulmark from Amerigroup. The contact lists for the MCOs will be sent electronically

Claims processing and payments issues

Randy Smith – UnitedHealthcare is processing claims daily and continuing to see consistent volumes in claims processing. Randy assumes this is reflective in the state reports for paid claims volume in the first quarter compared to 2012. Service levels continue to be strong organizationally, both high consistency and performance levels. The call centers are operated for members and providers between 98-100 % daily on service levels with providers.

Jean Rumbaugh – Sunflower is processing payments and track individually also. What is really important is we have a pay for performance measure that tracks nursing facilities under 14 days and others under 20-30 days. Jean explained claims age is closely monitored to catch them prior to going over the timeframes. Pended claims are



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monitored by why they are pended so they can flow through automatically. Calls are tracked as to how many received and response.

Gary Haulmark – AmeriGroup’s service levels remain high - paying claims 4 days a week. Continue to train and retrain employees.

Provider Contracting and Credentialing

Jean Rumbaugh – Sunflower is continuing to enhance the network and continue outreach to add providers to the network.

Gary Haulmark – AmeriGroup continues to enhance network by contracting. Continue to have meetings with providers in small group settings to discuss the KanCare process.

Care Coordination

Randy Smith – Actively accessing and developing care plans to coordinate services in the communities. UnitedHealthcare is working organizationally with the state agencies and program managers to ensure good continuity and care as working towards the care plan development. Randy addressed a question related to care coordination and their process. The care manager’s job, first and foremost, is to meet with members and also provide and coordinate care. The process to ensure that we maintain a one-on-one relationship is the 1-800 number for members to call in. This process provides basic care coordination activities, but if there is a need for a warm transfer that team is able to get that member to their care manager and that is the intent of this process. Randy explained this process to work best when care managers are in the homes doing assessments and provides the one-on-one attention, but also makes sure there is access to care managers.

Jean Rumbaugh – Sunflower believes care coordination is critical. The packet provided gives contact information including the general number, website and phone numbers for vendors. Care coordinators are out in the field, therefore names of their managers are provided. A provider territory relations map is included also.

Gary Haulmark – AmeriGroup has conducted one or more face-to-face meetings with the waiver participants. Service members are in the field and it is our policy not to give those cell numbers. Members are given 1-800 numbers to call into the office and speak with a case specialist. If the service coordinator needs to be contacted, an e-mail is sent to follow up with the member.

HIPAA – Procedure for Consumer Notification

Randy Smith – UnitedHealthcare follows the HIPAA release requirement and are notified through the providers if there is an issue. These issues are assessed and determined if it requires appropriate notification to the members. Currently under HIPAA, all of the contacted providers are considered covered entities. As covered entities, it is a requirement to notify us and also to destroy any information that has been inappropriately sent.

Jean Rumbaugh – Sunflower has a full compliance HIPAA program. Last week was compliance week which included lots of retraining on compliance issues and will continue to be a focus throughout the year. 14 HIPAA violations have been identified in the first 4 months. Sunflower notifies members in breach of HIPAA violations.



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Allen Schmidt – Have some people been slipping off Medicaid due to not receiving their annual resubmission? Believed this issue is watched closely by case managers so service is not lost due to paperwork not completed. Please confirm if caseworkers are involved in this issue.

Jean Rumbaugh – The care coordinators are aware when the eligibility period is up. However, the care coordinators cannot enroll them but can make sure they have the resources needed and reminders etc. to continue the coverage.

Kari Bruffett – This is a known issue and a work in progress. The contract states it is not the responsibility of the MCOs but care coordination includes this kind of coordination

Allen Schmidt – Good, this is the information I was looking for. Sounds like you are taking care of this issue.

Allen Schmidt – I believe Gary stated the pilot project for I/DD is up and running and I have seen communication for a July 1 up and running date. Can you provide more details?

Secretary Shawn Sullivan – The original start date was January 1st, but upon request was held off until March 1st for a slow rollout. In retrospect, this was a good decision not to start at the same time as rolling 370,000 beneficiaries into KanCare. There have been things completed since March 1st for the 500+ persons we serve that are participating in the pilot: 1) Notification has been received by us 2) Received communication from the MCOs or care coordinators 3) If appropriate or so desired, members are participating in the services the three MCOs offer 4) One of the main activities, a survey has been sent to help compile the baseline data. The Advisory Council for the pilot is in the process of establishing a timeline for a few activities: 1) Claims payment – roughly 25 providers who are participating and have expressed a desire to test the billing process. The 3 MCOs have voiced that same desire. During the months of May and June are working on the credentialing contracting before we start the billing. The staff and others are also working with KDHE and HP to get what is needed for the billing. Before going live with billing, we must obtain CMS approval and are scheduled to have a meeting in the near future. For those that we serve/family members and guardians, one of the largest changes to occur will be the plan of care process changes. This is something Greg Wintle, I/DD Program Manager, has been discussing with others. The pilot group will be finalizing the work flow for the target case manager and the managed care coordinator. Able to add in the additional flexibility KanCare brings to LTSS. This will be a major change and we would anticipate the plans of care for these 500+ members in the pilot care program will be reevaluated with the current providers, TCMs and MCO care coordinators when this happens. This will also need CMS approval in the near future. Billing and plans of care are the two primary upcoming activities.

Direct answer to questions.....Pilot program started in March with a couple different activities with a slow roll out and phased timeline between March and June and July. Would be happy to answer any further questions

Kari Bruffett – To clarify about CMS approval, the I/DD pilot is described in the 1115 waiver attachment and so one of the requirements is, if we are going to make any significant changes from the way it was originally laid out prior to Jan 1st, it has to be reviewed.

Audrey Schremmer-Philip – Today we began the FMS/MCO's/KDAD's call to discuss issues. My primary concern is we are seeing baby steps. I believe the FMS group has been very frustrated and recognize we are a drop in the bucket compared to the big picture and have not pressed for resolution as much as we should. I am getting very concerned, it is mid-May and we are not making the progress and feel solutions are being discussed between the state and MCOs without a provider present who might have details that they do not. I appreciate Margaret Zillinger who came out trying to work on the client issue, for example, but even at that, they think they have a solution...after talking practicality, it is not a solution. To solve these issues, perhaps a work group needs to be put together to talk about what can be done. *Secretary Sullivan* – To bring everyone up to speed this is in reference to the self-directed program. There is a lack of cohesion between the interface of our First Data vendor which is the electronic verification system for caregivers that are on the self-directed program and the HP billing platform (MMIS) system. KDADS and KDHE are working on proposed changes to the First Data system and some system enhancements.



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This does take time and will happen through contractual amendments for our First Data system. We have seen month to month improvements slow from January to now, but not where we need to be. Encourage everyone that this affects to call in to these Tuesday morning calls. Looking to these and our staff to have this serve as the conduit for the main way we resolve these. As you also call MCOs for specific situations, please let us know if resolutions are not found and we can help assist.

Audrey Schremmer-Philip – Center of Independent Living to help get people out of nursing homes and make a smooth transition from the hospital. In a recent regional meeting in the Manhattan/Salina area, I realized myself and the hospitals have misinformation on how to begin with the discharge planning. I have been directing the hospitals to call the MCOs.

Secretary Sullivan – We have a document that can be sent clarifying the care process.

Audrey Schremmer-Philip – The hospitals need this information again due to staff turnover. Discussion has occurred about placing a staff person in the larger hospitals.

Michael Conlin – Running down a hypothetical issue. A DME provider receives a request for a particular device, completes the prior authorization, orders the device they normally do not carry due to expense. We have a PA in place, dispense the product and let's say 5 months later receive a rejection. Common phrase from the MCOs is a PA is not necessarily a guarantee of payment. What is the value of a PA? Second question, another provider gets a phone call from a case manager and says anything under \$500 is covered. That particular provider dispenses less than \$500 worth of product because the case manager insists it is covered even though it is not on the KMAP. So then you have an argument and the patient is in the middle, only to find out that it is not covered because the MCO staff does not understand the coverage grid. Where is the provider and what is the recourse? I appreciate the phone numbers, but do not honestly see where a pharmacy or a DME provider would call.

Jean Rumbaugh – A call would need to be made to the 1-800 number. The prior authorization is not a guaranteed payment because there is still eligibility and benefits. The benefits should match what was covered before with the state.

Michael Conlin – But that does not necessarily happen and you say call that 800 number. I have 320 patients that we have had rejected. The money is taken away, the patient still has the product and I have 320 calls to make. It is a fundamentally broken communication. Why do we request the PA?

Kari Bruffett – What are the rejects for? Are you encountering denials?

Michael Conlin – Sleep apnea is an example. A patient is too old for the equipment.

Kari Bruffett – After receiving preauthorization for the equipment?

Michael Conlin – Yes. The case manager tells us it is covered and KMAP indicates it is not covered. The case manager insists it is covered and has a PA. I struggle at the value of a PA.

Jean Rumbaugh – This is why I talk about retraining and training again. I don't feel they have the correct information.

Michael Conlin – If they did not, it is on the back of the provider.

Jean Rumbaugh – I would say instead of making 320 calls, encourage a call to your provider relations representative to help work through the issue.

Michael Conlin – If they call back.

Jean Rumbaugh – If return calls are not occurring, please let us know.

Michael Conlin – So what is the value of the PA and what are we doing?

Randy Smith – If you are not receiving a response back on the calls, please let us know. The purpose of the PA is to understand the benefit requirements and if discrepancies occur, please bring these to our attention for education.

Michael Conlin – This is where I struggle, we do verify eligibility at the point of service and then somehow it disappears.



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Kari Bruffett – This kind of eligibility issue should be followed up with KDHE. KMAP is the authority. I don't know if you have raised this to Kelley but she can help you work through this eligibility issue. The prior authorizations should be in alignment with the benefit grid. Examples need to be given and the MCOs can work through this.

Michael Conlin– The promised pricing transparency does not seem to be there.

Kari Bruffett – MAC pricing lookup is in process. This is the first of its kind in the country and will be a good thing to have accomplished.

Michael Conlin – Thank you.

Ms. Bruffett asked if there were additional questions and none were raised.

Update on HCBS Plan of Care Review Process – Secretary Shawn Sullivan, Kansas Department for Aging and Disability Services

Secretary Sullivan of the Kansas Department for Aging and Disability Services updated the Council on the HCBS Plan of Review process. There are 6 HCBS programs the agency of KDADS manages. Five of the six are fully included in KanCare. The sixth one, and largest, is the waiver for members with intellectual/developmental disabilities. There are 12,000 people through HCBS. The five out of the six programs that are in KanCare fully went January 1st. KDADS has a number of program managers within our agency. The program managers review the submitted plans of care that come in a couple times each week. The plans of care reductions to date have mainly been from the physically disabled waiver (PD waiver), but here have been a few from the TBI and TA waivers as well. The process is the respective MCO requests the reduction of the service plan through an electronic plan of care reduction template and then the staff asks the MCO care coordinator to submit pieces of information on that template for consideration. Some of those questions are the person's risk of abuse/neglect, hospitalization, mobility concerns, medical devices, transfers, physical conditions, etc. If there are a number of concerns, we ask the respective MCO to complete and send in information and also provide an explanation for the proposed reduction. This plan of care is then placed into a work list that our program managers at KDADS have and are reviewed a couple of times a week. Those are then reviewed at a weekly team meeting where everyone weighs in on their recommendations and look at the information submitted by the MCOs, look at the level of care instruments, historical utilization data with the plan of care, number of hours approved, individual needs and preferences, services of care, etc. The specific program manager takes the lead in making the final decision to support or deny the plan of care reduction and the final decision is sent back to the MCO with that approval or denial. To date over 14,000 service plans of care have been developed with around 45 requests to have the service plans reduced. Out of the 45, there have been 7 approved with recommendations. The 38 remaining are still in review, pending review or have been denied or denied with recommendation to resubmit due to all of the information was not submitted. Secretary Sullivan stated the agency and staff take these items very seriously when reviewing because of the impact they have on those that we serve and the providers that serve them and also the MCOs that are serving in the care coordination role.

Upcoming Educational Events –Director Kari Bruffett, Kansas Department of Health and Environment

Director Kari Bruffett reiterated the topic with Mike Conlin. Kari stated the more we can receive of these specific claim examples and things we can run down the better. KDHE has staff whose entire jobs are to work with the



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managed care organizations and exercise oversight of various aspects of their programs, of the program overall and contract compliance. Ms. Bruffett encouraged items to be sent.

KanCare Educational Tour – May 21-23

Director Bruffett noted the *KanCare Advisor* included the announcement of the continuing education tour. This tour is a focus on consumers who receive long term services and supports. Details of each meeting are listed on the *KanCare* website page. The meeting locations will be Coffeyville, Garden City, Wichita, Hays, Lawrence and Salina. Each location offers 2 sessions, 1-3 PM or 6-8 PM, but individuals can come and go at any time during that session. The focus groups will be facilitated by state staff and managed care organizations' staff. Ms. Bruffett encouraged everyone to help get the word out for good attendance at these meetings.

Consumer and Specialized Initiatives Workgroup – June 4, 10am – 12:30 pm

Provider and Operations Issues Workgroup – June 26, 1:30 – 3:30 pm

Ms. Bruffett also noted a meeting was held last week for the Tribal Technical Advisory Group and will meet again the first Tuesday of June.

Audrey Schremmer-Phillip – I have lost track on the two work groups. Is there a mechanism for general public to give feedback on issues?

Kari Bruffett – Kari asked Kim Brown to address this question.

Kim Brown – The provider work group has lots of different provider types represented and those folks go back to their groups, gather information and bring it back to our group. I would assume it is similar on the consumer work group.

Audrey Schremmer-Phillip – Can the consumer group have access to large networks?

Kim Brown – There are a lot of advocates on the consumer work group with access to the networks.

Kari Bruffett – A lot of the consumers who are on the consumer workgroup are also nominated by advocacy groups that can also be resourced to them for support.

Allen Schmidt – When we have our meeting in July, is there a vision for us to meet with members of the new Bob Bethell oversight committee? If so, the information could be passed directly.

Kari Bruffett – That is a good suggestion. I am not sure what the calendar will look like at this point, but we could at least put out invitations to those interim committees to attend or call in to the *KanCare* Advisory Council meeting.

Allen Schmidt – We have such a broad representation for our advisory committee and this would help bring everyone up to speed with issues if we meet together.

Kari Bruffett – At the very least we will invite their participation. This suggestion will be taken to the legislature's leadership.

Next Meeting of KanCare Advisory Council

Director Bruffett announced the next *KanCare* Advisory Council meeting will be held July 16, 2013, Curtis State Office Building, Room 530, 2:00 – 3:30 pm

Adjournment

Dr. Robert Moser adjourned the meeting.