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Department of Health & Environment

Sam Brownback, Governor

KanCare Advisory Council Meeting Minutes
Curtis State Office Building – Room 530, Topeka, KS
Minutes of March 27, 2017

Council Members Present:
Dr. Michael Kennedy
Jamie Price
Lora Key
Mark Hinde

Council Members Absent:
Representative Susan Concannon
Senator Mary Pilcher-Cook
Representative Jerry Henry
Beth Simpson

Council Members Attending Via Phone:
Chairman Larry Martin
Senator Allen Schmidt
Walter Hill
Ed Nicholas
Njeri Shomari

Other Participants:
Mike Randol, Director, Division of Health Care Finance, Kansas Department of Health and Environment/Medicaid Director
Tim Keck, Secretary, Kansas Department for Aging and Disability Services
Brandt Haehn, HCBS Commissioner, Kansas Department for Aging and Disability Services
Kerrie Bacon, Ombudsman, Kansas Department for Aging and Disability Services

Other Participants Absent:
Susan Mosier, M.D., Secretary, Kansas Department of Health and Environment
Lt. Governor Jeff Colyer, M.D.

Welcome – Mike Randol
Mike Randol opened the meeting and led the discussion in place of Chairman Larry Martin who attended the meeting by phone.

Review and Approval of Minutes from Council meeting, June 30, 2016
Mike Randol asked if there was any discussion on the previous meeting's minutes. Jamie Price provided an addition on the attendance for the June 30, 2016 meeting, stated she was present but it was not reflected on the meeting minutes. Njeri Shomari was also in attendance and was not listed. Dr. Michael Kennedy moved the minutes be approved as amended. Mark Hinde seconded the motion and the minutes were approved by the Council.

KDHE Update – Mike Randol, Director, Division of Health Care Finance, Kansas Department of Health and Environment
Mike Randol briefly highlighted the KanCare Executive Summary dated 3.27.17.

Medicaid/CHIP Member Eligibility and Expenditure Compositions: The primary number of our beneficiaries are children which account for over 287,000 of the 425,000 KanCare population. The expenditure composition includes the same ratio with respect to women and children and the elderly and disabled. Our primary membership is children and pregnant women yet they have smaller expenditures. Notably, the elderly and disabled have a smaller membership with larger expenditures.

Members and Capitation Payments by Cohort: A cohort is a grouping of members by common characteristics or traits. We do this to set the capitated payments and this is broken down by each of the MCOs.

Provider Network: Our MCOs provide information on the provider network on a quarterly basis. Includes the number of providers in their individual networks for each of the MCOs.

Financial trends: Includes a breakdown of the Medical Loss Ratio for CY16; there has been a decrease for January through December. Per Mike Randol, the State has January and February 2017 information, but the CY16 was presented for this meeting with respect to KanCare.

Claims: Percentage of clean claims processed within 30 days for CY16 is greater than 99.8%. The document shows a comparison between 2015 and 2016.

Denied Claims: Includes a breakdown of the denied claim rate and a comparison of Q4 2016 to Q4 2015.

Value Added Services: Value added services are services that each MCO are allowed to provide to membership; those are submitted on an annual basis and approved by the State and they are services that do not cost the State any money. Mike Randol stated during his presentation on the 1115 waiver extension, more detail will be provided on cost and how many members have benefited from those value added services.

In Lieu of Services and Grievances and Appeals: Mike Randol briefly noted the summary on in lieu of services used by KanCare members by each of the MCOs. Grievances and appeals were also highlighted for CY2016 for each of the MCOs.

Questions and Answers:
Jamie Price – Do we have a backlog of people being re-determined for Medicaid?
Mike Randol – Last year we made a conscious decision to not do reviews, simply because we were working on processing the applications. With the reviews, the services were continuing for those members; so, if we didn't do a review, it didn't mean they weren't getting services, it just simply means we didn't do the review and would have to do it later. About 4-5 months ago, we started the discontinuances for reviews. That is where members have not provided us information on our request within a timeline and if they don't, we discontinue them. They can always reapply, but that date is not preserved. The peak we had for reviews, we were at about 38,000-39,000 last year; currently, we are at about 17,000 total this year.
Larry Martin – For medical loss ratios with PMPM for CY16, there was $100 less for PMPM, is that significant at all?
Mike Randol – What month are you looking at?
Larry Martin – Year-to-Date for CY16.
Mike Randol – No, this is driven from several different things.
Dr. Michael Kennedy – Under members' State Fair Hearings, Q1 had huge numbers compared to the other quarters, is there an explanation for that?
Mike Randol – I will ask the MCOs to respond to that when they do their presentations.
Dr. Michael Kennedy – Thank you.
Allen Schmidt – Just a quick question regarding the denied claims, I see there was a trend reversal on two of the MCOs moving down and one has moved up, did anything happen?
*Mike Randol – You're still at 1*8.6, I don't think that's significant. I'm not aware of anything that would be driving an upward trend.
Allen Schmidt – Ok, thank you.
Larry Martin – Are value added services totally discretionary on the part of the MCOs or is there any guidance at all from KDHE for MCOs?
Mike – The MCOs on an annual basis (Oct/Nov) submit to us a listing of their proposed value added services for the following calendar year. We will approve that and if we don't agree with them, we will work with them to

possibly have options that we'd like to see. For example, if we see very low utilization of one specific value added service and they're asking that it be continued in the following calendar year, I'm going to ask them to come up with something else that would be more of a benefit to the member. The state maintains control of that and approves them on annual basis.
Jamie Price – On the members' State Fair Hearings, are those the number of hearings that have occurred or is there a percentage of what was overturned or not overturned?
Mike Randol – That is the number that occurred and if you look at CY15, there were approximately 17 million claims in the KanCare program. We had about 34,000 grievances and appeals, 1,700-1,800 State Fair Hearings and less than 30 were overturned.

KDADS Update – Brandt Haehn, HCBS Commissioner, Kansas Department for Aging and Disability Services
Brandt Haehn provided an update on KDADS.

Corrective Action Plan: In the 1915c waivers, CMS requires that we ensure six items. These include: administrative authority, level of care, qualified providers, plan of care, health and welfare, and financial accountability. Under each of these assurances, we have performance measures that we have to review and report to CMS. In the letter dated Dec 14, 2016, CMS required a Corrective Action Plan for 5 of the 6 assurances. The Corrective Action Plan is based on data that we submitted from 2014 and we had already identified some of these areas and moved forward with remediation before receiving the letter from CMS as part of our process. Under administrative authority, CMS saw two things: 1. the submission of quarterly reports from KDADS to KDHE. When we first rolled out with KanCare, there were some processes that needed to be worked on the quality review. As a result, we have created a standardized quality review policy to ensure that we get those quality reviews to KDHE. By September 2017, we will be completely caught up and back on schedule. The second area was the submission of reports from KDADS waiver program managers and monthly reports to the Long Term Care Committee. KDADS staff were not reporting to KDHE and as soon as we saw that in reports, we immediately corrected it. From January to present, 100% of those reports have been submitted.

Under level of care, CMS noted that the level of care assessments were not being done annually. KDADS has gone into each of the waivers and we noticed on some of the level of care areas and the annual reassessments that there were folks on waivers who needed to come off as they had utilized services, had moved, or were no longer a KanCare member. The first step is going into those waivers and finding out who is not utilizing services or no longer wants services and cleaning those out, then going back and making sure we send our assessors out to do those annual reassessments for the level of care. CMS also found that the level of care assessments were not being done by qualified assessors. When we looked at this, we found that it was more of a documentation approach and we went out and looked at the quality documentation to prove that performance measure. To correct that, KDADS hired a full time ADRC Program Manager who has already gone out and collected the assessors' qualification documentation and we keep up with that quarterly. Secondly, we have instituted a process with the CDDOs on all of their assessors and we require that they submit documentation quarterly.

The next area under the Corrective Action Plan was qualified providers. When CMS looked at the data, they found that there was difficulty capturing and ensuring that all of the providers we had providing services met the qualifications that were in the waiver. As many of you know, some of the qualifications are quite lengthy and we have different areas or training that can be difficult to pinpoint down the documentation to show that they met that qualification. As such, KDADS has gone out to the MCOs and completed an onsite audit of the provider qualifications focusing on internal processes to see if there is a way to make that simpler for the provider and ensure that we are capturing those effectively. Under plans of care, one of the areas that they found was that our plans of care did not meet all of the federal requirements. One of the main concerns were the signatures of providers and we are on top of this now. Brandt Haehn indicated that 9 of the 13 measures in the plan of care were above 80%; 87% is the threshold CMS that requires us to do a more aggressive remediation. When looking at 2014 data, we are encouraged that over 75% of those measures were above 80%. Second, we look at our people getting the services in the frequency, scope and duration that they're supposed to and according to reports, 93% of our members are getting those it that scope, frequency and duration. To correct this, KDADS is looking at each of the MCOs' plans of integrated service plans, we've done a gap assessment against the federal regulations into what's in their plans now and now we're developing a standardized integrated service plan policy due out before August 2017 which will give us a clear playing field and clear rules on who is responsible for what and

standardized processes across the MCOs. The final area CMS found was that KDADS lacked a central repository to collect critical incident data. Upon moving into KanCare, we relied on three areas: 1. DCF process of abuse, neglect and exploitation and DCF investigates to substantiate or un-substantiate it; 2. We had an adverse incident reporting system so people could make those reports to KDADS directly; 3. MCO quality of care investigations. CMS stated that we need to bring all of those into one area and we are moving forward with that through bi-weekly meetings and we expect this to be rolled by August 2017. We have all of the AIR (adverse incident) policies made now and we are going through the current AIR system and establishing the connections with DCF to the system and what the process will be to get those reports to the MCO to review and follow up on. Lastly, Brandt Haehn addressed the concern of lack of tracking for critical incident data. Per Brandt Haehn, we were tracking, it just wasn't centralized but we are working to correct this. An accomplishment since we last met was there has been movement of many of the autism services that were previously on the waiver to the State Plan. That gives a lot of access to kids that are on the State Plan and it doesn't just serve the 64 who are the Autism waiver currently. This is very beneficial for the members of KanCare and we look forward to those children being able to receive those services.

Questions and Answers:
Larry Martin – This only partially addresses the CMS concerns expressed in the letter dated January 17, correct?
Mike Randol – Yes, there were three different letters and I will talk about one dated January 13, that's correct.
Larry Martin – Thank you.

Updates on KanCare with Q&A
Amerigroup Kansas – Fred Clepper
Fred Clepper provided a brief update on Amerigroup. Please review attached document.

Questions and Answers:
None.

Sunflower State Health Plan – Jonalan Smith
Jonalan Smith provided a brief update on Sunflower State Health. Please review attached document.

Questions and Answers:
None.

United Healthcare Community Plan – David Rossi
David Rossi provided a brief update on United Healthcare. Please review attached document.

Questions and Answers:
None.

Update from KanCare Ombudsman – Kerrie Bacon
Kerrie Bacon provided a brief update on the KanCare Ombudsman Quarterly Report. Please review attached document.

Miscellaneous Agenda Items – Mike Randol
Update on Jan 13 findings by CMS regarding KanCare: Mike Randol stated that this is the onsite audit that was conducted in October 2016 and this letter provided the finding from CMS. We have submitted our Corrective Action Plan as requested on February 17, 2017. We have had several meetings with CMS and they are overall pleased with the framework of the corrective action plan; they are pleased we are addressing the findings and issues that they asserted within the document. They have asked us to provide specifics around performance metrics and outcomes and how we're going to measure whether we were successful with those strategies. We continue to meet with CMS on a weekly basis and will remain until they accept our corrective action plan and we move forward. No concerns at this time regarding approval.

Questions and Answers:
Jamie Price – Once that's accepted, it will be posted to CMS' website and I'll have access to the corrective action plan at that point?
Mike Randol – Certainly.
Jamie Price – Okay.
Mike Randol – As we meet with them, it's a fluid document so it's dynamic, every time we change that. We have a meeting this week with them, so we'll go through some additional items and we have hired a consultant to help us navigate that process.
Larry Martin – CMS has given KanCare permission to move forward with 1-year contract extension?
Mike Randol – No, we've not gotten official approval for the extension. The January 13 letter were the findings from the onsite audit. The January 17 letter addressed the extension that was denied. We have also had discussions with CMS regarding the corrective action plan and the 1115 waiver extension and we're doing this concurrently. Soon, we will be submitting another request to extend the 1115 waiver.
Larry Martin – Are you going to address those comments on the Advisory Committee as well?
Mike Randol – The Medical Care Advisory Committee or the KanCare Advisory Committee?
Larry Martin – The KanCare Advisory Committee.
Mike Randol – I think that we probably need to discuss as a committee. Will add as an agenda item for next meeting. I don't know if I completely agree with their concerns but I think that we have to take a look at the composition of the committee and at least establish a periodic timeline in which we adjust that. We're in Year 5 and I think we have the same members so it's probably an overall comment that we need to review and see how we want to move forward with the structure.
Larry Martin – Okay. I had sent you an email.
Mike Randol – Yes, the STC is ambiguous to say the least.
Larry Martin – Thank you.
Mike Randol – You're welcome.

Mike Randol asked for additional questions. No other comments given. Mike Randol asked for a motion to adjourn. Jamie Price made a motion to adjourn the meeting and Dr. Michael Kennedy seconded the motion. Mike Randol thanked everyone for attending the meeting and adjourned. Mike Randol announced that the Annual KanCare Public Forum will be held here at 2:45pm today regarding the 1115 waiver extension. The presentation slides from the Public Forum to be sent out to the Council per request.

Next Meeting of KanCare Advisory Council – June 8, 2017, 2:00-3:30pm, Curtis State Office Building, Room 530