KanCare Update: Robert G. (Bob) Bethell KanCare Oversight

August 27, 2019

KanCare Update August 2019

AGENDA

- Update from the Secretary – Dr. Lee Norman
- KanCare Program – Adam Proffitt
  - 1115 Waiver
  - OneCare Kansas
  - Psychiatric Residential Treatment Facility (PRTF) Quarterly Report
  - Legislatively Directed Items
  - KanCare Quality Assurance
- MCO Update – Adam Proffitt
  - Aetna Corrective Action Plan
  - MCO Financial Review
- Eligibility Update – Kim Burnam
  - Clearinghouse Contract
  - Medicaid Eligibility Applications Update
  - Transition of Medicaid Application Eligibility Processing
    - KDHE Clearinghouse Staffing

UPDATE FROM THE SECRETARY

Dr. Lee Norman

STATE OF THE KANCARE PROGRAM

Adam Proffitt, Medicaid Director

- KanCare Program Update
  - 1115 Waiver Update
  - One Care Kansas
  - Psychiatric Residential Treatment Facility (PRTF) Quarterly Report
  - Legislatively Directed Items
  - KanCare Quality Assurance

1115 Waiver:

- Have completed 2nd quarter of first year of new five year demonstration, which is authorized through 12/31/2023
- Conducted training on the Standards Terms and Conditions to maintain compliance and avoid financial penalties
- Monthly status calls with CMS, as required by the STCs, to ensure State is making progress toward demonstration
- Have submitted application for amendment to Budget Neutrality, to account for changes in HCAIP program

OneCare Kansas Update

Important Upcoming Dates:

- Staff at KU Med currently analyzing State data to identify target population
  - Target completion date of 08/31/2019
- Once target population is identified, State actuary to develop rates for MCOs
  - Will take ~60 days to develop capitation rates, using multiple data sources
- MCOs and OneCare Kansas partners to negotiate payment structure for providers
  - Standard payment arrangement is PMPM from MCO to OCK partner, but other arrangements can be approved by the State (shared savings model, incentive payment for outcomes, etc.)
- Target implementation of 01/01/2020
- Outcomes and payments will be monitored over time to ensure program is delivering expected outcomes and is financially sustainable

Legislatively Directed Items

- Dental rate increase
  - KDHE appropriated $3.0mil All Funds ($1.6mil SGF) to increase dental rates
  - Increased 29 codes for preventive services by 6%, effective 08/01/2019

- Health Care Access Improvement Program
  - Increase provider assessment to 3.0% of net inpatient and outpatient revenue, up from current level of 1.83% of inpatient only
  - Requires renegotiation of Budget Neutrality with CMS
  - State submitted waiver amendment application on 07/29/2019; received notification of complete application on 08/12/2019
  - Targeting 01/01/2020 implementation date, but will be subject to timely approval by CMS, as this impacts rate setting and hospital reimbursement

- Implementation or Expansion of Prior Authorization Project
  - No update – will revisit during November meeting

- PRTF Update – KDADS and MCOs to present data on waiting list

Protected Income Limit

- New PIL will move from $747/month to $1,177/month
- On target to implement September 1, 2019, pending CMS approval
- Required technical amendment to each of the seven 1915(c) waivers
- Video collage of a few impacted members at https://youtu.be/nPwHCvtzEkA
  - Items that members said they will spend their money on:
    - Diapers
    - Bills
    - Community Transportation
    - Healthier Food
    - Groceries – "so I can have groceries every day of the month"

"she said not having a CO is going to allow her to buy healthier food. She said she's very excited to be able to buy fruit. She said she also hasn't purchased new shoes in 15 years so she plans to do that with the extra money as well."

- KanCare provider describing member reaction to reduction in Client Obligation

Quality Assurance

How are KanCare MCOs monitored?

- Member surveys and record reviews to assess physical health, behavioral health and social outcomes
- Annual state on-site auditing of Managed Care Organization's systems for program delivery and provider payment
- State tracking and trending of managed care required functions to report compliance to the Federal Authority
- Third party contract with Kansas Foundation for Medical Care (KFMC) to monitor the Kansas managed care program

State Strategies for Quality Management

The KanCare contracts require high performance from each of the KanCare health plans, and the program as a whole. Below are some of the key quality measurement programs that are being used to ensure high quality of care in KanCare.

Pay for Performance (P4P)

- The P4P program:
  - Is based on payment withhold for MCOs
  - Rewards the KanCare health plans who perform well
  - Measures are tied to health plan's operations

Performance Measures

- MCOs report on all of the measures for:
  - Home and Community Based Service waivers
  - Mental health and substance use disorder
  - Full set of HEDIS

Quality Assessment and Performance Improvement Plan (QAPI)

- MCOs QAPI plan will:
  - Describe how MCOs will meet the quality program requirements set forth in the KanCare contracts
  - Evaluate how care is provided in the KanCare program
  - Identify outliers related to specific quality indicators
  - Determine what needs to be accomplished to ensure high-quality care
  - Detail how improvements will be identified and documented

Health Plan Accreditation

- The MCOs and their subcontractors are required to obtain NCQA accreditation. They are:
  - Evaluated in the areas of quality management and improvement, utilization management, provider credentialing and consumers' rights and responsibilities
- Kansas will ensure that each plan is deemed capable of providing the highest quality of care and service to Medicaid members
- Complete the annual HEDIS Set measurements

Source: https://www.kancare.ks.gov/policies-and-reports/quality-measurement

How are issues identified and resolved?

- Stakeholder feedback opportunities including provider meetings and member advisory committees
- Provider and Member grievance and appeals systems
- State staff maintain communication on areas for improvement identified during audits and reporting errors until resolution
- Focused reviews, provisional approvals and corrective action plans for compliance enforcement

Quality Management Regulations

State Regulations

39-7,160 Joint Committee on HCBS and KanCare Oversight

In addition to other duties, the joint committee shall:

- Monitor access to and quality of services provided
- Review state data and information on KanCare programs that includes pay for performance measures and quality measures
- Review External Quality Review and quality assessment reports of MCOs providing services

High-level RFP Requirements

2.2.21 Quality Management (QM)

MCOs will report on all HEDIS, CAHPS, and other performance measures for specific populations as required in Appendices 1-12 of Attachment J of the KanCare contract

2.2.22 External Quality Review Organization (EQRO)

The EQRO will conduct annual, external, independent reviews of the quality outcomes, timeliness of, and access to the services covered in this contract

How is continuous improvement assessed?

1. A requirement of the KanCare 1115 demonstration waiver is development and evaluation of a Quality Management Strategy (QMS)

2. Required third party evaluation of the program by an External Quality Review Organization using a Federally approved evaluation plan

3. State reporting systems and contracting for day-to-day program management data maintenance to inform evaluation processes

Evaluation Design

KanCare QMS

- Overarching framework
- Drives quality improvement for the entire KanCare program
- Annual QMS Evaluation Process to assess progress

State Monitoring & Oversight Activities

- External Quality Review Technical Report
- KanCare 1115 waiver evaluation
- On-going MCO meetings and reporting
- Agency-specific waiver quality monitoring

MCO Update

Adam Proffitt, Medicaid Director

- Aetna Corrective Action Plan
- MCO Financial Review

Aetna Better Health of Kansas Corrective Action Plan

Notice of Non-Compliance

- State sent Aetna formal notice of non-compliance on July 24, 2019
  - Identified each area of the contract that ABH was out of compliance
  - Requested ABH submit Corrective Action Plan within 10 business days, detailing how each item would be brought back into compliance

Corrective Action Plan

- Aetna returned Corrective Action Plan to State on August 6, 2019
  - State did not feel that the CAP provided enough detail, so asked for a more comprehensive review
  - New leadership at ABH is engaged with KDHE leadership; finalizing plan and will submit back to State with necessary details

Goal

- KDHE hoping to partner with ABH to have them work themselves back into compliance, to ensure successful delivery of care to our members

KanCare Update August 2019

KanCare

MCO Profit and Loss per NAIC Filings

For the Quarter Ended March 31, 2019

	Aetna	Sunflower	United	Total
Total Revenues	$214,597,072	$381,564,327	$322,116,712	$916,042,949
Total hospital and medical	$191,550,275	$319,152,210	$270,469,193	$773,910,268
Claims adjustments, General Admin., Increase in reserves	$32,263,711	$58,335,542	$44,402,392	$135,146,105
Net underwriting gain or (loss)	($9,216,915)	$4,076,575	$7,245,127	$6,986,574
				$0
Net income or (loss) after capital gains tax and before all other federal income taxes	($8,825,262)	$5,023,038	$7,245,127	$9,474,205
Federal and foreign income tax/(benefit)	($2,003,094)	$980,282	$1,082,108	$372,680
Adjusted Net income (loss) - Through March 31, 2019	($6,822,168)	$4,042,756	$6,163,019	$9,101,525
GP before income tax	**-4.1%**	**1.3%**	**2.2%**	**1.0%**
Change from Q1 2018	-	***10,701,737***	***10,360,831***	***29,043,331***
Change from Q1 2018, adjusted for HIPF	-	***2,439,887***	***2,777,206***	***1,232,856***

- Gross Profit of 1.0%, exactly in line with program target
- Plans increased net profit by $1.2mil vs Q1 2018 (adjusted for HIPF)

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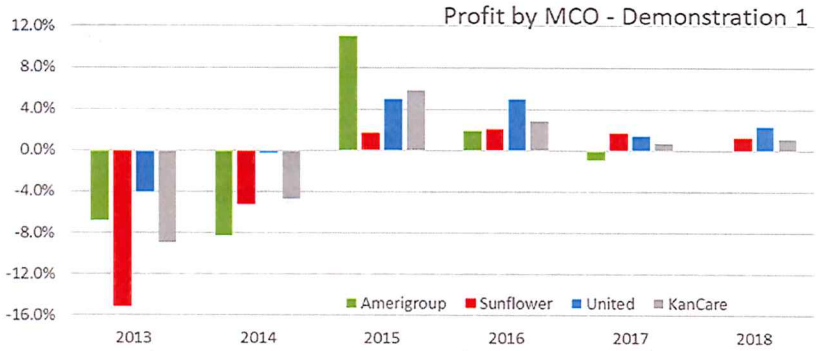
KanCare Gross Profit by MCO

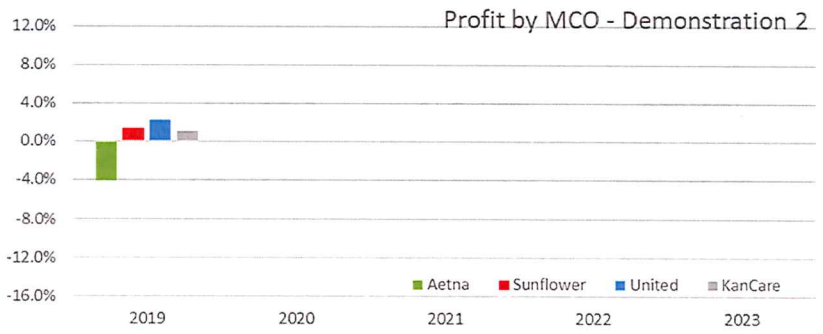
NAIC Filings

	2013	2014	2015	2016	2017	2018
Amerigroup	-6.8%	-8.3%	11.0%	1.9%	-1.0%	-0.1%
Sunflower	-15.2%	-5.3%	1.7%	2.1%	1.7%	1.2%
United	-4.0%	-0.2%	5.0%	5.0%	1.4%	2.4%
KanCare	-9.0%	-4.7%	5.8%	2.9%	0.7%	1.2%

	2019 **	2020	2021	2022	2023
Aetna	-4.1%				
Sunflower	1.3%				
United	2.2%				
KanCare	1.0%				

**2019 is through Q1 only





- Aetna gross profit of -4.1%, in line with early performance from original KanCare
- By year 5 of demonstration, both incumbent plans were ahead of performance expectations
- Both incumbents' Q1 2019 gross profit indicate continuity of performance

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FIGURE 17: STATE OF DOMICILE

STATE	N	MLR	ALR
ARIZONA	7	87.7%	11.1%
COLORADO	1	83.3%	11.6%
DISTRICT OF COLUMBIA	3	74.3%	17.7%
FLORIDA	9	87.7%	12.0%
GEORGIA	4	82.8%	14.4%
HAWAII	4	91.9%	11.7%
IOWA	1	91.9%	7.4%
ILLINOIS	5	90.5%	11.3%
INDIANA	3	86.3%	10.1%
KANSAS	2	85.1%	14.1%
KENTUCKY	4	88.4%	10.6%
LOUISIANA	5	85.2%	15.3%
MARYLAND	5	83.5%	12.7%
MASSACHUSETTS	5	93.7%	7.7%
MICHIGAN	9	85.0%	12.6%
MINNESOTA	4	91.0%	7.8%
MISSISSIPPI	2	87.0%	14.1%
MISSOURI	2	87.8%	11.3%
NEBRASKA	3	86.3%	13.0%
NEVADA	3	82.7%	13.3%
NEW HAMPSHIRE	1	89.8%	13.1%
NEW JERSEY	4	87.4%	12.7%
NEW MEXICO	4	84.9%	17.5%
NEW YORK	7	88.0%	12.5%
OHIO	5	84.2%	13.4%
OREGON	2	90.8%	10.0%
PENNSYLVANIA	7	87.5%	11.1%
PUERTO RICO	4	88.6%	9.4%
RHODE ISLAND	2	90.5%	10.8%
SOUTH CAROLINA	5	86.4%	11.7%
TENNESSEE	3	87.7%	14.2%
TEXAS	19	88.6%	11.5%
UTAH	3	85.0%	9.9%
VIRGINIA	4	92.3%	10.3%
WASHINGTON	5	85.5%	13.4%
WEST VIRGINIA	4	87.8%	9.3%
WISCONSIN	14	80.6%	13.4%

State	MLR	Notes
Kansas	91.5%	1.0% Profit, 7.5% Admin
State A	92.2%	
State B	85.0%	Pricing target is 89%; plans have additional 4% of admin as 'at risk', making effective target 85%
State C	89.1%	Blended average; each plan has a different MLR target
State D	88.0%	2% Profit, 10% Admin

- Based on survey of other States' Medicaid Directors
- Source was target MLR built into capitation rates
- Program size and complexity varies by state, making direct comparisons ineffective

- 2019 Milliman Study on Medicaid Managed Care
- Primary data source is NAIC Filings

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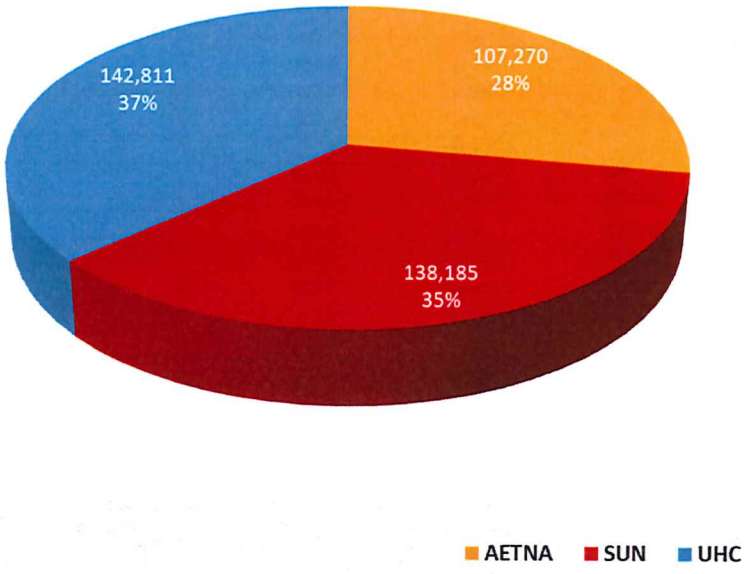
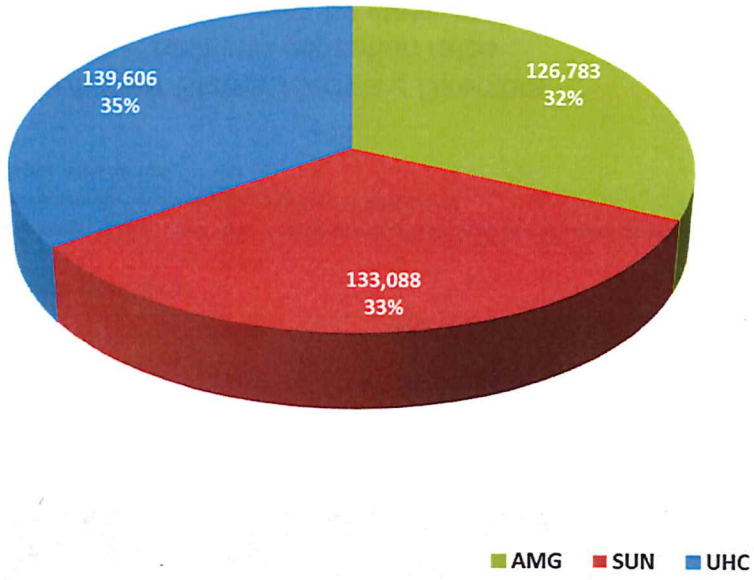
- MCO percent of population has seen a slight shift from 2018 to 2019
  - Aetna accounts for 28% of total membership, vs. a 32% average share for Amerigroup in 2018; this is up 1ppt from the Q1 average membership
  - United and Sunflower have seen an increase in the percent of total members

2019



2018



Eligibility Update

Kim Burnam, Director of Eligibility

- Medicaid Eligibility Applications Update
- Clearinghouse Contract
- Transition of Medicaid Application Eligibility Processing
  - KDHE Clearinghouse Staffing

Medicaid Eligibility Application Status

645 Over 45 days (Based on total applications in house- 7314)

- **Active Status- applications ready to be processed**
  - Family Medical – 25 (less than 1%)
  - Elderly & Disabled Medical –151 (6%)
  - Long Term Care Medical – 40 (4%)

- **Pending Status – applications waiting for information from applicant/provider/financial institution**
  - Family Medical – 44(1%)
  - Elderly & Disabled Medical – 262 (11%)
    - 218 of these are actually in compliance with CMS as any application awaiting disability has a 90 day processing requirement.
  - Long Term Care Medical – 117 (12%)

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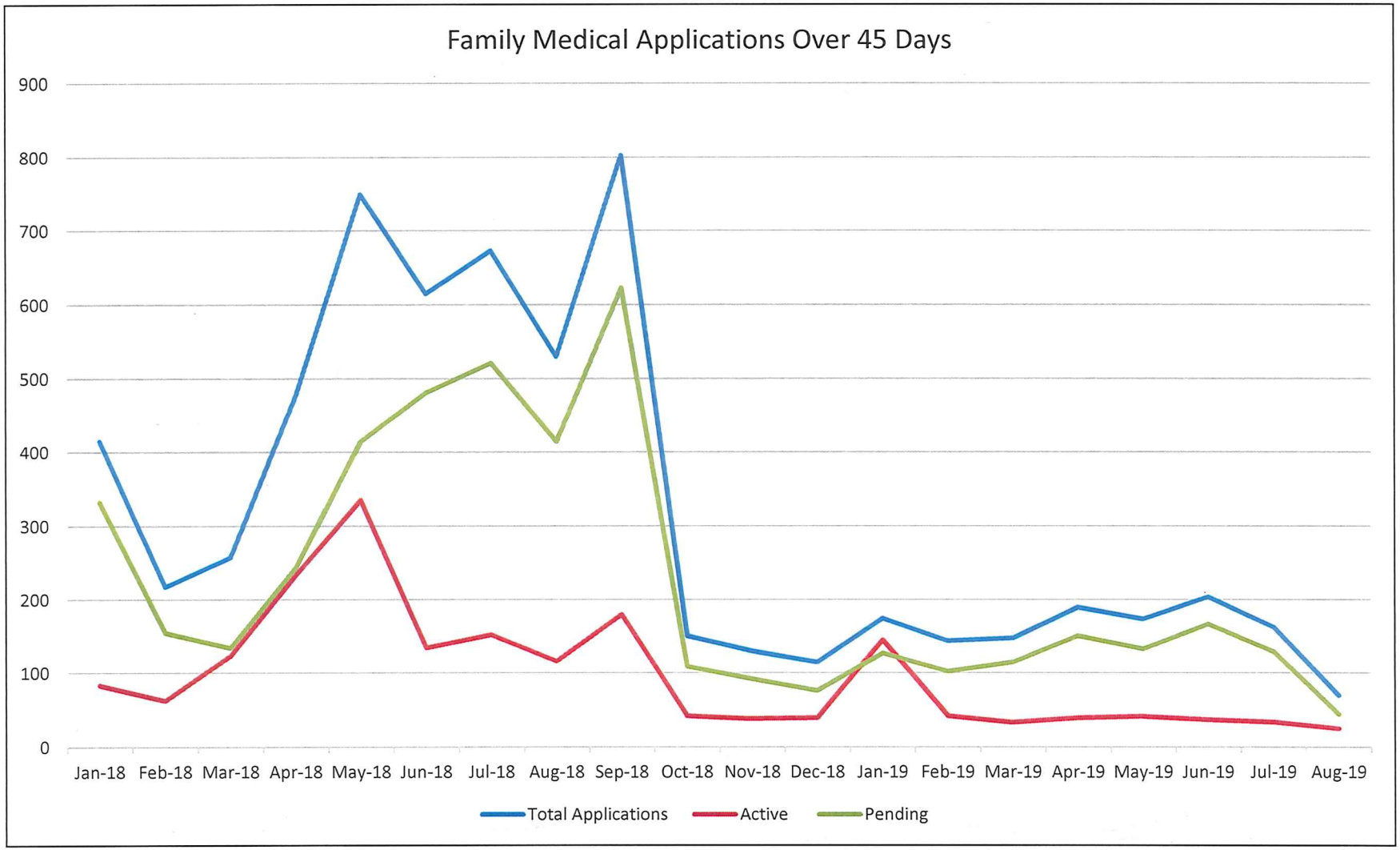

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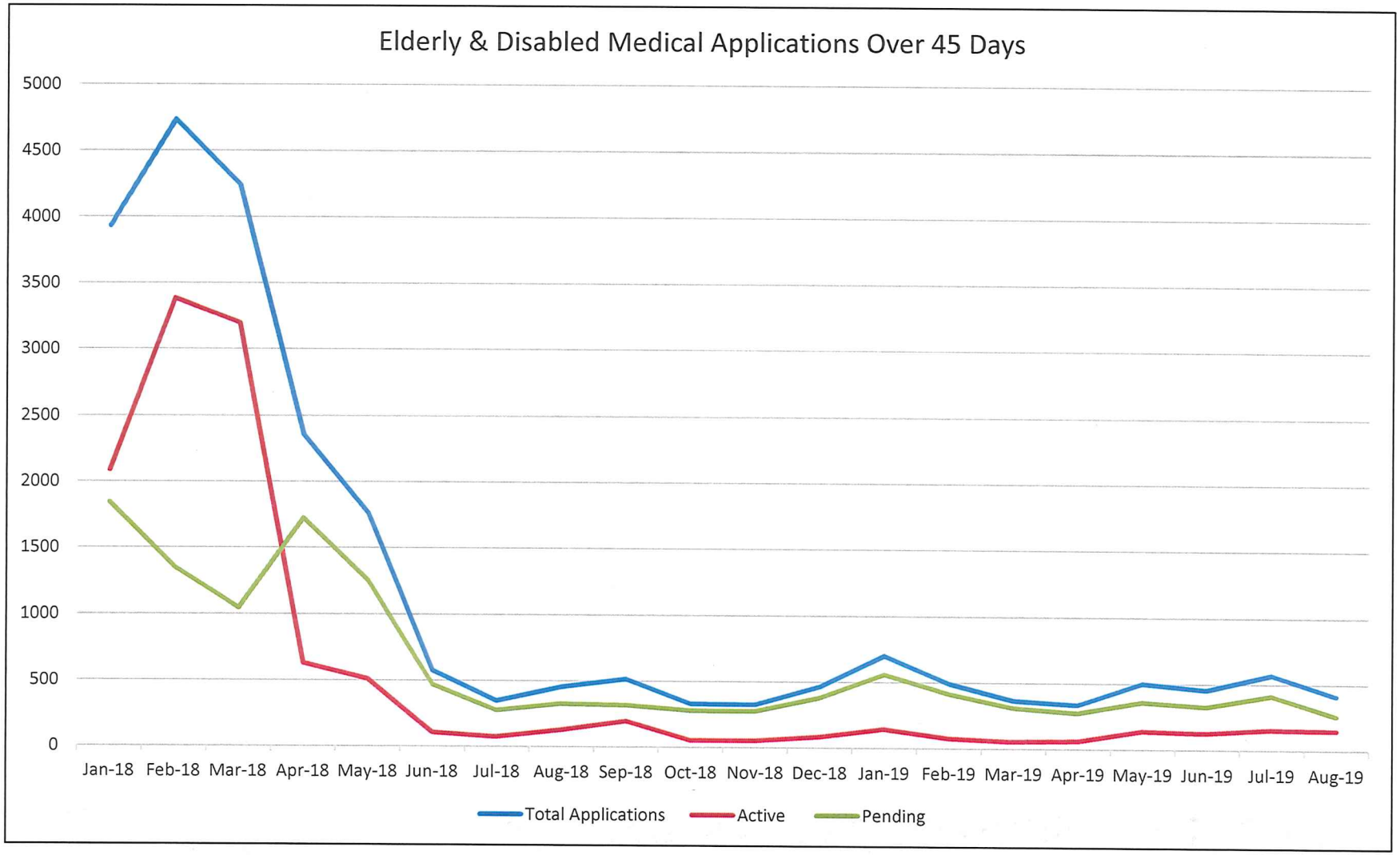

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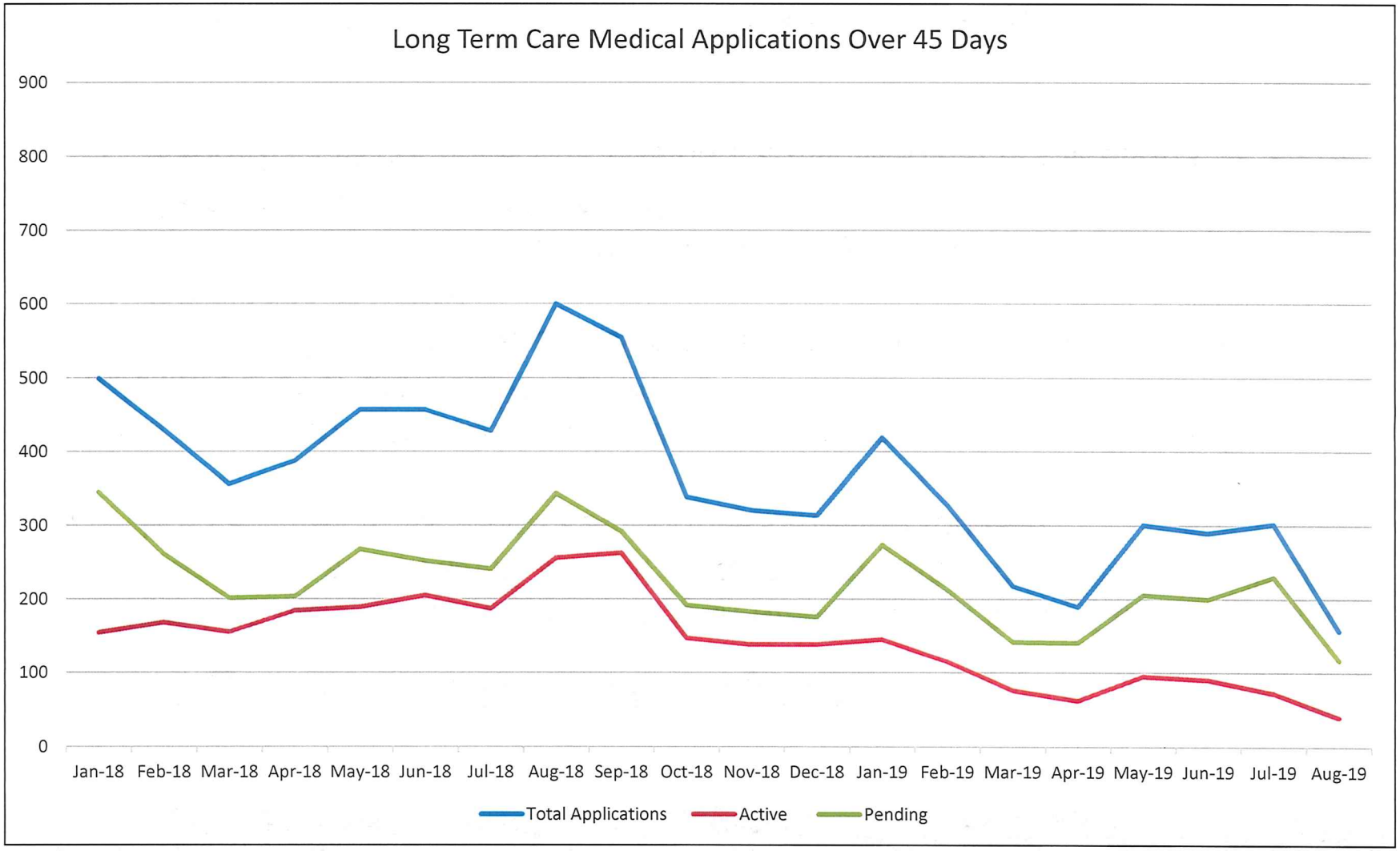

Clearinghouse Contract Update

- KDHE has reached an agreement with MAXIMUS to extend their contract
  - Terms will allow KDHE to stay on target for transition plan, and will allow both entities to focus on key priorities moving forward

- Total extension is for 18 months, but will reduce the scope of work for MAXIMUS over the next 6 months
  - MAXIMUS to continue processing all types of applications for the remainder of CY19
  - KDHE to assume responsibility for Elderly & Disabled and Long Term Care applications beginning 01/01/20
  - MAXIMUS to continue processing Family Medical applications for all of CY20

- KDHE has released an RFP for a new contract to begin at end of MAXIMUS contract; scope of new contract limited to Family Medical only

Transition Update

- Facility – construction occurring in two phases
  - July 15 - Moved Training and Quality Staff
  - September - Begin moving Eligibility Staff
  - Communication Plan
    - Rapid Response Calls
- Transition of Workload
- Hiring of Staff

KDHE Staffing Update

	Maximus	State
Training & Quality	44	27- Complete
Eligibility Staff (Elderly & Disabled, Long Term Care Medical Programs)	217	256 24 Supervisors (Complete) 123 Eligibility Staff (Hired) 44 Eligibility Staff (Interviewing) 63 Eligibility Staff (Future Interviews)
Operations	58	30/16 (Hired) 9 (Interviewing) 5 (Future interviews)
Total	319	313

THANK YOU/QUESTIONS