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

Kansas 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 September 17, 2012

Council Members Present:
Dr. John Calbeck
Dr. Craig Concannon
Mike Conlin
Steve Kelly
Representative Jerry Henry
David Sanford
Senator Allen Schmidt
Steve Ortiz

Council Members Absent:
Mary Barba
Dr. DeDe Behrens
Andrew Brown
Dr. Kevin Bryant
Randy Johnson

Council Members Attending Via Phone:
Dave Geist
Walt Hill
Representative Brenda Landwehr
Larry Martin
Barney Mayse
Colin McKenney
Audrey Schremmer-Philip
Susette Schwartz

Other Participants:
Secretary Robert Moser, 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
Dr. Susan Mosier, Medicaid Director

Welcome- Steve Kelly, KanCare Advisory Council Chair

Chairman Kelly began the meeting and welcomed Council members. The Chairman noted that during the meeting, Council members will hear presentations from each of the three selected KanCare managed care organizations (MCOs), an update from the external stakeholder workgroups, and information on the physically disabled waiver, educational tours, and 1115 demonstration waiver application.

Review and Approval of Minutes from July 9, 2012, Council Meeting

Chairman Kelly asked if there was any discussion on the previous meeting's minutes. Steve Ortiz moved the minutes be approved. Dr. Craig Concannon seconded the motion and the minutes were approved by the Council.

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Presentations by KanCare Managed Care Organizations

Each of the three selected KanCare MCOs was asked to provide a brief presentation regarding their authorization and utilization management processes.

UnitedHealthcare Community Plan

Nan Thayer Kartsonis, Plan President for UnitedHealthcare Community Plan began with an update on United's efforts to establish contracts with providers. United is progressing in developing their provider network. This includes updating contracts with existing United providers in various specialties and reaching out to all current Medicaid providers for contracting. United is also working to fill key staffing positions, and hiring a number of clinical staff as well as other additional individuals from across the State who will become part of the United team.

Utilization management is divided into three areas in United. There is a team devoted to inpatient case management that works to coordinate transitions and discharge planning. Additionally, specialized care coordination teams serve a wide variety of populations. Teams can focus on any given population, such as healthy families and children, people utilizing long term care services or behavioral health care, or other specialized populations. A large number of support staff work in the administration of specific programs and help support utilization management activities.

Utilization management also means that United will work to ensure a smooth transition care for people with complex needs to KanCare. United meets regularly with State staff members to identify and work through any issues that need to be addressed during implementation. United is also working to engage the current case managers and care managers who support consumers in the current programs. For staff that will join their team for the KanCare program, United is working with current employers to ensure that the training and on-boarding requirements for these individuals will not leave the current agencies with gaps in care prior to January 1st. United will (like other plans) honor existing service authorizations for 90 days to ensure consumers continue to receive essential services.

Regarding prior authorizations (PAs), United has a provider relations team on the ground in Kansas who will work with providers if an issue arises regarding PAs. The authorization system is divided into two general areas. The first is traditional services such as high-cost radiology, bariatric surgery, and others. The list of services that require PA is very small. The bulk of authorizations in KanCare will be linked to HCBS plans of care and other similar areas. These authorizations will be done by care coordinators who work with individual consumers and their providers. If a prior authorization is not approved and needs to be reviewed by a medical director, United has medical directors available to review claims. Physicians can request a peer-to-peer review if they believe it is necessary.

Ms. Kartsonis then took questions from Council members and provided additional information to participants in specific areas of interest.

Senator Allen Schmidt- Are the procedures the same for all three MCOs regarding their PAs and medication coverage?
Kari Bruffett- The preferred drug list and formulary will be covered by the MCOs as they are currently covered by the State. For authorization procedures, the plans have their own policies and these can differ from plan to plan. The plans must meet all State requirements and have transparent criteria for utilization management.

Dr. John Calbeck- For care management, you mentioned teams will be focused on inpatient coordination. What happens to people who are already getting outpatient services?
Nan Thayer Kartsonis- It depends on which category the person falls into. For example, they will be managed by the behavioral health team if they are receiving behavioral health services. United will use a number of algorithms to triage people and assign them to care managers based on service categories and risk factors.

Dr. John Calbeck- For care coordinators, what will be their general profile and qualifications?

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Nan Thayer Kartsonis- It depends on which category they fall into. For long term care or behavioral health, care coordinators are located throughout Kansas in the communities we serve. They are usually a registered nurse or licensed clinical social worker accredited as a case manager. They are salaried and receive a benefit package from United. Most care coordinators telecommute and work out of their homes because they spend most of their time in the homes of consumers.
Dr. John Calbeck- Behavioral health is a broad field; will there be people across the state with expertise in areas within behavioral health, such as substance abuse?
Nan Thayer Kartsonis- Yes, we are hiring care coordinators from various service areas and specialties.

Steve Ortiz- You did not mention program management support for Indian health. Will you have staff dedicated to this program?
Nan Thayer Kartsonis- Yes, we will have a program manager assigned to those members.
Steve Ortiz- How will this work for pharmacy? Will they be able to coordinate billing and other functions?
Nan Thayer Kartsonis- Yes.

Dr. Craig Concannon- For stakeholder meetings, do you plan to have both urban and rural providers present?
Nan Thayer Kartsonis- Yes, these meetings are focused on long term care providers for home and community based services as well as others.
Dr. Craig Concannon- How do we as physicians get information on how to get involved?
Secretary Moser- We ensured when compiling the workgroups that we had input from rural providers. We have worked with the associations to inform as many providers as we can. We also have held statewide educational meetings with providers to give them information.
Nan Thayer Kartsonis- United will also send out a finalized copy of our training schedule. When we do that we will work with the State and provider associations to get the word out.
Dr. Craig Concannon- We need to figure out how to best get the physician community engaged. We need that community to be represented in workgroups and contracting.
Kari Bruffett- The State has had input from provider organizations on the template contracts that the State reviewed for the plans to use.

Dr. John Calbeck- We need to have both physicians and hospitals involved in the process, and they have interdependent relationships.
Kari Bruffett- We are certainly interested in all suggestions to increase involvement.
Dr. Craig Concannon- This community is interested in process, but they may be disenfranchised if they do not have input on the contracts and time to negotiate.

David Sanford- When you put together your network for dental and vision services, should we hear from you for contracting or your subcontractor? Are you defining those benefits or will that be left up to the subcontractors?
Nan Thayer Kartsonis- United will define the benefits based on the current program and State requirements. In some cases you will hear from the subcontractor who will reach out to initiate contracts with providers. United staff will try to connect you with the people you need.

Mike Conlin- If you have a community pharmacy, and a pharmacy who also provides durable medical equipment (DME), and an independent DME provider, how will contracting work? When will these providers see contracts, how long will they have to digest and consider the contracts, and what will the process look like?
Nan Thayer Kartsonis- For pharmacies in Kansas, they are already part of United's network, so they will receive a contract addendum. For DME or hospice, we are trying to identify those providers who are not already in network; those contracts are going out now. For providers of DME and HCBS, they will get a contract with an addendum for HCBS services.

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Dr. John Calbeck - Relative to the previous question, how extensive is your provider list for substance use disorder providers?
Nan Thayer Kartsonis- The State provided us with a list of all providers who had submitted a claim in last 18 months. If we miss someone, they can reach out directly to us to get signed up.
Kari Bruffett- The baseline for plans at the beginning of KanCare is to have all Medicaid providers in their networks, but we will expect them to extend that in the future. The State provided the current Medicaid network list to the plans, but it is our hope that we can build the networks together.

Dr. John Calbeck - How many care coordinators will United need?
Nan Thayer Kartsonis- Approximately 100 or slightly more.

Steve Ortiz- For Indian health providers, will you try to support the current system?
Nan Thayer Kartsonis- Our goal is to have them fully engaged and support what is currently in place.

Amerigroup Kansas

Pam Perry from Amerigroup presented on behalf of plan president Laura Hopkins. Ms. Perry noted that Laura has experience in administering a similar program in New Mexico with long term supports and services included in the managed care system. Amerigroup has recently aligned its processes for utilization management and precertification among its plans in other states. There has been extensive focus on these issues in the last five years throughout the organization. Amerigroup has worked to improve its processes in these areas and decreased the number of services that require prior authorization. The utilization management process is now more focused on meeting the needs of members and coordinating care with providers. Amerigroup tries to ensure that members receive the best services clinically possible and inform providers about clinical guidelines.

For the Kansas program, Amerigroup will launch provider-specific training protocols using webinars, large group sessions with face-to-face training, and other specialized sessions discussing different operational areas, including utilization management. One of Amerigroup's goals in this process is to ensure provider continuity and coordination of care among providers. Ms. Perry noted that Amerigroup is working to attract new providers to the KanCare program, and they believe that part of attracting providers' interest will be accomplished through appropriate utilization management and providing upfront program guidance. The utilization management program will take into account coverage and benefit requirements, as well as CMS requirements. Amerigroup is also working to meet additional new National Committee for Quality Assurance (NCQA) accreditation standards established in the KanCare contracts.

For the certification program, Amerigroup has an online portal that is available 24 hours a day, seven days a week to receive requests from providers and track certifications. Amerigroup also conducts an annual review internally to see how the organization measures up against internal standards and the standards are revised as necessary for future years. The list of services requiring pre-certification includes high cost durable medical equipment, bariatric surgery, prescription drugs (according to the State's formulary and PDL), long-term services and supports, nursing facility care, and high cost imaging. During the pre-certification process, the Amerigroup medical director is closely involved. Amerigroup is currently in the process of hiring a medical director and other clinical staff. When KanCare begins, Amerigroup will have 14 registered nurses and 11 case specialists to work on utilization management on a daily basis. The process is accessible via web, phone, or face to face consultations. Peer to peer reviews may also be instituted through KanCare as needed.

Ms. Perry then took questions from Council members and provided additional information to participants in specific areas of interest.

Steve Kelly- Will you have pre-payment review?
Pam Perry- Yes, to ensure claims payment protocols are met.
Steve Kelly - How do you resolve issues that come up?

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Pam Perry – I will need to provide a response to that question as follow-up.
Nan Thayer Kartsonis - There will be no difference in how a claim goes through the system for KanCare than our other plans with the exception of payment rates. If your hospital experiences issues, there will be a contact they can reach out to for assistance.
Steve Kelly - Will there be requirements for plans to have a process for addressing issues that come up?
Kari Bruffett- Yes, the RFP and contracts require each plan to have a process set up for resolving grievances and issues.

Mike Conlin- What is high cost DME? What will require precertification?
Pam Perry - There are defined categories, but cases will be decided on a case-by-case basis.
Mike Conlin - For providers, if this happens late on a Friday, we will need a more defined list.
Pam Perry - We will review each case individually, looking at all the relevant information. We will be available 24/7 to assist.

Mike Conlin - If you have a community pharmacy, and a pharmacy who also provides durable medical equipment (DME), and an independent DME provider, how will contracting work?
Pam Perry – I will follow-up with you on that issue.

Steve Ortiz- What does it mean that all long-term services and supports and nursing facility admissions require pre-certification?
Pam Perry - Our case managers will be able to authorize those services in most cases.

Dr. John Calbeck - What does hospital observation status mean?
Pam Perry - That might occur, for example, if a patient were to come into the emergency department or physician's office and we could not find the source of the problem right away. In that case the patient could be admitted for observation.

Dr. John Calbeck - What is timeframe for pre-certifications?
Pam Perry – Twenty-four hours.

Dr. John Calbeck - I see your concept of staffing utilization management clinicians to help with this program. How many utilization management clinicians will you have, and are they the same thing as a care coordinator?
Pam Perry - We will have about 300 staff in Kansas. However, there will also be other staff that will support the Kansas program. This will include about 55 care coordinators plus the utilization management (UM) coordinators. The UM coordinators will be our medical director, behavioral health director, and our HCBS care coordinators. Total this will include about 24-25 staff. All staff in this area will be social workers (LCSW), nurses (RNs), or physicians (MDs).
Kari Bruffett- We also required all of the plans to have transparent UM criteria. Providers need to know up front what the criteria will be.

Steve Ortiz -You did not mention Indian Health Services in your contracts. I just wanted to confirm that we will be included. Also, who will provide education to people in long term care? Will people get to keep their current case worker?
Kari Bruffett- Information will be provided at enrollment for all Medicaid beneficiaries. There will be an initial assignment and materials to allow members to decide if they want to choose a different plan based on their providers and the value-added services offered by each plan. The State's enrollment broker and the Aging and Disability Resource Centers can assist in options counseling. We are also trying to reach out to members directly and help them understand their choices. We will discuss the other question later in the agenda.

Sunflower State Health Plan

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Monica Arter presented on behalf of Sunflower State Health Plan. Ms. Arter noted that under the medical management program, Sunflower has several departments within their organization. The focus at this meeting will be on UM. Sunflower's goal in this area is to ensure services are appropriate and that we are meeting professionally recognized standards of care.

For Sunflower's PAs, InterQual criteria is used for most services. American Society of Addiction Medicine (ASAM) criteria are used for substance abuse, and clinical practice guidelines are in effect for other services. Sunflower requires PA for only a few services. PA requests are accepted by phone, fax, and mail. After-hours phones are answered by NurseWise services staff, who can call a medical director if needed. Services which require PA include high-cost DME, high-tech radiology, certain outpatient procedures, inpatient admissions, and all HCBS. All out of network providers require PA, but emergency and crisis intervention do not require PA, even if they are rendered out of network. Sunflower will honor retro-active authorizations from other plans.

Sunflower asks that PA requests be submitted seven days in advance whenever possible, although we recognize that may not work in all cases. There is no penalty if you as a provider request a PA after this timeframe. The timeframe for decisions is in line with state regulations, but our internal goal is to process all requests in two to five days. Peer-to-peer review is available on request, within 24-72 hours if the need is urgent. Concurrent review is also completed with inpatient stays. Discharge planning is completed early in the process because we want to stay ahead of the game whenever possible. Sunflower also uses some national contracts that are not exclusive or carved-out. The list includes contracts with national laboratories such as Quest and LabCorp. Contracts are available for a provider to use if they do not have a contact for a particular service that a patient needs.

For continuity of care, Sunflower will honor existing authorizations for 90 days or until the member has been assessed by a care manager. Sunflower is trying to educate both providers and members regarding this policy. We will receive a file of existing authorizations and plans of care from the State so we can start approving those as soon as possible. Sunflower has received a list of providers from the State, and is currently reaching out and sending contracts. People are on the ground to work with providers, but providers can reach out to us as well. Sunflower is also doing orientation and training with providers now. Sunflower will have provider summit calls for 30 days, which includes a weekly hour for provider questions. Within 30 days of contracting Sunflower will send a representative out to help providers get oriented to billing.

Pharmacists will need to contract with US Script, for both DME and pharmacy. Providers for durable medical equipment only will contract directly with Sunflower.

Ms. Arter then took questions from Council members and provided additional information to participants in specific areas of interest.

Steve Ortiz- Will there be any differences for Indian Health Services providers?
Monica Arter- There are no differences for Indian Health providers, they use the same guidelines.

Dr. Craig Concannon- Are prior authorizations required for out-of-network referrals?
Monica Arter- Yes, if the specialist is out of network.
Nan Thayer Kartsonis – It will depend on the service, but usually yes.
Dr. Craig Concannon – We will need to ensure it would be an efficient process.
Nan Thayer Kartsonis - If you have examples, we can walk through it in advance.
Kari Bruffett- We have asked the plans for information on out of network procedures and we will provide guidance to providers in that area soon.
Dr. John Calbeck- It will be important to consider urban and rural factors. It will be relevant to different provider groups.

Walt Hill- Ms. Arter mentioned using Current Procedural Terminology (CPT) look-up to determine prior authorizations. The CPT 2013 will go into effect in 2013. What are plans doing to prepare for this in their utilization management and payment systems?
Monica Arter - I will get back to you with that information.

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Kari Bruffett- The contracts define the payment floor as 100 percent of current fee for services rates, but the State has the ability to make adjustments to rates. We retain responsibility for establishing baseline rates.

Update on Care for the Physically Disabled in KanCare- Secretary Sullivan

Many have asked how care coordination for home and community based services (HCBS) will be handled. Essentially we hear three basic questions:

- How will care coordination work?;
- How will transitions in case management and MCO's be handled?; and
- Is this approach a return to the "medical model" of working with people with disabilities?

The RFP and contracts require that the plans contract out for service provision. Specifically for care management, we stated the plans would be responsible for targeted case management (TCM) either directly or indirectly. TCM helps coordinate consumers' attendant care, meals support, and other in-home services. The State's options were to allow the plans to directly take over this function, to require plans to use existing providers, or to do a combination of both. Other states have done all three different things, including contracting out for a defined time period or taking over this responsibility from the beginning. We asked the three plans to help us define a strategy that will utilize the strengths of the current system. When we look at our data, there are certain systems that are not as effective as they could be for care management. The TCM for the KanCare program will align medical and social supports. The plans will focus on the social supports more heavily, with some clinical coordination. Currently, we know that we have poor outcomes in keeping people out of nursing facilities. Our systems are not coordinated well, so we need to figure out how to fix that. Generally, we are not doing well at coordinating care for the entire person for people with complex chronic conditions. The State looked at all of those factors, and decided we wanted a mix of clinical and social service coordination.

Regarding the waiver for people with developmental disabilities (DD), TCM will be through a Community Developmental Disability Organization. For the waiver for children with a severe emotional disturbance and people with mental health concerns, case management will continue to work as it does now because of the specialized clinical nature of those services. For other large HCBS waivers (including the frail elderly and physical disabilities waivers), TCM will be done directly through the MCOs, except potentially in rural locations where it could be contracted out.

The State has heard concerns about the transition of the current systems into the new program and requirements. We have been asked what will happen if a person loses their case manager. In some cases people will lose them, in some cases they will be hired by the MCOs. We want to ensure there will be an incentive to have a robust system. The MCOs will be responsible for coordination of physical care and long term care. They will use same tools for assessment. The reimbursement structure and incentives in the contracts will incentivize plans to coordinate care and keep people out of institutional settings. The State (KDADS) has 42 quality management specialists for the waivers, providers, and plan of care management. These staff will work closely with the MCOs' care coordinators during the transition.

The State is also working with community providers who provide care management now to ensure those services continue until KanCare begins. We will ensure flexibility during the hiring and training processes for KanCare. We will work with plans to provide continuity of care with care managers and flexibility in assessments.

The State is often asked what care coordination will look like in KanCare. It will be more broadly focused with mix of social supports and clinical components. If the State were to require contracting with current providers we would perpetuate the current issues which lead to a lack of clinical coordination. The plans will also use value added services to coordinate and serve some additional needs of members. Several pay for performance measures focus on long term services and supports and will be subject to payment withholds if standards are not met. There are several pay for performance measures that are not strictly medical components.

Secretary Sullivan then discussed specific questions with Council members.

Senator Allen Schmidt- You mentioned there are three systems where the MCOs will take over case management. Which systems are those?

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Secretary Sullivan- They will take over for the frail elderly, physically disabled, and traumatic brain injury waivers.

Dr. Craig Concannon- Will the MCOs do education on using the appropriate site of service for beneficiaries, for example not using the emergency room?
Secretary Sullivan- Yes.
Kari Bruffett- Plans will be required to help beneficiaries learn about taking ownership of their own care and using the correct level of services they need.

Barney Mayse- What about people with a traumatic brain injury who are eligible for programs now, how do they get into the program?
Secretary Sullivan - If they are not on the waiver, the process will be how it is now. The Aging and Disability Resource Centers will serve as a gate keeper for the traumatic brain injury and physically disabled waivers, and nursing facility placements.
Barney Mayse- What about getting services before January 1st?
Secretary Sullivan – Consumers should reach out to current targeted case managers for that program.
Barney Mayse- Most centers for independent living are not taking new consumers.
Secretary Sullivan - We have lists of providers who are taking on new consumers and can get that to you.
Barney Mayse- If an individual needs to apply for HCBS, how can they do that?
Secretary Sullivan - They use current case management system, and we can give you a list of providers taking new consumers.

Representative Jerry Henry- Last week we discussed the timeline, and established a go/no-go date. How is that decision triggered, who will make the decision, and what will be considered?
Kari Bruffett- Generally, the timeline we gave to this Council previously has been modified with additional dates. We can get the updated document to the Council. The go/no-go decision is primarily related to whether or not we will run the first enrollment file in late October and begin mailings to beneficiaries. What the State is doing in advance of that date involves readiness reviews. These are intensive, on the ground reviews of the MCOs' staffing and information technology systems. We will also have a second round of readiness reviews in October in advance of the go/no-go. We will also examine network adequacy with 90 percent benchmark date of October 12.

1115 Waiver Update- Secretary Moser

Secretary Moser noted that the State continues to have conversations with CMS on the waiver application. The waiver was resubmitted on August 6th and CMS notified the State that the application met all requirements. The comment period began at that point and will end soon. The State is pleased with the process up to this point in time. We are able to respond to CMS' questions and concerns, pointing to the work that we are doing with the readiness reviews and in other areas. Beyond that, negotiations continue around the process as a whole. We are working to bring in other partners to the discussions.

Representative Jerry Henry- When will the provider manuals be ready?
Kari Bruffett- Manuals are being reviewed for two of the three plans now, and these can be released in draft form on request of providers. We expect to receive the third manual by the end of the week.
Representative Jerry Henry - Can you suggest changes?
Kari Bruffett - Yes, we have asked plans to use the format of the current KMAP manuals so that providers are used to the format and flow of the document.
Dr. Craig Concannon - Will those be automatically sent to providers or received on request?
Kari Bruffett - They will be sent because they are part of the contracts. We will also approve any changes to the manuals in the future.

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David Sanford- If the current timeline remains, when will members receive their automatic assignment?
Kari Bruffett - Members will receive initial assignment after the file is validated in late October. Consumers will receive a packet around November including information about all the plans to make a choice. Consumers will be assigned based on where their primary service providers are enrolled, their nursing facility (if applicable), and the algorithm will keep families together in one plan.

Barney Mayse- Regarding the provider list for each plan, will that be given to consumers to compare the plans where their providers are enrolled?
Kari Bruffett – Yes, they will either receive a hard copy if they request it, or they can go online to check where their providers are enrolled. Plans are required to have provider lookup on their websites so people can view the most up-to-date information.
Barney Mayse- Will MCOs have a process to contact providers for contracting if a member's provider is not in network?
Kari Bruffett - Yes.

KanCare Educational Meetings- Kari Bruffett

Ms. Bruffett stated that the State will hold educational meetings with providers and consumers September 24-26 in twelve cities across Kansas. A teleconference call will also be available for each group on September 27th for people who cannot attend in person. Later this fall, the State will have pre-enrollment meetings for consumers and Indian Health educational meetings.

Next Meeting of KanCare Advisory Council

The next meeting of the KanCare Advisory Council will be Tuesday, November 13 from 2:00-3:30 p.m. in Topeka at the Curtis State Office Building.

Adjournment

Chairman Kelly noted that the Council did not have time to address all scheduled agenda items during the meeting, so those items will be addressed at the November meeting of the Advisory Council. Chairman Kelly then asked for a motion to adjourn the meeting. Steve Ortiz moved that the Council adjourn, and Dr. Craig Concannon seconded the motion. The motion passed and the meeting was adjourned.