

ADMINISTRATION, KANSAS DEPARTMENT OF

Moderator: Rebecca Ross
September 27, 2012
1:00 p.m. CT

Operator: Good afternoon. My name is (Delaina), and I will be your conference operator today.

At this time, I would like to welcome everyone to the KanCare Meeting. All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Ms. Rebecca Ross, you may begin your conference.

Rebecca Ross. Thank you.

Welcome, everyone. This is the KanCare Provider Education Meeting. So we had a little confusion. I think we may have some consumers on the line. If you've joined this call, we'll ask that you drop off and dial in again at 3:00 o'clock using the conference I.D. number, pass codes that you were provided.

Hopefully, everyone has downloaded or has up on their computers the materials that we posted on the Web site that goes along with this call. We will be doing a short presentation about KanCare and then the three MCOs will do brief presentations. And all of that was available for you on the Web site.

Can I just ask – and, (Delaina), you may have to help us here. Can I ask if there's anyone from Sunflower on the line who is prepared to present?

Operator: If you would like to present, please press star one and we'll open up your line.

And no one has hit star one at this time.

Rebecca Ross. OK. We'll just go ahead. So I'm going to turn it over to Kari Bruffett. And she's going to present the state's PowerPoint presentation.

Kari Bruffett: Thank you, Becky. And thanks, everyone, for joining the call. It sounds like we've got a good turnout on the call as we've had in-person and our on-site meetings both this week and the ones we had earlier in various parts of Kansas, both in the late July and early August and in the KDADS Tour that some of you may have attended also or heard about in late August.

The teams – the four teams of (K-Tag) and KDADS folks also just came back from being on the road the earlier part of this week in 12 different locations throughout the state, so. But if you were able to join us there and it sounds like probably, if you're on this call, you may not have been able to, we're very pleased you're able to join us on this conference call.

I'm going to real briefly go over our agenda. And we'll try to rely as little as possible on the PowerPoint slides because we don't know whether everybody has been able to download them. But on that agenda, we do – we're going to, like I said, just through a KanCare overview.

We'll have some presentations from the managed care organizations themselves. And then I'll do a real quick run-through of some frequently-asked questions. There's a flyer or a handout that's also on the KanCare Web site that has those for both providers and members, so you may have downloaded that as well. But, if not, again, we're going to through – not every one of them, I won't read them all, but we'll read a handful that may answer some of the questions you come into the meeting with.

Then on the agenda, if you have the printed agenda, it says there's a break. That was for when we were in the in-person sessions. We'd have folks write

their questions down and then divide them up. Since we're not able to do that on the call, we'll just have the operator at that point, instead of taking a break, we'll have the operator take over and kind of organize how we collect our questions. And then the state and the MCOs, as they're able to, will respond to all those we're able to today. If there's any we're not able to respond to, we will take note of those and add those to the KanCare Web site with the responses.

So that's what it looks like for today's call. And, again, we really appreciate you for joining us.

So what is KanCare? Beginning January 1st 2013, KanCare will move nearly all Medicaid consumers and services into a capitated managed care model. The program will include nearly all Medicaid beneficiaries, including those currently enrolled in the HealthWave and Fee-for-Service or traditional Medicaid programs.

The HealthWave Program, that program right now for children and families primarily, will end on December 31st. That "HealthWave" name will go away and all HealthWave beneficiaries will become part of KanCare. So, currently, Coventry and Unicare are HealthWave contractors. Those contracts actually expire on December 31st. So all the kids and families that are part of HealthWave now will become part of KanCare. Similarly, everybody using the – pretty much everyone who's in the standard Medicaid program or traditional Medicaid program will also become part of KanCare on January 1st.

The state selected three managed care organizations to serve as partners to the KanCare program. And you'll be hearing from them today. They are Amerigroup of Kansas, Sunflower State Health Plan, and United Healthcare of the Midwest. Each of these companies has significant experience of providing similar scope of services to Medicaid beneficiaries in other states.

It was very important to the state when we were selecting our partners for moving forward in KanCare to work with partners that have had experience in particularly long-term services and supports, long-term care, (HCB S) services

and other states in a managed care setting. There's a – it's not a very funny joke, but I guess the joke is, if you've seen one state's Medicaid program, you've seen one state's Medicaid program.

There's none that are exactly alike. So when we go to KanCare, there's not going to be any other state that looks exactly like that. But, for that reason, it was very important to us that we find partners that had experience in long-term care in a managed care setting. And these three MCOs do.

What is covered in KanCare? All Medicaid services that are currently covered will continue and will be covered by KanCare. So that's behavioral healthcare, including treatment for mental illness and substance use disorders, that's physical healthcare, acute care services and also includes pharmacy, dental, vision, and non-emergency medical transportation. Long-term services and supports, including nursing facilities, the private ICF/MR and HCBS waiver services, all are covered in KanCare.

You have probably heard, and this is very familiar to many folks, that waiver services and targeted case management for individuals on the waiver with intellectual and developmental disabilities that the (IDD) waiver services and (TCMs), that will be delayed for one year. So January 1st 2013, those waiver services will not be in KanCare, but those will continue to be provided through the traditional Medicaid model. However, it's an important distinction to remember that the individuals who are on those waivers will be enrolled in KanCare for all of their other services, including their physical health and behavioral health services.

Also, one exception of services that is not included in KanCare are the (LEAs) and (ECI) services, the school-based services. Those remain Fee-for-Service, so are not in KanCare. However, the kids that are receiving those services, if they're enrolled in the Medicaid program and KanCare, they will be in KanCare so the KanCare organizations will be required to coordinate with those school-based services. The services themselves won't be in KanCare, but the kids will be.

All Medicaid and (inaudible) beneficiaries will be covered by KanCare with some very few excluded or exclusions or exceptions. And those excluded populations include the (inaudible) population – so, basically, emergency services for the non-citizens; the (MediKan) program, which is a state-only, but a program that is sort of like the pre-Medicaid while you're folks are waiting to get their disability determination; and the (PACE) program. So since that is already a program of all-inclusive care for the elderly that's already all-inclusive, it will run parallel to KanCare, it will not be included in KanCare.

One other exception is that the state had a consultation with Indian Tribes and sovereign nations and Kansas and Indian Health Providers and concluded that Native Americans or American Indians and Alaskan Natives in Kansas who are eligible for Medicaid will be presumptively enrolled in KanCare. However, they will have the opportunity to opt out, preserving a protection that's in the Federal Law.

So what stays the same in KanCare? (Inaudible) we've received a lot of questions both for providers and members about eligibility requirements, changing or being impacted by KanCare. And, in fact, eligibility does not change with KanCare. KanCare doesn't propose to either limit or expand eligibility for the current Medicaid program. Certainly, the currently providers, the existing providers will be invited into the networks of all three managed care organizations.

The state has established a pretty tough contract standard for the MCOs to contract with all of the current Medicaid providers and, in fact, go beyond that and try to sign up providers who are currently in Medicaid so we can address some of the access issues we have and special needs in certain parts of the state. Current services, again, those stay the same. They're still covered by KanCare. There's not a service limitations built into the KanCare.

(And current rates), the state built in to the contract with the MCOs. You saw it in the (RFP) and it's in the final contract as well, a requirement that the Fee-for-Service payments serve as a floor for what MCOs can pay you as providers. Also, what stays the same are the Medicaid I.D. numbers. So your

members will still have the same Medicaid I.D. numbers. Their eligibility review dates will remain the same as well. The (Kan Be Healthy) benefits, those stay the same. And the state oversight of Medicaid and the CHIP program remains in place.

We've seen sometimes reported in the press, and it frustrates us and the state programs here when it's reported that we're privatizing Medicaid. And that's not what's going on. We're working with the private sector partners in the administration of the program and the delivery of these benefits, but these services and benefits are still the responsibility of the state of Kansas and we maintain the oversight for their delivery.

What is changing with KanCare? Providers will contract with and be paid by three managed care organizations. So if you were a provider who now only deals with the fee for service program, that's going to change for you. You won't be billing just the Kansas Medicaid Program anymore.

Now, for those providers who dealt with the HealthWave program, this is not so much of a change, you've probably dealt with fee for service Medicaid as well as two of the managed care organizations, the Coventry and UniCare programs we mentioned before.

Members will choose one of the MCOs, so they'll have that choice of which plan they want to be in and that's different for those members who have not been in the HealthWave program. They've not had a choice of how they had their services delivered, so that's changing.

MCOs are also offering additional services at no cost to the state. And you've heard about these a little bit and we'll chat about those a little bit more later. And particularly we talked about this in the member's session too. So the value added services, one that's most commonly mentioned is preventive dental coverage for adults.

Currently, children receive these dental benefits but it's been quite a while since the Medicaid program in Kansas has offered these for adults, and this will be available to KanCare beneficiaries.

Member's medical cards will be issued by the MCOs. So instead of getting the medical card or for the white plastic medical card, they will receive an identification card that looks like an insurance card basically from the MCOs. It will be clearly marked that it's KanCare, but it will identify which MCO that member – that beneficiary is a member of.

There's also new services that are being added into the contracts to bridge the gaps in the current Medicaid program and improve the overall coverage. So we talked about some of the value-added services and there's a lot of variety in those, in addition to preventive dental, there's also rewards programs for healthy behavior, for example.

But the state is also expanding a couple of services that have not been covered previously, that now the state will cover. And they're not – services that are going to be commonly offered to a lot of folks who will need them but they're lifesaving and sort of critical services.

And one are the heart and lung transplants for adults. Those have been covered for children and youth in Kansas, but they have not been covered for adults for many years. And then bariatric surgery is a new coverage option. In our coverage, it's not just an option, it's going to be a covered service in the State of Kansas certainly with restrictions on access to that for medical necessity and it has to be under medical supervision, failed diet and that sort of thing. But we think it's a good investment for the State of Kansas on the health and outcomes and quality of life for individuals and the long-term health of the Medicaid program as well.

Also changing is we will have increased care coordination as part of KanCare. So instead of services being coordinated around the service line for individuals, the concept, and our expectation of the plans that total care will be coordinated around the person's needs, not just based on what their individual services may be.

Health homes will be available for available for certain people. So by the end of the first calendar year of KanCare, so the end of calendar year 2013, those will be available for individuals with severe persistent mental illness, with

diabetes or with both. And then by the end of the second year of KanCare, all folks in the Medicaid program with complex health needs, with chronic health conditions, those health homes will be available to them.

And we sort of heard described health homes as being care coordination, you know, times two or to the max, or (inaudible) that it's on steroids. So it's a concept and not a place, so we get a lot of questions about this afterwards and we'll expect to have some on health homes.

But it's very similar to the patient-centered Medicaid home model, but it's more expansive in that it includes a lot more providers and has the ability to be led by not just a primary care physician but the providers that members have the most familiarity and contact with.

Consistency in certain MCO processes, this is something we heard loud and clear in the build-up to KanCare is that particularly for those providers who really only have the experience dealing with fee for service Medicaid, that certain processes would be valuable to them to have standardized. And one good example that we worked on with all three of the MCOs and with stakeholders was standardizing credentialing for those providers that don't use the CAQH form. And for those who do, we're expecting the MCOs are required to use a CAQH form. So these – so if you fill out a credentialing form for one of the MCOs here, you can check a box and it's actually for all three.

We also have in the KanCare contract a strong emphasis on quality, including pay for performance measures for the managed care organizations. And those are actually payment withholds, so those aren't just incentives where we're paying extra, we actually aren't paying them the full amount of their capitated payment until they can demonstrate they meet some of those standards.

And earlier, and we'll talk about these slides ahead in a minute, that the first year is based on, in a lot of ways, the relationships with providers and the transition. And in the second year and beyond, it changes to a focus on outcomes or individuals. Not just physical health outcomes but quality of life kind of outcomes as well.

The state is leveraging this private sector experience we talked about earlier in innovation while maintaining the policy and hands-on oversight of the Medicaid program to ensure improved outcomes and sustainable growth. We've got requirements in the contracts that each health plan must maintain a health information system, report data to the State of Kansas and to CMS, to submit to external quality review and then meet these performance standards we talked about. Not only the pay per performance measures but a whole slate of additional transparent measures that we will be keeping and maintaining to ensure that our folks are getting access to the best care available.

We also have established the KanCare advisory group under – the State of Kansas has established a KanCare Advisory Council. But in addition to that, each of the MCOs is required to develop member advisory councils and other advisory groups to advise them.

So it's important for us that we have an unbiased streamlined set of data that we can act upon to make – to have objective performance measures. And for example, in future years, there will be a basic report card that members can review, once they're getting ready to select which plan they want to be with or stay with.

The performance measures for health outcomes, again, they begin in the second year of the KanCare contract and will be based off the benchmarking figures from the first year. And those kinds of – those measures would be based upon ideas like less reliance on nursing homes and other institutional settings.

We're also looking to, you know, people have asked how are you going to save money if you're not reducing eligibility and if you're not reducing provider payments. The idea is by coordinating care better, it's also going to result in pure hospital visits, less of this institutional care when it's not necessary, better care for ongoing illnesses and improving access to health services and to other supports and allow folks to stay in their homes.

And an important distinction here is we're not saying restrict access to institutional care when it's needed, whether that's a nursing facility or a hospital. It's also an important measure for us to make sure that people have access to the care they need. And if it is that higher level of care, KanCare will deliver it.

In KanCare, we've structured Medicare and a managed care model that puts an emphasis on service outcomes rather than just the quantity of services provided. And that we're seeing the beginning of that when we talked about these payment withholds, their outcome space.

In the long-term and over the long run, we anticipate having more of these kind of measures and even involving into more of an outcomes-based system. And through the coordination of each individual's care, and as mentioned before, these are how we're going to actually achieve the savings but also improve the health outcomes and quality of life for everybody involved.

So KanCare MCOs are currently signing up as many providers as possible. So if you have not been contacted by a KanCare MCO yet, I know they are eager to hear from you. It's a safe expectation that they do everything they can to get all the current Medicaid providers into their networks and to provide and add providers as we said before, whether there are current access issues.

So you must be offered at least three reasonable offers. And again the baseline for those offers is 100 percent of the fee for service rate in Kansas. Your rate will not dip below that current Medicaid rate for the life of the KanCare contracts. So one question we hear often as well, that's fine, you're guaranteeing 100 percent of fee for service I the first year but what happens in years two, three and beyond.

As long as the life of the KanCare contract, that same payment floor exist. And so that means whether it's over the base three years of the contract or the optional extension years, the state's option, that three to five years that we have that protection in place for provider payments.

And again the MCO should be reaching out to you, but you don't have to wait to hear from them. If you've not received information from all three of them, you need to contact them directly to make sure you're signed up before January.

And you can go to the KanCare Web site and there's links to each of the MCOs pages and it shows those rates, how you can sign up to be a provider with each of them. And we've also given the list of all of the Medicaid providers in Kansas to the MCOs. So, hopefully, with that, they're able to make some proactive outreach to you.

The state has worked with the MCOs to make the credentialing process easier. I've mentioned this before. All (inaudible) that standardized credentialing form that was developed together or the CAQH process. It's the provider's choice to sign up with any given health plan. We have that high expectation of plans and we're hopeful that all providers will sign up with all three plans.

We recommend that in fact you do sign up with all three. And your current patients or consumers will be distributed across those three MCOs. So if you want to continue to see the patients, you see the days. And in network provider, you'll need to sign up. If you choose not to contract with one or more of the MCOs, you may still be able to see those patients or consumers but you will likely receive a lower reimbursement rate if you do so.

In some cases, the MCO may ask the consumer to choose a provider that is in their network. So it's the goal of the state and it's in the best interest of beneficiaries and as providers that many providers realize this as well. For the members to be able to make a choice on the plan they want to be involved with not based on which particular plan a provider has signed up but maybe on those value-added services that are going to be important to them.

And so to really serve our beneficiaries fast, we need those networks to involve as many providers as possible. So we encourage you to do that both in your interest and the interest of the folks you take care of.

And I think one last point here before a couple of last points before I hand it off to the MCOs for their brief presentations, as mentioned, although the

waiver services and targeted case management for folks on the HCBS waiver for IDD, for intellectual developmental disabilities, we'll be delayed for one year. There are other services that population will not.

So providers who serve IDD consumers may still do the KanCare MCOs before January 1st of 2013 if you provide any non-waiver services to this population. One example that we heard on our meetings down the road was transportation, for example.

As a KanCare provider, you'll have three options to submit claims. One of the other standardization options that we've talked about with the legislature last year was receiving funding to create a single front door billing interface managed by the state. So that providers who currently build the state MMIS system could continue to do so. And so that is an option. However, we've made it an option. It's not mandatory for you to use that front door billing interface.

You can use an established commercial clearinghouse for example, or you can build the MCOs directly online or in other format and they have to accept those claims either individually or batch format.

The (K-map) system will still be available for historical claim search and for member lookup and eligibility verification. So while you'll have the card that indicates which plan that member is enrolled with, they can still go in. And if you have a member shows up and doesn't have that, you can still go to the (K-map) site, confirm their eligibility and confirm which plans they're actually signed up with.

The MCOs is part of our paper performance measures in the first year must pay all, and that's everyone, of clean claims within 20 days to receive their full payment from the state. The KanCare program will use a federal definition of a clean claim and we'll go over that in the frequently asked questions as well.

On top of that, non-clean claims, 99 percent of those must be processed within 60 days and each MCO will have billing training sessions for providers and I think they'll chat about that a bit as well in the call. So, I'm going to hand it

off to – right now, to our MCOs to make some brief presentations, come back and do some frequently asked questions and then get right down to the Q&A.

So I'm going to ask Christine Jones from the United Healthcare to start first.

Christine Jones: Thank you, (Carrie).

Hello everyone. My name is Christine Jones. I'm the director of Network Programs for United Healthcare Community Plans in Kansas. I am joined today by our Chief Operating Officer, (David Rossi) and we are both happy to be here and enjoy working with you.

Our mission statement at United Healthcare is "helping people live healthier lives". That is really more than a mission statement for us. It is a way of doing business. We do serve a large and diverse population of individuals across the country and we come to you with the experience and the resources to make the KanCare implementation a successful venture for the state, for the beneficiaries and also for our provider partners.

United Healthcare currently serves over 246,000 Kansans in our employer-sponsored or commercial health plans in the state of Kansas currently, as well as our Medicare programs. And we also already employ over 2,000 individuals within the State of Kansas and we'll be adding more than 300 additional physicians in the state to support KanCare and the program.

Many of those individuals who will be – the physicians that will be added will be individual who'll be hired across the state in local communities so that we can have local presence and have staff in the communities close to the members and close to the providers. And we will work collaboratively with you to ensure that your patients receive the right care at the right time and in the right setting.

Our primary goal over the next couple of months really is focused on network development. As (Carrie) mentioned, our goal is to build the network that includes all practitioners, facilities and organizations that are serving the Kansas Medicaid population today and then to put strategies in place to

enhance that network and build upon that network to increase the access to Medicaid beneficiaries.

We also have the (CAQH) application. We accept for all providers that currently utilize that application and have developed in conjunction with the state and the other MCO, standard credential and applications for non-CAQH types of providers like facilities to make the credentialing process more streamlined and more efficient for providers so you can compete those applications one time and to make (pseudo) copies and put them in the packet sheets of the CMOs to really avoid the needs to complete multiple applications.

The reimbursement levels and policies will be consistent with the Kansas Medicaid B schedule and payment guidelines. So you can expect that, how you follow your claims today will be accepted and you can follow your claims that way moving forward with United Healthcare.

We also want to encourage individuals. We are working diligently to get contracting packets out to you and want to encourage you that as soon as you receive those, take a look at those, give us a call with questions or concerns that you might have and that we try to get those conversations wrapped up as quickly as possible so we can get contracts back in house.

We want to make sure that we have providers listed in provider directories so that as members begin to receive their packets later this year, they will be able to verify that the providers that they want to receive their services from are actually in the network.

And on one other note, there is a disclosure form that providers will need to complete. Whether you are a new provider to United Healthcare or an existing provider, there is a disclosure form that all providers will need to complete as it is a federal requirement.

And one other note, relative to credentialing, if you are already credentialed with United Healthcare for our commercial or Medicare plan, we will not need to credential you again for Medicaid. We will send the appropriate regulatory appendix and contract amendments to you as well as the disclosure

form, but it will not be necessary for you to go through a credentialing process.

We did stagger the distribution of our contracts to get those out to you as soon as possible. We have completed contract distribution for hospitals, medical groups, federally qualified health centers, rural health centers and have met with Indian health services providers.

We also have contracts available and out in the market for behavioral, health, and substance use disorder providers, nursing facilities, home and community based service providers. And most pharmacies in Kansas, I believe, are already contracting with this through Optum RX which is our pharmacy network.

However, we have distributed addendums to those contracts for the additional dispensing fee that is available under the Medicaid program. We also have contracts that are in the process of getting out to you, as we speak.

The FMS or financial management services contracts should be in the mail. You should be receiving those this week. I believe they were mailed last week. Hospice (Inaudible) (Home Health) are going out this week and transportations until envisioned are coming within the next week or so.

We will get those out to you as absolutely humanly – as soon as humanly possible. We do want to also highlight for you our network relationships we have for behavioral, health and substance use disorder. Optum Behavioral Health is our network partner. That is a company that is owned by United Health Group.

For vision, we are using VSP or Vision Service Plan; dental is Scion Dental; for pharmacy, I mentioned earlier, Optum RX, which is also a United company; and for non-emergent medical transportation, our network partner is Logisticare.

One note, if you're a provider and you provide services that would be applicable to one of those networks, your network contract will actually be with that contracted entity – so, you may – your packets will be from those

different network partners. So you will want to look for their names as you are expecting your contracting packets.

Once the contracts and the (inaudible) information is completed and returned to us, we will work very diligently to complete the provider credential and verification process as quickly as possible and to get provider demographic information loaded into our system so we can have provider directories available to members as soon as possible.

And we'll also build and populate our online provider lookup processes on our Web site so that – again, beneficiaries can use those functions to verify that their providers are in the network. We'll also get the provider information loaded into our claims platform so that claims can be processed accurately and quickly beginning the first of the year.

And of course, we will get a welcome packet mailed out to all of our providers to let you know that you've completed that process and give you some resources that you will want to review as you start to work with us and we will also return an executed copy of the provider agreement.

Over the next few months, we will also finalize the scheduled provider orientation session. That is very important to us that we give you all of the information you need to work effectively with us and to assist your patients as necessary. So we are planning a number of provider education opportunities.

We will schedule onsite meetings across the state and get schedules out to you so you will know when those meetings are scheduled, where we will do onsite training and a number of locations across the state. We will also host Webinars to provide training for individuals when it is too difficult or time consuming for them to get out of the office to travel for their training.

And in addition, we have a staff of provider advocates and we have increased the size of that staff again to support KanCare implementation. And our provider advocates contractors are also available to assist providers with questions and can come onsite and do one-on-one training at provider offices and facilities as necessary to make sure that you have the information that you need.

And we do have a preliminary list that describes some of our plans for provider education sessions. We will get that posted on our Web site and we will provide – we will finalize the details on some of those as far as the specific locations and times of those training sessions and we'll get that information posted on our Web site and get it to the state so they will have it on the KanCare Web site as well.

And we'll do e-mail blasts and fax blasts to all providers that we have their information, so that we can get the information about the training and educations out to you. And we also do have a contact information depending upon your provider type and that information is available currently on our Web site and there's contact information for United Healthcare also on the KanCare Web site.

So if you have any questions that need to reach us, you can check one of those two sources and be able to find the contact information for the individual that can assist you. And regarding prior authorization, we have a limited prior authorization list for the Medicaid program and providers can submit their authorization requests in a variety of ways.

You can phone those in, fax them in, or enter them through our secure provider portal. We do have a staff of prior authorization intake coordinators who will enter those authorizations into the system for any that came in by phone or fax so that providers can check the provider portal and verify or see the status of their prior authorization request.

And then, in addition to that, we have our care coordinators who will be – we will have a KanCare coordinator for all individuals who are nursing facility residents as well as individuals who are in a waiver program and then, with other individuals out of their medical need warrants with complex conditions or individuals that are in a high-risk situation.

And those care coordinators, as they are coordinating those individuals' care, they will secure the prior authorization for any services that are necessary for the individual that they are working with. (Carrie) did mention earlier that

there are some strict claims payment operational goals that we have to meet and which includes payment of 100 percent of all clean claims within 20 days.

So we are working diligently to make sure we are prepared to meet and exceed those goals. Providers again may submit claims in a variety of manners. You can select those – you can submit those claims through the MMIS system on the state's Web site, also electronically through your claims clearing house vendor or to your provider portal and also on paper. Most claims for (inaudible) and providers, checks will be issued twice a week and then five days a week for nursing facilities and home and community based service providers. And again, a provider portal and we include training for that provider portal in all of our provider education session.

It's a good resource for you and you will be able to access a variety of information from that resource including verifying the status of claims and making claims corrections and re-submitting those online, as well as verifying member eligibility, the prior authorization request and looking at primary care physician panels. So there are a lot of information and resources that are available to you in one quick resource. And then of course we do have our provider advocates that will be available throughout the state to educate providers and help with escalating claims issues as necessary.

We do have our member toll free number and that number is 1-877-542-9238. Our customer care professionals are in training as we speak. They're all located within the state of Kansas and they are in training so they will be well-educated and experienced and prepared for member calls when those start to come in. Our member toll free line will be staffed by live individuals from 8:00 AM to 8:00 PM, Monday through Friday and then there, the phone line will also have an automated system available to assist members 24 hours a day seven days a week. And of course there are translation services available through our language line for any individuals that need some additional help with communication with us.

We also have our value-added services, I think these value-added services are available on the KanCare Web site and we will get them posted on our Web site as well. But they are an important component of the KanCare Program,

that we encourage providers to be familiar with just so you can call them out to your patients as necessary and our value-added services include a number of things including adult wellness rewards where adults can earn rewards for completing certain screenings and check-ups if they are diabetic and need a hemoglobin A1C, those types of services and preventive services that are important to maintain their health, and we will make rewards available to them to help encourage them to receive those.

We also have things like weight management programs where we will pay for Weight Watchers programs for members that are interested in weight loss and we'll cover things like YMCA, boys and girls clubs, 4H memberships for kids to encourage exercise. So we have just a variety of services that we are offering that are available and those will be provided to all members but we want to make sure that providers understand what those services are as well. So again that you can encourage your patient to utilize those services and hopefully we can work together to improve their health.

So I think that is it. I'd like to thank you all very much for participating and for allowing us to speak with you today and we look forward to working with you.

Rebecca Ross: Thanks, (Christine). For those of you who joined us late and I think (Delaina), our operator may tell you about this again at the end of the call but we have arranged for a transcription of this call that will be available after the call and also for the encore dial-in so that you will be able to access this call and hear the information that was discussed for a 30-day period and that information I think will be provided later. (Delaina) you can correct me if I'm wrong.

Operator: No, ma'am, that is correct.

Rebecca Ross: OK, now (Delaina) if you could open (Holly Benson's) line. She's on one of the lines and we'd like her to speak next for Sunflower.

Operator: Can we have her hit star one so it's easier for me to find her.

Rebecca Ross: OK.

Operator: OK, I'm going to open her line now. Holly, your line is now open.

Holly Vincent: Thank you very much. My name is Holly Vincent, I'm representing Sunflower State Health Plan today. It's an honor to join you all.

Sunflower State Health Plan is actually part of the Centene Corporation which is a corporation based in Saint Louis, Missouri. We do business in 18 states and serve over 2.1 million members who are served through Medicaid programs in various states.

In the states that we serve we already serve four long-term care programs and 12 programs that serve aged, blind and disabled individuals. We also have already contracted with over 130,000 providers across the country.

As a company we have a certain number of core philosophies that we bring to Kansas that will make us a good partner for doing business with. At the top of the list is our commitment to local approach and job creation. Our core philosophy is that quality health care is best provided locally and that means we are better able to provide accessible, high quality and culturally sensitive healthcare services to our members.

We are also committed to care coordination. We believe that each one of our members deserves a true medical home where their care is coordinated and communication between providers is ensured. But finally we are very committed to ensuring good quality outcomes for our members. In most states we are held accountable to certain (inaudible) outcomes and we are working with the state of Kansas to develop appropriate outcome measures to ensure that we are serving Kansans on the Medicaid program well.

As I mentioned, we are absolutely committed to having a local team on the ground. We have a CEO who is based here in Kansas and we have a team including a local call center and local integrated care teams who will be coordinating care all across the state. While our headquarters will be in Overland Park we'll also have offices in Topeka and Wichita, but we will have people scattered all across the state to ensure that they are close both to our

members and to our providers. We want to make sure that we will have a speedy response time to your needs.

We will have a local board of directors and we will have a number of advisory committees including a provider advisory committee and a hospital advisory committee and for those of you who are listening in who might be interested I hope you'll let us know.

One of the commitments we made to the state of Kansas when we agreed to do business here was that we would work to coordinate long-term support services. We want to make sure that our members have a voice and a choice in what services they receive and in how they receive them. We believe in meaningfully engaging not only our members but also their families and the advocacy networks to ensure that we are best coordinating care and providing the services that our members need.

We are firmly committed to promoting a culture of independent living and we want to make sure that our members have peer support to help them with access to the support services they need. Some of you may know that we have been doing business in Kansas for a number of years with our sister company, Cenpatico. They coordinate behavioral health services for a number of Kansans already.

They've demonstrated their commitment to quality treatment and holding to evidence-based standards of care. They have focused on the whole person rather than just only the behavioral health issues or the physical health issues. And they have worked to support providers in working with complex members to increase treatment adherence.

In order to do business here in the state of Kansas we are working with a number of Centene subsidiaries and with a couple of outside vendors. The Centene subsidiaries we're working with include Cenpatico as I mentioned previously, Opticare, who helped with our vision benefits and US Script who is a pharmacy benefit manager. In addition we have entered into contracts with DentaQuest to provide the dental benefits we promised and with MTM in order to ensure that our members have transportation to their appointments.

Now one of the things that a lot of folks are concerned about is that we will make sure that there is a smooth transition to the new KanCare program. We want to make sure that our members and providers don't miss a beat on January 1st so we are working with the state to get access to claims history for our members to ensure that we know the current treatment that they are receiving. We are getting data from many existing managed care organization that may be serving these folks and we are also making sure that we do outreach to our members and to providers to identify any of those who need to be addressed first.

Once we go live we will make sure that we honor existing treatment authorizations for the initial 30 days and then for any medically necessary services that are being provided by a provider who chooses not to contract with us. We will make sure that we cover the services for at least 90 days or until we have the ability to rendition them to a participating provider.

Now as (Kari) mentioned earlier one of the reasons Kansas wanted to do business with managed care organizations is they recognize we have some flexibility in the benefits that we offer. We have agree to offer a number of value added services including (CentAccount) which is a member incentives program for people who engage in healthy behaviors like well-child check-ups, immunizations, well-woman visits, well-man visits, we offer rewards to them and it will be applied to a (CentAccount) credit card.

The dollars on that credit card can be spend for health-related expenditures like over the counter medications or even things like diapers for new babies. We also make sure that we support our connections plus representatives who are out around the state who will have face to face contact with our members. We make sure that we incentivize children for doing follow-up visits after a behavioral health visit. We make sure that we are providing preventive adult dental coverage in addition to the children's coverage that's currently offered.

We offer things like pet therapy and a healthy school, adopt-a-school program. But in addition for families who are caring for loved ones we are prepared to offer some additional (inaudible) care. But I think what you all are calling in today is you want to know what you can expect from Sunflower

as a partner. At the top of the list we want to make sure that we ensure timely and accurate claims payment to our providers.

Even before we go live we expect to do testing of claims, submissions, in order to make sure that that's a smooth transition. We do offer electronic payment to our providers. We have relationships with clearing houses, many of whom you all are doing business with now.

We will have local dedicated resources to help you if there any problems and resolving your claims issues. We will also make sure that we have provider relations representatives in your communities who can respond to your needs more immediately.

As a company we are committed to reducing administrative hassles so that you can focus on what you do best, providing quality healthcare and services.

Now you all don't have access to the PowerPoint, I don't believe but if you go to the KanCare Web site you should be able to see some of the things that we offer through our provider portal. We want to make it easy to do business with us and on the provider portal we offer you can do things like checking member eligibility, viewing your patient list, submit, view and adjust claims, view payment history and even see a member health record. We believe these tools are really valuable to our providers and we will continue to work to enhance them.

Now (Kari) mentioned that we are all running around the state working to get our contract signed with you all, if you all have not yet received a contract from us I hope you will let me know how we can get one to you. You can always e-mail me at hbenson, B as in boy, E-N-S-O-N, at Centene, C-E-N-T-E-N-E dot com.

We also have a 1800 number that's a valuable resource. That number is 1877-644-4623. Let me repeat that. It's 1877-644-4623. And we also have a Web site which is www.sunflowerstatehealth.com. That's www.sunflowerstatehealth.com.

As I mentioned we will be working with you all to ensure smooth transition of care for our members and for your patients. But we really look forward to working with you.

In addition, we are working very diligently to build a quality strong team here in Kansas. And if you all know of people who might be interested in joining the team, again, refer them to our Web site. We are doing interviews all around the state and welcome enthusiastic, bright, committed employees.

It is an honor to be here in Kansas to do business with you all. We look forward just working with you and with serving Kansans. Thank you very much for your time today. And I look forward to answering your questions.

Thank you.

Betsy Yadon: Thanks, Holly.

Now, (inaudible) for Adrienne from (Amerigroup). And I think Adrienne if you press star one, that will open your line so you can present.

Adrienne Adams: I think I am already on.

Betsy Yadon: OK. Thanks.

Adrienne Adams: My name is (Adrienne Adams-Brancado) and I am with the Amerigroup as the Director of Network Development and I am here to express to you our gratitude in attending today's presentation and we hope that you will look forward to joining and participating in this project and contracting initiative.

Amerigroup has 16 years of experience providing access to healthcare for about 2.7 million members in 13 states and Kansas represents our 14th state and we are very excited to begin out contracting efforts here.

We are one of the first companies to integrate coordination for physical, behavioral and social needs while emphasizing community-based care. Member-centric care is at the heart of our business. Our coordination and our provider collaboration programs ensure that members receive care for all facets of their healthcare.

And we've enjoyed working with providers, community-based organizations and outreach services to bring healthcare to your neighborhood.

We also help with non-health needs. Our foundation and our employees have donated more than \$15 million and more than 64,000 hours to communities that we serve in.

What do we offer our moms and kids to frail elderly and people with disabilities? Amerigroup serves additional extra benefits which I'll get into in just a few minutes. We also provide disease management programs to keep chronic conditions at bay; long-term services and support that promote home and community-based living; help navigating in healthcare system and coordinating care. We have a nurse help line which provides triage services and helps direct members to appropriate levels of care that's available 24/7.

Case management programs that address physical, behavioral and social well-being and robust tools and reports to make providing care easier.

And just as I alluded, you can find our link at the KanCare Web site also. We will be glad to – once you get there, you can see a bunch of available tools. You do not need a password or a special provider ID to access the majority of our tools and eligibility.

Amerigroup is offering a rich set of extra benefits to all eligible members. One of them is dental care for people 21 and over which provides two free exam, cleaning and scaling for a year and free teeth whitening for certain conditions.

Members can earn between \$10 and \$50 in debit cards credits each time they get certain health checkups and screenings and they are eligible up to \$200 in credits per year.

We help certain members to get free cellphones through SafeLink and up to 250 minutes of service each month. They can also get additional bonus minutes and wellness texts as reminders to renew and unlimited minutes to call or Member Services if they have any questions.

Taking Care of Baby and Me prenatal and postnatal program with health resources, coaching, a special self-care book and more debit card credits.

Free programs for adults such as smoking cessation, losing weight, obtaining a GED and improving relationships. These are free healthy-living coaching. There is free healthy-living coaching for pre-teens.

Extra over-the-counter medicines through mail order for all waiver groups and members receiving SSI. There is \$120 annually or \$10 monthly towards the purchase of over-the-counter products.

Free rides to community health events and free caregiver transportation to doctor visits for all waiver groups and members receiving SSI.

Career development help and money to buy professional clothes for job interviews. Free in-home pest control for all waiver groups and members receiving SSI.

(Respite) care for caregivers of Frail Elderly waiver members and extra respite care for members of Autism, Developmental Disability, and Serious Emotional Disturbance waiver groups.

Continuing on, this is also on the KanCare Web site. If you want to print out a copy for your own reference.

Our member and provider services for members of Amerigroup are on-call. It is available for members where they can talk to a doctor anytime of the day or night. For members also, we have an Amerigroup mobile app. We have Health A to Z which is our online health resource library with symptom checkers, information on hundreds of topics and other tools.

We have online communities where they can talk to others with similar issues. And we provide health assessments to identify their special healthcare needs so that we can get more direction in what they need and the support that they will require.

For providers, there is local provider relations. Our office will be located in Overland Park, Kansas. And we have various remote personnel throughout the state of Kansas.

Orientation, education and ongoing support to our account management services, a dedicated support unit to resolve problems immediately. Cross-functional teams to help you with more complex problems and over a thousand doctors, nurses and social workers to execute disease and care management program for conditions common to our members.

For our subcontracting, for pharmacy benefits, our PBM is CVS Caremark. We are not currently carving our behavioral health and Amerigroup is contracting directly for those services.

For dental services, we are using Scion Dental. For vision services and ophthalmology we are using Occular Benefits. And for non-emergency medical transportation, we are using Access2Care.

If you provide one of those services, you can still contact our provider services number and we will help you get in contact with those organizations to complete your contracting efforts.

What do we provide or what do we offer to our providers? We have partnered with doctors and specialists and (waiver) providers for years and we refined our model to make it easier to do business with.

Ninety-nine percent of our claims are paid within 30 calendar days and over 99.99 percent are paid within 90 calendar days.

As (Carrie) noted also we have to follow the Kansas guidelines so there is no departure from that.

We use electronic claims submissions, resubmissions, status payments and EOP systems so providers always knows where their money is and what status their claim is in.

We configure our systems to auto adjudicate. Most claims of providers are paid timely and accurately.

We give providers the pre-certification tools that they need to keep their practices moving. And, again, online we have many of those tools available and accessible without having to require a password.

We have a limited list of services that will require pre-certification. Those are using nursing facility admissions, long-term facilities and support, (elective admissions), outpatient high tech high cost imaging; some outpatient services like plastic or obesity-related surgery; high cost durable medical equipment and high cost pharmaceuticals.

No pre-certification is required for most outpatients in network specialty visits and have no gatekeeper process. Emergency department visits and hospital observation statuses do not require pre-certification.

For providers our member-centric model means that your hard work ensures better health outcomes and that is our both common goal is to make sure that we can provide the best care in the timely manner to assist members on a positive health continuum.

Our focus on service coordination ensures that medically and functionally necessary services are authorized. No-hassle online tools and local support with national resources make it easy for us to do business with you all.

A collaborative approach gives us more time to focus on your practice.

For members, our care managers to meet with them in person will allow them to identify health goals. To work towards a large network of quality doctors and hospital will also ensure easy access to care.

Extra benefits to help you and your family or help members' families live a healthier life. And our prowess to the community and then in your neighborhood mean that we have more help to offer to everyone.

Contracting right now is going on daily. If you have not heard from Amerigroup, we would love to hear from you. We can be – you can reach us at 188-821-1108 and request an application. And we will get one out to you immediately.

We are holding jobs there in several communities that are serving in to hire local providers, case managers and personnel, providing training sessions in community-based organizations so that they know what to expect with KanCare.

And we're sponsoring events for local organizations that make the community a better place.

And, again, I want to thank you for your time and consideration and we look forward in working with the providers inside Kansas.

Thank you.

Betsy Yadon: Thank you, (Adrienne). And now, I'm going to have (Carrie Buffet) go over some frequently-asked questions. And then, we'll open the lines for your questions.

(Carrie Buffet): Thank you, Betsy.

As I mentioned earlier on the call, we had frequently-asked questions documents that are both for providers and members who got – have two different sets on our KanCare Webpage.

I have a hard time speaking right now all of a sudden. But I am going to go over a handful of those from the provider frequently-asked questions. These are the ones that even though you may have downloaded this document, we have seen that we often get some follow-up questions about this. So, this may help you either answer a question or maybe will prompt another question that we can address in this call.

We addressed it very briefly earlier. But what is the definition of claim? We talked about the timely processing of claims. I mentioned that we are using

the federal definition of claiming claims. And that boils down to clean claim is one that can be processed without obtaining additional information from the provider of the service or from a third party. That definition also excludes claims that are related to providers that are under investigation for fraud or abuse.

Will all three MCOs have the same prior authorization requirements – a similar question, will all – each MCO have different medical necessity requirements? Each may have different prior authorization requirements, but the state is requiring those to be transparent. Requirement supervisors will easily know what those requirements are, and so that has to be accessible both in the provider manual and on the Web site – the provider Web site.

Will each MCO have the different medical necessity requirements? The – all three must use actually the state definition outlined in the Attachment C of our RFP which is incorporated by reference into the contract with each MCO, so it's the same definition of medical necessity. As far as utilization management criteria, we also are requiring that to be transparent and available to providers, to the provider portal for each of the three plans.

Will providers who submit in-home service claims through Authenticare continue to do so? Yes. Providers will continue to work with Authenticare.

If you provider service to someone who self-directs, what will change for you? Well, you will continue to work with the FMS agency and report your hours through Authenticare.

Will each MCO have it's own preferred drug list? We have a lot of questions we get about pharmacy. No. The state will maintain the Preferred Drug List. In fact, the process for adding drugs for prior authorization to the PDL will remain the same in order to get drugs added to those lists. The Managed Care Organizations can suggest those to the state but otherwise, it's going to go to the same process that we use right now. And so, that will be the same and consistent for all three plans.

Are MCOs incentivizing mail order pharmacy? No, they're not allowed to under the terms of the contract. They may offer it as an option for members, but that may not be incentivized.

What are your options to file a grievance or appeal as a provider? You must file your grievance or appeal with the MCO involved. Each of them has established processes that must meet federal regulations and our contract and will be described in their contract with you or in their provider manual. And sort of late breaking news is we've also made it clear or clarified that providers will also have access to the state fair hearing process after they exhaust that grievance and appeal process with each MCO (or within – the MCO involved) that is.

And there are a handful of other questions on there. Again, will I submit claims to the three MCOs, or continue to submit them to the State's MMIS, just to reiterate the point from before. The state will maintain a single, front-door billing interface where providers can submit claims, but you can also submit claims to each health plan directly, or you can use an established commercial clearinghouse.

So those are some of the common questions we hear. But now, we're very happy to answer and response all those questions that we can that are either more specific or haven't (inaudible) so far. Thanks.

Rebecca Ross: OK. (Inaudible) and this Becky and we're ready for you to open up the lines for questions.

Operator: Yes, Ma'am. At this time, if you'd like to ask a question, please press star then the number 1 on your telephone keypad. We'll pause for just a moment compile the Q&A roster.

Your first question comes from the Karen Sessler.

Rebecca Ross: Hi, Karen. Go ahead.

Operator: Karen, your line is open.

Karen Sessler: Can you hear me now?

Female: We can.

Karen Sessler: OK. I'm asking about the client services related to case management and how that will receive training on that before the program starts on communication about client needs and such, and client changes and client hospitalization, that kind of information.

Female: OK. So your question is basically about transition case management?

Karen Sessler: Right.

Female: OK.

Karen Sessler: Will each individual company be doing training then to let us know about how that – how that's going to happen and who the contact is for client A and client B?

Female: So, generally, about that transition, we have established some specific guidelines around that that are actually being distributed this afternoon by e-mail. So if you get that, read it over and have any other questions, there are contact people there.

More broadly, when a member selects an MCO or is assigned one and doesn't change, that MCO will be reaching out to the member and also to the member's current providers to ensure that they have all the necessary information about how to support that member.

Karen Sessler: Thank you.

Operator: Your next question comes from Jackie Clifton.

Jackie Clifton: Hello. I'd like to – it might be a two-part question, but I was in attendance at the DD – drill down session last week, and I just want to confirm, it's something that I heard and I don't know that – I thought of it before, but DD services are excluded for one year as far as long-term care (HCBS) services.

But when the TCMs are developing a plan of care for those excluded services, will it be the MCOs approving those plans? Or will the state still be approving those plans? I thought I heard the MCOs but I just want to clarify.

(Liz): So, hi, Jackie. It's (Liz).

Jackie Cliffton: Hi, (Liz)

(Liz): Hi. So for the first year, there will be no change in the current process. In the second year, when those services come under the KanCare umbrella, the role that the state currently plays in that planning care review and approval process will shift to the Managed Care Organization, otherwise, the process will remain the same.

Jackie Cliffton: OK. So it's still the second year. Wonderful. And then could I ask one more question before my – before you move on?

Female: Sure, one more.

Jackie Cliffton: And this is more for the (MCOs), possibly the state but reviewing – we've only received one FMS specific contract, so the bottom part of my question is when can we expect – expect the other two, but looking through the language, I'm noticing we have a 90 day billing limit to submit a claim, whereas currently, we have a 12-month period with (K-map), so can someone talk about that? And if that is the new normal or how we proceed with that?

Female: So, generally, that is the new normal.

Jackie Cliffton: OK.

Female: And the billing requirements will be articulated by each of those MCOs in their provider manual. But it's basically, either 90 or in some limited cases, 160.

Female: (180).

Female: (180), sorry, my math is (inaudible). But 12 months is no longer.

Jackie Clifton: (That's going away).

Female: (Going away) and they did (inaudible) (FMS) contract.

Jackie Clifton: Yes.

Female: We do have one. We're waiting for the other two. And then we'll make those available to (inaudible).

Jackie Clifton: (inaudible). Wonderful. Thank you very much.

Female: Sure.

Male: So that 90 day to follow up, (Liz), is it true across provider types. So basically, the minimum – maximum, I guess, is 90 days. There may be some – some of the plans, may be talking about 180 day. But we also require them – in their contract with you and were in the provider manuals to talk about those kinds of exceptions.

So, for example, when Medicaid is not the primary payer, the 90-day clock or 180-day clock as it may be, it doesn't start until you have adjudication from the primary payer, that's one example. Or if you have retroactive eligibility, they have to have policies that account for that.

Operator: Your next question comes from Anne Archibald.

Anne Archibald: Hi. Dr. (Wilson) is an oral surgeon, so we do file both medical claims and dental claims, so kind of a two-part question myself, do we – once we sign-up with all three MCOs, are we automatically signed up with Scion Dental and Dental Quest or do we have to sign-up specifically with those subcontractors?

Rebecca Ross: OK. This is Becky Ross. And essentially, you sign-up with the subcontractors, they are handling dental for the three MCOs, so you would sign-up with Scion for both United and Amerigroup and then Dental Quest for Sunflower.

Anne Archibald: OK. But we do file some medical claims.

Rebecca Ross: Then you would sign-up for that.

Anne Archibald: (inaudible) so we have to sign-up for all three.

Rebecca Ross: MCOs. Yes.

Anne Archibald: MCOs plus the Scion and the Dental Quest.

Rebecca Ross: Correct.

Anne Archibald: OK. Then within the Scion and Dental Quest, are there any changes to any extraction coverage, whether it's an adult or a child?

Rebecca Ross: Whatever we have covered in Medicaid will continue to be covered.

Anne Archibald: OK. I'm just – because I was just looking under the frequently asked questions that just states adults will only have preventive dental care, so that turns off.

Rebecca Ross: Well, that's – yes, that's only extra dental services that are coming in.

Anne Archibald: Yes. OK.

Female: (inaudible) extractions still covered, so I think we're talking about is (inaudible).

Anne Archibald: Right. OK.

Male: Yes.

Anne Archibald: OK. OK.

Female: It's a good clarification.

Anne Archibald: OK. I think – yes, I think that answers that.

Female: Right. Thank you.

Operator: Your next question comes from Brenda Mills.

Brenda Mills: Hello. I have not found this in the Q&A so far, but when the initial cards come out, when our members are assigned to one of the MCOs, is there an attempt to get all members of the family assigned the same MCO? Or will we have, you know, different MCOs with different members of the family? And how will you keep track of that when there's lots of kids who have different names from the rest – others in their family?

Female: Well, first of all, we – Medicaid eligibility is tied to a family head or case head, so even if they are different names, they would be tied together. And yes, the algorithm that HP will be running to assign people to MCOs will include that – include keeping families together as the assignment, so only if families want their kids in different plans, would they be moved to different plans.

Brenda Mills: OK. Great. Thank you.

Operator: Your next question comes from Deborah Blomquist.

Deborah Blomquist: Hi. And thank you, guys, for doing this today. It's really good to get down to some of the actual facts so we can get our processes ready on our end. And my first question comes about the 30-day honor of the authorizations as the (TA labor) drilled down last week, they said we'd have those plans (of care) will be honored for 90 days I thought.

Female: Yes, that's correct, 90 days for those (plans of care).

Female: So what would that 30-day authorization honor (inaudible)?

Female: That has been a mistake. The requirement is 90 days.

Female: OK. That's what I thought. And if (inaudible) had mentioned they did commercial insurance, too. When I contract with (inaudible) the other insurance company to provide Kansas Medicaid type services, am I contracting for their other programs also?

Christine Jones: Hi. This is (Christine). Are you a current United provider or would United be a brand new contract for you?

Female: It would be new.

Christine Jones: OK. So, what we will do is we may offer you an all-product contract. However, you do not have to participate in our commercial or Medicare plans if you choose not to. Some providers would like to, some would not.

So, if we offer you an all-product contract and you are only interested in participating for Medicaid, we will get that – we will take those other pieces out of the contract for you so that can sign a Medicaid-only contract with us.

Female: OK. And one final question and (inaudible) provider manuals and audits as soon as the provider (inaudible) are written, would they replace what we have for Kansas Medicaid now that we find on that (inaudible) Web site and will the interest (inaudible) conduct the audits (their self). What regulations they were going to be following I guess is what I'm asking.

Female: So basically the KanCare program is initiated for the services that it covers (it governs). So you came out providers manuals will no longer govern for those services. As far as the audits, that's really going to be a combination.

Under the (CBS) waivers the state folks will continue to be involved in some pieces of that. And when we finalize our quality improvement strategy, we will be (inaudible) some of those parts certainly at launch the state folks will still be involved in that. (Inaudible) will also be looking at various issues that they will audit, those quality of care and other areas of your performance.

Female: So audit can come from both?

Female: Yes.

Female: OK. That answers that question. Thank you.

Female: Sure.

Operator: Your next question comes from Christa Jones.

Christa Jones: Hi. I've got – I had one question but as other people asked questions, I came up with two others. First one is (inaudible) going to continue to work the Medicaid cases for individuals?

Female: So eligibility will remain the same so, yes, to think eligibility could still go to (DCF) or to the (inaudible) clearing house will be the KanCare clearing house starting in January and also the (inaudible) Web cycle will be – is available now as well. So that's not changing as part of KanCare, though ugh.

Christa Jones: OK. On the 90-day claims limit, is that going to be for (DDs) that first year also or is that not going to change for the first year of the (DD) claim?

Female: It will not change for the first year.

Christa Jones: OK. And – sorry – on the sign up with the subcontractors, is that also for transportation providers?

Female: Yes.

Christa Jones: They just go with the (sub). They don't have to have a contract with the MCO also?

Female: Correct.

Christa Jones: OK. Thank you.

Operator: Your next question comes from Leslie Mahoney.

Leslie Mahoney: Yes. Are you there?

Female: We are.

Female: Yes.

Leslie Mahoney: OK. I've had – I've got questions about enrollment. Are members – are they – do they get to choose which plan they do with or are they assigned?

Female: Go ahead.

Female: So, both. So basically, this fall and the date we have established would be (inaudible) (late) October. The HP is (inaudible) broker will actually run an initial assignment for all the members who are going to enrolled in KanCare. Those members will then receive a mailing with a packet of materials that will let them know which plan they were initially assigned to and then also information about the other two plans so that if they can compare, for example, value added services.

And then when those folks receive those packets, they will have from when they receive them until January basically until December 31st to contact us and indicate if they wish to switch to another plan. And they have the ability to do that. And then they'll also have after January 1st at least 45 days.

So at least halfway through February to change to a different plan even after they've established experience with that plan. So, if sometime in January, for example, they decide they would like to change to a different plan, we will do that for them starting February 1st. So that – so there is an initial assignment and it's based upon that (inaudible) that Becky talked about.

The first – the first test is if they're in a nursing facility, is that nursing facility with plans A, B and C. And if so, you go to the next test, the primary provider that they see is not a nursing facility or was it a physician or another kind of provider, community health center. Is that provider in networks A, B and C?

And then as Becky noted, are there multiple members of the family. And if so the presumption is to put them all in the same plan. And then after you kind of run that entire algorithm and there's other elements as well, you end up with assignments that is roughly equal in number and risk for the three plans. But then it's immediately opened for choice for each member.

Female: OK. Thank you.

Operator: Your next question comes from Luann McMannis.

Luann McMannis: Yes. We (are still) nursing facility and we are currently using the (inaudible) software from the state to submit our claims. Is that (going) still available to us or is that going away?

Female: Yes. You can continue to use that.

Luann McMannis: OK. But we have to submit three separate batches then to each MCO or will the system sort it out?

Female: If you – if you choose to submit it – continue to submit it to HP, the (inaudible) you can continue to do that and they'll sort it to the three MCOs but any adjustments to claims, you would have to work with the MCOs on.

Luann McMannis: OK. Thank you.

Operator: Your next question comes from Jennifer Watts.

Jennifer Watts: Yes. Our only dental service that we provide are the dental varnishes. And we currently bill those through Medicaid for that service so I just wanted to make sure do we have to enroll in each dental provider for just billing dental varnishes?

Female: If you want to continue to provide that to all the Medicaid beneficiaries that you serve now, yes, because they will choose among those three plans. And so you want to – you want to be contracting with all three of them in order to continue to have that patient base.

Jennifer Watts: OK. Thank you.

Operator: Your next question comes from Teresa Mills.

Teresa Mills: Yes, ma'am. I'm a hospice provider and I haven't heard anything mentioned about how hospice claims will be handled.

Female: They'll be handled the same way except things will be billed to the MCO now instead of to Kansas Medicaid.

Teresa Mills: Well, I, you know, currently we also bill the room and board claims per patient that are (inaudible) hospice, will we be doing that also or will the nursing homes bill the room and board claims and we'll bill routine?

Female: No. It should not change. Everything will remain the same.

Teresa Mills: OK.

Female: (inaudible) yes, who will be paying those claims won't change for those Medicaid claims as opposed to Medicare.

Operator: Your next question comes from Lina El Orra

Lina El Orra: Yes. Hi. We're an ophthalmology office. Can we contract with the MCO and choose not to contract with the vision plan of that MCO?

Female: Yes.

Lina El Orra: We can.

Female: Correct.

Lina El Orra: Contract with the UnitedHealth but not with (VSP).

Female: Right.

Lina El Orra: OK. OK. But if we want to contract with both of them then we have to sign a separate contract with each one of them, correct?

Female: Yes, ma'am.

Christine Jones: Yes. This is (Christine) with United. I just want to clarify something for you. You said you are an ophthalmology office. So most of the time ophthalmologists provide, you know, surgical services that would be covered under the medical benefit and so in that regard, you would contract with UnitedHealthcare.

If your ophthalmologists also provide routine vision care, then you would want to contract with the dental network for the routine vision care to get, you know, their annual eye exams and do the prescriptions for eye glasses.

But if the ophthalmologists really just provides surgical and ophthalmology services that are medical in nature, you would not need to contract with the

dental or the vision provider – I'm sorry, I'm saying the wrong thing – the vision provider. Does that make sense?

Lina El Orra: Yes. Yes. Yes. OK. But if we need to contract with both, we have to sign separate contracts, correct?

Christine Jones: If you provide those types of service and want to continue to do those in network then that would be recommended, yes.

Lina El Orra: OK because we received the contracts from, you know, like Sunflower and the Amerigroup but that's all the contracts we received so we should contact the separate subcontractors to get those contracts to sign them?

Christine Jones: Yes, you can. Or if I can give you my e-mail address, if you send me your information, I will be happy to contact our vision provider and have them reach to you.

Lina El Orra: OK. That would be great. I would (inaudible).

Christine Jones: OK. My e-mail address is christine – C-H-R-I-S-T-I-N-E_I_jones – J-O-N-E-S@uhc.com. And if you send me an e-mail with your information, I will make sure that someone reaches out to you with that contract information.

Female: Thank you. (inaudible)

Female: OK.

Operator: Your next question comes from Jan Lies.

Jan Lies: Hello. We're a large organization with about 80-plus providers currently credentialed with Medicaid and all of our provider's bill under the organization's tax ID number. My question is for the state concerning this disclosure of ownership and control interest statement. One of our MCOs, one of the three MCOs sent out individual packets to each of our credentialed Medicaid providers containing this form, asking them to complete it even though they are billing under the organization's TIN number. They state that this is a required federal regulation to have this form completed. However, the other two MCOs have not sent out this form.

So is this really a federal requirement and why have not the other two MCOs also sent out this form if it is a requirement?

Female: I think we'll follow-up with – thank you for raising the question and we'll follow-up with the individual MCOs and make sure they're communicating those requirements correctly.

Jan Lies: OK, so how...

Female: Would you mind giving us your information so that we can follow-up and contact you?

Jan Lies: Sure, I'm very happy to. My name is Jan – do you want it right now or later?

Female: Yes, right now, (inaudible).

Jan Lies: OK, Jan, J-A-N. Last name is spelled L-I-E-S. My address here is 4505 East 47th Street, South Wichita, Kansas. ZIP code is 67210.

Female: What's the provider organization's name?

Jan Lies: Oh, United Methodist Youthville.

Female: OK.

Jan Lies: Thank you.

Female: Thank you.

Operator: Your next question comes from (Christine) (inaudible). (Christine), your line is open.

Christine Jones: Can you hear me?

Female: Yes.

Christine Jones: OK, my question is who will be doing the functional assessments for each of the HCBS waivers? Will the ADRCs do that or will the MCOs do that?

Female: OK. So the MCOs will be doing none of those. The ADRC will be doing many of them and then there are some others that are kind of specialty services that – excuse me – have standing processes that we're going to continue.

Christine Jones: OK, thank you.

Female: Sure.

Operator: Your next question comes from Nancy Davis.

Nancy Davis: Good afternoon. I'm Nancy Davis, with Sunflower. And I just wanted to follow-up with the lady who was from the ophthalmology office, for Sunflower, our subcontractor is (Opticare), and they will actually handle not just the contracting but all the claims process due for a routine as well as medical. So she would need to contract with the subcontractor and not with us directly. So I just want to pipe in and verify that for her.

Female: Thanks, Nancy.

Nancy Davis: All right, thank you.

Operator: Your next question comes from (Kimberly) (inaudible).

(Kimberly): Hi. I'm with a hospice provider and we were at one of the training session yesterday. And I just wanted to verify, will hospice services need prior authorization? Hello?

Female: We're sorry because there's different prior authorization requirements from the different plans. So in general, yes.

(Kimberly): OK. Because they currently did not, so that will be changed?

Female: For some of the plans, yes. So the provider manuals and also the Web sites at least from the provider will include all the services that require prior authorization.

(Kimberly): OK, thank you.

Female: Thank you.

Operator: Your next question comes from Kelly Merth.

Kelly Merth: Hi. Can you hear me?

Female: Hi, Kelly. Yes.

Kelly Merth: Great. And my question is in the line of claims. Now, I understand that each one of the MCOs will have provider portals to do single claims submission. Can you tell me what other EDI clearing houses are available to do batch billing for it to get to each one of the MCOs at the same time or does the state have a particular Web site that they're going to have available to do that?

Female: Any claims clearing house can be used, any EDI system.

Kelly Merth: So can – so then, like, PCA is eligible, EDI Midwest?

Female: So the clearing houses, I think you want to reach out – the plan is basically established. They have to have a connectivity with those clearing houses. But they (inaudible) established clearing houses can be used. Also, the plans can also accept batch claims directly as well. And then the state can – we will also continue through that single front door billing, you can submit claims to MMIS. It then will be distributed to the plans. So there's kind of three different choices (inaudible) batch options.

Kelly Merth: Is there a helpful link on KanCare that I can check claim through?

Female: Pardon me?

Kelly Merth: Is there any way that I can go through KanCare to see if my clearing house is working or should I go through my clearing house?

Female: I've worked with your clearing house and then they could test directly with each of the plans.

Kelly Merth: OK.

Female: Thank you.

Female: Thank you.

Operator: We are showing no further questions at this time.

Female: OK, thank you.

Female: Did the operator say that she would have the additional information about the call? For those of you who may have joined us late and there is initially some – for some folks, there may have been some confusion about the passcode for this. And we do have both – we'll both have the transcript and recording of the entire call available.

Female: And we'll post that.

Female: And we will post that on the KanCare provider Web site. You may be able to get some additional information from the operator as well.

Female: The playback and the transcription report will be available within 24 to 48 hours to the company.

Female: Great. So we will post that when it is received. And then with callback information as well as the transcript. So thank you.

Female: Thank you all. Thank you, Delinah.

Operator: Thank you. This does conclude today's conference call. You may now disconnect.

END