

**Provider External Implementation Workgroup
Meeting Minutes
7-26-12
Landon State Office Building, Room 106
10:00 a.m. – 3:00 p.m.**

Attendees:

<u>Name</u>	<u>Affiliation</u>	<u>In person or by phone</u>
DeDe Behrens	Dentist, Ismile KCK	
Kim Brown	Vice Chair, KDADS	X
Kent Cerneka	Sunflower State Healthplan	X
Dennis Cooley	Pediatrician	
Ruth Cornwall	Kansas Medical Society	X
Jim DeCoursey	KDADS	
Jerry Delashaw	PMMA	X
Sandra Dixon	KAAP/DCCCA	X
Paul Endacott	Chair, KDHE	X
Steve Hatlestad	Americare	X
Jennie Henault	Lawrence Douglas County Health Department	X
Laura Hopkins	Amerigroup	
Jim Johnston	HCA Health Systems	X
Christine Jones	United	X
Mike Larkin	Kansas Pharmacists Assoc.	
Jim Leiker	Alliance for Developmental Disabilities	X
Mike Malone	Kansas Optometric Association	
Cissy McKinzie	Minutes, KDADS	X
David Mohr	Via Christi Health	
Michelle Morgan	NW KS Area Agency on Aging	

Mike Quintero	University of Kansas Hospital	X
Dulcinea Rakestraw	Preferred Family Healthcare	
Sharon Spratt	Cottonwood, Inc.	
Barbara Timberlake	KU Physicians	X
Deone Wilson	RCIL	X
Dwight Young	The Center for Counseling & Consultation	X

I. Introductions:

Paul Endacott and Kim Brown introduced themselves to the Workgroup members. The Workgroup members introduced themselves and their health care experience for this team. A gallery of stakeholders was also present to observe, but were not participants in the discussion.

II. Organization/Housekeeping

The Workgroup was reminded that this group is one of four external workgroups associated with the implementation of KanCare. Summaries of the meetings will be posted on the KDHE KanCare website. The schedule for this meeting, facilities (such as locations of restrooms and vending machines in Landon) were provided to the group.

III. Recap of MCO Workgroup Charge

A KanCare Organizational Chart was displayed for the Workgroup. Accompanying roles and responsibilities of each entity were discussed.

The Workgroup was reminded of their charge: the purpose of the Provider Workgroup is to bring to the state's attention concerns about provider issues from affected constituencies. The Provider Workgroup will work with us through implementation to ensure that issues and concerns are fully addressed in a timely manner.

It was discussed that the internal and external implementation provider workgroups would feed into each other. The group was asked their initial thoughts on the charge and based upon their experience what known hot spot issues they knew of. The Workgroup then went through each topic area they are responsible to review, discussed key issues to address, and associated values.

IV. Considering our purpose...

A. Provider network contracting and adequacy

The Workgroup was directed to see the RFP on KDHE's KanCare section of website, section 2.2.15 and Attachment J for more information: <http://www.kdheks.gov/hcf/kancare/index.htm>

It was discussed that we would like to ensure network providers are credentialed under NCQA guidelines, enrollment and needs of enrollment are considered along with the number of specialty providers for each

network. The State wants all the providers we have now and those we don't have now (expansion). MCOs will be contracting with out-of-state providers when needed to meet requirements, but will try to contract within the State wherever possible. The MCOs are currently working on network adequacy.

1. Key Issues to Address

- One of the providers noted they just want to be included in the network
- Mental Health carved in due to issues with determining psych or medical diagnosis and billing to different locations (*State response- KanCare system should alleviate this*)
- Credentialing (geographic issues)
- Credentialing requirements with KanCare that may differ from current Managed Care providers such as whether providers need to be nationally credentialed, level of licensing for staff, etc.
- State's requirements for network adequacy (*State response - the expectation is that on Dec. 31st, the member will also be served and in the network Jan. 1st. There are benchmarks in place for MCOs on enrollment*)
- Where are the plans and how do providers get in touch with the plans? (*State response - The State required that the credentialing process by the MCOs is standardized and approved by the State along with contract templates. The State does have a draft credentialing document, Facility/Provider Initial and Re-credentialing application, to share with providers and is currently in the process of finalizing it. The purpose of this one standard application is so MCOs will use the same application form, and thereby benefit providers so they will not have to fill out a different form for each MCO. Providers can complete one application and copy, but they will need to submit an application to each MCO that they choose to apply to. The MCOs are waiting for the State approval and the State goal is to approve the draft next week. Next week is also the statewide educational tours, so the draft will be reviewed while out on the road. MCO contacts are available before the official documents are approved.)*
- Network adequacy requirements related to patient assigned a new primary care and when there is not a PCP assigned right now – how will they be assigned and introduced to the member? (*State response – MCO's to address*)
- More contract clarification – what is the reason for approval of contract document? Is it going to be flexible? Will there be a standard regulatory set of requirements?
- Why is the State not managing the credentialing process?
- Is transportation included? (*State response - yes*)
- MCOs might be challenged to divide transportation by three, specifically in Western Kansas; greater volume might be better.
- Clinical level staff meets BSRB requirements and other rehab staff (who are not BSRB). How will new MCOs address for CMHCs?
- Anticipating there will be a KanCare directory of all providers or will there be a MCO specific directory? (*State response - Each MC vendor will have a directory online and potentially printed with the most current online; the directory will be updated regularly showing service, area, language, hours of operation that are federally required; sometimes by county and sometimes by service type. Often MCOs are now creating online, searchable directories.*)
- MCOs are required to work with existing providers – LTC and HCBS providers are seeking clarification of what that will look like (*State response - This is complex and evolving – currently each type of service does case management differently. The MCO is responsible for having people under certain waivers (PD, TBI, and non DD) and doing*

care coordination. In Behavioral health, case management is more clinical in nature, but responsible for contracting with CMHC's and SUD providers for that case management. DD is separate.)

- Billing case management for Medicaid in SUD world - it is still reimbursable for providers?
- Care coordination vs. targeted case management distinction (semantics). Targeted CM talking to Care coordinator (daily function) – provide a definition of terms to help understand differences.

2. Values

- Everyone that wants to be in the network gets in. *(State value)*
- People have at least adequate services. *(State value)*

B. Provider credentialing

1. Key Issues to Address

- Credentialing to be standardized as much as possible so providers are doing one process and not 3 different processes *(State response- the Initial draft Standardized Credentialing Application was then reviewed with the group. The application is not applicable to Professional practitioners. Professional Practitioners are still credentialed through the Department of Insurance. This process is for HCBS, nursing facilities, hospitals (everyone other than professional practitioners). The draft does not address Behavioral Health yet – this is pending. The State hopes to have the finalized version tomorrow of this draft. The idea is that all MCOs gathering same pieces of information and providers completing one application and giving copies to each of the 3 MCO's (providers will need to submit to each MCO and be contracted with each MCO). Draft document includes basic credentialing items and may add page for hospital credentialing.)*
- It was noted by a provider that for Behavioral Health, this draft does not appear much different from what providers have completed in the past. *(State response - If a provider is already credentialed with a MCO, the State will not force providers to re-credential. This form is for those that are not already credentialed. Providers can choose to do the new process if they choose. Contracting and credentialing are different processes (Contracting comes later). If the provider has a current contract with a MCO, there is no need to re-credential but providers will be sent an appendix to do KanCare.*
- A provider suggested consideration of another option – CAQH (Council of Accreditation of Quality HealthCare); MCOs are participants. *(State response - This standardized credentialing process is for those that are not members (Kansas Insurance Department).*
- Providers are getting many requests for information or can providers give CAQH number? MCOs all have contracts with CAQH and pay fees for information rather than filling out credentialing forms again. *(State response - This only applies to clinical staff. Rehab service providers will not be included in this process. MCOs already have list of*

KMAP providers and the contract process will be completed before CAQH invitation (private practitioners).

- *Consideration to using information the State already has through HP? (State response – the State has tried to transfer, but MCOs cannot deem using somebody else’s information. They can get data, but cannot credential just with that info. MCOs are required to build their network and comply with NCQA credentialing standards. MCOs cannot deem provider information from another entity. MCOs need to get their info directly from the provider.)*
- *Contracting (MCOs have provider contracts with multiple addendums for commercial business, Medicaid, Medicare. The State is looking at specific requirements for Medicaid. MCOs sent initial attempt at parts of the contract and State provided feedback. Hopefully, there will be approval next week. These cannot be standardized. Providers have to enter contract with each MCO.)*
- *Will contracts be back-dated if not done by January 1st? (Sunflower – yes if both parties make genuine effort; United Heath – will need to confirm).*
- *Providers are concerned about the capacity of the MCOs to get all this done by Jan. 1st. (There are benchmarks in place. Sunflower response - Contracting and credentialing can be parallel processes. They have credentialing meetings frequently (daily if needed), probably within 5-10 days).*
- *For Health Centers, will there be negotiations with each MCO about reimbursement? (State response – the State can’t standardize contracts).*
- *What statutory requirements are there for contract provisions? Division of Insurance or KDHE requirements for example hold harmless; payment requirements? (State response – to see what is open and what’s negotiable (see RFP). Simple assurances are currently being worked into the contract. MCOs will have to follow Medicaid assurances. Medicaid covered services, claims payment guidelines, medically necessary definitions (see RFP rather than the guiding document).*
- *Will a Behavioral health contract be developed? How many types of contracts will there be? (State response – There will be a standardized one for credentialing including hospital pieces and behavioral health will be included. There will be two types – NAQH and the draft distributed).*

2. Values

- *Experience with MCO is to treat each individual differently– One contract with entity and credentialed for individual (all billing under one entity). For example, a Group practice agreement with DCCCA and each individual credentialed. There are federal requirements too with the need to credential each individual.*
- *Behavioral Health issue - MCOs are often contracting with private practitioners vs. group – clinical licensing is for individual practice. There are a number of people not working at the clinical level; important for MCOs to keep in mind for reimbursement. There is a difference between licensing for clinicians within facilities (agreements and reimbursing facilities) and private practitioners within facilities (some C level and some supervised by*

C level). *(State response - This discussion is happening on Fridays with the MCOs (LAC and LCAC differences and oversight). Discussions will occur next Friday).*

C. Provider grievance and appeals process

1. Key Issues to Address

In the RFP (Attachment D) , majority of the attachment is about grievances for members. Page 10 is the section for Provider complaints and appeals. The State is requiring contractors to report on grievances for members and providers. MCO Liquidated damages and timelines are required.

- Are Providers required to go through the MCO process first? Is the assumption to go to the MCO first, and if not resolved, go to the State?
- Is there any other process outside of the State Fair Hearing process in between the MCO and the State Fair Hearing? *(State response - anyone can file a State Fair Hearing at any time. The hearing office is a separate entity.)*
- Providers are looking for some process between the MCO and a State Fair Hearing. Is there a State entity overseeing this contract? *(State response – several. Standards of care are dependent upon the contract like what is a clean claim and medical necessity.*
- Is there a timeframe to respond to appeals? *(State response – Yes in attachment D).*

2. Values

- MCOs to get both sides of the issue (such as in member claims) - get explanations from providers.

D. Provider Quality including Pay for performance, Quality measures and reporting, EQRO and working with the federal government on quality issues

Attachment J, Quality section of RFP, was displayed to Workgroup members. Attach J has lists and lists of quality and access metrics. There is a federal requirement for EQRO participation in validating performance measure validation (our EQRO is Kansas Foundation for Medical Care (KFMC). Quality metrics will be validated by this external entity and will be helping us determine methodology. For example, life expectancy, not used or measured much and about improving quality of life for people. They will also be reporting on all HEDIS measures.

1. Key Issues to Address

- MCOs to address in their proposal how they would address each P4P measure? *(State response – State and MCO to establish methodology for each measure).*
- MCOs need to partner with providers and work with a variety of providers on how to standardize reporting and using a shared methodology with each MCO of provider data in reporting. For example, admission and readmissions can be measured differently. *(State response - Data systems and methodology are important and the State can have KFMC attend this meeting and report out.)*

- How do we plan to get data out of the AIMS system and interface with the MCOs? *(State response - The AIMS process is included in the RFP as part of the non-MMIS system. The advantage is 20 years of experience and definitions.*
- Any next steps for quality metrics? Measured Statewide? Across the 3 MCOs? Across all providers? Focusing on different types (by MCO, P4P, etc.)? *(State response - For the first year, P4P will be operational but outgoing years more about improving quality of life. We will never be able to standardize across providers as they are so different such as physical health, behavioral health (mental health and SUD), waivers (HCBS), nursing facilities, etc.*
- Who sets benchmarks? *(State response – The first year is just data collection measures: HEDIS measures and national measures, and some new measures just defining and setting in first year. First, we need to set the methodology and then first year measures as benchmarks.*

Next agenda, we will discuss Attach J more after providers have reviewed.

E. Key questions about our work and KanCare

- Will State policies (manuals) be maintained at the KMAP website? *(State response - not determined yet, but MCOs will get manuals to see how Kansas works for their internal set-up. Operational guidance will rest with the MCOs rather than KMAP. For example, general billing manual (refer to MCO manual).*
- A concern is how this will play out for patients that can't work (for example a patient in a burn unit)? Presumptive eligibility and there are concerns about how paperwork goes through. *(State response - MCO manuals are available that will be Kansas specific and some National. Services that MCOs must cover in Medicaid are in Attachment F and specifically delineate services (everything now covered will be covered plus additions).*
- Members that will be eligible for Medicaid but are not now? Once the State determines eligibility, how will MCOs be determined? *(State response – auto enrollment algorithm evenly distributes across MCOs based upon several different pieces of info. Members can switch MCOs, but will originally be auto-assigned. Members can determine the MCO within a choice period. Members can change their MCO annually unless for cause reason.*
- Keeping track of member's eligibility in their KMAP file – will providers be able to check before billing electronically? *(State response - each person will have an I.D. card they get from their MCO. Providers may have to check enrollment with each MCO. Corrections to information are system issue question outside the scope of this workgroup. There will also be a KEYS system. The State will maintain the eligibility file, but unsure how providers can access eligibility electronically.)*
- Providers are concerned about the transition time and services authorized by current Managed Care companies. What will the transition be like? Currently for Addiction providers (AAPS vs. MCD eligible), one company will have authorized. Will current MCOs honor authorization for care that was made within a different funding stream like AAPS or MCD? The majority of SUD members are AAPS that do not qualify for MCD

and do qualify later. *(State response – This will be based on need, but intent is to continue care throughout transition).*

F. Existing Service Systems Not to Lose

- KMAP manuals information

V. Health Homes

Health Homes is an Affordable Care Act service delivery model. In order to be reimbursed, the State model must be approved by a CMS State Plan Amendment (SPA). An internal group is currently working on this along with an external focus group. Health homes are different from medical homes - Medicaid option to provide coordination of physical, behavior health, etc. support for people with chronic conditions. A group of providers treat people within a health home (could be physically co-located or not). People must have chronic conditions, and a health home addresses whole health coordination of care. In KanCare, Health Homes must be operational within the end of the first year. Approval by CMS may not come until then. The State Plan Amendment must say to CMS how we want to do health homes (the MCO role within Health Homes), then CMS must approve, then MCOs implement with providers and members. In August, a concept paper will be submitted to CMS. This topic could be dived into deeper in August or a future meeting. The State is currently requesting educational activity planning money from CMS and hope to have it in September, then hope to get this information out. The State will be developing a SPA in January – July. We are hoping to look at health homes by the end of the year. Providers would like to hear more about the provider role in Health Homes, so Kim will ask Becky Ross (KDHE) to come to the next meeting to discuss.

VI. Next Steps

The State to follow-up on question, page 3: Network adequacy requirements related to patient assigned a new primary care and when there is not a PCP assigned right now – how will they be assigned and introduced to the member?

Next agenda: 1) The State to invite Becky Ross (KDHE) to the next External Provider meeting for the purpose of discussing the provider role in Health Homes. 2) Discuss Attach J more after providers have reviewed.

The State to provide reading materials to the team (pull a highlight reel).

The State to distribute an updated list of members for this workgroup.

The Workgroup then discussed how they would organize themselves. The group will be meeting monthly for approx. 3 hours in the morning. Workgroup updates and workgroup postings of meeting summaries will be on the KanCare website.

Next meeting: An appointment will be sent out by the State.