

# Provider and Operational Issues Workgroup

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## Minutes

DCF Learning Center Conference Room, Topeka KS  
June 19, 2014 10:00am – 12:00pm

### **Those attending in person:**

Jeremy Whitt, Carrie Kimes, Jerry Delashaw, Larry Martin, David Rossi

### **Those attending by telephone:**

Scott Hines, Lora Key, Allen Schmidt

### **Review of last meeting minutes:**

*Shirley Norris, KDHE*

Larry Martin pointed out that the corporate name of his company was misstated in the minutes of the last meeting.

Shirley pointed out that Cindy Stortz, formerly the organizer of the POI meeting, is no longer with KDHE. She is working for Stormont Vail now.

### **MCO Updates:**

*Carrie Kimes and David Rossi from UHC*

Shirley asked the two representatives from UnitedHealthcare to provide an update on recent activities over the last quarter.

David Rossi, COO of UnitedHealthcare: Most of our energy is focused on the Health Homes implementation. July 1<sup>st</sup> is right around the corner. We have a number of provider education webinars, which hopefully give good information to everyone. This is a comprehensive educational effort. We've received lots of questions from providers on how to contract with UHC. And we'll have experts available on the phones for help with contracting and credentialing. We hope that this will be beneficial. I will send Shirley the provider education webinar schedule for distribution. The next will be June 24<sup>th</sup> at 10:00.

Also I wanted to give an update on the I/DD implementation. UHC continues to work with the various members on completing assessments and reassessments. We have completed all assessments for those on the underserved list except for a few that for whatever reason, could not be completed. We are working to re-schedule these folks for assessment immediately, and schedule meetings with families.

Critical list for I/DD claims operationally has an emergency 5-7 day turn around in claims payment for these I/DD provider claims. Not a whole lot of issues from an operations perspective.

Carrie Kimes, UHC: We are really hyper-focused on provider overall satisfaction. We want to make sure that providers have high satisfaction. We are working with providers to make that all any outstanding issues are remediated, or at least working with them closely to identify those issues. The last few months have been focused on this initiative to identify and work through provider items or problems and maintain high satisfaction with United, this has been our focus for the last couple months.

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Shirley: Now Carrie, I know that your organization has had some success when there is a particular focus group that has had some issues, like the local health departments, that you have assigned someone to that group and sort of triage their issues. Can you go into that please?

Carrie: Sure, we realized that if we could do that sort of targeted approach with providers that have issues. We have a pilot group with LHD providers, we knew that we could use the targeted approach with that group. UHC is able to remediate their issues using this approach. We are transitioning that model with RHC and FHQC providers. All those providers have similar, if not the same, issues. This approach has the UHC representative to meet with the group on a large basis every other week, then also work with each clinic individually to resolve the issues.

David: On the fun side of things, UHC sponsored the Iron Kids event in Lawrence on Saturday June 7th. There was really good participation, about 120-130 kids showed up for the event. Of course, UHC sponsored a number of young kids who couldn't afford the enrollment fee. This event benefited the Boys and Girls club in Lawrence, and UHC donated \$3,000.00 to this organization.

We have grant money for innovative approaches to employing persons with disabilities. One pilot program started in May, another in June. We'll another RFP going out in the next couple of months.

Larry: Are you looking at outcomes and progress of care? This came up a little bit in the previous POI meeting. Part of the objective of KanCare was to improve outcomes for patients.

David: We do measure some of the outcomes pertaining to members and their experience. There are the required CAPHs member surveys to review and patient admission/readmissions reports which we always analyze. It will take a while to get all the data and crunch the numbers. There are also the pay for performance measure data targets for review. Overall the impact of KanCare versus the impact of other programs available prior to KanCare is available, but it's not a one-to-one comparison.

### **I/DD Waiver Implementation Updates:**

*James Bart, KDADS*

James Bart: Good morning, I wanted to touch base today. I guess the hot topic in the I/DD area is the CMS final rule regarding home and community based settings. First, note that this is not a Kansas-specific issue, but it is kind of bearing on Kansas since we are one of the first handful of states that in the process of waiver renewals, specifically the I/DD waiver and the TBI waiver. As part of that renewal process, Kansas is asked to make a transition plan in regards to the CMS final rule home and community based settings. Part of KDADS mission during this process is to try to provide more in-depth information and user friendly information on the website than what was traditionally provided in the past.

I've got a few documents here, the first is from the provider information resource on the KDADS website and it gives a whole breakdown of the waiver transition plan. And the documents are pretty unique, showing the evolution on how KDADS is trying to communicate issues and seek input on effecting compliance with the CMS final rule, that's the transition plan submitted to CMS. It is a relatively readable document, 5 pages long, and gives a breakdown on how providers and members can

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understand how that process may impact Kansas, and to provide input into that process. There is also a document of which I am particularly fond, the Consumer Rights and Freedoms. It is a single page document for consumers, designed for folks to understand their rights and responsibilities under the program. A brief summary of the new federal rule, if you tried to read the rule and the various interpretations afterwards, it gets pretty far into the woods. The summary makes it understandable as to what CMS has expressed and the priorities going into the new interpretation of what goes into a home and community setting.

If anyone wants additional information on HCBS services or the final rule, KDADS has established an email for HCBS questions and services. It is [HCBS-KS@KDADS.KS.GOV](mailto:HCBS-KS@KDADS.KS.GOV), so if you have any questions regarding HCBS services, email this address. This website is monitored by and responded to by HCBS staff on a daily basis.

Taking a step back from the I/DD specific information, regarding where we are at with KanCare and KDADS specifically - I visited MD Anderson, very eye-opening visit and the medical care there is wonderful. I feel strength in the healthcare of our providers in the US, specifically in Kansas. Digressing a little bit, there is a report from AARP for people receiving LTC, not just the elderly but also the disabled and family caregivers. The report covered folks from all over the country. Reading this report, you can see that our problems and opportunities here in Kansas are not unique. Kansas is behind the curve getting intermediate level providers involved in the provision of services. Hopefully this is an area of opportunity.

Shirley: Just a note, a new Health Homes newsletter came out yesterday or the day before. On the agenda, there is a link to the latest information if you would like to review. Something that James said, reminded me of the good things happening with Kansas care. Stormont Vail now has a partnership with Mayo. KU is also recognized as a very advanced in cancer treatment as well. The issue is that if you don't have the funds or a way to get to those centers of excellence, then those folks don't seem to have much of a chance. That might be something in the future where providers, maybe with telemedicine or internet technology, could form alliances with these centers so that folks who do not live in major metro areas can still have access to that care.

James: That all starts with the member, person centered planning and meeting the individual needs are really the building blocks for building those bridges. Many of those bridges still need to be built, but we are building them every day.

### **Comments from the Chair:**

*Shirley Norris, KDHE*

Shirley: Our next item on the agenda is the annual audit results. I put the link to the KFMC report on the current agenda. This KFMC report is the annual audit report. It covers all the standards and has pretty lengthy discussion of the findings.

Another related topic request from the workgroup is the P4P standards. The P4P report has been finalized. We discussed P4P at the most recent KanCare Advisory board meeting. I'll send everyone the

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link once the notes for the June meeting have been posted. The report gave the percentage of payouts for the three plans. I don't think it would be a surprise to anyone that there were significant challenges in the first year of KanCare. None of the plans met the claims processing standards for any month. It's a difficult standard, because you have to meet three measures to earn the bonus. Very aggressive percentages are required, and none of the plans were able to meet all three measures in any given month. Now, some of the other measures were met, and each of the plans did earn incentives. I'm sure that all three plans are hopeful that they will better their results in the next year.

After the last POI meeting, Jeremy Whitt forwarded a spreadsheet that contained items which the providers would like to see, measures reporting that providers could use for forecasting and trending. I did send the spreadsheet to each of the plans. None of them could see a way to do this quite as requested. Partly because of the request that the provider could do their own data pulls upon request. There are ways for the plans to pull the data, but not for providers to do this pull for themselves. Carrie, do you have anything to add?

Carrie: We have ways of creating reports for providers. The claims data is on the remittance advice, so the data is there on this standard reporting tool. And we are more than willing to provide reports to individual providers in a way that they can slice and dice, and in a format they can use.

Jeremy: We need the data and visibility on a provider level, rather than a member level. We can see what happened with each claim by member from the RA. The format of the file provided to us doesn't matter, the point is that the data by provider would give us the information that we could use for trending and not have to compile 100 RA's to find the same information.

Carrie: You would like a daily or weekly report?

Jeremy: Yes, because they pay that often. Every time we get the payment today, we need to go down a member-centric path to get the data, including denied claims. That's not efficient. It would be nicer if it would go down a provider-centric path. That's the fundamental request.

Carrie: I think we could run a report on several different levels. It's challenging when they have multiple provider numbers, NPIs.

Jeremy: By the way, UHC has been very gracious to run this report for us several times this year. If we could have this report weekly, or even more valuable, on an ad hoc basis, would be enormously beneficial. Every time we go out to your system and pull this report, would be so beneficial. It's a difference between, I think we calculated something like 15 clicks for member reports vs one click per a provider report. It seems like we could get all the data we need, you've all been gracious to provide this report.

Carrie: I guess for me as an interim, we could provide reports those providers who wanted such reports could contact us and we could set up a weekly run. Long term solution would be a change to the portal, which would require IT effort. We'd just need a collective list of providers who want it and on what time frame.

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Jeremy: The portal is really designed for member use. For a provider who has a number of members with their practice, it is very time consuming to gather the data.

Carrie: Why don't I give you a call and we could run through some test models and see what we can come up with.

Shirley: As you know other providers would also want this as well, has there been any thought as to how to roll this out to other providers?

David: Long term vision, is to provide this on the portal. But the claims processing platform that we use is fairly new, and this sort of functionality will need to be reviewed. In short term, providers could contact us and we can provide the reports.

Shirley: There is a constant complaint from providers about the number of man hours it takes to reconcile accounts, particularly when there are payments and recoupments and payments again. So whatever you can do to help them would really be appreciated.

Anything else on the data spreadsheet to help providers with their billing? No.

Another item that was mentioned was a scorecard on utilization data from the MCO's. There is some of that in the KFMC report and also the KanCare Advisory notes. We need to review admission/readmission, negative outcomes, etc. Compilation of this data can take a year or more on a cohesive basis for the review. Unfortunately, I don't have that, I don't know if anyone has that yet. I will continue to try to ferret this out, wherever that may be.

James: I'd like to offer information from KDADS, we do have pre KanCare data and some post KC data, it is in differing formats and gathered by different agencies. It really is something of a challenge to gather, because you are comparing apples to oranges in many ways. It's not for lack of effort or analysis, comparisons are out there. Health plans are presenting hundreds of reports, some on a daily or weekly basis. Reconciling with historic data is a real challenge. Year 1 to Year 2 KanCare will be probably be the most important comparison.

David: Just a note that all three MCO's are NCQA accredited. There are reporting requirements regarding outcomes required for the accreditation. They are giving degrees of ratings for the measures. HEDIS measures are an integral part of the measures for accreditation.

Shirley: One other item, the committee would like a report on how referrals are assigned. How are they channeled? There is some concern that small providers would not be considered for a referral. Does UHC have additional thoughts or an update?

Carrie: This really has to do with member choice. Our primary goal is to allow the member to select their specialist. They are provided with a list of providers who perform the service. If they have no choice, then the critical case coordinator will make the choice. There isn't a set algorithm or set way to make assignment.

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David: Certainly if providers want to provide services or have made changes to the services that they provide, they need to make sure that UHC knows all the services they provide and their credentials. There is a database called Community Services Connect that helps providers make sure that they have everything covered.

Shirley: Anything that members would like to have addressed at the next meeting?

We do have a guest speaker, our pharmacist. I would ask that the plans have their pharmacy and DME specialists available for that discussion.

And after that, at the December meeting, I'm hoping to have reports from the subcontractors, particularly behavioral health. Perhaps also dental care. I would like us all to get a better overall understanding of the program. I hope that you as providers not only advocate for your own niche or specialty, but also for your fellow physicians and health care providers in your community.

Lora Keith: Health Homes begin date, is it July 1<sup>st</sup>? I'm hearing pushback to Aug 1<sup>st</sup>?

Shirley: July 1<sup>st</sup> is correct

Lora: We've not been gathering enough information. If a physician's group is contacted by a Health Home, and the Health Home is requesting information from them, how does that flow? I thought I read in one Health Home newsletter that it is the responsibility of the provider if they see a Health Home patient in the ER, then they are to report that back to the Health Home? Does the Health Home subcontracts to physician providers?

Carrie: The language that the ER should refer a new patient to the Health Home. There is no requirement to report the data for established Health Home members.

Lora: Will they still be coming to the ER or do they have to get permission from their Health Home to go to the ER?

Carrie: No, the Health Home should not have approve ER care. They should be engaged with the member, so they would like to know that members are there. But no prior approval for ER care from the Health Home is needed.

James: Health Homes are a supplemental service, doesn't replace existing services. The care should just function as today. The Health Home is just another tool to assist in organizing the care for the patient. As the ER visit occurs, the hope is that the information would flow back to the member's providers, and leading to an elevated transition care.

Shirley: New Health Home manager at KDHE, Rick Hoffmeister, can answer this question as well.

Lora: Letters have gone out to identify these people. Opt in or opt out, do my group of physicians have to subcontract with a Health Home partner to be the PCM?

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Carrie: No, you wouldn't need to do so. The core services of Health Home do not replace the care already provided to members.

Shirley: We could ask the Health Home manager to visit with us at the next Sept meeting to give us an update.

I'll adjoin the meeting and speak to everyone in September.