

Provider and Operational Issues Workgroup

Minutes

DCF Learning Center Conference Room, Topeka KS
December 11, 2014 10:00am – 12:00pm

Those attending in person:

Mike Larkin, Larry Martin, Jerry Delashaw, Ted Jester, Ric Dalke, Lora Key, Cheryl Rathbun, Kim Brown, Ron McNish, Gina Hyatt, Keith Durkes, Heather Torrey, Doug Klise, Bryan Swan, Carrie Kimes, Sandy Hashman, Dr. Friedebach, Kerrie Bacon, Fran Seymour-Hunter, Dr. Fasbinder, Sandra Burg, David Rossi, Carla Berdeaux, Tami Bookman, Shirley Norris, James Bart

Those attending by telephone:

Jeremy Whitt, Frank Clepper, Jacque Clifton, Allen Schmidt

Review of last meeting minutes:

Shirley Norris, KDHE

Does anyone have any questions or concerns pertaining to the minutes for our last meeting?

Mike Larkin: A correction needs to be made under Guest Speakers. Kelley was talking about Amerigroup working with Alcon, I think that should read CVS Caremark.

MCO Updates:

Frank Clepper, Amerigroup

I would like to start by introducing some new people on our team. Lianne Vickers is our new Director for Healthcare Operations. Also, Dennis Radio as the head of our Provider Relations Team.

In October we evaluated our Behavior Health Authorization process and revised some of the authorization requirements for outpatient services. There is a relaxation of requirements across the board.

In late September/early October we automated a large portion of our Client Obligation Process. There are still some data challenges that we are continuing to work through. This includes the 834 data from the State into our claims system. We appreciate the providers bringing to our attention any disconnects as we continue to refine that process. Now that we have two years of claim data we are going to analyze the data and put a major initiative in place in 2015 to determine opportunities for additional authorization relaxation.

We are analyzing AR's for providers across the board. In terms of AR balances that are running greater than 20% our provider representatives will contact the providers to resolve those issues.

Currently in development is our 2015 Provider Servicing Plan that will include additional touches out in the field. Increasing training opportunities for providers, and specific provider groups such as Community Health Centers, HCBS providers, and I/DD providers.

From a claim data perspective our claim TAT stands at about 6.5 days. We did have a spike in late August and September due to some high claim volumes.

Bryan Swan, Sunflower

Around the time we last met, we had a few webinars that we had conducted to assist providers utilizing our secure web portal. We held those webinars in September and October. In November we had a series of Provider Workshops throughout the state. Also, looking into a webinar version of that in addition to in 2015 having topic driven webinars. Providers will be able to take advantage of these through e-mail sign-up through our website. We had been doing Provider Summit calls weekly, just general questions and answer sessions. The attendance on these were low so we are going to replace that with this webinar series.

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Sunflower recently updated a Provider Quick Reference Guide that we started distributing at last week's KHA's HFMA meeting in Topeka. Making sure that provider's had access to that information. There was some information distributed during that meeting and on the Quick Reference Guide pertaining to updates on our Provider Appeals process for 2015. Which includes some of the feedback that we had received from provider's about providing more robust first level of appeal where medical information is being reviewed. This will probably be one of the topics of the webinars that we rollout in 2015. We have published this on our website and our provider representatives are out distributing this information.

In conjunction with quality assurance are some new HEDIS quick reference guides for adults, women, and pediatric patients that providers might have. That information is on our website and we are working on getting that information out as well.

We have a new Provider Representative in the Southwest Kansas area and also working part of Sedgwick County named Emily Gagnebin. Also, I recently assumed Provider Representative duties for some counties in the Northeast area outside of the Kansas City area. These counties include Shawnee, Douglas, Lyon, and counties near the Nebraska border.

We published a bulletin about the change in paper claims submission. Providers who are continuing to file paper claims as of February 1, 2015 these claims will go directly to the MCOs. The bulletins that have gone out list the PO Box's that any paper claims submissions would go too. It is important to review those because Sunflower works with several specialty vendors that may have a different PO Box than the actual medical plan.

Lori Key: Could you speak to any disconnect there may be between claims processing and prior authorization? A prior authorization claim we are in the process of looking at we received a prior authorization on with a number and everything. But, we received it back stating no prior authorization is why the claim was denied.

Bryan: I do know that in some cases our prior authorization system and claim system do not talk to each other. We have seen instances where the authorizations may be mistakenly setup under one NPI number but the claim gets billed under a different one. We usually resolve these by gathering this information and going back to the prior authorization team and retriggering that authorization and we are able to push the claim through.

Dr. John Fasbinder: With United Healthcare we have an Advisory Committee that allows us to give feedback that we hope is useful. With Sunflower we had one with DentaQuest but we have not had one since. Is there any thought of having an Advisory Committee in specific to receive some feedback from the dental contingency?

Bryan: We are in the process of trying to set those Committees up and anyone that is interested in participating please let myself or Doug Klise know.

Doug Klise: Sounds like this is strictly for dental though. We may need to check with our Dental Health and Wellness vendors to see what they will be doing. We will get back with you.

Kim Brown: How are the webinars that you are doing announced to providers? Will these be topical or still formulating?

Bryan: They will be topical and we would post those to our website. Also, we have e-mail subscription on our website that you can sign-up that anything we update you will receive an e-mail. You can choice the type of information that you would like to receive.

Kim: What type of topics are you looking at? Is it all claims based?

Bryan: Since we are making some changes and updates to our appeals process we will probably start with that. We are still discussing internally what people would like to talk about.

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Kim: I have had some communication with Sharon Traylor pertaining to a Health Home billing but it appears we have had some denied claims based on an eligibility cap issue that has to do with timing of exchanging eligibility files? In August when a member opted-out they were getting assigned as opting-out at the beginning of the month instead of at the first of the next month. We would have provided the service and when we submit the claim it looks like they were not eligible at the time of providing the service even though they were. The opt-out process was going backward instead of forward. Have you heard or know anything about this?

Bryan: That has not been specifically directed to me. We have a pretty robust Health Homes group that has been handling that implementation and moving forward with that so this should be brought directly to one of them.

David Rossi, United Healthcare

With United Healthcare we routinely look at our prior authorization procedures to determine if there are any procedures included that do not need prior authorization. The goal is to reduce the number of procedures that require prior authorization. We do have a list on our website that require prior authorization. If you are unable to find the information please contact us and we will provide that list to you.

Paper claims submissions will go live February 1, 2015. If you have any issues once we go live we have 30 days to process paper claims in the system. As of March 1, 2015 the paper claims will be rejected back to providers if they do not file them directly to the MCOs.

Something that we shared with the State; our Care Coordination Model for high risk case management has been mostly telephonic. What United Healthcare realizes is that similar to what we have in Kansas for our Care Coordination Model for long-term care; HCBS services in the community aspect of care coordination is more affective in multiple ways. You can have experts on the phone that can help members get the services they need. Especially with high risk medical conditions. The patient center care model that United Healthcare is implementing throughout Kansas is resulting in a reallocation of resources back into the community they are serving. We want to make sure we have individuals out in the communities speaking directly with members and their families.

A lot of work is being done pertaining to Health Homes. Please continue to share the success stories as well as the problems with us so we can make improvements.

In 2015 we are going to work with the health plan team to determine how to simplify the provider experience. Please provide any feedback to us. We start our planning cycle about mid-year. We know there are some pain spots for our providers partners that we want to make sure to correct.

Carrie Kimes: One item we are working on operationally with providers is to clean up 2013 and 2014 issues. You will be contacted by myself or your provider advocate to determine if there are any unresolved issues that you have.

For almost a year our timely filing edit has been relaxed. Our goal is to turn it back on around the February time frame. This allows providers a couple more months to clean-up their 2013 and 2014 issues without having to worry about timely filing denials.

We are working with providers to get their AR balances over 90 days down. We have been working with a lot of hospitals and are moving into other areas of providers to identify and help reduce that.

We report provider issues to the State on a weekly basis. This information is updated weekly on our website. If you have any issues within your clinic or office that you believe is a global issue that is not included on the CR log please contact us so we can identify it and get it on our tracker. We want to make sure that your claims are going through the first time without a lot of backend work.

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I/DD Waiver Implementation Updates:

James Bart, KDADS

There are a lot of moving parts in the Waiver updates with CMS. I would refer individuals to the KDADS website. There is a wealth of information regarding final rule. The Department of Labor rulings and the interactions on how that is affecting the waiver updates. Aquila Jordan has been out conducting public meetings regarding these issues. Providers are always welcome in those forum to ask questions.

Shirley: Are the meeting dates and sites on the website?

James: Yes, they are. Probably the most important piece of information is that there is an opportunity for people to comment until December 20th about the I/DD Waiver. The link is on the KDADS website.

Guest Speaker:

Rick Hoffmeister, KDHE

Shirley Norris: Rick Hoffmeister is not able to attend the meeting today but asked me to read some material for him. He stated, as of last week we have 34,151 members enrolled in Health Homes. This is for the Serious Mental Illness group.

We are beginning to see a number of early implementation success stories. Many of the successes are familiarizing the members with existing KanCare benefits such as transportation, dental services, and vision services.

He gave me a few of these success stories which I will e-mail to everyone. I believe they are illustrative of the success of Health Homes trying to integrate the care, making sure members receive all of the benefits that they need instead of just one particular aspect. Getting the physical health benefits in addition to the behavioral health benefits.

Here is one from Sunflower Diversified Services in Great Bend. Our gentleman came into Case Management Only services in September of 2012 with diagnoses of Mile MR, IED and Adjustment Disorder with Disturbance of Conduct. In November of 2012, he was found naked in his front yard, unresponsive due to inability to manage his diabetes. He was unable to stop family members from exploiting him, unable to manage his finances and unable to maintain employment due to inability to follow instructions or keep up with the pace. There was a risk of homelessness. Crisis funding was applied for and denied. In April of 2013, continued concerns of lack of diabetic monitoring, not keeping appointments, continued exploitation by family and members of the community. A second Crisis funding was requested and denied.

In September of 2014 he was admitted into Health Home services with Sunflower Diversified Services. It was discovered during his HAP that he was unable to read and write, but is able to read and write numbers. Health Home staff are taking him grocery shopping to help him choose healthy foods in appropriate amounts and are doing routine house checks to make sure that he is not overstocking on certain items or buying foods he doesn't need that will spoil. They are helping him develop a shopping notebook with pictures to help him identify brands. They are slowly moving him towards independence. He is meeting them at the store and eventually he will be going shopping on his own.

He turns in his glucose readings weekly to the care coordinator who submits them to medical to review, to make sure they are being monitored. They are working on nutritional training, the portion sizes, and weight management. He is being transported and attending all psychiatric and physician appointments. They recently discovered that he is allergic to grapefruit and broke out with a rash because he was eating inappropriate foods and they were able to identify the possible citrus allergy. That prevented trips to the ER that he had been having.

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After the initial admission into Health Homes; staff was able to identify more exploitation that required law enforcement involvement. This is a great success story helping this gentleman become more independent, gain better physical health, and with some of these unfortunate exploitation issues.

There is one from Valeo, a person who has TBI; difficulty communicating; and several health conditions which make every moment a painful struggle. She becomes frustrated and angry when she has difficulty communicating, feels that people are being unjust towards her because of her mental health and physical health. Has difficulty verbalizing and is argumentative with care givers because she is frustrated.

She often becomes agitated and fires her care givers; we expected to get the same resistance when Health Homes tried to reach out to her. When she became very angry the Health Homes worker asked questions, answered questions, gave education and positive feedback.

The person was quiet, excited, and happy that she was getting the information. She paused, reached for my hand, and with tears in her eyes said thank you. Finally, someone who listens, is interested in what's happening to me, and doesn't run away.

The last one is from Bert Nash in Lawrence. A male Bert Nash client who recently lost his housing has been in 3 psychiatric hospitals from August to September. This client is engaged in a variety of services at Bert Nash, but he had yet to engage with Health Connections. His blood pressure was high, so his PCP at Heartland Community Health Center was consulted for this blood pressure problem. Also, a Depression screening with Health Connections the client reported thoughts of self-harm. They were able to send him to Crisis at Valeo.

Speaking with Rick about Health Homes he really believes that we are starting to see a number of these success stories. He told me verbally they have been able to help people gain transportation. A lot of members were unaware that transportation benefit was a part of the KanCare program. After speaking with people; some are aware that transportation is available, but they are not sure how to set it up. With Health Homes they are able to receive transportation to appointments. Which leads to some success with getting members dental care, and other types of physical health issues have been prevented.

David Rossi: I believe that the concepts that you shared and the success stories are on target. We continue to see an excellent coordination of care. As well as, some complex cases where we were able to coordinate due to Health Homes and their services.

Shirley: For those of you that are on the phone I will send you an e-mail with several success stories so you are able to share them with others that might be interested and other physicians within the community. It would be helpful to have the success stories shared so we get more people involved in Health Homes.

Some people opted out because of misunderstandings about the program. Some people opted out due to the fear that it was a way to restrict their benefits; in essence it is the opposite.

Lori Keys: My questions is for Sunflower and Amerigroup. Are you two trying to help provider's wrap-up any lingering issues? Have you relaxed your timely filing?

Heather Torrey: Amerigroup has not relaxed their timely filing. If you need a bypass to timely filing you would need to request that specially. We are working diligently to clean-up our 2013 and 2014 claims.

Bryan: Sunflower has not relaxed their timely filing. But, if there is a system issue that we are aware of that we need to run a claim project to address an issue that is on our end we do wave any timely filing or corrective claims timelines and reprocess those claims.

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Shirley: The HEDIS data collection is starting soon. The three MCOs gathered together and created FAQs to help the providers understand the process. Last year some providers were reluctant to provide data that predated KanCare. If Medicaid paid the claim no matter when; that is data owned by Medicaid. The MCOs are asking for it in our name. It is something that is required by CMS and the State of Kansas. There are no HIPPA violation involved with such data if it is under the HEDIS program.

The front end billing process is a big change that will be coming up. I will add to the links to the KanCare information. I will add the KanCare Claims Resolution Log. These are bulletins so I will not be able to provide a direct link. These are updated weekly, you will just need to click on the most recent open log.

Behavioral Health Question and Answer Discussion

Ted Jester, KDADS

Right now the State hospital census is our first priority. We have an ongoing multi-disciplinary team that goes out to the hospitals to access high risk and complex cases. They try to identify resources that will help them return to the community. Recently we have instituted a new admissions policy for community hospitals that have psychiatric units. We have put a moratorium on voluntary admissions for these hospitals. We average around 36% of voluntary admissions. With the moratorium they must be served in the community using crisis services which have been underutilized.

The second policy change is that we want a doctor consultation with a clinician prior to admission if they are seeking involuntary admission. Prior to filing that petition the clinician is required to contact the hospital staff for a consult to discuss the issues to try to help divert and make sure that the admission is appropriate. State hospitals are not set-up to handle IDD, organic brain syndromes, or any personality disorders. This does not mean that we will not take any involuntary admissions. If the court has ordered that an individual be admitted, they will be admitted. This policy took effect of December 3, 2014. Since that time we have had 36 new admissions to Osawatomie and 21 diversions.

We have a \$1.5 million grant that we are going to be announcing soon open to the public specifically for enhancing community services and recovery. There are an array of things that people can bid on to provide such as transportation or crisis services for the uninsured. This should come out in the next week or so. Since this is not coming out of SGF we can extend the contract past the fiscal year. We are looking at up to an 18 month contract.

A year ago we started looking at our screening processes and we made some changes to that. That has come back and we are reconvening the Screening Focus Group that will involve our community partners but also the MCOs to re-examine our processes again. One item is to form some options to use some valid and reliable screening instruments that we currently do not have in Kansas. Suicide Risk Assessments, Violence Risk Assessments, etc. Also, developing protocols and expectations for our screeners to help them respond to a crisis. Lastly, involve the MCOs up-front for adult screenings which we already have for children.

Mike Larkin: I have heard during the upcoming Legislative session there will be some discussion about mental health drugs and step therapy may be requiring prior authorizations. What is your thought on that?

Ted: I am not aware of that at all.

James Bart: It was part of the agenda for the Legislative Oversight Committee. I am not privy to the legislative agenda so I am not able to give you the official take on that. Specifically, in the Legislative Oversight Committee they were talking more about the use of anti-psychotic medications in the nursing facilities. I will speak with leadership and see if I can get you more information for our next meeting.

Mike: If you get the information sooner, maybe it can be distributed electronically.

Shirley: Yes, definitely.

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Ted: I believe there is going to be a task force to look at the abuse and use of psychotropic medications.

Rick Dalke: From the CMHC side when you discuss the access of mental health drugs it is certainly an issue for us. I think here in this meeting the MCOs would take a position or engage this discussion. I think this is very important to look at. If you look at the two subjects that James' just said the big issue is hospital census right now. From the CMHC side, one way to insure you increase your hospital population is to restrict access to mental health drugs. I know there will be different positions and I believe this is a great place to be looking at that.

Cheryl Rathbun: There is also a focus on foster care kids and the assumption of overuse of psychotropic medications. It is part of our contract to monitor the use of psychotropic medications. We will be working on this and have representatives from the MCOs involved.

Kim Brown: I have heard from MCOs of exploring, this is a statute change that would be needed. It would be good however we decide to discuss this topic to include the right people at the table from the MCOs in that discussion as well.

David Rossi: Is part of the \$1.5 million grant to look at potentially innovative ideas that might be scalable as well?

Ted: Yes.

Kim Brown: Is that money from the sale of Rainbow?

Ted: Yes, that is why it is not part of the state general fund. The sale is not final yet this is in anticipation of the sale going final.

Rick: Another subject has come up a couple of times pertaining to screening. I appreciate the Screening Committee and know that the CMHC system is represented well there. As we talk about that it has been suggested that we need that good data. I think that what is so tough is that if you use State data that's generated and the State has paid through you for Medicaid public screens. The State has only paid for about two-thirds of the year on unfunded screens. So when we start looking at that data it starts getting mixed up about what is a screen. For many of the CMHC's we move from what is a screen, versus what is just an evaluation, versus what is a crisis service, and what is a regular daily service for a lot of our adults who experience severe and persistent mental illness. All four of those kind of areas could be called a screen; should be called a screen because we are diverting out of about three different codes that we use there that will never be tracked in this type of data collection. You need to be careful at what you are looking at.

Gina Hyatt: To go along with that too when you talk about involving the MCOs upfront there were several things to take into consideration. Whether or not they have OHI or if it is a State hospital screen with the medial age of 22 to 65. We would not be involved with that after they are admitted. There are a lot of components to look at there.

Shirley: We had asked the MCOs to consider discussing some of their issues that they see through their Behavior Health claims process, authorizations, etc. We did hear briefly from United, did Amerigroup or Sunflower have anything they would like to add?

Sandra Burg: I am on the phone and I believe my Director Carla Berdeaux is also on the phone. If you have any questions for us we will try to answer them. Our provider relations person is out travelling but we will try and answer what we can.

Shirley: Can you briefly address some of the challenges that you see with KanCare in the last year? Some innovations that you are planning on for the next year trying to coordinate with the providers. Making sure that claims are processing correctly and authorizations are flowing smoothly.

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Sandra Burg: I think one of the challenges that we have has been around the medical necessity and making sure that documentation is fully completed. But, there has been improvement. Our staff has been talking with providers and when information comes to us incomplete we reach out to the provider to get that as complete as possible. One of the things that we just rolled out this week is on our web portal we do have our web authorizations up and running. Providers can now do their authorizations online.

Shirley: Have you had any feedback on the new authorization process? Are providers finding it easy to use? Have they contacted you with issues? I know sometimes people have difficulties when something is new.

Carla: Not that I am aware of. With it being brand new it just went live a few days ago. We are in the process of informing the providers that it is available. I do not believe that we have had any issues come up yet. But, we will be watching for those. We are still training our staff on the new process. Hopefully, they will let us know what their issues are when they start using it.

Shirley: Tami since you are in the field can you give us any updates of issues that providers may have with current processes? What is Cenpatico doing to address those?

Tami Woodman: There are a lot of problems and we are working with our team to get the system reconfigured so we can have these claims auto-adjudicated for less back and forth with the providers themselves.

Shirley: So right now there are a lot of manual processes involved?

Tami: Unfortunately, yes.

Heather Torrey: On October 1, 2014 we relaxed some of our Behavior Health edits. We hope this is helping you with your pre-specified limits on certain codes that are billed by CMHC's.

Gina: One of the things that we are working on now is to try and improve the authorization. We have heard back that there are still some issues with authorization denials after an authorization is in there. We are working with our team that does that to see what those glitches might be and help that flow more smoothly.

Heather: That was on October 1, 2014 so we hope that is helping providers in terms of the initial treatment. Once you have reached that pre-specified number you would need to get authorization.

Ron McNish: The codes are for CPS, TTCM, and PRI which are the common big volume ones for CMHCs.

Heather: We are as I mentioned previously working through the CMHC RA's for 2013 and 2014. We have had our challenges certainly, we own those and are trying to make it as easy as possible and clean-up your RA's as soon as we can. You will be hearing from your provider representative shortly if you have not already to try and set something up to get this figured out.

We have also been hearing from mostly behavior health and private practice providers of some new NCCI edits that have been put in place effective October 1, 2014. Some therapy codes can no longer be billed in conjunction with each other on the same day by the same provider. There is a Medicaid NCCI website that providers can refer to for this information.

Ron: We are also working on further addressing the credentialing requirements for those services that do not require a license but training. For example, to provide some of the Autism services you had to complete certain training that we have to input into our system and verify it. The new home-based (HB) family therapy which is shifting and how it is being pushed out and Positive Behavior Support (PBS).

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Kim Brown: I have a couple of things for all of the MCOs. We have brought this up in our Association meeting but we are really looking for Behavioral Health data specifically SUD data. We do not have any utilization data, just the basic information that we are used to receiving for Managed Care. I realize part of the issue is KDHE developing templates for the reporting. Maybe there would be a way to get some interim data. Would be willing to work with folks from Managed Care to receive this.

Cheryl: Is that data that comes from the MCOs?

Kim: MCO data which is utilization claims based data.

Ron: For Amerigroup, I think that Gina brought some sample data last time. Which is the same level of data that you are seeing historically. It included the level of care, volume of authorizations that we provided, etc. Is that the information you are wanting?

Kim: That would be a great place to start to just see the utilization. If we could see utilization for all three MCOs we will have an idea about what the utilization looks like now compared to what it was before. Not just are the same number of people able to access services. Are they accessing different kinds of services now? If they are, what are they? Have we moved from less residential care to more outpatient care since we have peer support now on the SUD side? This data would be beneficial to use for system planning.

The report cards that only United provides are fine. I don't know if you also do a State aggregate one of those also? It is fine to see our data as an agency but it is not very meaningful unless we can compare to State-wide aggregate. We used to receive regional breakouts, I don't know if that is as imperative as just seeing what the utilization looks like by modality of care.

Ron: When the State created the templates is when the regional breakouts were eliminated. We did the exact opposite, we took the KDHE template identified the off-reach level of care and that is what we presented.

Kim: Also, we asked at our last Association meeting if any of the MCOs are making any movement of alternate payment models with Behavioral Health. Some type of global funding of some sort. Our KanCare contract requires that this must be State approved if there is an alternative payment method. If there is movement, what level of movement is there? This might be a future topic.

Pertaining to predictive modeling, what does each MCO using around predictive modeling specifically toward Behavioral Health? How is that driving care? Interested especially in those transitions between hospitalization and the community. Is there a way with predictive modeling to look at something in the community that can avoid hospitalization and how can we help with that?

Sandy Hashman: Some of the things that the Behavioral Health team has been working on in the past quarter is we are getting ready to roll-out our scorecards for our CMHC's. We have been providing scorecards to the SED providers for the last year. We are getting ready to send out to the Executive Director scorecards which will allow them to see where they are performing within their organization in comparison to their peers.

We have been doing a lot of work looking at crisis data within United Behavior Health. We have been partnering with the State on their endeavors to reduce their state hospitalization. Making sure that members are using their crisis services when appropriate within the community first. We have some data that we are going to make available to the Executive Director's so that they can see how crisis services are being used compared to those for going into the hospital.

Our clinical team has just finished up visiting every CMHC this year. We have worked on the in-patient facilities and the CMHC's in 2014. We are about ready to head out SED providers, then go to our larger private practice providers, and foster care agencies.

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Comments from the Chair:

Shirley Norris, KDHE

We have it on the agenda that all future meetings will be moving to the Landon Building. The DCF Learning Center is going to be sold. James and I brought a spreadsheet of information that Jeremy shared with us last time. We did take that to the last Joint MCO meeting. The MCOs are reviewing that information and we hope to have an answer soon. Does anyone have any ideas that they would like to share? Our next meeting we were planning on having a discussion on our Dental Program.

Would anyone like to hear about Nursing Facility program? Does anyone have a topic that we have not discussed recently?

Rick: The next meeting would be well into the Legislative session, is there anything that would be working at that point that could be reported on?

Shirley: Yes, we can try and address that. I know that funding is a hot issue. That would be a good idea. If not, I will try and determine a topic that we have not discussed.

Lora Key: This is an article that was in our local paper. It is discussing Midland Care and their PACE program. They made a statement that they are the fourth option for managed care for Kansas Medicaid recipients. In addition to Amerigroup, United Healthcare, and Sunflower.

Fran Seymour-Hunter: PACE is a managed care entity, the criteria of being accepting into the program is that you are at least age 55 and have met the criteria for a nursing home admission. It is all inclusive; medications, physician visits, and hospitalization. If any person requires a nursing facility placement and it is within one of their network providers. It is very specific right now, there are only certain counties where it is available. Some additional counties will be expanded into in 2015. Individuals can come into that program that are Medicaid only, dual eligible, Medicare only, and even some private pay.

They are more expansive than just a Medicaid program. It is an option for folks that feel that services that are more concentrated on an older population group may suit them better. Daycare services and other things that may or may not be included in normal managed care.

Lora: Is the PACE concept along the lines of the Health Homes concept?

Fran: I would say that it is more towards the concept of a managed care program where you need to get your services from those individuals who are contracted with the PACE entity to provide those services or you may become financially liable. However, there is a difficult case management requirement that has to be followed. They touch base with the members face-to-face that includes home visitation services. In some regards, because it is a much smaller program and is very limited county wise. There probably is the ability to touch people on a more individual bases like Health Homes have. But, they see themselves as a managed care entity.

Kerrie Bacon: Your choice is either KanCare or PACE is one difference. The other difference is it is agency-directed only. People who are self-directed have to make a choice to go agency-directed. The other thing is that others who are 55 to 65 that are of the PD Waiver waiting list may be eligible on this. A lot of people that are on the PD waiting list are used to being self-directed and want to stay that way. Those are some of the things that providers need to be aware of that are different about PACE.

Fran: The enrollment is month-by-month, they are not locked in.

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Kerrie: Yes, then they go to the bottom of the PD waiting list.

Fran: If they were Medicaid eligible then they would be reassigned to one of our current MCOs. The criteria of getting in is more than you are Medicaid eligible and are 55. You also have to go through the screening process and be eligible because of your physical condition for nursing home placement.

Larry Martin: Is there any update on the DOL exempt status for care givers? Is there a projected implementation date right now?

Shirley: No, there are a number of States that are asking the same questions that we are.

James: If you look at some of the waiver changes that are occurring and the change in the FMS model are all inter-related and DOL Rule will determine the impact.

Shirley: Are there any other questions or concerns? Thank you everyone for attending. The next meeting will be in March at Landon. Thank you.