OneCare Kansas Planning Council
Meeting Summary

November 16, 2018

Members of the OneCare Kansas (OCK) Planning Council met for the first time on November 15, 2018 in Topeka, KS. The group was welcomed by Kansas Medicaid Director, Jon Hamdorf, and the meeting was facilitated by staff from the Wichita State University Community Engagement Institute.

Setting the Stage

Medicaid Initiatives Coordinator, Becky Ross, provided the group with an orientation to Health Homes and OneCare Kansas that included the federal definition of Health Homes and a review of the history of Health Homes in Kansas. Becky reviewed the lessons learned and provider feedback that was obtained from the initiative from Fiscal Years 2014-2016. Becky then explained the Legislative Proviso that is currently scheduled for implementation in the current fiscal year (2019). The Proviso reads:

> *"Add $2.5 million, all from the State General Fund, to reinstate a program under the federal Medicaid Health Homes option and add language directing the agency to reinstate a program operated under the federal Medicaid Health Homes option for FY2019.*
>
> *The program would be required to be:*
> - ***an opt-in program***
> - ***allow no more than a 10.0 percent administrative claiming*** *rate by the managed care organizations*
> - ***and have a narrower scope of eligibility for adults*** *than the previous program to ensure those who have a behavioral health diagnosis or chronic physical health condition are served."*

The OCK State team worked together to choose the name "OneCare Kansas" to reduce confusion with other services and to assist with future communication efforts related to the program. There are elements of the program that will be similar to the previous initiative including provision of the six core services and documentation requirements as well as maintaining the model of Medicaid Managed Care Organizations (MCOs) serving as lead entities. MCOs will not be allowed to provide direct services to members (except in case of emergency). The population to be served has not yet been identified and though the population will be more limited, the program will continue to be statewide in scope. Once the population is identified (with the assistance of Dr. Tami Gurley-

Calvez at the University of Kansas), potential OneCare Kansas providers will be invited to apply to participate in the service network.

In addition to identifying the population to be served, there are other elements of the program that are currently in development. These include the payment rates and structure, the provider application requirements and process, and provider team requirements. The OCK Planning Council may be asked to review or provide input on these issues at future meetings.

Members of the Council were presented with potential OCK logos to review and vote on and were provided with a short preview of the OCK information included on the KanCare website. The OneCare Kansas section is currently under development and will continue to be updated as details become available.

Following the presentations, members of the council were given the opportunity to ask questions of clarification regarding the information that was shared.

Q: Who will be identifying the population served?
A: Dr. Tami Gurley-Calvez from the University of Kansas and her team will be reviewing the data to help identify the population.

Q: When looking at narrowing the population, will geography be considered?
A: It could be. One challenge with this is that a new State Plan Amendment would have to be submitted to the Centers for Medicare and Medicaid Services (CMS) each time the program would potentially expand to a new location.

Q: Who does the inviting for members to opt-in?
A: The MCOs. They will be identifying eligible members who are enrolled in their plans and reaching out to them.

Q: How will hospital requirements be communicated?
A: This will be part of the OCK education process and an area where the Planning Council could be helpful in spreading the word.

Q: How will the payment scale be different?
A: There will be one level of payment – last time there was a four-tiered system.

Q: Why the change [in payment scale]?

A: The previous multi-tiered system was developed in anticipation of service need differences that ultimately didn't exist and proved to make billing very challenging for providers. The change will simplify the process for all.

Q: How does the potential OCK population overlap with the proposed work requirements for Medicaid? Will it create additional barriers for those under work requirements?

A: Work requirements are not being considered at the current time and are not anticipated to be implemented in the future.

Q: Can the population be defined by income?

A: No, CMS does not allow these types of exclusions.

Q: When the proviso definitions were being discussed, they were proposed also include individuals with substance use disorders – is this still the case?

A: Yes. The proviso includes language about "behavioral health disorders" which could include individuals with substance use disorders.

Q: The legislative budget for the next two fiscal years has already been submitted – is OCK already included or will this be up for debate in the next legislative session?

A: Technically, it is included through FY2021. However, changes are always a possibility.

Q: Is the $2.5 million the total allotted or is this for each of three years?

A: It is per year and is leveraged for the federal match funding that is available from CMS.

Q: Has anyone had the chance to discuss the program with Governor-Elect Kelly yet?

A: Governor-Elect Kelly currently sits on the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight and has heard updates as part of that process. There has not yet been any additional conversations about OneCare Kansas.

Q: What was the amount allotted for the program in the past?

A: Staff present at the meeting were unable to provide the exact amount that was allotted previously. However, the initiative was an opt-out

program and was intended to serve more than 36,000 individuals who were potentially eligible and therefore, had a much larger budget.

Q: When doing projections, how will you project the number who will be eligible for the federal 90/10 match vs. the traditional 60/40?

A: This will be a somewhat complicated process based on whether the number of currently eligible members who were previously enrolled and for how long. Any member who has not previously participated will be eligible for the 90/10 federal match rate.

Q: Will there be an anticipated limit on the number of individuals enrolled?

A: CMS does not allow a limit on number of individuals served. Any eligible member will be included.

Meeting participants were asked to talk with others at their tables about what excited them most about what was shared so far as well as what concerned them the most. These were then shared with the larger group:

What excites you the most?

- Dr. Gurley's involvement in identifying the population to be served.
- The State is much further along in Kancare implementation than we were in 2014.
- Liking the simplified rate structure. This was confusing last time.
- Start addressing issues connected to social determinants of health.
- Providers are at a higher level of knowledge/experience with health homes.
- Like the whole person concept.
- There will be more state control on how many providers you have in the rural/urban areas.

What concerns you the most?

- Timeline (FY19) and assuring provider access in the rural areas.
- Appreciate the process of using data to narrow population. 2 potential ways to save money – 1.) SMI and chronic conditions. 2.) Look at individuals with chronic conditions and depression/anxiety. An opportunity to improve in these areas and to save money.
- We are going to go through all this work a second time and it will get taken away again. This tempers excitement.
- This is a time of transition (MCO, administration) and this could be especially difficult.
- Will they be expecting annual results? We need to create measures that can show successes (shorter term).
- The amount of money allotted to this program and the effects it can have on the number of people who can be served.

Following the discussion, Becky Ross provided an overview of the current progress of the initiative as outlined in the OCK Implementation Timeline. (See separate document.)

Julie Figgs, Contracts and Procurement Manager at KDHE, reviewed the information in the OneCare Kansas Planning Council Charter in order to explain the role, structure, and expectations of the Council going forward. (See separate document.) The makeup of the Council may be adjusted when the population to be served is identified to assure appropriate representation the targeted group. The Council may also determine the need for smaller working groups based on activities and tasks that need to be accomplished along the way.

Getting to Work

Provider Qualifications

As mentioned previously, potential service providers will be required to apply to become part of the OneCare Kansas Provider Network. The application itself is currently in development and will be available for the Council to review at a future meeting. To assist in the application development process, participants were asked to consider:

> ***If you were responsible for choosing the OneCare Kansas providers, what would you like to know about them?***
>
> *What qualities must the organization be able to demonstrate (i.e. minimum qualifications)?*
>
> *What qualities would you like for the partner to be able to demonstrate (i.e. preferred qualifications)?*
>
> *How will you know these things? (What data/documentation do you need to collect?)*

Group #1: (* indicates *preferred* qualifications)

- History of working with or experience with chronic conditions (KDHE determines the threshold)
  - Billing data
  - Medicaid enrollment #NPI
  - Narrative (if no history, explanation of what you've done)
- Experience with working with people on Medicaid
  - (see above)
  - Any complaints filed
- Understanding of KanCare
  - Claims history
  - MCOs may give insight
  - Interview

- Established provider
  - KMAP number
- *Experience with collaborating with other providers, agencies, community resources (consider subcontracting with others)
  - Ask for a list of who they are currently collaborating with and contacts
  - Letters of support
- Open to coaching
  - Letters of referral
- Willingness to build culture integrating behavioral health/physical health/primary care
  - Letter of support
  - Narrative if you're already doing this
  - Include data (Number of patients, Number of visits)
- Organization's staff need to be community based
  - Attestation
- *Staff already in place or ability to hire quickly
  - Application narrative
- *Experience collecting and analyzing population
  - Health Data
  - Report examples from other projects
- *Previous Health Home Provider
  - KDHE will have list of previous providers
- Implement all 6 components or established relationships to do them
  - Application narrative
- Keep self-assessment as a component of the approval process

<u>Group #2:</u> (* indicates *preferred* qualifications)

- Staffing Plan/demonstrate ability to perform 6 core services
  - Written plan with organizational charts
- P & Ps
- Capacity to build and support partnerships in community
  - Letters of agreement/capacity/contracts
  - Example of past ability to meet population health management requirements
- IT Systems for collecting Protected Health Information
    - Meet the federal requirement for Electronic Health Records
    - EHR includes community referral tracking
- Experience in developing or ability to develop Health Action Plans in a timely way
  - Explain the process on the application
- Provider interviews – at least one, maybe multiple
  - Interview team that includes State and MCO leadership.
- *Track outcome of referrals – not just make them
  - EHR system
- *Demonstrate/track customer satisfaction
  - Survey results

- *Member engagement with "optional" services
  - Provide plan or description of past experience
- *Experience with previous Health Home initiative
  - State/MCO documentation
- *Documentation of prior experience with similar program concept (like care management)
  - Same as above or Patient Centered Medical Home or Accountable Care Organization provider
- *Data/reporting ability – documentation for health outcomes at the member level
  - Show examples
  - Interview
  - List applications/reporting systems/programs

Group #3: (* indicates *preferred* qualifications)

- Entity must have the capacity to ensure the person gets all 6 services or has access to them (contract/subcontract, if needed)
- Qualification of entity and infrastructure - ability to document (EHR); financial ability; familiarity and experience with the population: know the community partners; client outcomes; encounters; leadership
- Multi-disciplinary team (can treat whole person)
- Ability to coordinate care well (Primary care, I/DD, peer support, etc.)
- Accreditation
- Ability to engage with members and strategies to retain them
- *KMAP credentialed (have ability to meet if new)
- *Separate credentialing process if not a KMAP provider (?)
- *Access to a Health Information Exchange (42 CFR requirements)
- *Experience with Health Homes or Patient Centered Medical Home

Documentation:

- Letters of support from community partner or itemized checklist
- Past organizational audits
- EHR (confirmation from vendor? Attestation? Demonstrate?)
- Demonstrate commitment from leadership
- Display readiness and (some) staff on boarded

Group #4:

- Robust system to collect and report data
- Collaborate with other community providers (already positioned to be successful)
- Prior experience with similar work (including implementation and planning)
- Buy-in from agency leadership and/or board (must also have an understanding that the organization will likely have to start small and grow with the program)
- Has expertise or commitment to seek training based on population to be served
- Indicate current capacity to serve Day #1

- Ability to plan for multiple scenarios
- Capable of addressing adaptive challenges (innovation?)

Documentation:

- 1-5 bullets above are easily documented
- 6th bullet – organization's résumé
- 7th-8th bullet – partner Letters of Support, narrative, essay style response

Council members shared concern that providers may have a hard time showing their capacity when the need isn't quite known. This may make it difficult to get leadership/board support to hire staff. It was also expressed that confidentiality requirements outlined in 42 CFR will need to be addressed to encourage substance use treatment providers to participate. Finally, there is also concern that expectations may be high for the amount of money that is allotted for the program. (Example: DCF contract proposals – expectations made it financially unrealistic for some to apply).

Pre- and Post-Implementation Communication Needs

Communication with various stakeholders will be critical during both the planning phase and the implementation phase of the OneCare Kansas program, but they will look differently for each of these. OCK Planning Council members were asked to participate in a discussion group regarding communication needs during the phase of their choosing.

WSU staff facilitated discussion on the following questions:

- What needs to be communicated prior to/after the launch of the OCK program?
- Who should the audiences be?
- What steps will YOU (as an OCK Planning Council member) take to accomplish this?
- What do you need from the State team to support your efforts?

Prior to Launch:

Who do we need to talk to?	**What do we need to communicate?**
Incoming state policy makers and executive branch staff	History of Health Homes/OCK Why Health Homes are important Ask: What do you need to support this?
Legislators	What will the program look like this time? Expectations for success – including the amount of funding needed
Eligible Members	Eligibility requirements? What are the services & benefits of participation? What do I have to give up?

	How is this different from Community Service Coordination? Will the program last?
Ineligible Members	Why don't I have this service?
Family members/support persons	Foundational knowledge about the program Benefits to the member How services (SUD, I/DD, etc.) interact with one another
Potential OCK Service Providers	Knowledge about the program. Address risk – what are the risks now and in the future? (What's the contingency plan?) How are providers selected? Why should I apply to be a provider?
OCK Community Partners	Foundational knowledge about the program Understanding their roles and mandates Benefits to partnering with OCK Providers
MCO Staff	Roles and responsibilities

Members of this group also felt that all audiences needed to hear the lessons learned from the previous initiative to demonstrate the thoughtful process of development.

Members of the group indicated that they would:

- Work to develop a consistent message to be used with potential providers, partners, and members
- Engage association staff to push the message out to their constituencies
- Provide time on the Health Care Provider Association Meeting agenda for State staff to talk about the program
- Create an "echo chamber" to share each other's communications pieces (i.e. Retweets, Reposts on Facebook, etc.)
- Present as a united front with state and MCO staff to demonstrate that the service community is behind the effort
- Strategically communicate with members when the population is decided
- Ask constituencies what they need to know

In order to be successful in communicating with audiences prior to launch, group members indicated that they need the website to be kept updated; a mechanism to address misinformation; minutes from the Planning Council meetings; talking points; State staff to present and be available for meetings; webinars/conference calls for targeted audiences; and small communication bites to be used in newsletters and social media posts.

Post- Program Launch

The information to be communicated once the program is launched includes:

- Communicate program over and over to members. Including aspects of the program, services provided, and the process to opt-in.
- Standardized bullets for consistent messaging
- Standardized reporting/data
- Timelines
- Benefits of joining the program
- Value of supporting the initiative (Return on Investment)
- Basic outputs and outcomes
- Patient/Provider stories and testimonials
- Beginning data
- Scope of the program
- Purpose
- Who, what conditions, why, where they are located
- What is and isn't working
- Scorecard or dashboard measures

Audiences for the information include members that have opted-in; potential members that meet criteria but haven't opted-in; legislators – especially the Bethell Committee; general public; provider groups – enrolled service providers and potential candidates; health departments; social service agencies; families and caregivers; advocacy groups; media health partners; Centers for Medicare and Medicaid Services as well as other federal and state partners; medical community; and both traditional and social media outlets.

Members of the group indicated that some of the steps they need to take post-program launch include:

- Using media/social media, etc. to communicate information
- Gain buy-in and support messaging from organizations involved
- Face-to-face connecting with legislators
- Data mining to identify to whom we should be communicating to
- Identify what to communicate to potential members -> value of opting in
- Action plan/communication plan for when this will happen, how, timeline

- Network plan to engage them to sign up for services and other options
- Make sure members' voices are heard through focus groups, surveys (beyond members) and include what is and isn't working

In order to be successful in communicating with audiences post-launch, group members indicated that they need combined data; standardized talking points; regular updates; two-way communication; already designed social media posts; regular emails with promotion tools; recommendations on upcoming events/messages (flavors of the month); a listserv; and information on how to move members to other resources if they aren't eligible for OCK.

Next Steps

Members of the Planning Council were asked to identify opportunities for action prior to the next meeting on December 20.

Who?	What?
State team	Decide what information needs to be presented to the Bethell Committee
All	Communicate the big picture (using what was presented today) to constituencies represented and document any questions that are raised
Denise Cyzman	Identify a date for the Health Care Provider Association and invite the State team to present
All	Identify groups that you would like State staff to present to
State team	Put together talking points
State team	Continue to build information on the OCK website
State team	Present drafts of the provider application and sample newsletter articles for Council members to use

Mark your calendars!

OneCare Kansas Planning Council
Meeting Dates:

December 20, 2018
January 17, 2019
February 21, 2019
March 21, 2019
April 18, 2019
May 16, 2019
June 20, 2019

All meetings are currently scheduled for 10:00 a.m. – 4:00 p.m. and will be held at the Kansas Health Institute in Topeka, KS.