OCK Implementation Call FAQs

MCO PORTAL

What do I do if I'm having trouble with the MCO Portal?

Please reach out directly to the MCO for guidance. This will also be a topic for the learning collaborative in the future.

Can I get contact information for each MCO?
The correct contact information can be found in the program manual that is on our website. It can also be found at the top of the referral form.

Will I be able to see my clients' diagnoses in the MCO portal?
Information related to diagnoses will be in the portal.

What do I do if I call the MCO and they give out incorrect information regarding MCO partners?
If this happens, please reach out to the MCO using their OCK email address and make them aware so they can follow up with customer service regarding the issue.

HAP & HAP PORTAL

What do I do if I'm having issues with the HAP?
Direct specific HAP portal issues to Samantha Ferencik at: Samantha.Ferencik@ks.gov and/or Shaune Parker at: Shaune.Parker@ks.gov Please use the subject line "HAP portal issue".

Should partners have already received an email regarding the Health Action Plan (HAP) Portal administrator access?
Yes, State staff are still working on this. Many times, emails are being caught in the spam or quarantine folder. If partners are having this issue, email Samantha Ferencik at: Samantha.Ferencik@ks.gov and/or Shaune Parker at: shaune.parker@ks.gov

How do I save the HAP?
Once you are at a point that no other information can be submitted, or all imputable areas have been completed, click the "Save and Continue" button. This will save and continue to the next screen.

How do I print the HAP?
Please see detailed directions here: https://www.kancare.ks.gov/docs/default-source/providers/ock/how-to-print-the-hap.pdf?sfvrsn=f2134f1b_4

How do I complete the HAP if my member does not have an email address.
This field has been changed so it is not required anymore.

What do I do if it takes more than one appointment to complete the HAP?
HAPs will take a lot of time, which is why there is the incentive of the bonus rate. In the past, providers would schedule more than one meeting to get through the HAP. Flexibility is encouraged when filling out the HAP.

Is it okay to provide other community social supports if the provider hasn't had the opportunity to complete the HAP with the member?
Yes. Providers should exercise good judgement and meet the members' immediate needs especially if the health or safety of the member is in jeopardy. OCKPs have 90 days to complete the HAP.

If a partner can't get a member's qualifying diagnosis before filling out the HAP, will this cause problems?
Partners can get this information from the member or MCO. To submit the HAP, you only need to mark one possible diagnosis (for instance, tobacco user).

If an SUD assessment indicates that a member has a positive score, but it is not appropriate to refer the member for further assessment, how does the partner indicate this?
In the free text, partners can indicate that a referral for further assessment is not clinically indicated or that the person is currently in recovery.

Should the HAP be sent to the primary care physician as has been done in the past?
Yes, if a member has a PCP, please share the HAP with them.

When providers get members that had asthma when they were a child, but not currently, how should they fill out the asthma action plan?
The OCK partner is not responsible for filling out the asthma action plan. This is completed by the member's PCP or other treating physician. OCK care coordinators should work with the physician to obtain a copy for your organization's records and support the member with the use of the plan. Partners need to ensure that all members who are diagnosed with asthma have an asthma action plan.

Is the asthma action plan required to be uploaded into the HAP Portal?
No, the asthma action plan is not required to be uploaded into the HAP Portal.

Do both long-term goals and short-term goals need to be written in the SMART goal format?
Beginning 6/18/2020 all HAP goals are to be written as SMART goals. Within the HAP Portal the goal "Heading" can be general. The goal notes, however, will be written as a SMART goal in the proper format. OCKPs will not be penalized for failure to construct goals as SMART goals prior to 6/18/2020. The MCOs will follow these guidelines when auditing the OCKPs.

Can a member's diagnosis be added to the HAP Portal?
Due to privacy concerns, we cannot put a member's diagnosis in the HAP portal. You can obtain this information from the MCO if it is needed.

Relating to the quarterly review of the HAP, if it is completed after 90 days of the first HAP, is it considered late?

Quarterly updates is the minimum bar. It can be done more often than every 90 days. It is considered late after 90 days. New HAPs should be created with changes.

Will partners receive a reminder email if their HAP hasn't been updated within 90 days?
Currently, the only reminder is for the initial HAP. But there is a report, "Days Since Last Submission" which will show when the HAP was last submitted and how many days are left.

If a partner updates a member's HAP with a new goal, does that change the 90 day due date?
No, the partner will have to save and submit the HAP but not all information needs to be new and updated. It would start the clock over again. The reason KDHE has a 90 day timeline is to ensure members are getting treatment with proper care. These are living documents meant to reflect what is actually happening with the member.

Would the HAP timeline extension apply for a short-term hospitalization? How do providers know what the new due date is?
The new policy applies to any type of hospital stay. The restart is for the 90 days and will begin on the date of the discharge. There is an indicator check box that can be filled in by MCOs or Partner's with a place for "Date entered institution" and a "Discharged Date".

A provider usually expects members to be included in the HAP portal at the time the rosters are being sent. In August, there have been individuals added to and removed from this provider's list of members included on the HAP portal at other points of time during the month. Is this considered growing pains for the program or something else?
This is mostly growing pains for the implementation of the portal. For those members who have "fallen off" of the list, it could be that they were assigned to the wrong provider and corrections were made. There are occasions where a member's enrollment is expedited outside the traditional timeframe, in which case the rosters might change after the list has been issued. However, this shouldn't be happening at a large volume.

What list should providers work from? The roster sent on the 18th by the MCOs or the list within the HAP portal?
These two rosters should match for each month. There shouldn't be anyone on the HAP portal that isn't on the roster. If so, partners should reach out to the state to check in as well as notify the appropriate MCO of the discrepancy.

What do I do if a member refuses to complete a PHQ-9 for the HAP?
Partners should be able to enter N/A and put the date on which they attempted to complete the screening. In the notes, they can document the member refused to complete the PHQ-9 so that the info is available to the MCO during audits.

On the HAP portal, when a partner completes a HAP and sets the time for the 90 days. The time seems to start on the date of the member's signature. Is this the actual date being used to start the 90 day clock or is it the date the HAP was entered in the system?
It was previously connected with the signature date but is now using the actual submittal date.

Because of COVID, it was difficult to get some items that were listed in the HAP. When clicking 'N/A due to COVID', will this be acceptable for partners in the audit?
All partners are working under extraordinary circumstances and MCOs understand that partners are only able to get certain information. MCOs only ask that partners get as much information as they are able to. Even getting approximations will be useful. Any attempts to obtain information should be documented as well to show best efforts.

Getting physician signatures is difficult at this time due to an increase on COVID restrictions. When these people are not present, how do providers get a signature?
There is no requirement that the physician be physically present when the HAP is completed. The signature is documenting that they have looked at it and are in agreement with it. There may be a variety of ways to obtain the signature, such as a virtual signature.

A large number of providers are not physically in the building. Would MCOs accept a progress note that indicates the plan was reviewed, assessed and signed?
A progress note would be acceptable for this. There just needs to be acknowledgement that the HAP was reviewed and the provider agrees with it.

MEMBER ENROLLMENT & ROSTERS

Is there a way the MCOs can let partners know if there is no one on their roster?
All contracted partners receive communication from each MCO in the form of a blank roster or an email stating they do not have any members opting in for that month.

Will OCK Partners receive a listing of members who received letters inviting them into the program.
MCOs will only share a listing of invited members with OCKPs who have an existing relationship with said member. They will send these out on a monthly basis.

What happens if I don't receive my rostser?
If you have not received your rostser by the 20th, reach out to your MCO.

How do the MCOs determine who is eligible for the program?
MCOs look at claims from all potential providers to identify diagnoses. This includes looking at all the diagnosis codes, not just the primary diagnosis on a claim. If there is a member that the OCK Partner thinks may have been missed, they are encouraged to send in a Referral Form and include any additional information that might help make a determination.

The member I am helping lost their letter. Can they get a new one sent to them?
The member can get a new letter sent to them by calling the MCO with this request. The partner can also email the MCO with the members name and Medicaid ID and a new letter will be issued.

How many people have opted into the program?
As of the May enrollment, there are 322 total members enrolled in OCK.

What is the best way for a member to opt-in if they have lost their invitation letter?
During the current public health emergency, members may opt-in by calling their MCO member services number and opting-in over the phone. OCK Partners can be on a three-way call with the member to help with

the process, but the member has to be there to opt-in, an OCK Partner cannot opt-in a member on their behalf.

If a member loses their invitation letter, can the OCK Partner use the generic version of the letter and update it for the member?
The best thing to do if a member loses their letter is to have them call the MCO and request a new one be sent out to them. Members can also just call in and opt-in over the phone without having a new letter sent to them.

What do I do if a member is on my attribution list but I am unable to reach them or they do not want to participate?
You do not need to do anything if the member has not opted into the program. Members who have not opted-in will receive invitations in the future to engage at a later time.

What do I do if I call into the MCO with a member and the MCO representative doesn't know what OneCare Kansas is?
If this happens, please reach out to the MCO using the designated and appropriate MCO email address.

Is it possible for member addresses to be included on attribution lists?
All MCOs will start including member addresses on attribution lists.

Can a member's qualifying diagnosis be included on the roster?
Due to privacy and HIPAA concerns, a member's diagnosis cannot be included on the roster. If you need this information, please reach out to the MCO.

Why does a member still show up on a partner's roster if they have opted-out?
If they member opts out, they would still be eligibile for services for the following month. They won't be removed until services are no longer available. Additionally, a member must complete paperwork or call their MCO to opt out of the program. Until they do that, they will continue to show up on the partner's roster.

Is there an option for a member to get a call back if they are trying to opt-in on the phone, but don't have time to wait?
You can email the MCO and they can have a representative make an appointment to call the member. It can be a 3-way call if desired.

An adult client with a guardian opted themselves into the program without the guardian knowing. Who needs to opt the member out?
If the guardian is responsible for making legal decisions, the member shouldn't have been opted into the program with just their own consent. This would be an invalid opt-in. If the member has the authority to make these decisions on their own. They do not need to be opted-out.

In KMAP, the flag for a OCK member has changed from "OCK" to "health homes", is there a reason for this change?
"Health Home" is the federal name for the program that we branded OneCare Kansas. The change should not impact a members' eligibility at all.

Partners are assisting members with opt-ins, but then the member is assigned to a different partner. What is the proces for ensuring that the correct partner is assigned?
The member is ultimately the one who makes the choice of which partner they will work with. There was a small glitch with one MCO, but that has been taken care of. The MCO makes a partner suggestion by looking at the most recent claims or referralls.

Do all three MCOs accept signed letters via secure email/fax?
Yes, you have this option with all three MCOs.

How many people have opted into the program?
As of the August enrollment, there are 706 total members enrolled in OCK.

Do all of the MCOs have the same process for opt-ins?
Yes, the MCOs have tried to streamline this process as much as possible and keep it consistent between all of them.

FORMS and DOCUMENTATION

What is the difference between the referral, refusal and discharge notification forms?

- Referral Form- This form triggers the MCOs to search the member's health records to see if a qualifying diagnosis is present. If there is a qualifying diagnosis, the member will be invited to join the program.
- Refusal Form- This form is used when the assigned OCKP either cannot or will not provide services to the member. The member is still eligible to be in the prgoram.
- Discharge Form- This form is used when a member has lost eligibilty for the program.

Should the Discharge Form be completed if a member is not eligible due to spend-down?
Members in unmet spend down are ineligible to receive services until the spend down is met. OCKPs can consider suspending services so that a new assignment is not needed when the member becomes eligible.

If partners are working with new members, is a landlord a covered entity of is an ROI needed?
The landlord is not a covered entity. A ROI would be required.

What do I do if I contact a member who opted-in but they no longer wish to participate in the program?
The OCK Partner can submit a refusal form to indicate the member does not wish to work with them. This maintains the member's eligiblity and allows them to choose another OCK Partner (or not) to provide services. The refusal form will trigger the removal from the organziations roster.

What do I do if a member wants to opt-out of the program.
Please direct the member to call the MCO and opt-out of the program.

If a member is not engaging, making it impossible for a partner to update their treatment plan, will the partner be docked or penalized?
Make case notes about trying to reach out to the member. If the member hasn't participated for 2 consecutive quarters, they will be dropped. Providers will not be penalized.

REFERRALS

If a referral letter is sent in for a member, what is the standard turnaround time to get them enrolled?
When a referral is sent to the MCO, the MCO will verify that the member qualifies for the program. If the member qualifies, they are sent a letter. The amount of time this takes varies based on the information the MCOs have.

Is there a way that the process of sending the letter of acceptance could be faster?
The opt-in must come directly from the member by mail or, during the current public health emergency, by telephone. Providers can call in with the member to assist but cannot opt-in on the member's behalf.

In circumstances where hospitals refer members, will the hospital receive a confirmation that those members qualified?
Whenever possible, MCOs will respond to referring parties to acknowledge receipt of a Referral Form. However, due to privacy considerations, only contracted OCK Partners will be notified if a member has the appropriate diagnosis/diagnoses to warrant acceptance into the program.

Can you provide examples of supporting documentation for diagnoses to help with the referral process?
Any documentation that will help support the diagnosis is helpful.

If an OCK Partner is having issues with referrals and wants to get in touch with the MCO contact, who do they reach out to?
You can reach out to the MCOs by emailing them at the address listed on the referral form.

When is the best time to use a referral form?
If an organziation has reason to believe that a client/patient may be eligible but has not received a letter or lost their invitation letter, please send a referral. There is no penalty for sending a referral for a member that may have received an invitation letter.

Are hospitals required to send in documentation with referrals?
Hospitals are not requried to send in documentation with referrals to support program eligibility. If they have the information readily available to support the referral process, they can send it, but this is not required.

Some members frequently visit the ER. Are hospital emergency departments required to send a referral every time they see them?
Many of the members they see are already qualified to participate. If the member is enrolled and the hospital has access to KMAP, there is a flag indicating the member is enrolled. If a hospital has documented that a referral has already been sent, it is not necessary to send another referral.

TRAINING

What do I do with my training documentation?
Partners should keep their certifications and/or attestations from trainings and it will be reviewed during the audits. Training requirements will also be reviewed during a future learning collaborative.

How do we register for the learning collaborative or get information on how to register for this?
As a reminder, the Learning Collaborative is a required activity for all contracted OCK Partners. WSU is currently using the contact information for the person on the provider application to make these announcements. If this is not correct, mail vanessa.lohf@wichita.edu with the name of the person you would like to be designated to receive notifications for your organization. Vanessa will forward an invitation to allow you to get registered for the event.

Is the Care Coordinator training recorded?
The training is recorded, and the link will be included in the information being sent to partners. WSU reminded the group that the training is not required and will be offered again live (virtually) in the fall to allow new staff to actively participate.

HEALTH RISK ASSESSMENT

Where do partners review the Health Risk Assessment (HRA) that is to be done for MCOs?
MCOs will not complete an HRA for all members. To check if an HRA has been completed please contact the MCO.

What is the difference between the Health Risk Assessment (HRA) and the OneCare Health Assessment?
The HRA is a tool that some, though not all, members may have on file with the MCO. The OneCare Health Assessment is a tool that OCKPs should consider completing as part of the Health Action Plan development. The OneCare Kansas Health Assessment is recommended, but not required. For more specific guidance please see: https://www.kancare.ks.gov/docs/default-source/providers/ock/onecare-kansas-health-assessment-guidance-for-onecare-kansas-partnersa6f72e54f5e56149804cff0000ec1706.pdf?sfvrsn=aa124f1b_4

What do I do if I cannot get the diagnosis for my member?
Please contact the MCO if you are having difficulty obtaining a diagnosis.

FOSTER CARE QUESTIONS

What do I do if I have a foster child on my roster whose address has changed since they were assigned to me?
If the child's address change has caused them to fall outside of your service area, please contact the MCO for guidance and/or to ask for a reassignment of the child.

Who determines whether or not a youth in foster care will be opted into the OCK program?
The foster care contractor determines whether or not the youth would be a good fit for the program.

SERVICE PROVISION

How do we handle members who have been admitted to a Psychiatric Residential Treatment Facility (PRTF)?

OCK Partners should be delivering Comprehensive Transitional Care, similar to if a member is admitted to a hospital, to assist the member in transitioning back to the community. However, while the member is admitted in any institution (PRTF, nursing facility, incarcerated, etc.) they are ineligible for services. Services can resume after the member is discharged.

Can a member receive Targeted Case Management (TCM) through a waiver and receive OCK services?
CMS views TCM and OCK Care Coordination services as duplicative. It will be up to the member to choose which service they would like to receive.

If a member chooses to participate in OCK, do they lose case management through the MCO?
No. MCO Case Management continues and is not affected by enrollment in OCK.

When working on discharge planning with an individual in the hospital, when can partners bill for OCK services?
Partners should be billing once the member is discharged back in the community.

I was under the impression that Comprehensive Care Management could only be provided by medical providers. In the program manual, it says anyone but the peer support specialists can provide this service. Is that correct?
There is a table in the program manual that has a crosswalk to indicate the type of professionals who can provide each service (beginning on Page 9). In this case, any of the required professionals (which excludes Peer Support Specialists) can provide comprehensive case management.

Field staff have reached out to clients who are not engaging, and they are not interested in OCK. The manual indicates that programs cannot discharge a client unless they have not been engaged in 2 consecutive quarters. What constitutes as "client engagement"?
If staff reach out to a member and the member refuses to participate in services, this does not count as "client engagement". (This is different than a member missing scheduled appointments, for example.) It is recommended that the provider document these discussions for auditing. It is ok to counsel the member that they have the option to opt out if they do not wish to participate.

What should the process look like after the 6-month period of a member not engaging?
After two consecutive quarters, if the member is still not engaged, the OCK Provider can complete a Refusal Form and may be asked to submit documentation. It is important to note that unless the member has opted out, the MCO will then re-assign that member to a new provider.

Do the MCOs still have value-added benefits?
Yes, you can find these documents by visiting their respective websites.

Can OCKPs use Zoom for OCK services?
Use of a secure video platform is acceptable in addition to telephonic services.

QUALITY & REPORTING

When reporting the capacity that an OCK Partner has for OCK members, is it okay to answer with an overall capacity number?

When reporting your capacity, please report it per MCO. You will be asked to update this number monthly and we realize it will most likely be changing month to month. If you have more specific questions about this, please contact Samantha Ferencik at Samantha.Ferencik@ks.gov.

COVID 19 RELATED

How should OCK services be provided moving forward due to the lifting of restrictions across the state?
Partners are allowed to continue to provide services via a telehealth format, but it is not required. This will continue indefinitely. Partners are encouraged to use their best judgement for each case to determine the best strategy for delivering services in a way that is safe for the provider and the member.

COMMUNICATION

What information has gone out to the primary care network about OCK?
Some information has gone out to the primary care providers regarding OCK. This is a topic the team will continue to discuss and report back to partners.

OCK AUDITS

In the manual, in Appendix C- Section 3.1, it mentions a member survey. Who is responsible for doing this?
Details will be forthcoming on the survey, for the 2020 fall audit, providers will not be audited on this component.

Do all members need to get their LDL checked?
This only needs to be done if it is clinically indicated. For more guidance on this, please visit this link to the CDC, https://www.cdc.gov/cholesterol/cholesterol_screening.htm.

Is referring a member to KanQuit considered an acceptable smoking cessation service or does this have to be a service provided internally?
Referring the member to someone that could help them quit smoking is acceptable. If your staff/organization has this capability, you can utilize that, but it does not have to be internal.

In looking at the Audit Tool on the OCK website, Section 6 (Member Recruitment) indicates the need for MOUs with local physicians and hospitals for recruiting members. Do partners need written documentation of communication with other providers?
OCKPs don't need to document every communication they have, but if there are MOUs, they should be available for the auditors.

All the different MCOs will be doing separate audits. Is there a reason this cannot be done in one audit?
The MCOs have all contracted with Averify for the program audit. This is done in a single meeting that includes all three MCOs. The member portion is completed separately to protect member privacy. These meetings are completed either virtually or via email and are expected to be limited to one hour.

Will organizations be notified ahead of time on which members will be audited?
Yes, MCOs will let organizations know ahead of time which members will be audited.

Is there a list of documents organizations need to have during MCO audits?

Yes, MCOs will let organizations know which documents will be needed for the member audit well in advance of the meeting.

On the audit tool, it mentions updating the HAP in the case of certain circumstances. What needs to be updated on the HAP, and how should it be noted in the HAP?
Look at items such as medication reconciliation and capture any hospitalizations and transitions. If there are no changes necessary, document this as a note in the HAP to indicated that these things were considered.

Are there any resources to help partners prepare for the audits?
On the OCK website, there is an audit tool, https://www.kancare.ks.gov/docs/default-source/providers/ock/ock-partner-audit-tool.pdf?sfvrsn=ed3d4f1b_8 and an overview of the audit tool, https://www.kancare.ks.gov/docs/default-source/providers/ock/overview-of-the-ock-audit-tool.pdf?sfvrsn=387e4f1b_4 to help assist partners with the audit process.