Kansas Senior Task Force

HCBS, Rebalancing Kansas, Senior Day Care

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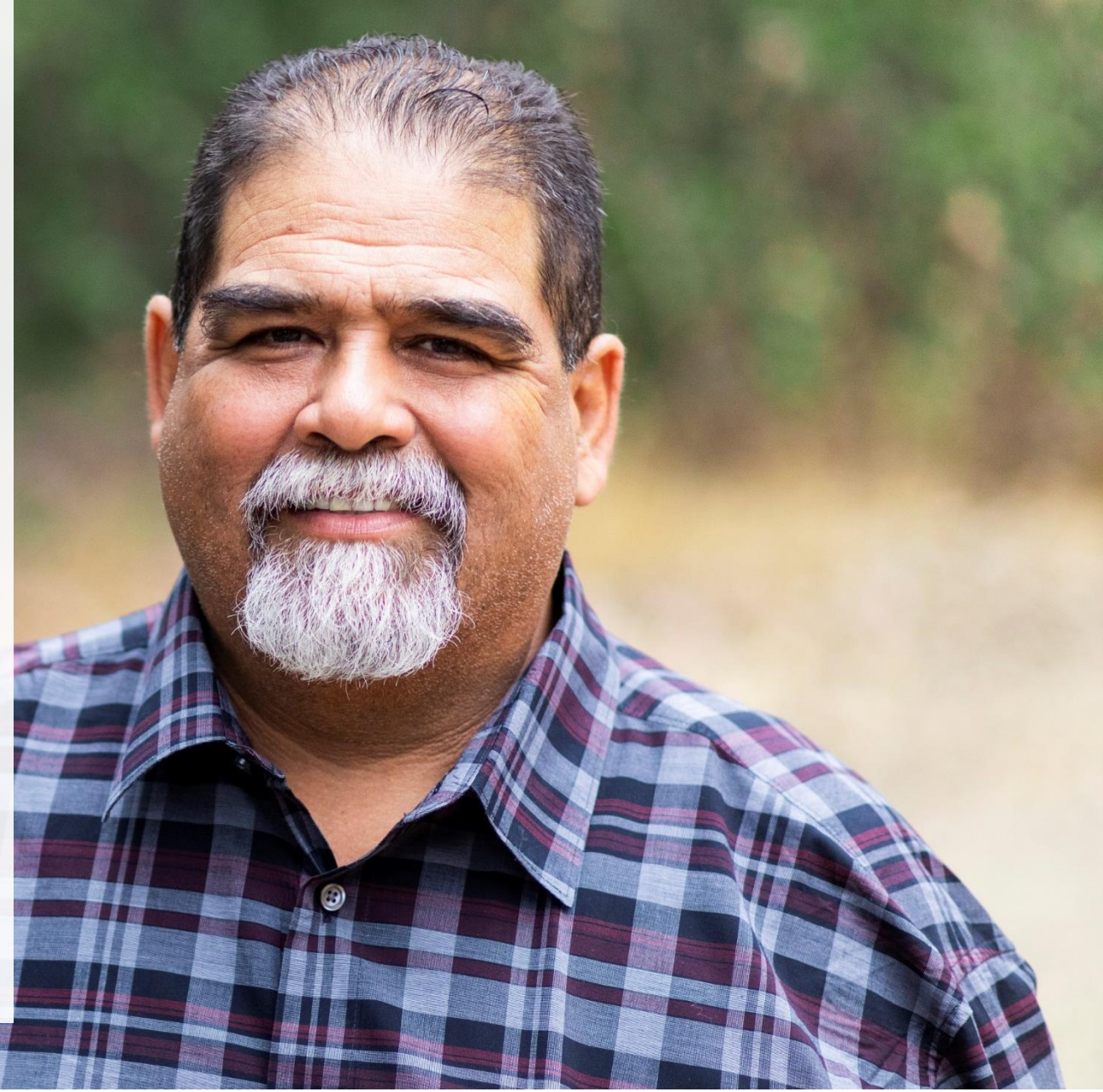
KanCare

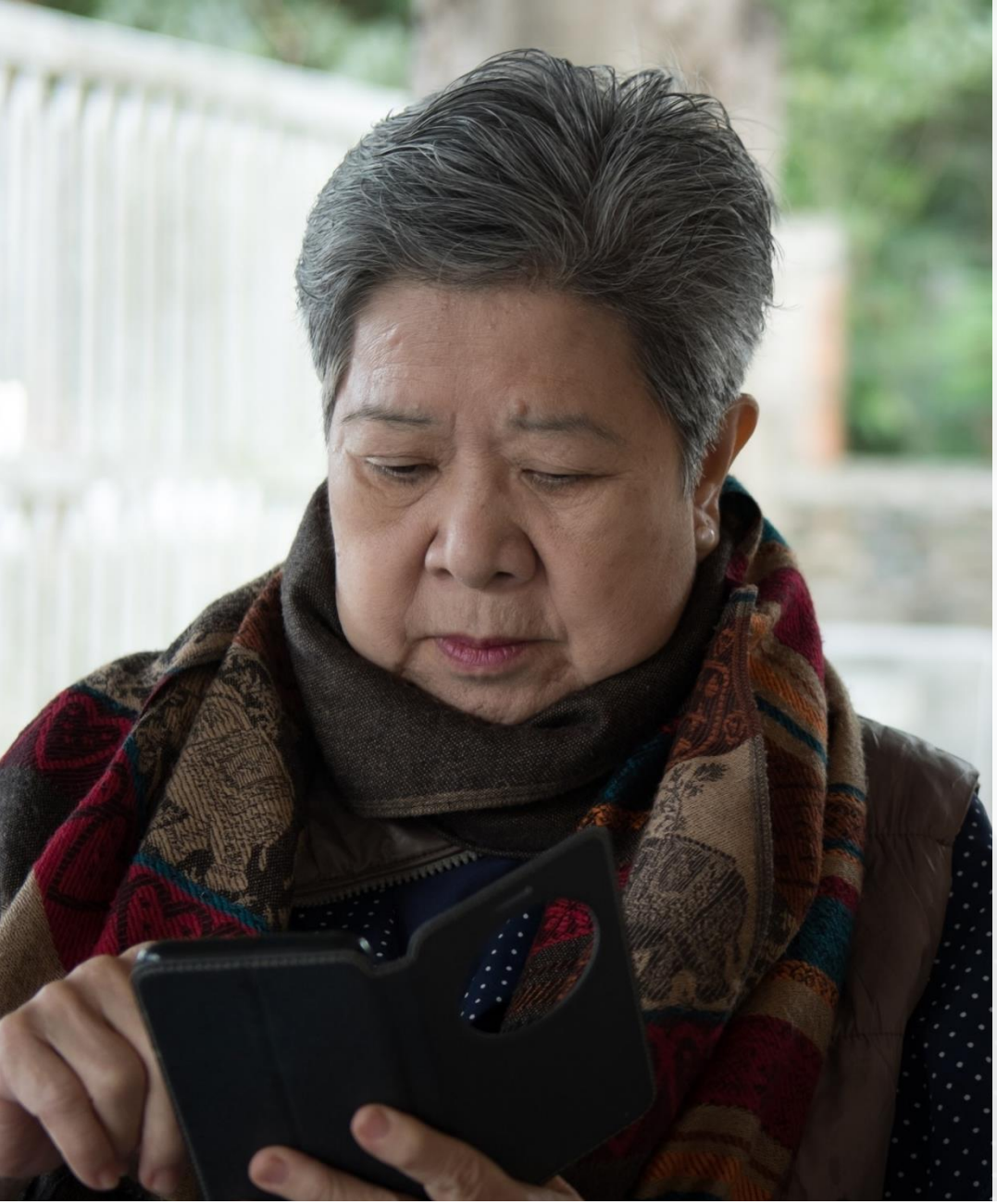
Home and Community Based Services

Aetna encourages and supports members to move to the community through our comprehensive Transition Program.

We continuously review our processes to improve our Transition Program, ensuring members are offered the option to receive services in the community, and community supports and services are adequate to meet member needs.

Supported 101 members to successful transition to the community in 2021.





Transition Program for Members

Aetna Service Coordinators:

- Are assigned to specific facilities, building relationships with staff, social workers and discharge planners
- Build relationships with members and facilitate conversations about member goals and interest in community options
- Identify members interested in moving to the community and provide intensive care coordination, communication, support and assistance to arrange services for members, caregivers, and providers through the transition period
- Have found alternative ways to communicate frequently and stay connected with members, families and providers
- Collaborate with members to develop a timely Person-Centered discharge plan and coordinate care, greatly reducing risk of readmission
- Assess members to determine the amount of support needed for the member to safely reside in a community setting, existing and available formal and informal supports, met and unmet needs, life planning and interest in community involvement
- Have partnered with community providers to help members access housing and community resources, accessibility assessments, setting up utilities, and purchasing start up housing items

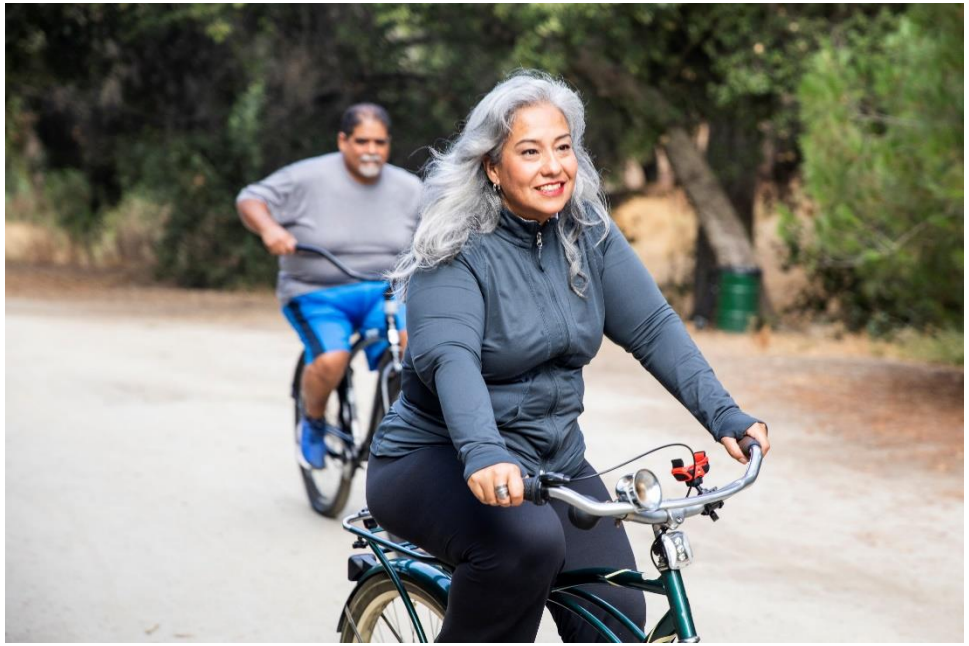
Rebalancing Kansas

The Aetna Long Term Services & Supports (LTSS) team monitors the number of LTSS members residing in a community setting vs. members residing in a custodial setting. Our Target goal is to support 70% of LTSS members to reside in a community setting.

Aetna Service Coordinators:

- Work with members to develop person-centered service plans that include interventions to support the member in achieving their goals
- Collaborate with Systems of Care transition, housing and employment experts to ensure full system access to community options
- Facilitate the safe transition of members between care settings by providing care coordination, communication, support and assistance to arrange services as the members needs change
- Comprehensively reassess member's needs and the appropriateness of the existing service plan post-transition

The pay-for-performance structure communicates the importance of rebalancing for Kansas and provides the MCO direction on prioritizing efforts and initiatives which match and work to improve the State's performance and the quality of care provided to Kansans.



Network Adequacy Task Force

The Aetna LTSS team works collaboratively with our Provider Relations team to identify and address workforce shortages that may impact network adequacy.

To mitigate risk to our members in need of services, we have implemented a Task Force to tackle hurdles related to workforce shortages.

These include:

- Weekly Network Adequacy Task Force meetings to review areas of Kansas that are, or may soon be, impacted by workforce shortages and develop strategies to reduce impact to our members.
- The Task Force identifies providers who are unable to accept referrals due to staffing shortages.
- Our Provider Relations team subsequently outreaches to these providers to discuss workforce concerns and offer support and review possible solutions.
- Out-of-Network provider alternatives are also explored, if necessary, in addition to leveraging single case agreements for enhanced rates when necessary.
- Regularly monitoring claims to ensure payments are timely and accurate.
- Reviewing our internal processes to ensure that we are removing unnecessary administrative hurdles for our providers.

Service Utilization and Member Support

Aetna Service Coordinators closely monitor service utilization to identify potential gaps in care.

- The Aetna LTSS team developed an HCBS utilization report that alerts the team when members go 30+ days with no utilization of HCBS services. The report is analyzed monthly by leadership and shared with the Service Coordinators, so barriers can be removed before members face them, ensuring easy access to services.
- Aetna Service Coordinators provide education to member on all service options, including self-direction, agency directed care, or a combination of both, to meet member's needs and goals.
- Flexibilities under Appendix K are also being offered to address care needs, allowing family members to be paid to provide supports.


Questions?