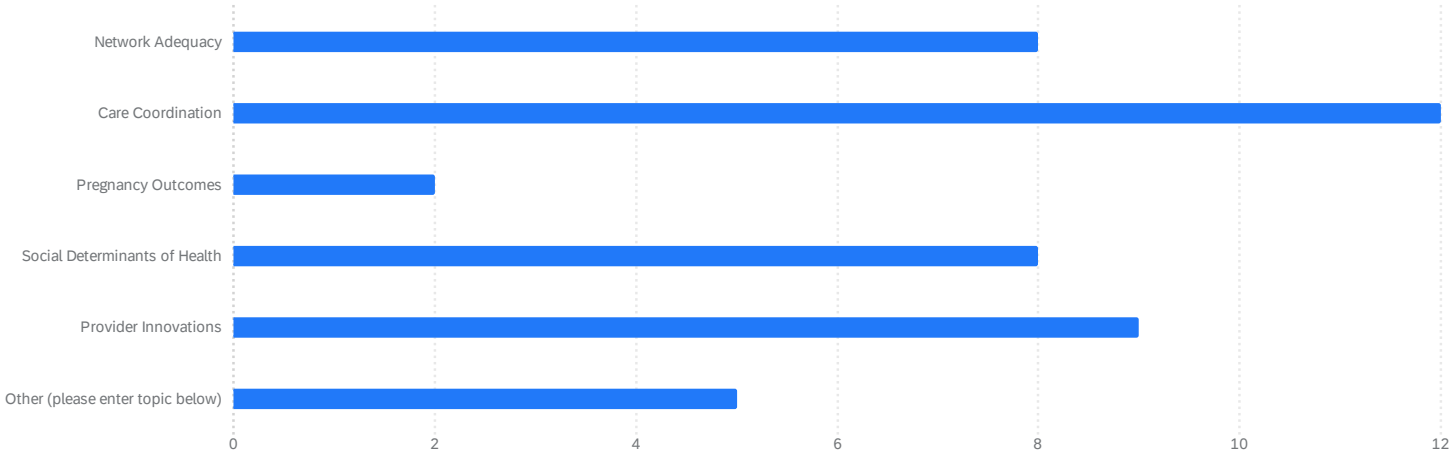
Responses: 29

Please select the topic(s) you are most interested in discussing during the discussion forum. Select up to three topics. 18



Please select the topic(s) you are most interested in discussing during the discussion forum. Select up to three topics.: Other (please enter topic below)

Medicaid Expansion

Prior Authorization

Restoration of Case Management for the FE, PD & BI populations

workforce and potential duplication of work

Based on your experience, what issue most needs addressed regarding KanCare?

Standardized prior authorization processes among all MCOs. More medication options available before getting prior authorization. Care Coordination - let providers manage this in-house with a CHW or nurse, or at least give them this option. MCOs are currently doing a terrible job at this. Improve access to behavioral health, especially finding ways to access specialists (telehealth)

social determinants of health supports, specific to rural communities

Readiness to assume risk and follow-through with contractual provisions. Under the readiness review, practices and policies will illustrate the ability to meet the obligations to the state, providers, and members. Additionally, the review will also discover how deficiencies will be mitigated while causing no harm to provider capacity and members.

The re-certification of current recipients.

Racial and ethnic disparities/ health equity

Transparency The State of Kansas must improve its ability to access, interpret and publicly share data from the KanCare model. Further, Kansas taxpayers deserve to know how state funds are being utilized by contracting managed care organizations as well as the amount of those funds being taken out of the state in the form of profits or administrative reimbursement to these large corporations. Web-based dashboards and similar technology that would improve transparency in KanCare would impose no new costs on the state budget and no significant administrative burden on either the MCOs or the state agency. Accountability The KanCare model lacks governance that reflects the populations it serves. Future iterations should adopt representative governance in order to ensure that all elements remain focused on achieving the identified outcomes for populations served. Strategies to improve Accountability in KanCare should be explained and offered to stakeholders early in the engagement process. Quality of care standards, types of compliance data the state will use, and the state's monitoring strategy should be reviewed, revamped, and vetted publicly. Oversight The State of Kansas must exercise greater control over managed care organizations. In order to do so, operating agencies must develop the required capacity to adequately manage their vendors. The bifurcation of oversight responsibilities between KDHE and KDADS has also caused difficulties and communication and coordination between these two entities must be improved in order to better manage the KanCare model. Modernization The IDD service system has largely been frozen in place since its inclusion in KanCare. The next iteration of managed care must encourage the exploration and adoption of innovations occurring elsewhere in the United States. For example, value-based reimbursement models, in widespread use in other states, have yet to be incorporated in any significant manner within the Kansas IDD system. Value-based reimbursement models could yield substantial benefits in the areas of employment, behavioral health and preventative health care for the IDD population. Further, better incorporation of technology as well as more holistic service models, could provide greater efficiencies while also better meeting the needs of persons served. Unmet System Needs Long-standing issues, such as transportation and housing, will continue to be barriers to inclusion for the IDD population until they are adequately addressed. Further, access to behavioral health services, dental care and some types of preventative health services still remain unresolved for many Kansans with IDD, despite a decade of KanCare. Managed care organizations are uniquely suited to addressing these types of systemic issues and should be compelled to produce positive outcomes as part of the next iteration of Medicaid managed care. Reinvestment Rather than allow for millions of Kansas funds to leave the state each year, the State should compel managed care organizations to engage in significant reinvestment in our communities for the purpose of addressing systemic barriers for populations served by KanCare.

Physician/provider reimbursement and prior authorizations

Prior authorization as a tool utilized to deny care.

Not having Medicaid providers in rural areas and in the metro. This is especially true of specialty care and mental/behavioral health. Messages need to be more consistent within MCOs and KDHE so training needs to be extensive so clients aren't getting different answers for questions. There also needs to be more accountability that patients' needs are being met. Case management needs to provide more cohesive services instead of referring clients out or providing a warm hand off when connecting with outside services as well as conducting regular follow-up with clients. MCOs need more access to Clearinghouse information and capabilities so they can answer questions regarding renewals, due dates, updating information, eligibility verification, etc.

Training for MCO case workers on how the system works - meaning giving choice - appropriate amount of hours for consumers - knowledge on how the system works for the MCO's

Strengthening options for vulnerable Kansans to remain in their home with long-term care supports and services.

The contracting and credentialing process has been a challenge since the privatization of KanCare. The administrative burden is too cumbersome and this creates financial challenges for providers. There would also be a benefit if MCOs help to support or place personnel in a health center/clinic setting vs. hiring duplicative case managers, nurses, etc. who may not have as strong of an relationship with members that the on the ground providers do have.

How MCOs will enhance the provider network so that people in all areas of the state can access critical healthcare services, including specialized medical services and therapies.

Network Adequacy, accountability, remove conflict of interest with care coordination

What ideas do you have for addressing the issue you identified?

Let practices have the option to provide care coordination in house with a CHW or nurse and allow them to bill for their time. Male more common medications available without prior authorization. Make all MCOs have the same process for prior authorizations so it's not a guessing game each time. Mental health co-located in clinics where possible. Behavioral health specialist available via telehealth.

broader transportation destinations, health education supplies and incentives, childcare and housing support, care coordination services

Demonstrating ability to assume risk by identifying and implementing quality metrics from stakeholder and member feedback in addition to federal and state requirements; Communicating efficiencies to ensure validity and reliability and potential replication; and Organizing care coordination in a manner that is result-oriented and person-centered to ensure delivery of services, and not just access;

Ensure people are given an opportunity to present their eligibility status

addressing social drivers of health, disaggregating and reporting on disaggregated REL data

InterHab will advocate for national best practice MMC contracting standards.

Make Medicaid reimbursement at least equal to Medicare reimbursement. Minimize and simplify the need for prior authorizations as this takes significant time away from actual patient care by the provider and entire care team.

Put strict timelines for MCO's to respond to emergency, urgent, and chronic care. Modernize the process to require it to be electronic. Eliminate prior authorization for birth, and emergency transportation.

More training, higher provider reimbursements, reduced provider paperwork, increased pay to workers, better communication from the top down, stronger relationships with community partners. MCOs allowed more access to Clearinghouse data.

Training, training and training for MCO staff

Restoring case management to the HCBS FE,PD, BI populations. In 2013, these Kansans lost case management services and in doing so lost the professional assistance that best represented their best interests and wishes.

centralized team to complete the contracting portion of state Medicaid approval work and centralized team to address credentialing portion. MCOs are required to house a % of staff on the ground level vs. housing in administrative buildings not located in the areas being served.

1. contractual requirements documenting actual community provider partnerships; 2. contractual requirements for provider incentives - examples: training and certification stipends, payment rates above Medicaid/Medicare set amounts, licensing support 3. requirements for MCOs to provide health insurance to "expanded" populations by creating pools for free or subsidized health insurance through their companies

Reduce barriers to attract providers, increase reimbursement rates with administrative caps. fiscal impacts for providers who do not meet plan of care needs with personal care attendants and nursing. Have 3rd party individuals determining needs

In your opinion, what is the most important issue that needs to be addressed for beneficiaries on KanCare?

Access to care

Appropriateness seems to be an important issue related to choice of provider, person-centered plan of care, model of care, and service delivery.

The prime issue is the absence of Medicaid expansion

access

Disaggregated service data, outcome data, and cost data must be available to meaningfully compare plan performance and advocate for system improvements.

Payment for things that affect social determinants of health—transportation, food, housing, mental health, education.

They need to have access to the right care at the right time.

Case management - working with the client until issues are COMPLETELY resolved and providing regular follow-up especially if they are having issues with services or accessing providers.

Choice and appropriation of realistic hours for care

That they receive quality person-centered care in the setting of their choice.

The contracting and credentialing process has been a mess for so long. It could be low hanging fruit to resolve. Connecting with members and better communication about overall outcomes reporting out and looking at data based on demographic data.

People need to actually be able to get health care using their KanCare insurance. When the only KanCare providers for mental health services are CMHCs, and those systems are stretched beyond capacity, their health insurance isn't working for them.

receiving the services on their service plan and improved care coordiantion

In your opinion, what is the most important issue that needs to be addressed for beneficiaries enrolled in KanCare?

What idea(s) do you have for addressing the issue you identified?

Increased transportation, community paramedicine, and health support in homes (both treatment and infrastucture)

There needs to be a solid understanding of person-centered care. Without a full understanding of the importance of this philosophy, a plan of care is inadequate, and service delivery is adversely impacted. Training is vital to start the process, but there needs to be a consistent practice of delivering person-centered care, including payment under ILOS to ensure informal and formal supports are inclusive.

State legislators need to support Medicaid Expansion

increased reimbursement rates and innovation

Require the plans to make data available to the State Medicaid Agency, policymakers, and the public.

Shifting resources/funding to cover those issues—would be a financially beneficial investment, possibly preventing ER visits and severe disease.

MCO contracts must provide transparency to the beneficiaries to what procedures require prior authorization, and a clearly defined process for appeals, with an impartial party to review complaints.

Utilize community health workers (CHWs) for case management and increase provider networks.

Restoring case management for these populations by clawing the dollars rolled into the initial KanCare contracts and allowing these Kansans to choose an independent case manager to assist them with care and provider issues.

Establishing one application that is accepted by all MCOs and the state for contracting and credentialing. And keeping a database of materials to minimize the need to constant resending of forms that are not expired or dates are still valid.

see previous comments

increased accountability for providers with incentives when they have 80% utilization rates and penalties when they fall below 70%. Create a way for complaints to be tracked and develop a matrix so if 20 complaints on the same issues that a state level systemic review will occur with course corrections

What changes do you want to see instituted related to transparency?

Data sharing in general

Contracts should require periodic reports that illustrate network capacity, service delivery utilization, needs versus authorization, hospitalization rates and whether admission could have been prevented with timely intervention (i.e. additional personal care, nurse visits, transportation for follow-up post-discharge), setting for service delivery to illustrate choice (i.e. home in the community versus assisted living facility, nursing facility, etc.), and other areas determined necessary to ensure person-centeredness and cost-effectiveness. Reports should be provided to legislators to determine effectiveness or modifications needed and to the public to ensure cost savings are not based on less service delivery.

Companies should provide more performance data File a Public Records Act request and post the performance data disclosed as a result of the PRA on your organization's website.

disaggregated REL data and reporting, performance reporting of MCO's,

Clear and dramatically improved standards for: Risk Contract Management MCO-Specific Medicaid Enrollment MCO-Specific Medicaid Enrollment (Child) MCO-Specific Medicaid Revenues (Total) MCO-Specific Medicaid Revenues (Child) NCQA Accreditation HEDIS Child Metrics HEDIS Maternal Health Metrics EPSDT Metrics

Ability for providers and patients to speak with kancare reps easily—email, phone.

I believe all provider and beneficiary complaints should be accessible in a searchable database to know which MCO's are having which issues on an ongoing basis.

MCO audits should be done by an outside 3rd party to make sure they're truly assisting clients the way they're claiming to and a well pubilicized avenue to make suggestions and file compliants that's actively responsive.

Communication from the MCO's and timeliness in submitting plans of care, knowledge of services and choice

Readily available data for the public. Current data collection is left to the MCO's to gather and share. Not gathered or reported consistently which makes the public suspicious as to how this system is actually performing on desired outcomes.

Need to ponder some.

Financial reporting that shows profit margins for the companies, what the difference is between their capitated rates and what they actually are paying out for beneficiaries. Transparency in their processes for prior authorizations, "value adds", and grievance and appeals processes and outcomes.

Reports about processes, services availability, cost studying, grievances filed, satisfaction surveys posted

What changes do you want to see instituted related to quality of services?

Quality of services is a subjective term, which needs to be defined. If quality means service delivery, there needs to be a substantial change in that services are delivered in a timely manner and according to the plan of care. If a member is not receiving services, then the capitated amount should be reduced or discontinued. If quality means the type of service, that should be person-centered, and not based on the workforce. Too many members are going without services, sometimes up to a year because they are unaware of potential homecare workers, and they do not know who to call, including the KanCare Ombudsman office. There needs to be increased transparency on how services are delivered, by which model, and the reason why services are not delivered.

Anti-racist practices that are culturally appropriate Improved care coordination among departments. Decreased medication administration errors. Improved electronic medical record documentation. Reduced medication-related adverse events. Spanish Speaking services, translation services,

anti-racist, culturally appropriate services

Best practice system improvements for things like elimination of HCBS waiting lists and community based care management. Person centered planning should be truly person centered. MCOs should not control service development. Language in contracts and waivers should be clear and easy enough for consumers and case managers to follow without taking direction from MCO staff.

Coverage of medications and services with minimal prior authorizations. When there are multiple steps and a gap in treatment/care, patients are more likely to forego care leading to worse health.

I want to see quality metrics rated by the beneficiaries and the providers of care to identify when quality cannot be achieved due to MCO requirements.

Improved care coordination and case management

MCO's having enough staff so as not to have such high case loads for services

Better delay and diversion from institutional care for Kansans who desire to remain in their home & communities with supports and services.

consistent measures across the MCOs that are reported consistently from all organizations. Ensure there is a focus on data that can have a positive impact on outcomes of populations most impacted by SDOH

Care coordinators should have caseloads limited/capped, or the companies should be required to offer people options to "purchase" actual, meaningful, supports coordination services

consumer survey evaluations completed by an 3rd party entity

What changes do you want to see instituted related to access to care?

Access doesn't necessary equate to service delivery. There needs to be more accountability when a member is not receiving services. I think the change to be instituted in this area is that members have appropriate and person-centered services delivered, because they already have access when they are found functionally and financially eligible.

Increased reibursement rates, get more doctors to accept medicaid

increased reimbursement rates, more services included

Use technology like GIS mapping and Tableau to provide up to date information directly to consumers to improve access and ensure provider directories are as accurate as possible.

Better reimbursement for physicians/providers. Providers can't keep their doors open for kancare patients if they get paid less than what their expenses are for a patient visit. Also Funding for transportation.

I want to see more robust plans for transportation challenges related to getting care.

Higher provider reimbursements and administrative burden to providers

Case management services offered to persons upon eligibility determination.

Access to transportation services needs to be improved. MCO provider relations communication seems to have become a challenge with frequent turn over. When providers have questions that impact access to care it is difficult to resolve when points of contact are not known or connections are not strong.

It needs to be improved in every respect.

easier access, more options, streamlined process for all MCO's. online and update to date list of service provider openings, database of available PCA and nursing staff.

What changes do you want to see instituted related to health equity?

If referring to the definition of "the attainment of the highest level of health for all people," then waivers must be reviewed for equitable services. Providers must be paid appropriately, and costs must be relatively equal. Members receiving services must have services based on goals and potential of reaching optimum health, which will required consistent coordination with specified health outcomes.

Need more doctors to accept medicaid patients

disaggregated REL data, SDOH reimbursable services

Data should be disaggregated by race, gender, and ethnicity. Gap analysis should result in projects and funding to target areas of low plan performance.

Focus on rural health equity in addition to racial equity. Need more access to resources and providers in rural areas.

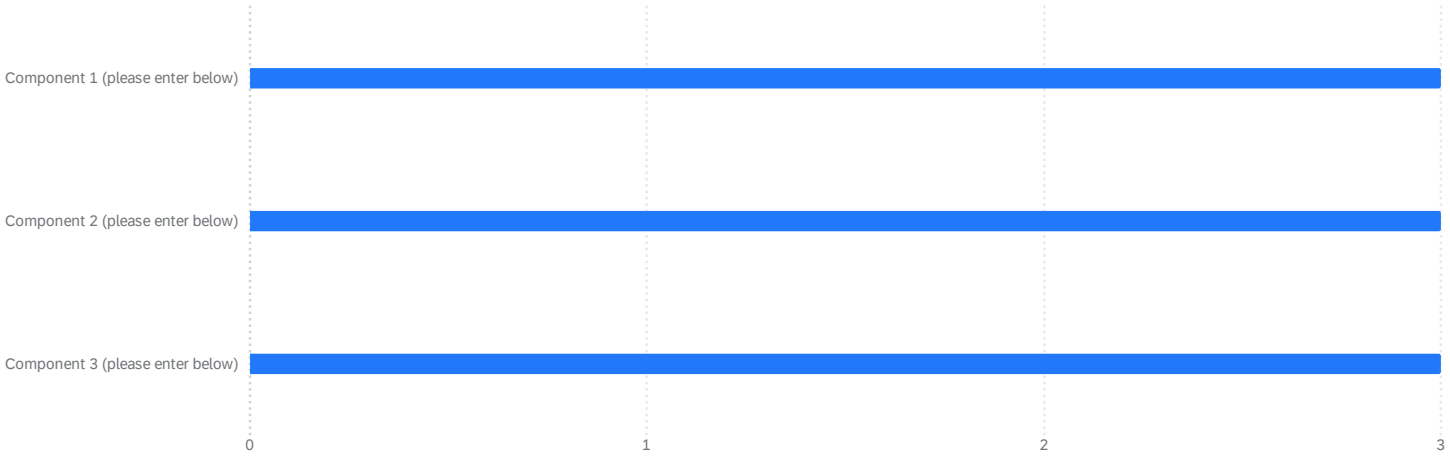
Have more workers that speak the languages of the clients they serve and/or go out of their way to provide communications in appropriate languages. Required trainings for ALL employees about race/ethnic discrimination, specifically around unconscious bias along with adjusting internal policies to reflect racism as a public health issue.

Same response. The I/DD population retained case management was that a mistake? Why wouldn't we allow other service populations to have similar services.

utilization of staff already employed by health centers who have strong relationships with patients could be helpful. MCO could fund this staff to support operations and help to meet health outcomes.

Again, better network development and support for health care providers, particularly in areas where racially marginalized people are clearly disadvantaged. Examples: 66604 zip code and the maternal/infant mortality rate - concentrate on cultivating maternal and child health care providers in this specific zip code and surrounding area and then help address the causal issues such as smoke exposure and overcrowding in housing and sleep health. The same is true with addressing things like Congenital Heart Failure and diabetes in the Black and Native communities in the state. In the current system people cannot even get CPAP supplies to help keep the equipment they need that would help address associated heart issues.

In your opinion, what components of KanCare are working well that should be expanded upon? 3



In your opinion, what components of KanCare are working well that should be expanded upon?: Component 1 (please enter below)

Treatment of obesity

Clearinghouse wait times were better before unwinding

ADRC services

In your opinion, what components of KanCare are working well that should be expanded upon?: Component 2 (please enter below)

Treatment of nicotine addiction

some workers process applications quickly

Functional eligibility process

In your opinion, what components of KanCare are working well that should be expanded upon?: Component 3 (please enter below)

Need better substance/opioid abuse funding

UHC's partnership with outside organizations

Financial eligibility has improved

Please enter your job title or leadership role below.

Executive Director

Program

Impact Strategist

Associate Director

Board Chair, Kansas Academy of Family Physicians

State Legislative Affairs

Program Director

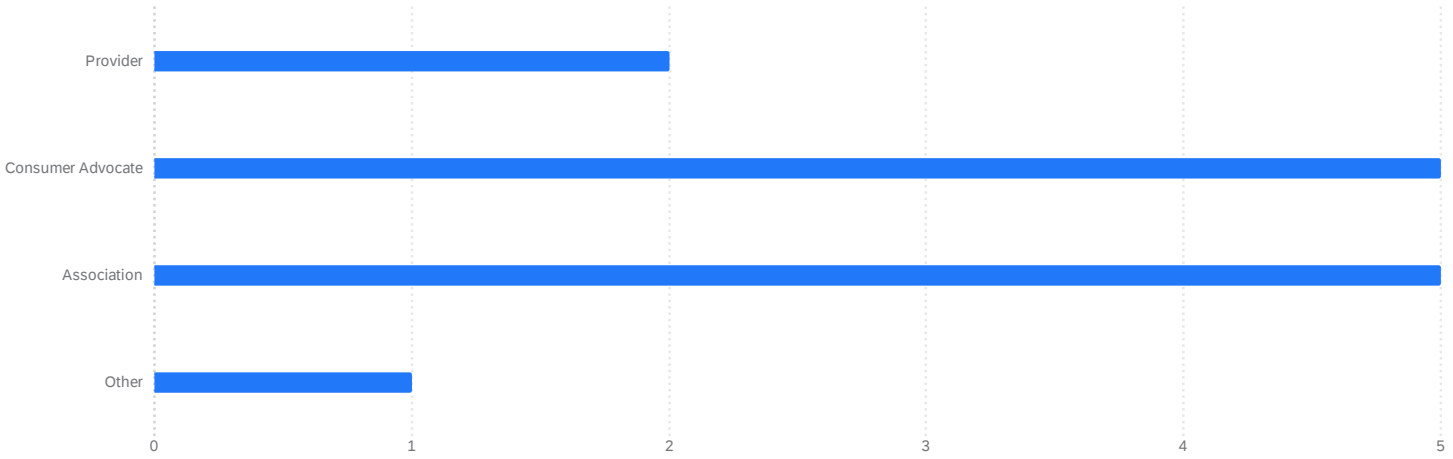
Exec. Director of Payroll FMS provider

Executive Director

Chief Strategy Officer

Executive Director/Attorney

What is your area of expertise related to KanCare (Medicaid in Kansas) 13



What is your area of expertise related to KanCare (Medicaid in Kansas): Other (please enter area of expertise below)

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