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Health Forward FOUNDATION

Considerations for Decision-Makers Regarding the Upcoming Medicaid Managed Care Procurement Process

Introduction

The current procurement process regarding Kansas Medicaid and CHIP (KanCare) Managed Care contracts provides an opportunity to reflect and engage with stakeholders to ensure improved managed care performance and attention to racial and ethnic disparities in KanCare coverage and service provision. This summary includes observations, considerations, and recommendations for the request for proposal (RFP) and KanCare going forward.

Background

The REACH Healthcare Foundation, in collaboration with the Health Forward Foundation, hosted a discussion forum with nonpartisan facilitation support from the Kansas Health Institute on May 10, 2023. Participants included state agency leaders, providers, consumer advocates and subject matter experts who came together to identify and recommend improvements to strengthen managed care performance for children and adults that the State of Kansas could consider when developing the next Request for Proposal.

Prior to the forum, participants completed a survey to prioritize discussion topics and provide suggestions for improvements needed within those areas. The survey results were used to organize the discussion around six topics (presented in no particular order): 1) Network Adequacy, 2) Care Coordination, 3) Pregnancy Outcomes, 4) Social Determinants of Health and Health Equity, 5) Provider Innovations, and 6) Data Monitoring and Transparency.

During the forum, attendees participated in two rounds of discussions on their preferred topic(s). Each group shared observations and recommendations for improvement related to each topic area, which are summarized below along with relevant survey responses.

Discussion and Recommendations

The following section summarizes key issues of concern and associated recommendations for decision-makers to consider and incorporate into the procurement process, RFP evaluation, selection process, and the final contracts.

Network Adequacy

This topic includes, but is not limited to, the availability of providers and services. It also includes goals and measures related to **Network Adequacy**.

Key Issues

Participants identified the following key issues that need to be addressed regarding Network Adequacy:

- Provider reimbursement and payment structure is not adequate.
- There is a lack of availability and access to providers (e.g., specialty care, rural access).
- The contracting and credentialing process for providers is too cumbersome.
- There is a need for better coordination between Managed Care Organizations (MCOs), providers and the communities they serve.

Figure 1 summarizes issues, recommendations and measures related to Network Adequacy for consideration during the upcoming MCO procurement and contracting process.

Figure 1. **Summary of Network Adequacy Issues and Recommendations**

Issue	Recommendations and Measures
Provider Reimbursement and Payment Structure	• Reduce barriers to attract providers by increasing reimbursement rates.
Availability and Access to Providers (e.g., specialty care, rural access)	• Allow the provider network to be expanded to include additional types of providers — e.g., community health workers (CHWs), in-home therapists, doulas. • Enhance the provider network so that people in all areas of the state can access critical health care services, including specialized medical services and therapies. • Consider providing incentives for providers (e.g., training stipends) to assist with recruitment and retention. • Develop standards for MCO monitoring and compliance when network adequacy is not met. • Ensure the provider network list is kept up to date. • Evaluate access to care by measuring and analyzing utilization rates, provider retention rates and timeliness of service(s) provided.
Contracting and Credentialing Process	• Consider standardized credentialing and contracting across MCOs. • Consider a centralized credentialing process. • Consider establishing one application that is accepted by all MCOs and the state for contracting and credentialing. • Consider establishing a database of materials to minimize the administrative burden associated with this process.
MCO Coordination with Providers and the Communities They Serve	• Ensure MCO staff across the state are accessible to KanCare members. • Provide funding for health care organizations to have MCO staff in their facilities across the state. • Obtain more member feedback about network adequacy and what success looks like.

Source: Medicaid Managed Care Procurement Discussion Forum and Pre-Discussion Forum Survey, 2023.

Care Coordination

This topic includes, but is not limited to, case management, the level of support provided for members, access to care connectors/case manager support, and any special considerations for consumers in waiver categories — e.g., individuals with intellectual and developmental disabilities (I/DD), home and community based services (HCBS).

Key Issues

Participants identified the following key issues that need to be addressed regarding **Care Coordination**:

- Access to care, including receiving timely care and the type of care needed, is a concern, especially for accessing specialty care and behavioral health care.
- The prior authorization process is cumbersome and inconsistent across MCOs, which could impact access to care.
- Case management challenges exist in several areas, including the lack of eligibility for these services among some KanCare populations including HCBS, frail elderly (FE), physical disability (PD), brain injury (BI), and children, as well as timeliness, cohesiveness and continuity, and the need for expanded and improved relationships with community partners.
- Improvements are needed regarding service delivery and accountability mechanisms when members do not receive the appropriate services according to their plans of care.
- Improvements are needed regarding MCO staff capacity to serve members in appropriate geographic settings, MCO staff knowledge of services and choices, training, and care coordination efforts.

Figure 2 summarizes issues, recommendations, and measures related to Care Coordination for consideration during the upcoming MCO procurement process and contracting process.

Figure 2. **Summary of Care Coordination Issues and Recommendations**

Issue	Recommendations and Measures
Access to Care	• Ensure that KanCare members have access to the right care at the right time. • Expand the availability of mental health providers to ensure access to mental health services. Options could include making a behavioral health specialist available via telemedicine or encouraging co-locating mental health providers in medical clinics where possible. • Ensure lists or databases of providers accepting patients are up to date and available.
Prior Authorizations	• The State of Kansas should consider: ○ Standardizing the prior authorization process across all MCOs. ○ Ensuring MCO contracts include transparency and accountability regarding the prior authorization process by clearly outlining procedures that require prior authorization, describing the appeals process, and requiring a third party to review complaints.

	○ Establishing stricter guidelines regarding prior authorizations, including the amount of time MCOs are allowed to respond to emergency, urgent and chronic care situations. ○ Minimizing the number of services, medications or procedures that require prior authorization.
Case Management	• Ensure comprehensive case management is timely, person-centered and offers choice of provider. • Case management should provide more cohesive services, including follow-up with KanCare members to ensure their needs are being met in addition to better relationships with community partners assisting clients. • Offer case management for HCBS, FE, PD and BI populations and all children to ensure they receive quality, person-centered care in the setting of their choice. • Use language that is clear and easy to understand for members and case managers to facilitate appropriate care.
Service Delivery	• Enhance accountability measures regarding service quality and delivery among providers and KanCare as a whole. Examples include: ○ The State of Kansas should develop and provide incentives and penalties for providers based on utilization rates (e.g., providers would receive incentive payment when their utilization is at least 80 percent). ○ Develop mechanisms to ensure members are receiving the services they need and better support to assist where needed if they are not receiving services. ○ Track and analyze complaints to ensure state-level review of common issues. • Improve transparency and communication around available services, costs, and complaints, and include the use of satisfaction surveys.
Staff Capacity	• Ensure MCO staff are provided with more training on provider choice and hours of care. • Consider allowing providers to have the option to manage care coordination outside of the MCO (e.g., community health workers). • Reduce caseloads and geographic coverage area for staff across the state.

Source: Medicaid Managed Care Procurement Discussion Forum and Pre-Discussion Forum Survey, 2023.

Maternal and Child Health/Pregnancy Outcomes

This topic includes, but is not limited to, timely access to prenatal and postpartum care, measures for births and maternal health.

Key Issues

Participants identified the following key issues that need to be addressed regarding **Maternal and Child Health/Pregnancy Outcomes**:

- Utilize best practices and pilots around maternal and child health.
- Collect and use disaggregated maternal and child health data to address disparities that exist in this area.
- Incorporate incentives for including safe sleep education in provided services.
- Provide support and referrals for members when postpartum coverage ends.
- Expand and improve MCO partnerships with communities to address maternal and child health needs of KanCare members.

Figure 3 summarizes issues, recommendations and measures related to Maternal and Child Health/Pregnancy Outcomes for consideration during the upcoming MCO procurement and contracting process.

Figure 3. **Summary of Maternal and Child Health/Pregnancy Outcomes Issues and Recommendations**

Issue	Recommendations and Measures
Best Practices	• Recognize and reimburse credentialed members of the health care team such as CHWs, home visitors, doulas and lactation consultants to improve access to culturally competent, quality and community-based care. • Require MCOs to adopt key evidence-based strategies around breastfeeding and postpartum care. • Encourage incorporation of community-based strategies and efforts around maternal and child health care, including pilots that focus on using CHWs, similar to those currently happening in the Kansas City metro area and Douglas County.
Disaggregated Data	• Stratify quality measures and other indicators of interest to Kansas for postpartum coverage extension by race, ethnicity, geography, and language, among others, as recommended by the Centers for Medicare and Medicaid Services (CMS). • Require MCOs to follow the Governor's Commission on Racial Equity and Justice 2021 report recommendation to collect and report Child Core Set measures disaggregated by race/ethnicity and service location for children ages 0-3.
Postpartum Care	• Ensure MCO case managers provide more support and coordination for services and resources to members when their postpartum coverage ends. • Require MCOs to increase postpartum care visits (PPC) through use of incentives, technology (text reminders, etc.) and home visits.

Safe Sleep	• Develop and implement incentives for incorporating safe sleep practices into services provided as unsafe sleep practices are a leading driver of infant mortality.
Community Partnerships	• Language in the 2018 KanCare 2.0 RFP requires contractors to coordinate with Women, Infants, and Children (WIC) Program, local health departments and other Title V programs in Section 5.1.5 (Cooperation with Other Agencies, Page 17). Maintain these references in the next RFP for MCO contract language. • Encourage MCOs to develop partnerships in the community between medical and non-medical entities to promote place-based care, as it is important in addressing social determinants of health and disparities.

Note: For additional key issues and recommendations related to this topic, see Appendix B, KanCare 3.0 Recommendations for Maternal and Child Health submitted by the Kansas Breastfeeding Coalition, Inc.

Source: Medicaid Managed Care Procurement Discussion Forum and Pre-Discussion Forum Survey, 2023.

Social Determinants of Health and Health Equity

This topic includes, but is not limited to, services and resources that should be provided to address social determinants of health (non-medical factors that influence health outcomes). Examples include transportation, education, built environment, etc. Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. According to the Centers for Disease Control and Prevention (CDC), achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Key Issues

Participants identified the following key issues that need to be addressed regarding **Social Determinants of Health and Equity:**

- How KanCare, as a whole, defines and addresses equity and social determinants of health (e.g., transportation, childcare, housing, education, and other supports) for various populations, including racial/ethnic groups, those with disabilities, and those living in rural communities.
- Concerns exist specific to the I/DD population in Kansas.
    - Long-standing issues such as transportation and housing will continue to be barriers to inclusion for the I/DD population until addressed.
    - Access to behavioral health services, dental care and some preventive care remain unresolved for many Kansans with I/DD.
- Lack of integration of CHWs into the care team for those receiving services impacts social determinants of health and equity in KanCare.
- There is a lack of disaggregated data to understand and address disparities.

Figure 4 (page 7) summarizes issues, recommendations and measures related to Social Determinants of Health and Equity Issues for consideration during the upcoming MCO procurement and contracting process.

Figure 4. **Summary of Social Determinants of Health and Equity Issues and Recommendations**

Issue	Recommendations and Measures
Addressing Equity and Social Determinants of Health	• Require MCOs to provide robust plans and support for transportation, childcare and housing, as they impact members' ability to access care. • Encourage MCOs to invest in Kansas communities with the purpose of addressing systemic barriers for populations served by KanCare. • Provide specific additional support and resources for providers in areas where racially marginalized people are more clearly disadvantaged. • Require MCOs to provide anti-racist, culturally appropriate services. For example: o MCO staff should be required to receive training on unconscious bias and racial and ethnic discrimination. o MCOs should increase staffing with individuals who speak the languages of members they serve or provide appropriate translation services.
I/DD Population	• Encourage exploration and adoption of innovations that address social determinants of health, such as value-based reimbursement models, occurring elsewhere in the United States as it relates to individuals with I/DD.
Integration of CHWs	• Formal integration of CHWs into the care team is essential to addressing social determinants of health for KanCare members.
Disaggregated Data	• Data on services and outcomes should be disaggregated by race, gender, and ethnicity to identify disparities and target areas for improvement.

Source: Medicaid Managed Care Procurement Discussion Forum and Pre-Discussion Forum Survey, 2023.

Provider Innovations

This topic includes, but is not limited to, potential innovations in provider types and services offered. This could include incentives for expanding the use of community health workers or other types of providers.

Key Issues

Participants identified the following key issues that need to be addressed regarding **Provider Innovations:**

- Ability to use CHWs or other staff employed by health centers to provide services and provide care coordination.
- Efforts around modernization and utilizing strategies such as telemedicine to increase access to care.
- Adequacy of provider payment rates to see patients for services such as dental care or behavioral health needs.

Figure 5 (page 8) summarizes issues, recommendations and measures related to Provider Innovation for consideration during the upcoming MCO procurement and contracting process.

Figure 5. **Summary of Provider Innovation Issues and Recommendations**

Issue	Recommendations and Measures
Community Health Workers and other Support Staff	• Allow the use of CHWs or staff working in health centers to provide services and/or conduct care coordination and permit them to bill for their time. • CHWs and health center staff have strong relationships with patients, which could assist with addressing health needs and produce improved outcomes.
Modernization	• Create a more comprehensive data dashboard for providers to manage their patients. • Require more shared data between MCOs and providers to assist with access to care.
Provider Rates	• Establish provider incentives for seeing patients with disabilities, oral health needs and additional visits with health care providers that might be needed.

Source: Medicaid Managed Care Procurement Discussion Forum and Pre-Discussion Forum Survey, 2023.

Data Monitoring and Transparency

This topic includes, but is not limited to, data collection, monitoring, and reporting of data by MCOs, state agencies and other related organizations. It also includes key issues related to transparency, including care coordination, case management, data collection and reporting, audits, etc.

Key Issues

Participants identified the following key issues that need to be addressed regarding **Data Monitoring and Transparency:**

- The need for more transparency and publicly available data to understand quality of care, satisfaction, cost of care, and other areas of interest.
- Improvements needed regarding the oversight and monitoring provided by state agencies responsible for KanCare.

Figure 6 summarizes issues, recommendations and measures related to Data Monitoring and Transparency issues for consideration during the upcoming MCO procurement and contracting process.

Figure 6. **Summary of Data Monitoring and Transparency Issues and Recommendations**

Issue	Recommendations and Measures
Transparency and Publicly Available Data	• The State of Kansas must improve its ability to access, interpret and publicly share data from the KanCare model. This includes web-based dashboards and similar technology that would improve transparency in KanCare. • Establish consistent measures across all MCOs that are reported consistently from all organizations. Ensure the focus is on data that can have a positive impact on outcomes of populations most impacted by social determinants of health.

	• Provide MCOs greater access to Clearinghouse information and capabilities so they can answer questions regarding renewals, due dates, updating information, eligibility verification, etc. • Require financial reporting by MCOs that shows profit margins for the companies, and what the difference is between their capitated rates and amounts paid for beneficiaries.

Suggested Indicators	• Disaggregated service data, outcome data, and cost data must be available to meaningfully compare plan performance and advocate for system improvements.
	• Include indicators to assess patient quality of care (e.g., hold times, hold times for peer-to-peer consults to look at administrative burden; number of denials outright by MCO on a quarterly basis; prior authorization response times; and designated contacts at MCOs for providers and patients.)
	• MCO contracts should require periodic reports from MCOs to highlight key indicators such as:
	  ○ network capacity,
	  ○ service delivery,
	  ○ utilization,
	  ○ ability to receive all recommended services,
	  ○ hospitalization rates,
	  ○ preventable hospital admissions,
	  ○ service delivery setting (home, community or institutional), and
	  ○ other measures to ensure person-centeredness and cost-effectiveness.
	• Reports should be routinely submitted to legislators to assist in assessing effectiveness and modifications needed and to the public to ensure cost savings are not based on reduced service delivery.

Oversight and Monitoring	• Require satisfaction surveys to be completed by an independent party. • Adopt representative governance for KanCare to ensure that all elements are focused on achieving the identified outcomes for populations served. Strategies to improve accountability in KanCare should be identified and presented to stakeholders early in the engagement process. • Allow the state's monitoring process to be reviewed, re-vamped and vetted publicly.

Source: Medicaid Managed Care Procurement Discussion Forum and Pre-Discussion Forum Survey, 2023.

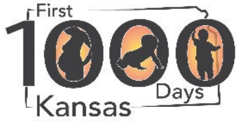
Concluding Thoughts

The REACH Healthcare Foundation and Health Forward Foundation want to acknowledge the time commitment, contributions and input provided by participants, and thank the leaders of Kansas state government agencies who attended and provided additional insights during the discussion. It is our foundations' shared desire that the information be reflected on and fully considered in the procurement process and beyond.

KanCare provides health coverage to approximately 500,000 Kansans, serving as a critical vehicle for strengthening the health and well-being across multiple and overlapping, diverse populations – ultimately impacting the immediate and long-term health of Kansans overall. We acknowledge the State of Kansas' commitment to engaging with partners and its ongoing efforts to improve KanCare. We look forward to continuing to engage health providers and community members in these discussions as well as more collaboration with state agencies and communities in the future.

A special note of thanks to the Kansas Health Institute (KHI) for assistance with developing this summary material, and to Sheena L. Schmidt, KHI Senior Analyst and Kari Bruffett, KHI President and CEO, for survey development, facilitation and reporting assistance.

For additional information and questions regarding the summary provided, please contact Pattie Mansur, Director of Health Policy at the REACH Healthcare Foundation at pattie@reachhealth.org.



KanCare 3.0 RFP Recommendations

Maternal and Child Health

Services:

1. Recognize and reimburse credentialed members of the health care team such as community health workers, home visitors, doulas, and lactation consultants (CMS Issue Brief) to improve access to culturally competent, quality, community-based care.

    a. Coverage of doula services to include community-based doulas.
    b. Coverage of lactation counseling by certified consultants and educational programs during pregnancy and continue after the birth of a child. Current coverage of lactation support is insufficient to support the 90% of Kansas families who choose to breastfeed. MCOs should be required to support breastfeeding in the outpatient setting, beyond the in-patient maternity care in the hospital. While doctors and nurses have great potential to support breastfeeding families, they do not have time or specialized knowledge to provide clinical lactation support. Lactation consultants are needed to provide skilled clinical lactation care.
    c. CMS encourages States to go beyond the requirement of solely coordinating and referring enrollees to WIC and include lactation services as separately reimbursed pregnancy-related services. Because primary care interventions to promote and support breastfeeding received a grade of B from the USPSTF, coverage of lactation services without cost-sharing is eligible for a 1 percentage point increase in federal medical assistance percentage (FMAP) per Section 4106 of the Affordable Care Act.
2. MCOs should be able to demonstrate having the following key evidence-based strategies:
    a. Written policies and protocols that identify breastfeeding and human milk as the normative standards for infant feeding and nutrition;
    b. Plan for the use of qualified breastfeeding support and lactation care to offer comprehensive breastfeeding services (chart of lactation support providers) such as contracted medical provider employs or contracts with IBCLCs to assist with complex breastfeeding issues and/or Contracted medical provider employs or contracts with individuals trained in providing basic breastfeeding support;
    c. Place for utilizing existing breastfeeding and lactation care providers in the community, and providing lactation training for current MCO employees;
    d. Ensuring access to breastfeeding support and lactation care is available during pregnancy, at birth and during the postpartum period, including encouraging all birth facilities to seek the Baby-Friendly designation, and providing access to breast pumps and breastfeeding aids.
3. Provide postpartum care that follows the American College of Obstetricians and Gynecologists (ACOG) recommendations that all postpartum individuals have contact with their health care providers within the first three weeks after delivery followed by individualized ongoing care as needed. This will require coverage of additional postpartum visits and with providers currently not covered by KanCare contracts.

4. Cover team-based primary care, high-performing medical homes, and comprehensive home visiting as strategies to support “two-generation” care.
5. Increase breast pump reimbursement rates for DME’s to increase accessibility. For example, due to the current low reimbursement rate for a covered breast pump (E0603), only one DME in Topeka has them in stock. This lack of access leaves KanCare beneficiaries waiting critical days for a breast pump to be shipped. More DME’s would stock breast pumps if they received a higher reimbursement rate.

Equity:

1. MCOs should be required to conduct a health equity assessment and submit a Health Equity Plan that includes how they will support the development of a diverse maternal and child health workforce (lactation support providers, doulas, community health workers, home visitors, etc.).
2. From CMS guidance for postpartum coverage extension - “CMS strongly encourages *states to stratify these quality measures and other metrics of interest to states by race, ethnicity, geography, language and other indicators in order to identify disparities in access to care and health outcomes and to develop targeted initiatives to improve maternal health equity*.”
3. From the Governor’s Commission on Racial Equity and Justice 2021 Report - “*collect and report child core set measures de-segregated by race/ethnicity and service location for children ages 0-3 [...] to track progress in the state’s effort to address disparities*.”
4. Require clinical training for healthcare providers on health equity and implicit bias as a requirement for credentialing by MCOs.

Outreach:

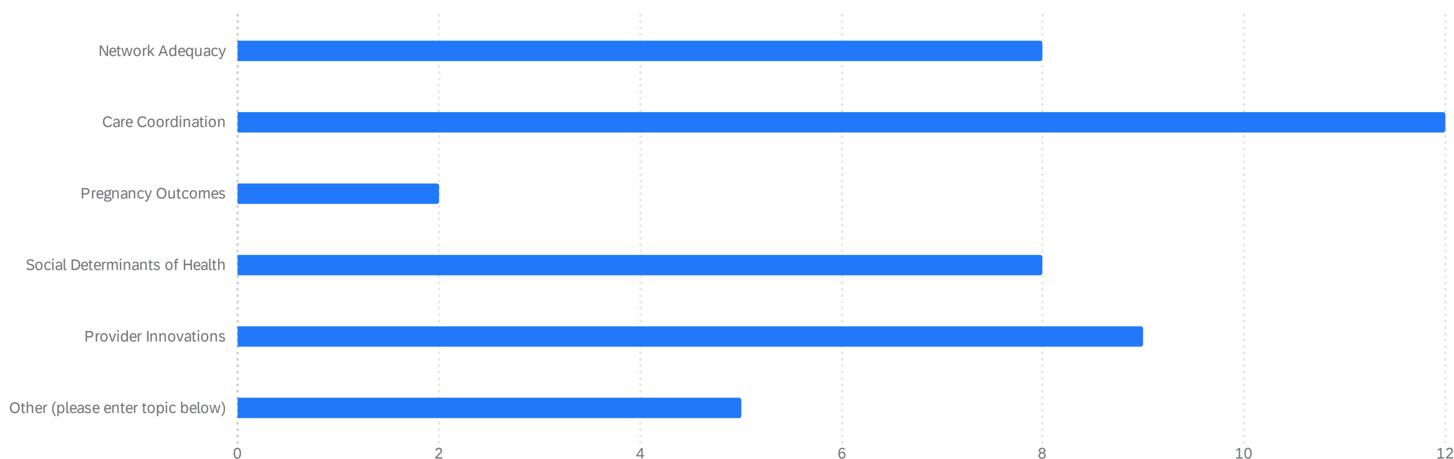
1. Provide outreach to beneficiaries and providers about the extension of postpartum coverage to 12 months.
2. MCOs should be required to increase postpartum care visits (PPC) through use of incentives, technology (text reminders, etc.) and home visits.
3. Incentivize optimal hospital maternity care practices through increased global payments to hospitals who have achieved the Baby-Friendly Hospital designation.
4. MCOs should be required to integrate training and information about infant feeding during emergencies into their emergency plan development, aligned with the American Academy of Pediatrics Infant Feeding in Disasters and Emergencies.
5. Language in the 2018 KanCare 2.0 RFP requires contractors to coordinate with WIC, local health departments and other Title V programs in Section 5.1.5 (Cooperation with Other Agencies, Page 17). These references should be maintained in the next RFP for MCO contract language.

Prepared by:

Brenda Bandy, Co-Executive Director, Kansas Breastfeeding Coalition
bbandy@ksbreastfeeding.org

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

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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

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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.

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

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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.

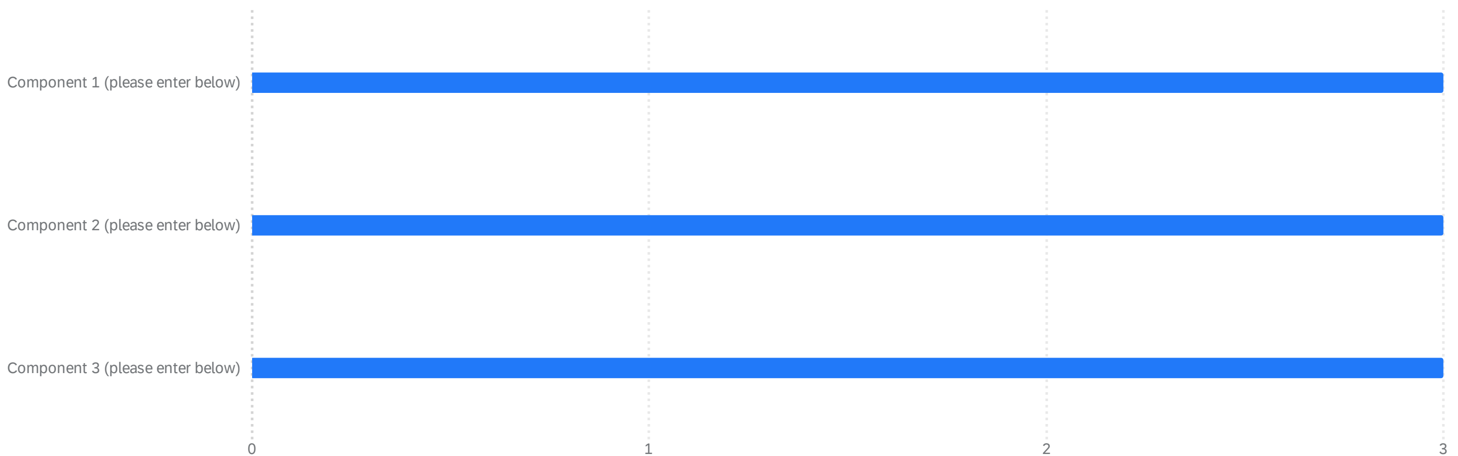
Have more workers that speak the languages of the clients they serve and/or go out of their way to provide communications in appropriate languages. Required trainings for ALL employees about race/ethnic discrimination, specifically around unconscious bias along with adjusting internal policies to reflect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

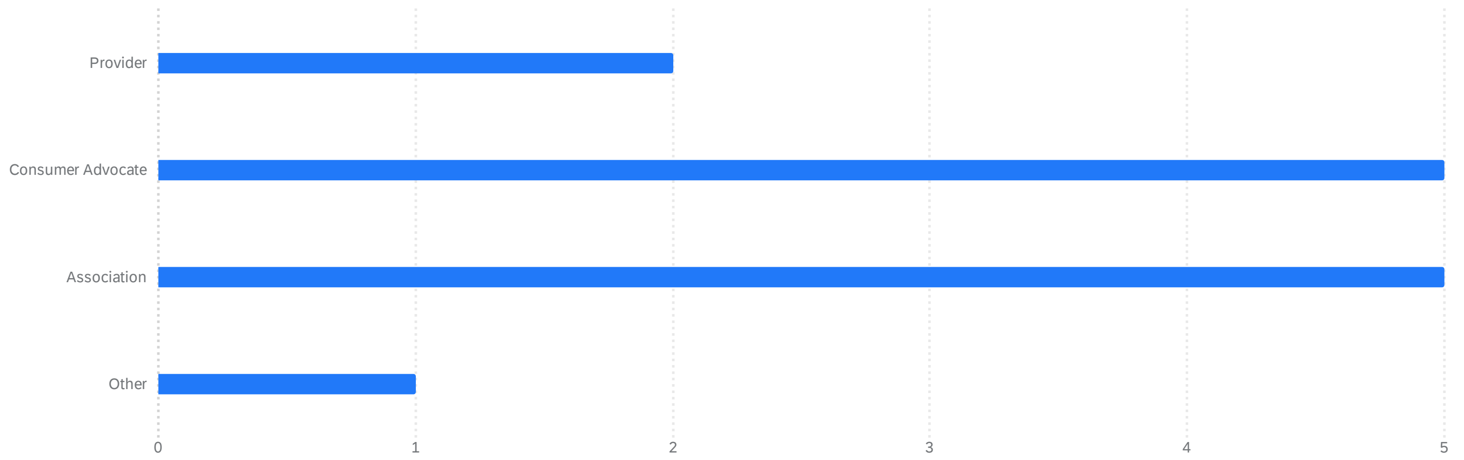
Exec. Director of Payroll FMS provider

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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