UNDERSTANDING KANCARE'S CHALLENGES:

Is the program living up to its original rationale and commitments as it approaches its five year waiver renewal with CMS?

Presented to the Kansas Hospital Association, Kansas Medical Society, and Kansas Association for Medically Underserved

November 2016

INTRODUCTION

One of the critical issues that the Kansas Hospital Association (KHA), the Kansas Medical Society (KMS), and the Kansas Association of Medically Underserved (KAMU) focus on is evaluating current health care delivery systems, how those delivery systems can be improved, and how they can be leveraged to improve the health and quality of life for Kansas residents.

Leavitt Partners (LP), a health care intelligence firm, was asked to complete a review of the KanCare program. The review has two goals:

- Assess KanCare program information and data against the program's original rationale and commitments as the program approaches its five-year waiver renewal review with the Center for Medicare and Medicaid Services (CMS) to understand whether existing challenges are limiting the program's ability to meet its commitments.

- Assist KHA, KMS, and KAMU in developing a strategy to leverage the upcoming KanCare state and federal renewal process to seek improvements to KanCare.

To complete this analysis, LP conducted a review of available federal and state documents and data related to the metrics and provisions outlined in the waiver's terms and conditions. These documents include, but are not limited to:

- KanCare quarterly and annual reports to CMS;
- Kansas Department of Health & Environment (KDHE) publicly available data, information, and reports;
- Relevant legislative reports and presentations;
- KanCare Program Annual External Quality Review Technical Reports;
- Quarterly and annual reports from the KanCare independent evaluator; and
- Reports and information generated by providers and/or stakeholders.

LP also conducted a series of interviews to obtain information and experiences from KHA, KMS, and KAMU staff and members, health care providers, and other key stakeholders. Leavitt Partners conducted a total of 19 interviews.

Finally, LP issued a voluntary survey to KMS members. 189 members responded to the survey, providing their thoughts on KanCare. **Survey results show that over 75% of respondents do not feel KanCare has met its stated goals.**

QUALITY OF CARE

LEAVITT
PARTNERS

IMPROVEMENTS IN QUALITY OF CARE FOR KANSANS RECEIVING MEDICAID

Rationale & Commitments

	Data/Information	Provider Experience

Commitment #1

- Implement long-lasting reforms that improve the quality of health and wellness for Kansans.
- By holding the managed care organizations (MCO) to outcomes and performance measures, and tying measures to meaningful financial incentives, the state will improve health care quality and reduce costs.

Commitment #2

- Measurably improve health care outcomes for members in areas including:
  - ➢ Diabetes
  - ➢ Coronary Heart Disease
  - ➢ Prenatal Care
  - ➢ Behavioral Health

The current system is meeting the stated rationale/commitments (based on assessed data).

The current system is meeting the stated rationale/commitments, but improvements could be made (based on assessed data).

The current system is not meeting the stated rationale/commitments (based on assessed data).

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Focus Area #1: Quality of Care

IMPROVE QUALITY OF CARE

- In general, interviewees do not believe that moving to a managed care system has led to improvements in the quality of care provided to Kansas Medicaid beneficiaries.

- While interviewees feel as though the quality of care provided to Medicaid beneficiaries has not decreased, they note that they feel most quality improvement efforts have been provider driven.

- Almost all of the interviewees indicated they had not seen the MCOs actively engage in quality improvement projects or initiatives with providers, especially when compared to Medicare and commercial payers.

- Interviewees also noted limited transparency or discussion of KanCare quality measure reporting or performance.

- Some interviewees expressed concern that neither KDHE nor the MCOs seem to share any data, provide transparency, or engage in conversations with providers on quality improvement topics. The KanCare delivery model does not include a collaborative learning environment related to quality improvement issues.

> Providers feel that results showing improvement in care quality are provider driven as it is perceived that the MCOs have done little to promote quality.
>
> Examples of areas that could benefit from quality improvement activities align with the areas noted in commitment #2 and include:
>
> - Diabetes management
>
> - High-risk newborn care
>
> - Prenatal care

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Focus Area #1: Quality of Care

IMPROVE HEALTH OUTCOMES

- In terms of measurably improving health outcomes for members, interviewees' concerns focused on existing gaps in diabetes care, prenatal care, and behavioral health. These issues directly relate to KanCare's commitment to improve health in areas such as diabetes, coronary heart disease, prenatal care, and behavioral health.

- A few interviewees noted that a high need area MCOs are not adequately addressing is high-risk infants (i.e., those born with drug and alcohol addictions). Interviewees feel this is a reflection of pregnant women not receiving adequate pre-natal care.

- Other interviewees do not feel that the Medicaid MCOs are focusing enough on wellness compared to Medicare Advantage and other commercial plans offered in the same communities.

- In terms of KanCare meeting its stated goals of (1) improving the quality of care and (2) establishing long-lasting reforms that improve the quality of health and wellness, 68% of the KMS survey respondents indicated it has not met the first goal and 77% of respondents indicated it has not met the second (out of those who felt KanCare had not met its goals).

In terms of measurably improving health care outcomes, interviewees feel that few, if any, improvements have been made in areas that align with commitment #2 including:

- Diabetes care

- Prenatal care

- Behavioral health

Most KMS survey respondents don't feel KanCare has improved quality of care—47% believe it has not, opposed to 13% who believe it has (the remaining did not respond).

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Focus Area #1: Quality of Care

IMPROVE HEALTH OUTCOMES

	KanCare HEDIS Aggregated Results (Percentage)		CY 2012 Pre-KanCare (if available)	NCQA Quality Compass 50th Percentile		NCQA Quality Compass 25th Percentile	
	CY 2014	CY 2013		CY 2014	CY 2013	CY 2014	CY 2013
Comprehensive Diabetes Care							
HbA1c Testing	84.8	83.1	76.5	↓	↓	↑	
Eye Exam	58.6	50.1	41.7	↑	↓	↑	
Medical Attention for Nephropathy	76.8	75.8	66.3	↓	↓	↓	
HbA1c Control (<8.0%)	39.3	39.0	16.0	↓	↓	↓	
HbA1c Poor Control (>9.0%) (lower percent is goal)	52.9	54.4	83.4	↓	↓	↓	
Blood Pressure Control (<140/90)	52.6	53.1		↓	↓	↓	
Diabetes Monitoring for People with Diabetes and Schizophrenia	60.1	62.9		↓	↓	↓	↓
Controling High Blood Pressure	51.5	47.3		↓	↓	↑	↓
Prenatal Care	70.4	71.4	57.9	↓	↓	↓	↓
Postpartum Care	55.8	60.3	54.8	↓	↓	↑	

Key Findings

- HEDIS scores related to diabetes, coronary heart disease, and prenatal care are mixed, but the majority fall below the 50th percentile.

- There also has been little to no improvement over time.

Source: Kansas Foundation for Medical Care, 2015 KanCare Evaluation Annual Report, Year 3 Jan. – Dec. 2015.

Focus Area #1: Quality of Care

IMPROVE HEALTH OUTCOMES

	KanCare HEDIS Aggregated Results (Percentage)		CY 2012 Pre-KanCare (if available)	NCQA Quality Compass 50th Percentile		NCQA Quality Compass 25th Percentile	
	CY 2014	CY 2013		CY 2014	CY 2013	CY 2014	CY 2013
Behavioral Health							
Follow-up after Hospitalization for Mental Illness within seven days of discharge	56.2	61.0		↑	↑	↑	↑
Initiation in Treatment for Alcohol or other Drug Dependence							
Ages 13-17	50.8	49.0		↑	↑	↑	↑
Ages 18 and older	41.3	40.9		↑	↑	↑	↑
Total Ages 13 and older	42.6	42.1		↑	↑	↑	↑
Engagement in Treatment for Alcohol or other Drug Dependence							
Ages 13-17	31.0	32.5		↑	↑	↑	↑
Ages 18 and older	12.1	12.2		↑	↑	↑	↑
Total Ages 13 and older	14.8	15.2		↑	↑	↑	↑
Diabetes Monitoring for People with Diabetes and Schizophrenia	60.1	62.9		↓	↓	↓	↓

Key Findings

- MCOs' behavioral health related HEDIS results are generally positive, falling above the 50th percentile.

- It is important to note that while these scores exceed a majority of other states' scores (i.e., why the arrows are pointing upward), the overall performance levels lag behind physical health measures and further improvement can be made (e.g., the engagement in treatment measures).

Source: Kansas Foundation for Medical Care, 2015 KanCare Evaluation Annual Report, Year 3 Jan. – Dec. 2015.

Focus Area #1: Quality of Care

IMPROVE HEALTH OUTCOMES

KanCare Pay-For Performance (P4P) Measures	No. of MCOs meeting 2014 Performance Target
Comprehensive Diabetes Care (CDC)	
CDC - Hemoglobin A1c (HbA1c) Testing	1
CDC - Eye Exam (retinal) Performed	3
CDC - Medical Attention for Nephropathy	0
CDC - HbA1c Control (< 8.0%)	1
CDC - Blood Pressure Control (<140/90 mm Hg)	1
Well-Child Visits in the First 7 Months of Life (W7m) W7m - 4 or more	2
Preterm Delivery (PtD) Percent of Deliveries with Gestational Age < 37 Weeks	1
Annual Monitoring for Patients on Persistent Medications (MPM) - Total Rate	2

Physical Health

Key Findings

- Beginning in year two, P4P measures focused on beneficiary access to services and health outcomes. MCO are responsible for 15 performance measures in areas of physical health, behavioral health, long-term services and supports (LTSS) and home and community-based services (HCBS), and nursing facility outcomes.

- None of the MCOs met all of the physical health measure targets. The only area where all three MCOs met a target was a sub-measure under comprehensive diabetes care (eye exam).

Source: KDHE Annual Report to CMS Regarding Operation of 1115 Waiver Demonstration Program, Year Ending 12.31.15. Baselines for each measure and MCO were established using 2013 data; 2014 targets are a 5% improvement level over the baseline.

Focus Area #1: Quality of Care

IMPROVE HEALTH OUTCOMES

	KanCare Pay-For Performance Measure	No. of MCOs meeting 2014 Performance Target
Behavioral Health	Follow-up after Hospitalization for Mental Illness (FUH) - 7 Day Follow-up	0
	National Outcomes Measures (NOMS)	
	Percent of SUD members whose employment status increased (Per 10,000)	2
	Percent of SPMI members whose employment status increased (Per 10,000)	2
	Percent of SPMI members with increased access to services (Per 10,000	2
	Percent of SED youth members with increased access to services (Per 10,000)	1
	Utilization of Inpatient Psychiatric Services (UIPS): Percent of members utilizing inpatient psychiatric services, including state psychiatric facilities and private inpatient mental health services (Per 10,000)	2

Key Findings

- Within the behavioral health measures, no MCO met the target for follow up after hospitalization for mental illness.

- Two MCOs met their target for utilization of inpatient psychiatric services.

- Two MCOs met three of four National Outcomes Measures (NOM) and the third MCO met one of four.

IMPROVEMENTS IN CARE DELIVERY

IMPROVEMENTS IN CARE DELIVERY

Rationale & Commitments

	Data/Information	Provider Experience
Commitment #1		
• Preserve and stabilize the safety net.	🔻	🔻
Commitment #2		
• Improve quality in Medicaid services by integrating and coordinating services and eliminating current silos between physical health, behavioral health, mental health, substance use disorder, and LTSS.	NA	🔻
Related Concerns		
• Value-Based Payments • Communication • Standardization of MCO Policies • Provider Payments • Access	🔻	🔻

The current system is meeting the stated rationale/commitments (based on assessed data).

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The current system is not meeting the stated rationale/commitments (based on assessed data).

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Focus Area #2: Improvements in Care Delivery

PRESERVATION OF THE SAFETY NET

- A main concern of safety net providers is the inconsistent interpretation of payment policies across the three MCOs. Interviewees feel like the payment policies for safety net providers—Federally Qualified Health Centers (FQHC), critical access hospitals, rural health clinics, etc.—are being interpreted differently by each MCO, which results in inaccurate payments.

- While not directly related to KanCare, an additional concern is the limited coverage available to adults through Kansas Medicaid. Some safety providers operate more as medical or health home and would be able to provide more comprehensive care that better meets the health care needs of these low-income adults if more benefits and services were covered under Medicaid.

Many safety net providers operate with minimal staff, margins, and reserves. Receiving inaccurate payments not only negatively impacts their cash flows, but it also results in high administrative costs and resources as these providers seek resolution.

In terms of KanCare meeting its stated goal of preserving and stabilizing the safety net, 66% of KMS survey respondents indicated it had not met this goal (out of those who felt KanCare had not met its goals).

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Focus Area #2: Improvements in Care Delivery

PRESERVATION OF THE SAFETY NET

One indication of preservation of the state's safety net is the closure of rural and critical access hospitals.

- In October 2015, Mercy Hospital closed.

- In September 2016, Stormont Vail Health (Topeka) announced it was closing two regional clinics because of the recent cuts in Medicaid reimbursements and the decision by state leaders not to expand Medicaid.

- A 2016 report by iVantage Health analytics shows that of the 107 rural hospitals in Kansas, 31 are at risk for closure. This represents nearly 1/3 of all rural hospitals.

107 Total number of rural hospitals in Kansas

31 Number of at-risk rural hospitals in Kansas

Another indication of preservation of the state's safety net is funding to safety net clinics.

- In 2015, the administration made a mid-year cut of $245,000 to the safety net clinic grant program.

- The administration also cut an additional $378,000 from the grant program in SFY2017.

- Community mental health centers estimate reductions totaling $30 million as a result of 2016 budget cuts, the elimination of the health home program for the SMI population, and other factors.

Focus Area #2: Improvements in Care Delivery
IMPROVED CARE COORDINATION/INTEGRATION

- Most interviewees have not seen any indication of improved care resulting from increased integration and coordination of physical health, behavioral health, mental health, substance use disorder, and LTSS services.

- A key focus of the Sunflower Foundation has been integrating medical and mental/behavioral health care. It was noted that the Sunflower Foundation tried to engage the MCOs in this initiative, but that the MCOs declined.

- While the three MCOs were selected, in part, based on their commitment and offerings related to innovative and integrated care approaches, providers see little to no evidence of this to date.

- A few MCO case managers are focused on coordinating care; however, it was noted that MCO case managers coordinate covered benefits and are not focused on helping connect individuals to other community services or benefits that might assist in achieving positive health outcomes.

- In cases where there had been improvements in care coordination, interviewees couldn't differentiate whether the improvement had been driven by the MCOs or if it was a result of the Affordable Care Act (ACA). For example, increased access to preventive care is driven by ACA mandates.

Two of the MCOs subcontract with separate entities for behavioral health services, which perpetuates silo'd or fragmented care. If functions aren't coordinated at the administrative level, how can they be coordinated at the clinical level.

Most KMS survey respondents do not feel KanCare has improved integration of services—45% believe it has not, opposed to 10% who believe it has (the remaining percentage did not respond).

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Focus Area #2: Improvements in Care Delivery
IMPROVED CARE COORDINATION/INTEGRATION

- Several concerns were mentioned with regard to behavioral health integration. First, credentialing, payment, and authorization problems persist with some of the MCOs' behavioral health subcontractors.

- Second, there is limited access to behavioral health providers due to low Medicaid reimbursement rates. The Governor's mental health task force recommendations to improve behavioral health services and increase coordination has not resulted in noticeable improvements.

- Third, KanCare enrollees receive inadequate information on what integrated services are available to them. Providers are having to educate KanCare enrollees about their benefit, when this is a responsibility of the MCOs.

- Fourth, the Health Home model for the SMI population was discontinued after the two-year period of enhanced federal funding ended. Some interviewees felt that the model was not given sufficient time to achieve cost and quality outcomes. Significant resources were also invested in developing the health home model for chronic conditions, which was discontinued right before it was due to be implemented.

Beyond the problems experienced with the MCOs, some providers feel that the state's closed behavioral health and assessment codes limit the ability to integrate physical and behavioral health.

Providers noted that state policies have not kept pace with the overall trends in health care with respect to value and service integration.

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Focus Area #2: Improvements in Care Delivery
VALUE-BASED PAYMENTS

- Only a few interviewees noted that MCOs had reached out to them with plans for value-based payment and one did indicate that they were moving toward a shared savings arrangement or other alternative payment model. Some interviewees felt these conversations could increase as contracts are renewed.

- In general, interviewees were not aware of MCOs implementing value-based payment arrangements or even approaching providers on this issue.

- There was some concern expressed that the MCOs were targeting value-based payments to providers who are not meeting quality standards and need reinforcement rather than those who have proven quality.

- Some hesitancy was expressed in engaging in value-based payments until MCOs can reduce the number of problems with credentialing, payments, and other policies. Others interviewees indicated that they don't believe the state has the capacity to handle a system where providers are paid for outcomes.

Value-based payments are used by payers to shift from pure volume-based, or fee-for-service payment, to payments that promote improvements in care delivery and health outcomes.

While value-based payments are not a direct goal of the KanCare model, they can be a reflection of MCOs' commitment to quality.

Most Kansas providers are supportive of value-based payments and would like to see more incentive based payments and rewards for high quality.

More than 85% of survey respondents indicated that they were not engaged in value-based payment arrangements.

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Focus Area #2: Improvements in Care Delivery
COMMUNICATION

- Almost all interviewees noted communication as an issue of concern that has the potential to limit improvements in care delivery.

- Concerns with communication are twofold: Providers feel that very little communication flows from the MCOs to providers; and that very little communication flows from KDHE to providers.

- Communication with the MCOs is generally described as reactionary. It was expressed that MCOs make commitments to correct issues, but don't always follow through.

- Onsite visits and communication from MCO representatives are described as infrequent, inadequate, and inefficient (e.g., the use of faxes). Some interviewees noted that local MCO representatives are not empowered to resolve issues because of national corporate policies. They also feel that the MCOs lack the necessary resources to provide adequate technical assistance.

- It was also noted that communication is made even more difficult given that the three MCOs have different interpretations of state policies and issues.

While communication was not a focus of this review, many providers mentioned it during the interviews as an area needing to be improved.

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Focus Area #2: Improvements in Care Delivery

COMMUNICATION

- In addition to having communication problems with the MCOs, several interviewees noted a lack of communication and support from the state on a program that, some noted, was intended to be developed through a collaborative process with providers.

- Some interviewees noted that the state generally only addresses high-level concerns that span the three MCOs, rather than individual provider concerns. It has also been the experience of some interviewees for KDHE to direct the provider to online material rather than addressing their concerns.

- Some interviewees noted that the state does not provide enough avenues for stakeholders to raise problems and concerns with the program. Some interviewees feel as though the meetings that do exist are preplanned and that the state is not really looking for suggestions on how to improve the program.

- Finally, interviewees noted that communication from the state and the MCOs does not always seem to be consistent. Some providers indicated that they often have to "fact check" statements made by MCO representatives or the state.

On of the biggest challenges for some providers is accessing enrollee information.

Providers indicated that they have to wait a couple of months to get enrollee lists from MCOs in order to use those lists to better coordinate care.

Providers also indicated that communicating with the MCO to get the "right" information can be challenging and requires a high level of administrative resources.

Focus Area #2: Improvements in Care Delivery
COMMUNICATION

According to the 2016 Q2 KanCare Quarterly Report to CMS, the state hosts a myriad of stakeholder meetings related to KanCare, including but not limited to:

- KanCare Advisory Council (quarterly)
- HCBS/MCO Provider Lunch and Learn teleconferences (1 hour, bi-weekly)
- HCBS Provider Forum teleconferences (monthly)
- Big Tent Coalition meetings to discuss KanCare and stakeholder issues (monthly)
- Presentations, attendance, and information is available as requested by small groups, consumers, stakeholders, providers and associations across Kansas
- Community Mental Health Centers meetings to address billing and other concerns (monthly)
- Series of workgroup meetings and committee meetings with the Managed Care Organizations and Community Mental Health Centers
- Regular meetings with the Kansas Hospital Association KanCare implementation technical assistance group (TAG)
- Series of meetings with behavioral health institutions, private psychiatric hospitals, and PRTFs to address care coordination and improved integration
- State Mental Health Hospital mental health reform meetings (quarterly)
- Systems Collaboration with Aging & Disability, Behavioral Health and Foster Care Agencies
- Monthly meetings with the Association of Community Mental Health Centers, including MCOs
- Crisis Response & Triage meetings with stakeholders including MCOs (bi-weekly)
- Periodic meetings with MCOs and the FQHC TAG

Despite the number of monthly and quarterly stakeholder meetings, it is providers' experience that communication issues still persist with the state.

The state may need to better advertise these forums, assure the meetings provide amble opportunities for expressing concerns, and better address providers' issues raised during the meetings.

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Focus Area #2: Improvements in Care Delivery

STANDARDIZATION OF MCO POLICIES

- The need for consistent and standardized MCO processes and policies was the most common discussed issue.

- **Credentialing.** Beyond the Disclosure of Ownership form, there is currently no standardization across MCOs' provider credentialing processes. Having to work through three different MCO processes, the MCO subcontractor processes, as well as the provider enrollment process with KDHE, is a major administrative burden and cost to providers. Interviewees also noted that the processes are often delayed, which can impact access to care.

- Some of the interviewees noted that they were promised a streamlined credentialing process. The current process is not streamlined and results in providers having to submit duplicate information on different forms. While it appears some efforts are being made to standardize the submission process, this process has been delayed.[1]

- MCOs also hold back 10% of payments for non-credentialed providers as well as credentialed providers who have not yet been added to the network. As such, delays in credentialing result in a financial hardship to providers.

While MCO contracting, standardization, and regulation were not a focus of this review, many providers mentioned them during the interviews as areas needing to be improved.

[1] Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 06.30.16.

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Focus Area #2: Improvements in Care Delivery

STANDARDIZATION OF MCO POLICIES

Other areas of concern related to MCO policy standardization include:

- **Enrollee assignment.** A few providers indicated that the current enrollee assignment process lacks the necessary information for providers to predict caseloads and ensure appropriate providers. Some providers also noted that they will get assigned enrollees from MCOs they don't contract with.

- **Recertification.** Interviewees did note that recertification processes have improved They noted this was the result of a working group that focused on the issue and worked through the details with each MCO in order to produce alignment.

- **Billing and claims.** Interviewees also noted that there is a lack of standardization in billing and claims processes, which results in denied claims or delayed payment. This impacts cash reserves and increases providers' administrative costs.

One common concern is that the MCOs' policies are not reflective of the state's and local providers' needs because they are nationally based organizations.

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Focus Area #2: Improvements in Care Delivery
STANDARDIZATION OF MCO POLICIES

Other areas of concern related to MCO policy standardization include:

- **Prior authorization.** Some interviewees noted that there are still problems with prior authorizations which are not standardized across the MCOs. Interviewees noted that sorting through prior authorizations policies creates a tremendous amount of administrative burden. Providers have to sort through three different websites, three different policies, etc. It was indicated that a one-stop shop for prior authorization policies would be extremely helpful.

  It was suggested that all MCOs should adopt a policy clarifying that if a primary third-party payer doesn't need an authorization, then Medicaid as the secondary payer should not need one as well.

  Some interviewees feel the prior authorization process has improved over time, but there are still issues that could be addressed. It was noted that prior authorization approvals can take several days to two weeks (and still result in a denied claim), which prevents the timely provision of care.

- **Retro-eligibility.** A few interviewees noted concerns with MCOs making timely and accurate payments related to retro-eligibility and the number of denied claims.

Over 70% of KMS survey respondents ranked the following activities as being a "serious" or "moderate" challenge:

- Prior authorization
- Claims submission, adjudication, and payment
- Referring or connecting patients to needed services
- Navigating different MCO policies
- Receiving information and timely communication from the state

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Focus Area #2: Improvements in Care Delivery

STANDARDIZATION OF MCO POLICIES

VII. *STANDARDIZATION OF PROCESSES:*

The Contractor agrees to standardization of work processes between the State and all KanCare providers to provide the most efficient implementation and management of the KanCare Program.

Processes to be included, but are not limited to, are as follows:

a. *Provider credentialing (forms, criteria, processing)*
b. *Credentialing Requirements for pharmacists to provide Medical [Medication] Therapy Management (MTM)*
c. *Pharmacy Website Information (Prior Authorization criteria/forms, Provider Manual, Preferred Drug List information, Pricing Lookup, etc.)*
d. *Authorization procedures for services*
e. *Claims billing processes*
f. *Provider network documentation*
g. *Provider surveys*
h. *Operations, quality, customer service, and grievance report formats*

Key Findings

- MCO contracts include provisions to standardize the work processes between the state and all KanCare providers.

- Many of these processes have not been standardized to date.

Source: 2013-2015 KanCare MCO Contracts.

Focus Area #2: Improvements in Care Delivery

STANDARDIZATION OF MCO POLICIES

In its first year of operation, KanCare's Pay-For-Performance (P4P) system withheld 3% of MCO premiums. MCOs could earn back that amount based on their performance on 6 measures with each measure worth .5%:[1]

1. Timely claims processing: (1) 100% of clean claims are processed within 20 days; (2) 99% of all non-clean claims are processed within 45 days; and (3) 100% of all claims are processed within 60 days.

2. Encounter data submission

3. **Credentialing: 90% of providers completed in 20 days; and 100% of providers completed in 30 days. (Note: begins when "all necessary credentialing materials have been received.")**

4. Grievances: 98% of grievances are resolved within 20 days; and 100% of grievances are resolved within 40 days

5. Appeals

6. Customer Service: 98% of all inquiries are resolved within 2 business days from receipt date; 100% of all inquiries are resolved within 8 business days.

In CY2013, Amerigroup and United met the provider credentialing performance targets in 11 of 12 months; Sunflower met the targets in 1 of the 12 months.[2]

Credentialing performance continues to be a contractual requirement, but it was not included in the P4P system beyond year one. Network adequacy data is reported and analyzed in KDHE and KFMC annual reports, but credentialing timeline performance is not reported.

[1,2] KanCare website, Quality Management section; KanCare RFP section 2.2.4.1.7; KDHE, Annual Report to CMS Regarding Operation of 1115 Waiver Demonstration Program, Year Ending 12.31.14.

Focus Area #2: Improvements in Care Delivery
STANDARDIZATION OF MCO POLICIES

Provider Inquiries	CY2014			CY2015				CY2016	
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Credentialing Issues	285	177	90	163	239	208	195	231	162
Authorization-New	2,149	1,968	1,841	2,351	2,369	1,880	1,759	1,942	1,812
Authorization-Status	3,649	2,961	2,306	2,456	2,417	2,323	2,594	2,773	2,373
Claim denial inquiry	4,843	5,256	4,760	5,182	3,990	5,498	4,411	5,605	4,423
Claim status inquiry	18,401	18,822	18,284	19,457	21,314	19,898	22,399	23,613	21,685

Key Findings

Provider inquiries to MCO customer service centers regarding claims status show an increasing trend since 2014.

Provider inquiries related to credentialing and authorizations show a slightly decreasing trend since 2014.

Sources: KanCare Quarterly Reports to CMS. Earliest data is CY2014 Q2. Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 06.30.16.

Focus Area #2: Improvements in Care Delivery
PROVIDER PAYMENTS

- For most providers, Medicaid is the lowest payer in terms of reimbursement.

- Interviewees noted that MCOs payment policies are not standardized and that each MCO interprets payment policies differently. Problems with payment are consistent across the three MCOs and interviewees noted they experience problems with both over- and underpayment.

- Interviewees consistently mentioned that seeking reimbursement from Medicaid and the MCOs is extremely resource intensive. The administrative burden of managing the claims billing and adjudication process has tripled for providers.

- Some interviewees noted that there have been improvements related to clean claims and payments. However, if any difficulty with the claim or payment emerges, then it is nearly impossible to find a resolution.

While provider payments was not a focus of this review, many providers mentioned this issue during the interviews as an area needing to be improved.

The issues was also frequently raised in the open ended comments submitted by KMS survey respondents.

Focus Area #2: Improvements in Care Delivery
PROVIDER PAYMENTS

- Some interviewees noted that issues with provider payments extend past the MCOs to KDHE as well.

- For example, interviewees noted instances when KDHE staff modified rate policy interpretations resulting in miscalculations of rates, which later had to be adjusted to incorporate back payment amounts.

- In general, interviewees feel like there is a lack of accountability around claim and denial processes. They would like to see the MCOs held to a higher level of accountability by the state.

> The administrative burden of dealing with provider payments has reached the point that some interviewees feel the state is achieving savings by "shifting" the costs to providers.
>
> Some also question whether it is a strategy of "wearing the providers down" so they don't go after every payment.

Focus Area #2: Improvements in Care Delivery
PROVIDER PAYMENTS

KanCare Hospital Accounts Receivable Over 90 Days
All Hospitals Reporting
December 2013 - December 2015

Medicaid FFS December 2012 - 32.1%
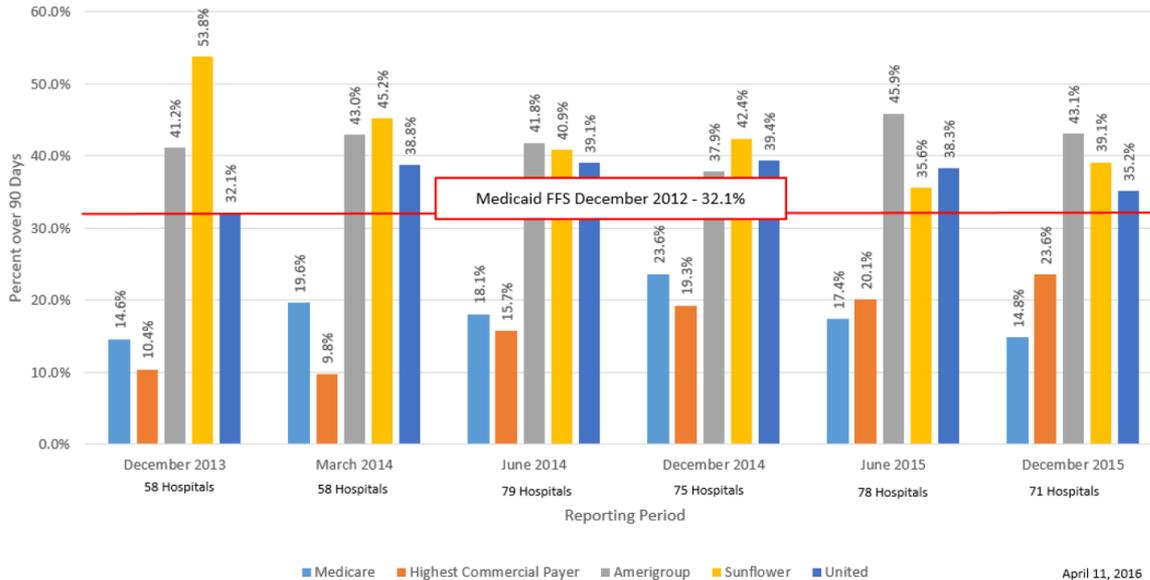
April 11, 2016

Key Findings

- KHA conducted a survey early in 2016 of its member hospitals with respect to accounts receivable (A/R) over 90 days.

- Data provided compared pre-KanCare Medicaid A/R rates with rates for KanCare MCOs, Medicare, and the highest commercial payer in a region.

- The chart illustrates how resource intensive the current Medicaid managed care system is compared to other payers.

Source: KHA report to Robert G. (Bob) Bethell Joint Committee on Home and Community-Based Care and KanCare Oversight, April 18, 2016.

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Focus Area #2: Improvements in Care Delivery
PROVIDER PAYMENTS

MCO	CY2014 % Claims Denied	CY2015 % Claims Denied	Most Recent Quarter Data CY2016, Quarter 2		
			April 2016	May 2016	June 2016
Amerigroup	14.57%	18.37%	17.46%	16.21%	16.97%
Sunflower	16.26%	17.17%	18.76%	17.71%	19.39%
United Healthcare	15.79%	17.81%	16.33%	15.08%	15.86%

Source: CY2014 and 2015 Data pulled from Kansas Foundation for Medical Care Q4 reports. 2016 Quarter 2 (April, May and June 2016) data pulled from KDHE report of KanCare Oversight Committee on Aug 5, 2016.

Key Findings

- The percentage of all claims denied in CY2015 were higher than in CY2014 for all three MCOs, which supports the findings from the interviews regarding the rate of denials rising over time

- In CY2016 Q2, claim denial rates were lower than CY2015 levels for two of the three MCOs, but rates remain higher than CY2014.

- When claims denial rates are examined by services type, the highest denial rates are associated with pharmacy claims followed by hospital inpatient claims.

Focus Area #2: Improvements in Care Delivery
PROVIDER PAYMENTS

Table 7. Average Monthly Turnaround Time (TAT) Ranges for Processing Clean Claims, by Service Category				
	CY2016		Average TAT Monthly Ranges by Year (CY2014 & CY2015)	
Service Category	Q1	Q2	CY2014	CY2015
Hospital Inpatient	8.1 to 15.1	7.1 to 12.4	5 to 19.2	6.4 to 15.9
Hospital Outpatient	4.8 to 10.5	4.3 to 9.5	3.6 to 12.8	3.5 to 10.8
Pharmacy	same day	same day	same day	same day
Dental	7.0 to 13.0	7.0 to 13.0	2 to 21	4 to 13.1
Vision	9.0 to 12.7	7.0 to 12.0	7 to 12.5	9 to 12.5
Non-Emergency Transportation	9.0 to 14.0	9.5 to 14.4	10.9 to 18	10.4 to 16
Medical (Physical health not otherwise specified)	4.4 to 9.9	4.4 to 8.9	3.3 to 10.6	3.4 to 10.5
Nursing Facilities	5.6 to 9.0	4.7 to 9.0	4.3 to 11.5	4.1 to 9.7
HCBS	5.8 to 9.7	6.0 to 8.7	3.2 to 15.6	4.1 to 10.2
Behavioral Health	4.2 to 10.3	4.2 to 9.3	3.4 to 8.6	2.7 to 10.5
Total Claims (Including Pharmacy)	4,409,846	4,315,854	16,763,501	17,820,402
Total Claims (Excluding Pharmacy)	2,646,703	2,622,624	10,370,998	10,999,807
Average TAT (Excluding Pharmacy)	5.3 to 10.0	5.2 to 9.1	4.3 to 11.5	4.3 to 10.3

Key Findings

- These data support interviewees' claims that improvements have been made in processing clean claims.

- There has been a slight improvement in the upper end of that trend, with the maximum number of days becoming shorter. However, on the lower end, the minimum numbers of days has actually increased.

- Data also show that hospital claims and NEMT have the longest TATs.

Source: Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 06.30.16.

Focus Area #2: Improvements in Care Delivery
PROVIDER PAYMENTS

In its first year of operation, KanCare's Pay-For-Performance (P4P) system withheld 3% of MCO premiums. MCOs could earn back that amount based on their performance on 6 measures with each measure worth .5%:

1. **Timely claims processing: (1) 100% of clean claims are processed within 20 days; (2) 99% of all non-clean claims are processed within 45 days; and (3) 100% of all claims are processed within 60 days.**

2. Encounter data submission

3. Credentialing: 90% of providers completed in 20 days; and 100% of providers completed in 30 days. (Note: begins when "all necessary credentialing materials have been received.")

4. Grievances: 98% of grievances are resolved within 20 days; and 100% of grievances are resolved within 40 days

5. Appeals

6. Customer Service: 98% of all inquiries are resolved within 2 business days from receipt date; 100% of all inquiries are resolved within 8 business days.

No MCO met all 3 sub-measures under timely claims processing during any month in CY2013. However, it should be noted that the performance standards are high.

While this area of performance continues to be identified as an issue for providers, timely claims processing was not included in subsequent years P4P measures. The identified measures do remain as contract expectations and data is tracked and reported.

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Focus Area #2: Improvements in Care Delivery

ACCESS

- While improved access is not a direct commitment or goal of the KanCare model, it is a direct output of improvements made in care delivery.

- In terms of positive impacts, some providers feel that KanCare had improved coverage and access, particularly for children, infants, and pregnant women.

- That said, many interviewees are concerned that the problems with credentialing, payments, and other policies are or have the potential to negatively impact access to care.

- For example, it was mentioned that due to Medicaid's low reimbursement, coupled with recent rate reductions and the administrative burden of getting paid, they are now having to determine if they need to limit the number of Medicaid patients they accept as well as what additional services they had funded outside of Medicaid they can eliminate.

- Interviewees also noted that enrollment and eligibility delays are impacting access to care. Individuals seeking care aren't able to get into the system when they need to. This also creates a backlog for enrollment specialists, which leads to further delays and increases the administrative burden to providers.

In terms current access problems, interviewees most frequently mentioned problems accessing:
- Dental care
- Behavioral health
- Specialists
- Pediatricians
- NEMT providers

KMS survey respondents were split in terms of whether KanCare has resulted in increased access to care—43% believe it has not increased access, opposed to 39% who believe it has (the remaining percentage did not respond). However, of those who noted that KanCare has resulted in benefits to the health care system in Kansas, 71% noted "increased access to care for Medicaid enrollees" as the benefit.

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Focus Area #2: Improvements in Care Delivery
ACCESS

- While most interviewees feel that access to care is being sustained by the providers in the system (rather than being improved by the MCOs), they do note several problems that have the potential to limit access or, at a minimum, create delays in KanCare enrollees being able to receive timely access to care. Examples of these problems are outlined below:

- First, one interviewee noted that an MCO's system glitch sent out letters to enrollees saying that their providers were no longer in network. While the MCO fixed the system glitch, it did not follow up with enrollees to let them know that those letters had been sent in error. The provider was left to inform both the patients and other providers of the error.

- Second, another interviewee noted that it received "premature discharge" coverage denials for enrollees who were readmitted to a hospital within 30 days. The MCO claimed that the 30 day requirement was included in their contract with KDHE, but the contact provision was actually determined to be 72 hours. The provider had to spend its time and resources fighting the claim in order to get payment.

- Third, several interviewees mentioned issues with MCO transportation contractors (e.g., responsiveness, timeliness in scheduling, no-shows). This results in patients staying in the hospital longer than needed, which drives up costs (and MCOs pushing back on covering the costs to providers). These interviewees recommend reverting back to the system that was in place before KanCare that allowed them to use local providers who bill Medicaid.

- It was also noted that the MCOs are actively recruiting doctors, where the state never did this before. However, another interviewee noted that some MCOs are beginning to narrow networks.

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Focus Area #2: Improvements in Care Delivery
ACCESS

A few providers have indicated that they are reconsidering whether they can continue to offer care to Medicaid enrollees.

- As an example, one interviewee noted their experience with KanCare has been so frustrating and costly from a resource and administrative perspective that they are no longer going to take Medicaid patients. Instead they will take a few charity cases each year. This provider is currently the only type of specialty provider in the area seeing Medicaid patients, which will limit access to care.

A few written responses to the KMS survey include:

- "Due to the low reimbursement and the difficulty in getting patient referrals due to a decrease in the number of participating physicians I anticipate that I will no longer provide care for Medicaid patients in the future."

- "I have avoided working with Medicaid patients because of the bureaucracy that I expected would be involved."

- "I have quit taking KanCare patients."

- "It is so difficult to obtain authorization for tests and procedures that I reluctantly stopped accepting any new Medicaid patients last month."

Focus Area #2: Improvements in Care Delivery
ACCESS

Number of Grievances Reported by MCO Enrollees By Category								
	CY2013		CY2014		CY2015		Jan-Jul 2016	
Category	#	% of total	#	% of total	#	% of total	#	% of total
Transportation	897	50%	936	41%	870	43%	301	37%
Claims/Billing Issues	242	14%	593	26%	379	19%	176	22%
Quality of Care or Service	139	8%	266	12%	172	9%	70	9%
Access to Service or Care	69	4%	105	5%	144	7%	78	10%
Health Plan Administration	101	6%	78	3%	52	3%	26	3%
Customer Service	163	9%	130	6%	194	10%	57	7%
Member Rights/Dignity	25	1%	36	2%	59	3%	29	3%
Benefit Denial or Limitation	37	2%	66	3%	54	3%	18	2%
Service or Care Disruption	37	2%	29	1%	19	1%	21	3%
Clinical/Utilization Management	33	2%	14	<1%	8	<1%	6	<1%
Other	37	2%	30	1%	65	3%	35	4%
Total Grievances Reported	1780		2283		2016		817	

Key Findings

- **Access to Service or Care** has increased as a percent of all enrollee grievances in each year.

- Consistent with the interviews, transportation is a major issue and has accounted for more than 40% of reported grievances each year.

- Claims/Billing Issues has the second highest number of grievances and has increased since CY2013.

- Quality of Care or Service as a percent of all grievances increased 50% in CY2014; CY2015 reflects a 25% reduction from CY2014, but it remained higher than CY2013.

Sources: Kansas Foundation for Medical Care, 2015 KanCare Evaluation, Quarterly Report, Year 3, Quarter 4, October – December. Issued Feb. 16, 2016. Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 06.30.16.

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IMPROVEMENTS TO HEALTH

IMPROVEMENTS TO HEALTH

LEAVITT PARTNERS

Rationale & Commitments

	Data/Information	Provider Experience
Commitment #1		
• Promote wellness and healthy lifestyles.	⬇	▭
Commitment #2		
• Encourage personal responsibility by creating paths to independence.	▭	⬆

⬆ The current system is meeting the stated rationale/commitments (based on assessed data).

▭ The current system is meeting the stated rationale/commitments, but improvements could be made (based on assessed data).

⬇ The current system is not meeting the stated rationale/commitments (based on assessed data).

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Focus Area #3: Improvements to Health
PROMOTE HEALTH AND WELLNESS

- In terms of promoting wellness and healthy lifestyles, one piece of data is the value-added services, or extra services, provided by the MCOs beyond what is covered under KanCare.

- Interviewees generally feel that providing value-added benefits are a positive and that they have seen improvements in the number of programs made available to KanCare enrollees.

- Other interviewees feel that some of the value-added benefits provided by the MCOs have very little or no benefit (e.g., offering teeth whitening to people with dental decay).

- The one value-added benefit that most providers agree is beneficial is the annual dental exam. Before, providers had nothing to incentivize patients to get a dental cleaning. Now that the service is covered, they have a stronger case for why patients should seek oral care. However, some providers do note that the dental benefit is fairly limited. Enrollees generally can't afford the expensive treatments that are often required after an exam and cleaning.

> The one value-added benefit that most providers agree is beneficial is the annual dental exam.

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Focus Area #3: Improvements to Health

PROMOTE HEALTH AND WELLNESS

Value-Added Services Provided by All Three MCOs				
Year	# of Value-Added Services Provided	Total Members with Access to a Value-Added Service	Total Units	Total Value
2013	9	Not reported	1,225,216	$6,270,145
2014	48	244,689	280,266	$3,933,784
2015	48	175,230	217,155	$4,430,506
01–06 2016	NR	NR	90,087	$1,922,272

Key Findings

- Total valuation of value-added services fell from 2013 to 2014.

- The valuation increased from 2014 to 2015, but not to the same level as 2013.

- While the total number of value-added services remained steady between 2014 and 2015 across the 3 MCOs, **the total number of members accessing the services fell**.

Focus Area #3: Improvements to Health

ENCOURAGE PERSONAL RESPONSIBILITY

- In general, interviewees had few, but positive things to say about personal responsibility. As an example, one interviewee noted that there has been a reduction in ED use and felt that being enrolled in managed care has helped to ensure that Medicaid beneficiaries are receiving the proper care at the proper place. Other interviewees noted they had not seen any reductions in ED visits.

- Another interviewee noted that before KanCare there was a lot of appointment "no shows." KanCare enrollees, however, tend to hold their appointments. The interviewee noted this could be a result of MCO case managers, but was not certain.

- One interviewee noted that some of the MCOs had implemented initiatives focused on ensuring patients are compliant with physician instructions. These processes in turn made clinics and specialists more cognizant of the care that they provide patients.

- That said, some interviewees did caution against putting too much emphasis on personal responsibility. They noted that many Medicaid enrollees don't have access to the information they need to make informed decisions about Medicaid, managed care, cost sharing, etc., and effectively engage in personal responsibility.

> Most KMS survey respondents do not feel KanCare has resulted in more appropriate use of health care services—48% believe it has not, opposed to 13% who believe it has (the remaining did not respond).

> In terms of KanCare meeting its stated goal of encouraging personal responsibility by creating and preserving paths to independence, 71% of KMS survey respondents feel this goal has not been met (out of those who felt KanCare had not met its goals).

Focus Area #3: Improvements to Health
ENCOURAGE PERSONAL RESPONSIBILITY

ED Visits Per 1,000 Member Months -MH Excluded

— AMG — SUN — UHC
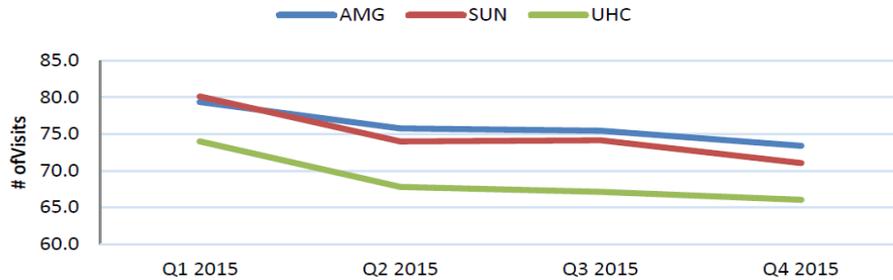
ED Visits Per 1,000 Member Months with Hospital Admission -MH Excluded

— AMG — SUN — UHC
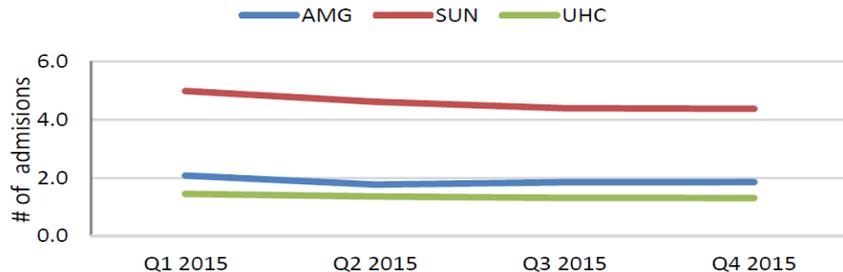
Key Findings

- Recent KDHE data indicate the KanCare program has corresponded with decreased use of the ED in CY2015.

- ED visits associated with hospital admission also declined in CY2015.

Source: KDHE report to oversight committee on Aug 5, 2016.

CONTROLLING COSTS

CONTROLLING COSTS

LEAVITT
P A R T N E R S

Rationale & Commitments

	Data/Information	Provider Experience
Commitment #1		
• KanCare will: ➤ Lower the overall cost of care ➤ Reduce growth in Medicaid spending by 8-10%; equating to 1/3 reduction in total Medicaid growth • The state estimates savings of $853 million (all funds) over 5 years (based on a baseline of 6.6% growth without KanCare reforms).	⬆ (green)	▶ (yellow)
Commitment #2		
• Savings will occur without cutting provider rates, throwing people off the system, or reducing essential benefits.	⬇ (red)	⬇ (red)

⬆ (green) The current system is meeting the stated rationale/commitments (based on assessed data).

▶ (yellow) The current system is meeting the stated rationale/commitments, but improvements could be made (based on assessed data).

⬇ (red) The current system is not meeting the stated rationale/commitments (based on assessed data).

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Focus Area #4: Reductions in Costs

# CONTROLLING COSTS

- Interviewees noted that they had not seen recent data, but generally feel that overall costs of care have increased because of the inefficiencies of the MCOs. The lack of standardization across the MCOs and problems with credentialing, payments, and other policies results in high administrative costs, which in turn increases the costs of care for providers.

- A few interviewees noted that the current for-profit MCO system has a different perception with respect to the provision of services compared to the state's previous non-profit based system. In the previous system, there was a greater focus on allocating resources back to enrollees. Today there is no perceived transparency around what, if any, resources the MCOs put back into the system.

- In terms of KanCare meeting its stated goal of controlling costs, 60% of KMS survey respondents indicated it had not met this goal; additionally, 66% felt the program had not met its goal of making the program more economically rational (out of those who felt KanCare had not met its goals).

Providers feel that if any cost savings have been achieved, it is because costs have been shifted to the providers.

Most survey respondents do not feel KanCare has resulted in better management of health care costs—47% believe it has not, opposed to 13% who believe it has (the remaining did not respond).

Focus Area #4: Reductions in Costs

CONTROLLING COSTS

KanCare Cost Comparison
CY2006- CY2017
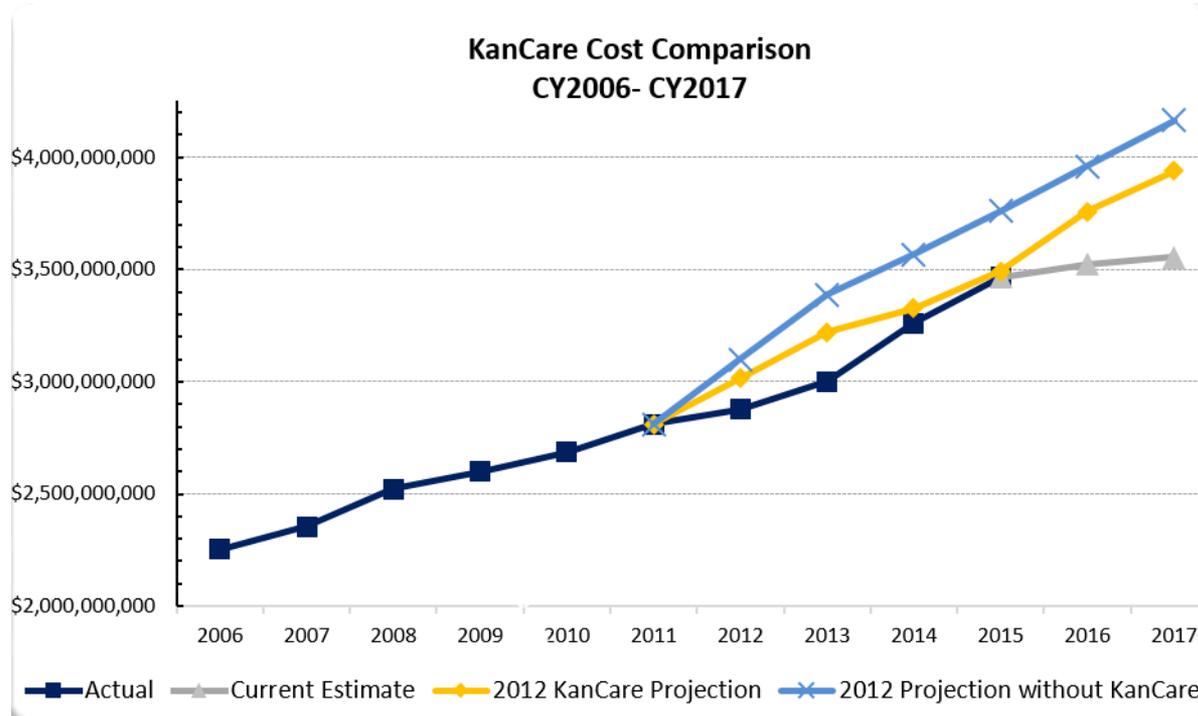
Key Findings

- To date, KanCare costs are exceeding cost control targets, which are based on the established baseline of 6.6% annual growth.

- Total expenditures, however, show a stagnant trend (see slide 47).

- The fact that at least one or more MCOs reported losses every year questions whether the program is underfunded.

Source: KDHE report to the KanCare Oversight Committee.

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Focus Area #4: Reductions in Costs
CONTROLLING COSTS

Total Expenditures/Total Member-Months (Quarterly)
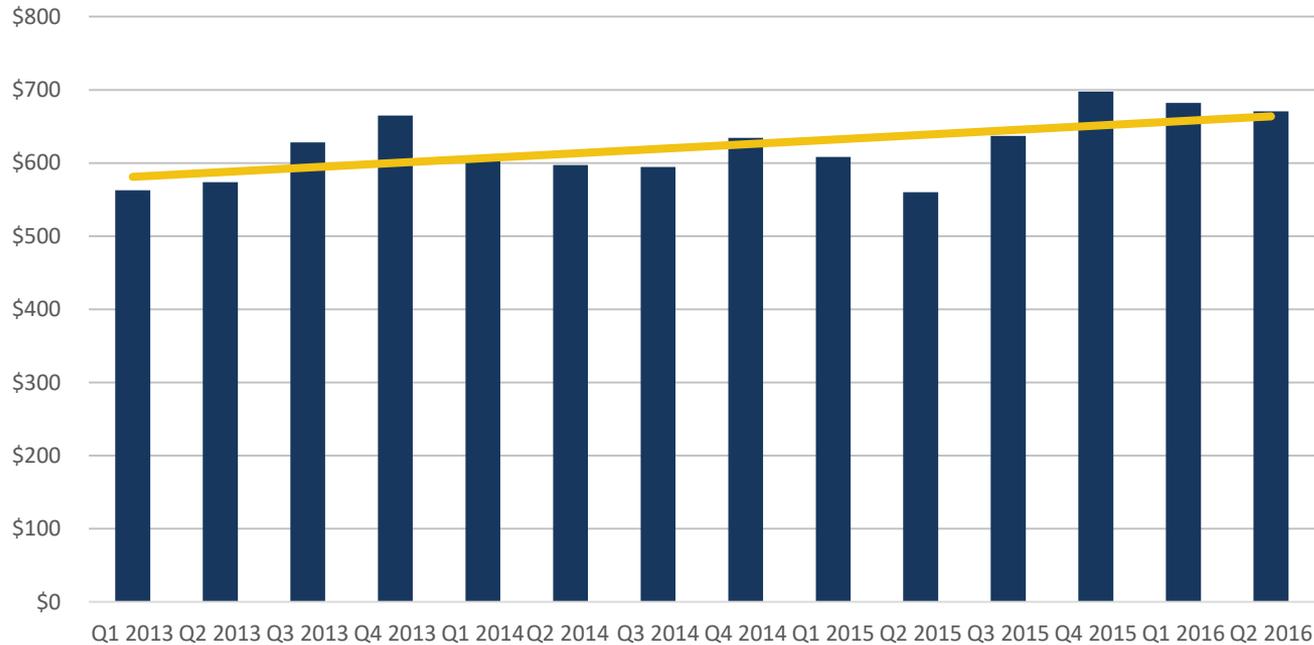
Key Findings

- Total expenditures show a stagnant or slightly increasing trend (i.e., yellow trend line).

Sources: Quarterly Reports to CMS Regarding Operation of 1115 Waiver Demonstration Program; Q1 2013 to Q1 2016. Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 06.30.16.

Focus Area #4: Reductions in Costs

CONTROLLING COSTS

Financial Metric 2013	National Composite Mean	25th percentile	50th percentile	75th percentile	Kansas
MLR	87.4%	83.5%	87.3%	92.0%	100.0%
ALR	11.4%	8.3%	11.0%	13.7%	11.1%
UW Ratio	1.2%	(1.8%)	1.0%	4.2%	(11.2%)

Financial Metric 2014	National Composite Mean	25th percentile	50th percentile	75th percentile	Kansas
MLR	86.0%	81.8%	86.5%	90.8%	97.3%
ALR	11.9%	9.1%	12.1%	14.6%	8.4%
UW Ratio	2.1%	(2.3%)	1.9%	5.2%	(5.7%)

Financial Metric 2015	National Composite Mean	25th percentile	50th percentile	75th percentile	Kansas
MLR	85.4%	81.2%	85.8%	89.3%	83.4%
ALR	12.0%	9.6%	12.0%	14.7%	10.7%
UW Ratio	2.6%	(0.5%)	2.6%	5.5%	5.9%

Definitions

- MLR – Medical Loss Ratio; percent of premium revenue used to fund claim expenses.

- ALR – Administrative Loss Ratio; percent of premium revenue used to fund administrative expenses.

- UW Ratio – Underwriting Ratio; sum of MLR and ALR subtracted from 100%; positive UW ratio reflects financial gain and negative reflects a loss.

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Source: Milliman. Medicaid risk-based managed care: Analysis of financial results for 2013, 2014, & 2015.

Focus Area #4: Reductions in Costs
CONTROLLING COSTS

Financial Metric 2013	National Composite Mean	Kansas
MLR	87.4%	100.0%
ALR	11.4%	11.1%
UW Ratio	1.2%	(11.2%)

Financial Metric 2014	National Composite Mean	Kansas
MLR	86.0%	97.3%
ALR	11.9%	8.4%
UW Ratio	2.1%	(5.7%)

Financial Metric 2015	National Composite Mean	Kansas
MLR	85.4%	83.4%
ALR	12.0%	10.7%
UW Ratio	2.6%	5.9%

Key Findings

- CY2013–2014 show that all three plans lost money in terms of directing all premium revenue to claims (100% in CY2013 and 97.3% in CY2014).

- In CY2015, the MLR for Kansas MCOs fell to 83.4%. Kansas MCOs also reported increased administrative expenditures (10.7%).

- The combination of a MLR of 83.4% and ALR of 10.7% led to a positive UW ratio of 5.9% in CY2015. This compares to a national composite mean UW ratio of 2.6% and represents significant gains from prior years where the UW ratio was negative.

- It also brings into question the MCOs' low administrative costs (ALR), compared to the national average. This low ALR may aligns with interviewees' comments about the MCOs' poor customer service, not being responsive, and potentially using payment delays to reduce both their ALR and MLR.

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Source: Milliman. Medicaid risk-based managed care: Analysis of financial results for 2013, 2014, & 2015.

Focus Area #4: Reductions in Costs
CONTROLLING COSTS

Medical Loss Ratio CY 15-16 — AMG — SUN — UHC
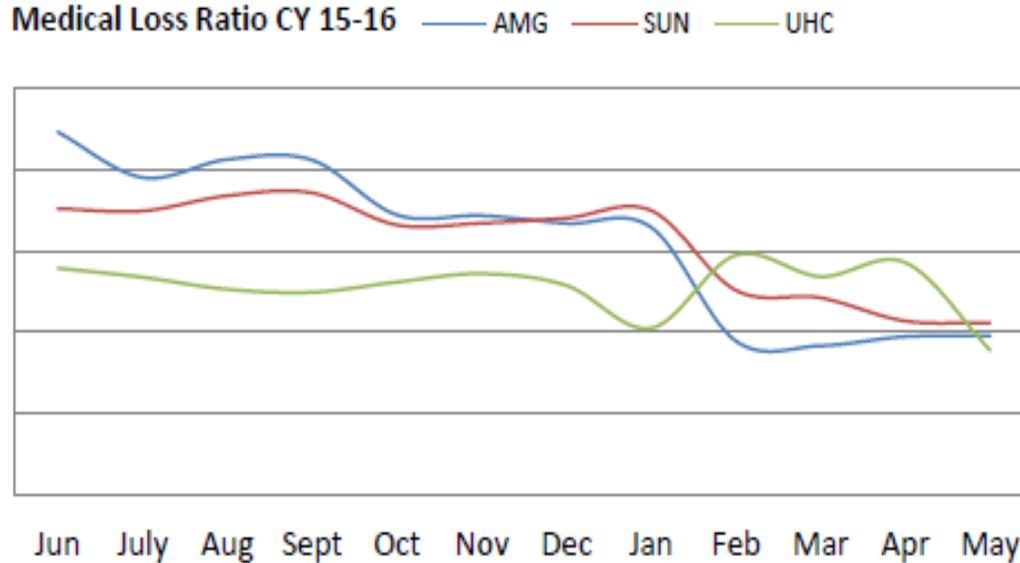
Key Findings

- The reduced MLR reported in the Milliman CY2015 report is also reported by KDHE.

- The 2016 Medicaid managed care rule include provisions related to MLR and a recommendation that states require a minimum level of 85%. States have the authority to impose a higher MLR (several states require 90%).

Source: KDHE. August 4th report to the Robert B. (Bob) Bethel Home and Community-Based Services and KanCare Oversight Committee.

Focus Area #4: Reductions in Costs

CUTTING PROVIDER RATES

- The recently announced rate reductions have placed providers in the position of making choices they never wanted to make, including whether to limit acceptance of new Medicaid enrollees, whether to exit as a Medicaid provider, whether to limit the number of MCOs the provider is willing to contract with, and whether to eliminate other optional/value-added services to compensate for rate reductions (e.g. transportation services).

- Interviewees noted that rate adjustments have been significant. Some rate cuts have been publicly called for by the administration. Others have been made through technical adjustments outside of a SPA.

- Rate reductions could have a negative impact on access to specialists given that interviewees feel the number of specialists willing to serve Medicaid beneficiaries in some areas is already limited. This could lead to an increase in costs if the number of out-of-network providers increases.

- Interviewees also mentioned that the most recent rates cuts are not clear and that there is confusion on exactly what services are impacted by the reductions.

> One of the commitments of KanCare was to achieve savings without cutting provider rates.
>
> This commitment has not been kept. Additionally, provider rates have not increased in over a decade.

Focus Area #4: Reductions in Costs
# CUTTING PROVIDER RATES

2005: Medicaid fee schedules increased with implementation of hospital provider assessment.

2010: Provider rates reduced by 10%. This was a one quarter, time-limited reduction.

2016: Provider rates reduced by 4%. This is not a time limited reduction. The only provision the state has offered to offset the loss is raising the hospital tax.*

Effective 7/1/16; SPAs were submitted on Sept. 30, but as of Oct. 17, KDHE has yet to receive necessary CMS approvals

Payments proposed to be excluded from the reduction:
- Critical Access Hospitals, Rural, and Frontier Hospitals (Inpatient and Outpatient Services Only)
- Home and Community-Based Services providers
- Rural Health Clinics and FQHCs, Encounter Rate
- Electronic Health Record (EHR) Payments
- Fee-for-Service Pharmacy Claims
- Hospice Services
- WORK Program
- MFP Services
- State Hospitals
- Indian Health Services

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Focus Area #4: Reductions in Costs
ELIGIBILITY DELAYS
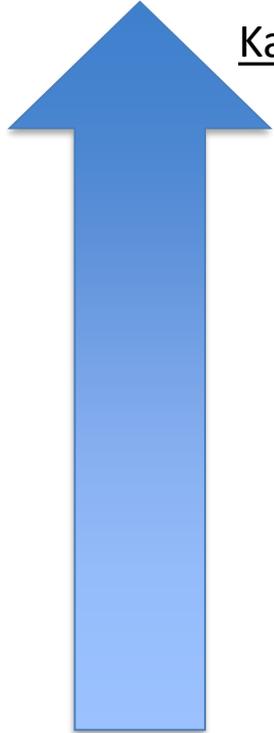
Kansas Medicaid Backlog

- May 15, 2016: 15,400 (the number increased by 12,000 due to a contractor error; 10,900 had been in the queue for more than 45 days)

- May 8, 2016: 3,500

- April: 7,700

- March 2016: 15,800

- February 2016: 18,200 (7,750 of which had been in the queue for more than the federal limit of 45 days)

- January 2016: ~10,000

Although KanCare is not "throwing" people off the system, the state's Medicaid application backlog has delayed eligibility and enrollment for thousands of people.

Interviewees noted that some providers are now unwilling to take patients if their Medicaid application is pending. Others noted the eligibility delays are increasing the costs to other programs (e.g. Adult Protective Services) that cover the services in the interim. This results in a shift rather than reduction of state costs.

Source: CJOnline & KHI

MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS)

Note: Seeking the experience of LTSS providers was not within the scope of this review so the provider experience reflected here comes from health care providers.

MLTSS

Rationale & Commitments

The current system is meeting the stated rationale/commitments (based on assessed data).

The current system is meeting the stated rationale/commitments, but improvements could be made (based on assessed data).

The current system is not meeting the stated rationale/commitments (based on assessed data).

	Data/Information	Provider Experience
Commitment #1		
• Reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired.	⬆	⬇
Commitment #2		
• Support members' desire to live successfully in their communities.	⬆	⬇
Commitment #3		
• Provide integrated care coordination to individuals with developmental disabilities, which will improve access to health services and improve the health of those individuals.*	NA	NA

*Note: Review of this commitment was not included in the review as it is specific to the narrow groups of providers that work with this population.

Focus Area #5: MLTSS

MLTSS

- Interviewees noted significant issues with MLTSS network adequacy, which limits care coordination and makes discharge and placement difficult. Some programs have waitlists that are 18+ months long.

- As a result, patients back up in hospitals while placement and services are secured and pre-authorizations are approved. Since hospital payments are based on DRGs, the delay results in increased costs to hospitals and reduced costs to MCOs.

- Another barrier is timely access to non-emergency medical transportation. As an example, one interviewee indicated that they have at least one patient every week that has to spend an extra day in the hospital because transportation is not available.

- Issues with eligibility and enrollment are a major barrier as well. It was noted that LTSS applications often pend for extended periods of time.

- MCOs exacerbate this problem by not updating eligibility and enrollment files in a timely manner.

Interviewees feel that the MCOs have not been helpful in terms of placing individuals in the community and that access to community providers is limited due to low reimbursements.

Focus Area #5: MLTSS

MLTSS

Total number of individuals in nursing facilities and public ICF/IDDs: Pre-KanCare and Years 1-3					
Program	CY2012	CY2013	CY2014	CY2015	% Change CY2012–2015
Nursing Facilities	14,913	14,517	14,565	14,163	-5%
Public ICF/IDDs	350	344	337	328	-6.3%

Source: Data pulled from KDHE annual KanCare Reports for Years 1, 2 and 3.

Note: Some providers question whether part of the decline can be attributed to delays in eligibility and enrollment processing as opposed to individuals accessing HCBS in lieu of placement in a nursing facility or public ICF/IDD.

Key Findings

- Aligning with the state's original commitment and continuing a trend begun before KanCare, the state has experienced declines in the number of individuals in nursing facilities and public ICF/IDDs each year of KanCare implementation.

- Through December 31, 2015, the decline in nursing facility residents totaled 5% from the pre-KanCare baseline used in evaluating the waiver and the decline in ICF/IDDs totaled 6.3%.

Focus Area #5: MLTSS

MLTSS

Number of Individuals Transferred from Nursing Facilities to HCBS in Money Follows the Person (MFP) Program					
MFP Program Transition	FE	IDD	PD	TBI	Total
CY2013 Actual	35	29	110	8	182
CY2014 Actual	53	18	137	6	214
CY2015 Actual	55	30	150	7	242
CY2016 Actuals (through 6/30/2016)	27	4	48	0	79
CY2016 Target	65	37	198	10	310

Source: MFP data pulled from KDHE KanCare Reports for Years 1, 2, and 3 and from KDADS report to KanCare Oversight Committee on August 5, 2016. FE = frail elderly; IDD – individuals with intellectual/developmental disabilities; PD = Physically Disabled; TBI = traumatic brain injury.

Key Findings

- With exception of CY2013, KDADS reports meeting or exceeding all MFP transition benchmarks.

- Data from KDADS show that under KanCare, the state is meeting or exceeding its post transition benchmark of 80% of individuals who transition receiving adequate services/supports to remain successfully in the community for all of the target populations.

Focus Area #5: MLTSS

MLTSS

Waiting List	Total Number of Individuals on Waiting List			
	YR 1: Data as of 12/31/13	YR 2: Data as of 1/12/15	YR 3: Data as of 1/31/16	YR 3: Data as of 06/16
Intellectual/ Developmental Disabilities Waiver Program	3,141	3,073	3,455	3,387
Physical Disabilities Waiver Program	Est. 2,000 (noted list undergoing verification)	2,523	1,469	438

Sources: Waiting list and number entering HCBS data reported by KDHE KanCare Annual Reports for Years 1, 2 and 3. Annual reports also report on the number of individuals moved off the waiting lists and the reason why including whether the individual was placed on services. Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 06.30.16.

Note: In August 2016, it was reported that the waiting list for Kansans with physical disabilities fell by more than 1,700, effectively clearing the waiting list. (Article here). However, some interviewees expressed concern with the accuracy of these reports and questioned whether it was a reflection of individuals receiving services or being dropped from the list because current contract information was not available.

Key Findings

- Data reflect annual increases in the number of individuals entering HCBS.

- In CY2013, 182 individuals were reported to be placed in HCBS from the I/DD Waiting List and 858 individuals with physical disabilities were placed in HCBS.

- In CY2014, 243 individuals from the I/DD Waiting List entered HCBS; 461 individuals with physical disabilities entered HCBS.

- In CY2015, 347 individuals from the I/DD Waiting List and 1,025 from the Physical Disabilities Waiting List entered HCBS.

Focus Area #5: MLTSS
MLTSS

Percentage of Long-Term Services and Support Expenditures that Home and Community-Based Services, Kansas and United States, 2009-2014

- KS - Percentage of LTSS that is HCBS
- US - Percentage of LTSS that is HCBS
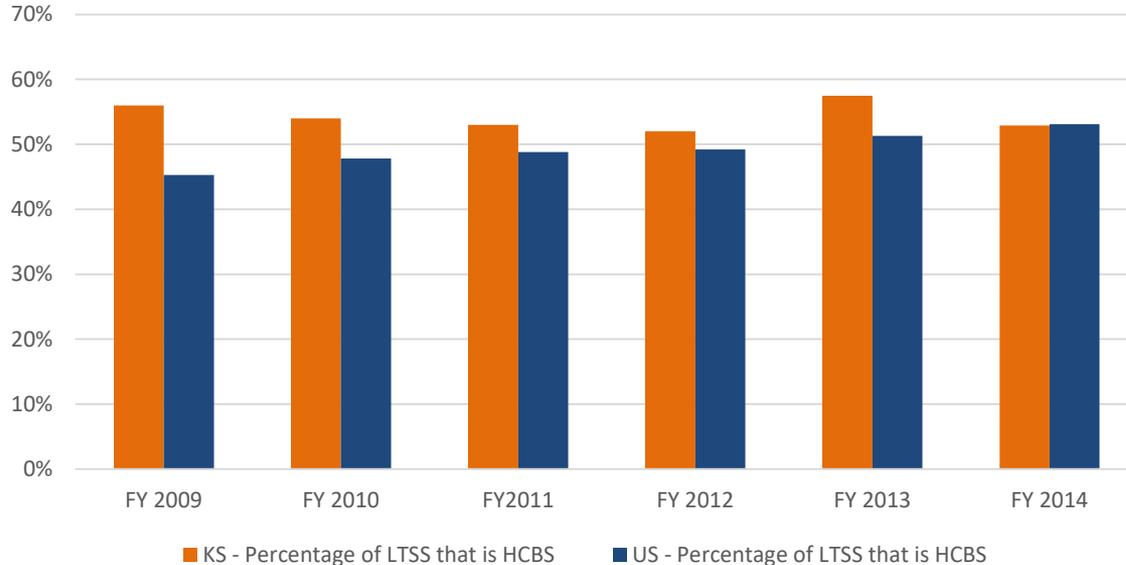
Key Findings

- The percent of LTSS expenditures that are dedicated to HCBS has trended down in Kansas since 2009. This is contrary to the national trend.

- The percent did increase in the first year of KanCare, but reverted to prior levels in 2nd year while, nationally, the number increased each year.

- Of specific note, caseloads in HCBS waivers for the frail elderly and physically disabled have trended downward.

Source: Truven Health Analytics; Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY2014: Managed LTSS Reached 15 Percent of LTSS Spending; April 15, 2016.

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RECOMMENDATIONS

RECOMMENDED CHANGES TO THE PROGRAM

- **MCO administrative simplification and standardization:** Interviewees would like to see greater standardization across the MCOs, including appeals processes, prior authorization processes, encounter data provision processes, credentialing processes, and clear guidelines on approval and payment of emergency services.

  Recommendation: MCO contracts include provisions to standardize "work processes" between the state and all KanCare providers (see slide 24); however, many of these processes have not been standardized to date. The state should strengthen language in the current contracts and hold MCOs accountable to these contract provisions by setting specific dates and expectations for compliance.

  The state should also consider implementing a one-stop, electronic credentialing system. The Arizona Health Care Cost Containment System (AHCCCS) initiated a centralized credentialing system in 2012 that processes all initial credentialing forms for the Medicaid MCOs and their network providers. Arizona initiated creation of this system in order to create a one-stop process "… making the credentialing and re-credentialing process easier for our providers…."[1]

  If greater standardization cannot be achieved, then the state may consider limiting the number of MCOs to two (federal regulations require a minimum of two MCO per region to ensure enrollee choice). KDHE should evaluate KanCare populations and providers on a regional basis and determine if two MCOs may be appropriate.

[1] Announcing New Coordinated Credentialing Process to Ease the Credentialing Burden on Arizona Providers, AZAHP (October 31, 2012). Available from http://www.azahcccs.gov/Shared/Downloads/News/CredentialingAlliance.pdf.; AHCCCS website. Available from http://www.azahcccs.gov/commercial/.

RECOMMENDED CHANGES TO THE PROGRAM (CONT.)

- **KanCare MLR**: Both data and interviewees suggest that KanCare is underfunded. For example, the MCOs' low administrative costs (ALR) in CY2015 could have resulted in higher profits for the MCOs compared the national average. The low ALR may also be a reflection of interviewees comments about MCOs' poor customer service, general unresponsiveness, and potentially using payment delays to reduce both the MLR and ALR.

  Recommendation: The state should amend current MCO contracts to include a minimum MLR of at least 85% and rates should reflect this level. This would help to ensure that the MCOs comply with the Medicaid managed care rule, which imposes a minimum 85% MLR effective July 1, 2017. It would also help to ensure that the MCOs do not reduce medical or administrative expenditures to the point where care delivery is negatively impacted. The managed care rule does not set a maximum MLR, but indicates that states should consider an appropriate maximum to ensure that the capitation rates are adequate for necessary and reasonable administrative costs.

RECOMMENDED CHANGES TO THE PROGRAM (CONT.)

- **Pay-for-Performance Standards**: As noted earlier, in its first year of operation KanCare's Pay-For-Performance (P4P) system withheld 3% of MCO premiums that the MCOs could earn back based on their performance on 6 measures: (1) timely claims processing; (2) encounter data submission; (3) credentialing; (4) grievances; (5) appeals; and (6) customer service.

  Recommendation: The state should consider reinstituting P4P measures that encompass administrative processes related to claims processing and credentialing. Measures should reflect contractual standards. This would reinforce the importance of making improvements in these areas and allow performance to be tracked over time.

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RECOMMENDED CHANGES TO THE PROGRAM (CONT.)

- **Increased oversight of the MCOs:** Interviewees noted that KDHE needs to be more involved in monitoring MCO systems and sharing results with providers. Interviewees felt increased oversight could help resolve many of the problems they identified, including reducing the lag time between state policy changes (both programmatic and rate changes) and MCOs making system adjustments.

Recommendation: The Medicaid managed care rule modernizes MCO monitoring standards to include, at a minimum, the following mandatory components of an oversight program: (1) administration/management; (2) appeal/grievances; (3) claims management; (4) enrollee materials/customer services; (5) finance/MLR reporting; (6) information systems; (7) marketing; (8) medical management; (9) program integrity; (10) provider networks; (11) availability and accessibility of services; (12) quality improvement; (13) LTSS; and (14) other provisions as appropriate. States are required to use monitoring and oversight activities to improve MCO performance.

In addition to monitoring the MCOs, KDHE should ensure accountability and oversight of subcontractors engaged by the MCO (e.g., behavioral health subcontractors). This should include clear expectations and standards for care coordination and integration that flows from the administrative level to the clinical level.

It should be noted that KDHE is engaged in several monitoring activities that should continue. Consistent updates on these activities and their results should be better communicated to providers through stakeholder meetings and making meeting minutes available on the state website. The KanCare Advisory Committee could also help facilitate these conversations.

RECOMMENDED CHANGES TO THE PROGRAM (CONT.)

- **Increased transparency:** Related to improved communication, several interviewees noted the need for more transparency from the state and the MCOs in terms of cost, quality and MCO financial and performance data.

  Recommendation: One of the requirements from the Medicaid managed care final rule is that states develop a website dedicated to its managed care program. The website must include: (1) copies of MCO contracts; (2) verification that the MCOs comply with access and availability of services requirements; (3) the name and title of individuals with MCO ownership and control responsibilities; (4) results of any applicable audits; (5) network adequacy standards; (6) MCO accreditation status; (7) evaluation and effectiveness of the quality strategy reports; and (8) encounter data (optional, but must be provided upon request).

  The state should move quickly to comply with these requirements and develop a website that is easy to use and navigate (compliance dates for most of the data, documents, or information is July 1, 2017). This would help increase transparency in terms of cost, quality and MCO payment data.

RECOMMENDED CHANGES TO THE PROGRAM (CONT.)

- **Improved communication with the MCOs:** Interviewees would like communication with the MCOs to be more streamlined and consistent. Improved communication is especially needed around the payment denial and appeals process. Going through the state appeals process every time there is a concern is not effective given the number of denied claims. They would like to work with a single representative that has time to adequately answer questions and concerns. Providers would also like more timely information on enrollees. Having this information can facilitate provider outreach and enrollee engagement.

  Recommendation: MCOs should work to improve communication with providers in their network. This could include assigning one or more designated representatives to each provider organization. This representative should have established relationships with the provider organization and make regular onsite visits. These or other representatives could also provide basic billing education and address questions related to payments that don't warrant going through the full appeals process.

  MCOs should work to ensure that their administration, provider relations, and customer service staff are adequately trained and responsive to provider inquiries.

RECOMMENDED CHANGES TO THE PROGRAM (CONT.)

- **Improved communication with KDHE:** Interviewees would also like to see improved communication and stronger supports from the state. Interviewees also mentioned that they would like more frequent and regular opportunities to provide input on proposed policy and/or rate changes.

  Recommendation: Despite the number and frequency of stakeholder meetings, providers don't feel supported or engaged. In order to improve communication, the state should consider whether an existing workgroup could be repurposed to better support providers and address the problems noted by interviewees (e.g., the Provider Operations Issues (POI) Work Group, which was "disbanded in favor of short term, targeted workshops"). Repurposing these workgroups could include more frequent and ongoing information sharing as well as mechanisms to identify and resolve problems. Workgroup members should be reevaluated to assure that individuals with decision making authority are included.

  If repurposing an existing workgroup is not a viable approach, then KDHE could be encouraged to designate a single point of contact for MCOs and providers to address problems and resolve issues with the state.

  Two of the stakeholder groups that were mentioned as being effective were the KanCare implementation technical assistance group (KTAG) and the FQHC technical assistance group (TAG). KDHE should continue to support these groups and providers should consider joining or finding ways to obtain key learnings.

RECOMMENDED CHANGES TO THE PROGRAM (CONT.)

- **Increased benefit education for enrollees:** Interviewees noted that there is a need for a comprehensive beneficiary on-boarding process developed and provided by the state. This will ensure information is uniform and consistent and that beneficiaries have the information they need to be responsible consumers.

Recommendation: KDHE should seek and utilize the input and guidance of providers, enrollees, and other stakeholders in the development of its Beneficiary Support System as required under the Medicaid managed care rule. The system must be available in multiple ways (phone, internet, in-person, and via auxiliary aids and services) and must perform three minimum functions: (1) choice counseling; (2) assistance to all beneficiaries in understanding managed care; and (3) assistance for enrollees who receive or desire to receive LTSS.

With respect to beneficiaries that use or desire to use LTSS, the beneficiary support system must provide: (1) an access point for complaints and concerns about enrollment, access to covered services, and related matters (this provision also applies to PCCM and PCCM entities); (2) education on enrollees' grievance and appeal rights, the state fair hearing process, and rights and responsibilities; (3) assistance, without representation, upon request, in navigating the grievance and appeal process and appealing adverse benefit determinations made by a plan to a state fair hearing; (4) review and oversight of LTSS program data to assist the state Medicaid Agency on identification and resolution of systemic issues.

This system is in addition to the beneficiary support system developed and operated by MCOs. KHA and other provider groups should hold KDHE accountable for the development and effectiveness of this system.

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RECOMMENDED CHANGES TO THE PROGRAM (CONT.)

Other suggested improvements include:

- Updating outdated medical policies.

- Offering value based payment options for those providers who are ready to engage in alternative payment models.

- Developing organized, enterprise level efforts spanning KDHE, MCOs, and providers to focus concerted efforts on improving population health outcomes for the Medicaid population.

- Improving the eligibility and enrollment system.

- Developing a streamlined post-acute care application and approval process.

- Looking for opportunities to increase investments and strengthen the overall system, such as Medicaid expansion.