

Medicaid Service Access Monitoring Plan – October 2016



**State of Kansas
Kansas Department of Health and Environment
Division of Health Care Finance**

Table of Contents

I. Background and Context	1
II. Managed Care Protections.....	4
III. Member Surveys.....	4
IV. Reviews of Managed Care Organizations.....	6
V. KanCare Information Reported to CMS	8
VI. Conclusion	9

I. Background and Context

The purpose of this plan is to comply with the new terms of 42 CFR 447.203 (b), related to monitoring access to Medicaid services in a fee for service (FFS) program. Pursuant to sub-section (5) of that new rule, the state Medicaid agency is to develop its access monitoring review plan for FFS programs by October 1, 2016, and then update the plan by October 1 each subsequent year (and in special situations such as provider rate reductions or restructuring).

Effective January 1, 2013, Kansas was granted authority by the Centers for Medicare and Medicaid services to operate an 1115 demonstration waiver, which moved nearly all of the state’s Medicaid services into a comprehensive managed care structure. The program launched pursuant to that authority is the KanCare managed care program, through which capitation payments are made to three contracting managed care organizations to manage and pay providers for Medicaid-funded services in Kansas.

As noted in the “Final Rule With Comment Period” issued with the regulatory changes associated with the FFS access monitoring plan requirements:

Comment: Many commenters requested that we broaden the proposed regulatory framework to apply to provider payment rates beyond those authorized under the Medicaid state plan. Commenters specifically requested that the regulation apply to rates paid by Medicaid managed care organizations and rates paid under Medicaid waiver programs. Many commenters were concerned that a proposal to address access issues under managed care delivery systems is needed. Some commenters called for specific revisions to managed care regulations to set forth clearer standards for managed care rate reviews. One commenter suggested that CMS should incorporate into the actuarial soundness review, standards for transparency in rate setting for managed care organizations and require states to evaluate the impact of managed care rate cuts on access. Another commenter offered that the rule should be extended to apply to children enrolled in managed care.

Response: As stated in the May 6, 2011 proposed rule, section 1902(a)(30)(A) of the Act specifically applies to payment for care and services available under the state plan, which **we interpret to refer to payments to providers and not to capitated payments to managed care entities. While Medicaid access to services under managed care arrangements is an important issue, that issue is addressed through reviews of network sufficiency and managed care quality review processes. As a result, we are not addressing access to care under managed care arrangements in this rulemaking effort. Similarly, methods to assure access to care, including payment methodologies, are reviewed in the approval process for Medicaid waiver and demonstration programs (and, when appropriate, may be monitored in the evaluation of a demonstration program).** As a result, we did not specifically address those programs within the context of this rulemaking process. Separate recent CMS initiatives have addressed the framework for Medicaid managed care and home and community based service programs, including access and quality review methods. In January 16, 2014, we issued the “Home and Community-Based State Plan Services Program, Waivers, and Provider Payment Reassignments” final rule ([79 FR 2947-3039](#)), and on June 1, 2015, we published the “Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions related to Third Party Liability” proposed rule ([80 FR 31097- 31297](#)) which proposed to align the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans. **The Medicaid managed care proposed rule specifically discusses requirements for network adequacy.**

* * *

Comment: Commenters requested specific exceptions to the procedures described in the final rule based on state Medicaid program features. As examples, commenters requested exceptions for states with a majority of individuals enrolled in managed Medicaid and relatively few enrolled in FFS systems, states with all payer payment systems, states that pay Medicare rates,

and for services where Medicaid is the only or primary payer of care. The commenters stated that requiring states with these program features to follow the procedures described in the rule would be inefficient.

Response: This final rule with comment period applies to all covered services under the state plan for which payment is made on a FFS basis. However we are soliciting comments through the final rule with comment period on whether we should consider further rulemaking or guidance, as appropriate, to allow for such exemptions to the scope of required access reviews required under § 447.203(b)(5), including whether to permit streamlined approaches to measuring access to care based on specific circumstances within states. For instance, we are particularly interested in whether states with higher percentages of beneficiaries enrolled with managed care organizations should be exempt from conducting the ongoing access data reviews and/or the rate reduction monitoring procedures and what threshold for such exemptions would be appropriate. **We understand that many states carve out certain services from managed care capitation rates and continue to pay for those services through FFS.** We also understand that many of the individuals who remain in state FFS systems may have complex care needs. We note that states already have significant flexibility within the final provisions of the rule to choose measures within their access monitoring review plans that are tailored to state delivery systems. This could allow, for instance, a state with high levels of managed care enrollment to focus on specific care needs of the populations that remain in FFS after a managed care transition.

<https://www.federalregister.gov/articles/2015/11/02/2015-27697/medicaid-program-methods-for-assuring-access-to-covered-medicaid-services> (retrieved 8.8.16)

The KanCare managed care program does not include any significant carve out of services; substantially all services and members are included in the capitation rates. There are no significant numbers of members or services that continue to be paid as FFS. As noted in the CMS Special Terms and Conditions issued for the KanCare program (item #19), the only excluded eligibility categories are: SOBRA; QMB; LMB; E-LMB; PACE; ICF/ID; and residents of NFMH facilities. The result of those limited exclusions is a very limited FFS program. For example, regarding the six service areas addressed in 42 CFR 447.203(b)(5) as requiring analysis in the FFS access monitoring review plan, there are an extremely limited portion of Kansas Medicaid members receiving services paid through FFS. As reflected in this calendar year 2015 service information:

Service Type	Percentage of Kansas Medicaid/KanCare Members With A Service Paid As Fee For Service in 2015
Primary Care Services	1.90%
Dental Services	0.09%
Physician Specialist Services	2.45%
Behavioral Health Services	2.97%
Pre- and Post-Natal Obstetric Services	1.74%
Home Health Services	0.28%

As noted in the access monitoring plan regulatory comments above, there are many safeguards included in the managed care structure, which ensure that access issues are regularly monitored, reviewed, reported and acted on by both managed care entities and the state. As such, it would not be an effective utilization of resources to develop a separate monitoring and reporting process for the small remnant of services paid for as FFS in Kansas. Accordingly, Kansas will utilize the managed care program protections, described further below, to ensure effective access practices for all Kansas Medicaid members.

II. Managed Care Protections

Consistent with the terms of 42 CR 447.203, and the CMS regulatory comments related to the intent of those terms, the KanCare program of managed care services in Kansas, and the extensive federal regulatory protections associated with managed care programs, functionally govern to address access monitoring issues for Medicaid services in Kansas. The managed care regulatory safeguards include numerous state agency compliance/performance monitoring and reporting requirements; multiple opportunities for member input about and avenues to raise concerns regarding their experiences specifically and the program more broadly; and a range of mandatory and optional external review organization validation and compliance/performance monitoring and reporting requirements. For the KanCare program specifically there is an additional level of access safeguards incorporated into the CMS Special Terms and Conditions issued for the KanCare program. Included within those safeguards are cycles of quality improvement that involve review, reporting, identification of any gaps, addressing the gaps by corrective action or compliance activities, and then the cycle beginning again. Because of the de minimis amount of services paid as FFS in Kansas, the managed care protections will govern to ensure service access in the Kansas Medicaid program.

Some of the many compliance review and performance monitoring/reporting safeguards required as part of the KanCare program are highlighted below for the reader's information.

III. Member Surveys

Every year under the KanCare program, a variety of surveys are conducted to gain information about member experiences involving access to and quality of services. These surveys are required by regulatory or contractual requirements and include:

- Consumer Assessment of Healthcare Providers & Systems (CAHPS). This is part of a family of surveys developed by CMS and overseen by the Agency for Healthcare Research and Quality.
 - There are 46 questions included within this survey set, conducted for members of each of the three KanCare MCOs, over multiple years, addressing issues related to access for both adult and youth members of KanCare. Some example questions follow.
 - In the last six months, did you (your child) have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?
 - In the last 6 months, when you (your child) needed care right away, how often did you (your child) get care as soon as you (he or she) needed?

- In the last 6 months, did you make any appointments for a check-up or routine care (for your child) at a doctor's office or clinic?
 - In the last 6 months, how often did you get (when you made) an appointment for a check-up or routine care (for your child) at a doctor's office or clinic (how often did you get an appointment) as soon as you (your child) needed?
- In the last 6 months, how often was it easy to get special medical equipment or devices for your child?
 - Did anyone from your child's health plan, doctor's office, or clinic help you get special medical equipment or devices for your child?
- In the last 6 months, did you get or try to get special therapy such as physical, occupational, or speech therapy for your child?
- In the last 6 months, did you get or try to get treatment or counseling for your child for an emotional, developmental, or behavioral problem?
- In the last 6 months, did you get or refill any prescription medications for your child?
 - In the last 6 months, how often was it easy to get prescription medicines for your child through his or her health plan?
- Kansas Medicaid Mental Health Consumer Perception Survey. The State has contracted with the Kansas Foundation for Medical Care, Inc., to administer this survey annually to Medicaid members since 2009. This survey has continued under the KanCare program, administered to a sample of both adult and youth members utilizing mental health services.
 - There are 21 questions included within this survey which address issues related to access for both adult and youth members statewide. Some example questions follow.
 - During a crisis, I was able to get the services I needed.
 - The crisis services were available as soon as I needed.
 - The location of services was convenient for me.
 - Services were available at times that were good for me.
 - I was able to get all the services I thought I needed.
 - I was able to see a psychiatrist when I wanted to.
 - Medication was available timely.
- Annual SUD Member Satisfaction Survey. This is a collaborative point in time convenience survey of members using Substance Use Disorder (SUD) services. It is conducted jointly by the three KanCare MCOs, building upon similar surveys conducted by the prior SUD managed care contractor in Kansas, under the guidance of the State and the state's contracting EQRO.
 - There are 9 questions included within the survey which address issues related to access for both adult and youth members statewide. Some example questions follow.
 - Thinking back to your first appointment for your current treatment, did you get an appointment as soon as you wanted?
 - Is the distance you travel to your counselor a problem or not a problem?
 - In the last year, did you need to see your counselor right away for an urgent problem?
 - If yes to previous question: How satisfied are you with the time it took you to

see someone?

- If yes to previous question: Were you seen within 24 hours, 24 to 48 hours, or did you have to wait longer than 48 hours?

Results of these surveys are included in compliance reviews, federal reporting and ongoing management of the KanCare program. In addition, Kansas participated in the first CMS Nationwide Adult Medicaid (NAM) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey in 2015 and will be reviewing the results of that process and member responses from Kansas vis-à-vis other states when the results are made available later this year.

IV. Reviews of Managed Care Organizations

Under the regulations which govern managed care programs, the state must contract with an External Quality Review Organization (EQRO) to conduct mandatory and optional independent review activities. For the KanCare program, Kansas has contracted with the Kansas Foundation for Medical Care, Inc., and works closely with them to ensure the required reviews are completed and reported timely. An annual summary of the EQRO activities is developed and submitted to CMS, and for the 2016 submission the following activities/results were reported:

- Balanced Budget Act (BBA) Compliance Follow-Up Review
- Information Systems Capabilities Assessment
- Performance Measure Validation
- Performance Improvement Projects (PIPs) Validation
- Mental Health Consumer Perception Survey
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan 5.0H Survey Validation
- Provider Survey Validation

Many of the EQRO activities address issues related to timely, appropriate and effective access to care for KanCare members. CMS has issued protocols for the EQROs to utilize when conducting their reviews of managed care programs and plans, which are an important part of the EQRO reviews of KanCare. For example, the protocols for the BBA Compliance reviews – which address all regulatory components that govern managed care organizations – include this sampling of compliance interview questions:

- From the “MCO Leaders” Section:
 - Availability of Services (438.206)
 - Describe the MCO’s process for assessing the needs for providers to deliver each type of covered service and need for major specialties within each type. What issues were considered in the assessment process?
 - How does the MCO determine the adequacy of its network to serve its Medicaid enrollees?
 - What assumptions and methodologies are used to project the number, type (in terms of training, experience, and specialization) and location of primary care providers and specialists necessary to serve its anticipated Medicaid enrollees?
 - Furnishing of Services and Timely Access (438.206(c)(1))
 - Describe how the MCO monitors for compliance with its Medicaid standards for timely access to care and services.
 - How does the MCO ensure the 24 hours per day, 7 day per week availability of Medicaid services included in its contract with the State when medically

- necessary?
 - How does the MCO determine that the individual and institutional providers it contracts with have sufficient capacity to make services available when medically appropriate 24 hour per day, 7 days per week to Medicaid enrollees?
 - How does the MCO ensure that its provider network's hours of operation do not discriminate against Medicaid enrollees (i.e., are not different for Medicaid enrollees than for commercial enrollees)?
- From the "Provider/Contractor Services Staff Interview" Section:
 - Enrollee rights (438.100)
 - How does the MCO inform its individual and institutional providers about enrollee rights to service availability, coordination and continuity of care, coverage and authorization of service, and to obtain a second opinion from an appropriately qualified health professional? How does the MCO monitor for compliance with these rights by its providers?
 - Availability of Services (438.206)
 - How is it determined that providers are geographically accessible to Medicaid enrollees and physically accessible to enrollees with disabilities?
 - Describe the processes for monitoring the provider network to determine that Medicaid requirements pertaining to timeliness, availability and accessibility are being met. What are the most recent findings from this process?
 - Timely access to service (438.206(c))
 - Does the MCO continuously monitor its provider network for compliance with established standards on timeliness of access to all care and member services? If yes, how, and what are the most recent findings?
- From the "Enrollee [Member] Services Staff Interview" Section:
 - Enrollee right to service availability, coordination and continuity of care, coverage and authorization of service, and to obtain a second opinion from an appropriately qualified health professional (438.100)
 - How does the MCO monitor for compliance with enrollee rights to service availability, coordination and continuity of care, coverage and authorization of service, and to obtain a second opinion from an appropriately qualified health professional? What are the most recent results of this monitoring?
 - Availability of services-Furnishing of services (438.206(c))
 - Are MCO/ PIHP and provider services available 24 hours a day, 7 days a week, when medically appropriate?
 - How frequently does enrollee services staff receive complaints about provider hours of operations not being available to enrollees when medically necessary?
 - Does the MCO conduct surveys, focus groups or other activities to receive the feedback of Medicaid enrollees? If so, what are the most recent findings about Medicaid enrollee perceptions about availability of MCO and provider services?

The reviews conducted by the state's EQRO include both desk review and onsite components, and address member access issues extensively, consistent with the protocol above and consistent with the managed care regulations. The EQRO conducts comprehensive reviews every three years, and in the interim years they conduct focused reviews which address how each MCO has followed up on the findings and recommendations of the EQRO's comprehensive review. In addition, state staff responsible for program operation, quality management, grievance/appeal/state fair hearing management, program

integrity, claims/encounter management, clinical, HCBS/behavioral health and other contract and operational areas also conduct annual reviews of MCO performance, including both desk review and onsite components. When the EQRO conducts comprehensive reviews, the state reviews are done in conjunction with the EQRO reviews so that state staff are present for all onsite review/interview components.

V. KanCare Information Reported to CMS

As noted above, in addition to the many member access safeguards and protections included in the regulatory standards and review requirements for managed care programs, additional compliance and reporting requirements are in place related to the KanCare program specifically. These safeguards will continue to be available and provide support for all Kansas Medicaid members. Some of the information provided routinely to CMS that relate to member access support includes:

- Quarterly Special Terms and Conditions (STC) Reporting
 - Enrollment information for each of the KanCare population groups
 - Outreach, education and advocacy activities for current and potential enrollees, conducted by the state and by each of the MCOs
 - Operational developments – including benefits available to members, access data, MLTSS implementation and operation, safety net care pool/DSRIP activities
 - Financial – expenditures and budget neutrality, claims adjudication statistics
 - Consumer issues – complaints/problems identified by consumers, and resolution/action taken to prevent recurrence
 - Quality assurance/monitoring activities
 - Managed care reporting
 - Network adequacy, including GeoAccess mapping
 - Appeals, complaints, grievances to determine trends
 - Summary of ombudsman activities including why people are accessing the ombudsman and outcomes of their assistance
 - Interim evaluation reports from the evaluation contractor
- Annual STC Reporting – this includes all of the quarterly STC components, plus these areas that relate to member access support
 - Utilization data, including HCBS and institutional services
 - CAHPS survey
 - Outcomes of focused studies
 - Annual summary of network adequacy and assessment of provider network
 - MCO compliance with provider 24/7 availability
 - Summary of performance improvement projects
 - Outcomes of performance measure monitoring
 - Summary of plan financial performance
 - Analysis of service reductions within first 180 days of transition of HCBS participants into managed care

All of these issues inform the management of the KanCare program on issues related to member access, and the STC reports are published at the KanCare website: www.kancare.ks.gov.

VI. Conclusion

Consistent with the notes accompanying the new FFS access monitoring review plan regulations, it would be inappropriate to apply those requirements to a program already protected by the managed care regulatory structure. That reality is borne out with the Kansas Medicaid program. There is a wealth of data and information related to supporting the timely, adequate and effective access to care for members of the Kansas Medicaid program, included within the required and additional managed care program monitoring, compliance and reporting activities completed by Kansas and the state's EQRO contractor. The performance results reflected in these data, and all associated review/follow up activities associated with the data, combine to ensure that all Medicaid members – including the very small remnant that receive services paid as FFS – have access to the services they need. Kansas will continue to utilize all of these managed care program safeguards and protections to monitor and ensure access, and identify and address any potential gaps.