



KanCare 2.0 Public Input

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The Center for Organizational Development and Collaboration



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Introduction

The state of Kansas is preparing to renew its 1115 Demonstration Waiver, reauthorizing Kansas' managed care model for Medicaid, known as KanCare. This renewal process is being referred to as KanCare 2.0. Prior to submitting renewal documents, the Kansas Department of Health and Environment (KDHE) conducted a series of public input sessions from KanCare Stakeholders to get feedback on KanCare.

KDHE hosted twelve public meetings throughout the state and one via conference call. Figure 1 below illustrates the cities visited. Kansas notified stakeholders of the public meeting locations and ways to provide input by mail, press release, website publication, listserv email, and provider bulletins. Public meetings facilitated by the WSU Community Engagement Institute Center for Organizational Development and Collaboration were held throughout the month of June. Each location held a session focused on providers and a session focused on KanCare members, though stakeholders could attend either session. In addition to the in-person meetings, a member-focused conference call was held.



Figure 1

Attendees were asked to provide feedback on specific areas that KDHE is considering modifying in KanCare 2.0. Topics were selected based on previous stakeholder feedback. At provider-focused meetings, attendees were asked to share feedback related to value based purchasing, administrative streamlining, training effectiveness and needs, and managed care organization (MCO) communication. Those attending member-focused meetings were asked to provide feedback related to care coordination, value added services, and MCO communication. All meetings included time for general comments and questions as well. In total, 482 people attended these meetings and had the opportunity to share comments and questions live and/or by writing on comment cards.

Technical Note

When the commenter provided comments on multiple topics in one statement, when possible based on clear language breaks, the statement is segmented and categorized into different thematic categories. When the statement is unable to be segmented, it is themed in the category that it overwhelmingly represents. Some comments overlap multiple thematic areas and are not repeated in both to keep the report concise.

Index

- Value Added Services..... 5**
 - Dental Services 5
 - Non-Emergency Medical Transportation (NEMT) 6
 - Improvement/New Benefit Suggestions..... 7
 - Consistency in Benefits..... 9
 - Value Added Services Education 9
 - Uncategorized Value Added Service Comments 9
- Value Based Purchasing 12**
 - Questions and Clarifications Around Value Based Purchasing 12
 - Experiences With Value Based Purchasing 13
 - Suggested Outcome Measures..... 16
 - Uncategorized Questions/Comments Summary 17
- Administrative Streamlining 19**
 - Billing 19
 - Credentialing 20
 - Kansas Client Placement Criteria 21
 - Prior Authorization 22
 - Communication 22
 - Other Suggestions of Processes to Streamline 23
 - Uncategorized Streamlining Comments/Questions 25
- MCO Communication..... 27**
 - Provider Representative 27
 - Understanding Communication 27
 - MCO Contact with Representatives 28
 - Contacting MCOs..... 29
 - Preferred Method of Communication 30
 - Uncategorized MCO Communication Questions/Comments 33
- Care Coordination 36**
 - Satisfied with Care Coordination 36
 - Targeted Case Management & Care Coordination..... 36
 - Don't Know Care Coordinators..... 38
 - Improving Care Coordination 39
 - Dissatisfaction with Care Coordination 40

Uncategorized Comments/Questions	42
Clearing House and Eligibility.....	43
General.....	43
KanCare Feedback Process	45
General.....	45
Home and Community Based Services Waivers	46
HCBS Policy.....	46
Waiting List.....	46
Uncategorized HCBS Questions and Comments.....	47
Network Adequacy/Capacity	48
Capacity of Specific Services.....	48
Plan to Address.....	48
Uncategorized	48
General Comments & Individual Situations.....	49
KanCare Renewal.....	49
Individual Situations	50
Impact of Federal Changes.....	51
Uncategorized General Comments	51

Value Added Services

There were eighty-three (83) comments and questions related to value added services. Twenty were (20) related to dental services, fourteen (14) related to non-emergency medical transportation, twenty (20) suggestions of new services or improvements to existing services, four (4) related to consistency of value added services, eight (8) requesting additional education about value added services, and seventeen (17) uncategorized comments/questions.

Dental Services	State Response
<p>There were twenty (20) questions/comments about value added dental services. Of these, ten (10) were requests that dental coverage be expanded for adults to cover more services. Six (6) comments were related to a lack of dentists being available, three (3) comments suggested increasing reimbursement for dental services, and one (1) other comment that dental service is “a big thing.”</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>

Comments

1. I use the dental services and helpful. Out in western Kansas. Have a lack of providers in that area. I think it’s because of low reimbursement rate. Why do it if not get paid to do it? Hopefully it can be resolved.
2. I would like to see more dental health services. I don’t think we should be pulling teeth because of cavities. I think we should be doing fillings. Dental is not just teeth good dental health effects mental, physical heart diabetes. If someone wants to go out and get a job, they might resist because they don’t have good teeth. [Applause.]
3. I’m with Oral Health Kansas representative. I do work in training and public awareness. We get so many calls from people who can’t find services. Dental health affects so many other aspects of health. It effects diabetes, it effects preterm birth weight baby’s respiratory deses. We are spending too much money on medical care that could be dealt with if people had good dental care. [Applause.]
4. We suggest instead of having a particular dentist in the network providing a voucher that can be used with any dentist since the dental network is reduced.
5. Dental is a big thing.
6. We were talking about the dental services she was saying that it would be helpful to have coverage for the fillings or partial dentures. Most of the time she has to pay out of pocket and it’s a large some, it would be a help for those services.
7. Much like the past table enhanced dental services for more prevention, a larger dental network. For many of the value adds, It’s hard to find dentists especially those that will do anesthesia.
8. I wanted to piggy back on what the other folks were saying, we get calls for people needing dental care and have no funding or no way to pay for the service so that’s something that we do get calls about.
9. Value based services and regarding the adult benefit of dental cleanings – we plan to submit further comments under the written comments, but want it said we want to see it as an option moving forward and that adults can get full coverage.
10. We are in the dental field and many of our offices are receiving referrals from other offices that receive Medicaid but are no longer doing root canals or crowns due to low reimbursement and the cost of service. There is only one oral service in Kansas that does extraction on over 18 we would like to see more incentive for dental care we are having to turn away patients. We are getting referrals for Lawrence down town Kansas City Kansas. We would like to see an incentive for more providers in the dental field.
11. Dental for elderly, we need more than just dentures.

12. Improvement in home dental hygienist reimbursement rather than dentist for cleanings. We have on that charges \$85 per visit for a cleaning. She is great.
13. Expand dental services and reimbursements to DDS so more of them will accept Medicaid.
14. Adult Dental Services: enhance payment so network can be expanded.
15. Dental cleanings are helpful but coverage is needed for follow up care.
16. Not enough dentists and dentist have dropped out of the program.
17. More than pulling teeth for adults.
18. Use amount towards any dentist vs a participating dentist difficult to find on close and one who takes Medicaid.
19. I like the idea of vouchers for dentists. Tim can't go to a dentist due to his trimmer. I found a hygienist who is certified to come into the home or nursing home. She charges \$85, which I pay. It's much more affordable than sedation dentistry.
20. It is very difficult to find a dentist that accepts Medicaid, so that has been a major problem.

<i>Non-Emergency Medical Transportation (NEMT)</i>	State Response
<p>There were fourteen (14) comments related to NEMT. Four (4) were that the service is difficult to use or often cancels, three (3) comments stated this is a beneficial service to members, two (2) each stated they didn't know the service was available, asked that the service be expanded, and increased flexibility in its use. One (1) other comment related to an individual's experience.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>

Comments

1. Transportation is a joke. The service left my son places for two hours. We use our own car, but we don't get reimbursement for mileage.
2. We struggle w/transportation. A lot of the times we struggle w/transportation. They keep us waiting for cancel on us.
3. Most helpful and useful, I get to go to a Wamego dentist for a small out of pocket and fee my transportation is covered. I'm grateful for that. My doctor has authorized transportation to and from appointments it is also covered that's most useful. My transportation keeps me out of the hospital.
4. The big one I use is the transportation. I can drive my son to Kansas City very frequently. The fact that our mileage is reimbursed helps out a lot. Having the transportation to Kansas City has been huge.
5. The NEMT – didn't know it existed until this year. Don't realize it's something that's available – but when in KC. Hospital that it happened often schedule ambulance transfer – logisticare, 2 hours were discharged and after 2 hours still in hospital room they called and made arrangements – they had to had to readmit him and he left next day – concern is they didn't know if anyone was tracking they have a ride and where the follow-through. Not IDD – transportation if ride doesn't show, how are they getting home? Is an issue they were seeing in KC, huge area? Happening often enough every nurse has a story.
6. Transportation for youth; There should be transportation for parents to PRTF to participation in family therapy. Medical transportation should allow for picking up parents at one location and picking up children at another. Parents with no transportation and kids at school are unable to get kids to appointments unless they keep them home from school.
7. Long-term care services. As my daughter is getting older. Those services are harder to find. There are simply not enough providers. There is no transportation available, especially after 4pm. Can you carve transportation out for developmental disabilities?
8. Transportation is a major social determinant, don't pass it don't limit it to the medical model. It is an important of daily life.
9. If we provide our own transportation, can we get reimbursed? We do for out of town doctors. Could we provide mileage and have it put on rewards cards?

10. For an extra service – pay for or provide transportation to out of town providers? I was unaware that was an option – the only dental provider available to us is in Larned, we didn’t know. We had to get a hotel room, had to stay in KC. Would have been nice to know that hotel and drive been covered.
11. I too didn’t know about the NEMT reimbursement. I discovered that I have an appointment – give 3 days advance notice. I was told 30 minutes in advance. Then she says – is this for reimbursement – you have to tell them which one you want.
12. Medicare or Medicaid covered trips to appointments that would be valuable thing that should be available to everyone. These were the two that struck me.
13. I appreciate the mileage reimbursement that they do when we go to appointments, especially when they’re far away. The only thing is sometimes it’s over an hour away, sometimes in case of emergency, the hospital will say, “Can you come now?” You can’t get reimbursement if you call immediately before or after your appointment. The first thing on your mind isn’t always calling for mileage reimbursement. Previously, they had it where at least you could call in that month or call in during the same day. If your apt was at 2 and you call in at 2:05 they won’t reimburse. Also there are time zone differences when they’re on east coast time because your appointment was at two and you call in at two. I wonder if it can be loosened to give flexibility for immediate appointments. When you have a medically fragile kid to get where you need to be seen, the first thing on my mind isn’t calling for reimbursement. Maybe able to call in day of appointment or month of the appointment, they have to verify anyway.
14. When my daughter calls to get access to care and gets a confirmation number, and is told to be ready at 7:15 in the morning to either go to a mental health appointment to get here required 28-day bloodwork done or to go in for any other checks and nobody shows up, and nobody calls her and tells her, “well we couldn’t find anybody”. From St Louis they could not find anybody, from Newton Kansas to be available. Now, for example she needs blood work on July 4. She had no idea that she had no ride on July 4th it was a holiday. Did they notify her? No. Then I was told that I could have taken her, and made \$.56 a mil, I wasn’t available to do that, and I’m her guardian conservator and so I can’t be compensated for things according to what I’ve been reading. So where does that put her? Again this is a required blood draw. You can tell me, “Yes it’s on paper”. But what are you going to do about it? How can we be sure that these individuals, because I know she is only one case, what are we going to do? How can we fix this?

<i>Improvement/New Benefit Suggestions</i>	State Response
<p>There were twenty (20) comments or suggestions related to new benefits or improvements to existing benefits. Six (6) comments suggested new services, including food/housing, air conditioning, internet, communication devices, psychological and developmental testing, and incontinence supplies - none of the suggested new services were duplicated. Four (4) comments stated a need for additional minutes for cell phone benefits, five (5) requested more flexibility in over the counter medication benefits including what is covered and the amount of the benefit, two (2) requested more flexibility in use of pest control services, and three (3) requested that services allowing access to exercise programs be extended to adults.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>

- Comments**
1. More minutes for cell phones currently at 250 a month this is not sufficient.
 2. More minutes needed or to be able to pay for your own minutes. Internet services needed. Phone wait times are long with case coordinators.

3. Value-Added Services: Food and housing services, these are fundamental and foundational to health, cannot improve outcomes without this.
4. Air Conditioning for asthmatic children.
5. Internet service would be a helpful service to add.
6. Value Adds: increase over the counter benefit, work on making over the counter prices more affordable. Never getting the healthy rewards cards from MCO when we ask for them.
7. Healthy programs should extend through adulthood. Club memberships up to 18 needed to go through adulthood.
8. Pest control – we had termites. It's costly to do that. Daughter w/HCBS, if she had a house wouldn't be on HCBS, what pest control is covered if it's not for her?
9. Some members cannot use phones, consider communication devices.
10. Extermination says you have to own your own home. Who owns their own home?
11. As we look at exercise to try to stay healthy. Recommendations from doctor were not covered, for instance certain supplements. A lot of these services he is not using because he is not healthy. I would like to see some things in place for individuals to access these services in homes.
12. Related to the value added benefit, I really like the over the counter catalog from Amerigroup. I wish the \$10 credit they give you could be on a card so we're not limited just to what they have. On the catalog, if the balance could be carried over to the next month. The way some of the pricing is, you could get an item for 5, if you get \$10 a month, then the item is \$5.01, and there might be another item for \$4 that you need, but there may be another one for \$5 or something. It's a plus, but if there is a way for us to have a card kind of like they give us for going to well child and stuff with your kids. They'll give you a card with \$5 or \$10 or something. Would be nice to have a card for over the counter as well, so we're not limited to the brand, maybe they have a tablet but we can't use tablets or capsules. We have to have liquid. That would be really helpful, I think.
13. I'd like to see the state of Kansas pay for development and psychological testing by licensed psychologists as required by the Social Security Administration.
14. See that – YMCA program for the youth but don't offer it for the elderly also. Y is also geared toward senior. I would see them also want to kept that for them also.
15. Joel. I have cerebral palsy and autism I am 18. We notice in one plan there is 250 free minutes of cell phones. I read a study on cell phone apps for people with autism. It would be good to add a service related to cell phones for people with autism.
16. Many programs end at age 13, 17 or 18, but their challenges do not end. In particular, have a need to encourage exercise to control and manage weight. YMCA age restrictions is another area. Attending the YMCA also meets a social need.
17. Increase the over the counter benefit. Make the prices of OTC more affordable. Also we're not getting the healthy rewards card from the MCO's when they are asked for.
18. The cell phones have been very helpful. Also need more minutes on the cell phone package.
19. I was looking at the incontinence supply waiver, I have never heard of these before and I deal with Medicare on a daily basis. They are losing access to LMB because they don't know it's there. Incontinence is a major issue with the elderly population. \$100 in incontinence supply won't get you very far. It needs to be higher or come as a prescription from the doctor.
20. On the value on the card, I know it's sometimes a lot of over the counter meds and all, many of us aren't ok'd for being able to get things through Medicaid or Medicare for getting things like disposable underwear for adults. That doesn't seem to be something you can get with the card, if I remember right. It would be nice and help save money for the individual because they aren't cheap. Also, I don't know if there's any way they have it limited to certain stores where you can use the card, to places like Dollar General, can it be set up for other places like Walmart?

Consistency in Benefits	State Response
Four (4) commenters requested there be consistency among the value added services offered by MCOs.	Value added services or benefits are one of the primary ways that MCOs can make themselves different from each other. They are also services that MCOs offer at no cost to the state, so requiring them all to have the same value added services would be difficult.
Comments	
<ol style="list-style-type: none"> 1. We do not make decisions based on VAS, need to be consistent. 2. MCO to offer more same services that would be less confusing. 3. It is confusing that the plans are all different. We are not sure it is a deciding factor in which you choose. 4. I just wish they some of these things like, United Health care and Sunflower for example, were a little more similar as opposed to being different. 	
Value Added Services Education	State Response
There were eight (8) comments regarding member knowledge about value added services. Six (6) stated there is a lack of awareness about services or needs to be more education, two (2) stated there are additional value added services that aren't on the list of services provided.	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.
Comments	
<ol style="list-style-type: none"> 1. There are services not on the list like food and mileage reimbursement. 2. 2 are aware of Value Added 3. Lack of knowledge of the value add services. 4. Some of these I didn't even know I had. This is the first time I've seen this document. I knew only about two of these. Those two were the reasons I chose Sunflower because the weight management and my strength was what my daughter needed. I checked out the weight watcher one, but it was a handful of sessions. My daughter is not able to understand concepts (like calorie). My strength is an online program and she is a non-reader. So I just want to point out that these are areas that we need to look at. 5. I think better communication of the value adds. I'm not sure that the members fully understand the value adds. It starts with the care coordinators are, they communicating across the plan going back to the value adds. 6. Training. It would be helpful for clients and people who don't know this to be trained. I don't see that service under the MCO that my mom belongs to, and that would help tremendously. 7. There are some things that are available that are not on here that I did not know about. One is food. Little did I know that I could get food for Timothy to give to his caregiver to give him. I think that there are things missing from this list but when you bring that up to your care coordinator and they are not discerning 'here is a person who needs this.' 8. Another challenge is getting the health rewards cards from MCOs when requested. Some lack of knowledge on what the services are among members; sometimes not knowing what that means, they are not accessing them. The restriction on owning your home for extermination. Knowing which dentists who have dropped from the program. Getting that updated. 	
Uncategorized Value Added Service Comments	State Response
There were seventeen (17) uncategorized value added service comments. These comments are formatted to allow the state to respond to each individual question due to their unique nature.	
Comments	
<ol style="list-style-type: none"> 1. Why they want to cut this service or that service. Why don't cut their own budget instead of their own services? 	Thank you for your comment.
<ol style="list-style-type: none"> 2. Wondering – anyone from I was told that the S (card) 	Thank you for your comment.

<p>3. Vision is one and there's only one that offer.</p>	<p>Thank you for your comment.</p>
<p>4. I only use the OTC benefit to get gloves and things like that. Pest control and an air purifier would be good.</p>	<p>Thank you for your comment.</p>
<p>5. I personally believe the cent account program that gives \$50 to groceries, I find it to be a bit useless. Also these programs have a bit to do with one another.</p>	<p>Thank you for your comment.</p>
<p>6. Thank you to the MCOs for many of these added values. They are beneficial to many of our loved ones.</p>	<p>Thank you for your comment.</p>
<p>7. If for any members – I have a KanCare, BCBS helping out w/bills. (dual) – for teeth, dentures, 5-10k, I'm looking at having to pay half price or what?</p>	<p>Thank you for your comment.</p>
<p>8. The value added services are good, but are they useful? Some are quite limited. For some individuals, They're not digital, the problem need a different kind of hearing aid. A basic model is only available. It's not useful to me. Would like to see more in the menu of choices and lee-way I think if might be useful to customize value add to the budget. What the participant needs and something needs as long as there's flexibility in the monetary issue.</p>	<p>Thank you for your comment.</p>
<p>9. Last year, the hospital companionship they cut the hours, it's lower it's for IDD and FE and specialized. Certain people who can't be left alone for various reasons – for them or for hospital staff. If there's any way to have a staff available instead of just 16 hours (possibly well in excess of that). I had to take 2 weeks off – and it was too far away for his staff to come 5 hours away – if more and have a few staff ride together. It's a bad/worse scenario. Everyone else trying to share the burden and do what's best for the individual. Certain individuals, may not be needed. He'll never need it.</p>	<p>Thank you for your comment.</p>
<p>10. Some services we do use and would like added to are dental and vision. I have not used the new asthma...before KANCARE did use it but, now I didn't know about it until this last week. Very important to use.</p>	<p>Thank you for your comment.</p>
<p>11. What can a shut-in do? I see one that offers medicine delivery. This looks good for a shut-in.</p>	<p>Thank you for your comment.</p>
<p>12. There has been an increased need for pest control, I think there is some health benefit for that.</p>	<p>Thank you for your comment.</p>
<p>13. We appreciate the Medicaid change for adult briefs. If someone has a diagnosis that fits the needs for adult briefs that will help as well so thank you Kansas for that.</p>	<p>Thank you for your comment.</p>

<p>14. One of the things I heard is they are providing sitters for IDD and not for FE in the hospitals.</p>	<p>Thank you for your comment.</p>
<p>15. We have comprehensive services. Between the state knowing the information on the waiver The state is really good at knowing that. The MCOs do not know that. Specifically, when referring to Alzheimer’s and dementia care. There is no concentration on dementia care. These are high level concerns. Following the money is a high level concern.</p>	<p>Thank you for your comment.</p>
<p>16. As we move into value based services a recommendation for MCO’s to identify a person or appointee to discuss these outcomes. We’ve seen some success with some payer but it’s been a labyrinth trying to find the person to negotiate with.</p>	<p>Thank you for your comment.</p>
<p>17. We talk a lot about the value added benefits being wonderful but we want to know if they are. They are not easy to find on the website. It would be nice to have that information in a more centralized place. We need to have a conversation about how those change from the competitor network.</p>	<p>Thank you for your comment.</p>

Value Based Purchasing

There were sixty-seven (67) comments and questions about value based purchasing. Twelve (12) questions and clarifications about value based purchasing, twenty-five (25) sharing experiences, eleven (11) related to outcomes, and nineteen (19) uncategorized comments/questions.

Questions and Clarifications Around Value Based Purchasing

State Response

There were twelve (12) total questions and comments concerning perceived opportunities in value based purchasing. Two (2) concerning MCO services, two (2) concerning billing, three (3) concerning the limits of the service, and two (2) concerning the integrated health care model, and one (1) each comments/questions about concerning rates, asking if an organization could opt out of the plan about the availability of this service for IDD. Continued overarching patterns were questions and comments concerning either Mental health or IDD persons served,

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Comments

1. The MCOs are going to be the ones the set the rates and not necessarily the state?
2. Right now we only have the MCOs working with two health clinics and the smaller ones get left behind. Is there a way that you direct, steer, or advise the MCO's to look beyond the big money makers?
3. To follow up, does a provider have the option to not be involved in the value base purchasing?
4. I wanted to address the disincentives in the system, whenever a provider gets someone a job then that's someone they can no longer bill for because the system is set up that way. Can we incentivize that? The other piece of that is that, the persons need for ongoing care doesn't go away this changes so we need to be able to address that in some way and find a way to fund that in creative ways.
5. In the beginning I asked if providers weren't going to get paid if for a service if it was determined it was not valuable, you said that you would work with us and you're also saying that there is no risk involved, and that they are going to get paid no matter what, I want clarification on that.
6. We are curious to know if any IDD providers are using value based services? Are they currently available?
7. In the selection of services that are a part of value based services do you see that some services would be in that value based and some services will remain in the pay for service realm?
8. Maybe I can approach that differently another way to look it is with groups of individuals with target types of services may be able to be provide in a value based system where as in the other cases not. In that mental health world there are targeted individuals that are identified by state criteria. My expectation is that those individuals and the needs that they have and the services they receive are more likely to be addressed by value based purchasing because it provides an incentive to improve the quality of care. Whereas someone that is not in that target group who still meet periodic or episodic care may not be as important to value based as it is limited to a point where it does not represent the kind of costs to me manage in such a way.
9. What I think I hear you saying is that persons in the target group are more specifically to be and what is desired to be accomplished in their health care?
10. Integration of various realms relative health care, you may as the Medicaid authority believe that this responsibility will rest within the organization. The comments and research that I hear about in terms of physical

health mental health is critical. Any primary health care professional that I talk to will frequently go to that as a piece in a reduction of costs in primary health care by taking care of mental health as well. Being able to find ways to integrate mental health into primary care will be important to figure out. Not only for high density populations but in rural areas not frontier areas, that is another matter I'm interested in finding ways to that that works for the primary care as well as the behavioral health provider.

11. I'm director of the Kickapoo Nation and for a community such as ours HIS has been providing integrated health care for some time in tribal areas. I'm new to Kansas in other tribal areas integrated care is the standard however in the state of Kansas I'm running into barriers.... I'm asking you for more assistance someone who can work hand so on with the tribe and understand what we are going through. I need some partners from the state that's all I'm asking for.
12. (person served) My question is, is there a way that we can incentivize the MCO's to coordinate more with the centers for independent living so we can to integrate people back into their own homes?

<i>Experiences With Value Based Purchasing</i>	State Response
<p>There were twenty-five (25) questions/comments about the experiences of providers with value based purchasing. Five (5) about its claim to be no risk, three (3) concerning the meaning of value in value based purchasing, two (2) about MCO accountability, four (4) about positive experiences with value based purchasing, four (4) stating that the MH and IDD community has had no opportunity to deal with value based purchasing, two (2) concerning outcomes and the reduction of ER visits, one (1) each stating the for IDD value should be based on quality of life outcomes, about dentistry, about increased scrutiny of providers, concerning Alzheimer's and TBI, and that a previous experience in value based purchasing led to a reduction of available services.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>

Comments

1. We've had experience at community mental health setting working with MCOs to improve outcomes with individuals that would fit into mental health populations around health care measures. We have been able to implement three different plans each with the MCO's. We are seeing improvements in outcomes related to A1C levels being monitored, access to primary care, and follow up post hospitalization. We have seen an impact, ER visit reduction, benefit to the agency financially. In terms off benefit from the agency standpoint We've experienced our first payment recently. We have heard from a few other mental health centers that it has been appositive experience. The value of the health home program that was discontinued last year, was it gave us an intensive taste of those activities. Some centers were able to benefit from taking advantage of staff from the health run program and health based approached. One of the thing that is a challenge, from a staffing point of view, is that the incentive payments follow the activities, because of the delay in measuring the HEATUS activities so you have to have money ahead of that in order to sustain those activities later until you receive payment. The fact that we have been able to begin that without risk as an opportunity to try it out has been a positive experience as well.

2. I had an experience with the pay for performance with the VR system. It only paid for the Positive outcomes. There are some reasons they prevent them from getting to the performance outcomes and you could never get reimbursed for it and a lot of providers around the state stopped providing the service. It costs in capacity and set us back in employment in the state. I think that there is a process to get there that will make it positive, it's just how long does it take you to get there? The Social Security Administration tried it with the Ticket to work program but could not get the incentives right because of the costs.
3. One of the things in looking forward to risk based a part of what we are looking at is cost in each agency to deliver care, and the ability to be effective in evaluating that. Being able to evaluate the level of care based on the severity of symptoms and presenting problems. As we look to those risk based, it will be important to negotiate payment so that providers can not only break-even but to improve and build. It is critical for MCOs and the state to look at that in terms of how the contracting will occur. How is that taken into account because we have to be able to provide opportunities for growing?
4. Something I would like to be considered is that what is considered valuable is clearly defined. If there is not that definition people are flying blind. Its human nature to focus on what's going to be approved. You're limiting "what's valuable" to your one experience of what worked. If you are limiting value you're missing what may be valuable for the clients.
5. Valued Based – Paying for Outcomes (What are they?). Going to look different based on providers. Incentive payment. Not going to interject risk into it.
6. Q: To what extent are MCOs being held accountable to the outcomes in their original contracts?
7. Been very happy to with KANCARE and the outcomes achieved.
8. There are many models you can implement. One MCO has an alternative payment agreement with a large physician group. The set-up a shared saving agreement with the provider with certain criteria...when we see savings in this group. There is no risk injected.
9. Q: The benefit of Valued based is focus depends upon the population in which you serve. I serve primary care, and the insurance savings program has been a positive experience for us because the outcomes have been very well defined. The benefit to our members is that they know exactly what we are focusing on.
10. Mental Health providers, – they have not had opportunity to valued-based...but look forward. I think there are some places that need to be tweaked with it, for example direct admits for hospitalizations. It would be nice if this was considered for improvement. It would be nice to have negotiation opportunities on those.
11. Q. We have IDD providers Mental Health Provider, and the long term care folks have not had the opportunity to value based or incentive planning. There is a need for more current data. Especially when it comes to hospitalization. Our goal is to reduce hospitalizations by 25% this year. Nothing is being done when they are in the hospital and, it is hard to track that data down The IDD provider would like to see some kind of outcome measure about their members reaching goals, all of us agree that there should be Employment goals for all of our populations. Need some mechanism to have staff time accounted for job development – that is important for employment. Would like to have outcome measures – goals reached in their plans.
12. Ok for outcomes to consider focusing on health metrics and health outcomes. Also reimbursing waiver services based on quality of life outcomes. Looking for opportunities for more independent situations like independent living, and competitive employment would be your opportunities value based purchasing, looking at higher rates the longer the individual is diverted from institutional for waivers like the PD, FE waiver. Lastly better collaboration with MCO's around benefits for plans and services on waivers.
13. Outcomes we said reduction high risk services like ER visits engagement Also engagement in retention rates to get people into services and to keep them in services. (Engagement in) such as social determinants, housing, and sobriety those kinds of things. We have limited experience with values based service. Some opportunities experimenting with some pilot programs. True integrated service delivery. Providing expanding what certain providers may be able to do. Engaging people in services and then keeping them engaged.

14. Most mental health centers believe that we achieve the best cost savings that we can. When you talk about SPMI we believe that we know more about it than most do. When we talked about value based purchasing we're going to continue to push the envelope on that getting better outcomes. When centering around health care outcomes to reduced cost, we are going to be incentivized to do that, but would recommend that a cost study be done that we are not again working for free or at a loss. That's a big piece of the feedback, is that we hail back to what we know to be successful home activity but do so in a way that we don't break out backs. Focusing on smoking cessation weight control and dual diagnosis really baring down on some evidenced based care, all of those three things will achieve better outcomes for all of our clients. I don't think we can do what we are doing now for less money. There is now an administrative burden having three MCO's, having (three separate) reporting and billing systems, one MCO Spent a lot of administrative time on the phone with our staff recommending that we reduce care and I really don't think they understand the population that we are working with. So if we are going to continue to get improvement in care, the MCO's are going to have to understand the population. It's not universal for everyone that works there but there is a fair amount of people who just don't understand the population we serve.
15. I think it is important to recognize that not all providers can bill. I'm a provider using the IDD waiver self-direct and personal care services so the value based services have no effect on me. I work with the IDD waiver so value based purchasing has no effect on me. I think the think to look for in terms of outcomes is staff retention, we can't continue to provide these services at such a low rate. So keeping providers and staff retention.
16. Focusing on health metrics, health outcomes. IDD waiver services should be reimbursed based on quality of live outcomes, higher rates for more independent settings smaller living arrangements, competitive employment. Higher rates for diverting institutionalization i.e. PD, FE, TBI. Better education and collaboration with MCO's around benefits offered on different plans and services on waivers. Specialty training and expertise reimbursed at higher rates i.e. challenging behaviors.
17. I was informed that with value based purchasing HCBA 1 C levels is critical to us in dentistry and we have a problem getting there quickly. That is very important in dentistry, we have a difficult time getting the HCBA1 C level how can I access it without having to pay another outside service like the Department of Health? How can I get that information?
18. We here with KanCare 2.0 they are looking at value based purchasing will there be some public information about what is meant by value based purchasing in the future?
19. In regards to value based purchasing is there going to be increased scrutiny if an individual in services, for example if that individual is not increasing their independence where there are factors preventing them from increasing their independence, will there be more scrutiny?
20. We hear with KanCare 2.0 they are looking at value based purchasing will there be some public information about what is meant by value based purchasing in the future?
21. Changes proposed: More concentration on specialized offerings, specifically Alzheimer's and Dementia care.
22. Value-Based contracting, 3 dental, 1TBI waiver, 1 SUD/MTT provider. What outcomes? Connected to social determinants such as housing, social support, physical behavioral health services. Prevention/education, reducing high end services, EK for example, engagement and retention? Opportunities: higher rates for preference, integrated service delivery, expanding what providers can do, pilot programs.
23. FKC (dialysis) in town – We do want to please management and work toward the outcomes which include: lower A1c, hypertension, decreased ER usage. We have experience with value based purchasing. We have joined an ACO (accountable care organization) with Medicare, and have been with in a value based purchasing agreement with Blue Cross Blue Shield of Kansas (BCBSKS) for 2-3 years for immunizations and other measures, and our patients are getting good care. We're hitting our measures and seeing increased quality of care and increased provider accountability.

- 24. At the recent training for the pay for performance program, the training was excellent. We are well underway with United Healthcare and just started with Sunflower. Amerigroup will be next. It was a little overwhelming to have them all at once, but I like pay for performance as it focuses on health for the people.
- 25. Pay for performance: Several providers stopped providing employment individual cooperation it reduced the availability of service. Drawback with cost before reinstatements. SSA ticket to work overtime.

Suggested Outcome Measures

<p>There were eleven (11) comments related to outcomes in value based purchasing. Three (3) asked who would determine outcomes, five (5) suggested outcomes, and three (3) general outcome questions/comments.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
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Comments

1. Who is going to determine those outcomes and what the criteria is going to be as far as whether they have been met or not?
2. Incentive outcomes closed system wait list no back filling.
3. Value based measures for improved outcomes, administration? Streamlining?
4. Outcomes, what outcomes? Preventative, Children, Annual Exams, Dental Vision, for children medical care continually psychoactive medical. Missouri State contracts managed care re-admissions follow up appointments kept. Streamlining Applications, waiting times for approval regarding applications. Credentialing applications and changing providers. PRTF monthly treatment revisions and utilization review redundant. Training effectiveness is very limited. MCO communication: the real questions are benefit plan. Changes, rates provider requirements, and timely clinical?
5. Outcomes: Reduction of hospital stays and of ER visits. Make credentialing user friendly. Improve advertise or promote taped webinars available anytime. Communications: bulletins, webinars monthly, e-blast.
6. Questions to consider: What outcome should we focus on? There are social and health indicators, housing employment, staying out of nursing homes. Train MCO's of populations. Enhanced case management, if the state or MCO's are not willing to share the date of providers it won't work.
7. Who determines outcomes?
8. What will determine if outcomes are met?
9. One to the things that we noted is that capacity is insufficient and access to care limits effect outcomes and we think with increased capacity and better access to care will increase outcomes. Are there measures to increase outcomes, for the value based are there anything we can be doing to increase outcomes with respect to access to care and improving capacity?
10. SKIL Resource Center – We work with people with disabilities – LTSS – PD, TBI, FE, payroll, and contract, IDD waiver in southeast Kansas – The outcomes [for LTSS] I'm trying to figure out, but so far I think increased independence; not sure how you measure that. I think that's very important outcome. Deinstitutionalization is easy to measure. Another is the integrated services in the community. I have some experience with this, as it might be along the same lines as pay for performance with vocational rehabilitation. There have been issues with the program and they are working to make progress, but there are some positives. Opportunities in value based purchasing include improving quality of care. I also believe that people with disabilities can make choices, and while many need family to help make decisions, many can do that on our own but the quality of care seen isn't the same as that of other people.
11. I have a Couple outcomes, a reduction in hospital stays and ER visits.

<i>Uncategorized Questions/Comments Summary</i>	State Response
<p>There were nineteen (19) uncategorized comments/questions about value based purchasing. Five (5) were about what this might look like for I/DD & LTSS, three (3) each related to considering rural vs. urban areas, clarification questions, and concern with the uncertainty of what this may look like and the burden on providers, and one (1) each regarding the impact on dental providers, hope for increased access, suggesting it be based on data already collected, and one suggestion of a model already used.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>Comments</p>	
<ol style="list-style-type: none"> 1. It is important to recognize the realities of rural-frontier versus urban. It is a challenge when talking with providers who are not used to working with or in rural communities, logistically, and helping them understand that the types of providers who work in rural-frontier communities are different. 2. It is important to be realistic about time frames, especially in regards to an evidence based practice or a standard, and how that works in an urban area. It doesn't translate well in a frontier area. 3. Clarify Value Based Purchasing versus Value Based Services. I'm confused on them. Can you clarify the difference between them? 4. I have a dream of keeping people out of emergency rooms (ERs) and ensuring adequate payments to providers so they will take on people in Medicaid. Many people in the area I serve don't have a primary care physician (PCP) and seek care in an emergency room setting which is very expensive. I would like to see them receive quality health care with one provider instead of them see three different doctors, and receive three different diagnoses because the ER doctors all saw a different piece of the puzzle. We recently had an urgent, quick care open here and was optimistic about people having somewhere to go other than the ER. Unfortunately, they don't take Medicaid. I'm not sure why, possibly it has to do with the fee they're able to receive due to the level of care or avenue of care. The point is in rural and frontier settings, once we lose a doctor, we lose them forever until we get another and the cost increases to receive services and to replace them. 5. Being a private practice dentist how does this affect us if we take Medicaid? 6. Thank you for coming. I appreciate that. One thing we are hoping to get with value based purchasing is more attention to technology including phone applications. For behavioral health and primary care, telemedicine needs smoother processes and increase care coordination in a better fashion. Look to value based purchasing as an opportunity to increase access to care for behavioral health services, but also take into account location barriers, code barriers, and address those value added services to expand services that address the social determinants of health people are experiencing. 7. In the hospital world, we have experience with value based purchasing. PPS and critical access hospitals are not required to do it, and don't because they don't have volume. It would be helpful if things that were measured are based on measures we already have such as HEDIS, or others that we already are collecting as we transition. Value based purchasing is going to take time in smaller facilities, as they are not used to it and will need time to transition. It important to make certain that we don't add to the extra time and energy that they're already spending on providing services. These providers are not in a larger group and will not get outcomes due to the lack of volumes, but might if group more providers in one reporting area to get the outcomes numbers or maybe align them with a larger group. 	

8. WellCare** Another idea that has been talked about with the hospital association, for groups like FQHCs and smaller regional crisis centers to network together. We're working in a value based purchasing agreement with about 20 FQHCs in Missouri and one of these is starting in Oklahoma. We're also seeing this in other states, and it might be working. ** Identify per Mike – is a potential contractor or bidder for future **
9. We weren't completely sure what you're asking for - the outcomes as an agency or for the individual we're serving and have they achieved their goals?
10. As far as experiences, when I read about this statement "voluntarily provide coordinated care", my brain hears, "provide more free service", and that has been my/our experiences with this; and so it brings the anxiety level up as our agency is concerned.
11. With the health homes, everybody put their skin in the game and now all of that is gone. We've had to hire and fire people related to that which has raised the anxiety level related to that.
12. DDSNWK – IDD – I'm curious what outcomes might look like for LTSS? The folks we serve have cognitive delays/setbacks. We teach and try to help them make good healthy choices. I'm having trouble with what that means in our model of service, what it looks like, and how it works. There are frustrations with the system and how it's been ushered along the last number of years and I'm not sure what the question is here and how does it all fit?
13. MH center – We agree that the following need to be looked at for factors in value based purchasing: HEDIS measures, health outcomes, decreased institutionalization, looking as measured use stratified by risk, ways to manage legitimate outliers, and difficulty defining episodes of care. Barriers to value based purchasing include red tape and administrative burdens and categorical barriers. Then there's the health outcomes with health homes which saw good improvements, outcomes, and increased integrated care. We need to focus on integrated care, not just mental and physical, but how do we integrate all of that.
14. In terms of whatever happens, the focus on IDD should be on timely, appropriate services that they need rather than services that have been cut that should not have been cut.
15. I'm not sure that value based outcomes are appropriate for LTSS, as it's not the same as healthcare. LTSS services are not the same as healthcare services, and you talk about stabilizing the current system and changing the system, and the idea of reporting providers, when there's already been reimbursement reductions.
16. I can only speak from the IDD perspective, but I don't see how [value based purchasing] works for that. If FFS is taken away, [inaudible]. We're talking about [inaudible] services for people with disabilities but to have to be judges [inaudible] that pieces of the puzzle doesn't [inaudible]. [inaudible] that's the hospital. We are not medical providers.
17. Thank you for the clarification, as this is something we have confusion about around the table. Our experience as IDD providers was pay-for-performance with vocational rehabilitation, and that was not a successful experiment for us. We do feel like the rates are so streamlined there's not room for creativity or room for experimenting with people. If it could be on top of it [FFS], we feel that could have some value.
18. I have a comment from before, on the 1st session about value based purchasing. I expect it could have an impact on quality for IDD services. But caution that it could have an impact that could be positive or negative. One concrete example: a person with an [Integrated Service Plan] ISP has a service and the service was eliminated, but we'll offer this lower-cost alternative instead. That's not quality.
19. Q: What is valued based? Is this financial based and what does it have to do with Person centered?

Administrative Streamlining

There were fifty-nine (59) administrative streamlining comments and questions. Eleven (11) related to streamlining billing, fourteen (14) for streamlining credentialing, three (3) for streamlining Kansas Placement Criteria, eight (8) for streamlining prior authorization, six (6) for communications, eleven (11) suggestions of other processes to streamline, and six (6) uncategorized administrative streamlining questions/comments.

Billing	State Response
<p>There were eleven (11) questions/comments about streamlining billing. Of these, three (3) comments were related to patient obligations; five (5) comments were about using a common system for all MCO's; one (1) comment suggested clarifying policy language; and two (2) described the "battle" or "burden" of billing.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>

Comments

1. On the billing side, there could stand for some improvement there. For our organization, we are still working claims from 2014 – battling is a reality, and shouldn't be.
2. Also, with 3 MCOs, it would help to have a common billing and payment system.
3. One of the things we hear about is typically billing issues stemming from policy issues. Policy interpretation, the way policy is written, it is not in the manual, I think anything we can do to stream line that, if we could streamline that, I think anything we can do to move towards that the sooner we can get that done it will be better.
4. Plans of Care are getting approved more timely we appreciate that. Streamlining for the billing system it is so complex, and authenticare system, the administrative costs have increased dramatically. Changing and keeping up with 3 different systems is incredibly complex and expensive to all providers. Care management/ coordination, since we've gone under a KanCare system, trying to figure out who is the care coordinator is even tougher. All we hear is call the 1800 number. We need some system where the providers and the consumers can find out who their coordinator is. Care Coordination has really declined in our waiver world; I'd love to see in improved. Communication systems all three MCO's have different methods of communicating with providers, some flash quick messages, others have quarterly newsletters, there is no consistency in how they communicate changes or how they choose to implement internal directions form the state. Appreciate getting paid more quickly. Getting things posted more quickly is helpful.
5. Echoing the same things and others – clearing house rework and billing processes are key on the admin side, when they don't work it crease a burden. Give me the thing that rises to the top, triple the effort, it takes triple the effort – not because of 3 MCO's. Same frustrations despite what should be a drop in learning curve. Our staff are experienced professional people (billing). Why is this taking so much?
6. Is there any way we can have standardization across the board as far as the FMS billing? Can they separate that from workers' side, we get one lump sum and it needs to be separated notice for the change in providers. To reiterate about the notice on a change in providers. Sometimes we don't know when a consumer has left or changed providers. Another thing is way the MCO's calculate the units for the month. Certain MCO's have different ways of calculating. We have issues because by the 31st day of the month the units are exhausted it causes a problem because they are not accounting for the 31st day.
7. We're from the IDD waiver also. We feel like there is a lot of duplication form coordinators land TCMs. We would like to take ourselves out of that system. We have MCO's that have different forms and different process. If they would get it all together it would make it so much easier. With work programs everyone has different forms and different process and sometimes you can't bill back those services. Those differences cause us to be slower than we should be and folks don't get services for however long it takes to get a job. Obligations have to go to the clearing house before it is authorized by the MCO That really slows it down. A provider can go months without

knowing what the obligation is and wind up with too much money in their bank accounts. Each MCO is different, it is difficult to figure out the value benefit and how to take advantage of it. Respite care as a value based benefit, there is no FMS provider that will bill for that. The authorizations for FMS, every time someone is going into PCS the authorization is just a mess, a lot of the time the care coordinator did not know what to do and it is a problem for the individual and we need a lot of education to straighten it out.

8. Billing claims: everyone has the same process for all MCO's. Separate the FMS billing form the PCSW billing. Notification of change for providers. Formula for MCO's for standardization for all 31 days in a month.
9. I also come from a long-term care facility and in regard to patient obligations, let's clear those up. Between KMAP and the MCO, which have discrepancies on what to charge, and providers don't know which is correct. The clearinghouse will be another section someday and of course payment verifications.
10. Another process is patient obligation that we go round and round with.
11. Client obligations, are still a mess could we make them go away? Could someone talk to the governor and have someone raise the threshold so they wouldn't have to pay them. Or have the MCO's collect them because we will hear 6 months after that the client has an obligation going back 6 months. There needs to be some standardization on who the MCO applies the obligation too. It wouldn't take much to say; 1 here's how you apply the client obligation, and 2 here's how you inform the client or consumer. If you have client obligation going back 6 months you should be forgiven.

<i>Credentialing</i>	State Response
There were fourteen (14) questions/comments about streamlining the credentialing process. Of these, five (5) expressed desire and support for standardized credentialing; four (4) described the current credentialing process in a negative manner; two (2) asked about the process; and one (1) restated that there was not a standardized process.	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.

Comments
<ol style="list-style-type: none"> 1. We would really like to see a standardized credentialing process. We waste a significant amount of hours giving people the same information. Sometimes it's 90 days; sometimes it's 20 days we hear back. They're supposed to make their decision in 30 days. We'd like to see some teeth behind that 30-day rule. 2. Critical Access Hospital – Credentialing is a nightmare. We do billing for a critical access hospital and the physicians through the hospitals, including their credentialing, and it's hard when you're contracting through three MCO's. I like the idea of a centralized place where once you submit the data, it goes out to the MCOs, but you still have to answer questions for each of those. We employ four (4) doctors, eight (8) mid-level practitioners, and four (4) part-time mid-level practitioners and with turnover this is an ongoing thing for us. 3. Something helpful would be standardized credentialing. 4. Standardized credentialing. 5. Of course we're very supportive of efforts to streamline credentialing. 6. Credentialing is a challenge. I work with a FQHC that services medical, dental, and behavioral health. I want to get providers in the door and credentialed in a timely manner so they can start billing for services. We're hearing rumors of centralized credentialing. What is the status of that? 7. So we have a similar problem with credentialing the majority of our table is dental. We have to credential in KMAP and with each of the MCO's. A lot of providers will not go through all of the paper work. Also there is a problem with what is paid and covered by each MCO. One MCO may cover an adult cleaning every 4 months and another every 6 months so it is difficult keeping track of what is being covered by each MCO. Also consistence in

the authorization process it seems like something get approved though one MCO and not through another MCO and then trying to find the authorization itself is difficulty.

8. Credentialing not standardized.
9. Why credential if KMAPP has approved us?
10. What process Credentialing?
11. Administrative: centralized credentialing for provider and KMAP. Consistency in what is paid and coverage. Consistency in authorization proves. SUD KCPC system needs to go. Multiple websites. FaceTime with an MCO representative.
12. Small safety net dental only clinic – I want to reiterate that it is easier to get referrals and authorizations. I also agree with the statements on credentialing. We struggle with another component; as a federally qualified health center (FQHC), we can't use temporary codes. Between that and we have multiple turnovers, it is frustrating. There needs to be improvements in the breakdown between KMAP and the MCOs with client eligibility. KMAP will say yes and the MCO will say no. How long until we clear those issues up?
13. We are on the Oklahoma Kansas state line and we are going through the Oklahoma credentialing process. Our experience with that that been very positive. Everything is online, you upload your license, and supporting documentation with the application. Can we look into similar process? All online is helpful. That is what the KS portal will eventually do.... will not have to provide it to 3 or 4.
14. Two issues, the initial application process I know we are trying to improve the process but that outpatient process is still taking months, especially for pregnant women. Some are going without prenatal care so we really have to figure out how to do that. The other thing is turnover among our people our experience is they get licensed and move on to better things. So we're constantly replacing people. As mentioned there are three providers, this really makes a burdensome process for us every time we bring on new people because we are doing everything in triplicate.

<i>Kansas Client Placement Criteria</i>	State Response
There were three (3) questions/comments about Kansas Client Placement Criteria. Of these, two (2) were about eliminating KCPC; and one (1) stated KCPC "is difficult to navigate."	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.

Comments

1. I'm obligated to mention that the KCPC [Kansas Client Placement Criteria] criteria is difficult to navigate and needs to be addressed. In value based purchasing (VBP) programs and fee for service (FFS) programs there needs to be some discussion about utilization management and length of stay, providing some flexibility managing that from a member perspective knowing that there's difficulty managing it from a provider perspective.
2. So I am a substance abuse provider, there is a unique system in the substance abuse world we have to use called the Kansas Client Based Criteria where all authorizations happen for Medicaid. I'm sure that our MCO partners as we would, be very happy if that went away. Authorizations are being lost in the system process. We spend a lot of time resending authorizations, resubmitting requests for payments, that's something we could have streamlined.
3. Someone mentioned the pc I want to pile on that soft war was created in the mid-90s I have staff that threaten to quit about having to use that process it is any way to eliminate KCPC process?

<i>Prior Authorization</i>	State Response
<p>There were eight (8) questions/comments about prior authorization. Of these, four (4) were requests that preauthorization be streamlined across MCO's; one (1) express appreciation for progress made; one (1) stated there was already work at the state level to eliminate problems; one (1) observed the process was different; and one (1) asked about the process.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
Comments	
<ol style="list-style-type: none"> 1. Appreciate the streamlining that has already been put into place including preauthorization for our residents before getting services. It has made it easier to get care faster. 2. Some MCOs have transitioned from behavioral health services being authorized to pre-authorized. It would be helpful if all MCOs could adopt a common methodology for authorization. It is my experience each do so in a different manner and there needs to be an effective and efficient way to address this. 3. We do pediatric Physical speech and occupational therapy mainly for children with disabilities and ADA services. Preauthorization for PTOT and speech is completely different for each MCO, we would like to see it streamlined. The forms are all different and if we are talking about streamlining that would be nice. Prudentially is a nightmare, it is not standardized every MCO is different even within the MCO there's differences, the behavioral health side of the ADA is different from the health side. 4. We have a lot of inconsistency with equipment approved for children. It depends on the MCO. We spend time on authorization evaluating the value or value or lack of value of authorization. A group has been working at state level to work with MCOs regarding prior authorizations where they can do some elimination. 5. Prior Authorization has become a considerably burdensome process across the 3 MCOs. The process from 2013 to where we are now is considerably different. Appreciate where we are at now but there is still a way to go. 6. Pre-authorization is different. 7. Process to authorize? Standardize how MCO's identify and work on outliers (UHC/Optimum and methods have? Standardize credentialing. The ACMHCK KanCare Clinical Committee that meet with representatives for all MCO's monthly to address clinical services related to issues. 8. The prior authorization process, we need some standardization there. 	
<i>Communication</i>	State Response
<p>There were six (6) questions/comments about communication. Of these, two (2) suggested streamlining the process for releasing information; three (3) expressed problems with current communication methods; and one (1) suggested giving providers just the "exceptions."</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
Comments	
<ol style="list-style-type: none"> 1. On Dental side of things, which I know it is a small piece of the pie. First thank you for saying that about the manuals it may be complex but it is the only way to know the rules, I think if instead of the manual if we only had the exceptions instead of having a full manual you have to print out, and try to train someone with when you have a new employee. If we just had the exceptions, it would make it a lot easier. In terms of what is working, we are now going to have a representative from the Sion side for the United Health Care and Amerigroup for four or five years we did not have anyone advocate for us. For all sides for time and resources it would be nice if they would read the entire claim and look at the documents before they just deny it and we have to process the claim with the exact same information three or four times it is one to the reason we get out. If the history could be 	

shared faster. Members go from one to the other and we end up duplicating services and we don't know how it's done. If they could streamline that but it's a question to be asked.

2. Right now we have to get a KMAP number it's not going away? Currently we have CAQH that they draw their data from. Will there be something similar to CAQH that the state will draw their information from? Streamlining information release in a timely manner with the recent autism waiver changes once MCO jumped the gun and created a nightmare for us and the state jumped in and made changes at the 11th hour and implemented the changes retroactively to January 1. The state did not communicate the changes to the providers and we heard second hand from the MCO's. That is a prime example of something that we would appreciate being streamlined.
3. One process is getting ahold of care coordinators through the MCO especially in a time of crisis. They tend to answer their phone during business hours. The MCO's are putting an extensive burden on families and providers to submit the right paperwork. I would like to see the responsibility of care coordinators reduced and see it transferred back to the TCM in order to quickly and safely serve the people.
4. I just wanted to piggy back on how hard it is for the clearing house and MCO's to talk, for example this individual left health home in October he was told that he had to reapply. Here is his application for January MCO said they had not received it and he was not in the system, he had to reapply. He reapplied in March MCO said that he was not in the system, he reapplied in April the MCO said he was not in the system. Here are all confirmations we got in May saying that he was in the system said that he was in the system but are no longer qualified for HCBS services because you're not medically needy and your back on the waiting list. He has been in services for four years it is a mess. Only half of his providers are getting paid since October. I think that needs to be looked at how the clearing houses and MCOL's are talking to each other. This is causing a problem for the IDD population, you used to be able to walk into the DCF office and get this taken care of. Now it's not it getting some one the phone. It's not working this is a terrible example of what worked in 2007 but is not working now.
5. Streamline information release in a timely manner.
6. I work for the Area Agency on Aging (AAA). We do the functional eligibility assessments for the frail elderly (FE), physical disability (PD), and traumatic brain injury (TBI) waivers. I don't have a huge concern. With streamlining – we go to [the participant's] homes and do their initial or annual assessments. They will have questions for us that we can't answer and many don't know who their care coordinator is or how to get ahold of them. There needs to be more streamlining, dedicated numbers for them so that we can relay that information for them, that the customer has some issues for them.

<i>Other Suggestions of Processes to Streamline</i>	State Response
There were eleven (11) uncategorized streamlining suggestions, four (4) related to functional and needs assessment, two (2) related to person centered service planning and individual service plans, and one (1) each related to assignment of MCOs, a list of suggestions, money follows the person, and practice management review, presumptive health for people with I/DD.	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.

Comments

1. The other thing is a standardized process with person centered planning with something like life course tools developed by families for families.

2. A client comes in and sees a sign on the wall that says the provider does not have an agreement with the MCO that they are assigned; that's one of the problems we have. Another is the client is assigned an MCO and goes to a provider, gets care/treatment. The provider then has to fill out what ever forms are required according to that MCO. There are three (3) different sets of requirements. Then [the MCO] submits it to a main database so the provider can be paid. Why not make assign the provider to an MCO and then the clients all get one MCO? That way when one MCO is not efficient, the providers all over the state will say "you have a problem" and [the state] can work with them to get it solved instead of three (3) of them solving problems two (2) of them don't have?
3. I appreciate the Lt. Governor's task force work. There are several specific areas that could be improved or streamlined.
 - a. Pay for performance project data needs to be validated before payments are made by the MCOs as the information sent out has quite a few errors and discrepancies that requires us to go back clarify.
 - b. It would help if audit reviews were timely. We sent out 20 charts in December, but have yet to receive a review of client needs for that audit.
 - c. It would be helpful to clarify the manuals and definitions, and it's a lot – the KHS manual, this MCO, that MCO – it's a circular debate that never goes anywhere.
 - d. It would be helpful if there's consistency in the level of service authorization as there's a discrepancy there.
 - e. We here talk about more than three (3) MCOs – which we think will be onerous, difficult, increase our costs, and increase cost confusion.
 - f. Pharmacy authorization calls are burdensome. They could be on paper, email, or online data uploads.
 - g. It is burdensome to have 30- to 50-minute review phone calls on cases; that could be streamlined. It would be helpful if they reviewed the chart ahead of the case, especially if looked at last progress note.
 - h. Also, a standardization of authorization forms for some things, such as the standardization of credentialing.
4. I'm with a long-term care (LTC) provider, and I too see the mix up with the obligations and would like to see more unity on the MCOs integrated service plans (ISPs). They are nothing alike. I had a MCO saying that one I have is incorrect and it needed an update as the service dates were not correct, they wouldn't put a tier on it, we would get it after the fact, and want to do [the ISP] a month or two ahead of time. They explained that once there's a signature on it they can't redo it but they will give me a piece of paper that is wrong and it makes it hard to support people. Another issue is the need for additional behavior supports in IDD. When there is somebody that has one (1) IDD diagnosis but eight (8) mental health diagnoses and are in crisis, I'm told they can't screen them because they're IDD. They have nine (9) areas that they need help in, we're at the ER with law enforcement officers involved, and it's after 5:00 pm. They say to call them tomorrow. Something's got to change; there's a flaw there. People in service are suffering and it's got to be fixed.
5. Things to streamline include the documents that come back for providers to upload and having a system to address that. Also, it's a duplication of service to have the BASIS done then have the care coordinator ask the same questions in their assessment, and this happens for the FE waiver too. The consumer will be asked the same question at three different meetings. Also, there needs to be a change in acronym for ISP-PCSP. People confuse the service plan for the support plan. It's a headache and causes questions for people when they're two different documents. Also, streamlining TCM scheduling and care coordinators with meetings. The care coordinators will contact the TCM to schedule a meeting and it doesn't work with the family, so it'll need to be rescheduled, creating inefficiencies, and it's non-billable time for TCMs.
6. (person served) one thing we were taking about would be great if it were standardized across the MCO's federal money follows a person is going away it will be up to the MCO's to fill that void it would be great if we could come up with a uniform policy to preserve the funding the it is critical in helping people reintegrate.

7. What process are to be standardized? Long Term care & IDD – are saying that the needs assessment differs by individual waivers...some are 30 pages; some are 5 pages. Some Care Coordinators are spending short time and others a long time. From MH –perspective it would be terrific to have a standardized time from when audits happen.
8. I think the practice management reviews we are receiving from all three of the MCO’s have similar processes but we are only aware of the process of one. It seems to be heavily loaded, and administratively burdensome. If the three could get together and get a similar process that would be helpful. So it seems odd and we aren’t complaining about but, at the same time there is always a worry will we be caught in some king of backlash because of the three process. What we like is the recent incentive payment for achieving certain outcomes. We got a check, so we appreciate that, but getting into the system getting to the data, finding the patients, there are three different process, three different access codes, to doing that. Also some consistency looking at high risk populations.
9. We have some suggestions for standardization among the MCO’s, we would like to see the assessments streamlined. An example is a needs assessment, United Health care has three assessments that take 2 and a half hours well maybe Sunflower, Amerigroup have on as assessment that takes one hour. we would like to see the individual life plans, that maybe we could do all of that at the annual base assessment and have the family sit through shorter meetings. We would like to see shorter ISP’s. It would be great if we continue to work with MCO’s the care coordinator sticks around? It’s not far to the families to have to repeat work with a new care coordinator. The redundancy of that seems to be a waste of money and time. Standardization between MCO’s be wonderful, if they could all have same agenda. We have no idea who the new care coordinator will be by the time he has a meeting. Sometimes the coordinator would go to a home and not announce themselves and make the family nervous thinking that they were going to be audited. I think being respectful of that is very important.
10. MCO’s: Standardized basis/NA/ individualized life plan. Case coordinators change all of the time. Streamline assessments one MCO has three. ISP; Shorten to less than 5 pages instead of a 42-page ISP. IDP: come to basis assessment for MCO’s.
11. In regards to LTSS and persons with IDD, it would go a long way with a presumptive health ability for people we’re serving, if they receive a diagnosis/HCBS eligibility before age 21. This is something that doesn’t go away. Any parent wishes it would go away.

<i>Uncategorized Streamlining Comments/Questions</i>	<i>State Response</i>
There were six (6) uncategorized questions/comments about administrative streamlining. Two (2) in support of streamlining and one (1) each don’t know processes, KMMIS question, TCM definition suggestion, and TCM workload.	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.

Comments
<ol style="list-style-type: none"> 1. We don’t know the processes, so we can’t address them. 2. I might add that [the hospital association] has been an advocate of standardization. The progress that’s been made with the Lt. Governor’s workgroup has to keep going on. Also, with talks of bringing on another MCO, we discourage more than 3. If a new player is added to the group, they should be able to display that they are able to hit the ground running and providers should have ample time prepare for and the transition to be made. 3. One of the things we’re wondering is when it [KMMIS] will go live? 4. One of the overriding questions is why couldn’t the state say what our definition of targeted case management (TCM) is and require for that to happen, and you as MCOs meet that definition or not? In terms of them, the MCOs authorize TCM by the quarter or by the year. In general, how the MCOs allocate services is very different across them.

5. You really helped us last year by reducing faxing. Streamlining, this is a competitive environment for the MCO's I would hate to see this turn into the Kansas "Hunger Games" where they fight against each other. I think that is contrary to standardization. One MH provider suggested this, "nothing about us without us." We can help with the planning process, but at least involve us. Some changes would be much more efficient.
6. As the administrative streamlining is occurring, TCM are required to do more and more, however it's all work that three or four years ago was deemed unbillable, it is causing capacity issues. All TCM in the Shawnee County area have been closed to referrals at some point, as well as the 4% cut. We need to look at what will be billable for TCM if we are going to continue offering the service.

MCO Communication

There were eighty-two (82) MCO communication questions and comments. Four (4) related to designated provider representatives, six (6) that communications are hard to understand, five (5) that member representatives have a hard time getting information from MCOs, seven (7) that MCOs are hard to reach, forty-six (46) expressing preferred communication methods, and fourteen (14) uncategorized MCO communication comments/questions.

<i>Provider Representative</i>	State Response
There were four (4) comments that requested return of designated provider representatives at MCO.	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.

Comments

1. At the beginning, I really appreciated the dedicated provider relations representatives who knew me by my first name and worked diligently to know my business. This has been lost due to a lot of turnover, it's in a fickle state, and the personal awareness is lost.
2. I second the previous commenter about a dedicated provider representative.
3. One MCO has a designated provider service representative who is extremely helpful. Others don't have that and you're stuck calling into a line. That dedicated rep is extremely valuable.
4. Few comments on admin issues – provider reps – reminded me of 1 MCO has assigned us a provider rep the one most business with, one other MCO we have a rep when she's on the road and can't look on her computer and I don't think we have 1 with the 3rd. it would be important to have all of them to have a rep assigned to deal w/billing issues. Related to a new MCO or to coming into the mix, that they are ready to hit the ground – billing with LTSS, any of the 3 that are currently are ready for LTSS billing, are medical model, had to fit into that, the client obligation and is still the issue we have. 1 doing it right, have issues w/them not doing it correctly, months and moths, ½ of our issues. To go from no issues to having 3 doing it wrong the last few years.

<i>Understanding Communication</i>	State Response
Six (6) commenters stated that communications are hard to understand.	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.

Comments

1. I have just recently been put on disability – the stacks of paperwork, the books and booklets, pamphlets, languages, the legalese, I don't understand. I live in Logan. I don't have – I've had a hard time to get it and understand it, follow it, don't get it wrong, don't get it the wrong way. Had a lot of help when I call. Get overwhelmed, put it aside, get another letter, the omg I screwed things up. I have called and sat down in tear and ldk what to ask and they said and I had written things down and reading things and what to answer and got luck and they've helped me. IDK my MCO I just call – I have Amerigroup. I've had great success.
2. There is too much legalese. We do receive booklets in the mail. We do refer to the information we need it, but it is voluminous. One suggestion is if we can select whether we want the information electronically or by paper. Also, I would love to help the state out by auditing the billing reports. I would like to be able to select whether I want English or Spanish because I get both. These billing reports combine things. I cannot ascertain what service was provided on what day and who provided that services. I can verify what providers came out and for what length of times. I appreciate everything the state is doing for my son. I don't know what I would do if I didn't have these services provided, and he has improved. Bit I would also like to protect the tax dollars. I would like to check the providers too. They come in my home. I want to be watch dog for the state. I have made that recommendation to Amerigroup. If you would just send me spreadsheet I would be glad to check it out periodically.

3. No trouble getting in touch with MCO and care coordinator for children on the TBI waiver. I was very clear with my care coordinator about how I wanted to receive communication through email. Getting care coordinators to attend meetings is challenge. Rural parts of the state have more issues receiving information form care coordinators. Getting care coordinators to attend meetings was mentioned before. Information coming from the MCO is not in a language our loved ones understand. We need the MCO to understand disability in aspects related to communication, such as speaking slowly, clearly, loudly, and having interpreters available, for autism the use of visual or the use of picture communication. Letters that came out about this meeting came Wednesday (for a Saturday meeting), but I knew about it from email.
4. MCO information not user friendly, need to call for clarification and understanding.
5. MCO Communication is not comprehensible, most of the times.
6. Mail outs are unclear many of the times.

<i>MCO Contact with Representatives</i>	State Response
There were five (5) comments that it is difficult for member representatives (guardians, parents) to get information from MCOs or MCOs won't talk to them.	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.

Comments

1. My brother had gone from Hays hospital to KC hospital. Got a letter – recoupment from the MCO wanting to know – he got it, IDD, non-verbal, gave him a timeline to respond to be responsible for cost of services- date of accident, who his lawyer was, was not in accident. When an individual gets a letter like this, way over their age range and comprehension letter, you're liable, will fail, if know answers, and there was no accident, gave to friends, asked where was, stubbed toe at rec, whatever comes to mind. MCOs in certain circumstances, all correspondences, to guardian and individual, to go to CM and individual, and individual, make sure and will go out and help them fill it out, will need help filling it out. Large amount of letters to individuals with cognitive disabilities and not understood what it means to them. Risk they can't keep taking. Harms them in the long run.
2. United Health Care – my sister gets calls weekly wanting information. They want to speak to her. They will not speak to my mother. My mother is her guardian. They won't talk to my mom about her needs. They want to do surveys, but they want my sister to do the survey.
3. My son turned 21 and there was no communication that dental services only included cleaning and nothing else. When he went to get cavities filled they said it was \$200. I was there and paid it but normally he would be there with his helper and no way to pay. Was it the MCO's responsibility to let us know about these meetings? I was told that the setae sent out 450,000 communications but we never received any information about this. How do you communicate with us?
4. There are a lot of comments about the MCOs or care coordinators not being able to communicate with guardians or people with POAs. I think it would behoove all to people at the state to say what specifically they need in writing to be able to have authority to do that. Would you ask MCOs to send everyone a list of what is needed?
5. I called my MCO they said they could not answer a question and told me that I wasn't durable power of attorney. The MCO said that they couldn't answer the question and I needed to call KanCare. So I called KanCare and they wouldn't answer the question because I wasn't the durable power of attorney. There for it was difficult for me to confer to my brother who is the power of attorney, to say I can't get this information for you. It was general information that was not given to me and I still don't have an answer. They said I would have to have permission to get the information, my brother would have to sign a durable power of attorney. We have to submit the form three times. It was frustrating dealing with that. It took almost two months to get the form from KanCare. I'm trying to ask questions and I'm not getting any answers. Even If I ask general questions not relating specifically to the case no one would answer my questions.

<i>Contacting MCOs</i>	State Response
There were seven (7) comments that it is difficult for members to reach MCOs, get the answers they need, or that it is time consuming to call MCOs.	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.
Comments	
<ol style="list-style-type: none"> 1. Our representative passed away. When we asked who are represented no one seemed to know after calling and calling they said someone out or Kansas City, we finally found a representative. But for over a year we did not know...Tomorrow we have meeting – we don't get any communication. We don't get any communication that has been for a year. There should be a better way. Also, we did not know about the value added services. If we knew about this my son has a horrible breathing problem, we could use an air purifier. We've tried everyone and eventually someone did help. A little hard. 2. MCO communication is horrible. I never hear from them unless I call, when I call they're not prepared, and not sure how to answer them and give me wrong directions. The first thing, you better get a speaker phone, won't get anyone to answer for 30-40 minutes. When you get someone, usually not sure where you are in state, when you ask questions you can hear them trying to find where it goes. When you point out physician says something, recommending this or that, tell you to continue the treatment. 3. There is no way we can get ahold of them by phone. That creates a problem when we cannot call a care coordinator directly. So I would ask if we can have their phone numbers. We can't do that with Amerigroup 4. She has problems with people being able to understand her because of her language she would like to have an interpreter available when she calls. She called and they said that would call her back. 5. I just say MCOs assure that the phone number given to you gets you in the right place. I was given a number and was on phone for an hour because I was on the commercial side trying to get specific information. (Follow-up from Director Randol indicates that the MCO that sent a communication out with the wrong number was United Health Care. The representative in the room agreed to meet with the commenter after the meeting to identify the exact document and assure the correct number). 6. 2014 – several different roles, the people who are answering phones don't have knowledge base of who they are talking to, who they need to send them to, etc. MCOs need to train their call centers. 7. The main phone number for the MCO is too hard to get through to. Between waiting in the cue for so long then being connected to a United employee operator that has no idea who and what is going on in the United Network, it's frustrating and inefficient. 	

<i>Preferred Method of Communication</i>	State Response
<p>There were forty-six (46) comments regarding preferred communication methods. Four (4) comments/questions requesting mail correspondence, fifteen (15) requesting email correspondence, six (6) negative comments about fax, four (4) comments requesting bulletins, three (3) requests for the improvement of web portholes and sites, two (2) requests for phone applications that provide explanations, two (2) requests for integrated luncheons and meetings, one (1) for a single encryption system, one (1) stating that communication was a fuzzy topic, one request to develop a contact list, one (1) request for video conferencing, one (1) request for picture communications systems for the members, one (1) requests for detailed spreadsheets. One (1) comment stating that the MCO's don't answer email. One (1) requesting an update of listserv. Two (2) requested updated provider manuals. Three (3) commenters admitted that they would accept varied forms of communication.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>

Comments

1. I appreciate the folks who are technology savvy. If you have a limited income, you are not going to spend that money to get that internet service in your house instead of paying electric or gas bill. Providers need to think about the economic decision of making everything electronic. Additionally, for people who have mental illness, or other addictions, if you get that internet connections you may not be doing other things. It may be a conscious decision not to get the internet to prevent things. Also its difficult to get an application from your website, I can't download a Medicaid application from kancare.gov, or I can get it in Spanish and not English. You have designed the assessment form in such a manner that you get a 90 percent satisfaction rate no matter my level of satisfaction.
2. We prefer email as the best way to communicate.
3. Hate the many different encryption types. I wish KDADS would buy an encryption program.
4. Improving communication – at the ground level I understand it's on us if someone gets fuzzy.
5. Committees that meet on certain days, it'd be helpful if they were written down instead of trying figuring it out on the fly.
6. At the MCOs, first line people don't open up emails.
7. The phone system - calling the 1-800 number. We all hate every one of the MCOs phone systems. You call it to get information and tell them here's so-and-so [referring to the MCO member], I need their care coordinator's name. It's an act of god and you need all the paperwork to do it. Trying to do it on the sly takes a lot of time and you need a lot of information. You have people on the waiting list for HCBS in crisis, trying to get a response. KDADS asks us to get the MCO to get us assistance. We try to get telephonic care coordinator – that's not going to happen. You don't know who to ask for; they won't tell us who it is. If we tell them KDADS hasn't made contact it causes a delay in getting services. We have to develop a rolodex – and you keep it close. If someone changes positions or you get a new MCO, you will have to start again.
8. On processes – If they get funding – a child – they get [Personal Care Service] PCS (agency or self-direct), you do the choice form to save time 9 times out of 10, choice is going to be granted. If MCO doesn't approve the date is before they had their meeting they want it done again. In a rural community we're doing it to expedite it,

because it can take 2 weeks to get the family tracked back down. They're holding it up. We don't understand why they're holding it up.

9. MCO communication – A variety, including email. Network is okay, but a recommendation, is that it is approved by the state and that it is also in line with the state contact and when questions are asked.
10. I like email, but I know we get a lot of stuff by fax. Not too sure, heard it is because expeditious way to transfer information.
11. Bulletins, want to see on the letter head, for 1 but all 3, found an error, based on a policy the state put out.
12. CC Turnover, lost paperwork, 800 # not for someone that has challenges to cognitive assistance. For family and members.
13. The only struggle is our members get info sent to them. They don't also send to the family to us or DPOA. Dementia doesn't know what it is, goes beyond time they're supposed to do something w/it. Families or with us. Client obligation. We would get it sent to us. Don't get it anymore. What we get and they get aren't on the same level. The MCOs that do, go by email and by phone are great communications. Agree to stop the fax.
14. We feel like the web portholes on each of the three MCO sites could be more member friendly. Early on it continues to be differences between MCOS and their care coordination and communication back with the members as well as with their guardians. There needs to be an examination on why that is occurring. Why can you reach some coordinators at some MCO's and not reach others, and get sent to call centers out of the state. With these your issues are resolved much later and with others your issues are resolved within 24-48 hours. Mail, some guardians get their mail, some individuals who are assigned get their mail, and mail some have court appointed guardians get their mail. From the state, to the clearing house to the MCO need to figure out a way between the organization that supports the members to insure the addresses are accurate so that they can coordinate in order to assure those court appointed guardians are getting the information for their wards
15. Emails are helpful so we don't have to check a website. MCOs validate their lists. Training their people how to route calls as you can sit on the phone for a long time
16. Potential it would be helpful if MCOs had video conference to do case conferences, troubleshoot issues, etc.
17. Email and possibly to be able to get on a listserv with the MCO for certain types of communication. One example is a situation where they need some training on extraordinary funding as I submitted information to them and then said I didn't get an email. I was made aware. I would have liked to get a direct communication.
18. Method of communication varies, but email works well. The problem is I get inundated with it and I'm not sure how important it is. I'm not sure how to address that.
19. We prefer emails on a regular basis, and in a timely manner. Not after something has happened and not faxes. A follow up phone call for something is a significant change, and make sure all the MCO's getting some information.
20. Kill the fax machine. It's not working. We have monthly meetings with several of the MCOs – issues are brought up, and they say put them on the agenda for the next meeting but it's not their decision to make. It ends up being this running log of decisions and questions they don't have time to answer. So keeping a log of decision status would be really helpful.
21. The Fax just does not work. If sending via email it works a lot better.
22. Kudos to Sunflower on their email system. We are getting timely and detailed information sent to us. Currently the recent emails that we are getting The KMAP bulleting round-up bulletin. It has been so helpful. We can go to their web site and sign up for the emails
23. 23. Single bulletin process is helpful. Doesn't cover everything. I think the Listserve by Sunflower is done very well. Different Practices don't have time check 3 sites or methods. It would be nice if the other MCO's can get on board with this. The other thing I think can be helpful is that there can there be a required number of reps for each MCO and really publicize those that are available. Have some expectations as to what the follow-up will be. And if we cannot get the rep can we get some additional information about who is available?
24. Email and by phone work the best. I had a question but person did not know answer and went to supervisor who had to go to someone else. When they did get the information back it was by phone and email.

25. We would like to see consistency between care coordinators, we frequently see one care coordinator one way and other say we don't do it that way do it this way. Email is fine for news. When care a coordinator leaves there some be some sort of automatic mass information sharing saying this person is gone. We frequently have no idea.
26. We said email and bulletins. Also Job aids laminated cards we can give out an incorporate in future meetings. Also incorporating a quarterly lunch and learn within the existing meetings.
27. Communication; regular emails, timely before something happens. Please don't fax Amerigroup. Follow up with phone call for significant changes. Ensure all levels in MCO gets same communication providers get.
28. Communication tools: Incorporate in existing meetings, quarterly provider luncheons, Email, bulletins job aids.
29. MCO Communication: No trouble getting in touch with the MCO and care coordinator. Children no TBI waiver and the case manager went to the MCO. Rural parts of the state seem to have more issues with reaching the MCO's and care coordinators for needed services. Getting care coordinator to attend meetings, frequent cancelations and sometimes failure to show up for meetings. Information coming from the MCO is not in the language our loved ones understand. Need for the MOC's to understand disabilities specific issues related to communications i.e. speaking slowly, speaking loudly, and having interpretations available. Picture communication systems vs words.
30. To improve, have an escalation feature so we know who to go to if we need more comprehensive help.
31. More detail in the spreadsheet so we can verify services provided and paid.
32. An app to explain everything, all options, what they are and be able to apply right then.
33. Topeka MCO fax machine does not work. They never answer. I have made multiple attempts.
34. Please ask MCO's to clearly communicate to all consumers how and what is needed for MCO to talk with guardians and power of attorney.
35. Cell phone app for autism (KU Autism Library has info).
36. MCI can communicate better by scrapping this privatized for profit system and return to the former system.
37. Going back to communication as fare as an outcome, with the MCOs the FMS providers and individuals on the waivers if we could look at the time line and the individuals having care coordinators changing constantly people are not notified and neither are we. So it really shows us down when we are trying to track down an ISP or an authorization for someone. If we can have better communication on that. The other thing is If we could work to do better on the ISP's. We have on MCO that has 40 page, a 10 page and 8 page if we could get those narrowed down it is very hard for the families to understand and read them.
38. Simple easy to understand should be the standard in communications. There continues to be a need for the personal touch at the community level. Applicants have difficulty getting answers to their questions, information about their status and help completing the forms.
39. Case of questions answered: not all are informed, no care coordinator and receives a slow response.
40. The MCO provider manuals for community based services (rehabilitation) are not equally detailed. Need all three to be detailed and more specific.
41. Is the KanCare steering committee is advisory, or does it drive decisions? Is there a vehicle that drives decisions that has a timely dissemination of information? Is this the purpose of the KanCare advisory committee?
42. Have names, population knowledge, who is ultimately responsive? Providers holding MCO's accountable.
43. I have a couples of things – comes back to the in-person assistance option for all populations – not just waiver folks. Can't sit down and discuss an application or renewal let along coverage. And timely processing. A lot of the communication, goes to the processing or renewals are the 2 things I have.
44. In terms of what would be improved, I think part of the problem is that we have to go looking for information. For example, they say go to the provider manual, I think there is a way to push information out without people trying to find it for themselves that would be helpful.
45. Why don't you offer the email as communication? We get written correspondence, we care for elderly and disabled. We get letters, we replied to them and don't hear anything for months. How come you don't have email available where you could get responses back immediately or at least mush faster and less chance in getting lost?

<p>46. I agree with email, that it’s a good thing. Dating documentation. We get emails reference a care coordinator who later says, “I don’t know what you’re talking about”. Their MCO has put out the communication, but their stuff is not dated. I got it on “this date” when came out. I don’t know, but that would be cool.</p>	
<p><i>Uncategorized MCO Communication Questions/Comments</i></p>	<p>State Response</p>
<p>There were fourteen (14) uncategorized comments and questions. These comments are formatted to allow the state to respond to each individual question due to their unique nature.</p>	
<p>Comments</p>	
<p>1. An example worth noting is when a clinical staff such as an APRN has to communicate with the MCO specialist about a case, and needs to talk to them for any length of time, especially in rural-frontier where provider time is golden. A 10-minute call turns into 30 minutes about things, that from a provider perspective are about how something is provided are general in nature and is seen as a waste of our time, but is a hoop to jump through to get the payment authorized, so we try to get our clinical director to handle these calls. It would help if we had a checklist to handle these so we could all be on the same page.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>2. This question comes from the CDDO reps at the table. We ran into this, how do we get care coordinators to communicate? To return a phone call is virtually impossible in some cases.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>3. Consistent. It has to be consistently submitted. In your bulletin, in manual, in an email. So we don’t have three (3) different ways of saying the same thing. Consistency has to be paramount. Every sort of communication you have and it has to reach varying people. Listserv – to my knowledge, only one (1) has an active listserv to get to the right individuals.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>4. We didn’t receive anything about this meeting. The MCO have our current contact information. Is the state mailing list kept up to date? I am trying to find out how you communicate with us. How do we correct our mailing address with you? How do we correct our mail address with you?</p>	<p>Thank you for your comment. The State sends out information about these meetings in provider bulletins, the KanCare and KDADS websites, and press releases.</p>
<p>5. There is a lot of confusion. A solution is an app to explain everything, all options, and what they are could be helpful.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>

<p>6. Will the 3 MCO's be able to submit all of their information to the state of Kansas? The State could review for consistency and guidelines? And then it (information) come from the state?</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>7. Two things, we would like the MCOs to come to one on one meetings. We have not seen MCO in a long time. We are an FMS. In the beginning we saw the MCO's come out but it's been a while since we have seen the reps. We need a 4th MCO. Do you really want? No!</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>8. Important to remember – can't do it without people, our members, without professionals, allied health. Struggling w/workforce issues in behavior. If there's a way to keep it as a context and contracts. Don't have a people can't recruit, can't deliver service. Workforce is a major issue. We – small issue – would be helpful if MCOs would issue clear written guidance about policy directive they a make – p4p – TCM for non-targeted members I p4p. can't get it in writing and are reluctant with the state plan and definition. (more details to come? Verbally/writing?)</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>9. Providers of services – reluctant to provide services and – some people, provider who is confused about the requirements if they don't reach out if someone is broken – when hearing – I needing clear guidance of what is and isn't covered for us and provider OS services. Gray areas of services? Clear details to the MCOs guidance – they are all confused what they can/can't provide for DME and aids.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>10. We have a good MCO person, keeps in contact with us and we're happy with the one we have.</p>	<p>Thank you for your comment.</p>
<p>11. I don't take care of the billing that's done through the FMS. I don't have any contact with them they don't send me any information my only interaction with them is in time of crisis. As the person spending all the time with the consumer an email I can keep us informed. Also on the MCO web sites if they could set up areas on there you can click on for tutorials saying, this is how you do this a, b, c, d, would be a lot more helpful. It would be a lot more efficient than waiting on the phone. There are some common areas all MCO's would want you to know</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>

<p>about, like grievances and how to submit billing. Being able to go and look in there if, many times we can do the on you own.</p>	
<p>12. When they were part of the spend-down and they would call, they were not giving the correct information for things like dental visits. No one gave information. A really large part has been the communication between the doctor and pharmacy and MCO in getting preauthorization's, it takes a lot of time. It took me a month to pay. I've had several preauthorization's once the pharmacy made a mistake and my son could not get his medications. It created an entire mess when I call and asked "where we are at in it" no one knows or tells me to call the other person.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>13. Coordination of services (state and MCO) state knows but MCO does not and vice versa. MCO changes known but state not informed.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>14. For ITE and BASIS – 1 MCO that has taken the position that it is a conflict of the interest to participate from the BASIS, 2 others have not, but 1 of the - we're removing to another where a MCO CC argues with the assessor and after the assessor is done, come on, you know they're not a tier 1. You get a full range of communication. What should we expect from the MCO in terms of communication?</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>

Care Coordination

There were sixty-one (61) care coordination comments and questions. Seven (7) relaying satisfaction with care coordination, ten (10) related to care coordination and targeted case management, twelve (12) commenters not sure if they have a care coordinator or who it is, ten (10) suggestions for improvement, eighteen (18) comments about dissatisfaction, and four (4) uncategorized comments/questions.

<i>Satisfied with Care Coordination</i>	State Response
There were seven (7) comments that relayed satisfaction with care coordination.	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.

Comments

1. Thank you for having these meetings. I'm on the Physical Disability Waiver & have a care coordinator. I seem to have better luck with it than when didn't have it. Thank you for starting care coordinators.
2. I really appreciate having a care coordinator that I can talk to. I've had recent problems related to not having a steady doctor and she's helping me find a primary care physician. My nephrologist prefers that I have one steady doctor and when one doctor leaves you get passed on to another and they leave. When you have a doctor who won't listen to you, you only have your care coordinator to turn to and she's really been there for me and I don't know what I'd do without that.
3. Nothing but good things to say. Everything has worked out fine so don't change too much. Responsiveness is what works best. Don't give "iffy" answer; give definitive answers.
4. We've been through 3 coordinators, but have had the same company. Each time we've had a good one.
5. The application process was a nightmare. For getting onto Medicaid in the first place but also the waiver – having to go through multiple appeals. I came today because I was confused. I was on the TBI waiver. I didn't know what Medicaid 2.0 was. I like my care coordinator. Because of their care I am on a home program. I appreciate them listening and trying to work through the bugs. I have had pretty good care and I wish everyone could get good care. There are so many of us and if all of us that want to be well if we could get the right care – not all of us might get there, but for some people the best thing they can give is a smile. That's a big deal. When you are really sick and struggling to keep up you can't do that. Some of us can get to a point where we are working part time or even full time. I appreciate the efforts that you are making and I hope you continue.
6. Personally I'm satisfied with my coordinators but I'm persistent and he does send me to the appropriate people. Who can help me?

<i>Targeted Case Management & Care Coordination</i>	State Response
There were ten (10) comments related to case management and care coordination. Four (4) comments were that care coordination is duplicative of Targeted Case Management (TCM), three (3) comments were requests to keep IDD (including to remove care coordination for those with TCM), and three (3) comments favor expanding TCM to all waivers and other populations.	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.

Comments

1. Know it a where if you don't know – why haven't you tried it – always failed. Looking @ waivers – my requ – preserve cm on IDD and keep as the primary and let CC enhance at their limited at. There are limitations. One is an enhancement instead of moving it all over to CC.

2. For the people who are here at the table are all under the IDD waiver. Our major problem is care coordination. Care coordinators are unresponsive to us, they come and go and we do not know their names. They are not overseeing the long-term care. They are not equipped. It is the wrong model for long-term care support. We have said that for three years. We have been patient. How are you going to remedy that? Our suggestion is to hand over the long term care to our case managers. The state is spending a lot more money on care coordinators and the whole MCO operation to get fewer services.
3. I'd like to put in a plug for TCM across all waivers the need for it that is huge.
4. Care support planning should be performed by independent targeted case managers who have access to serve all populations, all ages, not just those on waivers. Payment structure for TCM should be passed on stabilization and person centered care coordination and support planning that must be person centered.
5. Targeted Case management needed across all waivers. The coordinator of LATSSB needed in addition to coordination of health care. Ongoing training of care coordinators is needed. High turnover among coordinators results in a need for training. Communication is a problem coordinators change but families are not notified. Families don't know who to contact or attempts to contact go unanswered.
6. I don't really need one for my son on the IDD waiver because I'm knowledgeable and able to coordinate myself with the help of our TCM. I agree with what someone said, take the money from the MCO's and put it back into the local level to provide services.
7. I think we have amply shown over the three several years that people oi the IDD waiver are unhappy with the care coordination. We are convinced that the model does not work for IDD, the medical model foes not cover the needs that our people have on a daily basis. In KanCare 2.0 will you take out the long term supports from they care coordinators? It would be more efficient we would be more satisfied and it would be less expensive. What use is it having input from us?
8. Care coordination depends on who it is and who they are. Not which MCO they work for and that resonates for all the MCOs. It seems to be exaggerated in the KanCare world. We have a new care coordinator and she's doing well so far (she's here now). I think when we're looking at the waivers, care coordination is redundant of case management. There's been talk about a universal waiver and moving everything to the same pot. The families that I've spoken to with family members on the IDD waiver don't want to dissolve case management, as they've relied on it. Case managers spend time to get to know the person well, especially if you have a problem child like my family member and know care coordination better than others. Teasing out the IDD case management to keep it separate, preserving it, maintaining it, or using it to enhance targeted case management and having them know why it is unique is common sense.
9. My daughter is IDD – my experience of care coordination is that it is completely duplicative and unnecessary. My TCM is the person I go too. My TCM knows my child. The Case manager knows what is needed. From the beginning it has been my experience that in regards to Home and Community and day services KanCare is not a good fit. It makes me angry to see the duplication when it comes to the person centered plan. The Care Coordinator comes and does a plan and it just sits there. I get the same information several weeks later from the Care Coordinator that is the exact same information as the person centered plan from the case manager. So why is she there? What is her purpose? I would rather have the money that she is being paid be applied to the waiting list.
10. That is exactly my experience as well. The care coordination is a duplication of services and I would rather see that money used to expand access to those on the waiting list.

<i>Don't Know Care Coordinators</i>	State Response
There were twelve (12) comments that people didn't know they should have a care coordinator or who their care coordinator is.	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.
Comments	
<ol style="list-style-type: none"> 1. Tell us we have a care coordinator and who that is with contact information. 2. I'm here as POA for my mother who is in a Manhattan in a nursing home. Am I supposed to have a care coordinator? I have never heard from someone. I have an automatic voice mail I get and I have gotten a letter. But I have never heard from a person and I need one now. (Belongs to Sunflower.) 3. This family just doesn't get care coordination. They have never heard from a care coordinator. 4. I echo the comment from before. Two of us at the table have mothers who live in nursing homes and do not know our care coordinator and have not heard from care coordinator. We would like to know how care coordinators are assigned. They change too often. When they are assigned they sometimes know how to deal with children but for not have experience with the elderly. So I would like to know who my care coordinator is and what available to us. 5. I have two adult children on the spectrum, and we also have other folks who are here because of their loved ones. We started this in 2013. I have had four care coordinators and currently I don't even know who my care coordinator is. I guess the ultimate question is who is ultimately responsible for that? Is the state responsible or is it the MCOs? He's been denied two times. I don't know about the MCO's, I don't know these programs, all the phone calls and everyone I talk to tells me nothing. I just now learned what a care coordinator was. 6. No one at this table knows who their care coordinator is or didn't even knew that they exist. 7. I have been really helpful with my son's health insurance through United. My question is why is that most of us don't know about a care coordinator? I had never heard of it until we sat down. If I had a care coordinator perhaps I could have been able to connect with more services for my son with autism. I feel like I am on my own. I have had problems finding him services locally instead of having to go out of town. He is 17, so we are getting to that point where he will be transitioning into adulthood. Is that something that a care coordinator helps with? 8. Pleased w/United, sunflower, - Amerigroup. She's been w/7 days. Yet to speak w/cc, called every day. No response back. Struggle with getting the calls back. In limbo, don't know what to charge her, services to provide her. The 2, nice to get back, get shampoo, nursing home, great program, I don't think good about letting nh know United was super great, Sunflower, I'd like to address with Amerigroup, number of people with that service. Talk about cc, problem isn't the CC, the system of itself, call number, ldk, idk if I've gotten from the ADRC, KDHE hasn't gotten something to someone. System isn't moving smoothly. Processing within 47 days. One lady 100 days out, bill. 9. No-one at this table knows who their care coordinator is. 10. We have not been notified regarding who the care coordinator is. 11. Her Question about care coordination brought up an issue that has been troubling to me. We work with IDD population and the IDD folks on the IDD waiver they typically know care coordinator and will meet with them. I will tell you that the people on waiting list do not know that they have a care coordinator. They don't have contact with them. If there is coordination of care going on they are not familiar with it. They know they have a TCM and that's who they rely on. The Coordination is a little different depending on whether you are on the waiting list. 	

12. My wife’s mother moved from assisted living to a nursing home situation. I have been working for 6 months with the MCO trying to get the client obligation worked out, so far unsuccessfully. I didn’t even hear anything for the first four months. The only reason there has been progress is because of the billing coordinator at the nursing home. We don’t know who the care coordinator is. There has been a communication problem as far as I’m concerned.

<i>Improving Care Coordination</i>	State Response
There were ten (10) suggestions for improving care coordination. Four (4) for improving and documenting communication, two for having specialized care coordinators, and one (1) each for reducing caseload size, transition planning, that care coordination should focus on resource coordination and consistency.	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.

Comments

1. I have an idea that might clear this up a little bit, something that might help out – if you have some people with specialists – in a certain group or population and spread across the group or in that category – have a lead person. CC are less experienced. The experts who know how to handle that kind of case or issue, is a good idea, because I see if you have generalists, and they are good at everything, so how does someone above the CC who are a specialist in the area who can immediately answer they are not an expert in that they can try.
2. We were discussing that having care coordinators assigned that are more specialized. When families are looking for information they have coordinators that have to run across multiple populations, they may understand nursing but they may not understand immediate care facilities, they may understand, frail and elderly but that don’t understand the issued to child hood and intellectual developmental disability. So either additional training for the coordinator or more specialized coordinators, that may specialize in not understand highly specialized needs.
3. Some of the concerns that I have personally I am a parent guardian/advocate for my daughter. She has a person centered care plan, but we have had a problem with the coordination between the facilities she is at and the hospitals. She went into skilled nursing facility and had to be transitioned out. The hoops had to go thru to get in home supports. My care coordinator did the best that she could but if not for my case management it would have not happened. So making sure that the case manager is still a part of that connection and the seamless transition from hospital to home needs to be looked at. Improving care coordination, one of the things that we found out recently is that our “Care Coordinator” is actually not a care coordinator but long term nursing – which is very specific. She does not have the understanding of the resources that my daughter needs. Try to communicate with the long term care nurses in order to get the continuity of care that needs to be worked on. There needs to be a conversation between the guardian, care coordinator and the case manager. We need the conversation of educating the care coordinators and what supports are available in that part of the state.
4. Assign a care coordinator who communicates. Become accessible. Know how to communicate on subject matter.
5. Caseloads are too large for care coordinators. Standardize provider applications. Mandate notation of providers to address the possibility between MCO staff and providers. This doesn’t constrict patient choice it assures that MCOs don’t restrict to their providers.
6. A system that documents communications from and to the care coordinator would help to anticipate needs and to make sure the coordinator checks in. The MCO’s want to all kinds of paperwork form the providers. They should be held to some standard giving the state a mechanism to ensure coordination is being done. Also include key data like are they getting dental care.
7. Things care coordinators need to improve upon: when a service coordinator switches; when a member switches providers; Getting member plans updated before the expiration date and then making sure the provider receives documentation; plans of care, and ISP’s in a reasonable amount of time.

8. What we need most is consistency. Every consumer has a different experience, although each person is different and needs flexibility care coordinators need training and need to be held accountable.
9. Care coordinator should ask consumer to select at a minim annually, Electronic vs. paper, Spanish vs English, who they can speak to on the phone.
10. Care coordination housed in MCOs should only be resource coordination focused.

<i>Dissatisfaction with Care Coordination</i>	State Response
There were eighteen (18) general comments expressing dissatisfaction with care coordination. Eight (8) comments that care coordinators were undertrained/inexperienced, five (5) that they weren't helpful, two (2) comments from providers that they have to do a lot of administrative work for care coordinators, and one (1) each that there was high turnover, there is a conflict of interest, and poor communication.	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.

Comments

1. I want you to know the anxiety and distress our families go through in dealing with these things. Our children and loved ones are not numbers. They have names. We are all human and we should be respected in that. It's very tough having to go through, over and over again, the things that should be done and should be in place. Our care coordinators who are hired don't know the population. Have not had the training. As parents we want to be trained too. We want to know how we can help our loved ones and help train others as well. There is so much more that we could do with this. Sometimes I feel that we look at our deficits, not what our individuals can do. Let's give them the opportunity for employment and training processes too so they don't have to sit home or sit in a facility where they are not getting the care they and that they deserve.
2. My mother was in a nursing home several years ago. After some time of trying I did figure out who the care coordinator was. But the care coordinator wouldn't talk to me, and my mother was nonverbal. We weren't able to get any information on her and I was filling out all the documents. It kind of makes sense that you should be able to talk to the person actually filling out the documents. All I could tell the care coordinator did was a medical records review. She said there were things that needed to be done but I couldn't see that any of that was followed up on. Care coordinator was out of Kansas City, Kansas. She would leave messages on the phone, but I would call back and she was not there and I couldn't find anyone knowledgeable.
3. If you are listed as the contact and the person who can receive any information, KanCare still refuses to talk to you and says they are operating under federal restrictions. I am the contact for my son and his two disabled children. My name is on all the forms in multiple places. I have sent a HIPAA release form, to Sunflower, six times in one year, and they still claimed, yes they got a fax, but it wasn't on file. Now they are talking about closing all the cases, and I know that will take 45 days, and I know if I call I either need to lie on the phone about who I am which I won't do or I know they are going to tell me they can't talk to me. But his doctors talk to me.
4. Care coordination hasn't worked. Care coordinator was worthless for my son. Very little hospitals & specialists. She would never push the issue, do more PT, do more PT, a year went by and never went by and said PT wasn't working and didn't push and probably saved any money. If could change it – listen to parents, listen to the physician and PT – need contrast MRI. Say no, need PT another 6 months because it's cheaper. Do what's best for patient not for bottom dollar. She was over worked and held the bottom dollar. Get them a map of Kansas – "Where is Spearville? You can run over to Wichita" – no... where's the closest "oh GC" has one. That's till an hour away. They think it's near an obscure place. Closest neurologist was in KC.
5. Current care coordinators are overloaded, experience unacceptably high turnover, and lack sufficient experience to understand diverse populations. They are unacceptably ignorant about community resources. Those effective

- care coordinators are not rewarded for their high effectiveness rather they are given even more cases and increasingly more complex crisis laden cases that take significantly more time over long periods to coordinate.
6. Care coordinators do not know enough about the waivers to communicate intelligently.
 7. Care Coordinators are the worst. They do none of the functions or tasks case managers did. What is the job description of care coordinators since they don't assist HCBS consumers in resolving problems?
 8. Care coordinator is experienced in children rather than elderly.
 9. Care coordinator does not know how to help.
 10. I reviewed ISP when it was sent to me after completed by a care coordination and I signed it. I was not given a chance to review it. There were errors which I noted and scanned and returned to the care coordinator who acknowledged the receipt. But I'm not sure if it was updated. I've received no help in finding appropriate home health agencies and care givers.
 11. Waiting list is it still in existence and what the process PD and TBI? How hen we receive information for a care giver regarding the consumer. I take the information and track down the care coordinator. When I get a coordinator the coordinator says wow I don't know what to do with that. Like miss using meds Sometimes the care worker does not know what do with it.
 12. Never easy to get questions answered when you call United because: Care Coordinators were not trained and do not even know simple basics about the waiver for example "what's medical necessity?"
 13. From organization Families for KanCare Reform. Heard from other parents, as we have quantified and validated the concerns we have been hearing. We commissioned a survey of the Kansas Targeted Case Management Resource network. Of which there are approximately 200 state wide, we had 100 of those respond. We had a got pretty good response rate. Here's what the targeted case managers were telling us about care coordination. Only 4 out of 10 said they knew who the care coordinators were assigned to their caseload. 18% said cancellations of meetings have happened 4+ times per year, another 22% said these meetings had been canceled 6 or more times a year. Nearly half said that care coordinators do not show up to meetings at all. 4 out of 10 reported that care coordinators requesting clients or their designees to sign blank ISP's. 1 in 4 provided information that contradicted with what the TCM's has gotten form other care coordinators or MCO's. Care coordinators received low marks in terms of helpfulness in crisis situations, scoring less than 35% in major categories such as, completion of ISP's, getting authorizations in a timely manner, advocating with MCO administration, providing useful resources options and staying informed and available to assist. We intend to repeat this survey in January of next year.
 14. Gone through 4 care coordinators since current start. Currently don't know who the care coordinator is, and does not know services for resources. Needs continuity. Duplication of care coordination and case manager, case manager knows person best. Those members how have a case manger are further ahead and receive better coordination with case manager and care coordinator. Care coordinators need training. Care coordinators caseloads are too large for individualization and knowledge of the member.
 15. Care coordinator changes too often.
 16. I started working and got a crash course in how to be a case manager. I don't think that all service coordinators intentionally are bad. I think it's part their work ethic and part caseload. A lot of times I hear I have 50 cases. I have members that hacek gone through 5 or 6 case managers through a year. Providers know the people. Care coordinators know the numbers.
 17. I am a provider. I represent several hundred people who receive services. In the old days of SRS, we went through all these transitions. I feel in some ways that we are reinventing the wheel and re-solving issues we had worked out before. One of our disappointments is the lack of training and the lack oversight, these issues seemed to be thought out on paper but they are not really rolled out comprehensively. This of one of the things that we struggle with and we hear this from consumers all the time is that they don't know their care coordinators, and it is a complex system. We walk people though the system, but we are spending most of our

time and energy doing this as a provider when that is the MCOs' job. Five minutes on the phone with an agency is not effective service coordination. We end up doing all the administrative tasks for the consumer because we know the individual better than the care coordinator. They rely on our information but I don't feel that we should continually do their job when the other half of our time is spent making complaints with the MCO's. Some of the excuses we hear is that the caseload is too high. One of the things I would like to bring forward from the old case management days was there was a limit to the caseload to be effective. This is an area that I think needs to be addressed. We had an individual who was a new care coordinator who didn't really know the waiver that one consumer was on. The care coordinator didn't show up at a very important meeting. When we called them on it and called the supervisor on it, we heard that they weren't contractually obligated to attend that meeting. We're really disappointed in the involvement of the care coordinators.

- 18. MCO sited care coordination is inherently conflict laden for managing to profit creates the conflict that can't be mitigated. Current care coordinators are overloaded. Experience unacceptability high turnover, lack sufficient experience to understand divers populations, are unacceptably ignorant about community resources.

<i>Uncategorized Comments/Questions</i>	State Response
There were four (4) uncategorized care coordination comments, one (1) each related to reducing services, recommending care coordinator, question about how care coordinators are assigned, and levels of coordination.	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.

Comments

- 1. The issue with care coordination is the change from when we started in 2013 – that's the only thing we have ever been on – the change in the services they provide from somewhat of a case manager to a care coordinator. They do attend our team meetings and periodically we do an assessment. It seems that assessment is about how can we reduce the services not what does he need. Or if he hasn't been using the services because we can't find a provider so they reduce the service. One time they paid people in the home for providing care. I don't need that, but the nature of the care coordination I have seen from case management and navigation through the system to coming in to see if they can reduce the services. I can understand a lot of the system and navigate through it but a lot of people are not in the same position and need more intensive coordination.
- 2. 2 folks we recommend their cc or their case manager.
- 3. How is the coordinator assigned?
- 4. I didn't realize that there were two levels of care coordination. With my first year of care coordination through the MCO I wasn't getting anywhere. It wasn't until I talked to James Barth that I found out that I had a nursing care coordinator when you have a child that is medically fragile. For almost two years, I told my care coordinator I couldn't get services because they were no longer partnered with Children's Mercy and we couldn't use another clinic because he's medically fragile and has to be served in a hospital setting. I think for children who are medically fragile, they need to have better training for the care coordinators so they know that when we can't receive services and surgeries they know that they have a second level or we should be assigned a nursing care coordinator from the start. In order for my son to have surgery, I had a weekly prior authorization call and it took 6-8 months for authorization, depending on what the need was. I think the biggest problem is that all MCOs have to or should partner with Children's Mercy or a pediatric hospital where they can be served and during that time they shouldn't be able to drop the partnership or relationship with the clinic when that's the only place they can be seen. In that case, then my son wouldn't be able to have surgery, period, right?

Clearing House and Eligibility

General	State Response
<p>There were ten (10) comments about the clearinghouse and eligibility. Five (5) related to documents having to be sent repeatedly or being lost, three (3) regarding delays in processing applications and renewals, and one (1) each about the backlog and new requirements for eligibility.</p>	<p>The State continues to work on improving processes at the Eligibility Clearinghouse, including hiring more staff and assigning specific staff to specific nursing facilities to ensure quicker processing of applications.</p>

Comments

1. Clearing house issues continue in Johnson County; Patient obligations are not being changed when bills are sent in. Individuals still losing Medicaid, coding is incorrect, who is in charge of coding individuals with disabilities? Individuals are unable to go into a local office and get their questions answered. Although I am told that in Wyandotte County they are able to go into a DCF office and get assistance.
2. Clearinghouse is a mess and amount of time – and our people they call and get someone to help – and phone, not finding the faxes, constantly in an argument, like to see that addressed. When are they going to get services?
3. Will the stated request any new requirements for eligibility, e.g. work requirements? Drug tests, deductibles, copays? Is the enrollment backlog cleaned up? Will savings be used to fund HCBS waiting lists? Need an independent KanCare ombudsman office.
4. My biggest comment – there has to be something done w/the Clearinghouse. Eligibility and time taking for all of papers to go in. I’m working on resident since Jan. on Medicaid before and not getting, lost it, dates on papers. Those people through it. \$100k outstanding in services. Something has to be done w/that. We did a pilot w/LTC. 2 assigned to my NF – I hope it goes through and we have a certain person/people assigned to our facility.
5. Areas for improvement include issues with clearinghouse. In maintaining eligibility, we go back a half-step, how is this the problem that it is. I heard three (3) cases this morning of people who have been in the Kansas Medicaid system for many years, who were found not eligible for a timing reason and are now working through it. It is a spiral effect to undo what happens there and is a big challenge.
6. This was the first we heard there was a care coordinator. It’s been confusing trying to figure out what’s KRS and who’s KDCF. Then somehow we went from somebody that was a contact coordinator and case manager and then it became a group. Can we at least be able to talk to someone locally? Now we have to mail our information to Topeka. The fax number doesn’t work. It’s really confusing: Medicare/Medicaid/Working Healthy I never did get that all straightened out. There’s nobody to talk to. Someone did call back once from Topeka. They don’t use technology. We’re used to scanning and emailing attachments. It would be great if they could get up to date in technology.
7. Coding change issues: Spenddown, no MCO case closes for not meeting spenddowns. Spenddowns at Nursing homes not processed and still not processed. Resident deceased now, still playing phone tag for over a month.
8. Could you give us an update on the enrollment backlog?
9. My biggest comment – there has to be something done w/the Clearinghouse. Eligibility and time taking for all of papers to go in. I’m working on resident since Jan. on Medicaid before and not getting, lost it, dates on papers. Those people through it. \$100k outstanding in services. Something has to be done w/that. We did a pilot w/LTC. 2 assigned to my NF – I hope it goes through and we have a certain person/people assigned to our facility.

10. Medicaid apps, mostly Frail Elderly, also Physical Disability waiver. One issue is when we have applications that are pending for more than 90 days, then we get a determination that goes back more than 90 days, we run into the issue of pharmacy not being able to file claims back further than 90 days and the applicant is responsible for trying to get it covered by Part D. Why is it only 90 days now? Is it something that can be extended since determination can take so long? Many pharms out here tell people they won't file claims older than 90 days, not sure if not understanding or not want to go through trouble.

KanCare Feedback Process

General	State Response
<p>There were six (6) comments about the feedback process, one (1) stated not all participants understood abbreviations; one (1) expressed problems with a venue; one (1) suggested speakers use their full title; one (1) requested meeting times be made available further in advance; one (1) asked about the comment review process; and one (1) asked if drafts would be available at future meetings.</p>	<p>The State will continue to work that our public input process is simpler for stakeholders, including providing glossaries to help everyone understand acronyms and specialized terms. The State will also work to ensure that invitations to members and families are sent in time to allow members and families to attend.</p>

Comments

1. Beware that not everyone knows all the initials MCO, DCF etc.
2. We needed a better venue for this meeting the acoustics are not good I get an echo. I could not understand many of the respondents and even the male coordinators voice was rather hard (reverberation) but the female coordinators voice was perfectly clear. KU Edwards Campus has a great room. I noticed when I asked one of the young men helpers if there wasn't a volume button on the microphones. Everyone's speech not easier to understand.
3. Suggestion as you introduce yourself give the full title or give a hand with glossary.
4. Another example of incompetency is the notice for this meeting. It was dated 5/22/2017. It was delivered to our house 06/13/2017. Not enough time for caregivers to prepare. Was this intentional?
5. Who reviews the website that these comments that these goes to?
6. Will draft be available to us before the next meetings?

Home and Community Based Services Waivers

There were eighteen (18) Home and Community Based Service (HCBS) Waiver comments and questions. Four (4) related to HCBS policies, five (5) regarding waiting lists, and nine (9) uncategorized questions/comments.

HCBS Policy	State Response
There were four (4) comments related to HCBS policies, all related to the draft Person Centered Service Planning Policy open for public comment at the time of the tour.	KDADS has withdrawn this policy.

Comments

1. I was disappointed when I read the draft standard policy for KDADS. I participated on the CMS final work group at the state level at the person centered planning group. At your last meeting we spend a lot of time discussing the importance separating out the PCP. Not to confuse the language, some people didn't get it under the DD waiver in terms of what is going to be developed and supporting that individual. When this came out it says clearly, "integrated service plan". All that time and energy what occur there? Why did PCP state in that language? It went on to add this members' assessment inventory, I'm wondering if all that information is collected by a care coordinator what are they doing with it, what is the purpose of collecting it and who will be ultimately responsible for it? What is the purpose of the MCO collecting that information instead of the TCM doing what they are already in place to do?
2. The new ISP/PCSP is in draft form, this again is another example of conflict of interest on the part of the MCO's. How is this not a conflict of interest when they write the plan that defines the needs and then funds those needs?
3. Opportunities in value based independent targeted care management for all populations. In this model the MCOs don't act as care coordinators they would act as resource coordinators. MCOs as payers have a conflict in creating person centered plans.
4. I have a question on the new ISP, CSP in draft form. Not only are they going to do the person centered plan, they also do needs assessment, they also determine the money you get, how is this not a conflict of interest? It does not take that much brain power to figure it out, if your assessing that persons needs and then determining the amount of money they get, it should be two separate entities that are doing this. That doesn't answer my question? Who developed this new draft? They already have a person centered plan developed by the TCM you have a redundant service that does not save money that does not make any since.

Waiting List	State Response
There were five (5) questions and comments related to the waiting lists for access to some HCBS Waivers. These primarily focused on whether savings from has been or will be used to fund these services.	Some of the savings from KanCare have been used to place more people on the IDD and PD waivers.

Comments

1. Since managed care was supposed to save money for service why have we not seen the waiting list go away?
2. In the document that I received announcing this meeting it was indicated that some of the changes being considered moving forward would include applying savings to the HCBS waiting list. I am curious to know is that a plan or a platitude? We have heard this before. At the onset of KanCare the governor said that funds could be used to reduce the waiting list. Yet that hasn't occurred. The waiting list is still more than 4,000 people. There have been savings of more than \$1 billion is that correct? Can some of those "avoided" costs be directed to the waiting list?
3. KanCare has not improved or diminished the waiting list. How are you going to address this? 1/2010 last person off in Johnson County.
4. I've been told there's not a waiting list, I've been told there is. Is there or is not.
5. What is happening to waiting list? Is the waiting list being reduced? Are you reaching more people?

<i>Uncategorized HCBS Questions and Comments</i>	State Response
<p>There were nine (9) uncategorized HCBS service related comments. Three (3) expressed difficulty in accessing services or staff, two (2) requested a change to the Traumatic Brain Injury Waiver definition, and four (4) unique comments - one (1) each related to improving innovation, money follows the person, a person with an individual question, and the difference in models for HCBS services from medical services.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
Comments	
<ol style="list-style-type: none"> 1. There's a shortage of provider PE using IDD waiver for personal assistants. I think that a rate increase would help for providers to continue to do that kind of work. There's a lot of complications and problems with the time keeping system Authenticare. These have been ongoing and have not been resolved despite being brought up multiple times. 2. Under the waivers HCBS is hard to get agencies with qualified home health care providers. 3. We would ask that long-term services and supports is elevated to the same level of physical health and mental health in the same vernacular. Provider perspective we would like to see individuals on the waivers particularly where the nursing facility is the equivalent that in Kansas we become one of the most progressive states in the nation to try to reduce nursing facility mistakes. It feels like we can get there again with 2.0 but I think it is going to take some deliberate conversation. Make sure that LTSS stays on the table. 4. Do you know what a waiver is? What is the PD Waiver? Yes, because I used to be the- have you heard of the QMB... So who do you think I would talk to about the PD waiver? 5. MFP – I understand – got the info that as of tomorrow, it ends. Follows them for 365 days – need to look for FE or PD waiver? Is that correct? Will stop after 365? What happens if they're on the waiting list? Will they go on the wait list? 6. For the IDD and Autism population the medical model used by the MCO's treats these issues as a disease. Our loved ones will not get better. This is a lifetime situation it does not change from childhood to adult hood it is for their lifetime. Dual diagnosis: These people will transition into other waivers and need continuity for their health and safety. Extra Services needed: extend to adults, phone use, and difference in KC vs rural areas. And air purifiers. MCO Communication: with guardian, dental care needs direct mailing and release of information. Medical model, reduction of services. 7. As far as MCOs and HCBS program, I have good luck, they have been excellent for me. Only problem I have is on the PD Waiver, when I don't have a personal care attendant through agency so care coordinator calls and they tell her the same. This puts my health at risk and I don't feel that's fair to us. I'm sure there are others in the same situation. Those agencies are there and paid to provide services to us, it's not being completed. Yes. Last week I tried to cook my dinner and dropped a hot cookie sheet, could have burned myself. 8. I'm curious to know where you are in changing the definition of the TBI waiver to include individuals with strokes. The TBI waiver was cut by \$1.5 million last year, it has 200 fewer people on it than pre-KanCare. It's a time limited waiver people come off and become employed. You have a lot of people sitting on the PD waiting list who people that have had a stroke. We have families calling in hoping that they will fall and hit their heads to get on the TBI waiver. This is my 23 year asking for the TBI waiver could be changed. If someone could sit down and read some of my emails on the day you could be making a decision. It's a possibility? 9. Change the definition to acquired brain injury. 	

Network Adequacy/Capacity

There were ten (10) network adequacy/capacity comments and questions. Five (5) regarding capacity of specific services, three (3) related to plans to address capacity concerns, and two (2) uncategorized questions/comments.

Capacity of Specific Services	State Response
There were five (5) comments about specific service capacity. Three (3) regarding dental provider capacity and two (2) related to behavioral health capacity.	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.

Comments	
<ol style="list-style-type: none"> 1. No dental for dodge unless you go to a non-Medicaid provider. If going to do x-ray, that’s where expense is. Filling is nothing. Don’t need extractions. 2. It is hard to get dental services. Few dentists accept Medicaid and MCO is not helpful when trying to get services. 3. In the dental field – lost providers last year. Any way to recruit new ones? 10 providers and people are driving, 2-3 hours to get to facilities. 4. Any expansion about substance abuse and Mental Health co-occurring disorders? 5. A kid that needs to go to PRTF, work being done in regard to the “waiting time” – question being, can someone take a look at the MH centers seen as not doing their job because child not able to get in and we’re doing what we can, and it’s not available, and? 	

Plan to Address	State Response
There were three (3) comments/questions related to whether and how the state plans to address network adequacy.	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.

Comments	
<ol style="list-style-type: none"> 1. Lisa McIntire. Bonner Springs. I’m looking 20 years down the road, and there is a tsunami of elderly people coming down the road who are unprepared or underprepared financially and mentally. Is the state considering this? There is already a shortage of care providers and facilities. Will there be position papers put out on that? 2. Capacity and the strength of the provider network is eroding at a rapid pace. Very few new licenses are being given. Inadequate rates, processes that are not uniform or standardized across MCO’s. How are you going to address this? 3. Will there be any active recruiting so local providers will take the insurance? Family practice providers are <i>this close</i> to dumping us. 	

Uncategorized	State Response
There were two (2) uncategorized capacity comments, one (1) suggestion for addressing and one (1) about the distance to reach a provider.	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.

Comments	
<ol style="list-style-type: none"> 1. It’s going to need boots on the ground. You can go into Dillon’s and they have a big sign saying they provide flu shots and they accept any insurance, but if you won’t do labs or immunizations @ doctor’s office who has been our family practice for 17 years – send us across the street to the hospital or to the health department. The 4% isn’t going to fix it. Someone’s going to have to go in there in person with some cookies and talk to these providers. Need to make sure, pluck 1 person from dodge city and 1 from KC, need equal access. We don’t, no matter what you tell me, we don’t. 2. I wanted to know, when you have to have important procedures done, why they send you way off and they pay extra for mileage, when could be done closer to home area. Certain surgeons won’t accept – have to go way out to get what you need. 	

General Comments & Individual Situations

There were sixty-two (62) general comments and questions and individual situations. Six (6) related to KanCare renewal, six (6) individual situations, three (3) comments regarding federal changes, and forty-seven (47) uncategorized questions and comments.

KanCare Renewal

There were six (6) comments and questions around KanCare renewal. Two (2) about the process for contracting MCOs and one (1) each related to not using MCOs, the type of MCOs to look for, keeping the philosophy of not cutting services, and integrated care.

State Response

The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.

Comments

1. Do away with MCOs. State of Kansas can manage as it did before big insurance for profit companies. Put profit consumers care.
2. Clearly you are going to continue with the managed care model. When I was with the Menninger clinic in Topeka they needed to enroll and they need a clinician to go with them over a 4-year period I visited over 100 companies. The main take away was that all Managed Care companies are not alike. I was able to come up with four types I'll share with you two types type A and Type D. Type A managed care understands that doctors know what they are doing and they stay on the sidelines of managed care they pay a reasonable rate. They make their money in three main mechanisms preauthorization concurrent review and retroactive review. Type A companies do very little of that. Type D require considerable preauthorization and do a lot of retroactive review. My recommendation is that you screen carefully and understand the business philosophy and psychology that you choose mainly Type A companies.
3. Will the state solicit new MCOs for KanCare 2.0? What is the timeline for this process?
4. I wanted to remind you of the question earlier on enrollment. One thing you did not talk about was the scheduling for soliciting new MCO's for KanCare 2.0 So that will happen parallel to the process of negotiating? I was wondering how an MCO goes through the process of bidding and they don't know what they are bidding on?
5. Key concepts of KanCare – bend cost curve w/o reductive of services and increase coordination. Continue this to be in KanCare 2.0. MCOs slipping away and capping services.
6. Representing providers around the state that do substance abuse disorder treatment with younger kids, and foster kids. These folks are interested in going to the KanCare system in a new way, providing greater access to care and expanding the capacity in the system for mental health. They are interested in making sure that the funding and structure that you provide in KanCare 2.0 is accomplishing the secretary's goals in terms of integrating care and making sure that those issues go into the RFP.

<i>Individual Situations</i>	State Response
<p>There were six (6) individual situations relayed. One (1) regarding dental coverage and one (1) response to the comment, two (2) related to spend down, and one (1) each related to communication challenges and nursing home care.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
Comments	
<ol style="list-style-type: none"> 1. I am with Amerigroup, my son is with Sunflower. I want to talk about Amerigroup – in Amerigroup, they paid for my teeth to be removed, I can't find a provider that takes KanCare for dentures, and they say the only people under 20 who get false teeth. That sounds funny to me, usually people under 20 don't need dentures. How come they paid for removal then? I have a hard time eating because I don't have teeth and it's affecting my other problems. Everything else is ok, I just couldn't understand why they paid for extraction but not dentures. 2. This is kind of answering the person who just talked, Amerigroup will cover cleaning, extraction, x-ray, but you have to work that [dentures] out yourself. I have them and understand how it works and how Amerigroup works with you. I appreciate that they cover what they do. 3. I am so frustrated with the way your insurance, I mean, I've been with United and was happy. I've never had a problem with them on disability. I was cut off; I guess it was for a 6-month period which nobody told me about. Took me forever to get on insurance, I got on for a short time, now I'm off again. My 20% isn't getting paid. They're talking about spend downs. I have severe mental illness and so does my son. I'm so confused and I don't understand. This insurance situation is very confusing and lacking in organization and it's so unclear. I didn't have the same experience in other states I've lived in. They say I make \$40 too much, and I have to pay back \$2500. I don't understand this whole spend down situation and every time I ask someone, I get a different answer, can anyone tell me? 4. This family has been on Sunflower for two years and had a lot of issues. They have been denied services like a back surgery. He called and tried to talk about his children. They said they could only talk to his wife but she doesn't speak English so what is he supposed to do? 5. Leavenworth County. Our mother will be 100. After her dementia diagnosis, we care for her at home for four years. Each year after the evaluation, the number of hours of in-home care we received was reduced. It's my understanding the state provides \$16/hour for in-home care but by the time it got to the caregiver it was \$9/hour. After she fell, she went to live in a nursing home near where we live. In general, we are satisfied with her care. Several times recently she has rolled out of bed. Most recently she had a painful injury to one of her knees. We've been through this before and I suggested several ideas to protect against this, including a camera in the room so nurses could monitor her. Patients who have dementia don't know there is a call button. We were informed the camera was not allowed because of privacy issues. No railings on the bed and no straps because that was considered a restraint. I was told these residents have, "a right to fall." I don't know where this comes from but it makes no sense at all. The people have been helpful and tried to provide another bed, but she was in that bed when she had her last fall. I realized that she is 100 years old but she deserves the proper care and safety measures. I'm not looking for special considerations but I want to share the story. Each year when an evaluation was conducted at home the hours were reduced. As her condition began to deteriorate beginning in 1999 with 34 hours a week at home care each year it reduced by the time she fell it had been reduced to 12 hours. The care was provided through a particular agency. It's my understanding that the state provided \$16 and hour for the care but by the time it got to the individual providing the care it was \$9 and hour. It seems that it would be a lot more advantages for the care givers to get this money. 	

6. There is a problem with the spenddown, Medicare has a deductible, I'm not sure but older people have a deductible that has insurance to pick that up. They need to have that picked up. She has trouble getting the test run. Because of the spenddown, I'm still being paying for the first procedures and need to have next set of tests. I have a \$4,000 spenddown, and they need to include household expenses because there's no because no person is going to spend that much in 6 months if you're not on your death bed. I'm about to lose my insurance because I didn't meet my spenddown. Try to get on something Medicare will pay. I have talked to my state senator about this and the spenddown but she agreed. Is not possible for most people. She'd never heard of it. I'm working if State of Kansas can do something to help here

<i>Impact of Federal Changes</i>	State Response
There were three (3) questions/comments about the impact of potential federal changes.	The State continues to proceed with plans for the procurement of new managed care contracts and the renewal of the 1115 demonstration. Until such time as federal legislation passes that precludes those actions, we will continue to do so.

Comments
<ol style="list-style-type: none"> 1. At the Federal level of what is going on what are the impacts, thoughts on what is going on 2. Last time I talked to someone, I know it's not all of you all's fault. This "trump thing" I think we're in trouble. They have to spend money from the federal and I am prepared for that. 3. With the current healthcare bill, what effects will that have on KanCare?

<i>Uncategorized General Comments</i>	State Response
This category is formatted to allow the state to respond to each individual question due to their unique nature and acknowledge the comments the same as other comments.	

Comments	
<ol style="list-style-type: none"> 1. Behavioral Health and substance (co-occurring) has come up. Will you review and determine whether we cover additional services, but are there off setting costs? 	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.
<ol style="list-style-type: none"> 2. We work closely with MCO's to identify patient lists. 60% of the telephone numbers are bad. Is there something you can do about that at the state level? Is the something you can do state wide that would help with that? 	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.
<ol style="list-style-type: none"> 3. One of the thing from community mental health stand point is looking at technology and treatment coordination there seem to be a lot of opportunities in that regard. We believe that a full cost study should be done on any changes and opening billing codes that includes our hope for allowing CMHC's to go for primary care. Then any cost study should include the impact on any provider network system. 	The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.

<p>We need to make sure we are building the best infrastructure rather than just redirecting dollars.</p>	
<p>4. How are you going to address the understaffed, under resourced, and the lack of staff with historical program and budgetary knowledge?</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>5. A quick question regarding billing. We got some audits from 2014 and you were going to recoup some money we had to go back and correct the claim because you missed the timely filing deadline. Can you explain that? Is there an audit better than 3 years after the service was delivered? Please see the MCOs. Get with them.</p>	<p>This person was directed to talk with the MCO representatives at the public meeting.</p>
<p>6. Dental cleaning without basic follow up and appropriate need care. The current system is one that forces dental professionals to violate their professional ethic and or donate services when did the state of Kanas became an entity that places professionalism in such a situation?</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>7. For nursing homes: how about a clear list of what is considered as per diem rate? Budgeting issues: JC temp care for LMB (PIC #475?) RF admit month for spousal allocation PIL #62? What happened to standard unearned income disregard #20? When APS/PPS gets involved in financial abuse is standardized. It used to be a LTC/orang team worker would adjust PL. So NF resident did not suffer the financial consequence of not being able to pay the PL. What happened to that process? How does it work now?</p>	<p>You are encouraged to talk with KDADS NF rate-setting staff about these issues.</p>
<p>8. On the BH side, the state of KS, it's been 20 years – early CH bh and mh, discussion @ any level with MCO's the value of providing svc under age of 5. Certain national movement 0-3 at Washington dc, diagnostic classification for under 5, several states have implemented. Would like to ack of early ch mh, invest under 5 until junior high when the damage has been done.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>9. If managed care is for choice for the consumer, then I think it needs to be re-evaluated. My clients report they choose the MCO that offer the services they need or medications covered. Our company has lost</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>

<p>many employees to wages. Reimbursements too low to recruit great staff.</p>	
<p>10. Representing substance abuse disorder providers. We want changes in the behavioral health codes under KanCare 2.0. We believe in opening currently restricted codes only community mental health centers can use. Opening codes will expand the existing capacity, it will allow easier more open access to care. Finally opening behavioral health codes to qualified providers will allow for consumer’s choice. There is no consumer choice for behavioral health under KanCare. Expanding who can provide services benefits consumers provides more services for strained populations (i.e. kids in foster care) and individuals who may need to wait for access to behavioral health services when qualified providers exist already.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>11. Policy manuals being out of date. We need the MCO’s help to get these updated...this is a billing issue.</p>	<p>The State has reviewed and updated 35 of 39 provider manuals posted on the KMAP website. The remaining manuals are currently under review.</p>
<p>12. Ability to receive additional data that MCOs are collecting on provider patients.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>13. ICE and provider now has one less person to bill for. The need for support doesn’t totally go away, needs an ongoing support system. Employment opportunity, health, case coordination, social deterrents, health payment for value health equity for people IPP process.</p>	<p>Thank you for your comment.</p>
<p>14. Will the MCOs set their own rates or will it be for entire system? Want MCO’s to work with small clinics and not just big FQ’s like Gracemed and Cheser. Open HBA1 codes 96/50-96/55.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>15. Extended period to correctly revise client obligations after loss of VA benefit when moved from assisted living to nursing home.</p>	<p>Thank you for your comment.</p>

<p>16. 1 Kansas Association for the Medically Underserved</p> <ul style="list-style-type: none"> A. Increase Patient care B. Facilitate Coordination of behavioral healthcare across the care continuum. C. Improve health outcomes and reduce cost of care. D. Adult dental benefits would improve overall health outcomes E. Adopt a single enrolment and credentialing process. F. Solve issues related to payments especially for people who are dually eligible. 	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>17. I'm involved in the working group – meetings heavily – this week – It indicated there'd be 1 more meeting of the working groups – I suggested we meet a provider advisory council to continue the momentum. There's a ton of provider input to ensure its success.</p>	<p>Thank you for your comment.</p>
<p>18. I wish you had more money, if I had it, I would give it to you.</p>	<p>Thank you for your comment.</p>
<p>19. What's an MCO?</p>	<p>Managed Care Organization – one of the three health plans serving KanCare members (Amerigroup, Sunflower, UnitedHealthCare)</p>
<p>20. Ref to bulletin – one in May 17 specific to codes – h21 code, CIS code, implies not be improve svc, oversight.</p>	<p>We suggest you contact KDHE or KDADS with specifics about this issue.</p>
<p>21. The MCO in terms of pediatrics, are dental and vision considered added benefits or mandatory? I was at another meeting recently, another family on Sunflower and I'm on Amerigroup, they said the same. A lot of times, they say, we have a robust list of providers for dental and vision. The problem is when they do anesthesia in office, medically fragile children can't receive this in office. Can you require they (MCO) partner with pediatric hospital? I can't find the type of ophthalmologist that serves children. Children's Mercy is the only provider my child can see.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>22. Our DBT (dialectical behavior therapy) is one of the best, money saving things we've ever done (in terms of helping people with how to deal with crisis so they</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>

<p>don't land in the emergency room). It's a very expensive training but comes with cost savings to the agency and to the providers in the long run.</p>	
<p>23. My concern in Johnson County, we have on ombudsman for Johnson Leavenworth and Wyandotte County... that one cannot cover all the issues there are in nursing facilities so get use more ombudsman.</p>	<p>There is both an Ombudsman for KanCare and one for long-term care (nursing facilities) – each office has several staff and/or volunteers across the state.</p>
<p>24. Is there any correlation between 1115 (7/5 and 7/6) and this</p>	<p>The 1115 demonstration waiver is used to allow the State to manage KanCare. The July 2017 meetings were related to public comment concerning the State's extension request for a one-year extension of the 1115 demonstration.</p>
<p>25. I have a question about food stamps? In Johnson County there are people losing their food stamps because they live in for profit areas. In Wyandotte County they are not losing their food stamps and they live in for profit areas. Why are people able to keep in Wyandotte and not in Johnson county?</p>	<p>We have passed along your question to the Department of Children and Families.</p>
<p>26. Food Stamps: Johnson County has individuals losing their food stamps but not in Wyandotte County. There are agencies in Wyandotte County that are for profit and those individuals are not losing their food stamps. What is the state guideline? Or is it a county guideline?</p>	<p>We have passed along your question to the Department of Children and Families.</p>
<p>27. We have a hospice service – and I don't know the status of this – it'd be – we have to bill for the Medicaid room & board LTC unit for the coverage and get paid or not is questionable. Policy relative. Billing process. We have to bill for it and reimburse them for it.</p>	<p>This is a federal requirement.</p>
<p>28. In regard to integrated health care, clinics and health centers across the state are doing it right now. The process is working and going well but right now we cannot bill for so having HBI cods 96150-55 would be perfect in paying for services that have already been provided.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>29. How, I have a lot of ideas to balance the budget financially and I would like to know how I can be heard? I would like to see us spend our money more wisely. I think there are some things that could really help.</p>	<p>Please send your ides to your local Legislative representatives.</p>

<p>30. Other dental insurance have a way of helping us with children of sexual abuse in trying to report this through a MCO there is no way to help the individual. How can we change that?</p>	<p>It is unclear what the question is, but all medical professionals are mandated reporters of abuse and should report it directly to the Kansas Protection Report Center (KPRC) at 1-800-922-5330.</p>
<p>31. How does a person who live/come from another state get services?</p>	<p>Each state’s Medicaid program is different, so a person must apply in the state they reside for eligibility. In Kansas, you can find applications online at http://www.kancare.ks.gov/consumers/apply-for-kancare or call toll-free at: 800-792-4884.</p>
<p>32. We need an independent legally based consumer ombudsman. Consumers/beneficiaries deserve an advocate who can represent them in appeals hearings!</p>	<p>Thank you for your comment.</p>
<p>33. I know someone who wanted to can change MCOS last October. She couldn’t because she wasn’t allowed to change MCO’s how I can get to be easier for a person to change MCOs?</p>	<p>Each KanCare member can choose to change their MCO at their annual open enrollment time. They can also change MCOs under certain limited circumstances. To change in the middle of the year you need to have what is called a “good cause” reason to change. For more information, you can look at this list of FAQ Good Cause Reasons to Change Your Plan.</p>
<p>34. For the gentleman with the service provider, with the collaboration of the Kansas Lifespan Coalition, they have a personal care directory where you can go in (or your case manager) and see about finding staff. The website is www.rewardingwork.org and you can find providers. I just wanted to share that.</p>	<p>Thank you for your comment.</p>
<p>35. If you’re an MCO exactly what is the MCO? On the website, how can I find the information to follow along?</p>	<p>Managed Care Organization – one of the three health plans serving KanCare members (Amerigroup, Sunflower, UnitedHealthCare) www.kancare.ks.gov</p>
<p>36. Dental – Larned also – he told me a lot of dentists asked him to quit w/Medicaid also. Said he wouldn’t but was the only and they were trying to encourage him to quit and takes a while to get paid through Medicaid.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>37. Recommended to expand behavioral health access to care by opening up mental health codes in the next round or KanCare. This would fit if CMS is about consumer choice.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>38. Work with dentists to discount other services (cavity or crowns) like delta dental does. My son had a cavity that cost \$196. We didn’t know a head of time that Medicaid no longer provided. Had he been taken with a helper he would have come home</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>

<p>without it filled. I worry for individuals who don't have the \$200 who will let it get so bad, they have to have it surgically removed. Which Medicaid will pay for more money?</p>	
<p>39. So there's nothing for emergency needs for elderly going home from the hospital today?</p>	<p>MCOs are required to help ensure smooth transitions from inpatient to home care.</p>
<p>40. I would like to say that I'm very thankful for Sunflower. I am thankful for my medications. It (Sunflower) along with that (medications) keeps me in my own apartment with my cat. I cook for myself, and clean for myself I do other people's laundry. I couldn't be in my own apartment if it was not for Sunflower.</p>	<p>Thank you for your comment.</p>
<p>41. I'd like to know does the Medicaid program here have the money to consider offering developmental and psychological testing form licensed psychologists or is that something that needs to be covered by the state legislature? How does a person get to put their two cents in to that process?</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>
<p>42. I have questions about the need for someone who is on services the need for them to carry supplemental services like Blue Cross Blue Shield. Medicaid coverage for medications, room and board, equipment that kind of stuff. The person has Medicare A and B they qualify for medical I don't see the need for them to continue a supplemental insurance if Medicaid is going to pay for the same stuff.</p>	<p>A supplemental Medicare policy may not be necessary, but you should contact a Senior Health Insurance Counseling For Kansas (SCHICK) counselor to discuss this. You can reach one at 800-860-5260.</p>
<p>43. As a member, when you get to a point that something requires prior authorization and you go through your appeals and are denied, and you go get the higher authorization, why do you still get denied?</p>	<p>KanCare members have several steps they can go through when services are denied. Each MCO has a grievance and appeal process. The State also has a State Fair Hearings process, all of which can be used when you believed the MCO has denied a service inappropriately.</p>
<p>44. Every time you turn around, you sign something and get denied again and get regular denials when you do everything you're supposed to do. Even for prescriptions you're supposed to be on. I don't understand.</p>	<p>KanCare members have several steps they can go through when services are denied. Each MCO has a grievance and appeal process. The State also has a State Fair Hearings process, all of which can be used when you believed the MCO has denied a service inappropriately.</p>
<p>45. You said you're changing some of that, does that apply to assisted living? – assisted living – not</p>	<p>Assisted living will still be a part of KanCare. Applications for eligibility for those in assisted living are treated like any other KanCare eligibility application.</p>

<p>having, last KDADS meeting, Parsons. Oh well, those people are on the streets? – 45 days?</p>	
<p>46. When other services are needed for example a NF takes in a 55-year-old single male as Medicaid pending he will need a PMDT, he had a stroke then a fall and is now said permanently disabled due to brain injury from stroke or fall causing violent behaviors. Nobody is willing to take him for an evaluation or medications evaluation/adjustment. Small mom and pop NF's don't necessarily have the financial backing to provide upfront costs in hopes that Medicaid will approve or provide reimbursement. Where does this individual get help? This is why knowledgeable care coordinators and faster processing for special situations is needed</p>	<p>The State is expanding staff at the eligibility Clearinghouse and assigning specific staff to specific nursing facilities to help improve eligibility processing.</p>
<p>47. This is a specific situation, but in mental health, for a lot of folks we cannot get sleep studies authorized, but the sleep apnea machines are paid for. We need to work to break down the barrier and we have to be broad in our thinking with things like this and not be missing key elements.</p>	<p>The State will use these comments to help develop the Request for Proposals (RFP) for KanCare 2.0.</p>