OneCare Kansas
a program of KanCare, Kansas Medicaid

OCK Learning Collaborative

WSU Metroplex | Wichita
November 16, 2023

Wichita State University
Community Engagement Institute

Helping people live healthier lives by integrating and coordinating services and supports to treat the "whole-person" across the lifespan.


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Welcome!

Why are we here?

- Network with other OCK providers
- Learn new resources to share with members
- Create and offer ideas that can strengthen your program and the system

KanCare Re-Procurement Bidding Process

November 2023

Timeline for KanCare Bidding Process

*** Effective Date/Term of Contract**: The KanCare MCO contracts will go into effect on January 1, 2025, and continue through December 31, 2027. KDHE may elect to renew the KanCare contracts for two 1-year periods.

Round 1:

- Your name and organization
- What is the purpose of the OneCare Kansas program?

Round 2:

- Your name and organization
- Why does the OneCare Kansas program matter to the people you serve?

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Understanding Medicaid Annual Reviews

August-December 2023

Understanding Medicaid Annual Reviews

Objectives

- Better understand Medicaid annual eligibility reviews.
- Understand how to submit reviews.
- Understand how to access the Medical Consumer Self-Service Portal.
- Understand the importance of the facilitator authorization form and medical representative authorization form.

Understanding Medicaid Annual Reviews

Eligibility Reviews Reinstated As Of April 2023

- Annual eligibility reviews (or renewals) had been paused since March 2020 due to the COVID-19 Public Health Emergency and have now resumed.
- KanCare will let members know when their review month is via mail.
- If an individual would like to know what month their financial review is, they can call the Clearinghouse and ask. The person's MCO can also provide them with this information.

Understanding Medicaid Annual Reviews

Annual Eligibility Review

- Reviewing Medicaid eligibility annually is a CMS requirement.
- There are no blank renewal forms.
- If a member misplaces a renewal form, they can call 1-800-792-4884 to have another renewal form mailed to them.
- If the member has an account with the Medical Consumer Self-Services portal, a copy of the renewal form can be found there and will be available during the reconsideration time period.
- Though not recommended, if a member misplaces the renewal form and doesn't want to call to have a new renewal form mailed, they can fill out an application in place of a renewal form.

Understanding Medicaid Annual Reviews

Details

- Don’t confuse the annual financial review with the annual functional review for members who are receiving home and community-based services.
- Anyone that is 19-years-old or older and is on the IDD waiver must have a SSA disability determination.
- This is also a different process than the open enrollment process where members can choose a new managed care organization.
- Most likely these will happen at different times.

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More Details

- It is very important that we have the current address for the member and the medical representative, the facilitator, and the guardian and/or the conservator, if they have one.
- Renewal forms are sent to the member and the medical representative, the facilitator, and the guardian and/or the conservator, if they have one.
- There is a 3-month window following a closure for no review for the member to turn in the renewal form.
- If submitted in the following three months, the renewal will be treated as submitted timely. If the member is otherwise eligible the KanCare coverage will be back dated to the month of closure.

Understanding Medicaid Annual Reviews

Three Types of Reviews

- KanCare conducts **three** different types of annual reviews:
    1. Super passive.
    2. Passive.
    3. Pre-populated.

- KanCare's eligibility computer system can verify some income and some assets.
- The renewal form a member gets depends on how successful the computer system's interfaces are.
- The review process is a combination of renewal forms and renewal letters.

Understanding Medicaid Annual Reviews

The Three Different Review Types

1. **Super Passive Review**
   - If a member gets a super passive review letter, they will not get a renewal form with it.
   - They only get the super passive review letter and they do not have to sign or return any documents.
   - Member who get a super passive review letter are eligible for another year unless some new factor comes up during the next 12 months.

Understanding Medicaid Annual Reviews

The Three Different Review Types

2. Passive Review

- A passive review form will have the information already known to KanCare printed on the renewal form. Passive reviews forms are also accompanied by a passive review letter.
- The passive review letter informs the member what eligibility we have determined via the computer system interfaces.
- If any information on the passive review form is **wrong or out of date** the member should call KanCare Clearinghouse at 1-800-792-4884 right away or submit the change in writing.
- We will take their changes over the phone and request documentation if needed.

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The Three Different Review Types

3. Pre-populated Review

- Pre-populated review forms will have the information known to KanCare already printed on the review form but have sections to report changes and new people in the household.
- Pre-populated reviews must be signed, dated and returned to the KanCare Clearinghouse. **If not returned**, the member's benefits case will close.
- Pre-populated review forms **do not** get a passive review letter.

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The Three Different Review Types

- All three of the review types are covered by the medical rights and responsibilities (requests for a Fair Hearing).
- Renewals are due on the 15th of each month. This means in the Clearinghouse by the 15th, not in the mail by the 15th. You are highly encouraged to turn them in earlier than that, if possible.
- A member can drop off a renewal form at any local Department for Children and Families (DCF) office, fax the renewal in or place it in the U.S. Post Office mail.
- If a renewal is timely submitted, then current coverage will remain in place until the renewal is fully processed.

Understanding Medicaid Annual Reviews

Possible Verifications That May Be Needed

- Members do not have to send in any proof with the renewal form. To process the renewal quicker, a member can include any proof they want to. Proof will be requested by KanCare later if it's needed.
- We may ask you to send in proof for:
  - Your last 30-days of pay stubs or a statement from your employer with your gross income before deductions and dates received.
  - Verification of self-employment, such as a copy of your entire, most recent personal and business income tax returns.
  - Most recent checking/savings account statements.

Understanding Medicaid Annual Reviews

Possible Verifications That May Be Needed

- Current verification of the cash value of a whole life insurance policy.
- Verification of a non-irrevocable funeral/burial plan.
- Current values of any stock or bonds.
- Verification of any health insurance premiums. This would include any out-of-pocket premium for Medicare Part D plans or premiums for private health insurance.

- These suggestions of verifications would also apply to a new applications for KanCare.

Understanding Medicaid Annual Reviews

Who Can Sign a Review

- Verify before sending in the renewal form that the form is signed and dated. Unsigned renewals will cause a delay.
- If a member has a guardian and/or conservator, then the guardian or conservator must sign the renewal form. The member's signature would not be acceptable in these cases.
- A medical representative can sign a renewal form.
- Facilitators cannot sign a renewal form on behalf of a member.

Medical Representatives and Facilitators

- Where to find them
  - KanCare website: kancare.ks.gov/policies-and-reports/kdhe-eligibility-policy/policy-appendix under the Release of Information tab
- Duration of the form
  - Facilitator form can last up to one year.
  - Medical representative form will last until the member tells us to remove the person from the case.
- Both will get copies of KDHE notices, including the renewal form, any notice requesting information or case closure notices.
- The Medical representative can make decisions on behalf of member.

Medical Representatives and Facilitators

- Person collecting a medical debt, care coordinators, case mangers, advocacy groups and patient advocates *cannot* act as a **medical representative**.
- Person collecting a medical debt, care coordinators, case mangers, advocacy groups and patient advocates *can* act as a **facilitators**.

Understanding Medicaid Annual Reviews

Doing a Review Online

- A member has the option to create an account with the Medical Consumer Self-Service portal. The portal can be found at cssp.kees.ks.gov/apspssp/.
- Click on the ACCESS my KanCare icon. The member can create an account and complete the review online. It is important that a member link the account to their medical case.
- There are helpful demos on how to use the Medical Consumer Self-Service portal at vimeo.com/showcase/8602150.
- It is recommended to have the member's online account set up before the review month.

Understanding Medicaid Annual Reviews

KanCare Customer Service

Phone: 1-800-792-4884

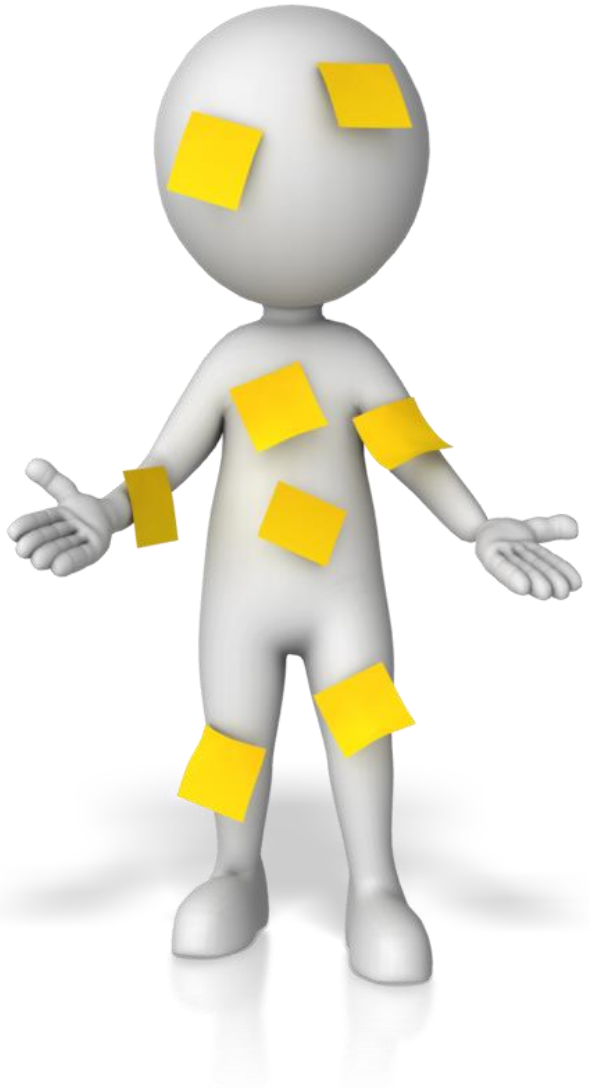
FAX for Children and Families: 1-800-498-1255
FAX for Elderly and Disabled: 1-844-264-6285
TTY: 1-800-792-4292

Mailing address

KanCare Clearinghouse
P.O. Box 3599
Topeka, KS 66601

Questions?

Lunch Break - We will resume at 12:45



DON'T FORGET:

- What is currently going well with the OneCare Kansas program?
- What would you like to see change?

Be sure to check out what others have posted as well!

OCK Program Data & HAP Updates

Alan O'Neal | Data Analyst | KDHE-DHCF

HAP Updates

- The Health Action Plan (HAP) is a tool used to document goals that the member will pursue within the OneCare Kansas (OCK) program
- The HAP also documents the proposed process for achieving these goals, as well as progress made in achieving them
- Recent updates include:
  - Removal of “N/A due to COVID” as an option on the health section of the HAP
  - Member phone number field was made fillable

Program Enrollment

- At the end of the last Fiscal Year (September 2023), there were 2,850 unique members on the OneCare roster
- Membership declined over the last fiscal year, mostly in the summer months, but the number of those opting-out has been steadily decreasing each month of this current fiscal year
- Membership decline may be due in-part to the end of the Public Health Emergency and loss of eligibility
- During the last quarter of the FFY (July – September), membership decreased by 8.1% (252 members)
- Even with this membership decline, there is an average of 113 people opting-in per month

Membership Engagement

- Membership engagement in the program is defined as the proportion of those utilizing OCK services to those who were enrolled, normalizing the results when the total enrollment in the program changes
- Due to claims lag, the team chose to analyze services occurring in the first 3 quarters of the last fiscal year (October 2022 - June 2023)
- During this time frame, it was found that an average of 1,447 unique members were utilizing services each month
- Taking the enrolled population as of June, it was determined that 48.2% of enrolled members were utilizing OCK services

OCK Utilization Data

- Utilization OCK services was analyzed over the last 9 months in which data was not affected by a claims lag (October 2022 – June 2023)
- Service Procedure Codes and Descriptions:
    - G9148: Health Promotion
    - G9149: Comprehensive Transitional Care
    - G9150: Patient and Family Support
    - S0221: Referral to Community and Social Supports
    - S0280: Comprehensive Care Management (completion of the HAP, one-time only)
    - S0281: Comprehensive Care Management
    - S0311: Care Coordination

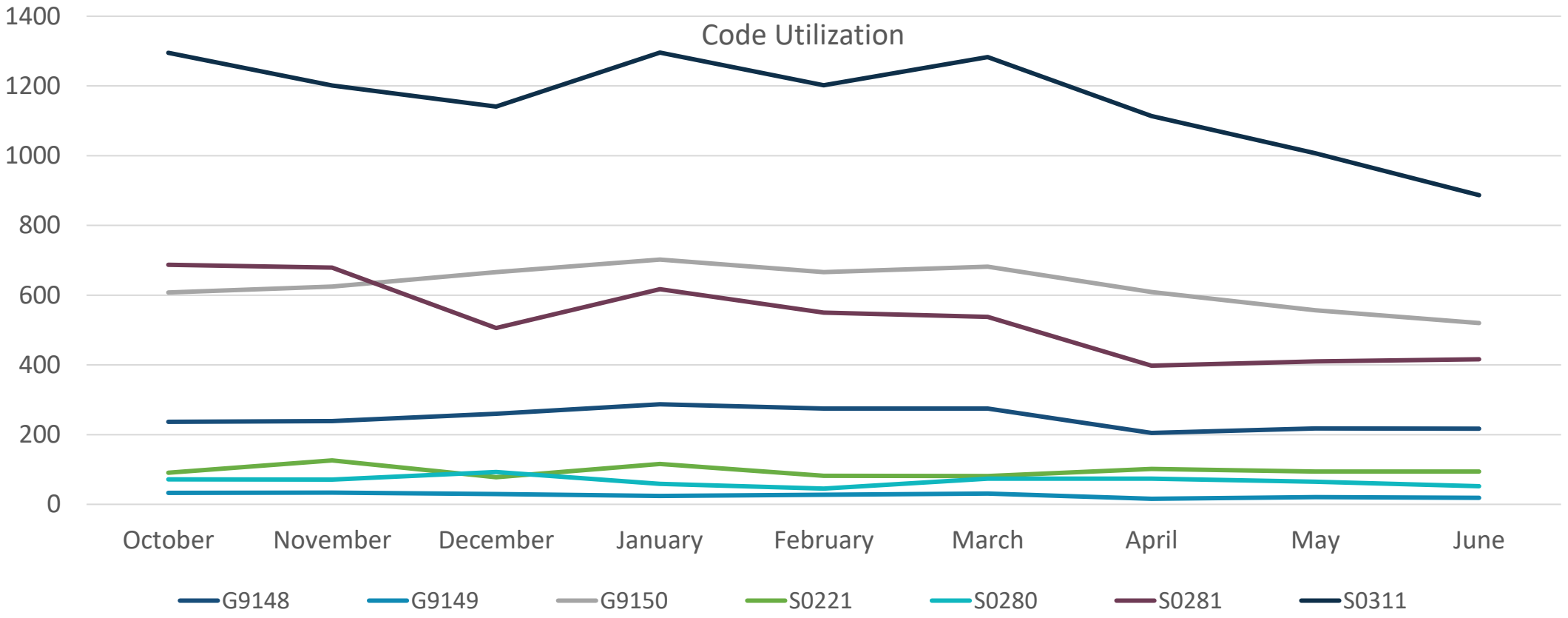
Claim Counts (1/3)

The table below shows the claim counts for each month of data:

	October	November	December	January	February	March	April	May	June
G9148	237	239	260	287	275	275	205	218	217
G9149	33	34	30	24	28	31	16	21	19
G9150	608	625	666	702	666	682	609	557	520
S0221	91	126	78	116	82	81	102	94	94
S0280	72	71	93	59	45	74	74	65	52
S0281	687	679	506	617	550	538	398	410	416
S0311	1295	1201	1141	1296	1202	1283	1114	1007	887

Claim Counts (2/3)

The chart below shows the utilization of each code over the time period:



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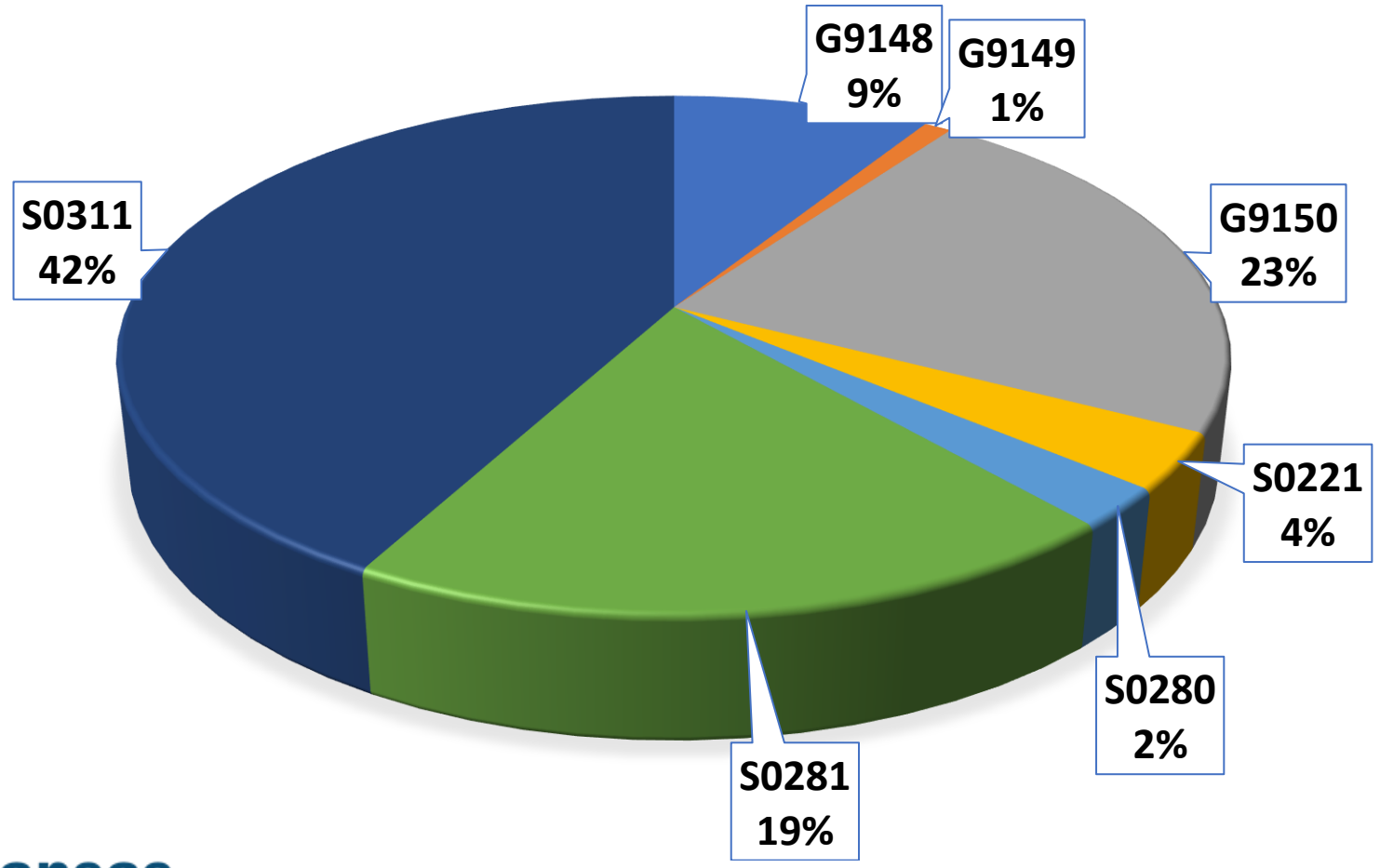
Claim Counts (3/3)

Below shows the proportional breakdown of service codes, over the 9-month period:



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OCK Cost Avoidance Data (1/2)

- To determine measures of cost avoidance, the data team reviewed cost, claim, and capitation data from fiscal year 2022 and compared it to the same data for 2023
- This allowed the team to directly compare costs, as well as look at how other metrics changed from year-to-year
- Due to different sample sizes between years, the following proportional measures were chosen for evaluation:
  - Cost per Claim
  - Claims per Member

OCK Cost Avoidance Data (2/2)

- The timeframe includes the last two fiscal years
- Claim data was separated by the following Claim Types:
  - Inpatient
  - Outpatient
  - Dental
  - Physician
  - Pharmacy
- Within each Claim Type, each member's total number of claims and the cost associated with them were aggregated, and the claims per member and cost per claim measures were calculated for that claim type
- These measures were then compared to the same data for FFY 2022

Cost Avoidance Trends (1/2)

- During the first-year analysis, the data team identified patterns that were expected to be seen in the data:
  - An increase in physician and pharmacy claims among members, primarily in the first year, resulting from efforts made in getting members to the doctor, especially those who may not have been in a while
  - The increased physician and pharmacy claims would later result in a decrease in high-cost inpatient claims
  - As the population becomes healthier, the claim volume by member will decrease, resulting in a cost avoidance

Cost Avoidance Trends (2/2)

- The following patterns were present in the data:
  - From FFY ‘22 to FFY ‘23, **the total cost avoidance was over $3.5 million on Inpatient Claims**
  - The yearly average claims per member dropped from 115 claims to 103 claims, which is around 1 claim per month
  - The **cost per member** (sum of the claim costs / number of members) **decreased by over $1,000**
  - While the cost per claim increased during this time frame, the reduction in claim volume offset it enough, resulting in a **cost avoidance of $6.45 million on all claims**

OCK Cost Avoidance Data Results (1/3)

Claim Type	Members 2022	Claims 2022	Claims per Member
Pharmacy	3152	175330	56
Dental	1198	2687	2
Inpatient	574	1020	2
Outpatient	2341	15477	7
Physician	3600	229238	64

Claim Type	Members 2023	Claims 2023	Claims per Member
Pharmacy	2934	151708	52
Dental	1201	2722	2
Inpatient	428	744	2
Outpatient	2201	13136	6
Physician	3454	200188	58

OCK Cost Avoidance Data Results (2/3)

Claim Type		Cost Difference '23 - '22
Pharmacy	$	(1,144,462.54)
Dental	$	66,009.72
Inpatient	$	(3,590,584.85)
Outpatient	$	(1,710,651.94)
Physician	$	(75,653.63)
Claims Cost/Savings:	**$**	**(6,455,343.24)**

In 2023, Dental Coverage was expanded for Adults on Kansas Medicaid

OCK Cost Avoidance Data Results (3/3)

Program Total Cost 2022:	Claims:		$ 77,011,640.46	Caps:	$ 2,881,916.51	**Total:**	**$ 79,893,556.97**
Members 2022:		3699					
Claims 2022:		423752					
Cost per Member 2022:	$	20,819.58					
Cost per Claim 2022:	$	188.54					
Claims per Member 2022:		115					
Program Total Cost 2023:	Claims:		$ 70,556,297.22	Caps:	$ 6,685,221.86	**Total:**	**$ 77,241,519.08**
Members 2023:		3573					
Claims 2023:		368498					
Cost per Member 2023:	$	19,747.07					
Cost per Claim 2023:	$	209.61					
Claims per Member 2023:		103					

Total Cost Avoidance from 2022 to 2023:	
$	(2,652,037.89)

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Dental Coverage

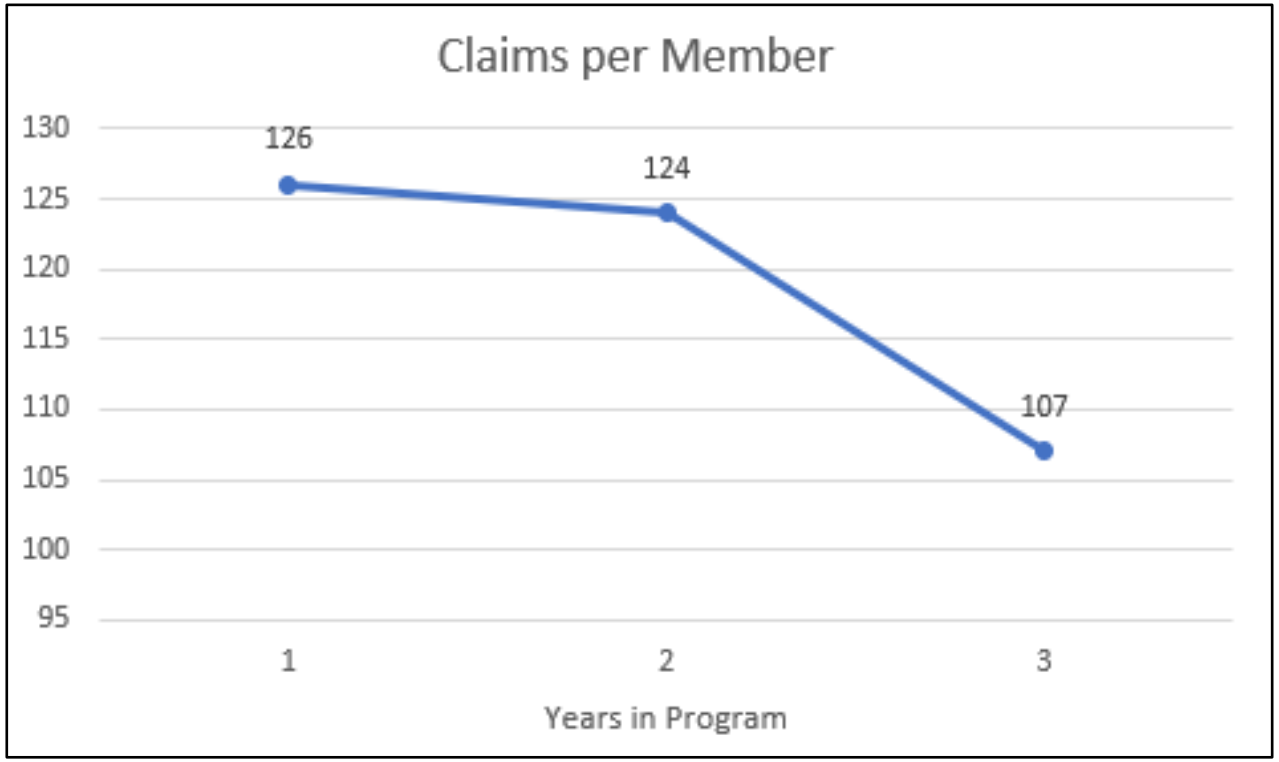
- Costs decreased across all claim types except for Dental
- Claim counts decreased across all claim types except for Dental as well, where an increase occurred
- Expanded dental services for adults on Kansas Medicaid contributed significantly to this trend
- **The increase in Dental costs ($66,009.72) was more than made up for by the cost avoidance in Physician claims ($75,653.63) alone**
- The team considers this a great success, given how important dental health is to overall well-being
- The increase in dental claims may show similar effects to the initial increase in Pharmacy and Physician claims in the first year

Data Success Story (1/3)

- Now in the third year of the program, the team is able to review long-term data on members and the effect that OneCare has had on them.
- The team identified long-term members, specifically those with claims for OneCare-specific codes each year since the program's start.
- Cost and Claim totals were found for each of these members across all claim types and separated by year.

Data Success Story (2/3)

Below shows **claims** for long-term members over three years, with the average claims per member displayed:



	FFY		
	2021	2022	2023
TOTALS:	371441	364255	313854
AVERAGES:	126	124	107

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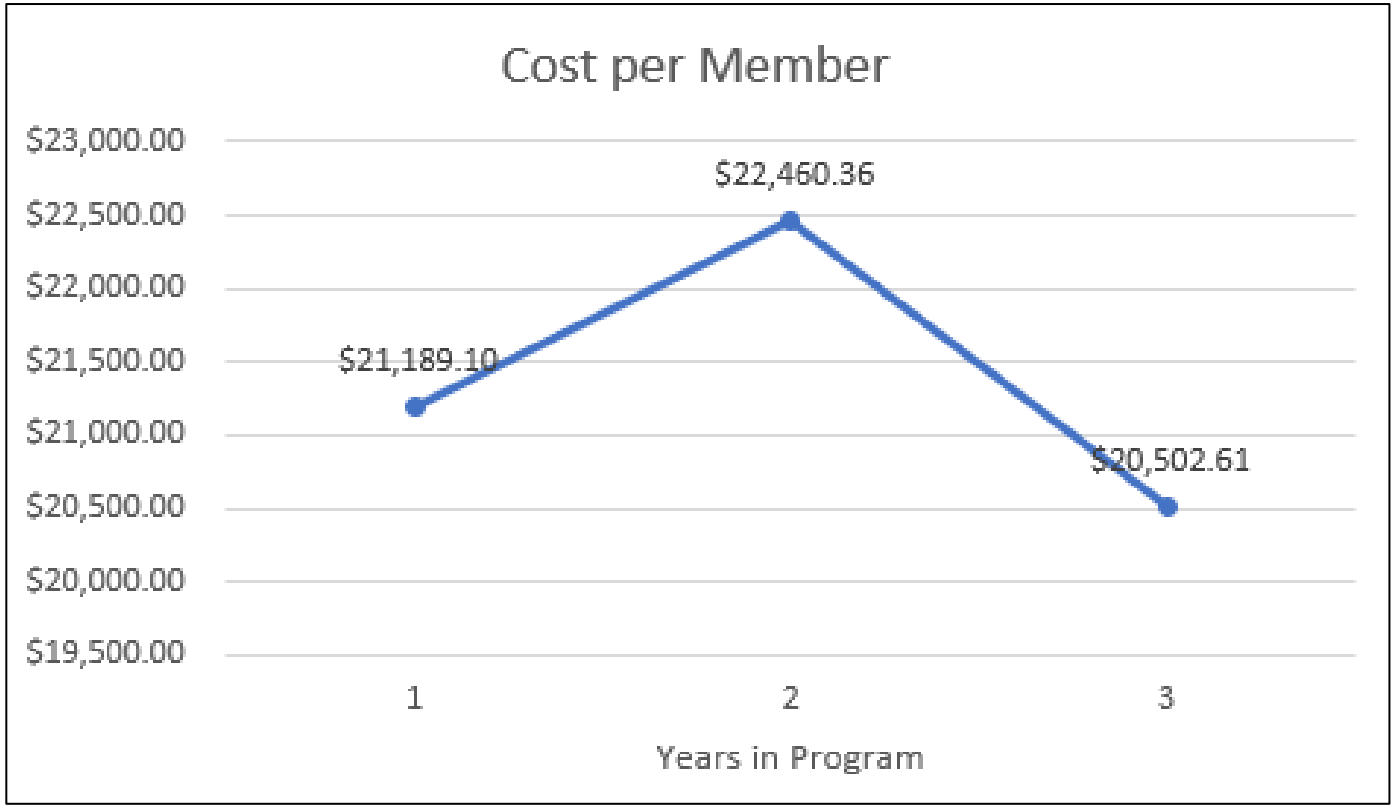
Data Success Story (3/3)

Below shows the **costs** for long-term members over three years, with average cost per member displayed :



FFY		
2021	2022	2023
$ 62,380,722.34	$ 66,123,309.45	$ 60,359,698.28
$ 21,189.10	$ 22,460.36	$ 20,502.61

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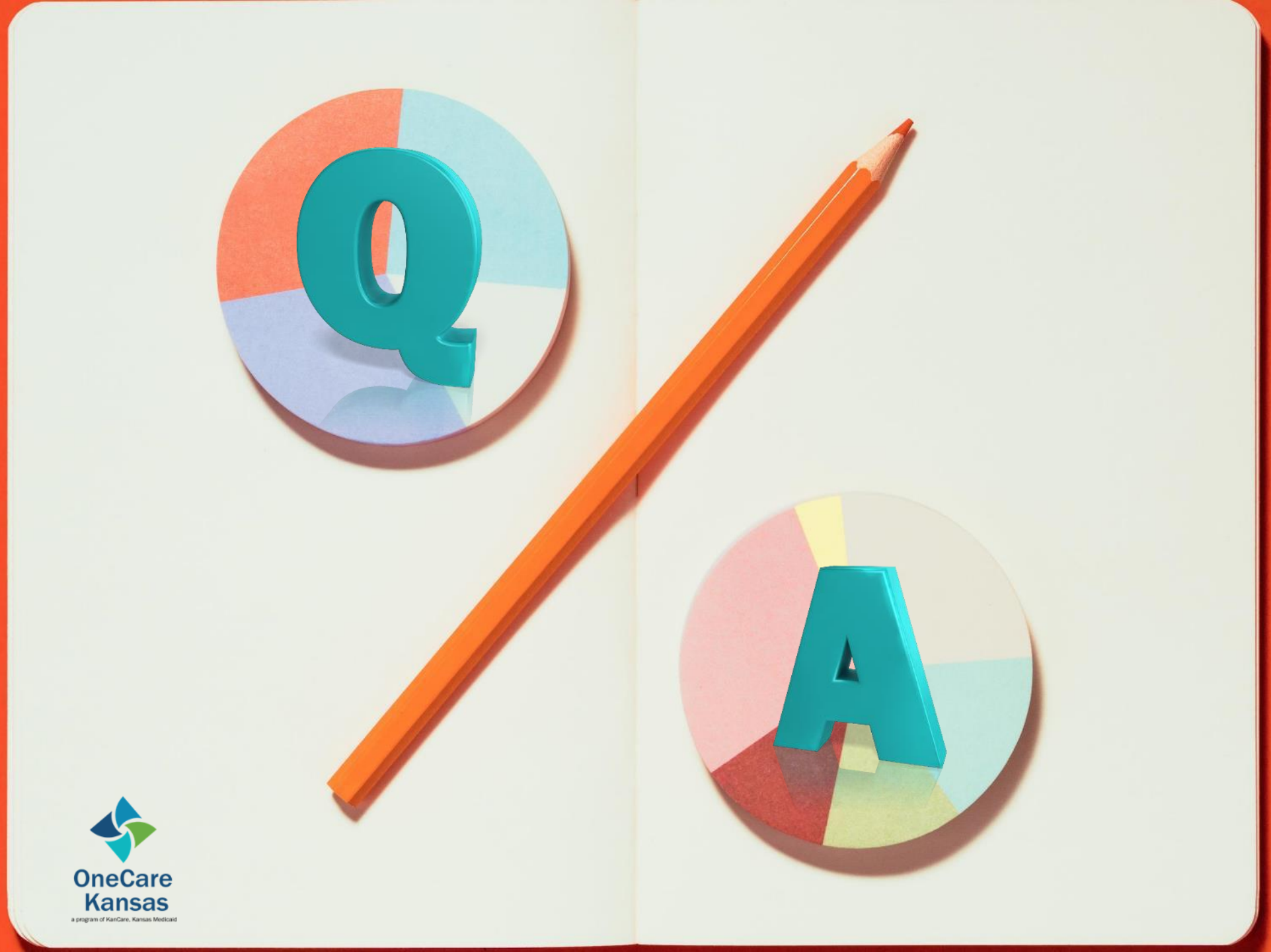
Data Success Story Overview

- Each year that members are in the program, their number of claims will decrease
- From the first year to the second, an increase in claim costs occurred, likely when they are receiving treatment for long-term medical issues
- From the second year to the third, a reduction in costs is seen, which puts the average cost per member well below the cost per member in the initial year
- While each member has their own individual course of treatment, as a whole, the program is making members healthier and reducing both claims and costs for those who remain in the program



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How could it be used to **advocate** for the program with community partners and potential funders?

How do/could you use this information to better **communicate** with your members about the OCK program?

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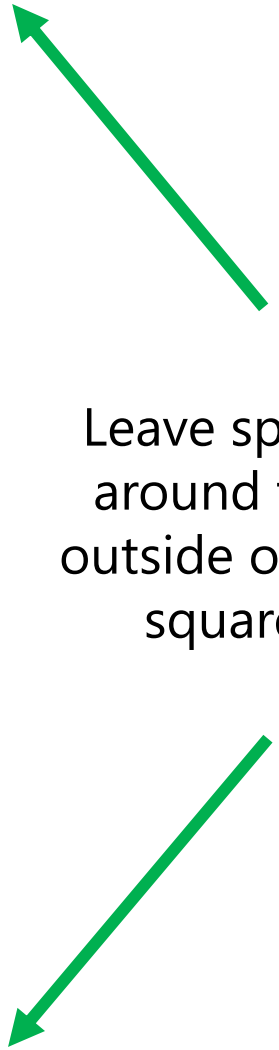
What can my organization do or contribute in the next 3-6 months to make progress toward this vision?

What would be needed to make this vision a reality?

What would the perfect OCK system look like for those you serve?

Leave space around the outside of the square



Thank you for being here today and for all that you do for OCK members!

Don't forget to leave your feedback on your table!

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