Kansas Department of Health and Environment

KanCare 2025 RFP Public Comment

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Report prepared by

The Center for Organizational Development

COMMUNITY ENGAGEMENT INSTITUTE

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Introduction

The state of Kansas is preparing to develop a request for proposal (RFP) for the 2025 managed care organizations' (MCO) contracts. To gather input from members and stakeholders, the State held two information sessions for association and advocacy groups on March 28, four information sessions for members and providers on April 11 and 13, and an information session for payors and bidders on May 2. In total, 437 people attended these virtual meetings and had the opportunity to share comments and questions.

Kansas notified stakeholders of the public input sessions and ways to provide input via social media, press release, KanCare website publication, listserv email, text messaging, provider bulletins, and during standing and ongoing stakeholder meetings. Virtual public meetings were facilitated by the WSU Community Engagement Institute Center for Organizational Development. Meeting materials were available in braille, large print, and Spanish. American Sign Language interpreters and Spanish interpreters were present at each session. The materials presented in the meetings and recordings of the meetings are posted on the KanCare website.

Technical Note

Stakeholders' questions and comments were recorded during the public input sessions. Basic transcription rules were utilized to eliminate filler words and statements, false starts, and repetitions. Non-verbal nuances are noted where appropriate and names are eliminated or enhanced to provide appropriate reference. When the commenter provided feedback on multiple topics in one statement, if possible, the statement is segmented and categorized into different thematic areas. 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. A summary of public comment themes is presented at the beginning of this document starting on page 4. All comments received in the public meetings begin on page 8.

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Themed Comments

Access to Care

Do you have access to the services you need when you need it?

There were no responses to this question.

What barriers have you encountered when trying to get the health services you need?

There were 65 responses to this question. Six themes emerged: **travel times and distance to providers** to access services, **issues with timeliness in DME processes** to get equipment, **providers stopping or not accepting Medicaid** to start services, **workforce issues and limited number of workers** to provide services, finding **inaccurate and outdated provider directories** when looking for providers, and challenges finding providers for approved **dental and vision services**.

What should the MCOs be doing to help kids stay healthy?

There were seven responses to this question. One theme emerged suggesting MCOs can help kids stay healthy by **increasing supports to families to help them navigate systems and processes**.

Care and Service Coordination

How well has your MCO care coordinator helped you obtain services?

There were three responses to this question. No themes, please see page 12 for responses.

What do you want to improve about care and service coordination? What other feedback do you have about care and service coordination?

There were 21 responses to the first question and 15 responses to the second question that complement each other. Comments indicated necessary improvements are to **reduce turnover** for care coordinators to avoid loss of knowledge in the position, have the position be a **more supportive role to families**, place a **cap on caseloads** to reduce burnout and be more helpful to their members, allow members to **choose their care coordinators**, require more **in-person visits** so care coordinators know their members better, and look at the **conflict of interest** in determining access to services.

Value-Added Services

Which extra services have been or would be most helpful to you?

There were two responses to this question. No themes, please see page 14 for responses.

Which extra services would help you reach your health goals?

There were 26 responses to this question. Out of many different suggestions, two themes emerged: increase availability of **respite care services** to be more accessible and provide **pet care services** to help people obtain and maintain pets and service animals.

What other feedback do you have about value-added services?

There were nine responses to this question. One theme emerged about ensuring value-added services are **accessible to members**.

General

What else do you want us to hear today?

There were 58 responses to this question. There were multiple questions about **how many MCOs** are expected to be chosen and general questions about **the RFP process**. Themes emerged requesting **additional opportunities to provide feedback** on the KanCare program in the future, conducting **independent evaluations** of MCOs, and **taking action to address trends** in complaints and appeals issues.

Provider Experience

What current administrative processes need to be standardized across all MCOs?

There were 73 responses to this question. Many responses requested standardizing the **credentialing and enrollment process**, closely followed by standardizing **prior authorization requirements**. In addition, themes emerged about standardizing **peer reviews**, improving **DME processes** for providers, increasing **transparency in data collection and reporting**, and standardizing **administrative forms and paperwork**.

What processes in your experience have been most helpful to you and the people you serve?

There were nine responses to this question. There was positive feedback about **new KMAP features**.

What other suggestions do you have about streamlining or standardizing the provider experience in KanCare?

There were 42 responses to this question. Multiple comments requested having a **central place to get information, access resources, and check prior authorization requirements**, have **access to provider representatives** to help with processes, and more **consistency in processing claims and denials**.

Workforce and Member Access to Care

What role should the MCOs have in improve the direct support workforce?

There were 13 responses to this question. Comments suggested MCOs can improve the direct support workforce by **increasing reimbursement** to retain workers in their role and **investing in professional development** opportunities for workers.

How can provider payment strategies and MCO training improve the workforce and access to care?

There were 30 responses to this question. Comments suggested **incentivizing providers** to take on challenges and work with more Medicaid members, **investing in training and professional development** opportunities to offset provider cost, and providing **training to help facilities navigate processes**.

Do you have additional comments or suggestions about the workforce or helping members access the services and care they need?

There were 35 responses to this question. Themes for suggestions included improving **access to specialized care**, improving **access in rural areas**, and **reinvesting money from unutilized services** into the workforce to increase access to services.

Performance Goals and Quality Assurance

What can the MCOs do to make it easier for members to achieve their health and independent living goals?

There were 30 responses to this question. Themes suggested improving **transportation services** to help people get to appointments, increasing access to **interpreters and provide content translated in other languages**, and ensuring members have **access to needed services**.

What role should the MCOs have in helping people with their health-related social needs (employment, GED courses, food security, safety, transportation)?

There were 33 responses to this question. Emerging themes suggested MCOs need to have a **better understanding of local community resources** to help members access resources, **increase utilization of local community resources** to help people meet needs and goals, **improve transportation services** to be more accessible and available, **expand transportation services** for non-medical use, and be a **partner with community organizations**.

What program or performance areas should be the focus for MCO pay-for-performance measures and liquidated damages?

There were 40 responses to this question. Emerging themes requested focus on **credentialing timeliness** to help providers, **MCO accountability** to ensure expectations are being met, **tobacco assessment and treatment goals** to improve member health, establishing **universal metrics** for the program, **diversion from institutionalization** to maintain independence, **timeliness standards** for MCO processes, and **community service utilization** metrics to measure partnerships and referrals.

Other questions and comments about KanCare

What else do you want us to hear today?

There were 84 responses to this question. There were multiple questions about **how many MCOs** are expected to be chosen and general questions about **the RFP process**. Emerging themes raised issues with requirements and experiences with **spenddowns**, requested **increased rates** for providers, complaints about **timeliness and communication accuracy with the Clearinghouse**, and **expanding case management** to more people.

All Comments and Questions Received at Public Meetings

Access to Care

Do you have access to the services you need when you need it?

Comments
No responses.

What barriers have you encountered when trying to get the health care services you need?

Comments
1. Eyecare – having difficulty finding providers for the services needed. Sometimes providers are 3-4 hours away which is unreasonable.
2. Young adults pursuing college degrees needing access to mental health therapy providers. Diversity of providers has been a challenge.
3. Lactation support services, trouble with access to skilled, cultural supports.
4. Dentures – can there be more providers to streamline the process? Multiple appointments in different places makes it difficult to access the service.
5. Have to "fight" for everything and frequently travel (even out of state) for services, medications, equipment, etc. Is there a breakdown in who is responsible to make these things happen? Rural areas specifically.
6. Home & vehicle modifications, the process creates barriers to access.
7. Access to behavioral health providers.
8. Limitations on reimbursement from travel.
9. Primary insurance has a cap and Medicaid won't cover as the secondary.
10. No services for 18+ yr old for speech therapy.
11. EPSDT – MCOs don't seem to know about it or have much of a network of providers to help families access EPSDT.
12. Network Adequacy, shortage of nurses willing to come in-home for services, even if hours are approved. Paying/recruiting of nurses by MCOs should be transparent information.
13. Timely manner of processes are concerning. MCOs are not identifying needs in a timely manner.
14. Lack of mental & behavioral health providers that will take Medicaid. Outdated provider directory given from State of KS and MCOs.
15. Seniors making calls to customer service are on hold for hours. Addition of email or a way to not have to be on hold for so long would help people through the process.
16. COLA/income requirements change and impact access to services for some people.
17. Wheelchair repair/maintenance coverage under medical equipment is difficult to access.
18. Case management issue- when doing "well" services are discontinued, which then starts the process over. Creates a cycle of barriers when services are needed to be maintained.
19. Need an exception for IDD waiver waitlist, because social security being included in "spend down" but expenses are still greater than "income."

20. Home care after services – having trouble getting enough caregiver/service hours – what are ways for the state to improve recruiting to fulfill these needs.
21. Many agencies say they are no longer accepting new Medicaid clients.
22. DME supplies.
23. Primary ins/Medicaid as secondary – lots of issues, not much flexibility – having to use companies that accept both.
24. Having to get renewals.
25. Certain supplies are no longer being provided (feeding tubes, wipes, etc.) or are inconsistent of being provided.
26. More standardization provided by MCOs – parents are having to determine what the child's needs are and what type and who fits best.
27. Inconsistency in hours approvals.
28. Hours provided by MCOs – need accountability for not providing what is needed to families – internal and external accountability. No one is asking the families how THEY feel the MCOs are doing.
29. DME – very few providers in KS have these services and having trouble with providers who don't take time to meet needs of family.
30. Primary ins. denial turns into a Medicaid denial when they are supposed to be "last resort" payor when it's an approved service/equipment through KanCare.
31. Listen to primary specialist for needs of patient, not have so many limitations of one size fits all for approval of equipment.
32. Providers leaving/no longer accepting KanCare due to restrictions of policies within KanCare.
33. Lack of accountability of MCO.
34. MCOs are creating barriers for the providers, which is creating barriers for Medicaid beneficiaries and not getting the care they need for the quality of life deserved.
35. I am a senior citizen and former dental assistant/hygienist. I am very concerned regarding dental care instead of just extracting my teeth, how will that be handled in the future?
36. Dental is a huge concern for me too. We had to travel an hour away for my 1st child to have a root canal covered, and now 2nd child needs braces. Dentist said it IS medically necessary due to the bite/arch being more of a point than an arch. And no providers will accept Medicaid for braces. Supposed to be covered by the MCO...but nobody actually takes it.
37. Can KDHE not enforce the MCOs to provide more dental in their contracts? Or say that they will not accept a contract that does not provide X minimum coverage?
38. Also what about contracts with glasses, a lot of them don't take state insurance, specifically Aetna.
39. I believe the dental problem is more to do with providers not accepting Medicaid. At least in my experience.
40. My daughter is sixteen years old, we have lived in Kansas since November 2014, and we have had to fight for every single item she requires to stay alive. I have given up on many insurance denials and just found items used.
41. We have to travel over 300 miles to specialists either in KS or going to Denver. Modivcare only provides gas mileage reimbursement for appts under 250 miles, unless there is an approval of some sort. Please take this into account.
42. Access to pediatrics pt/ot/speech are also an issue AND assistive communication evaluation and access.

43. The nursing issue also is because the rate increases the agencies have received have not made it to the nurses.
44. I work with low-income seniors and when they get a letter from the state and they try to call in, they are on hold for hours. Is there any way that more customer services representative could be added to help answer calls?
45. It is difficult to find care assistants and nurses for in home assistance.
46. An administrative cap and/or less administration/regulation for smaller nursing agencies to come into the marketplace as providers. Smaller agencies pay nurses more because they don't have the overhead to support like Phoenix, Maxim, Craig, etc.
47. MCO provider directories are so inaccurate!
48. The state should implement best practice service definitions for things like Assistive Services & Supported Employment and move toward having one statewide policy for those services. That's what other states do to address gaps and barriers to access between programs.
49. There has to be some way to encourage dental, eye care, and mental health providers to accept Medicaid. It is very difficult to find dental care.
50. DME access and delivery is a huge issue as well. KanCare just lost another DME provider in February (Alliance Rehab) which means we have less choice now for things like getting necessary equipment like wheelchairs, seating, walkers, etc.
51. Current language in Assistive Services definitions contains too much gray language that confuses families and results in too many inappropriate denials. Examples of conflicting/confusing language in the current Assistive Services definition: “All Assistive Services will be arranged by the MCO chosen by the participant.” “All Assistive services will be purchased under the participant's or guardian's written authority and paid to the qualified entity as determined by the MCO and will not exceed the prior authorized purchase amount.” “The participant or responsible party must arrange for the purchase.” “Work must not be initiated until approval has been obtained through prior authorization.”
52. The homeless in Shawnee County were only outreached via social media.
53. I will not use this transportation service, bad drivers.
54. Supplies, DME and home modifications.
55. Transportation.
56. Lot of trouble with keeping care givers.
57. Qualified caregivers, and continued supply of DME/supplies.
58. Sedation dental, DME supplies and medication,
59. Home modification process is so difficult that families often give up.
60. Transportation, they didn't fasten my husband in when bring him home from hospital and the I get a call, they are stopped on highway, because he fell out of his wheelchair.
61. Spenddowns are impossible to meet. My dad worked for this state for over 30 years, gets his social security and KPERS, and is totally disabled. Sometimes it feels like he is actually falling apart. The spend down is so high and they shut him down. Doctors won't see him if he doesn't have it. He can't afford insurance on the marketplace; he and his wife don't spend on anything except hospital bill after hospital bill. How are people supposed to even live like this?
62. Family member has access to services, but not always when they need it. They get put off for weeks. One example is he was prescribed diabetic shoes and it took over a year before he finally got an appointment for the shoes. As a family member, I could not get direct answers from his care coordinator, calls to his doctor were not returned. So, inability to get information, lack of communication to help my family member understand and find a way to

move forward. Transportation is an issue as well. I know everyone is busy, but when they have set times each week for tasks, grocery shopping, laundry, etc. These set times have been in place for seven years.
63. Our MCO gave my husband 24 hours a day, but the company I go through says they can't do that.
64. There's a lack of adult day service programs or other opportunities for adults who are complex. Providers aren't willing to apply for extraordinary funding because of the effort and low financial gain. Meanwhile the MCOs suggest parents to put their adult child into an environment where their safety is at risk. Same with other services that don't fit their cookie cutter approach.
65. "Medically necessary" barriers within transportation – allow other things beyond medical appts. Can also create an issue getting the person served there, but not home.

What should the MCOs be doing to help kids stay healthy?
Comments
1. Providing a systems navigator for families in the new RFP would be amazing.
2. Peers for parents too. Services for kids puts too many people in the kitchen. My boy has an IEP and dealing with Family Services and Guidance Center in Topeka is a nightmare.
3. Home based pediatric OT/PT/speech therapy.
4. Assistive technology evaluation, equipment, and training on how to use equipment.
5. MCOs should be noticing if kids aren't making their well checkups and immunizations in a timely manner, and then following up with families to learn about the why and addressing the why. Is it a transportation issue, can't time off work, don't have access to a provider that takes the child's Medicaid, don't have childcare coverage for other kids in home, don't understand importance of well child checkups, no access to translation services for appointments, or lots of other reasons? And then apply all the previous comments also to any needed treatments or therapies appointments that are missed.
6. Are there opportunities for connections between MCOs, Local Health Departments, and home visiting programs in communities to work together on kids' health issues, for parent education, for opportunities to talk to parents to learn about barriers and challenges parents face, connection to more community services, all with the mission of helping kids grow up healthy?
7. Families should not have to get their own bids for home modifications.

Care and Service Coordination

How well has your MCO Care Coordinator helped you obtain services?

Comments
1. We are having an issue with finding a dental surgeon for our child right now. She has an impacted tooth and yet we have gone through calling two different lists worth. Our Case Coordinator has not been of any help.
2. The care coordinator for my son has been very good. She has helped to get services that are needed.
3. Our current care coordinator Gailyn L could help train others how to be person and family centered and to be an advocate for their people.

What do you want to improve about care and service coordination?

Comments
1. Seem to be unaware of services or benefit for getting services. They need to be better educated. Need less turnover, more knowledge.
2. Conflict of interest of Care Coordinator being the one determining services for people.
3. No choice in who Care Coordinator is, they are assigned automatically.
4. Care Coordinators should be required to have in-person visits at least once a year. They are making decisions for someone they have never met.
5. Virtual visits feel inadequate when they are determining services/benefits for us.
6. It's difficult to navigate waivers. Who should be coordinating waivers?
7. Need a better Care Coordinator program overall.
8. Lots of turn over with CCs; burden put on parents for nursing agencies b/c CCs say it is not their job.
9. Parents having to advocate for themselves, not feeling like the CCs are doing that.
10. Feeling "ghosted" by CCs, being put-off by them – not having access when needed
11. Caseloads are too high.
12. Care coordinators should help coordinate care if multiple providers and caseloads should be limited to no more than 40 people.
13. Improvements could start with the care coordinator being an advocate for what members are eligible for or need. Most members/parents don't have the background in medical care and are not aware of what's available or what is needed.
14. MCOs should give a process on how to switch care coordinators without retribution.
15. No more than 50 people on a caseload with financial penalty if it goes over.
16. And maybe 40 max caseload with complex cases.
17. Return to in person visits.
18. Must be a requirement to meet the person you are basing decisions on.
19. Get the basics of care coordination right.
20. Response rate from Care Coordinators and MCOs is not good (not returning/answering calls).

21. Care coordinators need to spend more time with families to know them better.

What other feedback do you have about care and service coordination?

Comments
1. MCOs are well situated in the healthcare landscape to ensure more equitable access and outcomes. Require MCOs to: Designate health equity champions who are accountable to equity concerns. Have an organizational health equity plan. Employ a diverse workforce that reflects the community being served. Provide equity training to staff.
2. Review all clinical algorithms used to authorize services and make medical necessity decisions to ensure they do not reinforce inequity. Collect and share data about member race, ethnicity, preferred language, and to screen for social needs; include collection of these data in provider contracts as well. Develop health equity score cards and review data in real-time (in addition to retrospective measurement like HEDIS). Share data and results with community partners and providers. Connect every member reporting social needs with community resources. Require Z-codes for reporting SDOH. Focus Care Management on higher disparity conditions.
3. Explicitly building in equity to government contracts is critical to improving equity.
4. I am a person living with an SMI disability in Shawnee County. There is zero coordination of care. I am lucky to be alive because I learned my coping skills from the system in Phoenix AZ
5. In 2013 Kansas moved from a fee for service model, adopted a managed care model to serve Kansans receiving Medicaid long-term care supports and services. As a result of this action, the FE, PD, and BI waivers lost case management services. Without case management for home and community-based supports, Kansans have significant trouble managing and negotiating their in-home care needs, including managing provider related issues. MCO Care coordinators have large caseloads and serve a large geographical area. This prevents a timely response to the individual needing support and reducing their care coordinators' expertise in locally available services. As a result of this conflict of interest, caseload size and coverage area, the current community-based long term-care options are failing vulnerable Kansans.
6. At least one a year in person meeting and choice for care coordinators would be beneficial for many as well! Or have care coordinators tiered by experience for highly complex consumers, etc.
7. Need choice in care coordinator.
8. An App or website that is able to link us to our care coordinators, similar to a MyChart, would help to know what is going on rather than relying on phone calls and texts only.
9. It sounds like a Community Health Worker could be integrated working together with the Care Coordinators.
10. Create better and more strict accountability measurements on MCOs and removing conflict of interest wherever possible:
11. Care coordinators no longer visit in person.
12. Conflict of interest with care coordinators deciding service hours! Needs assessment needs to be completed by an outside party.
13. Allow members to give a grade card for coordinators.

14. Current care coordinator is amazing but we have had care coordinators who have been awful and felt like they were always trying to take hours and care away.
15. Members should be able to choose care coordinator.

Value-Added Services

Which extra services have been or would be most helpful to you?

Comments
1. Nutritional courses for staying healthy.
2. Money for housing.

What extra services would help you reach your health goals?

Comments
1. Toenail cutting services.
2. Meals on Wheels should be provided to all waivers.
3. Eyecare in a timely manner. Partner with more readily available providers in more areas.
4. Increase respite care and make it accessible for more people.
5. Life skills classes (Cooking classes, play therapy, mentoring, yoga)
6. Tobacco cessation programs
7. Training on vaping
8. Asthma (carpet cleaning, healthy food access) related needs
9. Lawn care, exterior home care
10. Pet care (walking dogs, etc.)
11. Employment skills, daily living
12. Programs that target the most isolated individuals, not just those seeking/capable of independence.
13. Car mechanic services.
14. Need respite for individuals on the IDD waitlist - only Aetna provides it now.
15. Respite care for families who provide the care for their person would be helpful.
16. Coverage for hearing aids
17. Help pay for training for a service animal.
18. Covering formula for kids who are g-tube dependent regardless of age.
19. Postpartum mental health support up to a year minimum
20. Adult briefs- more than a 3-month supply. If you are incontinent, you need these 12 months a year. And lift chairs and other durable medical equipment.
21. Allowance for more Chux and incontinence supplies.
22. respite for all waivers
23. Money for an Uber if transportation doesn't show up for medical appointments so people don't have to reschedule all the time

24. Giving aid for transportation when parents have to take to all appointments
25. lawn and pet care
26. Pet care that covers food for pets.

What other feedback do you have about value-added services?
Comments
1. Care Coordinators don't seem to know about these extra services.
2. These extra services really need to be open to ALL consumers. It would be easy to just add on the stipulation that certain extra service needs prior approval.
3. Dental benefits should not be an extra value-added benefit. Or only being able to get services if you are on HCBS. That's just an incentive to be on HCBS, exasperating the already years and years long waiting lists.
4. Extra? Can we just get our regular services delivered appropriately?
5. And reducing the difficulty signing up for mileage reimbursement
6. What does respite care cover? I have not had a day off in 5 years.
7. I would like behavioral supports like PBS post 21 when people age out of ABA through EPSDT
8. Network adequacy issues. If you don't have providers to offer the added services, it basically doesn't exist.
9. If it is going to be offered, it should actually be able to be used.

General

What else do you want us to hear today?

Comments
1. There needs to be a better place to express concerns for families by using their own voices.
2. We need more information from the State and more information about how to reach the State when needed.
3. Checks and balances for MCOs. Accountability and outside evaluation in a timely manner is needed.
4. Not all disabilities are the same, not enough buckets
5. Having more meetings with MCOs to get feedback from families
6. Getting additional help during transitions (facility to home) or change in family dynamics
7. Better accountability process for MCOs/KanCare.
8. Transportation improvements.
9. Not have MCOs be able to do their own investigations/evaluations.
10. Get to patient focus, versus money/employment focused.
11. Be able to take care of more things at home, so extra trips outside the home are not as necessary.
12. Preventative measures for more complex situations.
13. Do all of the health plans operate in the entire state or is there a regionalization approach?
14. When will an announcement or RFP/RFA be released for the 2025 bid?
15. There are clear disparities in healthcare outcomes across multiple domains, including race, ethnicity, location (urban/rural), and disability status. Where you live significantly impacts how long you live. I'm glad to hear that supports for social drivers of health are included in the current contract. I'm interested in knowing more about how KDHE is thinking about addressing health equity in the new RFP/RFA.
16. What is RFP/RFA?
17. I assume KanCare includes all the HCBS waivers as well, correct? In which case the statement about serving only low-income families would be false.
18. Are they only going to award contracts to 3 MCO's again or will they add more MCO's for additional choice?
19. Will there be only 3 providers or could more or less be awarded?
20. How is compliance for the MCOs handled? (reporting on service delivery success mainly)
21. How do you know MCOs are performing or not performing?
22. To my understanding the MCO's are providing the reports themselves without outside input or oversight.
23. When will the RFP language be available to review publicly?
24. I have a client who had heart attack and was taken to the ER for the treatment however the big chuck of bill was waived. He still have some bills that are being paid on a payment plans. My question is he is an elderly, working person and married however he does not have Medicaid benefit and worried for the future living lifestyle. How could we help like this kind of clients who are struggling to get the Medicaid benefits?
25. The SMI population in Shawnee county needs the RFP enforced following the Arnold Vs Sarn class action lawsuit. Shawnee County needs to invest in Peer Support employees to work side by side with clinical teams to reach the members.

26. Personal service assistants need ways to help them with burnout too.
27. Medicaid Reimbursement to be same as Medicare on all services.
28. Change the protected income limit to be at a minimum the same as the SSI income.
29. Work leads to meaning and purpose in life. Let people work.
30. State should do a better job of measuring and enforcing MCO response timeframes - getting Health Risk Assessments completed after gaining crisis access to IDD Waiver for example.
31. The Kansas Employment First Oversight Commission recommends that there are incentives in the Managed Care Contracts to implement Employment First. The MCO contracts should have the net effect of ensuring that competitive integrated employment is the first and preferred option for Kansans with disabilities. These incentives need to designed to require MCOs to track and make significant progress in increasing the numbers of Kansans with disabilities in competitive integrated employment. Additional provisions could include contractual incentives to ensure statewide coverage and funding of all the Medicaid services that supports competitive integrated employment (e.g., job coaching, supported employment, services to transition students with disabilities, etc. Additionally, the Commission would note that not all HCBS Waivers offer employment supports. We recommend that gaps be examined and recommendations be made to fill them. A contradiction exists between the goal of Employment First and the subminimum wage.
32. MCOs making large profits on Medicaid while the beneficiaries go without needed services is a major flaw of KanCare. MCOs receiving a monthly Medicaid payment when no services are provided to the beneficiary is a major concern.
33. Outside evaluation.
34. There is an External Evaluation that is done, but the MCOs do not provide good data to properly evaluate the program. Which means it's not a proper external evaluation. If they're receiving public dollars, they need to be publicly accountable to how they're using those dollars.
35. When I moved here I was shocked at the amount of Award nominations and ceremonies for mental health and health organization leaders in Shawnee County. Never seen that before.
36. We gave up on utilizing a nursing agency for our child's hours, as we were never able to get any providers in the home. They threw a fit when we pulled all the hours from them and placed them with a PCS agency.
37. I am uncomfortable that some MCOs donate to politicians in our state that are against Medicaid expansion.
38. Thank you for allowing us the opportunity to have a voice.
39. Grateful for the open forum and for the time/format.
40. Question pertaining to that- we received our paperwork to renew on Saturday, and stated it must be in by April 30. Are they going to get to that fast enough or are we possibly going to have a gap in insurance?
41. Are they still going to allow the parents to be paid as caregiver?
42. Is the RFP open to anyone or is it a selected group?
43. What happens if your company is not chosen?
44. MCO contracts should include including lactation counseling by certified consultants, and educational programs during pregnancy and continue after the birth of a child. • 90% of families in Kansas choose to breastfeed. Current coverage of lactation support is insufficient to support them. • MCOs should be required to support them in the outpatient setting, beyond the in-patient maternity care in the hospital.

• MCOs should be required to conduct a health equity assessment and submit a Health Equity Plan that includes how they will support the development of a diverse lactation workforce. • While doctors and nurses have great potential to support breastfeeding families, they do not have time or specialized knowledge to provide clinical lactation support. Lactation consultants are needed to provide skilled clinical lactation care. • It is not appropriate for health plans to refer families to WIC or to volunteer organizations for breastfeeding support instead of providing access to skilled lactation consultants. • Current coverage of lactation support relies on in-patient care. Only one “code” is available for outpatient lactation consulting (S9443). This code pays $9.91, which isn’t adequate and doesn’t match the health value of the service being delivered.
45. If MCOs drop below a certain utilization, they should be fined.
46. Financial penalties for utilization under 80%.
47. We need targeted case management for all waivers.
48. Bring back targeted case management for all waivers.
49. A list of providers who take Medicaid and how many opening updated by each MCO quarterly.
50. Financial incentives for providers who are doing innovated things to help families and helping fill service gaps.
51. Matrix if a certain number of complaints on same issue come in such as DME or lack of attendant and nursing care that triggers a systemic review at the state level and course corrections.
52. The state should make the MCOs pay for their own attorneys during appeals. Using Kansas lawyers to represent MCOs in appeals a conflict of interest.
53. Watch trends in appeals and make MCOs address them.
54. Is anything going to change or are you just letting us sound off at these meetings?
55. More state oversight and accountability with the MCOs.
56. Independent evaluation of the MCO’s.
57. Can’t each MCO have a member advisory committee that reports to KanCare for oversight?
58. The doctor that examined the patient should determine what is medically necessary. Not some computer's automated process, not someone at the MCO, if you did not see that person, your opinion does not matter.

Provider Experience

What current administrative processes need to be standardized across all MCOs?

Comments
1. Data collection and transparency from every MCO. Data should be publicly shared in a timely manner, specifically relating to children. Important to know what is being done by MCO that is helpful.
2. Credentialing with MCOs. The process hurts providers. Centralize and build transparency in the process.
3. Prior authorization timeframes.
4. Prior authorization peer-to-peer consultation should be conducted by actual provider peers, not providers that have a random medical license that isn't related to the issue at hand.
5. Process and time to obtain approval.
6. Prior authorizations being required for one MCO, but not from others. Streamlining authorization process is needed to help providers.
7. Clinical audits after a claim has been processed/paid, DRG downgrades, coding denial vs medical denial – streamline the process and do an overview of the audit process.
8. Provider credentialing and enrollment should be standardized. The current system is very time consuming and duplicative. If a single process for credentialing and enrollment can be allowed, it will be very helpful.
9. Streamlining the credentialing processes. Once for all three would be nice and modernize electronically.
10. Streamlined process for credentialing.
11. Standardization of which care procedures require prior authorization is absolutely necessary both for beneficiaries and for providers. The prior authorization process currently seems to be designed to block care rather than assure that care is provided in a cost effective manner.
12. DRG downgrades by the MCO's need to be streamlined to follow CMS traditional Medicare standards.
13. Prior authorization processes are too inconsistent (even within the same MCO, but also across the plans) and result in inappropriate delays and denials. This is directly due to the state's poorly written policies. It has resulted in huge overpayment and Compliance issues.
14. Peer to Peer Reviews.
15. Peer to Peer process needs standardized. A Cardiologist should be talking to a cardiologist when discussing an appeal or prior authorization or denial.
16. There's a difference in MCO Care Coordinators.
17. The quality and involvement with Care Coordinators make a big difference.
18. Inconsistent forms and processes (single case agreements, credentialing, assistive services, etc.) are pinch points.
19. Some of our MCO's pay the telehealth code and some do not.
20. Credentialing process.
21. Consistent forms and processes across all contracting MCOs are necessary. i.e., single case agreements, assistive services, provider credentialing, in lieu of services, etc.
22. Roster management! including recredentialing & updates.
23. Durable Medical equipment and home modifications processes.
24. Pre-authorization process.

25. Credentialing process.
26. Person-centered planning process, that is not happening.
27. ISP Information.
28. Same credentialing process.
29. Credentialing needs to be standardized.
30. One thing that would help increase access to care would be a streamlined credentialing process with only one portal/application that would credential providers for all MCOs.
31. Conflict of Interest process for parent workers on the Medicaid Waivers. Tons of conflicting information depending which care coordinator/MCO a client has.
32. Standardized process with billing/denials/etc. These should have standards for timeliness too.
33. Standardized credentialing across MCOs.
34. Case load size for care coordinators.
35. Person-centered planning processes.
36. Initial authorization and utilization process. Structure of programs and relationships of programs to one another
37. Credentialing and qualifications.
38. A consistent process for gaining access to durable medical equipment.
39. Medicaid law requires uniform access to Medicaid - any admin procedures that put up barriers in one MCO but not another should be streamlined to remove the barrier.
40. Standardization of credentialing. Timelines for credentialing CHOWs and LTC facilities.
41. How each MCO uses in lieu of services on plans of care.
42. Data collection and reporting.
43. Providers should have a standard set of paperwork to fill out (for instance, for doing an Autism Dx) instead of having to invest the time to manage three different processes.
44. Transparency of data.
45. Disaggregated data.
46. consistency between MCO's on what requires a prior authorization.
47. We want access to data on utilization of services for HCBS waiver participants.
48. Adherence to parity standards, assuming that they are included by KDHE.
49. Peer support services covered.
50. Some MCO's have dropped prior authorizations for some services, which is great, but of course it is different between MCO's.
51. Standardizes access to EPSDT services.
52. Processes for transportation services, reimbursement for transportation, meal accommodation for longer travel needs - though these processes also need good support.
53. Getting access to EPSDT and having a clear process for this.
54. Centralized credentialing process
55. TA to IDD waiver standardization (any streamline would be an improvement) Timeline for when to start the transition process (service & billing interruption)
56. Prior authorization & denials process standardization. Clear information and expectations about what is actually required?
57. Standardization of the peer-to-peer process and ensure peers have the relevant medical background and experience necessary.
58. Single case agreements
59. Credentialing and qualifications

60. Access to assistive services (durable medical equipment)
61. Consistent process for access to DME
62. Standardization of credentialing,
63. Data collection and reporting
64. Governance transparency
65. Peer support services covered
66. Medicaid law requires uniform access to Medicaid – any admin procedures that put up barriers in one MCO but not another
67. Standardization of paperwork
68. Transparency of data
69. Disaggregated data (race, ethnicity, location, etc.)
70. Consistency between MCOs on what requires a prior auth.
71. Policies across waivers for assistive technology
72. Access to data on utilization of services for HCBS waiver participants
73. Adherence to parity standards assuming they are included by KDHE

What processes in your experience have been most helpful to you and the people you serve?
Comments
1. I have not had a helpful experience. Unit 7 with KDHE supervisor Mica has been great to work with during my work with helping with KanCare application process. Our facility has a handful of individuals who use the different MCOs and so far UHC has been by far the best to work with.
2. For behavioral health, it was doing away with authorizations for non-SED Waiver services. That made our processes so much easier for staff and clients.
3. Presumptive eligibility works well.
4. New KMAP portal works well.
5. Ease of retrieving KMAP fee schedules is a great feature.
6. We appreciate Laura Leistra being able to correct names within 24 hrs.
7. Checking eligibility online that includes other insurance like commercial.
8. Giving the PCSP to the provider in addition to the family.
9. Transportation services, reimbursement for transportation, meal accommodations are helpful, although are not often working, are very helpful to have.

What other suggestions do you have about streamlining or standardizing the provider experience in KanCare?

Comments
1. Follow best practices. There is poorly written language in waivers that causes a lot of confusion among everyone involved.
2. Is it possible to credential once for all three MCOs, as opposed to one time per MCO?
3. Need timely authorizations to providers to support serving high need persons in IDD (financial, linking with specialists, environmental adaptations), crisis assistance for high behavioral needs.
4. If there could be a central place to check if pre-authorization is needed, that would be so much better for providers.
5. Need timely communication from KMAP to the MCOs.
6. Create an actual choice form that members sign.
7. The single case agreement for members. MCO's need to be held accountable with keeping their information current. This should not be the providers responsibility.
8. Utilization data for attendant care needs to be shared monthly.
9. Better demonstration and more transparency of on-going network adequacy.
10. Getting all MCO's to process new and corrected claims in a similar fashion. The MCO's all seem to have their own rules for processing claims and cause additional burden on how providers have to fix an unpaid/underpaid claim.
11. Limited time for MCO's recoup to the same as providers have for timely filing.
12. Better reps that are easy to get ahold of and don't tell us to call in repeatedly with no help.
13. I also believe any audit or "records checks" should be done by a provider (usually outsourced) that understands what type of service we are providing. We are constantly receiving requests for "Medical Records" but we are an FMS provider. After we explain it all to them, the outsourced provider then sends a letter to draw back any money that was paid to us.
14. Is there opportunity to have the Medicaid MCO's be required to follow the CMS Inpatient Only list for procedures? CMS will soon be requiring that Medicare MCO's will have to follow the 2 Midnight rule. This is a great opportunity for alignment, standardization and helping members achieve their health goals & reduce the burden of shorter hospital stays under OP level of care with the resulting increased need for post-acute services (DME, HH, SNF, LTAC etc.) because many of those needs can be met if the pt were able to appropriately stay longer than the anticipated <24hr stay in OP or Observation status. This will also greatly reduce denials.
15. As a CCBHC, it is frustrating when clients with Medicare primary automatically forward a client's claim directly to the secondary MCO. CCBHC billing requires us to first add the T1040 code to these claims before they are submitted to secondary. Often, the MCO's are paying the secondary claim that Medicare has forwarded which requires us to have that voided, recouped, and then a corrected CCBHC claim submitted. Lots of extra work for all parties. The MCO's need to be able to ignore secondary claims submitted directly from Medicare for CCBHC providers.
16. Standardize caseload size of care coordinators to no more than 50 with financial repercussions if it goes over.

17. Streamline process for provider notification of a new client choosing a provider-only some CDDOs do options counseling. Sometimes we have an authorization show up for someone we have never heard of and have no contact info on. Ideally, we would have case manager name and contact, care coordination name and contact, etc. to get those families into services faster.
18. Providers should have provider reps at each MCO.
19. It seems to take quite some time for the MCO's to update/verify when a member's primary insurance is no longer active.
20. All 3 MCOs should have one portal, one manual, all the same rules.
21. It would be really helpful for there to be one page or link to all contacts needed for all MCOs. And for those contacts to be updated regularly.
22. All MCO's should have a way on their portals to void or correct claims.
23. When it comes to credentialing, some of their MCO's do their own credentialing process after the provider has gone through KMAP and been issued a KMAP#; whereas other MCO's recognize once the provider is assigned a KMAP# they are good to see clients and bill.
24. MCOs revert to commercial claim processing with increased denials.
25. Enrollment process has a lot of back-and-forth info that could be avoided if there was more communication between MCOS.
26. EPSDT services should not require an authorization if diagnosis is met.
27. Paper communication and timeframe are not effective in the denial process.
28. Utilization data made available and published.
29. What guidance do other states have that we could learn from? Consider looking at improvements for a care coordination system structure.
30. MCOs can recoup payments made and providers cannot go back after it due to timeline for claim filing – recoupment period standardized across MCOs. MCOs cannot take money back unless it is in the timeframe for providers to re-file claims to commercial insurance.
31. EFT setup – consistency for payment types
32. Provider account manager/relations manager position added for MCOs to ask direct questions to get answers.
33. KDHE requires screenings to be billed, when KanCare is secondary & primary payer does not pay, then the MCOs tend to deny also.
34. Resolve challenges regarding credentialing and enrolling processes.
35. MCOs required to update rosters in accordance with what comes from KMAP file.
36. Standardization between CMS and MCO requirements (CMS Medicare in-patient only list) Lack of consistency creates administrative burdens.
37. Prior authorization expirations – equipment needs can be complicated due to supply chain issues. We need to be able to extend authorizations.
38. Access to data – the ability for provider systems to get information on utilization, prior authorizations, demographic utilization, etc.
39. There should be reasonable access to data, including showing how money is being spent to improve the program.
40. Electronic submissions should be the only avenue for communication for back-and-forth. Discontinue fax machine transmissions due to equipment failure and timeliness issues.
41. Post-acute transfer process. Should not have 30 unavoidable days in a hospital when not needed.
42. How we get authorization from MCOs (mail, email, fax). There should be one way to receive them, preferably electronically.

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Workforce and Member Access to Care

What role should the MCOs have in improving the direct support workforce?

Comments
1. Almost anything. Providers have not seen much help or support with the workforce issue. Increase wages, media campaign to highlight the position, etc.
2. Network adequacy – are there enough providers to serve the population? What are the MCOs going to do to address that? Are kids and pregnant women being served without having to drive 3+ hours for services?
3. MCO contracts with the State of Kansas to provide KanCare, namely HCBS, should be fluid enough to allow MCOs to mitigate the direct care worker/shortage related to lack of benefits & pay. Medicaid Expansion is a tool that can address the healthcare access issue which will be important when implementing a Community Supports Waiver because right now, people cannot afford to work as DSPs.
4. Low service plans further deteriorate the workforce. For example, consumer employer only has four hours per week on her service plan. A direct support worker must work for multiple consumer employers to have full-time employment with the added barrier that travel time between employers is unpaid.
5. Unused self-directed service plan funds should be sequestered for use to find DSWs and not go into MCO profits.
6. We were thankful for Rewardingwork.org, but it sounds like some MCOs are longer funding it. It took some liability off of self-directed providers and was a central location to send workers/clients.
7. MCOs could pay the providers' companies for the time providers need to take for professional development so this isn't also lost revenue to the company.
8. MCOs or state can pay better.
9. MCOs could support paid internships for developing the workforce.
10. DSWs should have access to health insurance, and since the MCOs are health insurance providers it seems like this could happen.
11. MCO's can provide increased rate for direct care staff reimbursement?
12. EPSTD – MCOs consistent for process – who it should go through first
13. Post-acute transfers – MCOs should have social workers on staff in consistent communication with hospitals for patients that are harder to place.

How can provider payment strategies and MCO training improve the workforce and access to care?
Comments
1. Rate structure does not support specialized care. Higher reimbursement rates for day services / residential living for adults with DD and medical complexity. Incentives for those providers who serve those with medical complexity. There are very few options for community living for those with medical complexity.
2. Ensure our KS rates are competitive across national rates.
3. Tertiary payments from Medicaid, which are overpayments. If somehow Medicaid MCO's could NOT process crossover claims from Medicare when COB shows there is a Medicare supplement, if would make facilities' billing much easier.
4. MCOs need to require their contractors or at least encourage to pay the home health workers wages for their full day, travel time, actual benefits like PTO, etc.
5. Bringing back the retainer services that allowed workers a limited number of hours per year while a client is in the hospital, especially the TA waiver! They risk losing great workers who can't financially weather a hospitalization.
6. Offer trainings to the facilities billing persons.
7. Have an MCO rep that can visit facilities to help with billing or coding.
8. If a provider takes time away from serving clients, for their professional development, this is a loss to the agency in terms of revenue and a cost to pay that full-time employee. This prohibits professional development during "company time".
9. Training from the MCO directly in how to navigate and understand the policy manuals created by KMAP and the individual MCO.
10. MCOs could provide incentives to organizations for improving justice, equity, diversity, and inclusiveness among provider organizations such that the workforce more accurately represents their communities.
11. Training hours for caregivers to attend trainings i.e., CPR/First Aid.
12. Maybe we ought to have a tier system to be paid more for more MDD.
13. I suggest a tier system to incentivize providers to take more Medicaid patients. We run into people taking 25 patients on their panel to say "they take Medicaid," only to boot people off when they lose their jobs and/or health insurance. Then they come to us. Maybe a panel of 100, 300, 500, 1000, 2000, etc. and increased payment associated with those larger numbers.
14. We are the largest Medicaid provider in the area, against all others combined, because we see kids who are the largest group of recipients of Medicaid, yet the local FQHC gets paid more than we do on a visit because they get government subsidies.
15. Reducing prior authorization issues. Administrative burdens due to not being streamlined. Providers are not feeling the "partnership" we would like to have.
16. Review current strategies to make sure the reimbursement methodology is fair and beneficial.
17. HCBS waiver program – the bid process.
18. MCO training on care coordinators – different coordinators don't seem to communicate enough to have a smooth process, which interrupts processes for clients. Providers seem to be training the care coordinators on the processes.

19. Other states have been required to do pilot programs around diversity in the workforce – would like to see that included.
20. DSWs have access to health insurance (should be possible since MCOs are health insurance providers).
21. MCOs can provide increased rate for direct care staff reimbursement.
22. Lack of direct support workers is a community capacity issue.
23. Access to health ins & benefits if the state plans on pursuing a CS Waiver. People cannot currently afford to work as DSPs.
24. Supporting Medication expansion.
25. Unused POC $$, funds should be able to be used to fund DSWs and not MCO profits.
26. Budget authority of HCBS consumers.
27. Encourage use of services like peer support in any health or behavioral health care.
28. Individual budget authority fully supported by all MCOs.
29. K-PASS, bring back.
30. Where do un-utilized funds go?

Do you have additional comments or suggestions about the workforce or helping members access the services and care they need?
Comments
1. MCO's should have an acceptable level of care coordinators and social workers available to help navigate patient flow.
2. We need to increase access to primary care in the adult population that will accept Medicaid and see adults with IDD.
3. The problem of provider availability is even more serious when we are looking at child dental services. Some families in rural areas have to travel nearly two hours to their nearest dental provider for their children, and providers for adults are nearly impossible to find.
4. MCO training on mental health and SUD parity requirements based on federal and state laws.
5. Dental as a whole is a huge issue. Braces, even when medically necessary, you can't get them because no one will accept Medicaid. Dentures, those are only covered if you're on an HCBS waiver.
6. In terms of improving workforce: What new solutions & expectations could be created as part of this RFP to help complex medical needs families navigate the KanCare and medical system not alone, supported, and without having to spend 60 hours/week on the phone advocating for their child or family member?
7. Neurologists and other specialized health professionals are difficult to find in western Kansas. Most are over a 2-hour drive one way.
8. Mobile integrated healthcare and community paramedicine could be very helpful for folks in rural and frontier counties.
9. The use of telehealth services proved to be very effective during the pandemic. This could help with access to services.
10. For Access to Care, KanCare should support Targeted Case Management. TCM is community based and better for service development than the current MCO-based service development model.

11. Increase peer supports for people; good example is the transportation agreement between the I/DD providers in JoCo and the local community health centers.
12. Remove conflict of interest with Care Coordinators being employed by the MCO.
13. TCM should be provided for all waivers
14. Neutral, third-party comparative analyses to demonstrate compliance with state and federal mental health and SUD parity requirements.
15. Due to the use of Community Health Centers, there is no consistency in primary health care. Fewer physicians are contracting with MCOs or they are not accepting new patients which requires many to use CHCs.
16. Regarding language access, there is concern in some parts of Kansas that MCOs are either not providing interpreter services or the providers are not aware that it is a service provided through the MCO. In the Kansas City metro area, this has not been concerning, but in other areas it has been.
17. Care Coordination services need to be improved, especially in cases of suicide attempts and coordination of crisis care to outpatient mental health; both directions and to other community providers.
18. KanCare has very robust tobacco cessation benefits (counseling and NRT/medication) but they are very under-utilized. MCOs could do a much better job of training case managers and representatives to communicate these benefits to support quit attempts.
19. Having MCOs that donate to politicians that are against Medicaid expansion instead of those that do support.
20. Reimbursement for certified community health workers.
21. Have workers connect with providers so they learn what providers are seeing.
22. How many services/service hours are not being utilized because of workforce shortages?
23. Lack of direct support workers is absolutely a community capacity issue.
24. Access to health insurance and other benefits will be vitally important if the state plans on pursuing a Community Supports Waiver. Right now, people can't afford to work as DSPs.
25. When people have unused plan of care dollars because they can't find workers that money should be sequestered for use to fund DSWs and not go into MCO profits. This would be an incentive for MCOs to figure out DSW issues.
26. Budget authority for HCBS consumers.
27. Encourage use of services like Peer Support in any health or behavioral health care.
28. Individual Budget Authority fully supported by all MCOs.
29. Where does un-utilized (because people can't find workers) money go. These dollars should stay in the system.
30. Support Self-Direction without unnecessary administrative barriers and ease of use for consumers and workers.
31. Transportation is always a barrier for job seekers.
32. Billing questions/confusion – making sure staff are trained for payment reimbursement requests. Takes time away from patient care when providers have to try to navigate unclear processes.
33. Provider relations – a lot of confusion, being given different information depending on who they talk to at the MCOs.
34. Need to we make sure providers are accessing the right program that is covered.
35. Prior approval given, prescription approved, services given, but then denied by Medicaid due to having a provider write a prescription that was not enrolled to provide Medicaid.

Performance Goals and Quality Assurance

What can the MCOs do to make it easier for members to achieve their health and independent living goals?

Comments
1. Pregnant women should have a paid for blood-pressure cuff to watch for early warning signs during pregnancy and postpartum.
2. Share health outcome data, cost data, service data, etc. Providers would like this information to be transparent.
3. ESL members receiving a lot of communication still in English only. There are lots of questions about what all the paperwork is for. Language barrier also in text communications.
4. Having nursing hours available as a pool to any agency (I'm mainly thinking of TA waiver nursing) rather than assigning a certain number of hours to one agency at a time. During this care crisis it's been a barrier to keeping good nurses once a family gets a nurse.
5. MCOs should invest in competitive, integrated employment options and outcomes.
6. Provide needed services such as nursing, direct care staff, respite, DME , home modifications, PT, OT, and speech.
7. To be independent, integrated members in their communities of their choice, members should have access to transportation that goes beyond medical appointments and (sometimes) employment; people need to actually access their communities.
8. Access to childcare to be able to attend medical appointments.
9. Housing stability, paid leave access, etc., in addition to the social needs already shared.
10. It would also be nice to have prevention measures as added services such as health club memberships, healthy diets, etc.
11. I like the idea of pilots funded by the MCOs to test the validity, helpfulness, and savings provided by new positions or roles. Examples are CHWs and doulas.
12. I understand that sometimes it's necessary for there to be a treatment goal regarding engaging in treatment, but this has limitations when the person's symptoms get in the way of engaging in treatment to work on that kind of goal. It would be great if MCOs could implement strategies to help people engage in treatment (make it to services) when that is of high concern.
13. A higher rate should be paid to MCOs for persons living in a community setting as opposed to an institutional setting; moving people out of institutions should be incentivized.
14. MCO Care coordinators have large caseloads and serve a large geographical area. This prevents a timely response to the individual needing support and reducing their care coordinators' expertise in locally available services.
15. To remember not everyone lives in a bigger city, there are lots of us that are rural.
16. The case management suggestions already made would go a long way to helping members achieve independent living goals.
17. Transportation and housing issues are barriers to inclusion.
18. Offer greater access to transportation that goes beyond employment and medical appointments.
19. Could MCOs help with renewals? Wouldn't the MCO want to keep their people?
20. Interpreter arrangements should be standardized across MCOS.
21. Using data to prioritize training for MCO staff. Tobacco treatment supports behavioral health treatment and provides immediate health benefits, and equals cost savings for everyone.

22. More coverage for dads.
23. Trying to get help for members to eliminate smoking/tobacco use. Increase access to evidence-based treatments.
24. Supporting Medicaid Expansion.
25. The best thing MCOs can do to support independent living goals is to provide referrals to community-based organizations, not acting like their care coordinators "do that" work.
26. In Kansas, nearly one third (30.2%) of adults with poor mental health (defined as reporting 14 or more days of mental health not good) smoke. That's more than double the prevalence as adults without poor mental health (14.3%).(KS BRFSS 2021). Many people with behavioral health conditions want to quit smoking but may need more support as the effectiveness of successful quitting is very low. How will the MCOs track providers in screening for tobacco use AND providing advice to quit and discussing cessation medications and strategies?
27. Improve access to equipment. There are only two clinics in the state for the appointment w/ 6 month wait. Kids can end up waiting a year for needed equipment. This is impacting their ability to move forward with independence. Eliminate process for having to go to clinic – bringing in a DME, CRT through the provider. Simplify the process to submit for authorization to eliminate delay at MCO level.
28. Timeliness of prior authorizations, there should be specific times for MCOs to be held to.
29. Prior authorizations need be addressed at state level. There are barriers when you have to get a denial from primary insurance before next approval. It's a time-consuming process**.**
30. Publicly displayed information about prior authorizations and denials.

What role should the MCOs have in helping people with their health-related social needs (employment, GED courses, food security, safety, transportation)?
Comments
1. Health centers have workers that are not reimbursed for their assistance. Have MCOs reimburse for those positions.
2. Advertising for extra benefits and services available in the community with other organizations. Some MCOs communicate these opportunities, some don't, and the members don't know these extra services exist. Metro areas do a better job than rural areas.
3. I know I've mentioned this previously, but MCOs need to hold their subcontractors accountable, and need to be accountable for their subcontractors' work. We generally don't have difficulty getting our problems with payment/etc. resolved unless a subcontractor is involved.
4. The MCOs do not actually spend much on 'Value Added Benefits'. It's not really a factor in determining outcomes.
5. KABC agrees with the need to restore independent case management for the FE, PD and BI waivers.
6. I'm not sure how much has changed, but when I was providing services a few years ago it was very difficult to help clients access transportation and translator services for appointments. This needs to be as simple and easy as possible for providers and/or clients. This could also be a focus of MCO Care Coordinators.
7. Cover additional behavioral health services for Medicaid QMB members that Medicare doesn't currently cover.

8. I feel like MCOs need to understand how rural facilities and towns function. Some things that are offered on the MCOs are great but don't work for some areas that are small.
9. Transportation is also an issue for the consumers too. Transportation is not covered until they are on Medicaid, so an unmet spenddown means no transportation to their appointments.
10. Can the state provide a statewide system like findhelp and Unite Us that all providers can use to refer patients to for non-clinical (SDOH) needs?
11. Transportation programs should not be so cumbersome for the providers to run.
12. MCOs should make referrals to community-based providers and track and report referrals to community-based organizations.
13. I like transportation idea but who going to drive? We barely have people working in the areas we need help with already.
14. Require plans to demonstrate success with managing the Social Determinants of Health and Independence and incentivize MCOs that coordinate Medicaid with other funding sources and other community-based organization.
15. The transportation rates need to be higher for short trips. It is impossible to run a transportation program if we get reimburse $50.00 for a trip in rural areas.
16. Offer workshops around soft skills, resume development, grooming etc.
17. Peer support transportation programs like the arrangement between JoCo government/JCDS and Johnson County mental health.
18. Support for Targeted Case Management can help people meet many of these needs.
19. Transportation. Access to community-based sources that everyone uses.
20. Train both client and workers about resources that they might find available.
21. Improved access to transportation.
22. Rides to non-medical providers.
23. MCO educate Care Coordinators on the WORK and STEPS program to offer to their members. I often hear from consumers they know nothing about the programs or that this was an option.
24. They need to support things that are available or could be in the local communities.
25. The best thing for mental and physical health is working. MCOs should be full partners in employment first.
26. Care coordination promises a good deal but offers little to consumers in a timely manner.
27. TCM agencies lose money on TCM trying to serve people, and a lot of the things done by TCMs are unbillable activities because no one else will do it. The MCO should really be paying for this.
28. The MCOs could help supplement, not replace, services available in the local communities.
29. Rural communities don't always have all services individuals may need. People need to know they have a right to get the services they need in addition to what is in their local communities.
30. Need to make sure the care coordination and the TCM services are not contradictory, thus confusing to clients. Sometimes consumers get told something is not an option, so they do not get an actual denial to appeal. Without a formal denial people are stuck with no appeal rights.
31. Bug problems – used to have it, but it seems to have gone away
32. Transportation is a great service, but timely set up is difficult based on appointment time knowledge vs. what transportation services require for timing. Having the services be on time.

33. Reimbursement for community health workers.

What program or performance areas should be the focus for MCO pay-for-performance measures and liquidated damages?
Comments
1. Ensure capacity to provide services. There's no action by MCOs or consequence when there isn't a service offered. It's a major issue.
2. Pay for performance measures would be great to just see. Only one other state that has a Medicaid system set-up like we do. Maybe a presentation on a PFP program from the state in this process.
3. The only validated data the MCOs are evaluated on are HEDIS and NOMS. Other service data, cost data, or outcomes data has been reliably available, even to the EQRO and Legislative Post Audit.
4. Should your contract be continued a second or third time if you have never delivered any of the original outcome targets?
5. Instead of just having quantity indicators, it would be a game changer if the MCOs could show if the members are better off by having received the MCOs service. Quality outcomes.
6. Ensuring the goals and quality assurance are inclusive. Measuring health and independent living goals are different for individuals who may require 24/7 care to those individuals who are living independently and working full time.
7. While quality and health outcomes are important, pay for performance could be used to address many of the issues raised tonight, such as long credentialing times.
8. A performance measure regarding utilization of allowable hours of specialized medical care as well as other approved hours on plans of care.
9. For quality, is there any type of survey that could be given to consumers and providers to ask if their issue was solved in a timely manner? How many attempts did it take to reach a conclusion, timeliness of answering calls, etc.? Given at least 1-2 times a year? It would need to be done by someone unrelated to the MCOs/KDADS/KDHE.
10. A comment was made in passing related to the length of time credentialing takes. This is an excellent, important issue. The current delay in credentialing and enrollment is ridiculous.
11. Also need to see great improvement in provider directories for beneficiaries to be able to seek a provider. The current MCOs in general have very sloppy processes for keeping the credentialing up to date and communicating this to beneficiaries.
12. Can we institute a tobacco assessment quality measure?
13. Assessment of tobacco use among adults. The percentage of members 18+ years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. Tobacco use documentation (current/former/never use) with ICD-10 codes, examples include: F17.21 Nicotine dependence, cigarettes; F17.22 Nicotine dependence, chewing tobacco; F17.29 Nicotine dependence, other tobacco product.
14. Have teeth in all requirements that make the MCOs accountable.
15. Make the per member per month on HCBS significantly higher than the PMPM they get for nursing facilities and ALFs so there is actual incentive to do the WORK to help people live in their own home.
16. Specifically, regarding maternal health: MCOs need to provide evidence-based treatment for pregnant women who are smoking. Nearly half (48.6%) of mothers whose primary health

insurance was Medicaid in the month before pregnancy smoked cigarettes compared to 13.9% of mothers who had private insurance.
17. Before we can have pay for performance, we need to establish program wide metrics that are universally applicable to the provider network. Many services, especially for HCBS do not have those.
18. Require the MCOs report the ultimate outcome to service questions and service resolutions indicating if the consumer's issue was resolved successfully.
19. Incentives for MCOs and providers for evidence-based tobacco cessation treatments.
20. Add standards related to medical necessity.
21. Performance measures: moving people out of institutions, returning people to their homes from hospitalizations.
22. Network adequacy - MCOs need to arrange for providers of all types (medical, behavioral health) in all parts of Kansas - meaning incentivizing providers to work in rural areas.
23. Provide incentives to providers to engage with tobacco users to address cessation treatment.
24. We need transparency around the State monitoring requirements.
25. Performance measures for diversion.
26. Competitive Integrated Employment Outcomes.
27. Performance measures for diversion from nursing home/institutional settings!
28. Enforce caps on caseloads for Care Coordinators under 100, required number of interactions with consumers (monthly contact, in person quarterly), pay higher rate to MCO for community living vs. institutional setting.
29. Performance measures for how long it takes to get assistive technology items from request to member receiving the needed item(s).
30. There should be caps on how many people one care coordinator should be able to work with- even lower than 100. Should be a max of 50 or 60.
31. Engagement with those served at discharge from hospital stay.
32. Require MCOs to report their referrals to community-based organizations.
33. People served in community and not nursing homes.
34. Number of people employed.
35. Timeliness of response and service resolution.
36. P4P related to level of utilization for HCBS consumers. If people can't get staff for the POC, then the MCO's need an incentive to help people receive the services they are authorized for.
37. The advocacy community expects a robust negotiation and for there to be significantly increased accountability, transparency, and quality.
38. A requirement that MCO's must provide a formal denial for any services requested.
39. Better incentives to drive focus more toward community-based care. No need for low care persons to be living in institutions.
40. Have harsh penalties for MCOs missing deadlines on prior authorizations and denials.

General

What else do you want us to hear today?

Comments
1. Addressing needs, but also screening beforehand.
2. Better reimbursement.
3. Transparent reporting.
4. Is there an opportunity to address challenges with EPSDT for children in this RFP?
5. It is becoming harder to justify being a Medicaid provider based on processes required by MCOs. It's not about making money; it's about helping people. But MCOs have made it too difficult, and it is financially challenging for providers to continue being willing to accept Medicaid.
6. If we need help with an MCO, who can I email?
7. Elimination of step therapy practices
8. Also need to have TCM available when clients are hospitalized also!
9. TCM for all waivers.
10. MCOs should also host these types of forums for direct feedback from Kansas.
11. When the MCOs subcontract out part of their service--e.g., behavioral health or dental claims processing--the subcontractors are almost always less responsive. If we do have difficulty with a payment issue, it is incredibly difficult to get the subcontractors to respond, and the MCOs don't step in on our behalf.
12. Service data, cost data, and outcome data are not readily available, even to KDHE-DHCF. KDHE-DHCF cannot evaluate performance, and neither can stakeholders.
13. What are the key things you are looking for with this RFP
14. Can you share dates when the RFP will be released? Due to the state?
15. Are there fixes and improvements to current contracts that have already been identified? If so, are those available for public viewing.
16. It's hard enough for providers to deal with 3 MCOs.
17. Can you explain why some members do not have an MCO and are straight through KMAP?
18. Does the MCO have to follow the same rules and regulations listed in the Kansas Medicaid Fee for Service Manual? Specifically, recognizing a provider type as an acceptable billing provider.
19. Are you considering adding community, provider and other stakeholders to the review committee?
20. With CMS requiring EPSDT be covered through Medicaid for children under age 21, how will KMAP manage MCOs who limit access to care through the authorization process for OT/PT/Speech therapies in the future when the child has a developmental delay diagnosis?
21. How will the significant uptake in telehealth service delivery and participating providers due to the pandemic factor into the new RFP?
22. Curious about the process KDHE-DHCF will use considering the new CMS guide around Medicaid Managed Care contracting. Will the state share information with stakeholders to show how we are meeting these standards?
23. Kansas recognizes LMSW as an acceptable billing provider. Aetna Better Health won't honor that provider type.

24. Disparities remain in cigarette smoking among certain population subgroups, including people with behavioral health diagnoses and KanCare. Kansas adults with Kancare (35.3%) have significantly higher smoking prevalence than adults with private insurance plans. (12.3%) (KS BRFSS 2021). How does KanCare and the selected MCOs plan to address that disparity, or what expectations are there for the MCOs related to this?
25. Who at the state will investigate potential violations by the MCOs for EPSDT limits, provider recredentialing not following KMAP rosters, etc?
26. What services will MCOs be expected to provide for people with Intellectual Disability Disorders, if any?
27. What services will MCOs be expected to provide for people with Brain Injuries (ABI, TBI, etc.), if any?
28. Also, it would be great to include state employees w/relevant experience in the RFP proposal review, if they're outside of Medicaid - i.e. child health and rural health folks from KDHE, DCF child welfare Medicaid staff, etc. Though, it might be helpful to have them review the RFP, if allowed as state employees.
29. Will KanCare MCOs provide reimbursement for doula services in the next contract?
30. Can the approved providers and locations criteria for reimbursement of provided SBIRT services be expanded?
31. KMAP is hard to use with the updates.
32. I have had great experience with case managers from MCO come to do their yearly visits with our residents on our unit.
33. Spenddown expectations seem excessive for so many members.
34. Spenddowns for some are insane, along with some patient liability amounts, not sure how the amounts are figured, but I never come up with the same amount and the patients are left with way less than the $64 a month. Sometimes a negative amount.
35. Spenddown is so hard when living in a nursing type facility.
36. I recently had to help with a spenddown, and they won't give financial advice but then came back and questioned items that were bought. The family was very upset. Some expenses are not allowable that really should be. Like paying a premium each month to cover a funeral plan. Why is that not allowed in spenddown?
37. New KanCare contracts need to be designed to accommodate for the restoration of independent case management for the FE, PD, and BI waivers.
38. Increase reimbursement rates to expand the provider network.
39. In 2013 Kansas moved from a fee for service model, adopted a managed care model to serve Kansans receiving Medicaid long-term care supports and services. As a result of this action, the FE, PD, and BI waivers lost case management services. Without case management for home and community-based supports, Kansans have significant trouble managing and negotiating their in-home care needs, including managing provider related issues. As a result of this conflict of interest, caseload size and coverage area, the current community-based long term-care options are failing vulnerable Kansans. Compared to other states TCM or Independent Living Counseling services need to come back for consumers on the TBI, PD and FE waivers.
40. When getting through to KanCare on the phone it takes about 3 minutes before I can actually reach the number option. It needs to be made faster for people to choose the option they need sooner than that? Its time consuming and takes too long to reach anyone to assist. Sometimes the call gets cut off for consumers.

41. We must continually increase wages to keep our staff from going to another facility, yet Medicaid has not increased their fee schedule for some service in over 15 years! How can we stay competitive while trying to get good people to serve your members?
42. I know there is no way to be able to cover every single item to buy or not buy, but better guidance would help especially when the spenddown needs to happen quick because with nursing type the person has to live in the facility to apply for it.
43. Has KanCare advocated for any provider cost relief at all for providers who endured servicing Covid-19 patients?
44. Just because someone is older doesn't mean they don't deserve to have the help they need. One hearing aid every four years? Hearing aid as in one ear not both ears. No dentures?
45. Has it been decided that family members can continue being paid as an HCBS care provider? It was allowed for COVID but there was talk it was going away. With it being hard to find staff to begin with, it should continue to be allowed.
46. MCO phone staff should be assisting with updating addresses, which then goes to the KanCare system. I'd love to know more about MCOs helping with the renewal paperwork itself though.
47. This year will be my first time helping with renewals. Only interactions I have had with MCO is when they come to do their yearly visit. I work in a CAH with a senior living unit. That is the only help or communication I ever have unless I call to ask a question. I have families worried about renewals. No one thinks applying or renewing is easy. But I have worked care coordination and know their case loads are huge.
48. Independent care plan development is needed to avoid conflict of interest.
49. Dentures should be available to anyone who needs them, not just on a waiver!
50. Deep cleaning for dental.
51. Expand dental services for Medicaid recipients.
52. Dental health is health. It isn't a special, separate thing.
53. Dental, eye, and hearing!
54. Transportation is a major issue in people being able to be employed, go to grocery store, and even get out in their community and live independently. Providers don't always provide transportation and aren't able to due to the staff limitations and expense.
55. I just want to know how to easily and effectively help families apply for help. Rural Kansas can be so hard when needing any type of help. Or better access to the experts at least.
56. With the continued shortage of skilled beds in rural Kansas, it would be helpful for KanCare to allow a swing bed option similar to Medicare where hospitals can offer a short-term swing option without it being a set-aside bed. This would be incredibly helpful on short stays.
57. HCBS services should be retro eligible, especially for facilities.
58. IL Centers (specifically SKIL) can help with renewals in Southeast Kansas.
59. When calling in to the Clearinghouse, the wait time can be up to 6 minutes or so. This makes getting help for our members difficult and cumbersome.
60. I am curious about current vocational/employment supports MCO's offer consumers.
61. Dental, vision and hearing, as well as behavioral health.
62. Having to talk to a new person each time you call clearing house and not all the notes were added from the last call.
63. Providers should be required to have admission privileges at local hospitals.
64. Calling Clearing House and not getting the same answer from a different person or not all the faxed info was there, but it was with the next person.
65. Random drug testing for members over the age of 18.

66. Clearing house things are missed and or not even processed right. I asked for a review of a case, and I did more work than needed and I found errors for them. I'm surprised they didn't call and ask me to work for them.
67. Do we know/can we know what other insurances are possibly interested in KanCare and becoming an MCO?
68. When helping a client with an application, KanCare chose the wrong MCO and on the application, it is clear as daylight which MCO they chose. When calling KanCare I wasn't allowed to correct the mistake, it was the client's job to call themselves to request the correction. It took so long for the member to fix a mistake made by KanCare. What can we do to make the correction faster and less complicated?
69. Find a good case worker. I have one who gave me their personal number. Probably shouldn't have but we work great together! Unit 7 is great at the clearinghouse.
70. Email with our unit 7 works great too.
71. I need a reliable person from KanCare. It was so embarrassing on my end. My job was to help the client get their application in and make the process faster and it was not that way at all that day, so stressful over something that should be simple.
72. If a provider is going to have MDD/MCO credentials, they should be required to have unrestricted admission privileges at the hospital closest to them. It motivates them to take care of their patients in clinic, where it is less expensive. Or they should be required to produce a written agreement to cover their patients on call – coverage which they may have to pay for because they are not doing the job, others are, and they should be paid.
73. I like this! I hope these meetings can become more often!
74. Meet and communicate with stakeholders more often.
75. Don't allow proprietary algorithms for determining hours on a POC with public dollars. Transparency.
76. A requirement can be made that you can't have proprietary algorithms or data - period - these companies would still be bidders but that needs to be made clear - the state owns the data/algorithms because its public funding.
77. We can talk about it or be about it!
78. FE/PD/BI need case management services to return.
79. Independent care plan development to avoid conflict of interest. There should be some parameters for who can get this and how It seems only those with loud advocates get offered a single case agreement.
80. Standard access to single case agreements which goes along with EPSDT access.
81. Overall stakeholders are looking for partnership. Make sure the next MCOs will be partners throughout the process, and don't select those who are in it for the money.
82. When MCOs have a subcontractor, accountability breaks down in that process. We want MCOs to advocate for us when their subcontractors are not meeting expectations.
83. SCA (single case agreements) – ex: child lives in rural area, nurse is hired at higher rate to give family the care needed is limited to 2 months. Then not able to care for that family due to large pay cut after SCA expires. Family should qualify for services for as long as needed. Stop using expirations for SCAs for rural/frontier areas.
84. Provider reimbursement rates are too low to continue doing business with Medicaid.

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Payor and Potential Bidder Questions

Are there any questions or comments?

Questions
1. As we collect our thoughts, will the state take written feedback post this session?
2. Would it be okay for us to provide a document to the State?
3. Is it accurate that from posting until submission KanCare would be looking for a 6-8 week turn around time?