



Q&A relating to KanCare and I/DD

General Questions:

“Isn’t it a bad idea to try to deliver home- and community-based services (HCBS) through managed care?”

Managed care is merely a financing mechanism. Managed care through the KanCare Managed Care Organizations (MCOs) is the financing mechanism that allows the state to pay for the outcomes it desired. The old Medicaid and Home- and Community-Based Services (HCBS) systems, with little accountability, are quickly going by the wayside across the country.

“Coordination of care is a good thing, and even those I/DD advocates who oppose KanCare agree. But aren’t there are other ways of ensuring care is coordinated? And isn’t the plan is only as good as state enforcement.”

The state gets what it pays for. In a fee-for-service system, such as is the care currently for HCBS for I/DD beneficiaries, the state pays for the volume of services provided regardless of outcomes. Under KanCare, the state pays for positive outcomes. In this case, it pays for coordination of care, employment supports and better supports for I/DD behavioral healthcare.

“How will this provide financial stability?”

When I/DD HCBS is included in KanCare, providers will enjoy stable reimbursement rates and persons with I/DD the stability of benefits and services as a result the KanCare contract requirements. If I/DD HCBS were to be carved out, those funding for those services becomes a vulnerable line-item in the state budget.

“Why can’t this be accomplished with just medical services for the I/DD population carved-in to KanCare?”

With long-term services carved in, the MCOs have a compelling financial incentive to keep the person in a home environment using the long-term supports the MCOs are paying for, rather than in an acute-care facility that is much more costly. The failure of the MCO to address medical issues early on will result in a bad outcome and cause the MCO to pay for much more expensive acute care and nursing-home care. More than 50 percent of the state’s I/DD providers are small and lack the clinical and behavioral care resources that a few large and long-standing CDDOs have. These resources—through better care coordination of the whole person, and not just long-term services and supports—will bring about better outcomes.

“What will happen to my case manager? I’ve been told that the MCOs will be taking over case management services.”

By state law, people on the I/DD waiver will keep their targeted case managers. Case management for the other HCBS waivers did become the responsibility of the MCOs. But due to state statute specifically addressing I/DD case management, and because relationships with persons with I/DD are more long-standing as compared to consumers on the other waivers, that is not how it will work for the I/DD waiver. Persons with I/DD waivers will retain their targeted case manager. These assurances are in the MCO contracts and/or state law.

<http://www.da.ks.gov/purch/EVT0001028.zip> The response is #489 in the Excel file labeled “Amendment Eight - Responses to Questions 01-13-12-1” at that link.

“I would love to see that in a contract. When I’ve asked if there’s anything in writing about that, I’ve been told there isn’t. And, even if there is, the contract is only as good as the state’s willingness to enforce it.”

An executive summary of the contract is at <http://www.kancare.ks.gov> and there is a link to all of the contract documents above.

Managed Care Organization/Performance Questions:

“Isn’t April, 2013, three months into KanCare implementation, too early to claim that long-term services have been successfully included and implemented under KanCare.”

There are other HCBS programs very similar to the I/DD waiver that were included in KanCare in January and have been functioning well for the more than 12,000 persons whose care and services are fully incorporated into KanCare. The problems that have arisen have been dealt with quickly.

“Problems have been quickly responded to.... that isn’t the same as problems being quickly resolved. One fairly large entity says it had to take out a line of credit just to make payroll due to delayed payments from the MCOs. Insurance companies are notorious for paying claims as late as possible because the longer they hold onto their money the bigger the profits are for them.”

The KanCare contract holds the MCOs to stringent payment guidelines and timeframes. There have been some payment issues revolving around billing practices. Go to the issues log on the KanCare website and you will see the state has been transparent about those issues and their resolutions. When the state and the MCOs have had problems brought to their attention, both have worked diligently to address them. With any transition this size, problems are to be expected. The issue you refer to with the line of credit has been resolved.

“I keep hearing stories about how disastrous the KanCare rollout has been and how many problems there have been with the non-I/DD HCBS services in KanCare.”

We have addressed problems as they have arisen through our frequent rapid response calls, through our KanCare Ombudsman, and through trouble-shooting by state staff. We have set up multiple avenues through which problems can be resolved. Many of the problem we see referred to by I/DD providers in forums or letters to the editor were either quickly resolved or haven’t been brought to the state’s attention.

“Given that the insurance companies are for-profit entities, where will their profit come from, without reducing services or payments to providers?”

The KanCare contracts stipulate that reimbursement rates cannot be reduced. Assessment for HCBS services will continue to be performed by CDDOs. MCOs will achieve outcomes through better coordination of care, resulting in fewer expensive hospitalizations, and better health care outcomes overall.

“The MCOs are for profit-companies beholden to investors. We all know who comes first when that is the case.”

Yes, the MCOs are for profit-companies, but so are many hospitals, nursing homes, mental health providers, substance-abuse providers and disability providers in the state. Like these other for-profit entities, the MCOs are beholden to the State of Kansas through a contract.

Access to Care Questions:

“What is to prevent providers from going under either because they are unable to absorb the administrative burden of dealing with three MCOs and three sets of requirements for filing claims, or being unable to continue operating due to delayed claims? If providers are forced to close their doors, who is going to provide services to the people who are being served now?”

As issues arise, the state and the MCOs are committed to addressing them quickly. It is difficult to look into the future and speculate. The Administration chose a system focused on outcome improvement through better care coordination instead of the alternative of cutting reimbursement rates, restricting eligibility and cutting services, which has happened in previous years.

For people with I/DD, a reduction in supports could pose serious health and safety risks. Do you expect providers to be able to absorb the cost of providing more services than are funded, or are providers supposed to just cut services off at the amount determined by the MCO, whether the person needs them or not?”

HCBS service levels will continue to be determined through an assessment completed by the CDDOs. Any enhancements or reductions to HCBS plans of care must be reviewed and approved by KDADS. The old HCBS system was more restrictive than the KanCare Care coordination model, in which there is more flexibility as to what can be provided. No forced reductions to HCBS are allowed during in the first 90 days of KanCare coverage. Following that period, any proposed changes must be approved by KDADS.

Legislation Questions:

“Legislation has been introduced that would allow the MCOs to perform the functions that CDDOs are performing now, and possibly case management and/or provide services as well. If an MCO is also the CDDO, then they'll have the ability to reduce services by simply finding people not eligible for them.”

This is a misrepresentation of facts being circulated by the provider system. The bill that was advanced out of committee a few weeks ago would not authorize the MCOs to act as CDDOs. The proposed bill would have addressed conflict-of-interest problems identified by two Legislative Post Audit studies from years past by requiring that CDDOs not be allowed to both complete the needs assessment that determines services and to provide services to the same person with I/DD. Information that has been put out by a provider association claiming that eligibility determinations and needs assessments (which determine the level of services consumers receive) would be done by the MCOs is patently false. Eligibility will continue to be determined by the CDDOs. The assessment to determine the HCBS level of services provided to persons with I/DD would still be determined by the CDDOs. **Under KanCare, MCOs will not be allowed to function as a CDDO and perform eligibility determination and needs assessments.**

“Most CDDOs in Kansas also provide services. Who would complete the eligibility determination and needs assessment if the CDDO is no longer permitted to serve in that capacity, per the pending legislation?”

CDDOs will continue to perform the same functions that they perform now. But they would not continue to perform those services for the same individual's case. If that bill were to become law, the service provision element of a CDDO would have to split off and form a separate entity with a separate board in order to eliminate the conflict of interest identified by the Legislative Post Audit studies. The CDDO would still complete the eligibility determination and needs assessments. If the CDDO declined to do this, another CDDO would have to be contracted to perform the eligibility determination and needs assessments. These functions may not be performed by an MCO because the Developmental Disability Reform Act still stipulates that the CDDOs are responsible for carrying out these functions.

“The majority of case managers in Kansas are employed by agencies that also provide services. Who will provide case management if those agencies can no longer do so? The bill before the Legislature expressly states that individuals can get case management through their MCO. In other words, if the bill before the legislature passes, most CDDOs and case managers will no longer be allowed to function as such. Who will step in and carry out those responsibilities?”

It has been widely understood since the bill was introduced, that should the bill have been debated on the floor or should it be taken up in the future, an amendment would have been offered to eliminate the proposed case management changes in the bill so that a CDDO, independent targeted case manager or service provider, not an MCO, would still perform case management services.