



Understanding KanCare's continuing challenges and how these challenges impact the program's ability to meet its original rationale and commitments

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One of the critical issues that the Kansas Hospital Association (KHA), the Kansas Medical Society (KMS), and the Kansas Association of Medically Underserved (KAMU) focus on is evaluating current health care delivery systems, how those delivery systems can be improved, and how they can be leveraged to improve the health and quality of life for Kansas residents.

In January 2013, Kansas launched KanCare, which shifted the delivery of Medicaid to three managed care organizations (MCOs). The program operates under a CMS approved 1115 waiver, which must be renewed by January 2018.

Many stakeholders question how effective KanCare is given that significant challenges persist. To better understand whether these challenges are impacting the program's ability to meet its original rationale and commitments, KHA, KMS, and KAMU engaged with Leavitt Partners to complete a review of KanCare using both primary and secondary research including interviews (19), a voluntary survey of KMS members (189 respondents), and a review of federal and state documents and data related to the metrics and provisions outlined in the waiver's terms and conditions.

Highlights from this review are outlined in this brief.

KanCare's continuing challenges limit the program's ability to meet its original rationale and commitments

Improvement in Quality of Care

Commitment #1: Improve health outcomes for Medicaid enrollees

Commitment #2: Hold MCOs accountable to outcomes/performance measures

- There has been little to no improvement in the MCOs' HEDIS scores related to diabetes, coronary heart disease, and prenatal care over time and these scores generally fall below the 50th percentile.
- However, the MCOs' behavioral health related HEDIS results are positive, falling above the 50th percentile when ranked against other states.
- Providers feel that few improvements have been made in enrollees' health outcomes and that any improvement in care quality are provider driven.
- The most common areas mentioned that could benefit from quality improvement activities include: (1) diabetes management; (2) high-risk newborn care; and (3) prenatal care.

Improvements in Care Delivery

Commitment #1: Preserve and stabilize the safety net

Commitment #2: Improve quality through service integration

- Safety net clinic funding has been cut while administrative costs and the cost of care have grown.
- Providers feel there is very little activity related to the integration of physical health, behavioral health, and long-term services and supports (LTSS). For example, the fact that some MCOs subcontract with behavioral health entities perpetuates fragmented care.

Other Issues of Concern related to Care Delivery

- There is a strong desire for standardized credentialing and payment processes. This is despite MCO contracts including provisions to standardize work processes.
- Provider inquiries to MCO customer service centers regarding claims denial or status have increased since 2014. "Access to Service or Care" has also increased as a percent of total enrollee grievances since 2013.

Improvements to Health

Commitment #1: Promote wellness

Commitment #2: Encourage personal responsibility

- Across the three MCOs, the total number of KanCare enrollees with access to value-added services, or extra services designed to promote wellness, has fallen since 2014.
- Providers generally do feel KanCare encourages personal responsibility, which is reflected in declining ED visits.

Results from the interviews and the survey show that an overwhelming number of respondents do not feel KanCare has met its goals and commitments.

Of those who felt KanCare had not met its original goals and commitments, 66% of survey respondents indicated that it had not met the goal of preserving the safety net.

Most interviewees feel that access to care is being sustained by the providers in the system (rather than being improved by the MCOs). Additionally, frustration with KanCare is causing some providers to consider whether they can continue to offer care to Medicaid enrollees.

70% or more of KMS survey respondents ranked the following activities as being a "serious" or "moderate" challenge:

- **Prior authorization**
- **Claims submission, adjudication, and payment**
- **Referring or connecting patients to needed services**
- **Navigating different MCO policies**
- **Receiving information and timely communication from the state**

Controlling Costs

Commitment #1: Lower costs & reduce Medicaid spending growth

Commitment #2: Achieve savings without cutting provider rates

- While the data indicate the state has achieved savings in relation to the established benchmark, there are concerns regarding how MCOs are spending KanCare funding.
- The percent of MCO premium revenue that went to paying claims, known as MLR, has fallen each year and in 2015 was below the national benchmark of 85%.
- The percent of MCO premium revenue expended on administrative responsibilities, known as ALR, has also been below the national mean for Medicaid MCOs each year. While this may reflect efficiencies, it may also align with providers' experience of poor customer service.
- While the KanCare MCOs experienced significant financial losses in the first two years, reflected in a negative Underwriting Ratio (UW), the UW ratio reversed in 2015, resulting in overall financial gains more than double the national mean (5.9% v. 2.6%).
- The percent of claims the MCOs deny has increased since 2014.

Managed Long-Term Services and Supports

Commitment #1: Reduce use of institutional settings

Commitment #2: Expand home and community-based services

- Providers* feel the MCOs have not been helpful in placing individuals in the community and that access to community providers is limited due to low reimbursements.
- While some data show enrollment in nursing and other institutional facilities has declined, the percent of LTSS expenditures dedicated to HCBS has trended down in Kansas since 2009.

As a result of these findings, it is recommended the following changes be made to the KanCare program

- **Increase administrative simplification and standardization** across the MCOs, including standardized appeals, prior authorization, and credentialing processes. This could be accomplished by setting specific dates and expectations for compliance in the MCO contracts as well as reinstating pay-for-performance measures related to claims processing and credentialing. The state should also consider implementing a one-stop, electronic credentialing system.
- **Amend current MCO contracts to include a minimum MLR of at least 85%.** This would help to ensure that the MCOs comply with the Medicaid managed care rule and to ensure that the MCOs do not reduce medical or administrative expenditures to the point where care delivery is negatively impacted.
- **Increase oversight of the MCOs and transparency.** Interviewees noted that KDHE needs to be more involved in monitoring MCO systems and sharing results with providers.
- **Improved communication with the MCOs and improved communication with KDHE.** Despite the number of stakeholder meetings, many providers don't feel supported, engaged, or heard.

*Note: Seeking the experience of LTSS providers was not within the scope of this review so the provider experience reflected here comes from health care providers.

The administrative burden of dealing with provider payments has reached the point that providers feel the state is achieving savings by "shifting" the costs to providers.

Financial Metric 2013	National Composite Mean	Kansas
MLR	87.4%	100.0%
ALR	11.4%	11.1%
UW Ratio	1.2%	(11.2%)

Financial Metric 2014	National Composite Mean	Kansas
MLR	86.0%	97.3%
ALR	11.9%	8.4%
UW Ratio	2.1%	(5.7%)

Financial Metric 2015	National Composite Mean	Kansas
MLR	85.4%	83.4%
ALR	12.0%	10.7%
UW Ratio	2.6%	5.9%

Source: Milliman. Medicaid risk-based managed care: Analysis of financial results for 2013, 2014, & 2015.

One commitment KanCare has not met is achieving savings without cutting provider rates. In 2016, the state announced 4% rate cuts that apply across most providers. This is in addition to the reductions made to the safety net clinic grant program.

The impact of KanCare’s continuing challenges on its original rationale and commitments

	Data/Information	Provider Experience
Improvements in Quality of Care for Kansans Receiving Medicaid		
Implement long-lasting reforms that improve the quality of health and wellness for Kansans. By holding MCOs to outcomes and performance measures, and tying measures to meaningful financial incentives, the state will improve health care quality and reduce costs.		
Measurably improve health care outcomes for members in areas including: <ul style="list-style-type: none"> • Diabetes • Coronary Heart Disease • Prenatal Care • Behavioral Health 		
Improvements in Care Delivery		
<ul style="list-style-type: none"> • Preserve and stabilize the safety net. 		
<ul style="list-style-type: none"> • Improve quality in Medicaid services by integrating and coordinating services and eliminating current silos between physical health, behavioral health, mental health, substance use disorder, and LTSS. 	NA	
<ul style="list-style-type: none"> • Other issues of concern related to improvements in care delivery <ul style="list-style-type: none"> ➤ Value-Based Payments ➤ Communication ➤ Standardization of MCO Policies ➤ Provider Payments ➤ Access 		
Improvements to Health		
<ul style="list-style-type: none"> • Promote wellness and healthy lifestyles. 		
<ul style="list-style-type: none"> • Encourage personal responsibility by creating paths to independence. 		
Controlling Costs		
<ul style="list-style-type: none"> • Lower the overall cost of care and reduce growth in Medicaid spending by 8-10%; equating to 1/3 reduction in total Medicaid growth. • The state estimates savings of \$853 million (all funds) over 5 years (based on a baseline of 6.6% growth without KanCare reforms). 		
<ul style="list-style-type: none"> • Savings will occur without cutting provider rates, throwing people off the system, or reducing essential benefits. 		
Managed Long-Term Services and Supports		
<ul style="list-style-type: none"> • Reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired. 		
<ul style="list-style-type: none"> • Support members’ desire to live successfully in their communities. 		

Legend:

Based on assessed data and information related to KanCare’s commitments and challenges:

- The current system is meeting the stated rationale/ commitments.
- The current system is meeting the stated rationale/commitments, but improvements could be made.
- The current system is not meeting the stated rationale commitments.