KanCare Report: Effects on Providers and Consumers

Note: This report came about as a result of conversations among a group of non-profit executives participating in the Sunflower Foundation Advocacy Fellowship. During a convening of the advocacy fellows almost a year ago, KanCare was discussed. An advocacy fellow in the group decided to conduct and document interviews with stakeholders to understand how KanCare would impact providers and Medicaid consumers.

This report includes perspectives on KanCare from both advocates and providers. These perspectives were gathered through interviews and a survey of media stories from the first half of 2013.

The transition to KanCare has been a mammoth, complex task. The State of Kansas, Managed Care Organizations, and medical providers have put in countless hours in order to make this new system work, and progress has been made. While there have been good intentions from all parties involved, the transition has been hard for many providers and Medicaid consumers. This document provides information, stories, and issues about the KanCare transition for the benefit of the Oversight Committee so that they may ensure Medicaid consumers receive the very best care.

KanCare's Effect on Providers

The switch to KanCare has impacted Medicaid providers. The first few months were trying, as the MCOs and providers learned how to work with each other in the new system. The transition affected some providers more than others, with certain providers saying they have had relatively few problems and others stating the experience has been a major stress to their organizations. Several areas of concern have emerged.

Delayed Payments

Many providers have had some problems with delayed payments, especially at the beginning of 2013. According to the Kansas Health Institute (KHI), some have had to cash in CDs or open up new lines of credit in order to make it through the first part of the transition. In June, Doug Wisby, president of Multi-Community Diversified Services, stated in the McPherson Sentinel that he expects many smaller health centers to close. During the beginning stages of KanCare, Dr. Sharon Lee of Southwest Boulevard Family Health Care Services decided to go without her normal paycheck for twelve weeks in part because of delayed payments. Though it appears most of these delayed payments have since been paid, many still struggle to get reimbursed. One provider in Wichita was still working in July to get paid for claims filed in January. She said they are owed around $18,000 total from all three MCOs, a large amount for a small provider, and that they are really having to "tighten their belts" financially to get by. Other providers have also said they are working on claims from as far back

as January. Kristen Feldmann is an independent provider under the Autism Waiver in Mission, KS who had a lot of problems with delayed payments from Amerigroup in the early months of KanCare. She would log in a whole week of work and only get paid for one seemingly 'random' day during that week. The payments came more regularly as time went on but then in June, she was only paid $24 out of $1300 owed. Others, such as Cari Barlett from the Wichita Ear Clinic have reported being overpaid for claims, presumably so that the MCO is able to make the payment within the state-designated time period. This creates the problem that the claim will have to be reprocessed later, creating more work for the providers.

Prior Authorizations (PAs)

Many providers have mentioned problems with prior authorizations since the KanCare switch. They have been required to fill out more PAs and there have been reports of difficulties in obtaining the authorizations in a timely manner. Providers are finding they have to file prior authorizations for services they did not have to before KanCare. These services include dental, durable medical equipment, prescription drugs, and routine procedures. There have also been a number of reports of confusion about what needs an authorization and what does not. A number of providers, such as Anita Kimmel from Great Plains of Ottawa County, said difficulties in getting authorizations have been a major barrier to getting delayed payments resolved. One home health provider has had ongoing prior authorization problems since the beginning. The provider's office manager said the HCBS prior authorizations did not show up for a long time and once they did, they kept on changing. Having to deal with new and difficult-to-receive authorizations has provided a lot of additional work for this small provider. The office manager says she still has difficulties but that some of the more recent authorizations have come back more quickly.

Pharmaceutical Reimbursement

There are also concerns about pharmacy reimbursements, especially for smaller, independent pharmacies that cannot purchase their drugs as cheaply as chain pharmacies. Ron Booth of Corner Pharmacy in Leavenworth, KS has spoken out about not getting reimbursed at cost for drugs, and then having reimbursement appeals denied. According to KHI, "since KanCare started he (Booth) has served hundreds of his customers at a loss and turned away more than that because he could no longer afford to fill their prescriptions." All three MCOs are reported to have different maximum allowable cost (MAC) rate sheets that they reportedly do not share with providers, even though they are required to publicize MAC prices. KDHE says they are looking into the problem and reports RX spending is up 8% from last year. Regardless, Mike Conline of Jayhawk Pharmacy and Patient Supply has said that if reimbursement does not improve, they might have to close.

Communication

Underlying the various problems already mentioned have been problems with communication with the MCOs and the additional levels of bureaucracy that

providers have to deal with in working with three different MCOs. Providers have described frustration with having three different standards and sets of paperwork for each of the MCOs. Growing pains must be overcome with three different organizations. There have also been complaints that once issues have been identified, it takes a long time to get them resolved. Several providers have said they feel this is because of the layers of bureaucracy in the managed care organizations preventing any one person from making a decision. Other problems some providers have faced include not receiving plans of care from the MCOs, difficulties finding specialists within the MCOs' coverage, and electronic systems, such as Authenticare, not working properly.

The KanCare Rapid Response call-in was created by the State of Kansas to provide more direct answers for providers with issues. This was effective for some, but others were not contacted by the MCO after these calls or are still trying to resolve issues presented at the call-in months ago. For example, one home health provider said when she called the Rapid Response line it took Sunflower Group two weeks to call her back about her issue. Months later, she is still dealing with the same issues, though some progress has been made. This provider said the MCOs and State are communicating with each other and her, which was not happening before, so she has hope things will improve.

Extra Work

Many providers have had staff working exclusively on the transition to KanCare. This has been true even of small providers, such as one in Wichita where a staff person said that in the first 3 months she only worked on the KanCare transition, and as of July continues to spend three-fourths of her time on it. Another provider said everyone at her office was doing the job of two people. KidsTLC had to hire 1.5 additional staff positions to manage the new paperwork from KanCare. While some of this extra work will lessen as MCOs and providers continue to learn from each other, some extra prior authorizations and other administrative work could continue indefinitely.

KanCare's Effect on Medicaid Consumers

The KanCare transition has also impacted Medicaid consumers, as some members have struggled to choose which of their regular doctors to keep, which MCO had the best benefits for them, and how to work the new system. Despite best intentions, Cayla Lewis of KAMU speculated that some people just gave up trying to figure it out. Unfortunately those are the voices that are often hard to hear. In choosing an MCO, Anna Lambertson of KHCC said some were enticed by the "value added services" only to find out later some of these services were limited to a very specific population.

One of these services is dental care. This was a positive addition to Medicaid services and quarterly reports have shown that many Medicaid consumers have taken advantage of it. However, many others say that this service is harder to access than they thought, due to their local dentist not accepting Medicaid or new

patients. In March, the Kansas City Business Journal reported that more than half of the counties in Kansas do not have dentists within the KanCare network. This means these consumers have to go out of town for dental care, a task that is much harder for this population due to lack of transportation.

The KanCare transition has also affected case manager/client relations. Under the new system case managers have much larger case loads, between 25-50 according to KHI. Case managers are unable to meet with clients as often, and many consumers have complained that it has been hard to get a hold of their case managers.

Some consumers have seen benefits arising out of the new Medicaid system. Mike Shields of KHI says he has heard from people who have gotten services approved in KanCare that were not before, with most of these being in the realm of durable medical equipment. Others have enjoyed having the transportation number directly on the KanCare card.

Providers have been working hard to make sure patient care has not been affected during the changeover, even while dealing with delayed payments or new administrative challenges. Despite the best efforts of all parties, there have been cases where continuity of care has broken down. Some concrete examples are as follows:

- Kristi Berning from Newton, KS is the mother of a daughter on Medicaid due to a severe seizure disorder. In January, her daughter was able to get her seizure medicine without incident. However, the next time she went to get a refill, the MCO wanted more information from the provider. After receiving it, they requested even more information, and the medical provider had to fill out a 'Med Watch' form. Part of the reason the MCO was having difficulties was because she needed two different strengths of a non-generic seizure medication. Because her doctor's office was small, they had a hard time keeping up with all the information requests from the MCO. Meanwhile, Kristi's daughter ran out of medication. The pharmacy forwarded a few more days of meds, but it wasn't enough. Her daughter was a without meds for a week before the MCO approved more medicine.
- A provider from Wichita reported having patients who needed medications, such as IV antibiotics, authorized the same day, but could not get the authorization for up to two weeks.
- Anita Kimmel of Great Plains of Ottawa County reported having patients not able to come back for timely appointments for rehabilitation therapy and home health patients being put on hold due to issues with the KanCare transition.
- Alice Weingartner of the Shawnee County Health Agency reported issues with the enrollment process. She described one patient who had to choose between their long-time specialist or PCP. She also said many patients who had been her agency's clients for a long time were assigned to another PCP and had to go through the process of switching back.

- As reported in the Topeka Capital Journal, Jill Bronaugh had two delayed prescriptions for her six year old son with severe medical problems. One medication was for Nexium to treat severe acid reflux and vomiting, which she was forced to pay for out of pocket.
- Anna Lambertson of the Kansas Health Consumer Coalition cited a number of issues consumers had faced due to the KanCare transition. One story is as follows: "One woman we spoke with described what she called a potentially life-threatening mental health crisis faced by her son. Her husband attempted to reach the son's MCO-appointed care coordinator, but was referred to another MCO representative. He left a message, and not until 48 hours later was his call returned, from an out of state office. When the call was finally returned, the MCO representative was only able to read information out of the policy manual that the woman and her husband had already read. It wasn't until after they relayed this story at a state-sponsored public forum later on that the care coordinator even called back to follow up."
- Anna Lambertson reported another woman has already been switched between several care coordinators. The woman routinely has trouble reaching them by phone when she has a question.
- Lambertson also stated that a frequent problem for consumers has been MCO-provided transportation. Some have said it works well for them, while others have reported difficulties arranging transportation or having it arrive late. One consumer told KHCC that their transportation was delayed for so long that they missed an appointment with a specialist and were told the next available appointment was in 4-6 months.
- KHI reported that Ron Booth's independently-owned pharmacy in Leavenworth has had to turn away hundreds of customers because he is not getting reimbursed at a high enough rate.
- According to Kansas First News, Albert Jones has been having trouble getting supplemental equipment for his CPAP machine, for sleep apnea, because the pharmacy says the state is behind on payments. The pharmacy has said that they will have to come take his equipment unless either the state starts paying or Jones pays for it out-of-pocket.

ID/DD Long-term Services

Despite organized pushback from ID/DD advocacy groups, the State will roll-in ID/DD long-term services starting January 2014. A pilot program is currently being conducted to help with this transition. The ID/DD carve-out debate has gotten more media attention than any other part of KanCare in recent months and a full report on it is not needed here. However, the concerns and problems listed in this report can serve as a learning opportunity so they are not repeated when the long-term services for the ID/DD population are rolled-in next year. The complexity of needs for this population's long-term care makes it all the more necessary to learn from KanCare's past successes and problems.

KanCare Issue Log

KDHE provided a written log of all the issues called in on their 'Rapid Response Call' that was held weekly each Thursday from 9-10 AM for the first six months of KanCare. The issue log recorded each question as well as the answers provided by the MCO and state representatives. The log was important as it provided valuable information to medical providers and was one of the only means of public accountability for the implementation of KanCare. Most of the issues are logged as being resolved on the same day they are called-in, even though many have to do with complex, long-standing problems. Talking to providers demonstrated that many of these issues were not resolved, though they had been referred on for resolution and thus no longer being considered by state of Kansas personnel.

For example: One provider, who wishes to remain anonymous, called on 4/16 with issues involving prior authorizations, especially with sunflower, and not being paid for claims. She also had problems with prior authorizations for waiver services being changed without notification. On the KanCare issue log, her call was issue number 557. The issue log states that her issue was resolved the same day. When I called her almost three weeks later, she said that nothing had changed yet with her situation. They were still having problems with prior authorizations, sunflower had denied all but one claim since January and they were owed a total of $8,000 from all three MCOs, a big strain for their organization. She said that after calling, it took Sunflower two weeks before they called her back.

The reason for such issues to be identified as "resolved" on the issue log is explained by Liz, a KMAP (Kansas Medical Assistance Program) representative: "Earlier on we had to make a decision as to whether we were, for the state issues log, just going to capture issues that were for state resolution or will we capture them all so people can see that they were brought up and treated in some way. So where we landed is that if it was an issue that the state needed to take action on or a systemic issue or a repeat issue, we would hold those as pending until they were considered to be addressed. But if it was an issue like many of them that you hear today where it's very specific to a provider, and the MCO has agreed to take it on and resolve it, we just reflect it which indicates it's been resolved by a referral."

The same use of "resolved" is used in KanCare's first quarterly report where the MCOs report near 100% call resolution within two days. Arguably, this use of the word "resolved" paints perhaps an inaccurate picture of how quickly the issues themselves are addressed and remedied.