Jonathan Jantz, MD, FAAP

1. **Limit the number of MCOs to two.** That would mean they still compete, but they would not present way too much variation in the way providers have to deal with them.
We realize KDHE wants "choice," but how much choice is there when almost all of the same things are covered? And how can the "choices" really be appreciated when the recipient really doesn't understand? Most people DON'T UNDERSTAND INSURANCE -- whoever they are and whatever insurance they have.
Further, each of the MCOs has idiosyncrasies that must be handled.

- UHC likes to differentiate between Title 21 and Title 19 in their group number, but neither of the others (AMR,SUN) do. This leads to duplicate profiles and denied claims.
- Sunflower can't seem to get their ducks in a row - we have had much difficulty with Sunflower managed care organization (MCO), and several area organizations just don't take them anymore. They just don't seem to be deep enough at the bench to handle changes, especially of the IT variety.
- Amerigroup is a GIANT PAIN on the preauthorization front.

For these reasons, it is not a good idea in our opinion to have 5 Medicaid contractors. It's hard enough to handle three MCOs.

2. In order to really evaluate effectiveness of care, an <u>analysis of the population served is important</u>.
a. **Evaluate the pediatric population and adult population separately** – they have widely different needs and vulnerabilities. The biggest health issue for pediatrics is immunizations and yearly health checks – "It's better to build healthy children than repair broken adults." – more cost effective, too.

b. **Consider population behavior issues** – for example, use of the emergency room for non-emergency items – there needs to be a nominal copay for the ER, unless admitted to the hospital which is what commercial insurances do. Also, an acute injury such as stitches or broken bone should be seen with no copay.

c. **Make PCP designations mean something**. The MCOs are careless about who they assign to us, and we have had obstetric patients on our panel and 80-year-old women. Further, our patients may be listed with a different provider and we take care of them and the other provider gets credit, or we are listed with a patient we have never seen, and we are dinged for the lack of care by another PCP.

In short, MCOs need to deliver **VALUE** for their price, and this needs to be tracked, with each MCO, each provider, each patient. This is exactly what computers are good at, and if MCOs will work proactively with the providers, we are sure this can be accomplished.

3. **All pediatric providers should be at the Rural Rate** – There is a shortage of pediatricians in Kansas, with no less than 6 open pediatric places, and KU is not producing enough capable pediatricians for any area except Johnson County. A better pay rate will help two ways. First, more pediatricians are likely to open their panels to see the Medicaid patients. Second, it will help practices that are not located in cities with medical school presence be more competitive in offering a fair salary to new pediatricians.

Further, the pay rate should increase with certain components:
a. A greater number of patients on the panel – ie, 500, 1500, 2000, etc.
We see doctors around us with 10-15 MDD patients, closed MDD panels, discharge of patients when they go on MDD. You can't force doctors to accept MDD, but you can incentivize it.

b. <u>Admission</u> privileges at a hospital – more and more doctors have decided to be "clinic-only," and the result is

- the rest of the medical community has to carry the load of after hours care in the form of "unassigned" patients, who may have to just be transported to Wichita/KC, which is expensive.

OR

- the practices/hospitals just can't recruit more pediatricians because they can't pay for them. Then it's more expensive because parents take patients to the ER or immediate care, where they get lower quality care (more antibiotics, steroids, breathing treatments), and no immunizations/well child checks.

4. **Eligibility and PCP/Title 19 or 21 all needs to be AT ONE WEBSITE** – this is a HUGE time-waster for us. AND we can't use our electronic eligibility checking for it, so it has to be done manually, one by one, which is expensive and a hassle and the reason practice business office staff hate MDD and advise doctors against taking it.

5. **Credentialing should be at one main site, or use CAQH, for ALL MCOs** – a recent discussion with another clinic administrator focused on $22,000 per provider to get credentialing done. And it isn't even finished yet. This is ridiculous in an age of computers and cloud-based information.