

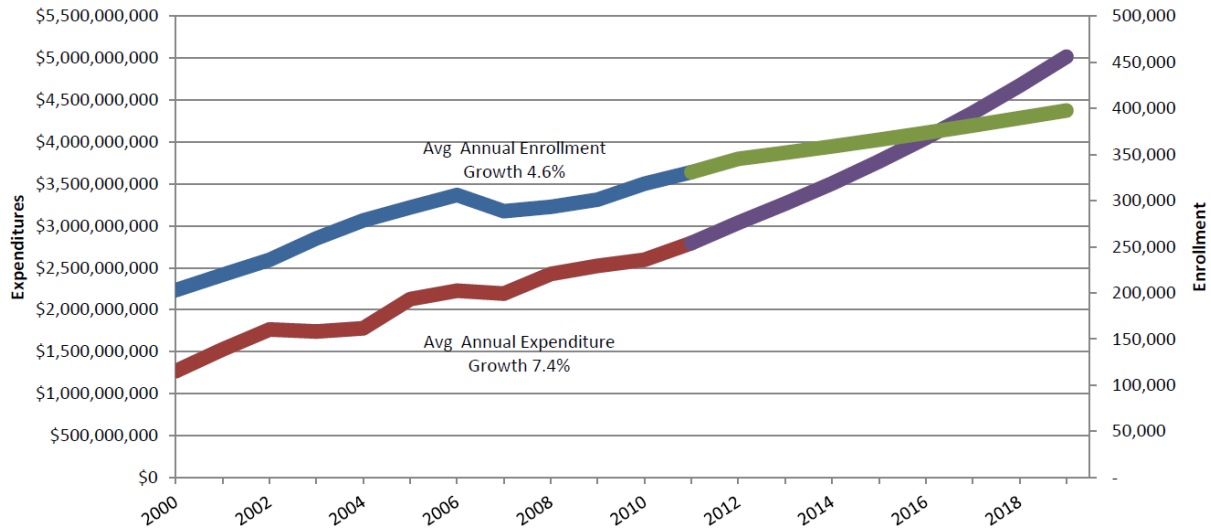
**STATE OF KANSAS
SECTION 1115 DEMONSTRATION, “KANCARE”
CONCEPT PAPER
January 26, 2012**

The State of Kansas (State), Department of Health and Environment (KDHE), is seeking Section 1115 demonstration waiver authority to fundamentally reform Medicaid in Kansas to improve outcomes and establish financial responsibility. This paper presents background on the urgent need for Medicaid reforms in Kansas, and the State’s development of a comprehensive Medicaid reform plan. It then outlines the State’s vision for a waiver that will proceed on two separate tracks. In the first track, the State will work with CMS to develop and implement by 2013 an integrated care system, “KanCare,” to provide Medicaid and CHIP services, including long term services and supports (LTSS), through managed care to all beneficiaries. In the second track, the State seeks to begin discussions with CMS to implement a global waiver that will administer an outcomes-based Medicaid and CHIP program under a per-capita block grant.

THE PROBLEM

Kansas Medicaid costs have grown at an annual rate of 7.4 percent over the last decade. Long-run trends in Medicaid are driven by widespread increases in enrollment and spending per person. While exacerbated by the economic downturn, Medicaid growth is not just tied to the economy. Kansas is in the midst of a sustained period of accelerated growth as baby boomers reach the age of acquired disability.

Figure 1: Historic Medicaid Growth, without expansion



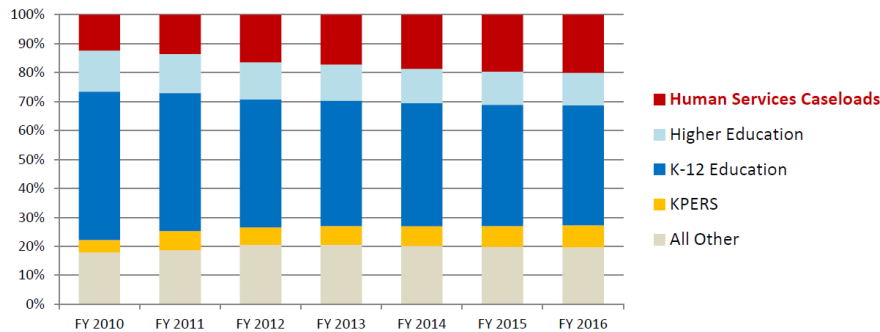
Yet the cost drivers in Medicaid are not confined to one service area or population. As Figure 2 illustrates, the projected sources of growth in Kansas Medicaid spending cut across populations. Tackling the structural deficit facing Medicaid cannot be accomplished by excluding or focusing solely on one population or service.

Figure 2: Projected sources of growth in Medicaid spending FY 2012-2017, without reforms

Percent of total growth	Aged Non-Waiver Population	Disabled Non-Waiver Population	Aged and Disabled HCBS Waiver Populations	Children and Families	Foster, MediKan and other populations	TOTAL by Service
Medical and misc. services	1%	14%	7%	22%	4%	48%
HCBS waiver services	0%	0%	25%	0%	0%	25%
Behavioral Health and Substance Abuse	0%	2%	3%	2%	1%	9%
Institutional care/PACE LTC services	11%	6%	1%	0%	0%	18%
TOTAL by Population	13%	22%	36%	24%	5%	100%

The State has determined that no short-term solutions—provider rate cuts, tweaks of eligibility requirements—could address the scale of the issue over time. Without intervention, projected Medicaid growth will continue to put downward pressure on other critical state priorities, including education and transportation.

Figure 3: The Crowd-Out Effect, Expenses as Percentage of State General Fund



FY 12-16 projected; illustrates impact on other programs if Medicaid growth continues unabated. Assumes projected deficits would be offset in other programs.

Just as important, focusing only on costs, to the exclusion of quality and outcomes, would be counterproductive. Kansas Medicaid historically has not been outcomes-oriented. The input the State has received from stakeholders and the public has validated the need for increased accountability in the services the State provides, and for a new level of investment in prevention, care coordination, and evidence-based practice.

KANSAS MEDICAID REFORM PLAN

In the summer of 2011, the State facilitated a series of Medicaid Public Forums, where more than 1,000 participants engaged in discussions on how to reform the Kansas Medicaid system. Forum participants produced over 1,500 comments and recommendations for reform. Web conferences were held with stakeholders representing Medicaid population groups and providers. The State also made a web-based comment tool available and received an additional 500 comments in that venue. A summary of the extensive process conducted in 2011 can be found at http://kdheks.gov/hcf/medicaid_reform_forum. The State carefully considered the input from this public process and, in November 2011, announced a comprehensive Medicaid reform plan.

The State's 1115 waiver will be designed to meet the goals of the State's reform plan. The goals are:

- improving the quality of care of Kansans receiving Medicaid;
- controlling costs of the program; and
- long-lasting reforms that improve the quality of health and wellness for Kansans.

The cornerstone of the reform plan is "KanCare," an integrated care system focused on improving health outcomes for Kansans that will bend the cost curve of Medicaid down over time.

WAIVER INITIATIVES

As set forth below, the waiver would proceed on two separate tracks simultaneously. In the first track, the State would implement by 2013 four major initiatives to reform its current Medicaid and CHIP programs: (1) move all Medicaid populations into managed care; (2) cover all Medicaid services, including LTSS, through managed care; (3) establish safety net care pools to reimburse uncompensated hospital costs and to provide payments to critical access and other essential hospitals; and (4) create and support alternatives to Medicaid. In the second track, the State would build on these initiatives under a global waiver that would administer outcomes-based Medicaid and CHIP programs under a block grant.

I. Track 1: Immediate Medicaid Reforms

A. Move All Medicaid Populations Into Managed Care

The State's current Medicaid program serves three distinct populations: (1) parents, pregnant women and children; (2) various disability groups (e.g., those with intellectual or physical disability (PD), or both, and persons with serious and persistent mental illness (SPMI)); and (3) seniors age 65 and older. Kansas' Medicaid eligibility criteria are narrow. For adult Medicaid recipients other than the SSI-based population, the income cutoff is 30% FPL.

Parents, pregnant women and children (low-income populations) are currently in a capitated, risk-based managed care program called "HealthWave," which serves both Medicaid and CHIP members. Roughly 238,000 are in this population. HealthWave services are provided through two managed care organizations (MCOs). Another 75,000 individuals are in the disabled group and about 30,000 are in the aged group. The HealthWave program is run under the state plan option to use managed care, Section 1932 of the Social Security Act (SSA). The aged and disabled (except those served under home- and community-based services (HCBS) waivers) currently receive care under fee-for-service (FFS) with, in some areas of the State, a primary care case management benefit (HealthConnect Kansas).

Under KanCare, the State will expand its Medicaid managed care program to include all Medicaid populations, including the aged and disabled, by January 1, 2013. In designing KanCare, the State will focus on the following themes:

- Integrated, whole-person care
- Creating health homes

- Preserving or creating a path to independence
- Alternative access models and an emphasis on home and community based services

All Medicaid and CHIP beneficiaries will be required to enroll in a managed care plan. All beneficiaries will be auto-assigned to an MCO upon enrollment, but may change plans for any reason for 45 days after assignment.

B. Cover All Medicaid Services Through Managed Care, Including LTSS

In Kansas today, the FFS and managed care populations receive the same package of state plan services, except that the two managed care plans, at their option, may offer some additional services. The package of state plan services covered is fairly narrow. Habilitation services may not be covered under the State Plan. Children receive rehabilitation services only under Early Periodic Screening, Diagnosis, and Treatment (EPSDT). Dental benefits are not provided to adult recipients.

Kansas has aggressively moved toward HCBS for its long-term care Medicaid population. The State Department of Social and Rehabilitation Services (SRS) currently administers six Medicaid waivers under Section 1915(c) of the SSA: (1) autism, (2) developmental disabilities, (3) physical disability, (4) technology assistance, (5) traumatic brain injury, and (6) serious emotional disturbance. SRS also administers a 1915(b)/(c) waiver for mental health (through a prepaid ambulatory health plan (PAHP)) and substance use disorder services (through a prepaid inpatient health plan (PIHP)), including services for adults with serious and persistent mental illness and youth with serious emotional disturbance. In addition, SRS administers a grant (under the authority of the Deficit Reduction Act of 2005) program to provide community-based behavioral health services for children as an alternative to placement in a Psychiatric Residential Treatment Facility (PRTF). In addition, the Kansas Department on Aging (DOA) administers a Medicaid 1915(c) waiver for the Frail Elderly.

All told, the Kansas Medicaid program is responsible for seven home- and community-based service waivers. Three of these waivers have substantial waiting lists.

KanCare Services. Under the initial phase of KanCare, the State will provide all Medicaid-funded services (except state-operated intermediate care facilities for the mentally retarded (ICF-MR)) through managed care, including LTSS. The State has determined that contracting with multiple MCOs will result in the provision of efficient and effective health care services to the populations currently covered by Medicaid and CHIP in Kansas, as well as ensure coordination of care and integration of physical and behavioral health services with each other and with HCBS.

In November 2011, the State issued a Request for Proposals (RFP) to obtain competitive responses from vendors to provide managed care for the Kansas Medicaid and CHIP programs.

Services included in the KanCare RFP are physical health services (including vision, dental, and pharmacy), behavioral health services, and long term care (LTC), including nursing facility (NF) care and HCBS. These services will be provided statewide and include Medicaid-funded inpatient and outpatient mental health and substance use disorder (SUD) services, including existing 1915(c) HCBS Waiver programs for children with a serious emotional disturbance (SED). Services for individuals residing in state-operated ICFs-MR will continue to be provided outside these contracts. Three statewide contracts will be awarded to winning vendors.

Population-specific and statewide outcomes measures will be integral to the MCO contracts, and will be paired with meaningful financial incentives. Moreover, the State intends to create health homes, with an initial focus on individuals with a mental illness, diabetes, or both. The State also intends to use Aging and Disability Resource Centers (ADRCs) to make functional eligibility determinations and provide information and assistance and options counseling. The KanCare RFP encourages contractors to use established community partners. Contractors will also be encouraged to refer enrollees to PACE programs where appropriate.

The contracts will include safeguards for provider reimbursement and quality, as well as provisions aimed at minimizing conflicts across assessment, case management, and service provision.

Home and Community Based Services. KanCare will include long-range changes to the delivery system by aiding the transition away from institutional care and toward services that can be provided in individuals' homes and communities. Kansas currently has the sixth highest percentage of seniors living in nursing homes in the country. Including institutional and long-term care in person-centered care coordination means KanCare contractors will take on the risk and responsibility for ensuring that individuals are receiving services in the most appropriate setting. Outcome measures will include lessening reliance on institutional care. The State intends to help nursing facilities build alternative HCBS capacity. The State will also develop, with a university research partner for implementation in 2014, a tiered functional eligibility system for the Frail and Elderly that restricts access to the highest cost institutional settings only to those with the highest level of need in order to utilize appropriate alternative home and community based settings.

Collaboration. KanCare will encourage providers to practice at the highest level of their licensed training, while reducing isolated, narrowly focused care provision. An example is engaging pharmacists to actively collaborate in managing patient education, compliance and self-management, particularly for patients with medications from multiple prescribers.

Inclusiveness. Services for Kansans with developmental disabilities will continue to be provided under the auspices of Community Developmental Disability Organizations (CDDOs), but their inclusion in KanCare means the benefits of care coordination will be available to them. MCOs will be accountable for functional as well as physical and behavioral health outcomes. Providing Kansans with developmental disabilities enhanced care coordination will improve access to health services and continue to reduce disparities in life expectancy while preserving services that improve quality of life.

Consumer Voice. Because these reforms were driven by Kansans, the State will form an advisory group of persons with disabilities, seniors, advocates, providers and other interested Kansans to provide ongoing counsel on implementation of KanCare. Additionally, MCOs will be required to create member advisory committee to receive regular feedback, include stakeholders on the required Quality Assessment and Performance Improvement Committee, and have member advocates to assist other members who have complaints or grievances.

KanCare Contracting Principles. In order to assure the highest level of service to Kansans, MCOs will be required to do the following:

- Undertake a health risk appraisal to identify health and service needs in order to develop care coordination and integration plans for each member
- Provide health homes to members with complex needs, starting with members who have a mental illness or diabetes, or both
- Take steps to improve members’ health literacy in order to make effective use of services and to share responsibility for their health
- Provide value-added services, at no additional cost to the state, to incentivize members to lose weight, quit smoking, participate in chronic condition management programs, and other health and wellness initiatives
- Create member Advisory Committees to receive regular feedback and to have Member Advocates to help members who have complaints and grievances.

The State will ensure performance by establishing significant monetary incentives and penalties linked to quality and performance, including:

- 3-5% of total payments will be used as performance incentives to motivate continuous quality improvement
- Additional penalties are associated with low quality and insufficient reporting
- Measures of plan performance will include prevention, health and social outcomes.

Savings. Based on a conservative baseline of 6.6% growth in Medicaid without reforms (the actual historic growth rate over the past decade was 7.4%), the outcomes-focused, person-centered care coordination model executed under the KanCare RFP is expected to achieve savings of \$853 million (total computable) over the next five years.

Savings	FY 13	FY 14	FY 15	FY 16	FY 17	5-year Total
All Funds	29,060,260	113,513,129	198,041,997	235,439,877	277,004,864	853,060,127
SGF	12,522,066	48,912,807	85,336,296	101,451,043	119,361,396	367,583,609

C. Establish Safety Net Care Pools

Kansas is also seeking to establish, as part of this waiver, safety net care pools that would permit payments from the State to hospitals based on uncompensated and non-hospital care, and payments from the State to critical access and other essential hospitals. In addition, the State is considering establishing an incentive program for hospitals that helps to create efficiencies in the health care delivery system (e.g., reducing hospital costs), but that would allow for additional revenue streams to hospitals that achieve defined cost containment and other measurable delivery system improvement outcomes.

D. Create and Support Alternatives to Traditional Medicaid

The State plans to develop and implement Medicaid “off-ramps,” i.e., programs to transition Kansans who are currently on Medicaid to private insurance coverage, such as a COBRA-like option, and Health Savings Accounts (HSAs) that can be used to pay private-sector health insurance premiums. For example, the State may propose a program under which certain Medicaid beneficiaries (e.g., families) could elect to receive an HSA instead of Medicaid, and would then be responsible for using it to obtain a high-deductible insurance plan. Other similar options are explicitly sought in the current RFP. Such programs will aid in the transition from Medicaid to independence while preserving relationships with providers. The State also plans to work with CMS on further development of PACE.

In addition, the State will request waiver authority to increase opportunities to work, particularly for the more than 2,000 disabled Kansans on Medicaid who have told SRS they want to find employment. An enhanced Medicaid to Work program will include collaboration with the Department of Commerce to match potential workers with employers. The State will focus its efforts on programs that will reduce the waiting lists for existing waivers. For example, the State may offer to individuals on particular waiting lists Medicaid health coverage and a monthly “capped” payment for personal assistance services and employment supports as those individuals seek and retain employment. Health coverage would end or be phased out, but supports would continue for a defined period. Individuals who select this option would leave the waiting list, but would retain the opportunity to reclaim their position during a limited transition period. The pilot would also work with youth and adults who have not yet received formal SSA disability determinations, to assist them in moving directly to employment with supports.

These programs would allow the State to offer a more targeted package of benefits that would supplement employer-sponsored coverage, as an alternative to the waiting lists. Another program under consideration would extend or replace transitional Medicaid up to three years for individuals exceeding the income threshold. One proposed option would provide funded HSAs to purchase a health plan as an alternative to Medicaid; other innovative proposals have been sought through the KanCare RFP.

Other elements of the State’s work programs may include:

- Reducing disincentives to work by enhancing Working Healthy and WORK program
- Creating a disability preference for state employment

- Leveraging state purchasing and incentive policies to encourage contractors to hire people with disabilities
- Establishing cash incentives for businesses that hire people with disabilities who are currently receiving state services
- Increasing awareness of the Kansas Use Law, intended to help provide employment for Kansans who are blind or severely disabled.

In order to implement the Track I waiver, Kansas seeks waivers of provisions of Section 1902 and costs not otherwise matchable under Section 1903 that include, but are not limited to:

Waivers

- Section 1902(a)(23) (freedom of choice) in order to enroll all populations in managed care, including for individuals specified at Section 1932(a)(2)
- Section 1902(a)(10)(B) (amount, duration and scope) in order to enable the State to offer demonstration benefits that may not be available to all categorically eligible or other individuals and to permit provision of a modified benefit package to individuals on the Section 1915(c) waiting list seeking employment

Costs Not Otherwise Matchable

- Expenditures for capitation payments in which the State auto-assigns enrollees and restricts enrollees' right to disenroll without cause to 45 days rather than the 90 days contemplated by Section 1903(m)(2)(A)(vi) and Section 1932(a)(4)(A)(ii)(I)
- Expenditures to provide home and community-based services that could be provided under the authority of Section 1915(c) waivers to individuals who meet an institutional level of care requirement
- Expenditures to enroll individuals who are receiving home and community-based services who would be eligible under 1902(a)(10)(A)(ii)(VI) and 42 C.F.R. § 435.217 if they were instead receiving services under a Section 1915(c) waiver
- Expenditures to pay, out of one or more safety net care pools, certain payments to hospitals for uncompensated care and for supplemental payments to critical access and other essential hospitals.

II. Track 2: Medicaid Redesign

KanCare is an important first step in improving health care for Kansans and controlling the spiraling costs in the Medicaid program. It is only a first step, however. Much more remains to be done, and for that Kansas will require a global waiver from CMS to maximize flexibility in administering the Medicaid program for the benefit of all Kansans. The State recognizes that this request will be breaking new ground and therefore believes it is imperative to begin those discussions now, on a separate but parallel track, so that it is ready to move forward as early as 2015.

Medicaid's status as an entitlement needs to be addressed. The State and federal government are spending hundreds of millions of dollars to provide benefits to individuals who otherwise could have access to alternative, affordable insurance. Tens of millions more are wasted on benefits that are mandated, where there are less expensive, more effective alternatives available. Nationally, actions to adjust provider payments are met with threats of litigation. The system is unsustainable, and it does not serve Kansans well, because the one entitlement that Medicaid does not promise is an outcome for a healthier population. Accordingly, in Track 2, the State will request broad flexibility in service entitlements, service delivery regulations, and Medicaid eligibility, in exchange for fixed federal costs (per capita), guaranteed savings and a commitment by the State to performance management and population-based outcomes.

Under Kansas' proposal, the State would receive a fixed global payment from the Federal government (with adjustments only for unanticipated enrollment), and would take responsibility for its own health system. The State would use the flexibility granted by CMS to redesign Medicaid to focus on critical outcomes—such as population-based measures of access to care and health care system performance—rather than outdated and unaffordable entitlements. The waiver would build on Kansas Medicaid's unparalleled, comprehensive program evaluation process and its leading health data measurement system.

Among other things, Kansas seeks authority for the following:

- Modifying the Medicaid entitlement for those who have access to affordable, accessible coverage
- Encouraging consumer choice and responsibility through HOAs or cash and counseling for recipients of all types
- Increasing personal responsibility through premiums and cost-sharing, e.g., increased premiums for CHIP families and for the federally mandated Medicaid expansion group of adults < 138% of poverty
- Implementing substantial payment reforms for medical care and other services to emphasize performance and outcomes at the provider level
- Coordinating care for individuals dually eligible for Medicaid and Medicare, including developmentally and physically disabled individuals
- Comprehensively identifying current need and effectively using prevention strategies, while streamlining access to needed services
- Mitigating reporting and administrative burden on providers, to support access to robust provider networks

This waiver would redefine the federal-state relationship in Medicaid and provide a model for reform of Title XIX in ways that honor the program's statutory goal of improving the health of Americans in the greatest need.