Curtis State Office Building
1000 SW Jackson St., Suite 540
Topeka, KS 66612-1367

Kansas
Department of Health & Environment

Phone: 785-296-0461
Fax: 785-368-6388
www.kdheks.gov

Robert Moser, MD, Secretary

Sam Brownback, Governor

KanCare
Section 1115 Demonstration Application

PUBLIC NOTICE

June 8, 2012

The State of Kansas hereby notifies the public that it intends to submit a Section 1115 demonstration proposal, "KanCare," to the Centers for Medicare and Medicaid Services (CMS). A copy of the proposed Demonstration application is available at www.kdheks.gov/hcf/kancare/download/KanCare_1115_application_public_comment.pdf, or at 900 SW Jackson, Room 900, Topeka, Kansas. Although the State has already conducted an extensive public input process relating to KanCare, the Department of Health & Environment (KDHE) has decided to open a formal public comment period and public consultation process in line with the new CMS public participation and transparency rules prior to formally submitting the application. We are providing this notice pursuant to CMS requirements in 42 C.F.R. § 431.408.

Demonstration Description, Goals, and Context

Currently, Kansas provides services to more than 380,000 Kansans through Medicaid and the Children's Health Insurance Program (CHIP), and this number is expected to rise. Approximately 238,000 low-income parents, pregnant women and children already receive Medicaid and CHIP services through a managed care program called HealthWave.

Kansas Medicaid costs have grown at an annual rate of 7.4 percent over the last decade. This growth is unsustainable. Short-term solutions like reducing services, provider rate cuts or changing the eligibility requirements will not address the structural issues within Medicaid that have led to this unsustainable growth rate. Moreover, care for our patients and clients is fragmented under the current program, and this lack of coordinated, integrated care can lead to less than optimal outcomes.

KanCare would improve Medicaid services and outcomes through four major initiatives:

(1) moving virtually all Medicaid and CHIP recipients into an integrated, whole-person-centered managed care model in order to better coordinate care;
(2) covering all Medicaid and CHIP services, including long-term support services, through this managed care model;
(3) establishing safety net care pools to ensure access to essential hospital services for our most vulnerable Kansans; and
(4) creating alternatives to Medicaid that provide needed support with greater independence for those who qualify.

Under KanCare, the State will expand managed care to virtually all Medicaid populations, including the aged and disabled, by January 1, 2013. Services provided at the two state-operated Intermediate Care Facilities for the Mentally Retarded will not be included in KanCare at this time. In designing KanCare, the State is focused on an integrated, whole-person care system; creating health homes for those with diabetes, chronic mental health conditions or both; preserving or creating a path off Medicaid to independence; and, developing alternative access models, care coordination, and an emphasis on home and community based services.

The plan is for all Medicaid beneficiaries to be pre-enrolled in a KanCare plan starting this fall. While beneficiaries initially will be assigned to a plan, they will be able to choose the plan they prefer during a 45-day enrollment period.

Three statewide managed care contracts will be awarded to winning vendors. Measuring population-specific and statewide outcomes will be integral to the KanCare contracts and will be paired with meaningful financial incentives. The selected bidders will be required to maintain current provider rates and services for Kansans on Medicaid. In addition, the KanCare request for proposal encourages contractors to use established community partners to deliver these necessary services.

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 will ensure performance by establishing significant monetary incentives and penalties for the plans that are 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.

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 for physical and behavioral health in 2013, and for physical, behavioral and long-term supports and services beginning in 2014, means the benefits of care coordination will be available to them. KanCare companies will be accountable for functional as well as physical and behavioral health outcomes. By bringing in additional resources, the KanCare plans will help provide enhanced care coordination for Kansans with developmental disabilities. Our goal is to improve access to health services and continue to reduce disparities in life expectancy while preserving services that improve quality of life.

Because these reforms were driven by Kansans, the State has formed an advisory group of persons with disabilities, seniors, advocates, providers and other interested Kansans to provide ongoing counsel on implementation of KanCare. Additionally, KanCare health plan companies will be required to create member advisory committees 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.

In conjunction with the implementation of the person-centered managed care model, KanCare would create up to four uncompensated care cost pools that would permit direct payments from the State to hospitals based on the uncompensated hospital cost of furnishing services to Medicaid and uninsured individuals (*i.e.*, individuals with no source of third party coverage for the inpatient and outpatient hospital services they receive).

The State has also proposed to develop and implement programs to transition Kansans who are currently on Medicaid to private insurance coverage. Such programs will aid in the transition from Medicaid to independence while preserving relationships with providers. Proposals include: (1) a pilot project offering a funded health account for the purpose of purchasing health services or paying health insurance premiums for members with Medicaid eligibility for at least three years, who would not reapply for traditional Medicaid for the next three years; (2) a COBRA-like option that would allow transitioning members to pay a sliding-scale portion of the applicable PMPM rate to maintain health coverage under their KanCare plan for a period of time after exceeding the Medicaid income threshold. Kansas will also seek waiver authority to increase opportunities for Medicaid recipients with disabilities to work.

In addition to the above-described initiatives, Kansas also has requested a second track of discussions, with the long-range goal of fundamentally reshaping Medicaid. That future global waiver would, as proposed, redefine the federal-state relationship in Medicaid and focus even more on outcomes and healthier Kansans.

For more on KanCare, including the full application, visit http://www.kdheks.gov/hcf/kancare/. CMS also offers online resources regarding the Section 1115 demonstrations, including the KanCare proposal, which can be viewed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html

Benefit Coverage

The State is not proposing reductions to the benefits currently offered through its Medicaid program, only requiring that such benefits will be offered through managed care. Services in KanCare will include physical health services, behavioral health services, and long-term care, including nursing facility care and home and community based services. Kansas's existing 1915 waiver authorities will be included in the KanCare Demonstration. The State intends for all 1915(c) services to be included in the managed care benefit package, and that the same amount of services will remain available to participants, based on individual need and existing service limitations. These waiver services will transition to KanCare beginning January 1, 2013, except those services under the 1915(c) waiver for individuals with intellectual and developmental disabilities and Targeted Case Management (TCM) for individuals with intellectual and developmental disabilities, which will be included in the managed care benefit package starting January 1, 2014.

KanCare 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).

In addition to State Plan services, KanCare contractors will provide value-added services for members at no additional cost to the State.

Eligibility Requirements

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 disabilities, or both; persons with serious and persistent mental illness); and (3) seniors age 65 and older. Kansas's Medicaid eligibility criteria are narrow. For adult Medicaid recipients other than the SSI-based population, the income cutoff is 30% of the federal poverty level. Eligibility tables, including categories and criteria, are included in Appendix C, Kansas Eligibility Tables, in the KanCare draft demonstration application, www.kdheks.gov/hcf/kancare/download/KanCare_1115_application_public_comment.pdf.

There are no proposed changes to current eligibility requirements.

Cost Sharing

Medicaid currently allows for nominal co-pays, typically no more than $3, and $48 co-pays for inpatient hospital services. The State's current managed care contractors do not charge co-pays, although beneficiaries may be charged co-pays for services not provided by the plans, such as dental services. The State also explicitly protects certain classes of beneficiaries and services from cost sharing (*e.g.,* American Indians receiving services from an Indian health provider, individuals receiving services under the breast or cervical cancer category, services provided to any beneficiary in a medical emergency).

Current protections, including federal regulations governing cost sharing, will continue to apply.

CHIP members may pay premiums up to $75, based on income. Select other eligibility groups may pay defined premiums or can be responsible for a portion of expenses, depending on income level, as detailed in Appendix C, Kansas Eligibility Tables, in the KanCare draft demonstration application, www.kdheks.gov/hcf/kancare/download/KanCare_1115_application_public_comment.pdf. The KanCare demonstration does not propose to increase premiums or impose new premiums.

Annual Enrollment and Annual Expenditures

The following table summarizes Kansas Medicaid/CHIP population expenditures and enrollment for populations to be included in KanCare, both historically as well as the period of the proposed demonstration. Historical years are shown as State Fiscal Years, while Demonstration years are shown as Calendar Years, given the January 1, 2013, implementation date. Historical data has been normalized to adjust for program changes.

Historical	SFY 07	SFY 08	SFY 09	SFY 10	SFY 11	Average Trend
Medicaid/CHIP Enrollment (member months)	3,665,337	3,653,813	3,767,748	4,075,157	4,427,823	4.84%
Medicaid/CHIP Population Expenditures	$2,082,685,608	$2,318,932,933	$ 2,433,266,382	$2,518,485,545	$2,716,871,135	6.87%

KanCare	CY 2013*	CY 2014	CY 2015	CY 2016	CY 2017	Average Trend
Medicaid/CHIP Enrollment (member months)	5,008,877	5,167,465	5,340,903	5,520,233	5,705,595	3.31%
Medicaid/CHIP Population Expenditures	$2,906,602,881	$3,028,862,798	$3,180,355,247	$3,341,300,840	$3,503,307,100	4.78%

* LTSS for individuals with Intellectual/Developmental Disabilities will not be included in KanCare in CY 2013, but associated expenditures are included in this table.

KanCare will reduce the rate of growth of Medicaid costs by improving care coordination and outcomes.

Hypotheses and Evaluation Parameters

The State will submit to CMS for approval an evaluation design for the Demonstration no later than 120 days after CMS approval of this Demonstration. The State will test the following research hypotheses through KanCare:

1. 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.
2. The KanCare model will reduce the percentage of beneficiaries in institutional settings.
3. The State will improve quality in all Medicaid and CHIP services by integrating services and eliminating the current silos between physical health services, behavioral health services, and long term care.
4. Providing health homes to individuals with complex needs will improve quality and reduce costs.
5. Extending a limited package of services to individuals who are not eligible for Medicaid or who are on the waiting list for waiver services will reduce costs, improve outcomes, and promote independence.
6. Providing integrated care coordination to individuals with developmental disabilities will improve access to health services.

The State's evaluation design for the KanCare Demonstration will:

- Test the hypotheses described above;
- Describe specific outcome measures that will be used in evaluating the impact of each Demonstration-related program during the period of approval;
- Detail the data sources and sampling methodologies for assessing these outcomes;

- Adapt applicable research questions and methodologies from the CMS-sponsored Money Follows the Person Grant Program, so that Kansas' planned reforms can be viewed within a national context;
- Describe how the effects of all Demonstration-related programs will be isolated from other initiatives occurring in the State; and
- Discuss the State's plan for reporting to CMS on the identified outcome measures and the content of those reports.
- No later than 60 days after receiving comments on the draft evaluation design from CMS, the State will submit the final design to CMS. The State will submit progress reports in quarterly and annual Demonstration reports, and submit a draft final evaluation report within 120 days of the expiration of the Demonstration.

Waiver/Costs Not Otherwise Matchable

In order to implement the waiver initiatives, 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 provide a limited package of benefits to individuals who are not enrolled in Medicaid but who are on a waiting list for home and community based services (or could be if determined disabled) and would be eligible under 1902(a)(10)(A)(ii)(VI) and 42 C.F.R. § 435.217
- 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

Comments and Public Input Process

The development of KanCare has been a public process for the past 18 months, as outlined in the application now posted for comment. Members of the public have had the opportunity to comment on the proposal via dedicated email from the State's website since April 26, and before that on the initial concept paper submitted in January 2012. Consistent with that spirit of transparency and as required by federal regulation, the State is now opening a formal 30-day comment period and again directs interested parties to the KDHE website, http://www.kdheks.gov/hcf/kancare/.

Please submit any comments or questions to KanCare@kdheks.gov or ATTN: Rita Haverkamp, KDHE-DHCF, 900 SW Jackson, Room 900, Topeka, KS 66612. Comments will be accepted for consideration until July 14, 2012.

KDHE will hold two public meetings to solicit comments on the KanCare proposal:

- **June 18, 2012 at 2 pm**:
  Hughes Metropolitan Complex
  Wichita State University
  5015 E. 29th St. N
  Wichita, Kansas

- **June 20, 2012 at 3 pm**:
  Memorial Hall Auditorium
  120 SW 10th Ave.
  Topeka, Kansas

Any individual with a disability may request accommodation in order to participate in either meeting. Requests for accommodation should be made at least two working days in advance of the meeting by contacting KanCare@kdheks.gov or calling Rita Haverkamp at (785) 296-5107.

As a courtesy, the State is also making teleconference access available for the June 20 meeting. Please see the KanCare website at www.kdheks.gov/hcf/kancare for dial-in information.