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Section 1115 Waiver Concept Paper

EXECUTIVE SUMMARY

January 31, 2012

On November 8, 2011, Governor Brownback announced that Kansas will be seeking a waiver from the Centers for Medicare & Medicaid Services (CMS) to develop a reformed Kansas Medicaid system that will be called KanCare. The concept paper for that waiver was sent to CMS on January 26, 2012. The Administration is committed to improving outcomes for consumers and curbing the cost of Medicaid, all without scaling back eligibility or cutting rates for health care providers.

The waiver will enable Kansas to implement four major initiatives to improve Medicaid: (1) move all Medicaid populations into an integrated, person-centered care model; (2) cover all Medicaid services, including Long Term Support Services, through that model; (3) establish safety net care pools to ensure access to essential hospital services; and (4) create and support alternatives to Medicaid.

Currently, Kansas Medicaid costs are unsustainable; care for many of our most vulnerable is fragmented, and the outcomes fall short. Tackling the structural deficit facing Medicaid cannot be accomplished by excluding or focusing solely on one population or service. Also, no short-term solutions—provider rate cuts, tweaks of eligibility requirements, or reducing services—will address the scale of the issue over time.

Kansas provides services through Medicaid and the Children's Health Insurance Program (CHIP) to more than 380,000 Kansans. HealthWave (serving low-income families, pregnant women and children) is a managed care program that already provides services for nearly two-thirds of the Medicaid and CHIP population. Under KanCare, the State will expand care management to all Medicaid populations, including the aged and disabled, by January 1, 2013. In designing KanCare, the State is focused on an integrated, whole-person care system and creating health homes for those with diabetes, chronic mental health conditions or both. KanCare will preserve or create a path off Medicaid to independence and help develop alternative access models, care coordination and an emphasis on home and community based services.

The plan is for all Medicaid beneficiaries to be enrolled in a KanCare plan starting this fall. While beneficiaries initially will be auto-assigned, they will be able to choose the plan they prefer during a 45-day enrollment period. After initial enrollment in January 2013, new beneficiaries will be able to select which of the three health plans in which they want to be enrolled.

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.

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. 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 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, KanCare health plan companies 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.

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.

The waiver concept paper submitted on January 26 will begin discussions with the federal government about the policies needed to implement KanCare, but in it Kansas also requests a second track of discussions, with the long-range goal of fundamentally reshaping Medicaid. That future global waiver would, as we propose it, redefine the federal-state relationship in Medicaid and focus even more on outcomes and healthier Kansans.

For more on KanCare, visit http://www.kdheks.gov/hcf/kancare/.