CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: **11-W-00283/7**

TITLE: **KanCare**

AWARDEE: **Kansas Department of Health and Environment**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration project beginning the date of the approval letter through December 31, 2023, unless otherwise specified. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of the state plan requirements contained in section 1902 of the Act are granted in order to enable Kansas to implement the KanCare Medicaid section 1115 demonstration for state plan populations and individuals eligible under the concurrent section 1915(c) waivers.

1. **Amount, Duration, and Scope of Services** **Section 1902(a)(10)(B)**

   To the extent necessary to enable Kansas to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, by providing additional services to individuals who are enrollees in certain managed care arrangements.

2. **Freedom of Choice** **Section 1902(a)(23)(A)**

   To the extent necessary to enable Kansas to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services. No waiver of freedom of choice is authorized for family planning providers.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00283/7**

TITLE: **KanCare**

AWARDEE: **Kansas Department of Health and Environment**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures for services furnished or uncompensated safety net care costs incurred by providers during the period of this demonstration made by Kansas for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall be regarded as expenditures under the state's title XIX plan.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable Kansas to implement KanCare Medicaid section 1115 demonstration.

I. SERVICE-RELATED EXPENDITURES

1. **Expenditures for Additional Services for Individuals with Behavioral Health or Substance Use Disorder Needs.** Expenditures for the following services furnished to individuals eligible under the approved state plan and concurrent 1915(c) waivers, pursuant to the limitations and qualifications provided in STC 19 to address behavioral health and substance use disorder needs:

    a. Physician Consultation (Case Conferences);

    b. Personal Care Services; and

    c. Rehabilitation Services.

2. **Residential Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental disease diseases (IMD).

3. **Disability and Behavioral Health Employment Support Pilot Program:** Pursuant to STC 22, expenditures for services furnished to (a) certain Medicaid eligible individuals (1) with specific behavioral health conditions who are also SSI or SSDI eligible or (2) on a 1915(c) waitlist for employment supports, independent living skills training, personal assistance, and transportation to encourage employment, and (b) medical assistance for SSDI eligible individuals not otherwise Medicaid eligible that also includes employment supports,

independent living skills training, personal assistance, and transportation to encourage employment.

SAFETY NET CARE POOL EXPENDITURES (SNCP): Expenditures for the following categories of expenditures, subject to overall SNCP limits and category- specific limits set forth in the STCs.

4. **Uncompensated Care Pool (UC Pool):** Pursuant to STC 53, expenditures for payments to hospitals to defray hospital costs of uncompensated care furnished to Medicaid-eligible or uninsured individuals that meets the definition of "medical assistance" under section 1905(a) of the Act, to the extent that such costs exceed the amounts received by the hospital pursuant to 1923 of the Act.

5. **Delivery System Reform Incentive Payment (DSRIP) Program:** Expenditures from pool funds for the Delivery System Reform Incentive Payment (DSRIP) Program, pursuant to STC 54, for incentive payments to hospitals for the development and implementation of approved programs that support hospital efforts to enhance access to health care and improve the quality of care. DSRIP incentive payments are not direct reimbursement for service delivery, and may not duplicate other federal funding. This funding is only for DY 7 – DY 8, and in DY 9 this expenditure authority will expire.

REQUIREMENTS NOT APPLICABLE TO EXPENDITURE AUTHORITY 3

All title XIX requirements that are waived for Medicaid eligible groups are also not applicable to the Voluntary Work Pilots. In addition, the following Medicaid requirement is not applicable:

1. **Comparability** **Section 1902(a)(10)(B)**

   To the extent necessary to enable Kansas to restrict comparability through the use of a voluntary work pilot for those on a 1915(c) waitlist, 1915(c) waiver participants who choose to leave the 1915(c) waiver to participate in the pilot, or those with specific behavioral health needs.

2. **Reasonable Promptness** **Section 1902(a)(8)**

   To the extent necessary to enable Kansas to restrict reasonable promptness to allow a cap of 500 individuals to participate in the voluntary work pilot.

CENTERS FOR MEDICARE & MEDICAID SERVICES SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00283/7**

TITLE: **KanCare**

AWARDEE: **Kansas Department of Health and Environment**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Kansas' KanCare section 1115(a) Medicaid demonstration (hereinafter "demonstration"). The parties to this agreement are the Kansas Department of Health and Environment (state) and the Centers for Medicare & Medicaid Services (CMS). CMS has granted the state waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs that are not otherwise matchable, which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to this demonstration. The demonstration will be statewide and is approved for a 5-year period from January 1, 2019 through December 31, 2023, with implementation no sooner than January 1, 2019.

The STCs have been arranged into the following subject areas:

Attachment E.	UC Payment Application Template
Attachment F.	DSRIP Planning Protocol
Attachment G.	DSRIP Funding and Mechanics Protocol
Attachment H.	Ombudsman Plan
Attachment I.	Verification of Beneficiary's Enrollment
Attachment J.	UC Pool Uniform Percentages
Attachment K.	DSRIP Pool Focus Areas
Attachment M:	Developing the Evaluation Design
Attachment N:	Preparing the Interim and Summative Evaluation Reports
Attachment O:	Reserved for Evaluation Design
Attachment P:	Reserved for SUD Implementation Plan Protocol
Attachment Q:	Reserved for SUD Monitoring Protocol
Attachment R:	Reserved for SUD Health IT Plan

II. PROGRAM DESCRIPTION AND OBJECTIVES

On December 26, 2017, the State of Kansas submitted a Medicaid section 1115 demonstration renewal application, entitled KanCare. KanCare will continue to operate concurrently with the state's section 1915(c) Home and Community-Based Services (HCBS) waivers. It will build on the success of the current KanCare demonstration, which focused on providing integrated and whole-person care, creating health homes, preserving or creating a path to independence, and establishing alternative access models with an emphasis on home and community-based services (HCBS). The goal for the KanCare extension is to help Kansans achieve healthier, more independent lives by coordinating services and supports in addition to traditional Medicaid benefits. This represents an expansion of the state's previous demonstration to further improve health outcomes, coordinate care and social services, address social determinants of health, facilitate achievement of member independence, and advance fiscal responsibility.

This five year demonstration will:

- Maintain Medicaid state plan eligibility;
- Maintain Medicaid state plan benefits;
- Continue to allow the state to require eligible individuals to enroll in managed care organizations (MCOs) to receive covered benefits through such MCOs, including individuals on HCBS waivers, except:
  - American Indian/Alaska Natives will be presumptively enrolled in KanCare but will have the option of affirmatively opting-out of managed care.
- Provide benefits, including long-term services and supports (LTSS) and HCBS, via managed care;
- Extend the Delivery System Reform Incentive Payment (DSRIP) program; and
- Design and implement an alternative payment model (APM) program to replace the DSRIP program
- Maintain the Safety Net Care Pool to support hospitals that provide uncompensated care to Medicaid beneficiaries and the uninsured.
- Increase beneficiary access to substance use disorder (SUD) treatment services.

- Provide work opportunites and support for individuals with specific behavorial health conditions and other disabilities.

The KanCare demonstration will assist the state in its goals to:

- Help Kansas Medicaid beneficiaries achieve healthier, more independent lives by coordinating services to strengthen social determinants of health and independence, and person-centered planning;
- Promote higher levels of member independence through employment programs;
- Drive performance and improve quality of care for Kansas Medicaid beneficiaries by integrating value based models, purchasing strategies and quality improvement programs; and
- Improve effectiveness and efficiency of the state Medicaid program with increased alignment of MCO operations, data analytic capabilities and expanded beneficiary access to SUD services.

The state's demonstration evaluation will include an assessment of the following hypotheses:

1. That value-based models and purchasing strategies will further integrate services and eliminate the current silos between physical health services and behavioral health services, leading to improvements in quality, outcomes, and cost-effectiveness.

2. That increasing employment and independent living supports for members who have disabilities or behavioral health conditions, and who are living and working in the community, will increase independence and improve health outcomes.

3. That the use of telehealth (e.g., telemedicine, telemonitoring, and telementoring) services will enhance access to care for KanCare members living in rural and semi-urban areas. Specifically:

    a. Telemedicine will improve access to services such as speech therapy

    b. Telemonitoring will help members more easily monitor health indicators such as blood pressure or glucose levels, leading to improved outcomes for members who have chronic conditions

    c. Telementoring can pair rural and semi-urban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions

4. That removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members will result in improved beneficiary access to substance use disorder (SUD) treatment services.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Laws.** The state must comply with applicable federal civil rights laws relating to non-discrimination in services and benefits in its programs and activities. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Such compliance includes providing reasonable modifications to individuals with disabilities under the ADA, Section 504, and Section 1557 with eligibility and documentation requirements, understanding program rules and notices, and meeting other program requirements necessary to obtain and maintain benefits.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs, expressed in law, regulation, and written policy, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid and/or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration, to comply with such change. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.

   b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments (SPA) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state

plan may be required, except as otherwise noted in these STCs. In all such instances, the Medicaid and CHIP state plans governs.

6. **Changes Subject to the Amendment Process.** If not otherwise specified in these STCs, changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP, whether administrative or service-based expenditures, will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in this STC, and failure by the state to submit reports required in the approved STCs and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

   a. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation;

   b. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

   c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

   d. An explanation of the public process used by the state consistent with the requirements of STC 13; and,

   e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than twelve months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal

requirements at 42 Code of Federal Regulations (CFR) 431.412(c) or a transition and phase-out plan consistent with the requirements of STC 9.

9. Demonstration Phase Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 13, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment, and how the state incorporated the received comment into the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries whether currently enrolled or determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to demonstration beneficiaries as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 C.F.R. 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

e. Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended.

g. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration authority expiration plan to CMS no later than six months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

1) Expiration Requirements. The state must include, at a minimum, in its demonstration authority expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the demonstration authority for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities.

2) Expiration Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to demonstration beneficiaries as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

3) Federal Public Notice. CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR 431.416 in order to solicit public input on the state's demonstration authority expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration authority expiration plan. The state must obtain CMS approval of the demonstration authority expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than fourteen (14) days after CMS approval of the demonstration authority expiration plan.

4) Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the expiration of the demonstration authority including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

11. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

12. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request.

    The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

    The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

14. **Federal Financial Participation (FFP).** No federal matching for expenditures, both administrative and service, for this demonstration will take effect until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

15. **Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. ELIGIBILITY

The KanCare demonstration affects mandatory and optional Medicaid state plan populations as well as populations eligible for benefits only through the demonstration. Standards for eligibility for mandatory and optional Medicaid state plan populations remain as set forth under the state plan, and approved 1915(c) waivers. Medicaid state plan services and 1915(c) services are delivered through a statewide comprehensive managed care delivery system through managed care organizations (MCOs). Most beneficiaries eligible under the state plan and most beneficiaries eligible for home and community based services provided through the concurrent 1915(c) waivers are required to enroll in MCOs to obtain covered benefits with the exception of Native Americans and Alaskan Natives. The state plan and 1915(c) waiver populations, as identified below, are affected by the demonstration through the requirement to enroll in the Medicaid managed care program under the demonstration in order to receive state plan and, if eligible, 1915(c) waiver services. Full benefit dual eligibles are covered under this demonstration for Medicaid services.

16. **Eligibility Groups Affected By the Demonstration.** The following tables describe the mandatory and optional state plan populations and the 1915(c) waiver populations affected by this demonstration.

Table A. Medicaid State Plan Mandatory Populations

State Plan Mandatory Medicaid Eligibility Groups	Description and Citation	Medicaid Eligibility Group (MEG)
LOW INCOME FAMILIES	Parents and Other Caretaker Relatives 1902(a)(10)(A)(i)(I) 1931(b) and (d)	Adults
TRANSMED – WORK TRANSITION (Transitional Medical Assistance (TMA))	Coverage for up to 12 months is provided to families who receive coverage on the Low Income Families program and have lost financial eligibility due to an increase in earnings, increase in working hours, or loss of time-limited earned income disregard. Children are covered through the month of their 19th birthday. 1902(a)(10)(A)(i)(I) 408(a)(11)(A)1925	Children (age 18 and under) Adults (age 19 and over)

State Plan Mandatory Medicaid Eligibility Groups	Description and Citation	Medicaid Eligibility Group (MEG)
EXTENDED MEDICAL – SPOUSAL SUPPORT	Coverage for 4 months is provided to families who received coverage on the Low Income Families program and lost financial eligibility due to an increase in spousal support. 408(a)(11)(B) 1902(a)(10)(A)(i)(I) 1931(c)(1)	Children (age 18 and under) Adults (age 19 and over)
PREGNANT WOMEN	Consolidated group for pregnant women 1902(a)(10)(A)(i)(III) and (IV) 1902(a)(10)(A)(ii)(I), (IV) and (IX) 1931(b) and (d)	Adults
CHILDREN UNDER AGE 19	Consolidated group for children under age 19 1902(a)(10)(A)(i)(III), (IV), (VI) and (VII) 1902(a)(10)(A)(ii)(I), (IV) and (IX) 1931(b) and (d)	Children
Deemed Newborns	Children born to a Medicaid mother 1902(e)(4)	Children
FOSTER CARE/ADOPTION MEDICAL (IV-E)	This program is for children who are receiving IV-E foster care or guardianship maintenance payments or with IV-E adoption assistance agreements. 473(b)(3) 1902(a)(10)(A)(i)(I)	Children
SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS	1902(a)(10)(A)(i)(II) 1619(a) 1619(b)	ABD/SD Dual ABD/SD Non Dual
WORKING DISABLED	1905(q)	ABD/SD Dual ABD/SD Non Dual
PICKLE AMENDMENT	Section 503 of P.L. 94-566 1939(a)(5)(E)	MN Dual MN Non Dual
ADULT DISABLED CHILD	1634(c) 1939(a)(2)(D)	MN Dual MN Non Dual
EARLY OR DISABLED WIDOWS AND WIDOWERS	1634(b) (Disabled Widow/ers) 1939(a)(2)(C) 1634(d) (Early Widow/ers)	MN Dual MN Non Dual

State Plan Mandatory Medicaid Eligibility Groups	Description and Citation	Medicaid Eligibility Group (MEG)
CHILD IN AN INSTITUTION	This program is for children through the age of 21 years old who are residing in an institution for a long term stay. Children eligible under this program whose income exceeds the protected income level are responsible for a portion of the cost of their care in the facility.	Children

Table B. Medicaid State Plan Optional Populations

State Plan Optional Medicaid Eligibility Groups	Description and Citation	MEG
FOSTER CARE MEDICAL (NON IV-E)	This program is for children under age 21 who are in foster care that does not meet the criteria for a IV-E foster care maintenance payment.	Children
INDEPENDENT FOSTER CARE ADOLESCENT MEDICAL (AGED OUT)	This program is for children transitioning to adult independent living who are being removed from the Foster Care Medical program because they are turning 18 years old. Medicaid coverage may continue through age 21. 1902(a)(10)(A)(ii)(XVII)	Children
ADOPTION SUPPORT MEDICAL (NON IV-E)	This program is for adopted children with special needs receiving non-IV-E state adoption assistance who do not meet the eligibility criteria for federal participation in the IV- E adoption support program and met the Medicaid eligibility requirements at the time of adoption and are under age 21. 1902(a)(10)(A)(ii)(VIII)	Children
BREAST AND CERVICAL CANCER	Uninsured individuals under age 65 who were screened and found to need treatment for breast or cervical cancer. 1902(a)(10)(A)(ii)(XVIII)	Adults

State Plan Optional Medicaid Eligibility Groups	Description and Citation	MEG
WORKING HEALTHY	1902(a)(10)(A)(ii)(XV)	ABD/SD Non Dual
WORKING HEALTHY MEDICALLY IMPROVED	1902(a)(10)(A)(ii)(XVI)	ABD/SD Non Dual
LONG TERM INSTITUTIONAL CARE	1902(a)(10)(A)(ii)(V) Except for individuals residing in a public ICF/ID	LTC
MEDICALLY NEEDY (Disabled, Blind, Aged, Pregnant Women, and Children)	1902(a)(10)(C)	MN Dual MN Non Dual ABD/SD Dual ABD/SD Non Dual

Table C. Section 1915(c) Waiver Populations. Individuals enrolled in the concurrent section 1915(c) waivers listed below are eligible for this demonstration.

Waiver Eligible Groups	Description and Citation	MEG
Autism Waiver	1902(a)(10)(A)(ii)(VI)	Waiver
Intellectual Disabilities/Developme	1902(a)(10)(A)(ii)(VI)	DD Waiver
Frail Elderly	1902(a)(10)(A)(ii)(VI)	LTC
Physically Disabled	1902(a)(10)(A)(ii)(VI)	LTC
Technology Assisted	1902(a)(10)(A)(ii)(VI)	Waiver
Traumatic Brain Injury / Brain Injury Waiver	1902(a)(10)(A)(ii)(VI)	Waiver
Serious Emotional Disturbance	1902(a)(10)(A)(ii)(VI)	Waiver

Table D. Voluntary Behavioral Health Employment Support Project Participants. Individuals enrolled in the Behavioral Health Employment Support Pilot who are not eligible for Medicaid without the pilot are eligible for this demonstration.

Waiver Eligible Groups	STC Reference	Expenditure Authority Reference
Individuals enrolled in the Behavioral Health Employment Support Pilot who are not eligible for Medicaid currently	#22(a)(i) and (b)(i)	#3

a. Individuals on the section 1915(c) waiver waiting lists who are not otherwise eligible for Medicaid through the approved state plan are excluded from the demonstration with the exception of the Behavorial Support Employment Support Pilot.

17. Exemptions and Exclusions. The following population is exempt from mandatory enrollment in mandatory managed care and is not affected by this demonstration except to the extent that individuals elect to enroll in managed care.

i. American Indians/Alaska Natives (AI/AN): The AI/AN population will be automatically enrolled in managed care under the demonstration. This population will have the ability to opt out of managed care at the beneficiary's discretion. The state will use the definition of Indian provided at 42 CFR §447.51.

Table E. Eligibility Exclusions. Notwithstanding STC 16, the following populations are excluded from this demonstration.

Exclusions from KanCare	Description
Aliens eligible for emergency services only	1903(v)(3)
QUALIFIED MEDICARE BENEFICIARY (QMB), not otherwise Medicaid eligible	1902(a)(10)(E)(i) 1905(p)(1)
SPECIAL LOW-INCOME MEDICARE BENEFICIARY (LMB) not otherwise Medicaid eligible	1902(a)(10)(E)(iii) 1902(a)(10)(E)(iii)

EXPANDED SPECIAL LOW-INCOME MEDICARE BENEFICIARY (E-LMB)	1902(a)(10)(E)(iv)(I)
PROGRAM OF ALL-INTENSIVE CARE FOR THE ELDERLY (PACE)	1934
LONG TERM INSTITUTIONAL CARE Individuals residing in a public Intermediate Care Facility for Persons with Intellectual or Developmental Disabilities (ICF/ID)	1902(a)(10)(A)(ii)(V)
RESIDENTS OF MENTAL HEALTH NURSING	1902(a)(10)(A)(ii)(V)

V. BENEFITS

18. KanCare Benefits. Benefits provided through KanCare managed care entities are described below:

a. KanCare Benefits. All populations outlined in STC 16 are entitled to receive all mandatory and optional services under the approved Medicaid state plan, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for children up to age 21. These Medicaid state plan benefits are provided through KanCare MCOs in at least the same amount, duration and scope that services are provided through the state plan. Individuals enrolled in the following 1915(c) waiver programs will also receive 1915(c) waiver services authorized through the waiver program from the KanCare MCO in which they are enrolled:

b. Autism waiver KS-0476;

c. Physically Disabled waiver KS-0304;

d. Technology Assisted waiver KS-4165;

e. Traumatic Brain Injury Waiver KS-4164;

f. Serious Emotional Disturbance Waiver KS 0320;

g. Frail and Elderly Waiver KS-0303; and,

h. Intellectual Disabilities/Developmental Disabilities KS-0224.

19. Additional Services. In addition to the benefits described in STC 18, KanCare MCOs will provide the following services to certain populations below.

a. Additional services covered in the demonstration:

Service	Populations Eligible
Physician Consultation (Case Conferences) – Communication between licensed mental health practitioners (LMHP), advanced registered nurse practitioner (ARNP) or Psychiatrist for a patient consultation that is medically necessary for the medical management of the psychiatric conditions. These services are prior authorized, and limited to scheduled face to face meetings to discuss problems associated with the member's treatment	Severely and Persistently Mentally Ill (SPMI) adults and Seriously Emotionally Disturbed (SED)youth

Personal Care Services – These are services provided a consumer with severe and persistent mental illness or a serious emotional disturbance who would otherwise be placed in a more restrictive setting due to significant functional impairments resulting from an identified mental illness. This service enables the consumer to accomplish tasks or engage in activities that they would normally do themselves if they did not have a mental illness. Assistance is in the form of direct support, supervision and/or cuing so that the consumer performs the task by him/herself. Such assistance most often relates to performance of ADL and IADL and includes assistance with maintaining daily routines and/or engaging in activities critical to residing in their home community. These services are prior authorized.	SPMI and SED not receiving personal care under the SED waiver
Rehabilitation Services (Substance Use Disorder detoxification and treatment including, ASAM Levels of Care 3.1 and 3.3/3.5) (Step down services from inpatient hospital) – These are services designed to meet more intensive needs of individuals with a substance use disorder in their community, including to preventatively avoid the need for inpatient hospitalization. These services are prior authorized, and include the specific ASAM levels of care noted above, as well as medically monitored detoxification service or other community based ASAM Level 3 service.	All demonstration enrollees meeting medical necessity.

20. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).** The MCOs must fulfill the state's responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).

21. **Opioid Use Disorder/Substance Use Disorder Program.** Effective upon CMS' approval of the OUD/SUD Implementation Protocol, the demonstration benefit package for Kansas Medicaid recipients will include OUD/SUD treatment services, including short term residential services provided in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD), which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Kansas Medicaid recipients who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. Kansas will aim for a statewide average length of stay of 30 days in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in STC 62 below, to ensure short-term residential treatment stays. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

    The coverage of OUD/SUD treatment services and withdrawal management during short term residential and inpatient stays in IMDs will expand 's current SUD benefit package available to all Kansas Medicaid recipients as outlined in Table 1. Room and board costs

are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Table 1: Kansas OUD/SUD Benefits Coverage with Expenditure Authority

SUD Benefit	Medicaid Authority	Services to be covered in this waiver under STC
Early Intervention (SBIRT)	*State plan*	
Outpatient Services (Individual, group and family therapy, peer recovery coaching/support for individuals and families, community psychiatric support, assessment)	*State plan*	
Intensive Outpatient Treatment (individual and group counseling and education)	*State plan*	
Residential Treatment (medically directed evaluation and treatment for SUD, reintegration, support for co-occurring medical and mental illnesses)	*State plan*	Services provided to individuals in IMDs
Medically Supervised Withdrawal Management	*State plan*	Services provided to individuals in IMDs
Medication-Assisted Treatment (MAT) (counseling and buprenorphine, combo products with naloxone and injectables, excluding methadone treatment)	*State plan*	Services provided to individuals in IMDs

The state attests that the services indicated in Table 1, above, as being covered under the Medicaid state plan authority are currently covered in the Kansas Medicaid state plan.

a. **SUD Implementation Protocol.** The state must submit an OUD/SUD Implementation Protocol within 90 calendar days after approval of the SUD program under this demonstration. The state may not claim FFP for services provided in IMDs until CMS has approved the Implementation Protocol. Once approved, the Implementation Protocol will be incorporated into the STCs, as Attachment P, and once incorporated, may be altered only with CMS approval. After approval of the Implementation Protocol, FFP will be available prospectively, not retrospectively. Failure to submit an Implementation Protocol will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the OUD/SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral.

   At a minimum, the SUD Implementation Protocol must describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of the SUD component of this demonstration:

i. **Access to Critical Levels of Care for OUD and other SUDs:** Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of OUD/SUD program demonstration approval;

ii. **Use of Evidence-based SUD-specific Patient Placement Criteria:** Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of OUD/SUD program demonstration approval;

iii. **Patient Placement:** Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of SUD program demonstration approval;

iv. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities:** Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in the Kansas Standards for Licensure/ Certification of Alcohol and/or Other Drug Abuse Programs, rev. 1/1/06. The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of OUD/SUD program demonstration approval;

v. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval;

vi. **Standards of Care:** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval;

vii. **Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for OUD:** An assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of SUD program demonstration approval;

viii. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

ix. **SUD Health IT Plan:** Implementation of the milestones and metrics as detailed in STC 21(f) and Attachment R; and

x. **Improved Care Coordination and Transitions between levels of care:** Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of SUD program demonstration approval.

b. **SUD Monitoring Protocol.** The state must submit a SUD Monitoring Protocol within 150 calendar days after approval of the SUD demonstration. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment Q. At a minimum, the SUD Monitoring Protocol will include reporting relevant to each of the program implementation areas listed in STC 21(a). The SUD Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in STC 64 of the demonstration. In addition, the SUD Monitoring Protocol must identify a baseline and a target to be achieved by the end of the demonstration. Where possible, baselines must be informed by state data, and targets must be benchmarked against performance in best practice settings. CMS will closely monitor demonstration spending on services in IMDs to ensure adherence to budget neutrality requirements. Progress on the performance measures identified in the Monitoring Protocol must be reported via the quarterly and annual monitoring reports.

c. **Mid-Point Assessment.** The state must conduct an independent mid-point assessment by June 30, 2021 of the demonstration. The state must require that the independent assessor collaborate with key stakeholders, including representatives of MCOs, SUD treatment providers, beneficiaries, and other key partners in the design, planning and conducting of the mid-point assessment. The state must require that the assessment include an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Protocol, and toward meeting the targets for performance measures as approved in the SUD Monitoring Protocol. The state must also require that the assessment include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and about the risk of possibly missing those milestones and performance targets. The state must also require that the mid-point assessment provide a status update of budget neutrality requirements. For each milestone or measure target at medium to high risk of not being met, the assessor will provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The state must require the assessor to provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS. The state must brief CMS on the report.

For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the SUD Implementation Protocol and SUD Monitoring Plan Protocols for ameliorating these risks subject to CMS approval.

d. **SUD Evaluation.** The OUD/SUD Evaluation will be subject to the same requirements as the overall demonstration evaluation, as listed in sections XII General Reporting Requirements and XV Evaluation of the Demonstration of the STCs.

e. **SUD Evaluation Design.** The draft Evaluation Design must be developed in accordance with Attachment M (Developing the Evaluation Design) of these STCs. The state must submit, for CMS comment and approval, a revision to the Evaluation Design to include the SUD program with implementation timeline, no later than one hundred eighty (180) days after the effective date of these amended STCs. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state must use an independent evaluator to develop the draft Evaluation Design.

i. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Quarterly and Annual Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

ii. **Evaluation Questions and Hypotheses Specific to OUD/SUD Program.** Consistent with Attachments M and N (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

f. **SUD Health Information Technology (Health IT).** The state must provide CMS with an assurance that it has a sufficient health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration—or it must submit to CMS a plan to develop the infrastructure/capabilities. This "SUD Health IT Plan," or assurance, must be included as a section of the state's "Implementation Protocol" (see STC 21(a)) to be approved by CMS. The SUD Health IT Plan must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The SUD Health IT Plan must also be used to identify areas of SUD health IT ecosystem improvement.

i. The SUD Health IT section of the SUD Implementation Protocol must include implementation milestones and dates for achieving them (see Attachment R).

ii. The SUD Health IT Plan must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) "Health IT" Plan.

iii. The SUD Health IT Plan must describe the state's goals, each DY, to enhance the state's prescription drug monitoring program's (PDMP)[1]

iv. The SUD Health IT Plan must address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[2] This must also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan will describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

v. The SUD Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state must also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

vi. The SUD Health IT Plan must describe how the activities described in (i) through (v) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.[3]

vii. In developing the Health IT Plan, states should use the following resources.

1. States may use resources at Health IT.Gov (https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/) in "Section 4: Opioid Epidemic and Health IT."

2. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration

[1] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

[2] *Ibid*.

[3] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

h. The state must include in its Monitoring Plan (see STC 21(b)) an approach to monitoring its SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.

i. The state must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Reports (see STC 64).

j. As applicable, the state must advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

i. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.

ii. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

22. Disability and Behavioral Health Employment Support Pilot Program (BH Pilot). The state will operate a voluntary pilot program for eligible KanCare members through this section 1115 demonstration. This pilot program will help certain members obtain and maintain employment by providing supportive services. The pilot program will operate during the KanCare 2019-2023 demonstration extension, with a possibility of renewal and expansion through an applicable title XIX authority if shown to be effective. The program will begin no sooner than July 1, 2019.

a. Pilot Program Eligibility: The following KanCare members who are ages 16 through 65 will be eligible for the Disability and Behavioral Health Employment Support Pilot Program:

i. Members who have any of the following behavioral health primary diagnoses and who receive services through Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI):):

A. Schizophrenia;

B. Bipolar and major depression;

C. Delusional disorders;

D. Personality disorders;

E. Psychosis not otherwise specified;

F. Obsessive-compulsive disorder;

G. Post-traumatic stress disorder; or

H. Substance use disorder (SUD) or co-occurring SUD;

ii. SSI Members currently enrolled in Medicaid and waitlisted for Home and Community Based Service (HCBS) on the intellectual or developmental disability (I/DD), physical disability (PD), or any potential Brain Injury Waiver waiver waitlists[4]; or

iii. Members who have an intellectual or developmental disability (I/DD), physical disability (PD), or Brain Injury Waiver, who are willing to leave their HCBS waiver.

b. Disability and Financial Eligibility and Cost Sharing: Members may be eligible for the Disability and Behavioral Health Employment Support Pilot Program depending on criteria specified below, including financial eligibility. Persons must also meet general and non-financial eligibility criteria, and may be required to pay cost sharing. .

i. Individuals with a behavioral health diagnosis and who have been determined disabled according to Social Security criteria (e.g. SSDI or Railroad Retirement disability recipients). To be financially eligible:
   A. Can have an income up to 300% of current Federal Poverty Level (FPL).
   B. Can have resources up to $15,000 for an individual or for a couple.
   C. Individuals with income up to 100% of FPL will not have a cost share. Participants with income that exceeds 100% of FPL who receive medical assistance under expenditure authority #3 will be subject to cost share that is the same as the Kansas "Working Healthy" program which can be accessed at the following site: http://www.kdheks.gov/hcf/workinghealthy/premium.htm

ii. Individuals with a behavioral health diagnosis and who are SSI eligible:
   A. There shall be no cost share for the participant.

iii. Individuals waitlisted for the Intellectual/Developmental Disability (I/DD), Physical Disability (PD) or Traumatic Brain Injury (TBI) Waivers and who are SSI eligible:
   A. There shall be no cost share for the participant.

iv. Individuals on the I/DD, PD, or TBI waivers who choose to leave the waiver and who are SSI eligible:
   A. There shall be no cost share for the participant.

c. Benefit Specialists: The state will make available Benefit Specialists who will provide program guidance to potential participants.

[4] As of this draft STC submission, there are no individuals on the TBI waiver waitlist. However, Kansas may be expanding the TBI waiver to include individuals with Acquired Brain Injury, in which case, there may be individuals on the TBI witlist in the future.

d. Needs Assessment: The state will use a standardized needs assessment process to determine eligibility for the Disability and Behavioral Health Employment Support Pilot Program.

e. Program Enrollment: Member enrollment will operate with the following conditions:

i. *For an individual on the waiver waitlist who leaves the waitlist to participate in the Pilot:* The individual will not lose his or her place on the waitlist should employment support services prove to be ineffective in helping the individual obtain and maintain employment.

ii. *For an individual who leaves his or her waiver to participate in the Pilot:* The individual will be able to return to the waiver if employment support services prove to be ineffective in helping the individual obtain and maintain employment.

iii. If there is a waitlist for the Pilot program, the list shall be managed on a statewide basis using a standardized assessment tool and in accordance with criteria established by the state. Waiting list policies shall be based on objective criteria and applied consistently in all geographic areas served.

f. Enrollment Targets: For this pilot project, the state will not enroll more than 500 individuals. The purpose of the target is to permit the pilot program to grow in a controlled manner, while assuring appropriate service to members enrolled in the program. Limiting enrollment will also allow the state to evaluate the effectiveness of the pilot program, before deciding whether to implement the program for all eligible members.

g. Managed Care Organization (MCO) Support: Employment Support Pilot services will be provded exclusively as a managed care benefit. MCOs may play a role in:

i. Identifying eligible members who are interested in employment.

ii. Promoting the benefits of employment to members.

iii. Referring members to employment services.

iv. Reauthorizing continuation of services (e.g., 6-month increments for pre-vocational services, independent living skills training).

v. Providing (or paying for) Community Service Coordination and other pilot services.

h. Employment Guidelines: Employment shall be a minimum of 40 hours per month in a

competitive, integrated setting at the federal hourly minimum wage or more with Federal Insurance Contributions Act (FICA) withheld. Employment in a sheltered workshop shall not constitute employment for purposes of this pilot.

i. Pilot Program Services: The program will assist members through several potential services available to members depending on their need as outlined in Figure 1. Where applicable, the state will promote the use of evidence-based practices in the delivery of these services.

Figure 1: ***Disability and Behavioral Employment Support Pilot Services***

Service	Service Definition
1. Pre-Vocational Services *(available to participants who have not or are unable to access Vocational Rehabilitation Services)*	Individualized services/supports that assist persons to develop or reestablish the skills, attitudes, personal characteristics, interpersonal skills, work behaviors, functional capacities, etc., described in the individual's person-centered service plan and designed to lead to integrated competitive employment. Services will occur over a defined period of time and are not indefinite. The individual and his/her planning team will use an ongoing person-centered planning process to identify goals for specific outcomes. Services may include: career exploration and planning, development of work-related skills such as interviewing, punctuality, attendance, appropriate work behavior, etc. and job development and placement. However, such services may only be furnished to a waiver participant to the extent that they are not available as vocational rehabilitation services funded under the Rehabilitation Act of 1973. When a state covers prevocational and/or supported employment services in a waiver, the waiver service definition of each service must specifically provide that the services do not include services that are available under the Rehabilitation Act (or, in the case of youth, under the provisions of the IDEA) as well as describe how the state will determine that such services are not available to the participant before authorizing their provision as a waiver service.

Service	Service Definition
2. Supported Employment	Employment-related support services provided to participants who need sustained support to maintain a job in a competitive, customized or self-employment environment. Services may include: job coaching, individual and small group employment support, and other evidence-based practices. However, such services may only be furnished to a waiver participant to the extent that they are not available as vocational rehabilitation services funded under the Rehabilitation Act of 1973. When a state covers prevocational and/or supported employment services in a waiver, the waiver service definition of each service must specifically provide that the services do not include services that are available under the Rehabilitation Act (or, in the case of youth, under the provisions of the IDEA) as well as describe how the state will determine that such services are not available to the participant before authorizing their provision as a waiver service.
3. Personal Assistant Services	Services that assist members with Activities of Daily Living (ADLs) and instrumental ADLs (IADLs) such as meal preparation, shopping, light housekeeping and laundry.
4. Independent Living Skills Training	Training designed to enhance or improve the ability of the participant to live as independently as possible in the community and use existing community resources (e.g., assessment, training, and supervision of an individual with self-care, medication management, task completion, paying bills, housekeeping skills, etc.).
5. Assistive Technology	Equipment, devices, and modifications not already provided under the Medicaid State Plan, that enhance the functional abilities of individuals with disabilities, with emphasis on supporting employment and independent functioning.
6. Transportation	Services to transport members to and from locations essential to obtaining and maintaining employment.

j. Evaluation: The state shall also include an evaluation of the Disability and Behavioral Health Employment Support Pilot Program in the demonstration evaluation design required per STC 97.

k. Pilot Program Requirements.

i. HCBS Electronic Visit Verification System. The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2020 and home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.

ii. HCBS Quality Systems and Strategy. The state is expected to implement systems that measure and improve its performance to meet the waiver assurances set forth in 42 CFR 441.301 and 441.302. The Quality Review provides a comprehensive assessment of the state's capacity to ensure adequate program oversight, detect and remediate compliance issues and evaluate the effectiveness of implemented quality improvement activities.

iii. For for services that could have been authorized to individuals served under a 1915(c) waiver, the state must have an approved Quality Improvement Strategy and is required to develop and measure performance indicators for the following waiver assurances:

A. Administrative Authority: A performance measure should be developed and track any authority that the State Medicaid Agency (SMA) delegates to another agency, unless already captured in another performance measure.

B. Level of Care: Performance measures are required for the following two sub-assurances:
   1. Applicants with reasonable likelihood of needing services receive a level of care determination and the processes for determining level of care are followed as documented.
   2. While a performance measure for annual levels of care is not required to be reported, the state is expected to be sure that annual levels of care are determined.

C. Qualified Providers: The state must have performance measures that track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to waiver requirements, and that the state verifies that training is given to providers in accordance with the waiver.

D. Service Plan: The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for HCBS participants. Performance measures are required for choice of waiver services and providers, service plans address all assessed needs and personal goals, and services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.

E. Health and Welfare: The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants health and welfare. The state must have performance measures that track that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death; that an incident management system is in place that effectively resolves

incidents and prevents further singular incidents to the extent possible; that state policies and procedures for the use or prohibition of restrictive interventions are followed; and, that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

iv. The state will submit a report to CMS following receipt of an Evidence Request letter and report template from the Regional Office no later than 18 months prior to the end of the approved waiver demonstration period on the status of the HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers. The Regional Office will send a DRAFT report to the state which will have 90 days to respond to the DRAFT report. The Regional Office will issue a FINAL report to the state 60 days following receipt of the state's response

v. The CMS Regional Office will evaluate each evidentiary report to determine whether the assurances have been met and will issue a final report to the state 12 months prior to expiration to the demonstration.

vi. The state must report annually the deficiencies found during the monitoring and evaluation of the HCBS waiver assurances, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or death, the actions taken regarding the incidents and how they were resolved. Submission is due no later than 6 months following the end of the demonstration year.

vii. HCBS Beneficiary Protections:

A. Person-centered planning: The state assures there is a person-centered service plan for each individual determined to be eligible for HCBS. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR 441.301(c)(1), and the written person-centered service plan meets federal requirements at 42 CFR 441.301(c)(2). The person-centered service plan is reviewed, and revised upon reassessment of functional need as required by 42 CFR 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

B. Conflict of Interest: The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCB services. The state also agrees that appropriate separation of

assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

C. Each beneficiary eligible for long term services and supports will have informed choice on their option to self-direct LTSS, have a designated representative direct LTSS on their behalf, or select traditional agency-based service delivery. Both level of care and person-centered service planning personnel will receive training on these options. (MLTSS with self-direction)

D. The state, either directly or through its MCO contracts must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant. (MLTSS)

E. Beneficiaries may change managed care plans if their residential or employment support provider is no longer available through their current plan. (MLTSS)

VI. COST SHARING

23. Cost Sharing. Beneficiary cost sharing, including premiums and co-payments, will be limited to those authorized under the Medicaid state plan with the exception of certain participants in the Behavorial Health Employment Support Pilot.

VII. KANCARE ENROLLMENT

24. KanCare Enrollment Process.

- Enrollment Process after January 1, 2019. All individuals must have the opportunity to make an active selection of a KanCare MCO during the application process. If no MCO is selected, the state will pre-select an MCO for each KanCare member and enroll the individual in that MCO. That pre-selection shall be based on the principles set forth in 42 CFR § 438.52, while taking into account the MCO affiliation of the individual's historic providers, with a prior history with the MCO being taken into account first.
- Supports for Beneficiaries using LTSS. For individuals residing in a nursing facility or other residential facility, the nursing or residential facility will be used first to determine the selection of a KanCare MCO. For individuals using HCBS providers at the time of enrollment, the selection process must be customized to the specific waiver with specific attention paid to the types of providers critical to positive outcomes of the individuals within each of the waivers. All individuals enrolled in a 1915(c) waiver at the time of KanCare enrollment must have the opportunity to receive counseling from an independent options counselor to assist them in making an MCO selection and switching MCOs if desired.
- Number of enrollees receiving 1915(c) services**.** The state must allow all eligible individuals to enroll into each 1915(c) delivery system until the enrollment cap has been reached in a given year.

25. KanCare Disenrollment. Individuals who are temporarily or permanently placed in a public Intermediate Care Facility for Persons with Intellectual or Developmental Disabilities (ICF/ID) will be disenrolled from their MCO.

26. For Cause Reasons for Disenrollment. In addition to the for cause reasons for disenrollment in 42 CFR 438.56, and any other state specific reasons for disenrollment, enrollees will have the following reasons for disenrolling from an MCO and will be able to choose a different MCO:

i. MLTSS Service Planning Dissatisfaction. Members with an existing LTSS service plan transitioning from FFS or a different MCO, who, when the new service plan is created, wish to change MCOs because of their service planning process experience, will be permitted to disenroll for cause within 30 days of the date of the initial service assessment. Members will only be able to use this for cause reason once annually.

ii. Residential provider leaves the MCO. Where an individual's residential provider is leaving a participant's MCO, the state shall allow the impacted participants the opportunity to change MCOs at any time within 90 days from the date of notice of provider departure from the MCO. If a safe transfer cannot be arranged within 90 days, there will be an extension of coverage provided to permit the individual to remain in his/her residence until an appropriate transfer arrangement can be made.

VIII. DELIVERY SYSTEM

27. Managed Care Requirements. The state must comply with the managed care regulations

published at 42 CFR § 438. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR § 438.5. The certification shall identify historical utilization of state plan and HCBS services used in the rate development process.

28. **Managed Care Benefit Package.** Individuals enrolled in any managed care program within the state must receive from the managed care program the benefits as identified in section V of the STCs. Benefits should be delivered and coordinated in an integrated fashion, using an interdisciplinary care team, to coordinate all physical, behavioral, acute and long-term services and supports.

29. **Managed Care Services During Appeals.** The state shall adopt policies that ensure authorized LTSS continue to be provided in the same amount, duration and scope while a modification, reduction or termination is on appeal. Notices of Action must clearly state the process to ensure services remain in place during appeal and state who is responsible for the cost of services during the appeal process. The notices must provide the contact information for one or more resources that may assist the individual. The state shall monitor MCO service authorization processes and participant appeals of service authorization, reductions, or expirations, and intervene if the results of appeal indicate broader problems in the service authorization process.

30. **Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR § 438 requirements prior to CMS approval of such contracts and/or contract amendments. The state shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 60 days to review and approve changes. If changes to contracts are needed based on CMS approval of initial or amended STCs, the state must submit amended contracts within 60 days of approval of the demonstration documents. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

31. **Public Contracts**. Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals.

32. **Network Requirements**. The following requirements must be included in the state's MCO contracts:

33. **Access to Care, Network Adequacy and Coordination of Care Requirements for Long Term Services and Supports (LTSS)**. The state shall set specific requirements for MCOs to follow regarding providers of LTSS, consistent with 42 CFR § 438 Subpart Part D. These requirements shall be outlined within each MCO contract. These standards should take into consideration individuals with special health care needs, out of network requirements if a provider is not available within the specific access standard, ensuring choice of provider with capacity to serve individuals, time/distance standards for providers who do not travel to the individual's home, and physical accessibility of covered services. The MCO should contract with at least two providers serving each county for each covered LTSS service in the benefit package, unless the county has an insufficient number of providers licensed, certified, or available in that county. See https://www.kancare.ks.gov/policies-and-reports/network-adequacy for more information

about network adequacy in Kansas.

34. **State Advisory Committee**. The state must maintain for the duration of the demonstration, a public managed care advisory group comprised of individuals, family members, interested parties, and stakeholders impacted by the demonstration's use of managed care, regarding the impact and effective implementation of these changes. The committee must have opportunity for participation in policy development and program administration, including furthering the participation of beneficiary members in the agency program. Membership on this group should be periodically updated to ensure adequate representation of individuals receiving LTSS as well as other eligibility groups. The state shall maintain minutes from these meetings and use them in evaluating program operations and identifying necessary program changes. Copies of committee meeting minutes must be made available to CMS upon request and the outcomes of the meetings may be discussed on the bimonthly demonstration calls in STC 63.

35. **MCO Participant Advisory Committees**. The state shall require each MCO, through its contracts, to create and maintain participant advisory committees through which the MCO can share information and capture enrollee feedback. These committees must fairly represent KanCare stakeholders, be operated in ways that are reasonably transparent and convenient to their members, and allow members free expression of opinions. The MCOs will be required to support and facilitate participant involvement and submit meeting minutes to the state. Copies of meeting minutes must be made available to CMS upon request.

36. **Independent Consumer Supports (Ombudsman).** To support the beneficiary's experience receiving medical assistance and long term services and supports in a managed care environment, the state shall maintain a permanent system of independent consumer supports (hereafter referred to as the Ombudsman) to assist enrollees in understanding the coverage model and in resolving problems regarding services, coverage, access and rights. Please see Attachment H for additional information on the Ombudsman Plan.

a. Core Elements of the Ombudsman.

i. *Organizational Structure*. The Ombudsman shall be autonomous to any KanCare MCO and the State Medicaid agency. If the Ombudsman operates within a sister state agency, the State shall establish protections such that no undue influence will be imposed that restricts the ability of the Ombudsman to perform all of the core functions. The organizational structure of the Ombudsman shall demonstrate transparency and collaboration with beneficiaries, MCOs, community based organizations, and state government.

ii. *Accessibility*. The services of the Ombudsman are available to all Medicaid beneficiaries enrolled in KanCare, with priority given to those receiving long-term services and supports (institutional, residential and community based). The Ombudsman must be accessible through multiple entryways (e.g., phone, internet, office) and must use various means (mail, phone, in person), as appropriate, to reach out to beneficiaries and/or authorized representatives

through.

iii. *Functions*. The Ombudsman assists beneficiaries to navigate and access covered health care services and supports. The services of the Ombudsman help individuals understand the delivery system and resolve problems and concerns that may arise between the individual and a provider/payer. The following list encompasses the Ombudsman's minimum scope of activity. The Ombudsman:

A. Shall serve as an access point for complaints and concerns about access to services and other related matters when the beneficiary isn't able to resolve their concern directly with a provider or health plan
B. The Ombudsman shall help enrollees understand the state's Medicaid fair hearing process, grievance and appeal rights, and grievance and appeal processes provided by the health plan, and shall assist enrollees in navigating those processes and/or accessing community legal resources, if needed/requested.
C. The Ombudsman shall develop a protocol for referring unresolvable issues to the State Medicaid Agency and other state officials as necessary to ensure the safety and well-being of beneficiaries.
D. The Ombudsman shall develop and implement a program of training and outreach with KanCare MCOs, providers, and community based organizations to facilitate cross-organizational collaboration, understanding, and the development of system capacity to support beneficiaries in obtaining covered plan benefits. The state shall track and report all such activities to the State Medicaid Agency and CMS, as specified in subparagraph v. of this STC.
E. The Ombudsman shall assist enrollees to understand and resolve billing issues, or notices of action.

iv. *Staffing and training*. The Ombudsman must employ individuals who are knowledgeable about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; the health and support needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs, and the community based systems that support them. In addition, the Ombudsman shall ensure that its services are delivered in a culturally competent manner and are accessible to individuals with limited English proficiency and people with disabilities. The state shall develop an access standard to measure the availability and responsiveness of the system to beneficiaries and others seeking support from the Ombudsman, and shall report compliance with this standard to CMS in its quarterly and annual reports, as specified in STC 64. The system shall be staffed sufficiently to address all requests for support consistent with this access standard.

v. The State and CMS will review the performance of the Ombudsman against this access standard and against the functions described in these STCs 12 months following approval of this demonstration. The State shall take any

necessary corrective action to comply with this standard.

vi. *Data Collection and Reporting*. The Ombudsman shall include a robust system of data collection and reporting. The state shall include this data in all quarterly and annual reports to CMS as specified in STC 64. The state shall also develop a mechanism for public reporting. At a minimum, the state shall collect and report on the following elements:

1) The date of the incoming request as well as the date of any change in status.
2) The volume and type (email, phone, verbal, etc.) of incoming request for assistance.
3) Time required for beneficiaries to receive assistance from the Ombudsman, including time from initial request to resolution.
4) The issue(s) presented in incoming requests for assistance.
5) The health plan (s) involved in the request for assistance, if any.
6) The geographic area where the beneficiary involved resides, if applicable.
7) Which 1915(c) waiver authority if applicable (ID/DD, PD, Aging, etc) the beneficiary receives services from.
8) The current status of the request for assistance, including actions taken to resolve.
9) The number and type of education and outreach events conducted by the Ombudsman.
10) System Enhancement. The Ombudsman shall generate periodic public reports that describe the functioning of the Ombudsman and any enhancements to the program that the state makes. The first report of the new demonstration period will be submitted to CMS within 6 months of approval of the demonstration. Subsequent reports will be submitted to CMS within 6 months of the end of the calendar year.
11) Transparency and Stakeholder Involvement. The State shall assure transparency in the operation of the Ombudsman, including public reporting of all aggregate data and performance reports and changes made to improve the Ombudsman program. The State shall develop a mechanism to secure stakeholder input into the operation and performance of the Ombudsman and demonstrate inclusion of stakeholder input in its on-going operation, evaluation, and enhancement of the program.

b. The State will evaluate the impact of the Ombudsman program in the demonstration evaluation per STC 97.

37. KanCare Website. The state must maintain and keep current a KanCare website for the lifetime of the demonstration. The website should include the approved or proposed program design features, descriptions of eligibility and enrollment processes, options for choice counseling, and an area for beneficiaries and stakeholders to provide input on the program design and implementation. The state must also publish information about its program operations and outcomes at least annually. The state must ensure that all information on this website is presented in an easily accessible manner (language, reading level), including for individuals with disabilities, in order to support beneficiaries in making decisions about their plans, providers, and care. The state must make this information available in hard copy upon request. MCO-specific information should be

included in the information that is considered public and is regularly published.

IX. HCBS SERVICE DELIVERY

38. **Service Planning Firewalls.** The State Medicaid Agency ensures:

    a. Has clear conflict-free guidelines for contracted entities participating in the service planning process so that these entities offer choices to the participant regarding the services and supports they receive and available alternatives;

    b. Includes a method for the participant to request changes to the service plan;

    c. Records the alternative HCBS and settings that were considered by the participant; and

    d. Grants beneficiaries the fair hearing and appeal rights provided for under Medicaid statute, regulation, and policy.

39. **Participant-Direction.** The State Medicaid Agency, either directly or through its contracts with its MCOs and level of care enrollment entities, must educate LTSS participants about the opportunity to self-direct their services and ensure that MCOs provide adequate supports to help beneficiaries be successful in self-directing their services. Both Level of Care and Service Planning personnel must be required to receive training to ensure they can offer participants sufficient information to make an informed choice on their option to self-direct

40. **Critical Incident Management System.** The State Medicaid Agency or the MCO must operate a critical incident management system according to the State Medicaid Agency's established policies, procedures and regulations. On an ongoing basis the State Medicaid Agency must ensure that all entities, including the MCOs, prevent, detect, report, investigate, and remediate instances of abuse, neglect and exploitation, and ensures participant rights are maintained through policies concerning seclusion, restraint, and medication management. MCOs, providers and participants must be educated about this system initially at the start or at hire, and at least annually thereafter. MCO and provider obligations include specific action steps that MCOs and providers must take in the event of suspected or substantiated abuse, neglect or exploitation, including risk mitigation. If the State Medicaid Agency delegates the responsibility for the critical incident management systems to the participating MCOs, the State Medicaid Agency must collect and analyze the data collected by the MCOs on a regular, periodic basis, and ensure that individual situations are remediated in a timely manner and that system-wide issues are identified and addressed.

41. **HCBS Settings and Community Integration.** The State Medicaid Agency must ensure that services are provided in a setting that has a home-like character by providing full access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas, and visitors at times convenient for the participant. The settings/services support community integration, including facilitation of employment and easy access to resources and activities in the community. HCBS LTSS are not provided in institution-like settings

except when such settings are employed to furnish short term respite to participants. The state, either directly or through its MCO contracts, must ensure that: (1) all participants receive appropriate services in the least restrictive and most integrated home and community-based setting, in accordance with CMS community- based setting requirements outlined in the regulatory text at 42 CFR 441.530; and, (2) all participants' engagement and community integration is supported and facilitated to the fullest extent desired by each participant and reflected in the member's service plan. The state must ensure that all HCBS settings comply with any revisions to Medicaid regulations.

42. **HCBS Authority.** The 1915(c) waivers of KS-0224, KS-0476, KS-0304, KS-4165, KS-4164, KS-0320 and KS-0303 will continue to be the authority under which HCBS operates the state must follow the section 1915(c) amendment process to make alterations to its HCBS waivers. The state must notify CMS demonstration staff in writing of any proposed amendments to the section 1915(c) waivers concurrently with the submission of the section 1915(c) amendment.

X. PROGRAM IMPLEMENTATION BENEFICIARY PROTECTIONS

The KanCare demonstration is a continuation of the comprehensive reform for the state's Medicaid program. The beneficiary protections below reflect the discussions between CMS and the state regarding continuity of care.

43. **Verification of Beneficiary's MCO Enrollment**. The state must implement the CMS approved process (see Attachment I) for an MCO, network and non-network providers, or the state to confirm enrollment of enrollees who do not have a card or go to the wrong provider.

44. **State Ride-Alongs**. The state must complete ride-alongs with each MCO that was not a provider on January 1, 2017 to observe the service planning process for each MCO. A ride along consists of an experienced state employee who accompanies an MCO employee to observe and assist in the performance of a needs assessment and service plan development for individuals enrolled in the concurrent section 1915(c) HCBS waivers. The amount of ride alongs should be a random sample that reasonably captures the experience of beneficiaries in the waivers.

45. **State Operated Call Center**. The state must operate a call center independent of the MCOs for the duration of the demonstration. This can be achieved either by providing the call center directly or through the enrollment broker or other state contracted entities. This entity should be able to help enrollees in making independent decisions about MCO choice, and members should be able to voice complaints about each of the MCOs independent of the MCOs.

46. **Call Center Response Statistics**. Data and information regarding call center statistics, including beneficiary questions and concerns, must be made available to CMS upon request.

47. **Auto-assignment Algorithm Review**. The state must review the outcomes of the auto-assignment algorithm, and if an MCO is found to get a larger number of beneficiaries associated with no match to an existing provider relationship due to a more limited network, that MCO will not be able to receive as many auto-assignees until such time as the network has improved.

48. **Implementation Calls with the MCOs**. During the first 30 days of the renewal period, the state must hold calls at least once per week with any new MCOs who were not providers on December 31, 2018 to discuss any issues that arise. The calls should cover all MCO operations and determine plans for correcting any issues as quickly as possible. After the first 30 days, if it is found that the frequency of calls is no longer needed then the state can scale back the calls, but must maintain biweekly calls for the first 90 days and monthly calls for the next 90 days. After the first 180 days of the program, the state may move to the regular timeframe intended for meeting with each of the MCOs.

49. **State Review of Beneficiary Complaints, Grievances, and Appeals.** During the first 180 days of the renewal period, the state must review complaint, grievance, appeal notices, and

appeal logs for each new MCO who was not a provider on January 1, 2017. and data from the state or MCO operated incident management system. The state will use this information to implement any immediate corrective action necessary including revising notices. The state must review the data at least weekly for the first 90 days and then at least bi-weekly for the next 90 days. The state shall monitor MCO service authorization processes and participant appeals of service authorizations, reductions, or expirations, and intervene if the results of the appeals indicate broader problems in the service authorizations process. The state will continue to monitor these statistics throughout the demonstration period and report on them in the quarterly reports as specified in STC 64. Data and information regarding the beneficiary complaints, grievances, and appeals process must be made available to CMS upon request.

50. **Protections from Improper Institutionalizations of ID/DD Beneficiaries**. When a beneficiary who resides in the community has been recommended for placement into an ICF/IID or nursing facility, the state must review and approve the placement before the beneficiary can be admitted into the ICF/IID or nursing facility.

51. **Care Coordination Reports.** The State shall design and include in its reports to CMS performance metrics on consumer satisfaction with care coordination.

XI. SAFETY NET CARE POOL

The terms and conditions in section XI apply to the operation of the state's safety net care pools (SNCPs), as authorized by Expenditure Authority II: Safety Net Care Pool Expenditures.

52. Terms and Conditions Applying to Pools Generally.

a. The non-federal share of pool payments to providers may be funded by state general revenue funds and transfers from units of local government that are compliant with section 1903(w) of the Act. All payments must remain with the provider and may not be transferred back to any unit of government. CMS reserves the right to withhold or reclaim FFP based on a finding that the provisions of this subparagraph have not been followed.

b. The state must inform CMS of the funding of all payments from the pools to hospitals through a quarterly payment report, in coordination with the quarterly monitoring report required by STC 64, to be submitted to CMS within 60 days after the end of each quarter. This report must identify and fully disclose all the underlying primary and secondary funding sources of the non-federal share (including health care related taxes, certified public expenditures, intergovernmental transfers, general revenue appropriations, and any other mechanism) for each type of payment received by each provider.

c. The state may not amend its Medicaid state plan to authorize supplemental payments for hospitals, except as related to Graduate Medical Education payments, so long as the expenditure authorities for pool payments under this demonstration remain in force.

d. The state will ensure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of services available under the state plan or this demonstration. The preceding sentence is not intended to preclude the state from modifying the Medicaid benefit through the state plan amendment process.

e. Each quarter the state makes a pool payment (for either pool as described in STCs 53 and 54 below) and claims FFP, appropriate supporting documentation will be made available for CMS to determine the allowability of the payments. Supporting documentation may include, but is not limited to, summary electronic records containing all relevant data fields such as Payee, Program Name, Program ID, Amount, Payment Date, Liability Date, Warrant/Check Number, and Fund Source. Documentation regarding the Funds revenue source for payments will also identify all other funds transferred to such fund making the payment.

53. Uncompensated Care (UC) Pool. Through DY 8, the UC Pool is available to defray the actual uncompensated cost of medical services that meet the definition of "medical assistance" contained in section 1905(a) of the Act, that are provided to Medicaid eligible or uninsured individuals (defined as individuals who have no source of third party coverage) incurred by hospitals. Starting DY 9, the UC Pool is available to defray the actual uncompensated cost

of medical services that meet the definition of "medical assistance" contained in section 1905(a) of the Act, that are provided by hospitals to uninsured individuals as charity care, including uninsured full or partial discounts, that provide all or a portion of services free of charge to patients who meet the provider's charity care policy and that adhere to the charity care principles of the Healthcare Financial Management Association.[5] Annual UC Pool payments are limited to the annual amounts identified in STCs 53(b) and 55. Expenditures for UC payments must be claimed in accordance with CMS-approved claiming protocols for each provider type and application form in Attachment E. The methodology used by the state to determine UC payments will ensure that payments are distributed to hospitals without any relationship to source of nonfederal share. Expenditures must be claimed in accordance with the methodology described in STC 53(c) below.

a. UC Pool Eligibility. The UC Pool is made up of two sub-pools: the Health Care Access Improvement Program (HCAIP) Pool and the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool.

   i. Hospitals eligible for the HCAIP Pool are listed in Attachment C.

   ii. Hospitals eligible for the LPTH/BCCH Pool are listed in Attachment D.

   iii. Changes to Attachments C and D must be submitted to CMS for review and approval prior to implementation, but are not subject to the amendment process outlined in STC 7.

b. Annual UC Payment Limits. The state may claim FFP for UC Payments in each DY up to the limits (total computable) described in the table in this STC.

Demonstration Year	HCAIP Pool (total computable)	LPTH/BCCH Pool (total computable)	UC Pool (total computable)
DY7	$41,000,000	$9,856,550	$50,856,550
DY8	$41,000,000	$9,856,550	$50,856,550
DY9	$41,000,000	$9,856,550	$50,856,550
DY10	$41,000,000	$9,856,550	$50,856,550
DY11	$41,000,000	$9,856,550	$50,856,550

c. UC Payment Methodology

   i. Payments are made each calendar quarter based on a UC Payment Application that contains information reported by each hospital from its Medicare hospital cost report associated with the state's most recent DSH audit collection tool net of any DSH payments received in that fiscal year. All UC payments must be based on uncompensated care costs calculated in accordance with the General DSH Audit and Reporting Protocol, CMS-2198-F. In DY 9 and subsequent years, UC payments must be based on the uncompensated cost of medical services provided to uninsured individuals as charity care, and no longer need to be net of DSH payments received

[5] Available at http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=14589.

during the fiscal year as DSH payments can be applied to Medicaid shortfall.

ii. HCAIP Pool. The payment structure for the HCAIP UC payments is as follows, subject to the annual limits in STC 53(b):

A. *Uniform Percentage*: The state shall calculate aggregate uncompensated care costs for HCAIP hospitals based on the information identified in STC 53(c)(i) above. Each hospital eligible under the HCAIP UC section shall then receive a uniform percentage of its eligible uncompensated care costs (UCC);

B. *Specialty Service Uniform Percentage*: Each hospital that furnishes at least 1 of the following specialty services shall receive an additional uniform percentage of its eligible UCC:

a. Psychiatric services;
b. Level II or Level III Neonatal Intensive Care Unit (NICU) services; or,
c. Level I or Level II Trauma Services.

C. *Tri-Level NICU Services Uniform Percentage*: Each hospital system that furnishes all 3 levels of NICU services (Levels I, II, and II) shall receive an additional uniform percentage of its eligible UCC.

D. *Tri-Specialty Uniform Percentage*: Each hospital that provides all 3 specialty services identified above and has inpatient net patient revenue less than the amount identified in Attachment J shall receive an additional uniform percentage of its eligible UCC. The goal of including an inpatient net patient revenue threshold as a criterion for this adjustment is to recognize the added difficulty in providing access to multi-specialty services in smaller facilities. As such, the threshold must be evaluated annually to ensure smaller facilities that offer such multi-specialty services would not be inadvertently ineligible for such payment merely based on standard industry growth in patient revenues.

E. In addition to the inpatient net patient revenue threshold applicable to the Tri-Specialty adjustment the uniform percentages for each of the four adjustments for each demonstration year may also be found in Attachment J. By February 28th of each year (DY 7 through 11), the state must submit a revised Attachment J to CMS for review and approval. This revision is not subject to the amendment process provided in STC 7.

iii. LPTH/BCCH Pool. The payment structure for the LPTH/BCCH UC payments will be calculated in accordance with STC 53(c)(i), up to the limits set forth in STCs 53(b) and 55. Within the LPTH/BCCH Pool, 75 percent of the funding is available to the designated LPTHs while the remaining 25 percent is available to the designated BCCHs (see Attachment D for additional information on LPTH/BCCH Pool eligible hospitals).

d. UC Payment Application. To qualify for a UC Payment, a hospital must submit to the state an annual UC Payment Application that will collect cost and payment data on

services eligible for reimbursement under the UC Pool. The UC Payment Application is Attachment E. Data collected from the application will form the basis for UC Payments made to individual hospitals. The state must require hospitals to report data in a manner that is consistent with the Medicare 2552-10 cost report. By July 1, 2019, the state must submit to CMS for review and approval a revised UC Payment Application template that is consistent with the revised focus of the UC Pool on unreimbursed cost of charity care for the uninsured.

i. The state may accept applications from hospitals for UC Payments for DY 7 and 8. After CMS has approved the revised UC Payment Application template, the state may begin accepting applications from hospitals for UC Payments in DY 9. Hospitals are required to submit their UC Payment Applications to the state by December 31st of each year, in order to qualify for a UC Payment for the DY that begins on January 1st.

ii. Cost and payment data included on the application must be based on the Medicare 2552.10 cost report, or similar Medicaid cost report for hospitals not enrolled with Medicare. The state may trend the data to model costs incurred in the year in which payments are to be made. Subsequent DY application will be used to verify that a hospital's UC Payments, when combined with Disproportionate Share Hospital (DSH) payments under the state plan, did not exceed its actual uncompensated care costs in that year. For example, uncompensated care costs data from a DY 9 application will be used to determine the actual uncompensated care for DY 7 UC Payments for a qualifying hospital and the state will verify that UC Payments plus DSH payments attributable to DY 7 did not exceed the hospital's actual uncompensated care costs. Any overpayments identified in the verification process that occurred in a prior year must be recouped from the provider, with the FFP returned to CMS.

e. **UC Payment Protocol.** The UC Payment Protocol, also known as the funding and reimbursement protocol, establishes rules and guidelines for the State to claim FFP for UC Payments. By July 31, 2019, in addition to the revised UC Payment Application template, the state must submit a draft UC Payment Protocol to CMS for approval that will establish rules and guidelines for the state to claim FFP for UC Payments beginning in DY 9. CMS and Kansas will work collaboratively with the expectation of CMS approval of the protocol within 90 calendar days after CMS receives the draft protocol. The state cannot claim FFP for any UC Payments for DY 9 or later until a UC Protocol has been approved by CMS. The UC Payment Protocol must include precise definitions of eligible uncompensated provider charity care costs (consistent with the Medicare cost reporting principles and revenues that must be included in the calculation of uncompensated charity care cost for purpose of reconciling UC payments to unreimbursed charity care cost). The Protocol will also identify the allowable source documents to support costs; it will include detailed instructions regarding the calculation and documentation of eligible costs, and a timetable and reconciliation of payments against actual charity care cost documentation. This process will align the application process (based on prior cost periods) to the reconciliation process (using the application costs from subsequent years to reconcile earlier payments). The Protocol will contain not only allowable costs and revenues, it will

also indicate the twelve (12) month period for which the costs will apply. Once approved by CMS, the UC Payment Protocol will become Attachment L of the STCs.

f. All applicable inpatient and outpatient hospital UC payments received by a hospital count as title XIX revenue, and must be included as offsetting revenue in the state's annual DSH audit reports. Providers receiving both DSH and UC Payments cannot receive total payments under the state plan, DSH, and the UC Pool (related to inpatient and outpatient hospital services) that exceed the hospital's total eligible uncompensated costs. UC Payments for physicians, non-physician professionals, pharmacy, and clinic costs are not considered inpatient or outpatient Medicaid payments for the purpose of annual hospital specific DSH limits and the DSH audit rule. All reimbursement must be made in accordance with CMS approved cost claiming protocols that are consistent with the Medicare 2552-10 cost report.

g. Annual Reporting Requirements for UC Payments. The state must submit to CMS two reports related to the amount of UC Payments made from the UC Pool per demonstration year. The reporting requirements are as follows:

i. By March 31st of each demonstration year, the state shall provide the following information to CMS:
   1) The UC payment applications submitted by eligible providers for the current DY; and
   2) A chart of estimated UC Payments to each provider for the current DY.

ii. Within 90 days after the end of each demonstration year, the state shall provide the following information to CMS:
   1) The UC Payment applications submitted by eligible providers; and,
   2) A chart of actual UC payments to each provider for the previous DY.

h. UC Pool Timeline

i. DY 7 through 11:

   1) By December 31st of each year, hospitals must submit to the state the UC Payment Application for the DY beginning January 1.

ii. DY 7 through 11:

   1) By February 28th of each year, the state must submit a revised Attachment J to CMS for review and approval.
   2) By March 31st of each year, the state must submit to CMS the UC Payment Applications and a chart of the estimated UC Payments to each provider for the DY.
   3) Within 90 days of the end of the previous DY, the state must submit to CMS:
      a. The UC Applications submitted by eligible providers; and,
      b. A chart of actual UC Payments for the previous DY.

54. **Delivery System Reform Incentive Payment (DSRIP) Pool.** The DSRIP Pool is available in DY 7 through 8 for the continuation of a program of activity that supports hospitals' efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve. The program of activity funded by the DSRIP will be those activities that are directly responsive to the needs and characteristics of the populations and communities served by each hospital. The metrics for the DSRIP will be updated to more accurately capture the success of the program and the programs for each hospital will continue to operate as they did in the previous demonstration period. The DSRIP Planning Protocol, DSRIP Funding and Mechanics Protocol, and Hospital Plans will remain in effect in the extension period.

    a. DSRIP Eligibility. Participation in the DSRIP is limited to hospitals designated as LPTH or BCCH in Attachment D.

    b. Project Focus Areas. The project focus areas for the DSRIP Pool must target specific care improvements, and may include those based on regional planning needs or state public health initiatives. Each focus area has an explicit connection to the achievement of the three-part aim. Each participating hospital will be required to select at least two projects from the menu of focus areas identified by the state through its public process. The approved DSRIP Project Focus Areas are listed in Attachment K.

    c. Project Categories. Each hospital project must include Category 1, 2 and 3 milestones. All hospitals must report the common Category 4 milestones and the Category 4 milestones specific to the selected projects:

        i. *Category 1: Infrastructure Milestones*. These are infrastructure-related milestones a hospital must achieve to move forward with its selected and approved project. These milestones lay the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services. These milestones must support the achievement of quality and outcomes milestones for each project.

        ii. *Category 2: Process Milestones*. These milestones focus on process changes and improvements. These milestones must support the achievement of quality and outcomes milestones for each project.

        iii. *Category 3: Quality and Outcomes Milestones*. These milestones address the impact of the project on quality metrics and beneficiary outcomes. This stage involves the broad dissemination of interventions from a list of activities identified by the state, in which major improvements in care can be achieved within 4 years. These are hospital-specific initiatives and will be jointly developed by hospitals, the state, and CMS and are unlikely to be uniform across all of the hospitals.

        iv. *Category 4: Population Focused Improvements*. This category evaluates the broader impact of the selected projects through the reporting of Performance

Indicators across several domains selected by the state in conjunction with CMS, and may include:

1) Patient experience;
2) Care outcomes; and,
3) Population health.

Category 4 will include both common (apply to all hospitals) and specific (apply to a given project) measures.

d. DSRIP Performance Indicators. The state has identified performance indicators that are connected to the achievement of providing better care, better access to care, enhanced prevention of chronic medical conditions, and population improvement. These DSRIP Performance Indicators comprise the list of measures that hospitals are required to report under Category 4: Population Focused Improvements.

e. Status of DSRIP Payments**.** DSRIP payments are not direct reimbursement for expenditures or payments for services. Payments from the DSRIP pool are intended to support and reward hospitals for improvements in their delivery systems that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Payments from the DSRIP Pool are not considered patient care revenue, and shall not be offset against DSH expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) as defined under these STCs, and/or under the Medicaid state plan. A hospital may only receive DSRIP payments following the successful achievement of metrics as reflected in its reports and as approved by the state. If the state determines that the hospital did not fully and successfully achieve a metric, payment to the hospital for that metric will not be issued.

f. Demonstration Years 7 through 8 Payments**.** Each hospital with a Hospital DSRIP Plan update approved by the state may receive DSRIP Payments in DY 7, and DY 8. The total amount of DSRIP Payments available shall be allocated 75 percent to LPTH and 25 percent to BCCH.

g. Annual DSRIP Payment Limits. Subject to the requirements of STC 54(j), the state may claim FFP for DSRIP Payments in each DY up to the limits (total computable) described in the table in STC 55.

h. DSRIP Pool Timeline. By Febuary 1, 2019, the state must submit to CMS its updates for the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol. The state and CMS agree to a target date of Febuary 28, 2019 for CMS to issue its final approval of these updated protocols. CMS may approve these protocols before the target date. The state may not claim FFP for DSRIP payments in DY 7 or 8 until after CMS has approved the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol updates.

i. Rapid Cycle Evaluation. The DSRIP will support a process of data-driven, rapid

cycle improvement that will gather data in real time and make recommendations to the state, CMS, and hospitals about how to ensure the timely progress in promoting the DSRIP goals. Under DSRIP, hospitals will implement continuous performance improvement in order to improve efficiencies, improve quality, improve experience, reduce inefficiencies, and eliminate waste and redundancies. Hospitals must disseminate their findings to allow other providers to learn from the DSRIP.

j. Federal Financial Participation (FFP) For DSRIP. The following terms govern the state's eligibility to claim FFP for DSRIP.

i. The state must not claim FFP for DSRIP until after CMS has approved the updated DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol.

ii. The state may not claim FFP for DSRIP Payments in DY 7 through 8 until the state has concluded that the hospitals have met the performance indicated for each payment. Hospitals' reports must contain sufficient data and documentation to allow the state to determine if the hospital has fully met the specified metric, and hospitals must have available for review by the state or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to activities listed in an approved Hospital DSRIP Plan.

iii. In addition to the documentation discussed in STC 52(e), the state must use the documentation discussed in the DSRIP Funding and Mechanics Protocol to support claims made for FFP for DSRIP Payments that are made on the CMS-64.9 Waiver forms.

55. Limits on Pool Payments. The state may claim FFP for the Safety Net Care Pool in each DY up to the limits on total computable listed in the table below. Annual SNCP total computable costs may not exceed $80,856,550 in any demonstration year.

	DY 7	DY 8	DY 9	DY 10	DY 11	Total
UC Pool HCAIP	$41,000,000	$41,000,000	$41,000,000	$41,000,000	$41,000,000	$205,000,000
UC Pool BCCH/LPH	$9,856,550	$9,856,550	$9,856,550	$9,856,550	$9,856,550	$49,282,750
DSRIP	$30,000,000	$30,000,000	$0	$0	$0	$60,000,000
Total	$80,856,550	$80,856,550	$50,856,550	$50,856,550	$50,856,550	$314,282,750

56. Assurance of Budget Neutrality.

a. By October 1 of each year, the state must submit an assessment of budget neutrality to CMS, including a summation of all expenditures and member months already reported to CMS, estimates of expenditures already incurred but not reported, and projections of future expenditures and member months to the end of the demonstration, broken out by DY and Medicaid Eligibility Group (MEG) or other spending category.

b. Should the report in (a) indicate that the budget neutrality Annual Target for any DY has been exceeded, or is projected to be exceeded, the state must propose adjustments to the limits on UC Pool and DSRIP Pool limits, such that the demonstration will again be budget neutral on an annual basis, and over the lifetime of the demonstration. The new limits will be incorporated through an amendment to the demonstration.

57. Amending the Safety Net Care Pool. Any changes to the SNCP (UC Pool or DSRIP Pool) are subject to the amendment process described in STC 7. SNCP amendments must be approved by CMS prior to implementation.

58. Alternative Payment Models (APM). The state will develop and implement an Alternative Payment Model (APM) to improve health outcomes and contribute to delivery system reform. The APM model will replace the DSRIP program no sooner than January 2021 contingent on CMS approval of a State Plan Amendment for state-directed payments under Section 42 CFR 438.6.

Under an APM, participating hospitals will receive performance-based payments for targeted conditions to address discharges back to rural communities. The state will develop a multi-year roadmap for how it will develop and implement an Alternative Payment Model. In developing this roadmap, the state will:

- Incorporate the APM framework, guidance, best practices, and lessons learned from the U.S. Department of Health and Human Services Health Care Payment Learning & Action Network to the extent appropriate
- Engage with its APM stakeholder group to propose recommendations regarding criteria for participation and guidance on how to structure, measure, assess, and fund the APM
- Collaborate with providers, manage care organizations (MCOs), and other stakeholders to evaluate the payment model options and set payment methodology standards

The state intends to implement APMs no sooner than January 1, 2021.

a. Stakeholder Engagement: The stakeholder group will meet monthly to design the APM proposal for the State and MCOs to consider. Stakeholders will include representatives from groups such as:
    A. The Kansas Hospital Association
    B. Critical access hospitals
    C. Large and small hospitals
    D. Hospitals representing urban, rural and frontier areas of the state
    E. Advocates
    F. Other provider types

b. APM Targeted Conditions: The state will work closely with the stakeholder group to select target conditions they will address. State and MCOs will consider proposals from providers and make decisions regarding stakeholder proposals and recommendations.

c. APM Eligibility: The state will work with the stakeholder group to finalize eligibility

requirements for participation. The stakeholder group will consider provider types such as:

i. Critical access hospitals
ii. Large and small hospitals
iii. Hospitals representing urban, rural and frontier areas of the state
iv. Federally qualified health centers
v. Other provider types

d. Potential APMs: The final APM design will depend on several factors, including stakeholder input, options analyses, and legislative support; however, the state expects to consider the following APMs:

i. Bonus payments and penalties for quality performance
ii. Bundled payments with upside or downside risk
iii. Episode-based payments

e. APM Milestones: The state intends to implement its APMs in 2021. The state has already begun communicating with stakeholders and the process of identifying APM goals, objectives, and accomplishments. In January 2019, the state will begin convening stakeholder group meetings.

Between January 1, 2019 and December 31, 2020, the state will conduct the following milestone activities:

i. Develop multi-year roadmap for implementing APMs by 2021
ii. Conduct ongoing APM stakeholder group meetings
iii. Solicit proposed APMs from eligible providers
iv. Select APM(s)
v. Complete the 438.6 preprint form based on APM approach and submit to CMS for approval
vi. Draft MCO contract language describing the APM requirements and approach for 2021 MCO contract period

f. Annual Updates: The state shall also include annual progress updates on the Alternative Payment Model development and DSRIP transition in its Annual Report as required per STC 64.

g. Evaluation: The state shall also include an evaluation of the APM models and DSRIP transition in the demonstration evaluation design required per STC 97.

XII. GENERAL REPORTING REQUIREMENTS

59. General Financial Requirements. The state must comply with all general financial requirements under title XIX of the Social Security Act as set forth in Section XIII of these STCs.

60. Compliance with Managed Care Reporting Requirements. The state must comply with all managed care reporting regulations at 42 CFR 438 et. seq.

61. Reporting Requirements Related to Budget Neutrality. The state must comply with all reporting requirements for monitoring budget neutrality as set forth in Section XIII of these STCs, including the submission of corrected budget neutrality data upon request.

62. Monitoring Protocol. The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after approval of the demonstration. Once approved, the Monitoring Protocol will be incorporated into the STCs, as an Attachment S.

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct quarterly and annual monitoring in accordance with CMS' template. Any proposed deviations from CMS' template should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through quarterly and annual monitoring reports. For quantitative metrics (e.g., performance metrics as described in STC 64(b) below), CMS will provide the state with a set of required metrics, and technical specifications for data collection and analysis. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g. operational updates as described in STC 64(a) below), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's quarterly and annual monitoring reports.

63. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

64. Monitoring Reports. The state must submit three (3) Quarterly Reports and one (1) Annual Report each DY. The information for the fourth quarterly report should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60 days) following the end of each demonstration quarter. The Annual Report is

due no later than ninety (90 days) following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework to be provided by CMS, which will be organized by milestones. The framework is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates - The operational updates will focus on progress towards meeting the milestones identified in CMS' framework. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics – The performance metrics will provide data to demonstrate how the state is progressing towards meeting the milestones identified in CMS' framework. The performance metrics will reflect all components of the state's demonstration, and may include, but are not limited to, measures associated with eligibility and coverage.

   Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals.

   The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook quarterly, using the Budget Neutrality Monitoring Tool described in STC 94, that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

e. SUD Health IT. The state will include a summary of progress made in regards to SUD Health IT requirements outlined in STC 22(f).

65. **Corrective Action.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

66. **Submission of Post-approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

67. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singularly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

    a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

    b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).

        i. CMS may decline the extension request.

        ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.

        iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.

    c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

    d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.

    e. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

    f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example, what quarter the deferral applies to and how the deferral is released.

68. **Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones.** Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Protocol and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once

CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

69. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 waiver reporting and analytics functions, the state will work with CMS to:

    a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

    b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

    c. Submit deliverables to the appropriate system as directed by CMS.

70. **Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 67.

71. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

72. **Close-out Report**. Within 120 days after the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

    a. The draft report must comply with the most current guidance from CMS.

    b. The state will present to and participate in a discussion with CMS on the Close-Out report.

    c. The state must take into consideration CMS' comments for incorporation into the final Close Out Report.

    d. The final Close Out Report is due to CMS no later than thirty (30) days after receipt of CMS' comments.

e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 67.

XIII. GENERAL FINANCIAL REQUIREMENTS

73. Quarterly Expenditure Reports: The state must provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

74. Reporting Expenditures Under the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality agreement:

a. Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX and section 1115 of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension which indicates the DY in which services were rendered or for which capitation payments were made).

b. Reporting by Demonstration Year (DY) by Date of Service. In each quarter, demonstration expenditures (including prior period adjustments) must be reported separately by DY (as defined in STC 74(f) below). Separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted for each DY for which expenditures are reported. The DY is identified using the Project Number Extension, which is a 2-digit number appended to the Demonstration Project Number. Capitation and premium payments must be reported in the DY that includes the month for which the payment was principally made. Pool payments are subject to annual limits by DY, and must be reported in DY corresponding to the limit under which the payment was made. All other expenditures must be assigned to DYs according to date of service.

c. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

d. Premium and Cost Sharing Contributions. Premiums and other applicable cost sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both

total computable and federal share) should also be reported separately by DY on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

e. Pharmacy Rebates. Pharmacy rebates must be reported on Form CMS-64.9 Base, and not allocated to any Form 64.9 or 64.9P Waiver.

f. Demonstration Years. The first Demonstration Year (DY1) will be January 1, 2013, through December 31, 2013, and subsequent DYs will be defined as follows:

Demonstration Year 1 (DY1)	Jan. 1, 2013 to Dec. 31, 2013	12 months
Demonstration Year 2 (DY2)	Jan. 1, 2014 to Dec. 31, 2014	12 months
Demonstration Year 3 (DY3)	Jan. 1, 2015 to Dec. 31, 2015	12 months
Demonstration Year 4 (DY4)	Jan. 1, 2016 to Dec. 31, 2016	12 months
Demonstration Year 5 (DY5)	Jan. 1, 2017 to Dec. 31, 2017	12 months
Demonstration Year 6 (DY6)	Jan. 1, 2018 to Dec. 31, 2018	12 months
Demonstration Year 7 (DY7)	Jan. 1, 2019 to Dec. 31, 2019	12 months
Demonstration Year 8 (DY8)	Jan. 1, 2020 to Dec. 31, 2020	12 months
Demonstration Year 9 (DY9)	Jan. 1, 2021 to Dec. 31, 2021	12 months
Demonstration Year 10 (DY10)	Jan. 1, 2022 to Dec. 31, 2022	12 months
Demonstration Year 11 (DY11)	Jan. 1, 2023 to Dec. 31, 2023	12 months

g. Use of Waiver Forms. For each quarter of each Demonstration Year, 22 separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the *Category Names* shown in quotation marks below, to report expenditures for the demonstration. Items i though ix below represent *Medicaid Eligibility Groups* (MEGs); STC 16 specifies the populations within each MEG. Items x and xi refer to the SNCP. Expenditures should be allocated to these forms based on the guidance found below.

i. "ABD and LTC" includes the following listed below as subcategories:

A. Aged, Blind, and Disabled/Spend Down Dual ["ABD/SD Dual"]

B. Aged, Blind, and Disabled/Spend Down Non Dual ["ABD/SD Non Dual"]

C. "DD Waiver"

D. Long Term Care ["LTC"]

E. Medically Needy Dual ["MN Dual"]

F. Medically Needy Non Dual ["MN Non Dual"]

G. "Waiver"

ii. "Adults and Children" includes the following listed below as subcategories:

A. "Adults"

B. "Children"

iii. "BH Pilot SSDI Buy-In": Medical assistance expenditures for individuals qualifying for BH Pilot Program under STC 22(a)(1) and 22(b)(i). "

iv. "BH Pilot SSI": Expenditures for BH Pilot services for SSI-eligible individuals."

v. Safety Net Care Pool – Uncompensated Care Pool ["UC Pool"]

vi. Safety Net Care Pool – Delivery System Reform Incentive Payment Pool ["DSRIP Pool"]

vii. SUD IMD – All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD ["SUD IMD"].

75. Expenditures Subject to the Budget Neutrality Limit. For purposes of this section, the term "expenditures subject to the budget neutrality limit" must include:

h. All demonstration medical assistance expenditures (including those authorized through the Medicaid state plan, through the concurrent 1915(c) waivers, and through the section 1115 waiver and expenditures authorities), on behalf of all demonstration participants listed in the tables in STC 16, with dates of services within the demonstration's approval period; and,

i. All Safety Net Care Pool payments, including both UC Pool and DSRIP Pool payments.

All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

76. Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

77. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue

to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

78. **Reporting Member Months.** For the purpose of calculating the budget neutrality limit and for other purposes, the state must provide to CMS on a quarterly basis the actual number of eligible member months for the demonstration enrollees. Member-month enrollment information must be provided to CMS in conjunction with the quarterly Monitoring Reports pursuant to STC 64.

    a. The state must report the actual number of member months for Eligibility Groups i though ix as defined in STC 74(g)(i), (ii), and (vii).

    b. The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of 4 eligible member/months.

    c. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

79. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality limit and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

80. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in Section XIV of the STCs:

    d. Administrative costs, including those associated with the administration of the demonstration;

    e. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

    f. Net medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the

demonstration period, including expenditures under the Safety Net Care Pool.

81. **Sources of Non-Federal Share.** The state must certify that matching the non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

    g. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.

    h. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

    i. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

82. **State Certification of Funding Conditions.** The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

    j. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

    k. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

    l. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

    m. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

n. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider- related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

83. Monitoring the Demonstration. The state will provide CMS with information to effectively monitor the demonstration (including but not limited to primary data on enrollment, quality, encounters, and expenditures), upon request, in a reasonable time frame.

84. Program Integrity. The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

XIV. MONITORING BUDGET NEUTRALITY

85. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method described in STC 88, and budget neutrality limits are set on a yearly basis with a cumulative budget neutrality limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

86. Risk. The state shall be at risk for the per capita cost (as determined by the method described below) for demonstration eligibles under this budget neutrality limit, but not for the number of demonstration eligibles. By providing FFP for all demonstration eligibles, the state shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have been realized had there been no demonstration.

87. Expenditures Excluded From Budget Neutrality Limit. Regular FFP will continue for costs not subject to budget neutrality limit. These exclusions include:

a. Allowable administrative expenditures;

b. Disproportionate Share Hospital (DSH) payments;

c. Medicaid Fee for Service (FFS) payments which are made outside the demonstration;

d. Pharmacy rebates (see STC 74(e)); and

e. Costs for excluded populations (see STC 16(a)).

88. Calculation of the Budget Neutrality Limit and How It Is Applied. The following are the PMPM costs for the calculation of the budget neutrality limit. ***The demonstration year is January 1 through December 31.***

Eligibility Groups	Trend Rate	DY 7 (CY 2019)	DY 8 (CY 2020)	DY 9 (CY 2021)	DY 10 (CY 2022)	DY 11 (CY 2023)
Adults and Children	3.8%	$347.66	$360.87	$374.58	$388.81	$403.58
ABD and LTC	4.1%	$2508.47	$2,611.32	$2,718.38	$2,839.83	$2,945.85

a. For each year of the budget neutrality agreement, an annual budget neutrality expenditure limit is calculated for each MEG. An annual MEG estimate must be calculated as a product of the number of eligible

member months reported by the state under STC 78 for each MEG, times the appropriate per member per month (PMPM) costs from the table in STC 88. Historical data used to calculate the budget neutrality limit are provided in Attachment B.

b. The annual budget neutrality limit for the demonstration as a whole is the sum of the projected annual expenditure caps for each EG calculated in subparagraph (b) above.

c. The lifetime (overall) budget neutrality limit for the demonstration is the sum of the annual budget neutrality limits calculated in STC 88(a). The federal share of the overall budget neutrality limit (calculated as the product of the overall budget neutrality limit times the Composite Federal Share 1) represents the maximum amount of FFP that the state may receive for demonstration expenditures during the demonstration period reported in accordance with STC 90.

d. The demonstration expenditures subject to the budget neutrality limit are those reported under the following Waiver Names: ABD/SD Dual, ABD/SD Non Dual, Adults, Children, DD Waiver, LTC, MN Dual, MN Non Dual, Waiver, BH Pilot SSDI Buy-In, UC Pool, and DSRIP Pool, plus any excess spending from the Supplemental Tests described in STC 89.

89. Supplemental Tests

a. **Supplemental Budget Neutrality Test 1: Substance Use Disorder Expenditures.** As part of the SUD component of this demonstration, the state may receive FFP for the continuum of services to treat OUD and other SUDs, provided to Medicaid enrollees in an IMD with a primary diagnosis of SUD. These "SUD Services" are, or could be state plan services that would be eligible for reimbursement if not for the IMD exclusion; therefore, they are being treated as hypothetical for the purposes of budget neutrality. Hypothetical services can be treated in budget neutrality in a way that is similar to how Medicaid state plan services are treated, by including them as a "pass through" in both the without-waiver and with-waiver calculations. The state may only claim FFP via demonstration authority for the SUD Services listed in Table XX that will be provided in an IMD for Medicaid beneficiaries with a primary diagnosis of SUD. However, the state will not be allowed to obtain budget neutrality "savings" from these services.SUD Services. Therefore, a separate expenditure cap is established for SUD IMD services, to be known as Supplemental Budget Neutrality Test 1.

i. The MEGs listed in the table below are included in calculation of Supplemental Cap 1, for the SUD IMD Supplemental BN Test.

Demonstration Eligibility Groups	Trend Rate	DY 7 (CY 2019)	DY 8 (CY 2020)	DY 9 (CY 2021)	DY 10 (CY 2022)	DY 11 (CY 2023)
SUD IMD	3.9%	$505.02	$524.72	$545.18	$566.44	$588.53

ii. The Supplemental Cap 1 is calculated by taking the PMPM cost projection for each group in the above table in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of Supplemental Cap 1 is obtained by multiplying the total computable Supplemental Cap 1 by Composite Federal Share 2.

iii. Supplemental Test 1 is a comparison between the federal share of Supplemental Cap 1 and total FFP reported by the state for hypothetical groups under the following Waiver Name:. SUD IMD.

iv. If total FFP for hypothetical group should exceed the federal share of Supplemental Cap 1, the difference must be reported as a cost against the budget neutrality limit described in STC 88.

b. **Supplemental Budget Neutrality Test 2: Disability and Behavioral Health Employment Support Pilots.** The state will operate a voluntary pilot program for eligible KanCare members with specific behavorial health diagnoses or disabilities through this section 1115 demonstration. This pilot program will help certain members obtain and maintain employment by providing supportive services. The pilot program will operate during the KanCare 2019-2023 demonstration extension, with a possibility of renewal and expansion through an applicable title XIX authority if shown to be effective. The program will begin no sooner than July 1, 2019. The state will receive FFP for this pilot.

i. The MEGs listed in the table below are included in calculation of Supplemental Cap 2.

Demonstration Eligibility Groups	Trend Rate	DY 7 (CY 2019)	DY 8 (CY 2020)	DY 9 (CY 2021)	DY 10 (CY 2022)	DY 11 (CY 2023)
BH Pilot SSI	N/A	$7,660,111	$7,853,302	$8,051,366	$8,254,425	$8,462,605

ii. The Supplemental Cap 2 ECM expenditures cap consists of the total computable dollar limits presented in the above table, summed across all DYs. The federal share of Supplemental Cap 2 is obtained by multiplying the total computable Supplemental Cap 1 by Composite Federal Share 3.

iii. Supplemental Test 2 is a comparison between the federal share of Supplemental Cap 1 and total FFP reported by the state for hypothetical groups under the following Waiver Name: BH Pilot SSI

iv. If total FFP for hypothetical groups should exceed the federal share of Supplemental Cap 2, the difference must be reported as a cost against the budget neutrality limit described in STC 88.

90. Composite Federal Share. The Composite Federal Share 1 is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, by the sum of total computable demonstration expenditures for the same period, reported under Waiver Names "Adults and Children" and "ABD and LTC". The Composite Federal Share 2 is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, by the sum of total computable demonstration expenditures for the same period, reported under Waiver Name "SUD IMD. The Composite Federal Share 3 is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, by the sum of total computable demonstration expenditures for the same period, reported under Waiver Name BH Pilot. Should the demonstration be terminated prior to the end of the approval period (see STC 9), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of the Composite Federal Share may be used.

91. Impermissible DSH, Taxes, or Donations. CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments (if necessary adjustments must be made). CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

92. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration extension, which for this purpose will be from January 1, 2019 through December 31, 2023 (i.e., DY 7 through DY 11). The budget neutrality test for the demonstration extension may incorporate net savings from the immediately prior demonstration period consisting of DY 2 through DY 6, but not from any earlier approval period. However, if the state's expenditures exceed the calculated cumulative budget neutrality limit by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative target definition	Percentage
DY 7	Cumulative budget neutrality limit plus:	0 percent

DY 8	Cumulative budget neutrality limit plus:	0 percent
DY 9	Cumulative budget neutrality limit plus:	0 percent
DY 10	Cumulative budget neutrality limit plus:	0 percent
DY 11	Cumulative budget neutrality limit plus:	0 percent

93. **Exceeding Budget Neutrality.** If, at the end of this demonstration period, the cumulative budget neutrality limit has been exceeded, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

94. **Budget Neutrality Monitoring Tool.** The state will provide CMS with quarterly budget neutrality status updates using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in Section XIV. CMS will provide technical assistance, upon request.

XV. EVALUATION OF THE DEMONSTRATION

95. Independent Evaluator. Upon approval of the demonstration, the state must begin arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved, draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

96. Evaluation Budget. A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

97. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than 180 days after approval of the demonstration.

Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable.

The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

a. All applicable evaluation design guidance provided by CMS.

b. Attachment M (Developing the Evaluation Design) of these STCs, technical assistance for developing SUD evaluation designs (as applicable, and as provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a draft evaluation design.

98. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

99. Evaluation Questions and Hypotheses. Consistent with Attachments M and N (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, CMS' measure sets for eligibility and coverage, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF). The state must also include measures provided by CMS for monitoring and evaluation of the SUD demonstration. The state should also include measures that evaluate Medicaid expenditures and trends in the demonstration.

100. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.

a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.

b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the final Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.

e. The Interim Evaluation Report must comply with Attachment N (Preparing the Evaluation Report) of these STCs.

101. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment N of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period, within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 days of receiving comments from CMS on the draft.

b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 days of approval by CMS.

102. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the interim evaluation, and/or the summative evaluation.

103. Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, Approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 days of approval by CMS.

104. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10 business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

105. Evaluation Goals and Objectives. The evaluation must include a discussion of the goals and objectives of the demonstration aligned with proposed research questions and hypotheses that the state intends to test. If the demonstration is extended beyond the current demonstration period, the evaluation design must include a summary of the previous evaluation findings and a discussion of how the evaluation design will build and expand on earlier findings.

106. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's interim evaluation report. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

XVI. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION APPROVAL PERIOD

The state is held to all reporting requirements as outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Date - Specific	Deliverable	STC Reference
July 1, 2019	Submit UC Payment Application template	STC 53
Within 120 days of expiration	Submit a Draft Close-Out Report	STC 72
Within 30 days of receipt of CMS comments	Submit Final Close-Out Report	STC 72
30 days after extension approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
90 days after SUD program approval date	SUD Implementation Protocol	STC 21(a)
150 days after SUD program approval date	SUD Monitoring Protocol	STC 21(b)
150 days after extension program approval date	Monitoring Protocol	STC 62
180 days after approval date	Draft Evaluation Design	STCs 97
60 days after receipt of CMS comments	Revised Draft Evaluation Design	STCs 98
30 days after CMS Approval	Approved Evaluation Design published to state's website	STCs 98
One year prior to the end of the demonstration, or with renewal application	Draft Interim Evaluation Report	STC 100
60 days after receipt of CMS comments	Final Interim Evaluation Report	STC 100
18 months of the end of the demonstration	Draft Summative Evaluation Report	STC 101
60 calendar days after receipt of CMS comments	Final Summative Evaluation Report	STC 101

90 days after middle of DY10 (September 30, 2022)	Submit Draft SUD Mid-point Assessment	STC 21
60 calendar days after receipt of CMS comments	Submit Final SUD Mid-point assessment	STC 21
30 calendar days of CMS approval	Approved Final Summative Evaluation Report published to state's website	STC 101
Within 120 calendar days prior to the expiration of the demonstration	Draft Close-out Operational Report	STC 72
30 calendar days after receipt of CMS comments	Final Close-out Operational Report	STC 72

	Deliverable	STC Reference
Annual	By April 1st - Draft Annual Report	STC 64
	By March 31st – UC Payment Applications	STC 53
	Within 90 days of close of previous DY – UC Payment Applications and a chart of actual UC Payments for the previous DY	STC 53
	By February 28the, Attachment J, UC Pool Uniform Percentages	STC 53
Each Quarter (02/28, 05/31, 08/31, 11/30)		
	Monitoring Reports	STC 64
	Budget Neutrality Monitoring Tool	STC 94
	CMS-64 Reports	STC 64
	Eligible Member Months	STC 78

ATTACHMENT A

Quarterly Report Content and Format

Under Section XII, STC79, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – KanCare
Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 1 (1/1/2013 – 12/31/2013)
Federal Fiscal Quarter: 2/2013(1/13 - 3/13)

Introduction

Information describing the goals of the demonstration, what it does, and key dates of approval and operation. (This should be the same for each report.).

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

Note: Enrollment counts should be person counts, not member months

Demonstration Populations (as hard coded in the CMS 64)	**Enrollees at close of quarter** (date)	**Current Enrollees** (to date)	**Disenrolled in Current Quarter**
Population 1: ABD/SD Dual			
Population 2: ABD/SD Non Dual			
Population 3: Adults			
Population 4: Children			
Population 5:DD Waiver			
Population 6:LTC			
Population 7:MN Dual			
Population 8:MN Non Dual			

ATTACHMENT A
Quarterly Report Content and Format

Demonstration Populations (as hard coded in the CMS 64)	**Enrollees at close of quarter** (date)	**Current Enrollees** (to date)	**Disenrolled in Current Quarter**
Population 9: Waiver			
Population 10:UC Pool			
Population 11:DSRIP Pool			

Outreach/Innovative Activities
Summarize marketing, outreach, or advocacy activities to current and potential enrollees and/or promising practices for the current quarter.

Operational Developments/Issues
Identify all significant program developments/issues/problems that have occurred in the current quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues, approval and contracting with new plans; benefits; enrollment; grievances; quality of care; changes in provider qualification standards; access; proposed changes to payment rates; health plan financial performance that is relevant to the demonstration; MLTSS implementation and operation; updates on the safety net care pool including DSRIP activities; information on any issues regarding the concurrent 1915(c) waivers and on any upcoming 1915(c) waiver changes (amendments, expirations, renewals); pertinent legislative activity; and other operational issues.

Policy Developments/Issues
Identify all significant policy and legislative developments/issues/problems that have occurred in the current quarter. Include updates on any state health care reform activities to coordinate the transition of coverage through the Affordable Care Act.

Financial/Budget Neutrality Development/Issues
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the state's actions to address any issues.

Member Month Reporting
Enter the member months for each of the EGs for the quarter, for use in budget neutrality calculations.

Eligibility Group	**Month 1**	**Month 2**	**Month 3**	**Total for Quarter Ending XX/XX**
Population 1: ABD/SD Dual				
Population 2: ABD/SD Non Dual				
Population 3: Adults				
Population 4: Children				
Population 5:DD Waiver				
Population 6:LTC				
Population 7:MN Dual				

ATTACHMENT A
Quarterly Report Content and Format

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Population 8:MN Non Dual				
Population 9: Waiver				
Population 10:UC Pool				
Population 11:DSRIP Pool				

Consumer Issues
A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity
Identify any quality assurance/monitoring activity in current quarter. The state must also report on the implementation and effectiveness of the updated comprehensive Quality Strategy as it impacts the demonstration.

Managed Care Reporting Requirements
A description of network adequacy reporting including GeoAccess mapping, customer service reporting including average speed of answer at the plans and call abandonment rates. A summary of: MCO appeals for the quarter (including overturn rate and any trends identified); enrollee complaints and grievance reports to determine any trends; summary of ombudsman activities including why people are accessing the ombudsman and outcomes of their assistance; and summary analysis of MCO critical incident report which includes, but is not limited to, incidents of abuse, neglect and exploitation.

Safety Net Care Pool
Provide updates on any activities or planning related to payment reform initiatives or delivery system reforms impacting demonstration population and/or undertaken in relation to the SNCP. As per STC 69, include projected or actual changes in SNCP payments and expenditures within the quarterly report. Please note that the annual report must also include SNCP reporting as required by STC 69.

Demonstration Evaluation
Discuss progress of evaluation design and planning.

Enclosures/Attachments
Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT B
Historical Budget Neutrality Data

HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY DEMONSTRATION COST DATA

	B	C	D	E	F	G	H	I	J	K	L	M	N
1	DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS												
2													
3													
4	ELIGIBILITY	TREND	MONTHS	BASE YEAR	TREND RATE 2	PB TREND	ACTUAL	Demonstration Years					TOTAL
5	GROUP	RATE 1	OF AGING	SFY18			TREND	DY1 (CY19)	DY2 (CY20)	DY3 (CY21)	DY4 (CY22)	DY5 (CY23)	WOW
6													
7	**Medicaid Pop 1**	ABD/SD Dual											
8	**Pop Type:**	**Medicaid**											
9	Eligible Member Months	5.91%	6	183,302	0.83%	Aged+Disabled		184,819	186,348	187,890	189,444	191,012	
10	PMPM Cost	1.99%	6	$ 263.68	1.99%	4.10%	1.99%	$ 268.93	$ 274.28	$ 279.74	$ 285.31	$ 290.99	
11	Total Expenditure							$ 49,703,320	$ 51,111,520	$ 52,560,287	$ 54,050,369	$ 55,582,521	$ 263,008,016
12													
13	**Medicaid Pop 2**	ABD/SD Non Dual											
14	**Pop Type:**	**Medicaid**											
15	Eligible Member Months	1.04%	6	350,396	0.95%	Aged+Disabled		353,727	357,090	360,486	363,913	367,373	
16	PMPM Cost	3.02%	6	$ 1,265.11	3.02%	4.10%	3.02%	$ 1,303.32	$ 1,342.68	$ 1,383.23	$ 1,425.00	$ 1,468.04	
17	Total Expenditure							$ 461,019,667	$ 479,458,200	$ 498,634,666	$ 518,576,427	$ 539,318,892	$ 2,497,007,852
18													
19	**Medicaid Pop 3**	Adults											
20	**Pop Type:**	**Medicaid**											
21	Eligible Member Months	-8.08%	6	599,801	0.39%	Adults		602,140	604,487	606,843	609,209	611,584	
22	PMPM Cost	0.00%	6	$ 574.53	0.00%	4.40%	0.00%	$ 574.53	$ 574.53	$ 574.53	$ 574.53	$ 574.53	
23	Total Expenditure							$ 345,947,228	$ 347,295,864	$ 348,649,758	$ 350,008,929	$ 351,373,399	$ 1,743,275,178
24													
25	**Medicaid Pop 4**	Children											
26	**Pop Type:**	**Medicaid**											
27	Eligible Member Months	5.29%	6	2,661,539	2.86%	Children		2,737,645	2,815,927	2,896,447	2,979,269	3,064,460	
28	PMPM Cost	3.70%	6	$ 260.10	5.10%	3.70%	3.70%	$ 269.72	$ 279.70	$ 290.05	$ 300.78	$ 311.91	
29	Total Expenditure							$ 738,397,571	$ 787,614,680	$ 840,114,408	$ 896,104,680	$ 955,835,852	$ 4,218,067,191
30													
31	**Medicaid Pop 5**	DD Waiver											
32	**Pop Type:**	**Medicaid**											
33	Eligible Member Months	-1.52%	6	107,700	0.03%	Disabled		107,729	107,758	107,787	107,816	107,844	
34	PMPM Cost	4.40%	6	$ 5,023.62	5.51%	4.40%	4.40%	$ 5,244.66	$ 5,475.43	$ 5,716.35	$ 5,967.87	$ 6,230.46	
35	Total Expenditure							$ 565,001,142	$ 590,019,684	$ 616,145,619	$ 643,428,047	$ 671,919,479	$ 3,086,514,270
36													
37	**Medicaid Pop 6**	LTC											
38	**Pop Type:**	**Medicaid**											
39	Eligible Member Months	-0.02%	6	242,658	0.04%	Aged+Disabled		242,767	242,876	242,985	243,093	243,202	
40	PMPM Cost	4.10%	6	$ 4,282.42	6.06%	4.10%	4.10%	$ 4,458.00	$ 4,640.78	$ 4,831.05	$ 5,029.12	$ 5,235.31	
41	Total Expenditure							$ 1,082,255,935	$ 1,127,133,489	$ 1,173,870,979	$ 1,222,546,236	$ 1,273,239,660	$ 5,879,046,299
42													
43	**Medicaid Pop 7**	MN Dual											
44	**Pop Type:**	**Medicaid**											
45	Eligible Member Months	6.69%	6	15,521	0.34%	Aged+Disabled		15,574	15,627	15,681	15,735	15,789	
46	PMPM Cost	0.00%	6	$ 809.51	0.00%	4.10%	0.00%	$ 809.51	$ 809.51	$ 809.51	$ 809.51	$ 809.51	
47	Total Expenditure							$ 12,607,350	$ 12,650,606	$ 12,694,010	$ 12,737,563	$ 12,781,265	$ 63,470,793
48													
49	**Medicaid Pop 8**	MN Non Dual											
50	**Pop Type:**	**Medicaid**											
51	Eligible Member Months	50.30%	6	15,087	2.24%	Aged+Disabled		15,424	15,769	16,122	16,483	16,852	
52	PMPM Cost	4.10%	6	$ 2,224.12	4.85%	4.10%	4.10%	$ 2,315.31	$ 2,410.24	$ 2,509.06	$ 2,611.93	$ 2,719.02	
53	Total Expenditure							$ 35,712,141	$ 38,008,000	$ 40,451,419	$ 43,051,892	$ 45,819,580	$ 203,043,032
54													
55	**Medicaid Pop 9**	Waiver											
56	**Pop Type:**	**Medicaid**											
57	Eligible Member Months	1.35%	6	53,982	-0.03%	Disabled		53,964	53,945	53,927	53,909	53,890	
58	PMPM Cost	1.46%	6	$ 3,078.86	1.46%	4.40%	1.46%	$ 3,123.81	$ 3,169.42	$ 3,215.69	$ 3,262.64	$ 3,310.27	
59	Total Expenditure							$ 168,571,894	$ 170,975,221	$ 173,412,493	$ 175,884,751	$ 178,391,959	$ 867,236,319
60													
61	**NOTES**												
62	"Base Year" is the year immediately prior to the planned first year of the demonstration.												
63	"Trend Rate 1" is the trend rate that projects from the last historical year to the Base Year and is the minimum of the 5-Year Average Historical Trend and the President's Trend.												
64	"Months of Aging" equals the number of months of trend factor needed to trend from the last historical year to the Base Year. There are 18 months between the midpoint of SFY11 (last historical year) and CY12 (Base Year).												
65	"Trend Rate 2" is the trend rate that projects the first 5 DYs, starting from the Base Year, through the end of the first 5-year demonstration period.												
66	"Trend Rate 3" is the trend rate that projects DY6, starting from DY5.												
67	"Trend Rate 4" is the trend rate that projects DY7 through DY11, starting from DY6. These trends are based on the most recent five years of historic experience (CY14 to CY18), limited to the level of trends found in the most recently approved 1115 waiver (Massachu												
68	Membership for DY1 through DY4 represents actual membership. Membership for DY5 is projected based on emerging membership for that year, and membership after DY5 is projected.												
69	Trends listed in "PB TREND" reflect trends from recently approved 1115 waiver (Massachusetts). This assumes that these trends are reflective of the PB Trend.												
70													
71													
72													
73	**Medicaid Pop A**	Adults and Children											
74	**Pop Type:**	**Medicaid**											
75	Eligible Member Months					Adults + Children		3,339,784	3,420,414	3,503,290	3,588,479	3,676,045	
76	PMPM Cost	3.80%	6	$ 334.93	5.61%	3.80%	3.80%	$ 347.66	$ 360.87	$ 374.58	$ 388.81	$ 403.58	
77	Total Expenditure							$ 1,161,109,443	$ 1,234,324,636	$ 1,312,262,473	$ 1,395,236,380	$ 1,483,578,041	$ 6,586,510,973
78													
79	**Medicaid Pop B**	ABD and LTC											
80	**Pop Type:**	**Medicaid**											
81	Eligible Member Months					Aged + Disabled		974,004	979,414	984,877	990,393	995,963	
82	PMPM Cost	4.10%	6	$ 2,409.67	6.97%	4.10%	4.10%	$ 2,508.47	$ 2,611.32	$ 2,718.38	$ 2,829.83	$ 2,945.85	
83	Total Expenditure							$ 2,443,259,529	$ 2,557,583,659	$ 2,677,269,767	$ 2,802,843,629	$ 2,933,956,709	$ 13,414,693,284
84													
85													
86													
87	**Final WOW PMPM**												
88	**Medicaid Pop A**	Adults and Children											
89	**Pop Type:**	**Medicaid**											
90	Eligible Member Months							3,339,784	3,420,414	3,503,290	3,588,479	3,676,045	
91	PMPM Cost						3.80%	$ 347.66	$ 360.87	$ 374.58	$ 388.81	$ 403.58	
92	Total Expenditure							$ 1,161,109,443	$ 1,234,324,636	$ 1,312,262,473	$ 1,395,236,380	$ 1,483,578,041	$ 6,586,510,973
93													
94	**Medicaid Pop B**	ABD and LTC											
95	**Pop Type:**												
96	Eligible Member Months							974,004	979,414	984,877	990,393	995,963	
97	PMPM Cost						4.10%	$ 2,508.47	$ 2,611.32	$ 2,718.38	$ 2,829.83	$ 2,945.85	
98	Total Expenditure							$ 2,443,259,529	$ 2,557,583,659	$ 2,677,269,767	$ 2,802,843,629	$ 2,933,956,709	$ 13,414,693,284

Budget Neutrality Summary

DEMONSTRATION YEARS (DY)

Without-Waiver Total Expenditures	**DY1 (CY19)**	**DY2 (CY20)**	**DY3 (CY21)**	**DY4 (CY22)**	**DY5 (CY23)**	**TOTAL**
Medicaid Populations						
Adults and Children	$ 1,161,109,443	$ 1,234,324,636	$ 1,312,262,473	$ 1,395,236,380	$ 1,483,578,041	$ 6,586,510,973
ABD and LTC	$ 2,443,259,529	$ 2,557,563,659	$ 2,677,269,757	$ 2,802,643,629	$ 2,933,956,709	$ 13,414,693,284
SUD WOW Total Expenditure	$ 119,271	$ 126,402	$ 133,957	$ 141,965	$ 150,451	$ 672,046
Voluntary Support Pilot Non-SSDI	$ -	$ -	$ 3,623,115	$ 7,428,982	$ 7,616,345	$ 18,668,442
TOTAL	$ 3,604,488,243	$ 3,792,014,698	$ 3,993,289,302	$ 4,205,450,956	$ 4,425,301,546	$ 20,020,544,745

With-Waiver Total Expenditures	**DY1 (CY19)**	**DY2 (CY20)**	**DY3 (CY21)**	**DY4 (CY22)**	**DY5 (CY23)**	**TOTAL**
Medicaid Populations						
Adults and Children	$ 1,107,833,943	$ 1,157,532,098	$ 1,209,703,187	$ 1,264,332,618	$ 1,321,539,087	$ 6,060,940,934
ABD and LTC	$ 2,371,878,995	$ 2,408,531,568	$ 2,446,201,377	$ 2,484,517,312	$ 2,523,491,361	$ 12,234,620,613
SUD WW Total Expenditure	$ 119,271	$ 126,402	$ 133,957	$ 141,965	$ 150,451	$ 672,046
HIPF	$ 65,876,282	$ 67,193,808	$ 68,537,684	$ 69,908,437	$ 71,306,606	$ 342,822,817
UC Pool : HCAIP	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 205,000,000
UC Pool : BCCH/LPH	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 49,282,750
DSRIP & APM	$ 30,000,000	$ 30,000,000				$ 60,000,000
Voluntary Support Pilot Non-SSDI	$ -	$ -	$ 3,623,115	$ 7,428,982	$ 7,616,345	$ 18,668,442
Voluntary Support Pilot SSDI	$ -	$ -	$ 362,311	$ 742,898	$ 761,634	$ 1,866,844
TOTAL	$ 3,626,565,041	$ 3,714,240,426	$ 3,779,418,181	$ 3,877,928,763	$ 3,975,722,035	$ 18,973,874,446

VARIANCE BY MEG						
Medicaid Populations	**DY1 (CY19)**	**DY2 (CY20)**	**DY3 (CY21)**	**DY4 (CY22)**	**DY5 (CY23)**	**TOTAL**
Adults and Children	$ 53,275,500	$ 76,792,538	$ 102,559,285	$ 130,903,763	$ 162,038,954	$ 525,570,039
ABD and LTC	$ 71,380,534	$ 149,032,091	$ 231,068,381	$ 318,126,317	$ 410,465,348	$ 1,180,072,671
VARIANCE TOTAL	$ 124,656,034	$ 225,824,629	$ 333,627,666	$ 449,030,080	$ 572,504,302	$ 1,705,642,710
HIPF	$ (65,876,282)	$ (67,193,808)	$ (68,537,684)	$ (69,908,437)	$ (71,306,606)	$ (342,822,817)
EXPENDITURE AUTHORITIES	$ (80,856,550)	$ (80,856,550)	$ (51,218,861)	$ (51,599,448)	$ (51,618,184)	$ (316,149,594)

	DY1 (CY19)	**DY2 (CY20)**	**DY3 (CY21)**	**DY4 (CY22)**	**DY5 (CY23)**	**TOTAL**
SAVINGS	$ (22,076,798)	$ 77,774,271	$ 213,871,121	$ 327,522,194	$ 449,579,511	$ 1,046,670,299

Hypothetical Budget Neutrality Test 1

Without-Waiver Total Expenditures	**DY1 (CY19)**	**DY2 (CY20)**	**DY3 (CY21)**	**DY4 (CY22)**	**DY5 (CY23)**	**TOTAL**
SUD WOW Total Expenditures	$ 119,271	$ 126,402	$ 133,957	$ 141,965	$ 150,451	$ 672,046
TOTAL	$ 119,271	$ 126,402	$ 133,957	$ 141,965	$ 150,451	$ 672,046

With-Waiver Total Expenditures	**DY1 (CY19)**	**DY2 (CY20)**	**DY3 (CY21)**	**DY4 (CY22)**	**DY5 (CY23)**	**TOTAL**
SUD WW Total Expenditures	$ 119,271	$ 126,402	$ 133,957	$ 141,965	$ 150,451	$ 672,046
TOTAL	$ 119,271	$ 126,402	$ 133,957	$ 141,965	$ 150,451	$ 672,046
VARIANCE	$ -	$ -	$ -	$ -	$ -	$ -

Hypothetical Budget Neutrality Test 2

Without-Waiver Total Expenditures	**DY1 (CY19)**	**DY2 (CY20)**	**DY3 (CY21)**	**DY4 (CY22)**	**DY5 (CY23)**	**TOTAL**
Voluntary Support Pilot	$ -	$ -	$ 3,623,115	$ 7,428,982	$ 7,616,345	$ 18,668,442
TOTAL	$ -	$ -	$ 3,623,115	$ 7,428,982	$ 7,616,345	$ 18,668,442

With-Waiver Total Expenditures	**DY1 (CY19)**	**DY2 (CY20)**	**DY3 (CY21)**	**DY4 (CY22)**	**DY5 (CY23)**	**TOTAL**
Voluntary Support Pilot	$ -	$ -	$ 3,623,115	$ 7,428,982	$ 7,616,345	$ 18,668,442
TOTAL	$ -	$ -	$ 3,623,115	$ 7,428,982	$ 7,616,345	$ 18,668,442
VARIANCE	$ -	$ -	$ -	$ -	$ -	$ -

ATTACHMENT C
HCAIP Hospitals

Hospital Name	City	County
Blue Valley Hospital Inc.	Overland Park	Johnson
Bob Wilson Memorial Hospital	Ulysses	Grant
Children's Mercy Hospital	Overland Park	Johnson
Coffeyville Regional Medical	Coffeyville	Montgomery
Doctors Hospital	Leawood	Johnson
Geary Community Hospital	Junction City	Geary
Hays Medical Center	Hays	Ellis
Hutchinson Regional Medical	Hutchinson	Reno
Kansas City Orthopedic	Leawood	Johnson
Kansas Heart Hospital	Wichita	Sedgwick
Kansas Medical Center	Andover	Butler
Kansas Rehabilitation Hospital	Topeka	Shawnee
Kansas Spine Hospital	Wichita	Sedgwick
Kansas Surgery & Recovery	Wichita	Sedgwick
Labette County Medical Center	Parsons	Labette
Lawrence Memorial Hospital	Lawrence	Douglas
Manhattan Surgical Hospital	Manhattan	Riley
McPherson Memorial Hospital	McPherson	McPherson
Meadowbrook Hospital	Gardner	Johnson
Menorah Medical Center	Overland Park	Johnson
Mercy Health Center - Fort	Fort Scott	Bourbon
Mercy Hospital - Moundridge	Moundridge	McPherson
Miami County Medical Center	Paola	Miami
Mid-America Rehabilitation	Overland Park	Johnson
Morton County Health System	Elkhart	Morton
Newton Medical Center	Newton	Harvey
Olathe Medical Center	Olathe	Johnson
Overland Park Regional	Overland Park	Johnson
Prairie View Hospital	Newton	Harvey
Pratt Regional Medical Center	Pratt	Pratt
Premier Surgical Institute	Galena	Cherokee
Newton Medical Center	Newton	Harvey
Olathe Medical Center	Olathe	Johnson
Overland Park Regional Medical Center	Overland Park	Johnson
Premier Surgical Institute	Galena	Cherokee
Pratt Regional Medical Center	Pratt	Pratt
Hutchinson Regional Medical Center	Hutchinson	Reno
Providence Medical Center	Kansas City	Wyandotte
Ransom Memorial Hospital	Ottawa	Franklin

Saint Catherine Hospital	Garden City	Finney
Saint Francis Health Center	Topeka	Shawnee
Saint John Hospital	Leavenworth	Leavenworth
Saint Luke's South Hospital	Overland Park	Johnson
Salina Regional Health Center	Salina	Saline
Salina Surgical Hospital	Salina	Saline
Select Specialty Hospital Kansas City	Overland Park	Johnson
Select Specialty Hospital Topeka	Topeka	Shawnee
Select Specialty Hospital Wichita	Wichita	Sedgwick
Shawnee Mission Medical Center	Overland Park	Johnson
South Central Kansas RMC	Arkansas City	Cowley
Southwest Medical Center	Liberal	Seward
Promise Hospital of Overland Park	Overland Park	Johnson
Stormont-Vail Regional Health Center	Topeka	Shawnee
Summit Surgical, LLC	Hutchinson	Reno
Sumner Regional Medical Center	Wellington	Sumner
Susan B. Allen Memorial Hospital	El Dorado	Butler
Via Christi Hospital St. Teresa	Wichita	Sedgwick
Via Christi Regional Medical Center	Wichita	Sedgwick
Via Christi Rehabilitation Center	Wichita	Sedgwick
Wesley Medical Center	Wichita	Sedgwick
Wesley Rehabilitation Hospital	Wichita	Sedgwick
Western Plains Medical	Dodge City	Ford
Hospital Name	**City**	**County**
Complex		

ATTACHMENT D
LPTH/BCCH Hospitals

Hospital Name	City	County
Large Public Teaching Hospital		
The University of Kansas Hospital	Kansas City, KS	Wyandotte
Border City Children's Hospital		
Children's Mercy Hospital	Kansas City, MO	Jackson

ATTACHMENT E
UC Payment Application Template

[PLACEHOLDER: Following CMS review and approval, the UC Payment Application Template (see STC 53) will be placed in this attachment]

ATTACHMENTS F and G
DSRIP Planning Protocol

Section 1. Preface

Section XI of the Kansas KanCare Section 1115 Demonstration authorizes a Delivery System Reform Incentive Payment (DSRIP) pool available in DY 3 (CY 2015) through DY 8 (CY 2020) for the continuation of a program of activity that supports hospitals' efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve.

This protocol serves as both Attachments F and G to the STCs and supplements the general DSRIP requirements specified in the STCs. Specifically, this protocol describes the specific delivery system improvement activities that are eligible for DSRIP funding (Attachment F, DSRIP planning protocol as described in STC 69 (e)) and also describes the State and CMS review process for DSRIP project plans, incentive payment methodologies, and reporting requirements for DSRIP payments (Attachment G, program funding and mechanics protocol, as described in STC 69 (f)).

This protocol is supplemented by five appendices, which will assist hospitals in developing and implementing their projects and will be used in the state's review of the approvability and the valuation of DSRIP projects.

Appendix A is a ***Project Toolkit*** that describes the core components of each DSRIP strategy listed on the DSRIP strategy menu below. This supplement describes how DSRIP strategies are distinct from each other and the state's rationale for selecting each strategy (i.e. the evidence base for the strategy and its relation to community needs for the Medicaid and uninsured population). The core components and other elements of the strategy description will be used as part of the DSRIP plan checklist (described below).

Appendix B is a ***Metric Specification Guide*** that provides additional information on the metrics described in the metrics list below. Specifically, this appendix specifies the data source for each measure (specifically whether the measure is collected by the state or providers), the reference for the data steward for each metric (i.e. National Quality Forum reference number, etc), and the high performance level for each pay-for-performance metric. The high performance level for each metric will be used to establish outcome targets for all pay-for-performance measures, as described further below.

Appendix C is the ***DSRIP Application Template*** which participating hospitals will use to submit their DSRIP plans in accordance with the requirements described in section 5 below.

Appendix D is the ***DSRIP Semi-annual Reporting Template*** which participating hospitals will use to reporting on progress achieving their DSRIP metrics in order to receive DSRIP payments, pursuant to the requirements in sections 6 and 7 below.

Appendix E is a Summary of the ***Public Engagement Process*** which led to the development of the project focus areas for DSRIP.

a. Background

The DSRIP pool program will be implemented in Kansas as part of a major delivery system

overhaul that converted nearly all Kansas Medicaid and CHIP populations and services into a risk-based capitated managed care program. That program is known as KanCare and represents one of the largest reform efforts for the Kansas Medicaid and CHIP programs in recent years.

The goals of the KanCare program are to improve overall health outcomes while slowing the rate of cost growth over time. This will be accomplished by providing the right care, in the right amount, in the right setting, at the right time. The selected KanCare managed care plans focus on ensuring that consumers receive the preventive services and screenings they need and ongoing help with managing chronic conditions. The DSRIP program will work alongside the KanCare health plans and the State to further promote delivery system reform with the end goals of improved outcomes and decreasing costs.

The Kansas DSRIP pool will have only two participants—the members of the Large Public Teaching Hospital (LPTH) and Border City Children's Hospital (BCCH) pool (The University of Kansas (KU) Hospital and Children's Mercy Hospital). Both of these participants, termed "participating hospitals" in this document, are unique in their ability to impact the systemic delivery of care across Kansas.

b. DSRIP and Healthy Kansans 2020- Public Health and System Reform Collaboration

Due to the statewide emphasis of the DSRIP program, Kansas considered the three-part aim of the Section 1115 waiver, the goals of DSRIP and how to best align these initiatives with the efforts already in process throughout Kansas to improve health and the health care delivery system. The Healthy Kansans 2020 (HK2020) initiative emerged as an important effort already underway in Kansas.

The Healthy Kansans Steering Committee began meeting in August of 2012. The Steering Committee is comprised of the leaders of more than 35 organizations across the state, and was gathered together to discuss the health issues facing Kansans. The Steering Committee used the Healthy People 2020 objectives as a springboard for discussion, but the primary focus was ensuring that the unique issues facing Kansas in the coming years were addressed. The Steering Committee represents a broad array of stakeholders in Kansas, and includes membership from health care providers, consumer groups, state and local government entities, and other groups.

The result of the Steering Committee's efforts was a document identifying the cross-cutting themes and priority strategies, which has been further developed as part of the state's ongoing public engagement process. More detail regarding this document is provided in Appendix E.

c. DSRIP Goals and Focus Areas

The three cross-cutting themes developed by the HK 2020 Steering Committee also serve as the overall goals of the DSRIP program, and embody the results that Kansas will attempt to achieve through DSRIP:Access to services

- Healthy living, and
- Healthy communities

The DSRIP program aims to advance the goals of access to services and healthy living by specifically focusing on incentivizing projects that increase access to integrated delivery systems and projects that expand successful models for prevention and management of chronic and complex diseases. The specific objectives for each of these focus area were developed and revised based on the stakeholder input received and are summarized below.

I. Access to integrated delivery systems
   a. Increase access to services, including primary care and preventive services
   b. Increase the effective and efficient use of population health management through health information technology (HIT)
   c. Increase integration of the health care delivery system, including medical, behavioral health, and social services.

II. Prevention and management of chronic and complex diseases
   a. Improve health literacy, including nutrition education and tobacco use prevention and control
   b. Expand health and wellness programs and develop incentives for participation in these programs
   c. Expand chronic and complex care management models

Participating hospitals continuting DSRIP projects are expected to advance the goal of healthy communities by assuming responsibility for the overall health needs of the Medicaid beneficiaries and low income uninsured people in their communities, not simply responding to the patients that arrive at the doors of a hospital. Participating hospitals are required to engage community partners in the development and implementation of their DSRIP projects, and the state will work with providers to ensure that the pay for performance metrics that are used to measure improvement on DSRIP projects adequately reflects the project's target population, rather than the patients enrolled in a particular intervention.

Section 2. DSRIP Projects and Project Metrics

This section presents a menu of projects and metrics from which participating hospitals may select when designing their individual hospital DSRIP plans. Within each project, participating hospitals must select infrastructure, process, and quality and outcomes milestones and related metrics, as well as population-focused improvements to report. Reported metrics and population- focused improvements must support the goals of the projects selected and align with the standardized target setting approach outlined below.

a. Projects

Participating DSRIP hospitals have designed and implemented at least 2 DSRIP projects, selected from the list below.

Each project was developed according to the specifications in the project toolkit (Appendix A) based on the community needs assessment of the baseline data for the target population selected by the hospital.

1. Focus area 1: Access to integrated delivery systems

- Project 1.a: Expansion of Patient Centered Medical Homes and Neighborhood

2. Focus area 2: Prevention and management of chronic and complex diseases
   - Project 2.a: Self Management and Care (SMAC)/Resiliency
   - Project 2.b: HeartSafe Community
   - Project 2.c: Improving Coordinated Care for Medically Complex Patients
   - Project 2.d: Statewide Expansion of Sepsis Early-Warning and Escalation Process

b. Metrics

In order to measure progress towards achieving the goals of DSRIP, each project must include metrics in all four of the following milestone categories. (A metric is a measure of the extent to which a participating hospital achieves a milestone; a milestone is a particular target related to the implementation and outcomes of the DSRIP project).

Participating hospitals will select and report on metrics associated with their projects from the metric specification guide in Appendix B. All metrics must be reported in accordance with the specifications described in the metric specification guide.

The metrics below are designated as pay for reporting (P4R) or pay for performance (P4P).

1. ***Infrastructure milestones (Category 1):*** Metrics associated with these milestones lay the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services. Because of the differing starting points for each provider, hospitals will select and the state will approve unique category 1 milestones for each project and provider. In addition, as part of the ongoing monitoring of DSRIP projects (as described in section 6 below), the state or CMS may add category 1 metrics to a project prospectively in order to address implementation concerns with "at risk" projects.

   i. Project specific metrics selected by hospitals and approved by the state for each project, as specified in Appendix A (P4P)
   ii. Additional project-specific metrics, established prospectively by the state or CMS for "at risk" projects (P4P)

2. ***Process milestones (Category 2):*** Metrics associated with these milestones focus on process changes and improvements. All providers must include a measure of the quantifiable patient impact of each project on the Medicaid and low-income uninsured population. In addition, as part of the ongoing monitoring of DSRIP projects (as described in section 6 below), the state or CMS may add category 2 metrics to a project prospectively in order to address implementation concerns with "at risk" projects.

   i. Number of Medicaid/ CHIP beneficiaries served by the project (P4P)
   ii. Project specific metrics selected by hospitals and approved by the state for each project, as specified in Appendix A (P4P)

iii. Additional project-specific metrics, established by the state or CMS for a particular project, especially "at risk" projects (P4P)

3. ***Quality and outcomes milestones (Category 3):*** Metrics associated with these milestones address the impact of the project on quality metrics and beneficiary outcomes. The Category 3 metrics for each project correspond to the project selected (as further described in Appendix A) and must be reported according to all metric specifications described in Appendix B). Since improving beneficiary outcomes is the primary goal of DSRIP, hospitals are not allowed to select Category 3 metrics (and their corresponding projects) if their baseline data indicates that the provider is within 15 percentile points from the high performance level on a particular metric (as described further in 2.c below).

   All DSRIP providers must select at least three Category 3 metrics per project from the list in Attachment B. The Category 3 metrics must meet the following standards:

   i. The metrics must be outcome measures, i.e. measures that assess the results of care experienced by patients, including patients' clinical events, patients' recovery and health status, patients' experiences in the health system, and efficiency/cost.
   ii. The metrics must align with existing state data quality infrastructure in order to ensure that all beneficiaries who are attributed to the hospital can be included in the calculation of the measure
   iii. The metrics must be reported to specifications by the relevant national measure steward, such as the National Quality Forum.

4. ***Population focused improvement milestones (Category 4):*** Metrics associated with these milestones evaluate the broader impact of the selected projects through Performance Indicators across several categories. As further described in appendix B, all hospitals must include the two state priority areas: (1) emergency department (ED) visits and (2) readmissions within 30 days of hospital discharge. In addition, hospitals will choose two additional Category 4 metrics from the CMS adult and/or child core set to ensure that the quality of care is maintained in areas that are not a direct focus of the provider's DSRIP projects.

c. Metric Targets

All participating hospitals must have a target for all pay-for-performance metrics, which will be used to determine whether or not the associated milestone was achieved (and whether the participating hospital is eligible for DSRIP payments, based on the mechanism described in section 6 below).

To assist participating hospitals in setting targets, the state will specify a high performance level for all category 3 pay-for-performance metrics in Appendix B. Performance targets should be based on the higher of top decile of performance for state or national data, or an alternative method approved by CMS.

Yearly improvement targets for project metrics will be established using the methodology of reducing the gap to the goal by 10%. For example if the baseline data for a measure is 52 percent and the goal is 90 percent, the gap to the goal is 38. The target for the project's first year of performance would be 3.8 percent increase in the result (target 55.8 percent). Each subsequent year would continue to be set with a target using the most recent year's data. This will account for smaller gains in subsequent years as performance improves toward the goal or measurement ceiling.

d. Metric attribution method

As further described in the metric specification guide (Appendix B), metrics associated with quality and outcome milestones (Category 3) and population focused improvement milestones (Category 4) will measure improvement for the Medicaid and CHIP populations served by the participating hospital and its community partners (as specified in the DSRIP project plan, described in section 3 below). Category 3 metrics will be reported based on the DSRIP project network (DSRIP hospital and identified project participants [e.g., community partners: other hospitals, outpatient providers, nursing facilities]) used for the associated DSRIP project. Category 4 metrics will be reported using all permutations of project networks for all associated DSRIP projects, but pay-for-performance payments for Category 4 will only be based on performance of beneficiaries attributed to the DSRIP hospital directly.

The state will prospectively determine the attribution of Medicaid/CHIP beneficiaries to Category 3 and 4 metrics as follows:

The DSRIP hospital must propose a target population including a specific geography and population for each of their selected DSRIP projects. The target population will be beneficiaries assigned to the hospital and identified project participants (IPPs). Assignment may occur through an enrollment or formal provider assignment process, or through patterns of service usage. Attributed populations may be identified based on exclusion/inclusion criteria for a particular measure (e.g., specific diagnoses). If there is overlap in DSRIP projects among the DSRIP hospitals, a beneficiary will only be attributed to one DSRIP project network, based on the methodology described below. Using the proposed geography and proposed population as appropriate, for each DSRIP project plan, KDHE will prospectively identify the Medicaid beneficiaries that will be attributed to that DSRIP project network at the beginning of the measurement year. This will provide an initial prospective attribution at the start of the measurement year to determine the populations to be included. For annual measurement purposes in determining the denominator, patient attribution will be defined as of the last day of the measurement year. Depending on the measurement, this will allow for adjustments at the end of the measurement year to remove beneficiaries that were not enrolled in Medicaid per the specific measure specification for continuous enrollment criteria. It will also allow for the addition of new Medicaid beneficiaries attributed to the DSRIP Project during the year, and any other adjustments necessary to assure a proper measurement denominator.

Attribution will be completed using the following hierarchy to determine assignment to one DSRIP hospital and associated identified provider participants:

1. Beneficiaries who do not receive qualifying services from the DSRIP hospital or project

associated community partners will be excluded from the attribution.

2. When there is only one DSRIP hospital that has selected an identified project, the entire matched Medicaid beneficiary population will be the assigned population. A match will occur in the following situations:

   - The beneficiary is assigned through an enrollment process to an IPP (e.g., assigned to a Primary Care Provider [PCP] or Health Home [HH]; resident of a nursing facility[NF])
   - The beneficiary has claims indicating receipt of qualifying services from the DSRIP hospital or IPP.

3. When there is more than one DSRIP hospital that has selected an identified project, the following method of assignment will occur:

   i. Matching Goal – the goal is to make the best assignment to the DSRIP hospital based on the beneficiary's current utilization patterns and assigned providers. If the project specifically targets IPPs that have a responsibility for beneficiaries due to assignment through an enrollment process (PCPs, HHs, and NFs), the provider with the current assignment will be matched regardless of past utilization of services. Otherwise, the DSRIP hospital and its IPPs that have provided a higher proportion of qualifying services for the beneficiary will be assigned the beneficiary.
   ii. Service Groupings – To meet this goal, the methodology will aggregate beneficiary service volume across four different groups of services (depending upon the identified project) and assign attribution using a defined hierarchy such as:
      - 1st priority – assigned providers (PCPs, HHs, NFs)
      - 2nd priority – other outpatient providers (specialists, behavioral health)
      - 3rd priority – emergency department (ED);
      - 4th priority – inpatient hospitalization.
   iii. Attribution Method – Once the identified project's network of providers (DSRIP hospital and associated IPPs) is finalized, the network will be loaded into the attribution system for beneficiaries to be assigned based on the above matching methods and service groupings. Depending on the specific project's hierarchical prioritization, the first step may be to try to assign a beneficiary to a DSRIP provider network based on enrollment/assignment to any of the project's IPPs. If no beneficiary assignments with the IPPs exist, the algorithm would move on to tally the number of services received by the beneficiary from IPPs that are other outpatient providers (specialists, behavioral health). The beneficiary would be assigned to the provider network with the most IPP services provided. If no outpatient provider visits, the algorithm would proceed to look for ED visits at

EDs within the project network. If no ED visits, the algorithm would look for hospitalizations at hospitals within the project network.

iv. Finalizing Match and Ties – For beneficiaries that have an equal amount of services based on the highest applicable service priority, the algorithm will tally total services for the beneficiary among all service priorities for each DSRIP project network. The network that has provided the most services to the beneficiary will be assigned the beneficiary.

Section 3. Hospital DSRIP Plan Requirements

Each participating hospital submitted an individual hospital DSRIP plan that identifies the projects, population-focused objectives, and specific metrics adopted from Section 3 and 4 of this planning protocol. DSRIP plans must meet all requirements pursuant to STC 69 (g).
Hospital DSRIP plans must be submitted in the structured format described in Attachment C and must include the following sections:

a. Executive Summary

The Executive Summary shall provide a summary of the hospital DSRIP plan, a summary of the hospital's vision of delivery system reform, and a table of the projects included in the plan, including project titles, brief descriptions of the projects, and goals.

b. Background Section

The background section shall include, at a minimum, a summary of the hospital's community context, a description of the hospital's patient population, a description of the health system, a description of challenges facing the hospital, and the goals and objectives of its DSRIP plan. The background section also shall include a brief description of any initiatives in which the hospital is participating that are funded by the U.S. Department of Health and Human Services and are directly related to any of the hospital's DSRIP projects.

Specifically, the background section will include the following components:

1) **Provider Demographics** including:
   a) Name, Address, Senior level person responsible for the DSRIP project and to whom all correspondence should be addressed
   b) The name of community partners participating in each project Definition of service area and the name of the community partners participating in the project that will be used for the purpose of attributing members for calculating metrics, according to the method described in 2.d above.

2) Identification of Need for Project:
The participating hospital will need to provide objective data-driven evidence that this is a relevant goal for the participating hospital and its service area. The participating hospital must demonstrate that all relevant Category 3 metrics for the projects selected align with community needs and that these areas have room for improvement by

submitting baseline data on its Category 3 metrics at the time of application. If the participating hospital's baseline performance on the majority of any chosen Category 3 metric set is within 10 percentage points or 1.5 standard deviations to the high performance goal (whichever is greater) , the project would not be approved.

Participating hospitals should also include brief rationale for project choice and summary (including citations) of existing evidence showing that project can lead to improvement on goals of project. Logic models such as driver diagrams may be helpful to demonstrate how the elements of the project all contribute to the central goals.

3) Public Input

The DSRIP plan should include documentation of collaboration with local departments of public health, public stakeholders and consumers. In addition, the participating hospital will need to document how there will be ongoing engagement with the community stakeholders, including active participation in any regional health planning activities currently underway in their community. Participating hospitals will need to include workers and their representatives in the planning and implementation of their overall project. Participating hospitals will (in collaboration with the state) maintain a website including contact information, overview of public comment opportunities, results of public processes, application materials, and required reporting.

c. Project Descriptions

Pursuant to STC 69 (g) (ii), each hospital shall include a narrative for each project that describes the following elements of the project:

1) Goals

This section should provide a description of the goal(s) of the project, which describes the specific challenges of the hospital system and the major delivery system solution identified to address those challenges by implementing the particular project. Analytics should be included to support these conclusions specific to the hospital.

2) Expected Results

The expected results section should provide a description of the target goal over the demonstration approval period, metrics associated with the project and the significance of that goal to the hospital system and its patients.

3) Rationale

The hospital DSRIP plan must include a narrative on the hospital's rationale for selecting the project, milestones, and metrics based on relevance to the hospital system's population and circumstances, community need, and hospital system priority and starting point with baseline data.

4) Relationship to Other Projects

The plan must also include a narrative describing how this project supports, reinforces, enables and is related to but does not duplicate other projects and interventions within the hospital system.

The participating hospital will submit a description of any initiatives that the provider is participating in that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiative currently in place. The participating hospital will, by signature, attest that the submitted DSRIP project is not a duplication of a project from these other funded projects and does not duplicate the deliverables required by the former project (s). It should be noted if this project is built on one of these other projects or represents an enhancement of such a project that may be permissible, but it must be clearly identified as such in the DSRIP project plan.

5) Rapid cycle evaluation

The plan must include an approach to rapid cycle evaluation that informs the system of progress in a timely fashion, and how that information will be consumed by the system to drive transformation and who will be accountable for results, including the organizational structure and process to oversee and manage this process. The plan must also indicate how it will tie into the state's requirement to report to CMS on a rapid cycle basis.

6) **Budget**: Participating Hospitals must provide a detailed budget for all 3 years of their DSRIP project.

7) **Governance:** The plan must include a detailed description of how the participating hospital and its community partners will be governed and how they will evolve into a highly effective Integrated Delivery System. A clear corporate structure will be necessary and all providers that participate in the project will need to commit to the project for the life of the waiver.

8) **Data sharing and confidentiality**: Metrics will be collected in a uniform and valid fashion across the participating hospital and its community partners. As a result, the plan must include provisions for appropriate data sharing arrangements that permit this and appropriately address all HIPPA privacy provisions. **Expectation of Sustainability:** Participating hospitals are asked to explain how the outcomes of this project will be sustained at the end of DSRIP and how gains can be continued after the conclusion of the project period.

d. Project Milestones and Performance Indicators Table

For each project, participating hospitals submitted milestones from Categories 1-4 for each demonstration year. The milestones and required performance indicators must be adopted in accordance with STC 69 (c) and (d).

e. Funding Estimates

The DSRIP project valuation will be described in the DSRIP plan and will be calculated by the state according to the methodology described in section 4 below.

Section 4. Project Valuation

a. Valuation for each project

The state will calculate a valuation for each DSRIP project according to the following method:

Step 1: Base Valuation

Each hospital's projects will be assigned a base, three-year valuation proportionate to the total amount of DSRIP funds available to each hospital, per demonstration year. For each DSRIP hospital, the base valuation is 75 percent of the total demonstration year funding. The following table is the sum of all projects in each pool.

Project Base Valuation								
DSRIP Hospital	**Base Value Proportion**	**DY 3**	**DY 4**	**DY 5**	**DY 6**	**DY 7**	**DY 8**	**Total**
LPTH Pool	75%	5,625,000	11,250,000	16,875,000	16,875,000	16,875,000	16,875,000	84,375,000
BCCH Pool		1,875,000	3,750,000	5,625,000	5,625,000	5,625,000	5,625,000	28,125,000
	Total	7,500,000	15,000,000	22,500,000	22,500,000	22,500,000	22,500,000	112,500,000

Step 2: Secondary Valuation

Hospitals will be eligible for secondary valuation payments based the number of Medicaid/CHIP beneficiaries served through the project, and the percent of patients primarily served by external community partners.

The secondary valuation will be applied as follows:

- Partner valuation payments: 15 percent secondary payment valuation if at least 20 percent of the patients served through the project are affiliated with external community partners.
- Trailblazer valuation payments: 10 percent secondary payment valuation for including outreach and capacity-building components that disseminate the project's outcomes and methods to rural and underserved areas of Kansas in order to expand access to best practices.

			Secondary Project Valuation						
DSRIP Hospital	**"Partner" Secondary Value Proportion**		**DY 3**	**DY 4**	**DY 5**	**DY 6**	**DY 7**	**DY 8**	**"Partner" Total**
LPTH Pool	15%		1,125,000	2,250,000	3,375,000	3,375,000	3,375,000	3,375,000	16,875,000
BCCH Pool			375,000	750,000	1,125,000	1,125,000	1,125,000	1,125,000	5,625,000
	Subtotal		1,500,000	3,000,000	4,500,000	4,500,000	4,500,000	4,500,000	22,500,000

DSRIP Hospital	"Trailblazer" Secondary Value Proportion	DY 3	DY 4	DY 5	DY 6	DY 7	DY 8	"Trailblazer" Total
LPTH Pool	10%	750,000	1,500,000	2,250,000	2,250,000	2,250,000	2,250,000	11,250,000
BCCH Pool		250,000	500,000	750,000	750,000	750,000	750,000	3,750,000
	Subtotal	1,000,000	2,000,000	3,000,000	3,000,000	3,000,000	3,000,000	15,000,000
	Total	2,500,000	5,000,000	7,500,000	7,500,000	7,500,000	7,500,000	37,500,000

Step 3 Calculation of Total Value

The total value for a project will be the sum of the base valuation plus the secondary values.

b. DSRIP Allocation

A total of $60 million is allocated for the Kansas DSRIP as specified below:

DSRIP Program	Funding Allocation	DY 3	DY 4	DY 5	DY 6	DY 7	DY 8	Total
LPTH (KU Hospital)	75%	7,500,000	15,000,000	22,500,000	22,500,000	22,500,000	22,500,000	112,500,000
BCCH (Children's Mercy Hospital)	25%	2,500,000	5,000,000	7,500,000	7,500,000	7,500,000	7,500,000	37,500,000
		10,000,000	20,000,000	30,000,000	30,000,000	30,000,000	30,000,000	150,000,000

c. Milestone Valuation

Once the overall project valuation is set,	Payment Type	DY 3 2015	DY 4 2016	DY 5 2017	DY 6 2018	DY 7 2019	DY 8 2020
Project Category 1 (Infastrusture Milestones)	Performance / Reporting	45%	25%	10%	10%	10%	10%
Project Category 2 (Process Milestones)	Performance / Reporting	30%	25%	20%	20%	20%	20%
Project Category 3 (Quality and Outcome	Performance	5%	25%	45%	45%	45%	45%
	Reporting	10%	10%	5%	5%	5%	5%
Project Category 4 (Population Focused Improvement Milestones)	Performance	0%	5%	15%	15%	15%	15%
	Reporting	10%	10%	5%	5%	5%	5%

Section 5. Hospital Plan Review Process

a. Overview of Review Responsibilities

Each DSRIP hospital submitted a plan in accordance with the DSRIP Plan guidelines outlined in this protocol and the demonstration's Special Terms and Conditions. Participating hospitals are expected to provide accurate information in their DSRIP plans and respond to the state and CMS' requests for additional information and/or plan revisions in accordance with the timelines specified.

The state is responsible for reviewing all DSRIP plans using a CMS approved checklist and other review process requirements described below. The state's review will be supplemented by a review of the state's External Quality Review Organization (EQRO), which should inform the state whether to approve a DSRIP plan.

CMS will monitor the state's review process sand approve projects in accordance with section (c) below.

b. State Review Process

KDHE members of the DSRIP Project Team will review the Plans, using the following checklist:

- The plan is in the format and contains all required elements outlined in the Kansas DSRIP Planning, Funding and Mechanics Protocols and is consistent with STC 69.
- All projects clearly identify Category 1, 2 and 3 milestones as described in STC 69 (c)(i-iii)
- All projects clearly identify the population focused health improvement measures (Category 4) to be reported.
- The description of the project is coherent and comprehensive and includes a logic model clearly representing the relationship between the goals, the interventions and the measures of progress and outcome
- The project selection is grounded in a demonstrated need for improvement at the time that the project is submitted and is sufficiently comprehensive to meaningfully contribute to the CMS three part aim for better care for individuals, better health for the population, lower costs through improvement (i.e. Triple Aim), and while at the same time charting a path towards future sustainability.
- The likelihood for success of this intervention is based on, where available, accurate and robust citations to the evidence base.
- The plan includes an approach to rapid cycle evaluation that informs the system of progress in a timely fashion, and how that information will be consumed by the system to drive transformation and who will be accountable for results, including the organizational structure and process to oversee and manage this process. The plan must also indicate how it will tie into the state's requirement to

report to CMS on a rapid cycle basis.

- The goals are mapped to a robust and appropriate set of research hypotheses to support the evaluation.
- The amount and distribution of funding is in accordance with STC 69 (g)(iii) , STC 70 and Section 8 of this combined protocols document
- The proposed projects are new or significantly enhance existing health care initiatives and do not duplicate other CMS and Department of Health and Human Services (HHS) funded initiatives in which the hospital participates
- The plan and all of the projects proposed are consistent with the overall goals of the DSRIP program

The ultimate decision on State approval will rest with the Secretary of KDHE and State Health Officer.

In in collaboration with its EQRO, KDHE will complete its initial review of each timely submitted Hospital DSRIP Plan and will respond to the hospital in writing with any questions or concerns identified. The hospital must respond in writing to any notification by KDHE of questions or concerns. The hospital's response must be received by KDHE within 3 business days of that notification. The hospital's initial response may consist of a request for additional time to address KDHE's comments; however, the hospital's revised plan must address all of KDHE's comments.

The state's EQRO will make an independent assessment of all DSRIP projects submitted and KDHE will take action on each hospital-specific DSRIP plan, approving each plan that it deems satisfactory according to the criteria outlined above. KDHE will then submit approved plans to CMS for final review and approval by September 30. Any deviations from the external quality review organization's recommendations should be clearly explained to CMS.

c. CMS Review

The State will submitted hospital DSRIP plans to CMS before September 30, 2014 for CMS review.

In addition to approving the review protocol, CMS reviewed the plans to determine whether the protocol was followed, identified any systematic gaps between the protocol and the actual reviews, and will provided such findings to the state to address these gaps in reviews by the independent assessor and by the state. CMS found the reviews were consistent with the review protocol and CMS accepted the state's recommendations for approval with the following possible exceptions which will be applied at CMS's discretion:

i. The state's decision about approval is not consistent with the EQRO finding
ii. There is evidence in the plan, or exogenous information made available to CMS that calls into question of funding duplication; and
iii. There is evidence in the plan, or exogenous information made available to CMS calls into question whether the project is new or significantly expanded or enhanced from a project already underway

CMS will completed its review before December 31, 2014. CMS reserves the right to

conditionally approve plans, and to allow modifications to plans to resolve issues it identifies in its review provided that the modifications are made to the plan and found acceptable by CMS according to the timeline provided by CMS.

Section 6. Reporting Requirements and Ongoing Monitoring

Performance management and assessment of DSRIP will occur throughout its duration and will take several forms. Each area of assessment is interrelated to ensure a continuous cycle of quality improvement and shared learning. The final DSRIP plans will provide the basis for monitoring each project.

1. As described in (a) below, participating hospitals will submit semi-annual reports and annual reports to the state using a reporting template developed by the state to document progress on milestones (for DSRIP payments) and to provide timely and actionable feedback on the initiative's progress, in terms of infrastructure changes, implementation activities and outcomes.
2. As described in (b) below, a learning collaborative will be implemented to discuss hospital input on project level development of action plans, implementation approaches and project assessment.
3. As described in (c) below, in addition to monitoring, an interim and final summative statewide evaluation of DSRIP will be completed by the independent evaluator to examine the effect of DSRIP activities on achieving the State goals. Among other things, the interim evaluation will provide broad learning both within the state and across the nation. Part of this interim evaluation will examine issues overlapping with ongoing provider-level evaluations, and part of this effort will examine questions overlapping with the final evaluation.

a. Semi-annual reports

Two times per year, DSRIP hospitals shall submit reports to the state and CMS. Semi-annual and annual reports must be submitted demonstrating progress on DSRIP projects. These reports will serve as the basis for authorizing incentive payments to each hospital for achievement of DSRIP metrics. Category specific metrics achieved during each reporting period will be measured. The reports shall be submitted using the standardized reporting forms approved by KDHE-DHCF and CMS. The following shall be included in the reports:

- Data on progress made for all Demonstration year metrics
- Narrative description of the project completion progress, lessons learned, challenges faced and other pertinent findings
- Copy or list of all data sources and supporting documentation as identified per metric in the hospital's approved DSRIP plans to demonstrate achievement of each metric for which the hospital is seeking payment

The state must certify that a hospital has met its approved metrics as a condition for the release of associated DSRIP funds to the hospital. A hospital may only receive DSRIP payments following the successful achievement of metrics as reflected in its reports and as approved by the state. If the state determines the hospital did not fully and successfully achieve a metric, payment

to the hospital for that metric will not be issued. DSRIP hospitals will have all supporting documentation available for review by the state, if requested.

The timeline for the hospital reporting process, the state and CMS review process, and the state payment process will be as follows:

	Report Period Begin Date	Report Period End Date	CMS Report Review Due Date	Payment Due Date
DY 3 Semi - Annual	1/1/2015	6/30/2015	9/30/2015	10/31/2015 *
DY 3 Annual	1/1/2015	12/31/2015	3/30/2016	4/30/2016
DY 4 Semi - Annual	1/1/2016	6/30/2016	9/30/2016	10/31/2016 *
DY 4 Annual	1/1/2016	12/31/2016	3/30/2017	4/30/2017
DY 5 Semi - Annual	1/1/2017	6/30/2017	9/30/2017	10/31/2017 *
DY 5 Annual	1/1/2017	12/31/2017	3/30/2018	4/30/2018
DY 6 Semi - Annual	1/1/2018	6/30/2018	9/30/2018	10/31/2018 *
DY 6 Annual	1/1/2018	12/31/2018	3/30/2019	4/30/2019
DY 7 Semi - Annual	1/1/2019	6/30/2019	9/30/2019	10/31/2019*
DY 7 Annual	1/1/2019	12/31/2019	3/30/2020	4/30/2020
DY 8 Semi - Annual	1/1/2020	6/30/2020	9/30/2020	10/31/2020*
DY 8 Annual	1/1/2020	12/31/2020	3/30/2021	4/30/2021
** Payment crossses state fiscal year, encumbrance may be required*				

Note: Because many category 2, 3, and 4 metrics are annual measures, these annual measures will only be available to be reported once a year for purposes of authorizing and determining incentive payments.

b. Rapid Cycle Evaluation

The DSRIP program will support a process of data-driven, rapid cycle improvement that will gather data in real time and make recommendations to the State, CMS and hospitals about how to ensure timely progress in promoting the overall goals of the DSRIP program. As previously noted, these goals are: healthy living; healthy communities; and access to services. Each Hospital DSRIP Plan will address their process for continuous performance improvement in order to improve efficiencies, quality and experience while reducing or eliminating inefficiencies, waste and redundancies. Upon completion and approval of the Hospital Plans, the State and the external evaluator developed the process for rapid cycle evaluation for the DSRIP program overall by submitting a learning collaborative plan to CMS before March 1, 2015.

The Learning Collaborative will be managed by the state and the EQRO designee through both virtual and in-person collaboration that both builds relationships as well as facilitates project analysis and measurement. The Learning Collaborative will be designed to promote and perform the following:

1. Sharing of DSRIP project development including data, challenges, and

proposed solutions
2. Collaborating based on shared ability and experience
3. Identifying key project personnel
4. Identification of best practices
5. Provide updates on DSRIP program and outcomes
6. Encourage the principles of continuous quality improvement cycles

An example of a process framework for continuous performance improvement, or rapid cycle improvement, is the "Model for Improvement," developed by the Associates in Process Improvement[1] and used by the Institute for Healthcare Improvement (IHI). This model has two parts:

- Three fundamental questions, which can be addressed in any order.
  - What are we trying to accomplish?
  - How will we know that a change is an improvement?
  - What changes can we make that will result in improvement?
- The Plan-Do-Study-Act (PDSA) cycle[2] tests changes in real work settings, by planning it, trying it, observing the results, and acting on what is learned.
- After testing the change, learning from each test, and refining the change through PDSA cycles, the change would be implemented on a broader scale, or at a minimum the findings would be disseminated to allow other providers to learn from DSRIP.

The semi-annual and annual hospital report requirements will also include instruction for the hospitals to provide descriptions of rapid cycle evaluations that occurred during the previous six month timeframe and any planned evaluations or changes during the upcoming timeframe. While the hospitals must submit semi-annual and annual reports to the State, more frequent evaluation

[2]Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009

[3] The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle to PDSA, replacing "Check" with "Study." [See Deming WE. *The New Economics for Industry, Government, and Education*. Cambridge, MA: The MIT Press; 2000.]

[2] The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle to PDSA, replacing "Check" with "Study." [See Deming WE. *The New Economics for Industry, Government, and Education*. Cambridge, MA: The MIT Press; 2000.]

will occur by the hospitals, State and the external evaluator. DSRIP meetings will occur, at least on a quarterly basis, with the hospitals, State, and external evaluator. During these meetings, rapid cycle evaluation and improvement will be discussed relevant to the various hospital processes and interim data points. These discussions will facilitate identification of potential issues that could interfere with the success of DSRIP improvement projects and plans, and assure changes are in place to help the hospitals successfully reach the outcome measures/milestones of each plan.

c. Independent Evaluation of DSRIP Program and Projects

The DSRIP evaluation will include review of process and outcome measures related to milestones identified in Categories 1 through 4. Quantitative and qualitative data sources will be used in calculation of the process and outcome measures. The DSRIP evaluation plan (see table below)

will be more fully designed once specific DSRIP project documents are further developed. The Kansas Foundation for Medical Care, Inc has been contracted with as the external evaluator, in accordance with STC 69 (e) vi.

At a minimum, the evaluation will address the following questions:

1. Were the participating hospitals able to show statistically significant improvements on measures within Categories 1 through 3 related to the goals of the three part aim: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population, and lower cost through improvement?
2. Were the participating hospitals able to show improvements on measures within Category 4 related to the goals of the three part aim?
3. What is the impact of health care delivery system and access reform measures on the quality of care delivered by participating providers?
4. What is the impact of DSRIP on managing short and long term per-capita costs of health care?
5. How did the amount paid in incentives compare with the amount of improvement achieved?
6. How did the performance of hospitals participating in DSRIP compare with the performance of other hospitals in the state and/or another appropriate comparison group?

Section 7. Disbursement of DSRIP funds

a. General principles

Aggregate incentive payments available over the 6 year demonstration period will be based on the project valuation approved by the state, subject to the limits set forth in section 4.c. above. DSRIP payments for each participating hospital are contingent on:

- The hospital fully meeting project milestones defined in the approved hospital-specific Hospital DSRIP Plan; and
- KDHE certifying the hospital's achievement of a given milestone, subject to CMS review.

In order to receive incentive funding relating to any metric, the hospital must submit all required reporting, as outlined in the Section 6 of this document, and the result must be certified by the state, and is subject to CMS review.

Hospitals will not receive credit for metrics achieved prior to CMS approval of their Hospital DSRIP Plans.

b. Incentive Payment Formula

Hospitals will receive DSRIP payments based on achievement of reporting milestones for projects. This is Pay for Reporting. Hospitals will receive DSRIP payments based on achievement of performance targets for metrics. This is Pay for Performance.

Within each project, the value for achieving each performance metric or milestone is the same (evenly weighted) and will be calculated as "meeting" or "not meeting" the milestone or metric. The points given for reaching a specified milestone or metric will be called an "Achievement Value" and will be calculated as a 0 or 1 value.

If a milestone or metric is met, the hospital will receive an Achievement Value of 1 for in the reporting period. If the hospital does not meet a milestone or metric, it will receive an Achievement Value of 0 for that reporting period. This will be done across every project in every category.

Hospital improvement metric targets will be established annually using baseline data for DY 3 and then annually thereafter for DY 4-8, as described in section 2.c above. The Achievement Value for Pay for Performance metrics will be established by comparing the hospital results for the reporting period with the improvement target for the hospital. If the hospital meets the improvement target for the metric, the hospital will receive an AV of 1.

Achievement Values will then be grouped into either a Pay for Reporting or a Pay for Performance classification for each category. The Pay for Performance and Pay for Reporting Achievement Values in each category will be summed to determine the Total Achievement Value for the category. A Percentage Achievement Value will then be calculated by dividing the Total Achievement Value by the maximum Achievement Value (the total number of metrics) for Pay for Performance and Pay for Reporting in each category. The Percentage Achievement Value will demonstrate the percentage of achieved metrics within the Pay for Reporting and Pay for Performance metrics for each category for that reporting period.

Example: A Participating Hospital has a project in year one with a project level valuation of $100,000 for year one. If the Participating Hospital achieves two out of five of its metrics/milestones for that project it would receive 40 percent of the $100,000 or $40,000. The metrics/milestone value would be assigned Achievement Values and Percentage Achievement Values as follows:

Metric/Milestone	Achievement	Achievement Value
Milestone 1	Achieved	1
Milestone 2	Achieved	1
Milestone 3	Not Achieved	0
Milestone 4	Not Achieved	0
Milestone 5	Not Achieved	0
	Total Achievement Value	2
	Percentage Achievement Value 2/5	40%

The Percentage Achievement Value will be used to determine the level of the total payment the hospital has earned for that reporting period based upon the performance payment distribution provided under the metric valuation. The level of payment for a hospital within a category will be proportionate to the Percentage Achievement Value allocated to that category.

If either the state or CMS determines that a hospital has failed to meet its approved metric, no incentive payment will be made. A hospital's failure to fully meet a performance metric under its Hospital DSRIP Plan within the time frame specified will result in forfeiture of the entire associated incentive payment. There will be no payment for partial fulfillment of a performance metric (on a metric-by-metric basis).

c. Non-Duplication of Federal Funds

Each DSRIP hospital will be required to provide to the state all of the CMS and HHS funded initiatives in which they participate. Also, each hospital will provide a detailed explanation of how it proposes DSRIP activities are not duplicative of HHS funded activities.

Unique accounting codes will be created within the state accounting system and assigned to DSRIP Pool payments as an additional means to ensure the selected DSRIP project funding does not duplicate existing or future federal funding.

Kansas will claim federal financial participation (FFP) for all DSRIP payments. FFP will only be available for DSRIP payments made in accordance with all pertinent STCs, including Attachment F DSRIP Planning Protocol and Attachment G DSRIP Funding and Mechanics Protocol.

All DSRIP project plans are subject to audits. The state will report DSRIP payments to CMS on the CMS 64.9 waiver form on a quarterly basis, using a specific waiver group set-up exclusively for DSRIP payments.

Pursuant to STC 76, STC 79 and STC's 80 through 84, DSRIP will be a component of the state's quarterly and annual operational reports related to the demonstration. These reports will include:

All DSRIP payments made to hospitals that occurred in the quarter

- Expenditure projections reflecting the expected pace of future payments for each hospital
- A summarized assessment of each hospital's DSRIP project activities during the given reporting period
- Planning, evaluation activities and interim findings pursuant to the reporting requirements outlined in section XI of the Demonstration's STCs

The LPTH and BCCH shall have available for review, by the state and CMS upon request, all documentation evidencing performance as described under the hospital's plan for DSRIP incentive payments. Failure of the LPTH or BCCH to maintain adequate documentation or inaccurate reporting of data may result in recoupment of DSRIP payments.

Section 8. DSRIP Plan Modifications in Limited Circumstances

No more than once a year, participating hospitals may submit proposed modifications to an approved DSRIP project plan for state and CMS review. These modifications may not decrease the scope of the project unless they also propose to decrease the project's valuation. The state and CMS will follow the same review process described in section 5 above.

Reasons to approve a plan modification request that will be considered are:

- New federal or state policies are implemented that impact a DSRIP project and a hospital seeks to update the affected project to reflect the new environment
- New national data definitions for a measure have been implemented that impact a DSRIP project and a hospital seeks to update the affected project to reflect the new standards
- Other acceptable reasons, subject to review and approval by KDHE and CMS, that are reasonable and support the goals of the DSRIP program

CMS may require that a plan be modified if it becomes evident that the previous targeting or estimation is no longer appropriate or that targets were greatly exceeded or underachieved. This process does not allow modification for failure to comply with the STCs 69 and 70 or the requirements contained in this document.

ATTACHMENT H

Ombudsman Plan

The following report was submitted by the state of Kansas on November 26, 2012, as a part of CMS' KanCare review. This report describes the qualified independent, conflict-free entity which will assist KanCare enrollees in the resolution of problems and conflicts between the MCOs and participants regarding services, coverage, access and rights. The Ombudsman should help participants understand the fair hearing, grievance, and appeal rights and processes at each MCO and proactively assist them through the process if needed. Ombudsman activities are available to all demonstration eligible populations, but specific focus and outreach activities will be directed towards KanCare enrollees utilizing LTSS (institutional, residential and community based). (see STC 36).

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Department of Health and Environment
Division of Health Care Finance

Phone: 785-296-

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Robert Moser, MD, Secretary
Sam Brownback, Governor
Kari Bruffett, Director

KanCare Implementation Activity: KanCare Consumer Ombudsman
Date Updated: Dec. 5, 2012

Purpose:
The ombudsman will help Kansas consumers enrolled in a KanCare plan, with a primary focus on individuals participating in the HCBS waiver program or receiving other long term care services through KanCare.

The ombudsman will assist KanCare consumers with access, service and benefit problems. The ombudsman will provide information about the KanCare grievance and appeal process that is available through the KanCare plans and the State fair hearing process, and assist KanCare consumers seek resolution to complaints or concerns regarding their fair treatment and interaction with their KanCare plan.

The ombudsman will:

- Help consumers to resolve service-related problems when resolution is not available directly through a provider or health plan.
- Help consumers understand and resolve billing issues, or notices of non-coverage.
- Assist consumers learn and navigate the grievance and appeal process at the KanCare plan, and the State fair hearing process, and help them as needed.
- Assist consumers to seek remedies when they feel their rights have been violated.
- Assist consumers understand their KanCare plan and how to interact with the programs benefits.
- Serve as a point of contact and resource for legislative and other inquiries into the provision of LTSS in managed care.

Organization:
The KanCare Ombudsman will be located in the Kansas Department for Aging and Disability Services (KDADS). The Ombudsman will be organizationally

independent from other KDADS commissions which set and direct Medicaid program, and reimbursement policy. The Ombudsman will receive administrative and legal support from the Office of the Secretary division of KDADS.

The Ombudsman will make an annual report to the legislature detailing the activities of the office and other relevant information related to the provision of LTSS in KanCare.

Personnel:
Recruitment of candidates for the Ombudsman position began November 12. Interviews are scheduled for the week of November 26. The Ombudsman will be selected and hired by January 1, 2013.

Program and Training:
Initially, the Ombudsman will be trained on the grievance and appeals process available through the KanCare plans, and the State fair hearing process, as well as the utilization management policies and procedures adopted by the KanCare plans, State Medicaid policy and the State contract governing the KanCare plans.

Additionally, the Ombudsman will receive orientation covering Kansas eligibility processes, KanCare covered benefits, and care coordination.

The Ombudsman will work with consumers and providers in distributing information about the Ombudsman services. Contact information for the Ombudsman will be provided through state processes and contractors such as eligibility offices, KanCare hotline and mailings, Aging and Disability Resource Centers, KanCare member materials, and consumer and provider advocates. In addition to assisting consumers with the items listed in the overview, the Ombudsman will provide information, assistance, and referrals to consumers with issues not covered in the Ombudsman's scope of work.

Supporting Resources:
The Ombudsman will be presented as a source for assistance when a consumer cannot find an acceptable outcome by speaking directly with their KanCare plan, or through the normal processes. While the Ombudsman will be trained on eligibility criteria and covered benefits, the State does not expect the Ombudsman's office to be the first contact for all such questions. The state's enrollment broker, MCO call centers, State eligibility staff, and the ADRC are established resources for member inquiries. Similarly, while the Ombudsman will assist individuals exercise their rights to the grievance and appeals process, the Ombudsman is not expected to file or represent the consumer in the grievance or appeal. The Ombudsman will assist in mediating those cases that cannot be handled by state eligibility case workers, hotline staff, or the ADRC, when assistance is needed in starting a grievance or appeal, and when satisfaction cannot be obtained through the grievance and appeals processes.

There have not been calls for an Ombudsman program for the current managed care population, suggesting the new Ombudsman's efforts will likely be focused on the new populations entering managed care. The following additional resources can be added as needed:

In the event contacts with the Ombudsman office exceed capacity of the full time Ombudsman, up to five administrative positions can be reallocated to assist in providing information and referral services to consumers seeking assistance with issues that may be properly addressed by other entities. These administrative positions may be supported by 40 QM staff with training and knowledge of the waiver systems. Administrative staff and QM support will identify and transfer appropriate cases to the Ombudsman.

Additionally, the Ombudsman will receive legal support through the office of the Secretary. The office of the Secretary includes nine legal staff that can support the Ombudsman with legal research and information.

These resources will be made available to the Ombudsman as need develops and may be deployed within five business days.

Following the implementation and transition to KanCare, the Ombudsman will develop volunteer resources in the state to assist in one-to-one assistance and other cases.

Policy and Advocacy:
As noted, the Ombudsman will advocate for the rights and proper treatment of KanCare consumers through direct involvement and mediation with consumers, State policy divisions, and KanCare plans. Additionally, the Ombudsman will represent the Secretary of KDADS on consumer councils and focus groups convened by the KanCare plans, and provide the Secretary with counsel on suggested policy changes or additions to enhance consumer protections and engagement under KanCare. The Ombudsman will present the Legislature an annual report detailing the activities of the office, summarizing major issues of concern, and present suggested policy changes or additions to enhance consumer protections and engagement under KanCare.

Coordination with Quality Oversight:
KanCare program quality and outcome performance will be monitored through an Interagency Monitoring Team, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both KDHE and KDADS. Key activities of the KanCare Ombudsman will be included as a critical component of monitoring the performance of MCOs and providers within the KanCare program, as part of the statewide quality improvement strategy and the operating protocols of the Interagency Monitoring Team.

ATTACHMENT J
Verification of Beneficiary's MCO Enrollment

Members are encouraged to contact the Kansas Member Services team for help with any questions, including inquiries about their eligibility. Member Services answers member calls live between the hours of 8 AM and 8 PM CST, Monday through Friday. Additionally, providers have the opportunity to contact Provider Services toll-free number 24 hours/7 days a week to access the *Self Service* tool, which provides eligibility information over the phone through an automated system.

Each MCO maintains multiple avenues for members and providers to verify coverage for a member including secure portals available on the MCO's website with 24/7 access, phone lines staffed during regular business hours and automated phone systems. MCO provider and member service staff receive training to access enrollment and eligibility information through use of the Kansas Medcial Assistance Program (KMAP) website. The MCOs are responsible for supplying members and providers with guidance for accessing portals, phone numbers and contact information in member and provider manuals and as requested.

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ATTACHMENT I
Verification of Beneficiary's
MCO Enrollment

The State's enrollment broker provides multiple options for verification of eligibility and enrollment into a plan through the current Kansas Medical Assistance Program (KMAP) system. KMAP has been the system used by providers over the past decade to access information related to eligibility, managed care enrollment, claims status, and other information. KMAP will provide the following access points for entities to verify a beneficiary's eligibility and KanCare enrollment in absence of a Medicaid or KanCare MCO ID card. Different access points are available to different stakeholders such as MCOs, network/non-network providers or DHCF.

Access Point	Functionality	Availability	MCO	Providers		State	Fiscal Agent
				Network	Non-Network		
KMAP Secure Web Site	Entities enrolled with KMAP have access to the Secure Web site. Through the site, a user can verify eligibility by keying a valid combination of the following: • Beneficiary ID and date of birth • Social Security No. and date of birth • Name and date of birth	22 hrs/day 7 days/week	X	X		N/A	N/A
State Secure Web Site	Approved users have access to the KMAP Secure Web Site realm used by enrolled MCOs and provider by accessing a dedicated State Secure Web site. Through the site, a user can verify eligibility by keying a valid combination of the following: • Beneficiary ID and date of birth • Social Security No. and date of birth • Name and date of birth	22 hrs/day 7 days/week	N/A	N/A	N/A	X	X
Automated Voice Response	Entities enrolled with KMAP have access to the Automated Voice Response System by	22 hrs/day 7 days/week	X	X		N/A	N/A

System	dialing 1-800-933-6593. Through the phone line, a user can verify eligibility by keying a valid combination of the following: • Beneficiary ID and date of birth • Social Security No. and date of birth						
MMIS	Access to all Medicaid-related information by authorized users. Users would share information verbally with requesting entities.	22 hrs/day 7 days/week		N/A	N/A	X	X
KMAP Customer Service	All entities can reach a KMAP Customer Service agent by calling 1-800-933-6593 (provider) or 1-800-766-9012 (beneficiary).	8 am – 5 pm Monday - Friday	X	X	X	X	N/A
MCO Processes	The MMIS provides each MCO eligibility and enrollment information via the 834 to allow the MCO to share through their own access points.		N/A	X	X		

The following chart profiles the information returned by the various access points in response to eligibility or enrollment verification.

Access Point	KMAP Eligibility	MCO Enrollment		TPL Carrier			Medicare	
		Plan Name	Phone	Name	Address	Phone	Part A	Part B
KMAP Secure Web Site	X	X	X	X	X	X	X	X
State Secure Web Site	X	X	X	X	X	X	X	X
Automated Voice Response System	X	X	X	X	X	X	X	X
MMIS	X	X	X	X	X	X	X	X
KMAP Customer Service	X	X	X	X	X	X	X	X
MCO Processes	X	X	X	X	X	X	X	X

ATTACHMENT J
UC Pool: HCAIP Uniform Percentages

The table below provides the uniform percentages for the UC Pool (STC 53). Should the state elect to revise the uniform percentages for DY 1 and the inpatient net patient revenue threshold, the state must submit a revised Attachment J by April 30, 2013. The state must submit a revised version of this attachment to CMS by February 28th of DY 2 through 11 for review and approval.

	DY 1	DY 2	DY 3	DY 4	DY 5
Uniform Percentage	18.55%	14.65%	12.67%	11.13%	10.94
Specialty Service Uniform Percentage	3.72%	3.72%	3.72%	3.72%	3.72%
Tri-Level NICU Services Uniform Percentage	10.92%	10.92%	10.92%	10.92%	10.92%
Tri-Specialty Uniform Percentage	11.83%	11.83%	11.83%	11.83%	11.83%
Tri-Specialty Inpatient Net Patient Revenue Threshold		$300,000,000	$300,000,000	$300,000,000	$300,000,000
Date revised	3/27/2013	3/31/2014	3/31/2015	5/27/2016	5/3/2017

ATTACHMENT K
DSRIP Focus Areas

Proposed Focus Areas

Delivery System Reform Incentive Payment Pool

March 29, 2013

Overview of Delivery System Reform Incentive Program (DSRIP) Work in Kansas

Beginning in early 2013, State staff and partners from the two participating DSRIP hospitals (the University of Kansas Hospital and Children's Mercy Hospital) formed a DSRIP project team. The team includes the membership of the Kansas Department of Health and Environment (KDHE)'s Division of Health Care Finance Director Kari Bruffett, Medicaid Director Dr. Susan Mosier, and the Secretary of KDHE, Dr. Robert Moser. Additional project team members include staff from both DHCF and the Division of Health at KDHE. The project team will also utilize input from the State's External Quality Review Organization (EQRO) and actuarial contractors for specific program deliverables. The project team will work to ensure the DSRIP project is implemented on time and according to the requirements of the Special Terms and Conditions (STCs) of Kansas Medicaid's Section 1115 Demonstration Waiver.

The team completed the following initial projects:

- Preparing a timeline of required deliverables for the DSRIP program based on the STCs
- Developing an summary document of the DSRIP program to share with stakeholders and other interested parties
- Brainstorming focus areas and strategies for ensuring meaningful input from a variety of stakeholders.

Development of Draft Focus Areas

Bearing in mind the statewide emphasis of the DSRIP program, the project team considered the three-part aim of the Section 1115 waiver, the goals of DSRIP and how to best align these initiatives with the efforts already in process throughout Kansas. The Healthy Kansans 2020 (HK2020) initiative emerged as an important effort already underway to improve the health and health care delivery system in Kansas.

The Healthy Kansans Steering Committee began meeting in August of 2012. The Steering Committee is comprised of the leaders of more than 35 organizations across the state, and was gathered together to discuss the health issues facing Kansans. The Steering Committee used the Healthy People 2020 objectives as a springboard for discussion, but the primary focus was ensuring that the unique issues facing Kansas in the coming years were addressed. The Steering Committee represents a broad array of stakeholders in Kansas, and includes membership from health care providers, consumer groups, state and local government entities, and other groups. A list of Steering Committee members and their affiliated organizations is provided as Exhibit A to this report.

The result of the Steering Committee's efforts was a document identifying the cross- cutting themes and priority strategies that will be used to drive health improvement initiatives. A copy of this summary document is attached as Exhibit B to this report. Three cross-cutting themes (healthy living, healthy communities and access to services)

were identified by the HK2020 Steering Committee. Eleven priority strategies to drive health improvements in the three cross-cutting areas were selected.

Given the deliberate process, stakeholder engagement, and strategic focus of the HK2020 Steering

Committee's work, the DSRIP project team recognized a great opportunity to capitalize on the wealth of knowledge and experience that went into the development of the priority strategies. After consultation with additional DSRIP hospital stakeholders and partners at CMS, the DSRIP project team decided to use the priority strategies as a basis for the proposed DSRIP focus areas. The goal of this approach was to build upon the intentional, focused work that had already been completed in Kansas, and to provide a future path for meaningful integration of DSRIP projects across Kansas communities and the existing health system infrastructure across the state.

Using the priority strategies as a guide, the DSRIP project team then produced a draft list of focus areas to discuss with stakeholders. The draft focus areas attempted to capture the goals and strategies identified by the HK 2020 process, while translating them into a format that could easily be used for the development of actual DSRIP hospital projects in the future.

Stakeholder Input Process from the Healthy Kansans 2020 Steering Committee

After creating the draft focus areas for stakeholder input, the DSRIP project team worked with staff in KDHE's Division of Health to reconvene the HK2020 Steering Committee. The Steering Committee agreed to meet once more, this time with the DSRIP project team. The purpose of this meeting would be twofold: to provide input on the proposed focus areas, and to provide the Steering Committee with an example of how their priority strategies were already being put into practice in the State. To prepare for this discussion, the Steering Committee received information about the DSRIP program, background information on why their input was important and necessary for the program's success, and the draft version of focus areas produced by the project team.

On March 14, 2013, the DSRIP project team met to discuss and receive input from the Steering Committee on the draft focus areas. The meeting included several presentations designed to help participants understand what the DSRIP program is and how it relates to the HK2020 project. Participants heard information from Ms. Kari Bruffett of DHCF, who provided an overview of DSRIP, the program goals, funding involved, and requirements for participating hospitals and the state Medicaid program. Ms. Bruffett also went over the proposed focus areas for DSRIP and described how the HK2020 priority strategies were used in their development. Then each of the participating hospitals presented on past hospital projects that served as examples of how their organizations could produce meaningful impacts on the service delivery system statewide.

Later in the meeting, Steering Committee members broke out into smaller roundtable discussion groups to consider the following questions:

- Given what you have learned about DSRIP today, what is your reaction to the focus areas selected – are they the right ones?
- Does the way we have synthesized HK2020 priorities make sense for DSRIP?
- Are there issues from HK2020 that we should add to the DSRIP focus area list?
- Which of the focus areas is the best fit for DSRIP? Are there clear priorities? Some that do not fit as well?
- What would a quality improvement process, similar to what KU Hospital and Children's Mercy outlined today look like in your organization? Are you currently using HK2020 priorities in your organization's QI processes?
- How has your organization used HK2020 priorities to date in other ways (recognizing that the priorities are fairly "new")?
- What suggestions do you have for KDHE with regard to how to make HK2020 more inclusive and actionable with respect to achieving improved health outcomes (besides DSRIP)?

As evidenced by the discussion questions, the DSRIP project team and KDHE Division of Health staff members not only intended for the Steering Committee to assist in refining the focus areas, but also to consider how the priority strategies for HK2020 could find other practical applications throughout participants' organizations. DSRIP was an example of how the HK2020 process could provide the basis for actual system reform projects that will impact the health of Kansans.

Summary of Input

The roundtable discussions produced helpful insights and information for the DSRIP project team that was integrated into the proposed focus areas. Some input will also be helpful as the DSRIP project moves forward into the development of protocols and specific hospital DSRIP projects.

The list below summarizes the key areas of input provided by stakeholders. Overall, stakeholder participants expressed excitement over the DSRIP program, and the opportunity to work with the participating hospitals.

- Overall, participants expressed that the alignment and translation of KH2020 strategies into focus areas was appropriate.
- Participants generally expressed satisfaction with the focus areas, noting that they would allow for numerous projects and strategies for health improvement.
- The proposed focus areas were sufficiently broad to allow for innovation by the hospitals to create projects that will produce true reform.
- The focus areas should support the involvement of a variety of community partners, including community health providers, schools, local farmers' markets and other organizations.

- Disparate populations should not be lost in focus areas or DSRIP projects. Although they are not an explicit area of focus, the needs of these populations should be considered in any and all DSRIP projects.
- The focus areas should allow for projects that improve supports for the social and emotional development of children and families.
- Participants emphasized that the focus areas should allow the hospitals to work in their areas of expertise, and involve community partners for their expertise as well.
- Participants would like to see proposed DSRIP projects work toward eliminating silos in the care delivery system.
- Participants expressed their support for DSRIP projects that truly produce statewide impacts.
- The focus areas should allow for the inclusion of oral health and dental programs.
- Environmental factors (such as clean air and water programs) should be included in focus areas and projects as needed.
- The focus areas should produce projects that help make healthy choices for individuals easier and focus on prevention.

KDHE also sought and received volunteers from among the Steering Committee to advise the DSRIP project team through focused input on the DSRIP planning and funding and mechanics protocols, as well as specific hospital DSRIP plans.

Proposed Focus Areas

The list below comprises Kansas' proposed DSRIP focus areas. The focus areas have been revised according to the stakeholder input received.

- Increase access to services, including primary care and preventive services
- Increase the effective and efficient use of population health management through health information technology (HIT)
- Increase integration of the health care delivery system, including medical, behavioral health, and social services.
- Promote physical activity through encouraging and marketing the benefits of physical activity and expanding access and opportunities for physical activity
- Improve health literacy, including nutrition education and tobacco use prevention and control
- Expand health and wellness programs and develop incentives for participation in these programs
- Expand chronic and complex care management models
- Promote healthy communities, including access to clean air and water and healthy food and lifestyle choices

The DSRIP project team respectfully submits the above proposed focus areas and looks forward to future collaboration with the DSRIP hospitals, CMS partners, and other stakeholders for the DSRIP program.

EXHIBIT A: Healthy Kansans 2020 Steering Committee Members

Sector	Organization	Name
Aging	KS Dept on Aging & Disability Services	Shawn Sullivan
Academia	KU Preventive Medicine-KC	Dr. Ed Ellerbeck
Children & Families	KS Dept for Children & Family Services	Phyllis Gilmore
Clinical Health	KU Cancer Center	Dr. Gary Doolittle
	KS Hospital Association	Leonard Hernandez
	KS Hospital Association	Tom Bell
	KS Medical Society	Dr. Mark Synovec
	KS Medical Society	Jerry Slaughter
	KS Dental Association	Dr. Hal Hale
	KS Dental Association	Dr. Kevin Robertson
	KS Academy of Family Physicians	Dr. Chris Cupp
Commerce	Dept. of Commerce	Pat George
	Public Square Communities	Terry Woodbury
Crime & Justice	Dept. of Corrections	Ray Roberts
	Juvenile Justice Authority	Terri Williams
Disability	KS Commission on Disability Concerns	Martha Gabehart
Disparate Populations	KS Hispanic and Latino American Affairs Commission	Adrienne Foster
	KS Native American Affairs Office	Chris Howell
	KS African American Affairs Commission	Dr. Mildred Edwards
Education	KS Dept. of Education	Dr. Diane DeBacker
	KS Association of School Boards	Dr. John Heim
Food & Nutrition	KS Dept. of Agriculture	Dale Rodman
	KS Rural Center	Julie Mettenberg
	KU Dietetics & Nutrition	Dr. Debra Sullivan
	KU Preventive Medicine-Wichita	Judy Johnston
Health Care Delivery Systems	KS Insurance Dept.	Sandy Praeger
	BCBS (Private Insurance)	Matt All
HIE/HIT	KS Health Information Exchange	Dr. Joe Davison
Housing	KS Housing Resources Corp.	Dennis Mesa
Injury	Safe Kids Kansas	Dr. Jeffrey Colvin
Legislature	KS Senate	Sen. Laura Kelly
	KS Senate	Sen. Vicki Schmidt
	KS House	Rep. Barbara Ballard
	KS House	Rep. David Crum
	KS House	Rep. Don Hill
	KS House	Rep. Brian Weber
Philanthropic	Kansas Health Foundation	Steve Coen
	Sunflower Foundation	Billie Hall
	REACH Healthcare Foundation	Brenda Sharpe
	United Methodist Health Ministry Fund	Kim Moore

EXHIBIT A: Healthy Kansans 2020 Steering Committee Members

Physical Activity	KS Recreation & Parks Assoc.	Doug Vance
Public Health	KDHE	Dr. Robert Moser
	Kansas Health Institute	Dr. Robert St. Peter
	KS Assoc. Local Health Depts.	Michelle Ponce
	Urban Health Dept.	Claudia Blackburn
	Rural Health Dept.	Gina Frack
	Consultant	Shirley Orr
Transportation & Planning	KS Dept. of Transportation	Mike King
	Sedgwick County Board of Commissioners	Tim Norton

EXHIBIT B: Healthy Kansans 2020 Cross-Cutting Themes and Priority Strategies

HEALTHY KANSANS 2020

Working together, working smarter to routinely connect state and local partners across disciplines and sectors to enhance implementation of innovative systems and strategies, and improve individual and community well-being in Kansas by 2020.

Cross-cutting Themes and Priority Strategies

Healthy Living	Healthy Communities	Access to Services
• **Promote physical activity** (encourage and market the benefits of physical activity, expand access to public places for physical activity, expand opportunities for physical activity in schools and child care settings)	• **Promote access to healthy foods, and support policies that promote healthy food choices** (label healthy vending and menu options, encourage farmers' markets and expand access to target seniors and low income Kansans)	• **Improve access to services that address the root causes to poor health** (food insecurity, homelessness, low education, income and health literacy)
• **Promote healthy eating** (provide nutrition education to address low health literacy, encourage healthy eating through marketing materials, promote availability of healthy local foods)	• **Support policies that make the default choice the healthy choice** (policies that influence/support the adoption of healthy lifestyle behaviors, reduce prevalence of chronic disease, injury and rates of infectious disease, and support the quality and availability of child care)	• **Effectively and efficiently use population health management through health information technology (HIT)** (optimize use of electronic health records (EHR's) and health information exchange (HIE))
• **Develop incentives for Kansans to participate in health and wellness programs** (smoking cessation, weight loss, nutrition classes, chronic disease self-management)	• **Promote environments and community design that impact health and support healthy behaviors** (ensure access to clean air and water, promote adoption of complete streets designs, promote walking trails, bike trails and ensure safe housing free of lead, mold and radon)	• **Promote integrated health care delivery, including integrated behavioral health, social services and medical care** (patient-centered medical home, trainings for health professionals)
• **Promote tobacco use prevention and control** (cessation, policy and education)		
• **Improve supports for the social and emotional development of children and families** (healthy home visitors, mental health, bullying, parents as teachers, breastfeeding education and prenatal care)		
Kansans equipped to take an active role in improving their health and supporting their families and friends in making healthy choices.	**Kansans working together to impact the natural as well as human-formed conditions that influence health and/or risk for injury.**	**Kansans ready access to information and health and social services to achieve the best health outcomes.**

Attachment M
Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

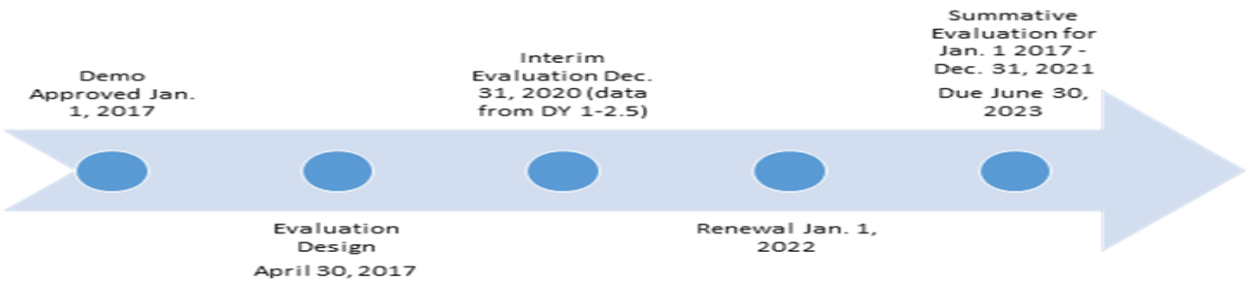
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

A. General Background Information;
B. Evaluation Questions and Hypotheses;
C. Methodology;
D. Methodological Limitations;
E. Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs
The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

3) Identify the state's hypotheses about the outcomes of the demonstration:
   a. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
   b. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references). This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
b. Qualitative analysis methods may be used, and must be described in detail.
c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
e. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

   If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
   a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
   b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
   c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
   d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

E. Special Methodological Considerations – CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include:

1) When the state demonstration is:
    a. Long-standing, non-complex, unchanged, or
    b. Has previously been rigorously evaluated and found to be successful, or
    c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes; and
    b. No or minimal appeals and grievances; and
    c. No state issues with CMS-64 reporting or budget neutrality; and
    d. No Corrective Action Plans (CAP) for the demonstration.

F. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

Attachment N:
Preparing the Evaluation Report

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. With the following kind of information, states and CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

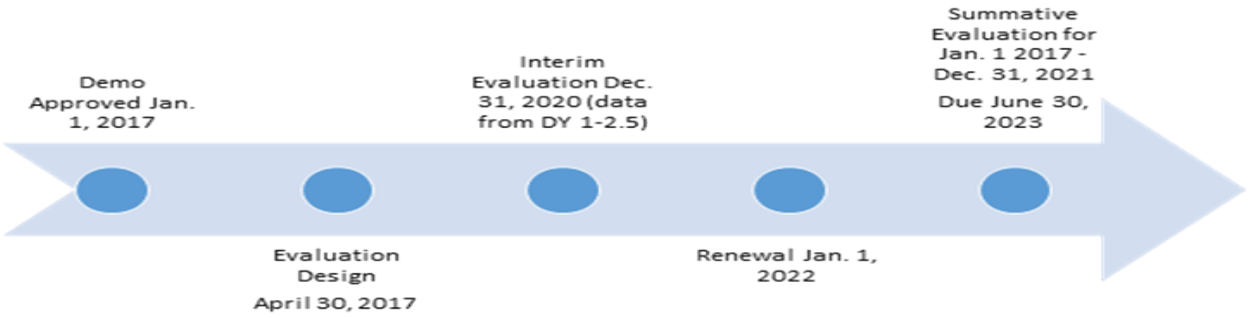
The format for the Interim and Summative Evaluation reports are as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;

D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design Attachment) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2. Identify the state's hypotheses about the outcomes of the demonstration;
   a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
   b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
   c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.
An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section

should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1) *Evaluation Design* – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc?
2) *Target and Comparison Populations* – Describe the target and comparison populations; include inclusion and exclusion criteria.
3) *Evaluation Period* – Describe the time periods for which data will be collected
4) *Evaluation Measures* – What measures are used to evaluate the demonstration, and who are the measure stewards?
5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data.
6) *Analytic Methods* – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations

This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results.

1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
   a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make

judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1) What lessons were learned as a result of the demonstration?
2) What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment

1) Evaluation Design: Provide the CMS-approved Evaluation Design

ATTACHMENT O:
Reserved for Evaluation Design

ATTACHMENT P:
Reserved for SUD Implementation Plan Protocol

ATTACHMENT Q:
Reserved for SUD Monitoring Protocol

Attachment R:
Reserved for SUD Health IT Plan