STATE OF KANSAS

"KANCARE"
SECTION 1115 DEMONSTRATION

APPLICATION
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TABLE OF CONTENTS

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The State of Kansas (State), Department of Health and Environment (KDHE), is seeking Section 1115 demonstration waiver authority to fundamentally reform Medicaid in Kansas to improve outcomes and establish financial responsibility. This application revises and builds upon the Demonstration Project Concept Paper submitted by the State on January 26, 2012, and the proposal initially submitted on April 26, 2012. Those documents outlined the State's vision for a waiver that will proceed on two separate tracks. In the first track, the State will work with CMS to develop and implement by 2013 an integrated care system, "KanCare," to provide Medicaid and Children's Health Insurance Program (CHIP) services, including long term services and supports (LTSS), through managed care to all beneficiaries. In the second track, the State will begin discussions with CMS to implement a global waiver that will administer an outcomes-based Medicaid and CHIP program under a per-capita block grant.

This application includes additional detail regarding **Track 1**.

THE PROBLEM

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

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

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

Just as important, focusing only on costs, to the exclusion of quality and outcomes, would be counterproductive. Kansas Medicaid – like the Medicaid program nationwide – historically has not been outcomes-oriented. The input the State has received from stakeholders and the public over the last 20 months has validated the need for increased accountability in the services the State provides, and for a new level of investment in prevention, care coordination, and evidence-based practice that will lead to improved outcomes for Kansans receiving services through Medicaid and CHIP.

REFORM PLAN DEVELOPMENT AND PUBLIC INPUT

In January 2011, Governor Sam Brownback charged Lt. Governor Jeff Colyer, MD, and a working group of cabinet members with the task of fundamentally reforming Medicaid to improve outcomes and establish financial sustainability in the face of mounting uncertainty. The Governor's FY 2012 budget sustained Medicaid through the current fiscal year and provided Kansas the time to reinvent its Medicaid program to better serve Kansans. The Administration sought public input through an open process that included a Request for Information in February 2011 and an open-door policy with stakeholders and advocates.

In the summer of 2011, the State of Kansas facilitated a Medicaid public input and stakeholder consultation process, during which more than 1,700 participants engaged in discussions on how to reform the Kansas Medicaid system. Participants produced more than 2,000 comments and recommendations for reform. After three public forums in Topeka, Wichita and Dodge City, web teleconferences were held with stakeholders representing Medicaid population groups and providers. The State also made an online comment tool available, and a fourth, wrap-up public forum was conducted in Overland Park in August 2011. A summary of the extensive process and the themes that emerged from it is attached in *Appendix A, Public Input and Stakeholder Consultation Process (Development Stage)*.

The State carefully considered the input from this process and from meetings with advocates and provider associations. In November 2011, Kansas announced a comprehensive Medicaid reform plan that incorporated the themes that had emerged from the public process, including integrated, whole-person care; preserving and creating paths to independence; alternative access models; and enhancing community-based services.

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

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

The cornerstone of the reform plan is "KanCare," an integrated care system focused on improving health outcomes for Kansans that will bend the cost curve of Medicaid down over time by effectively coordinating care and services to improve the quality of care provided.

Subsequent to the announcement of the reform plan, the State released a Request for Proposals (RFP) on November 8, 2011, and submitted to CMS a Section 1115 Demonstration Project proposal in the form of a concept paper on January 26, 2012. Advance notice of the Demonstration Project was distributed to tribal representatives, and an initial tribal consultation meeting with representatives of each tribal government was conducted on February 22, 2012.

The State posted the concept paper on the KDHE website, publicized it through the media and in direct email communications with stakeholders, and solicited public comment from a dedicated state email box. Representatives of the State also participated in more than 50 public meetings and 16 legislative hearings regarding KanCare between the time the reforms were announced and late April of 2012. A summary of comments and the State's response to issues that were raised is included in *Appendix B, State Response to Public Comments*.

After the State's submission of an application to CMS on April 26, 2012, it became apparent that two Indian Health Service (IHS) providers included in the State Plan consultation policy had been excluded from the notification. Upon learning of the omission, on May 17 KDHE emailed the full contact list detailed in the State Plan, including the two IHS centers that had been omitted. On June 5, to ensure compliance with the Tribal Consultation process, KDHE asked CMS to not consider the previously submitted application a formal proposal, allowing the State to continue the Tribal Consultation process. A description of that process, the resulting recommendations, and the changes incorporated by the State is included in the new *Appendix H, Tribal Consultation and State Response*.

The continuation of the consultation process also meant that the Section 1115 application would be subject to the new federal rules regarding public participation and transparency. KDHE posted notice of the process on its website on June 8, 2012, and announced the opening of the formal public comment period by media release and broad circulation to stakeholder email distribution lists. The announcement also included two public meetings, including one that allowed individuals to participate by teleconference. KDHE provided formal notice in the Kansas Register on June 14, 2012, pursuant to 42 CFR 431.408. Details of the process are included in the revised *Appendix B, Public Comments and State Response*, which also includes a summary of comments received during that round of public comment, which formally concluded July 14, and the State's response.

WAIVER INITIATIVES

In Track 1, the State will implement by 2013 four major initiatives to reform its current Medicaid and CHIP programs: (1) move all Medicaid populations into managed care; (2) cover all Medicaid services, including LTSS, through managed care; (3) establish safety net care pools to reimburse uncompensated hospital costs and to provide payments to essential hospitals; and (4) create and support alternatives to Medicaid.

1. Move All Medicaid Populations Into Managed Care

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

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

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

- Integrated, whole-person care
- Creating health homes
- Preserving or creating a path to independence
- Alternative access models and an emphasis on home and community based services

Medicaid and CHIP beneficiaries will be required to enroll in a KanCare plan. All beneficiaries will receive an initial plan assignment and enrollment information in the fall, during the open enrollment period. They will be able to change plan assignment prior to January 1, and they will also have 45 days from the enrollment effective date of January 1 to change to a plan of their choice, for any reason. The State will provide enrollment materials and education to aid in the selection process. KanCare expects MCOs to be actively engaged in care coordination for members; the revised choice period is requested to maximize continuity in care coordination while allowing members opportunity to exercise their freedom to choose a plan. Beneficiaries will be locked into the plan after the choice period until annual re-enrollment, but will be able to change plan assignments for cause at any time.

American Indians/Alaska Natives: Consistent with federal regulations, the State will provide for presumptive but voluntary enrollment for beneficiaries who are American Indians and Alaska Natives (AI/ANs). Indian Medicaid beneficiaries will be presumptively enrolled in KanCare, but they will have the option of affirmatively opting-out of managed care. The definition of AI/AN will be adopted consistent with the definition adopted by CMS in the implementation of Medicaid cost-sharing protections under the American Recovery and Reinvestment Act. The term "Indian" will be defined consistent with 42 C.F.R. 447.50.

CHIP: Since 1998, Kansas statute (K.S.A. 38-2001) has required CHIP to be provided in a capitated managed care environment. In addition, the statute requires the Kansas CHIP program to be as seamless with Medicaid as possible. Currently, dental services for CHIP members are carved out, as permitted by the revised statute. Physical health services are provided by the same two plans that provide Medicaid managed care, and this combined program is known as HealthWave. Behavioral health services in the current CHIP program are

provided via a capitated managed behavioral health plan. Within KanCare, CHIP beneficiaries will continue to receive the same covered services, but with no services carved out, and will greatly benefit from the new program. Moving CHIP into KanCare will:

- Improve the seamlessness between Medicaid and CHIP, as both will have comprehensive managed care, and eligible members for each will have the same services and protections;
- Improve integration of care, especially physical and behavioral health care, as each plan will be specifically responsible for integration;
- Improve health outcomes through the provision of enhanced quality requirements and more clearly defined coordination of care expectations, as well as the provision of health homes and other value-added services; and
- Continue to enable coordinated efforts for improvement of immunization and well-child visit rates across both Medicaid and CHIP populations.

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

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

Kansas has aggressively moved toward HCBS for its long-term care Medicaid population. The Kansas Department of Aging and Disability Services (KDADS) currently administers seven Medicaid waivers under Section 1915(c) of the SSA: (1) autism, (2) developmental disabilities, (3) physical disability, (4) technology assistance, (5) traumatic brain injury, (6) serious emotional disturbance, and (7) frail elderly. KDADS also administers a 1915(b)/(c) waiver for mental health (through a prepaid ambulatory health plan (PAHP)) and substance use disorder services (through a prepaid inpatient health plan (PIHP)), including services for adults with serious and persistent mental illness and youth with serious emotional disturbance. In addition, KDADS administers a grant (under the authority of the Deficit Reduction Act of 2005) program to provide community-based behavioral health services for children as an alternative to placement in a Psychiatric Residential Treatment Facility (PRTF). (The PRTF Community Based Alternatives grant is slated to end September 30, 2012, with claims payment run-out concluding by December 31, 2012, so this program will not be included in KanCare.)

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

KanCare Services. Under the initial phase of KanCare, the State will provide all Medicaid-funded services (except state-operated ICFs-MR, as discussed below) through managed care, including LTSS. The State has determined that contracting with multiple MCOs will result in the provision of efficient and effective health care services to the populations currently covered by Medicaid and CHIP in Kansas, as well as ensure coordination of care and integration of physical and behavioral health services with each other and with HCBS. Responding to feedback from the public and legislators, long-term services and supports for members receiving services under the Section 1915(c) waiver for developmental disabilities will be phased in and begin in Year 2.

Services included in KanCare will be physical health services (including vision, dental, and pharmacy), behavioral health services, and long term care (LTC), including nursing facility (NF) care and HCBS. These services will be provided statewide and include Medicaid-funded inpatient and outpatient mental health and substance use disorder (SUD) services, including existing 1915(c) HCBS Waiver programs for children with a serious emotional disturbance (SED). In addition to State Plan services, KanCare contractors will provide value-added services for members at no additional cost to the State. Services for individuals residing in state-operated ICFs-MR will continue to be provided outside these contracts (see *Appendix D, Public ICFs-MR*). Three statewide contracts have been awarded to contractors.

Population-specific and statewide outcomes measures will be integral to the KanCare contracts, and will be paired with meaningful financial incentives in the form of premium withholds. Moreover, the State intends to create health homes, and will work with the CMS Health Homes team to prepare a related State Plan Amendment. The State also intends to use Aging and Disability Resource Centers (ADRCs) to make functional eligibility determinations and provide information and assistance and options counseling. The State will hold the contract with the ADRC, but there will be direct and ongoing collaboration and coordination between the ADRC and the MCOs, and between the ADRCs and many of the local/regional systems included in KanCare. The KanCare RFP encourages contractors to use established community partners. Contractors will also be encouraged to refer enrollees to Programs of All-Inclusive Care for the Elderly (PACE) where appropriate.

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

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

KanCare members will not be responsible for co-pays. Current protections, including federal regulations governing cost sharing, will continue to apply.

CHIP members may pay premiums up to $75, based on income. Select other eligibility groups may pay defined premiums or can be responsible for a portion of expenses, depending on income level, as detailed in *Appendix C, Kansas Eligibility Tables*. The KanCare demonstration does not propose to increase premiums or impose new premiums.

Home and Community Based Services. KanCare will include long-range changes to the delivery system by aiding the transition away from institutional care and toward services that can be provided in individuals' homes and communities. Kansas currently has the sixth highest percentage of seniors living in nursing homes in the country. Including institutional and long-term care in person-centered care coordination means KanCare contractors will take on the risk and responsibility for ensuring that individuals are receiving services in the most appropriate setting. Outcome measures will include lessening reliance on institutional care.

The State proposes that all existing waiver authorities be included in the KanCare Demonstration. The core features of each waiver will be retained, and steps related to 1915(c) transition will be timely and coordinated in a person-centered, provider-supportive manner.

Further, the State intends that all 1915(c) services will be included in the managed care benefit package, and that the same amount of services will remain available to participants, based on individual need and existing service limitations. Waiver services will transition to KanCare beginning January 1, 2013, except those services under the 1915(c) waiver for individuals with intellectual and developmental disabilities, which will be included in the managed care benefit package January 1, 2014.

All existing participant direction structures will be retained. The State also will retain the core structure of the 1915(c) programs, including waiting list management practices and criteria. The State of Kansas remains committed to managing the program efficiently to reduce waiting lists. Likewise, it is anticipated that more effective resource utilization under KanCare will aid in the reduction of the waiting lists.

The core features of the existing quality strategies for the 1915(c) waivers will be rolled into the KanCare program, with additions: The existing health/welfare assurances will continue to be measured; additional performance measures that relate to the 1915(c) programs, services and providers will be added to the quality oversight for those programs; and the roles of the State vis-à-vis the MCO contractors vis-à-vis the providers will evolve over time so that for each quality measure involved, the responsibility for monitoring, reporting and overseeing the outcomes will shift as the program becomes more mature. The State will retain the responsibility for monitoring quality measures, either by direct measurement, sample measurement, probe, report analysis or other strategies. The State will provide a quality management strategy and will work with KanCare contractors to develop the details of some

features of that strategy; and will include in the strategy a regular review and update component.

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

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

People with intellectual or developmental disabilities often have multiple chronic conditions. A Medicaid Transformation Grant (MTG) project demonstrated that this population's health care was fragmented and poorly coordinated, and members did not consistently receive recommended health screenings for breast, cervical or colorectal cancer (*Kansas Medicaid Transformation Grant Final Report*, June 2010).

In addition, management of diabetes, which occurs at almost three times the rate in the general Kansas population, was lacking. Analysis of data during the MTG period (November 2007 through October 2008) indicated only 55% of adults with I/DD had an HbA1C test in a one-year period. This test is critical to assessing how well blood sugar levels are being managed and is an established clinical standard for diabetes care. National HbA1C testing rates in a similar period for Medicaid beneficiaries were 72% (*NCQA*, 2008).

In the same MTG period, cholesterol checks were done on only one-half of the adults with I/DD. During that time, 93% of the population studied had at least one visit with a primary care provider, yet these simple but important tests were not performed. Ultimately, despite the support systems currently in place, coordination and integration of physical and behavioral health care with community supports and services must improve.

In response to concerns about transition related to community-based supports services for individuals with intellectual and developmental disabilities, and to allow additional time to integrate those services with physical and behavioral health services, the State is proposing to stage implementation of those services into the KanCare program. Individuals will immediately become members of KanCare and benefit from the coordination of physical and behavioral health services in managed care during the first year of the KanCare demonstration, beginning January 1, 2013, while the long term services (those currently provided under the HCBS DD

waiver) will be phased in effective January 1, 2014. However, pilots are being designed to begin integrating DD waiver services with physical and behavioral health care services in 2013.

The Department for Aging and Disability Services has developed a Developmental Disabilities Pilot Project Advisory Committee that consists of thirteen organizations. The DD Pilot Project Advisory Committee has been charged with providing the state with recommendations for how the 2013 DD services pilots should be structured and measured. The workgroup worked with the State to develop a request for information that was published on August 3, 2012, to further engage the I/DD stakeholder community on how the pilots should be structured. The state will utilize this information to develop the pilot design and will then solicit provider applications to participate in the pilot. Provider participation in the pilot will be voluntary. Persons served by the pilot I/DD organizations will also sign up to participate on a voluntary basis.

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

The State's KanCare Advisory Council, appointed by the Governor, had its initial meeting on March 29, 2012. The Council was appointed to provide guidance and feedback to the State regarding the implementation of KanCare, as well as ongoing operations and policies after January 2013. The Council has met bimonthly to date. Individual MCO member advisory committees are to be focused on issues specific to that MCO and enhance member engagement.

In addition, since the announcement of the State's selection of three KanCare managed care contractors, the State convened four external workgroups to participate in the operational preparations for KanCare. Membership includes representatives of State agencies, but each workgroup is composed primarily of stakeholders.

Appeal and fair hearings rights referred to throughout the KanCare RFP, including the specifics described in RFP Attachment D, will be available to all KanCare members, including those receiving LTSS.

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

- Undertake a health risk assessment to identify health and service needs in order to develop care coordination and integration plans for each member;
- Provide health homes to members with complex needs;
- Take steps to improve members' health literacy in order to make effective use of services and to share responsibility for their health;

- Provide value-added services, at no additional cost to the state, to incentivize members to lose weight, quit smoking, participate in chronic condition management programs, and other health and wellness initiatives; and
- Create member Advisory Committees to receive regular feedback and to have Member Advocates to help members who have complaints and grievances.

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

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

3. Establish Safety Net Care Pools

In Track 1, Kansas is seeking authority to establish up to four uncompensated care cost (UCC) pools that will permit direct payments from the State to hospitals based on the uncompensated hospital cost of furnishing services to Medicaid and uninsured individuals (i.e., individuals with no source of third party coverage for the inpatient and outpatient hospital services they receive). Three of those pools are proposed to begin in Year 1.

As the pool payments replace payments that would be made to the hospitals under the State Plan if the State were to continue its fee-for-service system, they meet budget neutrality conditions. All cost calculations are consistent with Medicare cost reporting principles. The combined amount of the three pools beginning in Year 1 would be up to $76.9 million in Year 1; $78.4 million in Year 2, $80 million in Year 3, $81.8 million in Year 4, and $83.5 million in Year 5. Please see the Budget Neutrality Summary in *Appendix F* for details.

A. Large Public Teaching Hospital. The first pool is for large public teaching hospitals and would provide for payments to The University of Kansas Hospital (KU Pool). Payments would be made from the pool for its uncompensated care costs in serving Medicaid patients and the uninsured. Costs eligible under the KU Pool will be calculated in accordance with Medicare cost principles using the most recently available Medicare cost reporting period and will maintain consistency with the cost identification requirements articulated under the federal Disproportionate Share Hospital (DSH) Audit regulation.

Currently, KU Hospital, which is limited by the State Plan to .25 percent of the state's DSH allocation, receives inpatient payments equal to its charges (up to the Medicare UPL) and outpatient payments determined as reasonable cost. Under KanCare, KU Hospital will negotiate rates with the MCOs. Payments from the pool would ensure that the hospital continues to receive Medicaid payments that offset its uncompensated costs in serving Medicaid and the uninsured. The amount of the KU Pool would be limited to $28.9 million in Demonstration Year 1, consistent with the current level of UPL and outpatient differential reimbursement. The non-

federal share of KU Pool payments would be in the form of an intergovernmental transfer from KU Hospital, a statutorily created state public authority. This pool would begin January 1, 2013.

B. Border City Children's Hospitals. The second pool is for out-of-state children's hospitals located in a border city (BCCH Pool). The State Plan limits DSH payments to out-of-state hospitals to no more than 10 percent of the federal DSH allotment. However, the State Plan provides for an outlier adjustment payment to border city children's hospitals. Historically only Children's Mercy Hospital in Kansas City, Missouri, has qualified for this payment.

Kansas seeks authority for a BCCH Pool that would permit payments up to $7 million in Year 1, a limitation calculated using the BCCH methodology currently set forth in the State Plan. It is anticipated that the non-federal share of the BCCH pool payment would be appropriated from the state general fund. This pool would begin January 1, 2013.

C. Uncompensated Care Pool. The third pool is the uncompensated care pool (UCC) pool, which will assist hospitals in maintaining access to care for vulnerable populations by offsetting uncompensated care costs not otherwise supported by the State of Kansas' DSH program. As a low-DSH State, total eligible uncompensated care costs exceed the State's DSH allotment ($49.7 million in SFY 2012, excluding IMD) by $157 million. As such, the UCC pool will subsidize a portion of the remaining inpatient and outpatient unreimbursed costs of serving Medicaid and uninsured individuals after the State's DSH allotment has been exhausted. Hospitals that receive payments under the other pools will not be eligible for payments under the Uncompensated Care Pool. The pool is also proposed to begin January 1, 2013.

The UCC payments will replace Health Care Access Improvement payments (HCAIP) currently paid to Kansas hospitals, which are paid as supplements to the Medicaid rate. The current source of the nonfederal funding for HCAIP access payments, and the source of funding for the future UCC pool, is an assessment of 1.83 percent of net inpatient revenue for each qualifying hospital per state statute. Certain hospitals, including Critical Access Hospitals and state hospitals, are exempt from the assessment. Consistent with the federal policy guidance in October 1997, the State of Kansas continues to operate the fee under a federally approved broad based waiver as the tax structure remains unchanged (i.e., the tax rate and the taxpayers remain the same).

Under the direction of the statutory Health Care Access Improvement Panel, a portion of the proceeds historically has been used to support hospital and physician rates, as well as capitation rates of the State's current managed care organizations. Rate support does not represent any form of supplemental payment. It is anticipated that will continue at the current level. The remaining portion of the proceeds will be used to fund the nonfederal share of the $41 million UCC pool.

Payments from the UCC pool will be based on these components:

- Uncompensated costs, not otherwise covered by the DSH program, for providing inpatient and outpatient hospital services to KanCare enrollees ("Medicaid shortfall");

- Uncompensated costs, not otherwise covered by the DSH program, for providing inpatient and outpatient services to individuals with no source of third party coverage. This would include costs for hospitals not otherwise eligible for DSH as well as DSH-eligible hospitals. All calculations will be consistent with Medicaid DSH audit requirements.
- Each hospital eligible under the UCC pool will receive a uniform percentage of its eligible uncompensated costs.
- Hospitals that furnish certain specialty services (psychiatric, neonatal intensive care, and trauma services) will receive additional payments under the pool to ensure access to these critical services for Medicaid and uninsured populations.
    a. Each hospital that furnishes at least one of the defined specialty services will receive an additional uniform percentage of its eligible UCC.
    b. Each hospital system that furnishes all three levels of NICU services will receive an additional flat amount per Medicaid day.
    c. Each hospital that provides all three defined specialty services and has less than $250 million in net patient revenue will receive an additional flat amount per Medicaid day.

D. The State also proposes future development of a safety net pool for Critical Access Hospitals (CAHs). Kansas' 83 CAHs are integral for access to health care services in rural communities across the state, particularly in frontier areas. CAHs have been reimbursed on a cost basis under fee-for-service Medicaid, but not for their current HealthWave managed care volume. A safety net pool for CAHs could aid in the transition to KanCare and preserve vital access in rural communities. The State anticipates creation of the CAH pool in 2014. In 2013, expenses for CAH reimbursement have been added into managed care base costs.

Note: Graduate Medical Education (GME) payments will not be made from the pools described above. GME payments to facilities will be included in capitation rates, and MCOs will be responsible for GME payments to hospitals. The portion of GME that is paid directly to teaching physicians will continue to be made under the State Plan, as approved September 16, 2008.

4. <u>Create and Support Alternatives to Traditional Medicaid</u>

The State has proposed to develop and implement programs to transition Kansans who are currently on Medicaid to private insurance coverage. Such programs will aid in the transition from Medicaid to independence while preserving relationships with providers. Proposals include:

A. A pilot project to offer the option of a funded health account for the purpose of purchasing health services or paying health insurance premiums for members with Medicaid eligibility for at least three years, including those eligible under transitional Medicaid, who would not reapply for traditional Medicaid for the next three years:

- The option would be available annually at the time of Medicaid plan choice (open enrollment);
- Certain qualifying events would permit a change during the year (loss of employment, change in household composition);
- Individuals who took this option would retain the balance in their accounts even if their income would make them otherwise ineligible for Medicaid;
- Expenditures from the account would be limited to qualifying health expenses, health insurance premiums, or employee share of health insurance premiums; and
- Members could select a basic health plan offered by a KanCare MCO.

B. An option to allow transitioning members to pay a sliding-scale portion of the applicable PMPM rate to maintain health coverage under their KanCare plan up to two and a half years after exceeding the Medicaid income threshold (effectively extending transitional Medicaid by an additional 18 months).

Employment. Employment plays a major role in health and quality of life. Nationwide, only 30 percent of individuals with disabilities are employed. The Social Security Administration (SSA) reports that 47 percent of working-age people with disabilities receive 100 percent of their income from Supplemental Security Income (SSI). According to SSA, in January 2010, the average SSI payment was $498.70/month, less than the Federal Poverty Level of $902.50/month. Youth who begin receiving SSI before age 18 spend an average of 27 years receiving benefits. Each year, less than 1 percent of working-age Social Security recipients leave the rolls for employment.

Attachment to this system and lack of attachment to an employer result in lost opportunities to maintain and improve skills, loss of a sense of belonging to the workforce, or loss of the mindset that employment is possible. Lack of employment also contributes to a culture of poverty, including inadequate living conditions, poor physical health, and social isolation.

Working Healthy, the Kansas Medicaid Buy-In program, is a work incentive authorized under the Ticket-to-Work and Work Incentives Improvement Act, designed to promote employment by allowing individuals to earn and save more while still maintaining their health care. An 11-year study of *Working Healthy* by the University of Kansas shows that employed individuals enrolled in the program have significantly lower health care costs. Additionally, 83% of *Working Healthy* participants who receive personal assistance services through the ancillary program, *WORK,* report an increased level of independence since enrolling in the program.

In light of that experience, the State seeks to increase opportunities for members with disabilities to work. In 2011, the State passed the *Kansas Employment First Initiative Act*. Among other things, the Act requires all state agencies and their community partners to make competitive, integrated employment the first option when serving people with disabilities. An enhanced Medicaid to Work program will include collaboration with the Kansas Department of Commerce to match potential workers with employers, and the Kansas Vocational Rehabilitation program to provide the initial training and supports. In 2012, the State passed

legislation that established preferences for awarding state contracts to businesses that employ people with disabilities.

Using waiver authority sought in this application, the State will combine the employment efforts mentioned above with two pilot programs designed to assist Kansans with disabilities to become engaged in the community through employment, as well as reduce the waiting lists for existing waivers.

A. An employment pilot for up to 400 individuals on HCBS waiver waiting lists.

This pilot will target individuals with disabilities receiving SSI who are on HCBS waiver waiting lists. The pilot will provide services necessary to support independent living and employment. Pilot participants will receive:

- Benefits planning by certified Benefits Specialists;
- Assistance obtaining employment, or regaining lost employment, with employer-based health coverage;
- A limited package of funded employment support services to assist the individual in living and working in the community (capped at $1,500 per month); and
- Restoration to place on waiting list if employment is not found or is lost.

B. A pilot for up to 200 Kansans, particularly but not only youth, who have not yet been determined to meet Social Security disability criteria.

The second pilot will target individuals who meet the Social Security definition of disability but are not yet receiving it. The goal of this pilot is to place individuals with disabilities, particularly youth, on an employment trajectory in order to avoid outcomes that result from unemployment and dependence on benefits. The pilot will include:

- A Presumptive Medical Disability-"like" process to determine whether an individual would meet disability criteria;
- Assistance obtaining employment with employer-based health coverage;
- Wraparound Medicaid coverage, when necessary; and
- Accelerated PMD review to restore the path to Social Security disability status in the event of a worsening medical condition or loss of employment.

The State will conduct a study of the two pilots, comparing pilot participants to individuals with similar characteristics who are not employed.

The State also intends to work with CMS on further development of PACE.

WAIVERS/COSTS NOT OTHERWISE MATCHABLE

In order to implement the Track 1 waiver initiatives, Kansas seeks waivers of provisions of Section 1902 and costs not otherwise matchable under Section 1903 that include, but are not limited to:

Waivers

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

Costs Not Otherwise Matchable

- Expenditures for capitation payments in which the State auto-assigns enrollees and restricts enrollees' right to disenroll without cause to 45 days rather than the 90 days contemplated by Section 1903(m)(2)(A)(vi) and Section 1932(a)(4)(A)(ii)(I)
- Expenditures to provide home and community-based services that could be provided under the authority of Section 1915(c) waivers to individuals who meet an institutional level of care requirement
- Expenditures to enroll individuals who are receiving home and community-based services who would be eligible under 1902(a)(10)(A)(ii)(VI) and 42 C.F.R.§ 435.217 if they were instead receiving services under a Section 1915(c) waiver
- Expenditures to provide a limited package of benefits to individuals who are not enrolled in Medicaid but who are on a waiting list for home and community-based services (or could be if determined disabled) and would be eligible under 1902(a)(10)(A)(ii)(VI) and 42 C.F.R. § 435.217
- Expenditures to pay, out of one or more safety net care pools, certain payments to hospitals for uncompensated care and for supplemental payments to critical access and other essential hospitals.

BUDGET NEUTRALITY

Budget neutrality estimates and documentation of budget neutrality development are included in *Appendix E and Appendix F*. Kansas requests budget neutrality be measured based on a per capita cap combined with all approved supplemental payments. The without-waiver ceiling for

each year would be the sum of 1) the number of waiver-eligible individuals multiplied by an agreed-upon per member per month (PMPM) allowance based on spending for services, and 2) all approved supplemental payments covered under the demonstration.

The with-waiver expenditures will consist of Medicaid costs for waiver enrollees and all expenditures made from approved safety net pools. The State does not include ACA-related Medicaid expansion in either the with- or without-waiver calculation. If the State chooses to make future changes to eligibility, Kansas would adjust the without-waiver budget cap to reflect any changes required as a result of population increases. The current without-waiver budget cap already reflects an adjustment to reflect payment increases up to Medicare levels in 2013 and 2014 for primary care services as established under Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), amending Section 1902(a)(13) of the Social Security Act.

ANNUAL ENROLLMENT AND EXPENDITURES

Savings from KanCare will not come from restricting eligibility or reducing services, but from better managing services to improve outcomes and reduce cost growth without cutting benefits or provider payment rates. The following data summarize Kansas Medicaid and CHIP population expenditures and enrollment for the populations included in KanCare, both historically as well as the period of the proposed demonstration. Historical years are shown as State Fiscal Years, while demonstration years are shown as calendar years, to align with the January 1, 2013, KanCare implementation date.

Historical expenditures have been normalized to adjust for program changes, consistent with the methodology used in Budget Neutrality development. Long-term services and supports for individuals with Intellectual/Developmental Disabilities will not be included in KanCare in Calendar Year 2013, but associated expenditures are included below.

Historical and Projected Medicaid/CHIP Enrollment, in member months

SFY 07	3,665,337	CY 13	5,008,877
SFY 08	3,653,813	CY 14	5,167,465
SFY 09	3,767,748	CY 15	5,340,903
SFY 10	4,075,157	CY 16	5,520,233
SFY 11	4,427,823	CY 17	5,705,595

Historical and Projected Medicaid/CHIP Population Expenditures

SFY 07	$2,076,724,480	CY 13	$2,848,123,148
SFY 08	$2,312,673,605	CY 14	$2,938,995,781
SFY 09	$2,426,796,848	CY 15	$3,085,691,765
SFY 10	$2,511,896,775	CY 16	$3,333,763,694
SFY 11	$2,709,932,926	CY 17	$3,495,136,774

HYPOTHESES AND EVALUATION DESIGN

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

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

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

- Test the hypotheses described above;
- Describe specific outcome measures that will be used in evaluating the impact of each Demonstration-related program during the period of approval;
- Detail the data sources and sampling methodologies for assessing these outcomes;
- Adapt applicable research questions and methodologies from the CMS-sponsored Money Follows the Person Grant Program, so that Kansas' planned reforms can be viewed within a national context;
- Describe how the effects of all Demonstration-related programs will be isolated from other initiatives occurring in the State; and
- Discuss the State's plan for reporting to CMS on the identified outcome measures and the content of those reports.

No later than 60 days after receiving comments on the draft evaluation design from CMS, the State will submit the final design to CMS. The State will submit progress reports in quarterly and annual Demonstration reports, and submit a draft final evaluation report within 120 days of the expiration of the Demonstration.

IMPLEMENTATION

The State has outlined an implementation schedule that will build to January 1, 2013, initiation of KanCare. A high-level, updated implementation timeline from April 2012 to January 2013 is attached as *Appendix G*.

The RFP was released November 8, 2011. Technical proposals were due January 31, 2012, and cost proposals were due Feb. 22, 2012. The State received proposals from five bidders and awarded contracts to three selected contractors on June 27, 2012. Contracts signed by contractors and the State were sent to CMS on June 29. The State has contracted with a consulting firm to assist in readiness reviews and has mapped out an implementation plan that includes providers, as well as a multiphase educational campaign for members and providers, including an eight-city tour the week of July 30 that featured extended question-and-answer sessions. Additional rounds of targeted and general educational sessions are scheduled in August, September and October.

LOOKING AHEAD TO TRACK 2: Medicaid Redesign

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

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

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

Among other things, Kansas will seek authority for the following in Track 2:

- Modifying the Medicaid entitlement for those who have access to affordable, accessible coverage

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

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

APPENDIX A: Public Input and Stakeholder Consultation (Development Stage)

With grant support from the Health Care Foundation of Greater Kansas City, the Kansas Health Foundation, the REACH Healthcare Foundation, the Sunflower Foundation, and the United Methodist Health Ministry Fund, the State of Kansas engaged Deloitte Consulting, LLP to design and implement a Public Input and Stakeholder Consultation process in 2011. The process was designed to gather and summarize ideas about how to reform the Medicaid program in Kansas. Extensive input was collected throughout the process via:

1. Three Public Forums held during the summer of 2011
   June 22, Topeka – 500 attendees
   July 7, Wichita – 400 attendees
   July 8, Dodge City – 250 attendees
2. A public input online Survey – 150 respondents
3. Three population-specific Stakeholder Workgroup conference calls
   August 9, Children and Families – 20 participants
   August 9, Aging – 30 participants
   August 11, People with Disabilities – more than 100 participants
4. A final Wrap-up Forum, where participants were asked to further develop issues and considerations brought up during the previous phases
   August 17, Overland Park – 300 attendees

A complete summary of the events in the process and the extensive feedback received can be found on the KDHE website, http://kdheks.gov/hcf/kancare/index.htm. The primary themes that emerged from that process were:

Integrated, Whole-Person Care
- Implement patient-centered medical homes
- Enhance health literacy and personal stake in care
- Incentivize development of integrated care networks to improve quality
- Advance provider use of electronic health records/e-prescribing

Preserving or Creating a Path to Independence
- Remove barriers to work
- Align incentives among providers and beneficiaries

Alternative Access Models
- Utilize technology and non-traditional settings
- Think creatively about who can deliver what care

Utilizing Community Based Services
- Delay or prevent premature placement into Nursing Facilities
- Incentivize Nursing Facilities to diversify

APPENDIX B: Public Comment and State Response

Kansas submitted to CMS a Section 1115 Demonstration Project proposal in the form of a concept paper on January 26, 2012. The concept paper was posted on the KDHE website, and it was widely publicized through the media and in direct email communications with stakeholders. The State solicited public comment directed to a dedicated state email box. Representatives of the State also participated in more than 50 public meetings and 16 legislative hearings regarding the KanCare reform proposal since it was introduced (see tables below).

Because of the accessibility of State officials, the majority of comments that were received prior to the April 26 proposal were during public and individual meetings, rather than through the official email box. As a result of feedback, the State made a number of changes and enhancements to the reform plan. Substantive issues, and the State's response, focused on the following themes:

1. Timely claims payment: Medicaid providers raised concerns about managed care organizations delaying claims payment. Providers cited problems in other states transitioning from fee-for-service to managed care.

   State response: The State has included stringent prompt payment requirements among its Year 1 pay for performance measures for MCOs, including a benchmark to process 100 percent of all clean claims within 20 days. Prompt payment requirements for nursing facilities require processing of 90 percent of clean claims within 14 days.

   While much of Kansas Medicaid and CHIP is already provided through managed care, there are large groups of providers who are accustomed to fee-for-service Medicaid only. In part to ease the transition, the State has proposed allowing providers to use the Medicaid Management Information System (MMIS) to submit claims to KanCare MCOs.

2. Implementation timeline: Some stakeholders have raised concerns about the timeline for implementation, particularly for populations not currently in managed care.

   State response: In recognition of the change KanCare will bring for members, the State will conduct a multiphase educational campaign, including at least three rounds of community meetings and direct member communications, statewide in preparation for implementation. The first two rounds, during the summer, will feature education about the changes coming in 2013 for Kansans receiving services through Medicaid and CHIP, including current HealthWave enrollees, and what they will need to decide in the fall. The third round will be timed around the fall enrollment period.

Now that contracts have been awarded, the State is actively engaging providers and other stakeholders in implementation activities, including external workgroups and, beginning later this summer, weekly operational status meetings. The State is also contracting with a consulting firm to assist in readiness reviews for the selected plans and for State agencies. Please see *Appendix G, Implementation Timeline*, for an overview.

3. Waiver services for members with intellectual and developmental disabilities: Some providers and advocates questioned the effectiveness of integrating the coordination of physical and behavioral health services with LTSS for individuals with I/DD.

   State response: The State maintains that integrated care coordination, combined with service protections, will benefit individuals with intellectual and developmental disabilities. As noted in the application, the existing, siloed service system has not produced successfully integrated care.

   To support continuity, the State and MCOs will continue to recognize the powers and duties of Community Developmental Disability Organizations, as established by statute and regulation.

   The State recognizes the difference between health services and LTSS, particularly for this population. Postponing including LTSS for this population in KanCare until January 2014, a decision supported by legislative action, will allow members with I/DD to receive the benefits of health services coordination and build MCO experience with those members, increasing the effectiveness of the eventual integration with LTSS.

4. Accountability for outcomes: Legislators and advocates want to ensure the goals of KanCare are achieved and assurances (such as service protections and provider reimbursement floors) are maintained.

   State response: The State supported legislation creating a KanCare legislative oversight committee. While the committee was not created during the 2012 legislative session, the State remains committed to communication and consultation with existing legislative committees, as well as to the creation of a KanCare committee in 2013.

   The State also has said performance measures in KanCare will be transparent and publicly available.

Formal Public Comment Period. After the State's submission of an application to CMS on April 26, 2012, the State learned two Indian Health Service (IHS) providers included in the State Plan consultation policy had been excluded from official notification. As a result, the State asked CMS to not consider the previously submitted application a formal proposal, allowing the State

to continue the Tribal Consultation process, as described in *Appendix H.* The formal Section 1115 application, consequently, was to be subject to the new federal rules regarding public participation and transparency.

KDHE posted notice of the public participation process on its website on June 8, 2012, http://www.kdheks.gov/hcf/kancare, and announced the opening of the formal public comment period by media release and broad circulation to stakeholder email distribution lists. The announcement also included two public meetings, including one that allowed individuals to participate by teleconference. KDHE provided an abbreviated formal notice in the Kansas Register on June 14, 2012, pursuant to 42 CFR 431.408. The relevant page from the Register is included at the end of this appendix.

The first of the formal meetings was conducted in Wichita, Kansas, on June 18, attended by more than 200 Medicaid consumers, providers, and other interested Kansans. Participants were provided with an overview of KanCare, the main features of the demonstration, and frequently asked questions about the proposed demonstration. Attendees were then invited to speak and provide comments; in total, 36 participants made comments in person.

The second meeting was conducted in Topeka, Kansas, on June 20, attended by more than 180 people in person, and another 74 participants by teleconference. The format was identical to the Wichita meeting. A total of 23 participants made comments in person. A summary of comments received at both meetings has been posted on the State's KanCare website, at http://www.kdheks.gov/hcf/kancare/download/1115_Public_Forum_Comments.pdf.

The State also opened a formal comment period that officially closed on July 14, accepting email and written comments. Those comments can be viewed on the KanCare website, at http://www.kdheks.gov/hcf/kancare/download/Section_1115_Public_Comments.pdf.

Common themes were heard in these and other forums, and the State's response, include:

Question or Concern	**State Response**
Do these companies have experience with long term care services for Medicaid waiver populations?	The companies that bid to participate in KanCare were required to demonstrate they had previous experience in furnishing Medicaid services to similar populations in other state programs, similar to KanCare in their size and complexity. During the bidding process, each contractor furnished information to the State that demonstrated this experience, specifically including long term care, in other Medicaid programs.
Will I be able to keep my current providers?	The State appreciates the value of the provider-patient, and provider-consumer, relationship. The KanCare contracts require that contractors use established community partners to deliver care and services, and the companies are required to offer

	contracts to all current providers participating in Medicaid. The State will review the adequacy of the contractors' networks prior to implementation during readiness reviews. Persons with intellectual and developmental disabilities will continue to work with their current case managers. The law ensures community developmental disability organizations (CDDOs) will conduct – either directly or by subcontract – the waiver eligibility assessments, case management and service.
Is KanCare sending our tax dollars out-of-state?	Each of the contractors will be required to establish a Kansas-based facility where key operations such as customer service and quality management will be located. A number of key staff will be required to be based in Kansas as well. It is estimated that more than 800 Kansas jobs will be created through KanCare.
Will providers be paid on time?	The contracts stipulate that providers must be paid within 30 days, or KanCare companies will face financial penalties. To further encourage timely claims payments, the State included a pay for performance measure for contractors to process 100% of clean claims within 20 days.
Will there be legislative oversight?	While legislation to create a dedicated KanCare oversight committee was not adopted in 2012, the State is committed to continuing oversight by the Legislature. A number of committees will be involved in oversight of KanCare, including the public health, budget, and financial/insurance committees of the House of Representatives and Senate.
Is the implementation timeline too fast?	KanCare is the result of an involved, detailed planning process. Full implementation of KanCare, from the Request for Proposals to implementation, will take more than 14 months. To ensure a smooth transition, the State will conduct readiness reviews and consult with providers and will only move to final implementation if reviews indicate readiness.
What will happen to the pharmacy benefit? Will I have to change medications?	The State will continue to manage the Medicaid formulary and preferred drug list under KanCare. Contractors will be required to abide by the State's pharmacy requirements.

There were lots of issues with a similar program in another state. How will you keep those problems from happening in Kansas?	Kansas has contractual requirements that will ensure providers are paid adequately and on time. Additionally, nearly 75% of Kansas Medicaid consumers already are part of managed care programs, so the switch to managed care will be less disruptive. Kansas is drawing from the best examples from around the country.
Consumers need to fully understand the program. What will you do to educate them?	The State has responded to the desire for full education by designing an extensive educational campaign so all Kansas Medicaid and CHIP consumers and their families, legal guardians and caregivers understand KanCare and the transition process.
Where are details behind the savings assumptions?	The formal Section 1115 Demonstration Application contains details of savings estimates *Appendix E and F*.
The proposed 45-day choice period seems too short. How will the State ensure members are allowed choice among the KanCare plans?	To encourage continuity of care, Kansas is requesting that the official choice period be reduced from 90 to 45 days. Consumers will receive their initial assignment to a KanCare plan in the fall. They will also receive information on how they can change plans. Consumers can change plans at any time before January 1 once they receive their initial assignment. The official proposed 45-day choice period will not begin until January 1. They will have the option to change plans anytime from when they receive their assignment, in late October or early November, to February 14, 2012. In most cases, this will allow for more than 45 days for consumers to make an informed choice.
Will my services be cut? Will my hours be cut?	Services will not be cut. There are protections in the KanCare contracts which ensure that all beneficiaries receive the services they need.
How will the health homes program work?	Health homes will be implemented through the managed care companies by the end of 2013 for people with severe and persistent mental illness, diabetes, or both. By the end of 2014, all beneficiaries with complex needs will have a health home.
How will the State transition beneficiaries from the HealthWave program and other current programs that are well known?	During the statewide public education campaigns, education materials will emphasize that the former HealthWave program (and other programs such as Health Connect) will become KanCare on January 1, 2013.

How does the State intend to address the HCBS waiting lists in KanCare?	The State projects that the KanCare program will reduce cost growth in Medicaid substantially over time, which will aid in the reduction of waiting lists.
The State must ensure that KanCare includes meaningful measures of health outcomes.	The KanCare program has literally dozens of required performance measures that will help gauge the performance of the KanCare health plans, and the program as a whole. KanCare plans will be required to report on how well they have done increasing utilization of preventive health services, better coordinating patient care, and integrating physical and long term care services. These measures will be reported widely, and stakeholders will be involved through a number of avenues, such as the State Quality Committee.
The KanCare contracts should include clearly defined claims processing and payment guidelines.	Responding to provider concerns, KanCare contracts clearly detail the State's expectation that KanCare health plans pay providers in a timely manner, and impose penalties if they do not. Payment floors have been set for all providers at no less than the current fee-for-service rates paid by the State. Health plans are required to use the federal definition of a clean claim.

The full Public Notice related to this application is at http://www.kdheks.gov/hcf/kancare, and the abbreviated formal notice published in the Kansas Register follows after the list of previous public and stakeholder meetings and legislative hearings related to KanCare.

PUBLIC AND STAKEHOLDER MEETINGS (Post-RFP to initial application submission date):

Date	Event	Location
Nov. 8, 2011	**RFP released**	
Nov. 8	Stakeholder and advocate briefing	Topeka
Nov. 10	South Central AAA	Wichita
Nov. 16	Kansas Mental Health Coalition	Topeka
Nov. 17	Southeast AAA	Chanute
Nov. 17	Center for Independent Living	Parsons
Nov. 18	CommunityWorks	Overland Park
Nov. 18	Coalition for Independence	Kansas City
Nov. 18	Finney County Regional Health Department	Garden City
Nov. 21	Center for Counseling and Consultation	Great Bend
Nov. 22	Area Mental Health Agency	Dodge City
Nov. 23	Independent Connection	Salina
Nov. 23	Pawnee Mental Health Services	Concordia
Nov. 29	East Central Area Agency on Aging/Elizabeth Layton Center/COF Training Services	Ottawa
Dec. 6	Kansas Home Care Association Conference	Wichita

Dec. 6	Comcare of Sedgwick County CMHC	Wichita
Dec. 9	Johnson County Mental Health Center	Mission
Dec. 9	The Whole Person	Prairie Village
Dec. 9	Johnson County Developmental Supports	Lenexa
Dec. 13	Big Lakes Developmental Center/Pawnee Mental Health Services	Manhattan
Dec. 13	Central Kansas Mental Health Center	Salina
Dec. 14	Interhab Board Meeting	Lenexa
Dec. 14	The Guidance Center CMHC	Leavenworth
Dec. 16	Stakeholder meeting	Topeka
Jan. 6, 2012	Resource Center for Independent Living	Osage City
Jan. 6	Stakeholder meeting	Topeka
Jan. 13	Cottonwood/Bert Nash	Lawrence
Jan. 17	Kansas Hospital Association	Topeka
Jan. 18	Family Medicine and Surgery Advocacy Day	Topeka
Jan. 24	Kansas Health Care Association Winter Conference	Topeka
Jan. 26	**Section 1115 Demonstration Project Concept Paper**	
Jan. 27	Kanza Mental Health and Guidance Center/Brown County Developmental Services	Hiawatha
Feb. 3	Topeka Independent Living Resource Center	Topeka
Feb. 7	Medical Society of Sedgwick County	Wichita
Feb. 10	Three Rivers	Wamego
Feb. 10	Disability Planning Organization of Kansas	Salina
Feb. 17	Advocates for Better Living for Everyone/Achievement Services for Northeast Kansas	Atchison
Feb. 27	Forum on KanCare/Developmental Disability Services	Pittsburg
Feb. 29	Forum on KanCare/Developmental Disability Services	Independence
Feb. 29	Down Syndrome Guild of Greater KC	Shawnee
March 2	Sedgwick County Developmental Disability Organization/Independent Living Resource Center	Wichita
March 2	Stakeholder meeting	Topeka
March 6	National Alliance on Mental Illness	Topeka
March 7	Mental Health Advocates Day	Topeka
March 7	Town Hall	Louisburg
March 15	Douglas County Transitions Council	Lawrence
March 16	Wyandotte Center for Community Behavioral Healthcare	Kansas City
March 16	Families for Mental Health	Prairie Village
March 22	Johnson County Commission	Olathe
March 23	Tri Valley CDDO	Chanute
March 29	Dodge City Senior Center	Dodge City
March 29	Pioneer Health Network	Garden City
March 30	Sedgwick County Developmental Disability Organization	Wichita
April 4	Lawrence Douglas County Health Department	Lawrence
April 6	Kansas Psychiatric Association	Wichita
April 13	Stakeholder meeting	Topeka
April 24	Governor's Public Health Conference	Wichita

LEGISLATIVE HEARINGS RELATED TO KANCARE:

Nov. 15, 2011	Joint Committee on Health Policy Oversight
Dec. 20	Senate Ways and Means Committee
Jan. 11, 2012	Senate Public Health and Welfare Committee
Jan. 17	Senate Ways and Means Committee
Jan. 17	Senate Public Health and Welfare Committee
Jan. 17	House Social Services Budget Committee
Jan. 18	Senate Public Health and Welfare Committee
Jan. 19	House Appropriations Committee
Jan. 19	Senate Ways and Means Committee
Jan. 19	Senate Public Health and Welfare Committee
Jan. 20	Senate Ways and Means Committee
Jan. 23	Senate Public Health and Welfare Committee
Jan. 26	House Health and Human Services Committee
March 13	House Health and Human Services Committee
March 14	House Health and Human Services Committee
March 14	Senate Public Health and Welfare Committee

State of Kansas

Criminal Justice Coordinating Council

Notice of Meeting

The Kansas Criminal Justice Coordinating Council will meet at 9 a.m. Friday, June 29, in Room 106 of the Landon State Office Building, 900 S.W. Jackson, Topeka, to determine final grant awards for the Federal Edward Byrne Memorial Justice Assistance Grant (JAG) Program for federal fiscal year 2013.

Jennifer Cook, Administrator
Governor's Grants Program

Doc. No. 040596

State of Kansas

Department of Health and Environment Division of Health Care Finance

Notice of Meetings on KanCare Demonstration Application

The State of Kansas, Department of Health & Environment (KDHE), hereby notifies the public that it intends to submit a Section 1115 demonstration proposal, ''KanCare,'' to the Centers for Medicare and Medicaid Services (CMS). KDHE is providing this abbreviated notice in compliance with CMS requirements in 42 C.F.R. § 431.408(a)(2)(ii).

KanCare involves four major initiatives. First, KanCare will move virtually all Medicaid and Children's Health Insurance Program (CHIP) recipients into an integrated, whole-person-centered managed care model. Second, virtually all Medicaid and CHIP services, including long-term support services, will be covered through this managed care model. Services provided at the state-operated intermediate care facilities for the mentally retarded will not be part of KanCare at this time. Third, KanCare will establish up to four uncompensated care cost pools that would permit direct payments from the State to hospitals based on the uncompensated cost of furnishing services to Medicaid and uninsured individuals (*i.e.*, individuals with no source of third party coverage for the inpatient and outpatient hospital services they receive). Fourth, KanCare will create programs to transition Kansans who are currently on Medicaid to private insurance coverage.

The goal of these initiatives is to improve Medicaid and CHIP health services and outcomes, as well as to curb the unsustainable growth in the cost of the programs.

Kansas hopes to pre-enroll Medicaid and CHIP beneficiaries in a KanCare plan starting this fall, with regular enrollment and demonstration launch to occur in January.

The State's full public notice, which describes KanCare in more detail, can be found online at www.kdheks.gov/hcf/kancare. The draft KanCare application can be viewed at the same site and directly at 900 S.W. Jackson, Room 900, Topeka, or at www.kdheks.gov/hcf/kancare/download/KanCare_1115_application_public_comment.pdf.

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

- June 18 at 2 p.m.:
  Hughes Metropolitan Complex
  Wichita State University
  5015 E. 29th St. N, Wichita
- June 20 at 3 p.m.:
  Memorial Hall Auditorium
  120 S.W. 10th Ave., Topeka

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

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

Comments on this demonstration application proposal can be emailed to KanCare@kdheks.gov, or mailed to ATTN: Rita Haverkamp, KDHE-DHCF, 900 SW Jackson, Room 900, Topeka, 66612. KDHE will be accepting public comments until July 14.

Kari Bruffett, Director
Division of Health Care Finance

Doc. No. 040606

State of Kansas

Public Employees Retirement System

Request for Proposals

The Kansas Public Employees Retirement System (KPERS) is soliciting proposals for Global Inflation Linked Bond investment management services. A copy of the RFP may be downloaded from www.kpers.org. All proposals must meet the minimum qualifications as set forth within the RFP. Respondents should deliver three written copies of their proposal to the System's offices by Noon July 12. Questions about the RFP may be directed in writing to Julie Smith, Fixed Income Investment Officer/KPERS, 611 S. Kansas Ave., Topeka, 66603, or via email to rfp_globalILB@kpers.org. Deadline for submission of questions is 5 p.m. June 29.

Alan D. Conroy
Executive Director

Doc. No. 040605

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North Central Regional Planning Commission

Notice to Bidders

Sealed bids for three Live-Scan Fingerprint systems will be accepted by the North Central Regional Planning Commission, 109 N. Mill St., Beloit, 67420, until 3 p.m. Monday, June 25, at which time they will be publicly opened and read aloud at the same address. Copies of Instructions to Bidders and project specifications can be accessed at www.procurement.ncrpc.org/HS/projects.html or by contacting the NCRPC at (785) 738-2218 or jcyr@nckcn.com. This action is being taken on behalf of the Southwest Kansas Regional Homeland Security Council. The estimated project value exceeds $50,000.

John Cyr
Special Project Coordinator

Doc. No. 040594

APPENDIX C: Kansas Eligibility Tables

MEDICAID ELIGIBILITY CATEGORIES **– Included** in KanCare

CATEGORY	**CRITERIA**	
POVERTY LEVEL PREGNANT WOMEN 1902(a)(10)(A)(i)(IV) 1902(l)(1)(A)	This program is for pregnant women whose family income is less than 150% of the FPL. Individuals eligible for this program receive a complete benefit package which also includes prenatal care, delivery, and two months of postpartum coverage. The household size is based on the pregnant woman, unborn child or children, father of the unborn child or children, and other legally responsible individuals in the home.	
	Income (150%FPL)	$1650 two individuals
		$2075 three individuals
		$2500 four individuals
	Resources	No resource test
POVERTY LEVEL CHILDREN	Children qualify for Medicaid coverage at varying poverty levels depending on the age of the child. Only the children are eligible, not adults. Children are continuously eligible for 12 months.	
NEWBORNS 1902(a)(10)(A)(i)(IV) 1902(l)(1)(A)	Children under the age of 1 with family income equal to or less than 150% FPL	
	Income (150%FPL)	$1225 one individual
		$1650 two individuals
		$2075 three individuals
		$2500 four individuals
	Resources	No resource test
AGES 1-5 1902(a)(10)(A)(i)(VI) 1902(l)(1)(C)	Children age 1 through 5 with family income equal to or less than 133% FPL.	
	Income (133% FPL)	$1087 one individual
		$1463 two individuals
		$1840 three individuals
		$2217 four individuals
	Resources	No resource test

CATEGORY	CRITERIA	
AGES 6-18 1902(a)(10)(A)(i)(VII) 1902(l)(1)(D)	Children age 6 through 18 with family income equal to or less than 100% FPL.	
	Income (100%FPL)	$817 one individual
		$1100 two individuals
		$1384 three individuals
		$1667 four individuals
	Resources	No resource test
DEEMED NEWBORNS 1902(e)(4)	Children born to a Medicaid mother are eligible for Medicaid coverage through the month of their first birthday.	
LOW INCOME FAMILIES WITH CHILDREN 1902(a)(10)(A)(i)(I) 1931	Coverage is provided to families with children who meet income standards related to TANF. Income standard is based on the county in which the family resides, the household size, and whether there are additional individuals sharing the home. Families are continuously eligible for 12 months. Guidelines below are averages, taking into consideration the above mentioned factors that make up the income limit.	
	Income	$296 one individual
		$325 two individuals
		$402 three individuals
		$470 four individuals
	Resources	No resource test
TRANSMED – WORK TRANSITION 1902(a)(10)(A)(i)(I) 402(a)(37) 1925	Coverage is provided to families who receive coverage on the Low Income Families with Children program and have lost financial eligibility due to an increase in earnings. Coverage is provided for 12 months without regard to income.	
	Income	Must exceed income guidelines for Low Income Families with Children program
	Resources	No resource test

CATEGORY	CRITERIA	
EXTENDED MEDICAL 1902(a)(10)(A)(i)(I) 406(h)	Coverage is provided to families who received coverage on the Low Income Families with Children program and lost financial eligibility due to an increase in child or spousal support. Coverage is provided for 12 months for children and 4 months for adults.	
	Income	Must exceed income guidelines for Low Income Families with Children program
	Resources	No resource test
FOSTER CARE MEDICAL (IV-E) 1902(a)(10)(A)(i)(I)	This program is for children who have been removed from a home whose family members meet the eligibility criteria for federal participation in the IV-E foster care program, taken into state or tribal custody, and placed with an individual, family or institution.	
FOSTER CARE MEDICAL (NON IV-E*)*	This program is for children who have been removed from a home whose family members do not meet the eligibility criteria for federal participation in the IV-E foster care program, taken into state or tribal custody, and placed with an individual, family or institution.	
FOSTER CARE MEDICAL (AGED OUT) 1902(a)(10)(A)(ii)(XVII)	This program is available for young adults 18 to 21 years of age, who on their 18th birthday were in state or tribal custody and in an eligible out-of-home foster care placement.	
ADOPTION SUPPORT MEDICAL (IV-E)	This program is for adopted children with special needs who were in state or tribal custody and meet the eligibility criteria for federal participation in the IV-E adoption support program.	
ADOPTION SUPPORT MEDICAL (NON IV-E) 1902(a)(10)(A)(ii)(VIII)	This program is for adopted children with special needs who were in state or tribal custody and do not meet the eligibility criteria for federal participation in the IV-E adoption support program.	
PERMANENT CUSTODIANSHIP SUBSIDY	This program is for children age 14 to 18 years old who are in DCF custody, are not receiving SSI benefits, and have a permanent qualifying custodian. The child will receive coverage through the Foster Care Medical program.	

CATEGORY	CRITERIA	
PRESUMPTIVE ELIGIBILITY FOR CHILDREN 1920A	Temporary coverage provided to children under the age of 19 based on meeting a series of simplified eligibility requirements. Presumptive coverage is determined by a qualified entity given specific authority by the agency.	
	Income:	See income for poverty level children.
	Resources:	No resource test.
CHIP-HEALTHWAVE XXI 2102	Children with family income equal to or less than 241% of the FPL who do not qualify for one of the other Medicaid programs and do not have comprehensive health insurance. Only the children are eligible, not adults. Children are continuously eligible for 12 months. Premium obligations apply to families above 150% FPL.	
	Income (241% FPL):	$2,175 one individual
		$2,927 two individuals
		$3,678 three individuals
		$4,429 four individuals
	Resources:	No resource test.
PRESUMPTIVE ELIGIBILITY FOR CHILDREN 1920A 42 CFR 457.355	Temporary coverage provided to children under the age of 19 based on meeting a series of simplified eligibility requirements. Presumptive coverage is determined by a qualified entity given specific authority by the agency. Children must not qualify for one of the other Medicaid programs and do not have comprehensive health insurance.	
	Income:	See income for HW XXI children.
	Resources:	No resource test.
MEDICALLY NEEDY 1902(a)(10)(C)	This program is for the elderly, blind or disabled, pregnant women, or children under 19 years old. Individuals eligible under this program may be responsible for a portion of their medical expenses if income exceeds the protected income level.	
	Income	$475/month (single)
		$475/month (couple)
	Resources	$2,000 (single)
		$3,000 (couple)

		There is no resource test for pregnant women or children under 19 years old
	Income:	Varies depending on the specific underlying medical program.
	Resources:	Varies depending on the specific underlying medical program.
BREAST AND CERVICAL CANCER 1902(a)(10)(A)(ii)(XVIII)	This program is for women ages 40-65 with income below 250% FPL who have been diagnosed with either breast or cervical cancer through the Early Detection Works program.	
	Income (250%)	$2257
	Resources	No resource test
SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS 1902(a)(10)(A)(i)(II) 1902(a)(10)(A)(i)(II) 1619(a) 1619(b) 1902(a)(10)(A)(i)(II) 1905(q)	This program is for aged, blind, or disabled individuals who receive a Supplemental Security Income (SSI) payment as determined by the Social Security Administration	
	Income	$674/month (single)
		$1011/month(couple)
	Resources	$2000 (single)
		$3000 (couple)
QUALIFIED MEDICARE BENEFICIARY (QMB) - if dually eligible for Medicaid 1902(a)(10)(E)(i) 1905(p)(1)	This program covers the Medicare out-of-pocket expenses of Medicare recipients, including premiums and co-payments.	
	Income	$903/month (single)
		$1215/month (couple)
	Resources	$6600 (single)
		$9910 (couple)
LOW-INCOME MEDICARE BENEFICIARY (LMB) - if dually eligible for Medicaid 1902(a)(10)(E)(iii) 1902(a)(10)(E)(iii)	This program only pays the Medicare Part B premium eligible Medicare recipients	
	Income	$1083/month (single)
		$1457/month (couple)
	Resources	$6600 (single)
		$9910 (couple)

CATEGORY	CRITERIA	
QUALIFIED WORKING DISABLED (QWD) - if dually eligible for Medicaid 1902(a)(10)(E)(ii) 1905(s)	This program pays the Medicare Part A premium for eligible individuals who lose Medicare coverage due to earnings from employment. Eligible individuals may not be otherwise Medicaid eligible or seeking Medicaid eligibility.	
	Income	$1805/month (single)
		$2429/month (couple)
	Resources	$4000 (single)
		$6000 (couple)
MEDICARE PART D SUBSIDY - if dually eligible for Medicaid 1860D-14	This program helps pay the costs associated with Medicare Part D prescription drug coverage for eligible individuals, including premiums and deductibles.	
	Income	$1354/month (single)
		$1822/month (couple)
	Resources	$11,010 (single)
		$22,010 (couple)
WORKING HEALTHY 1902(a)(10)(A)(ii)(XV)	This program is for employed disabled or blind individuals who are age 16 to 64 years old. Individuals whose income exceeds the protected income level must pay a monthly premium towards their cost of coverage.	
	Income	$2708/month (single)
		$3643/month (couple)
	Resources	$15,000 (single)
		$15,000 (couple)
WORKING HEALTHY MEDICALLY IMPROVED 1902(a)(10)(A)(ii)(XVI)	This program is for individuals eligible for coverage under the Working Healthy program who lose their disability status due to medical improvement. Individuals whose income exceeds the protected income level must pay a monthly premium towards their cost of coverage.	
	Income	$2708/month (single)
		$3643/month (couple)
	Resources	$15,000 (single)
		$15,000 (couple)

CATEGORY	CRITERIA	
PICKLE AMENDMENT Section 503 of P.L. 94-566	This program is for certain OASDI recipients who lost their SSI eligibility solely due to a cost-of-living increase in their OASDI benefit.	
	Income	$674/month (single)
		$1011/month(couple)
	Resources	$2000 (single)
		$3000 (couple)
ADULT DISABLED CHILD 1634(c) 1935	This program is for individuals who currently receive Adult Disabled Child (ADC) benefits from the Social Security Administration, lost eligibility for SSI benefits due to receipt of the ADC benefit, and would otherwise be eligible for SSI benefits if not for receipt of the ADC benefit.	
	Income:	$674/month (single)
		$1,011/month (couple)
	Resources:	$2,000 (single)
		$3,000 (couple)
EARLY OR DISABLED WIDOWS AND WIDOWERS 1634(b) 1935 (Disabled Widow/ers) 1634(d) 1935 (Early Widow/ers)	This program is for individuals who currently receive Early or Disabled Widows and Widowers benefits from the Social Security Administration, lost eligibility for SSI benefits due to receipt of the Widows/Widowers benefit, and would otherwise be eligible for SSI benefits if not for receipt of the Widows/Widowers benefit.	
	Income:	$674/month (single)
		$1,011/month (couple)
	Resources:	$2,000 (single)
		$3,000 (couple)
REFUGEE MEDICAL	This program is for individuals identified as non-citizen refugees for a period of 8 months commencing with the month of entrance into the United States. Eligibility is based on the Refugee Cash Assistance program guidelines.	
	Income:	$267/month (single)
		$352/month (couple)
	Resources:	$2,000 (single)
		$3,000 (couple)

CATEGORY	CRITERIA	
LONG TERM INSTITUTIONAL CARE 1902(a)(10)(A)(ii)(V) Except for individuals residing in a public ICF/MR	This category of coverage is for individuals residing in a nursing home or similar facility for a long term stay. Eligible individuals under this category are generally budgeted separately from other family members. Individuals eligible under this category whose income exceeds the protected income level are responsible for a portion of the cost of their care in the facility.	
	Income:	$62/month
	Resources:	$2,000
HOME AND COMMUNITY BASED SERVICES (HCBS) 1902(a)(10)(A)(ii)(VI)	This program is for individuals exhibiting a medical need for services in the community which prevent placement in an institution. There are currently 8 different HCBS programs, each with its own set of eligibility requirements. Eligible individuals under this program are budgeted separately from other family members. Individuals eligible under this program whose income exceeds the protected income level are responsible for a portion of the cost of their care.	
	Income:	$727/month
	Resources:	$2,000
MONEY FOLLOWS THE PERSON	This program is for institutionalized individuals transitioning from the facility to the community. In-home medically related services are provided for a period not to exceed 365 days. Individuals eligible under this program whose income exceeds the protected income level are responsible for a portion of the cost of their care.	
	Income:	$727/month
	Resources	$2,000
SPOUSAL IMPROVERISHMENT 1924	This process allows married couples to shelter additional amounts of resources and income for the community spouse where the other spouse is either institutionalized or eligible for HCBS.	
	Income:	The community spouse may protect income up to $1,822/month (up to $2,730/month if there are excess shelter expenses).
	Resources:	The community spouse may protect resources up to $109,560.
	Resources:	No resource test.

CATEGORY	CRITERIA	
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.	
	Income	$62/month
	Resources	$2,000
CASH ASSISTANCE PROGRAMS		
STATE SUPPLEMENTAL PAYMENT PROGRAM (SSPP)	This program is for Medicaid recipients age 18 or over residing in a Medicaid approved institution whose SSI benefit continues but has been reduced to below the protected income level due to residence in the facility.	
	Income:	$62/month
	Resources:	$2,000

MEDICAID ELIGIBILITY CATEGORIES **– Not Included** in KanCare

CATEGORY	CRITERIA	
SOBRA 1903(v)(3)	This program is for non-citizens who are undocumented or who do not meet other non-citizen qualifying criteria and would otherwise qualify for Medicaid if not for their alien status. Eligible individuals may only receive coverage for approved emergency medical conditions.	
	Income:	Varies depending on the specific underlying medical program.
	Resources:	Varies depending on the specific underlying medical program.
EXPANDED LOW-INCOME MEDICARE BENEFICIARY (E-LMB) 1902(a)(10)(E)(iv)(I)	This program also only pays the Medicare part B premium for eligible Medicare recipients. However, eligible individuals may not be otherwise Medicaid eligible or seeking Medicaid eligibility.	
	Income	$1219/month (single)
		$1640/month (couple)
	Resources	$6600 (single)
		$9910 (couple)

CATEGORY	CRITERIA	
PROGRAM OF ALL-INTENSIVE CARE FOR THE ELDERLY (PACE) 1934	This program is for disabled individuals age 55 years or older residing in selected counties within the state. Eligible individuals receive long term care coverage through a managed care network. HCBS guidelines apply to individuals living in the community and institutional guidelines apply to those living in a facility. Individuals eligible under this program whose income exceeds the protected income level are responsible for a portion of the cost of their care.	
	Income:	$62/month (institution)
		$727/month (HCBS)
	Resources:	$2,000
TUBERCULOSIS	This program is for individuals diagnosed with tuberculosis and in need of care for this condition. Coverage for eligible individuals is limited to inpatient hospital care or alternative community based services related to the condition	
	Income:	There is no income test.
	Resources:	There is no resource test.
RESIDENTS OF MENTAL HEALTH NURSING FACILITIES	This program is for individuals residing in a mental health nursing facility for a long term stay who are between the ages of 21 and 65 years old. Individuals 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.	
	Income:	$62/month
	Resources:	$2,000
MEDIKAN	This program is for individuals who qualify for a cash payment under the General Assistance (GA) program. Eligible individuals must meet program disability guidelines and must not be eligible for Medicaid.	
	Income:	$267/month (single)
		$352/month (couple)
	Resources:	$2,000 (single)
		$2,000 (couple)

CATEGORY	CRITERIA	
AIDS DRUG ASSISTANCE PROGRAM (ADAP)	This program is for individuals diagnosed with AIDS. Coverage for eligible individuals is limited to payment of prescription drugs related to treatment of AIDS. Individuals may be eligible for Medicaid or MediKan as well as ADAP.	
	Income:	$2,708/month
	Resources:	There is no resource test.
HEALTHY KIDS	Children of state employees with family income equal to or less than 241% may be eligible for subsidized state employee insurance. The program is designed for children who would otherwise qualify for HealthWave XXI but are ineligible due to their parents' employment with the state.	
	Income (241% FPL)	$2,175 one individual
		$2,927 two individuals
		$3,678 three individuals
		$4,429 four individuals
	Resources:	No resource test.

APPENDIX D: Public ICFs-MR

Kansas intends that state-operated Intermediate Care Facilities for individuals with intellectual or developmental disabilities (commonly known as ICF-MRs) will be provided through the State plan option, and not be included part of the KanCare program at this time.

There are two state-operated ICFs-MR, currently serving some 320 people. Kansas has a long and rich history of building community capacity so that people are able to confidently choose and access community-based services and supports, while also continuing to honor the choices of those decreasingly choosing to access public ICF-MR services.

Kansas Neurological Institute (KNI):
KNI's census has declined gradually for many years based on the State's commitment to limit admissions and to facilitate moves into the community services system for all who desire community services. For many years KNI has only admitted people when their needs cannot be met within the community services system.

When possible, KNI has tried to limit the length of admissions and to facilitate moves back to community-based services for people whose needs can be met through the community services system. Following is a summary of KNI's average daily census, and the number of people admitted to KNI in each of the past 15 years:

Fiscal Year	ADC	Admissions
1998	222	4
1999	203	1
2000	190	2
2001	186	0
2002	182	0
2003	177	0
2004	170	0
2005	165	1
2006	166	2
2007	164	2
2008	160	1
2009	158	3
2010	157	2
2011	153	2
2012 YTD	150	1

Parsons State Hospital and Training Centers (PSH):
Data indicates the State has averted 351 out of 396 potential admissions since FY 2002, an 89% diversion rate. Specifics as to PSH admissions, discharges and average daily census over the past 10 years:

Fiscal Year	Admissions	Discharges	ADC
2002	20	28	193.6
2003	17	15	190.4
2004	13	16	188.0
2005	21	13	194.5
2006	15	15	197.5
2007	16	20	194.7
2008	15	27	194.0
2009	17	23	192.2
2010	14	23	186.4
2011	17	21	186.2
2012	7	16	180.3

KNI's policy #2.1.05, Review of Requests for Admissions to KNI, outlines the organization's policy and procedures related to admissions. In short, the policy calls for the following:

- Requests for admission must be routed through the Community Developmental Disability Organization (CDDO);
- The CDDO must attest that the person's needs cannot be adequately met through the community services system at the present time;
- The CDDO must agree to actively support the person's return to the community services system within an agreed-upon amount of time;
- Appropriate documentation will be submitted to KNI through the CDDO so that a documentation review can occur;
- Consideration will be given to attempting to meet the person's needs by providing community outreach and/or other technical assistance prior to admission;
- Prior to admission the guardian must obtain district court authorization for the person to move into a more restrictive setting; and
- Prior to admission plans for what will be accomplished during the admission, responsibilities of various parties and tentative plans for discharge are developed.

KNI anticipates these procedures would continue if a managed care system is implemented.

In practice, there are instances in which a return to community services is difficult to attain because of the complex medical or behavior support needs of specific individuals and because guardians conclude the services provided at KNI result in their loved one having a better quality of life at KNI than he/she had prior to admission. In these instances KNI encourages guardians to continue to look for viable community-based options, and the State encourages CDDOs to continue efforts to increase community capacity.

The process for transitioning to/from an ICF-MR into or out of managed care will include periodic and ongoing evaluation of interest and service needs via person-centered planning; ongoing attention to building capacity of community based service providers and service systems; and utilization of the Money Follows the Person (MFP) grant project for all eligible persons.

As for the planned interface between KanCare MCOs and the state-operated ICFs-MR, the interface will be through comprehensive care coordination strategies and use of the MFP program, both those that currently exist and additional resources and strategies as part of the KanCare program. For example, at this time there is intensive engagement at both the front and back door of the public ICFs-MR with CDDO network. Extensive evaluation of need and efforts to either avoid or shorten ICF-MR service length occur in the collective efforts of the CDDOs, their affiliating community service providers, and the state ICF-MR staff. This includes access to targeted case managers and CDDO/state facility administrative staff. These efforts will be strengthened with the presence of the KanCare contractors, to include additional skills and experiences regarding behavioral health, physical health and co-occurring conditions.

There are 25 private ICF-MR facilities in Kansas, 22 of which are classified as small facilities (with 4-8 beds) and three of which are classified as medium facilities (9-16 beds). Residents of those facilities will be enrolled in KanCare.

Appendix E: Description of Budget Neutrality Development

Overview

The purpose of this document is to describe the development of the budget neutrality calculations for the Kansas 1115 demonstration. Budget neutrality consists of the following three worksheets: Historical Data, Without Waiver, and With Waiver. The processes utilized to populate these three sections are further described below.

Historical Data

The State of Kansas (State) developed the budget neutrality demonstration using fee-for-service (FFS), encounter, and financial data. The data covers the five year period from 7/1/2006 - 6/30/2011 (SFY07-SFY11) and groups Kansas' 56 rate cohorts into the following thirteen Medicaid Eligibility Groups (MEGs):

MEG	Rate Cohort
CHIP	CHIP < 1
CHIP	CHIP 1 – 5
CHIP	CHIP 6 – 14
CHIP	CHIP 15 -19 F
CHIP	CHIP 15 - 19 M
Delivery	Delivery
Foster Care	Foster Care/Adoption Non Dual M & F <1
Foster Care	Foster Care/Adoption Non Dual M & F 1 – 6
Foster Care	Foster Care/Adoption Non Dual M & F 7 – 12
Foster Care	Foster Care/Adoption Non Dual M & F 13 – 17
Foster Care	Foster Care/Adoption Non Dual M & F 18 – 21
Long Term Care (LTC)	ICF/MR
LTC	Mental Health Nursing Facility
LTC	LTC Dual
LTC	LTC Non Dual
Medically Needy (MN) Dual	Medically Needy Aged, Blind, and Disabled Dual M & F < 65
MN Dual	Medically Needy Aged, Blind, and Disabled M & F Dual 65+
MN Non Dual	Medically Needy Aged, Blind, and Disabled Non Dual M & F < 65
MN Non Dual	Medically Needy Families Non Dual All Ages M&F
Other	Breast and Cervical Cancer
Other	Child Institution Non Dual All Ages M & F
Other	LMB/LL/LP Dual M & F All Ages
Other	QMB Dual M & F All Ages
Other	Refugees Non Dual All Ages M & F
Other	Working Disabled M & F All Ages
Spend Down Dual	Spend Down Medically Needy Aged, Blind, and Disabled Dual M & F < 65
Spend Down Dual	Spend Down Medically Needy Aged, Blind, and Disabled M & F Dual 65+
Spend Down Non Dual	Spend Down Medically Needy Non Dual
SSI Dual	SSI Aged, Blind, and Disabled Dual M & F < 22
SSI Dual	SSI Aged, Blind, and Disabled Dual M & F 22 - 44

MEG	Rate Cohort
SSI Dual	SSI Aged, Blind, and Disabled Dual M & F 45 - 64
SSI Dual	SSI Aged, Blind, and Disabled Dual M & F 65+
SSI Non Dual	SSI Aged, Blind, and Disabled Non Dual M & F < 1
SSI Non Dual	SSI Aged, Blind, and Disabled Non Dual M & F 1 - 5
SSI Non Dual	SSI Aged, Blind, and Disabled Non Dual M & F 6 - 21
SSI Non Dual	SSI Aged, Blind, and Disabled Non Dual M & F 22 - 44
SSI Non Dual	SSI Aged, Blind, and Disabled Non Dual M & F 45 - 64
TAF	PLE Pregnant Woman < 30
TAF	PLE Pregnant Woman 30+
TAF	TAF & PLE < 1
TAF	TAF & PLE 1 - 5
TAF	TAF & PLE 6 - 14
TAF	TAF & PLE 15 - 21 F
TAF	TAF & PLE 15 - 21 M
TAF	TAF 22 - 29 F
TAF	TAF 22 - 34 M
TAF	TAF 30 - 34 F
TAF	TAF 35 +
TAF	Deliveries
Waiver	Autism Non Dual
Waiver	Developmentally Disabled Dual < 45
Waiver	Developmentally Disabled Dual 45+
Waiver	Developmentally Disabled Non Dual
Waiver	Mental Health Non Dual
Waiver	SED
Waiver	TA
Waiver	TBI

The MEGs were determined based on grouping rate cohorts into similar risk categories from a cost and actuarial perspective.

The historical data was blended by reviewing the PMPMs and assigning varying credibility to each year, resulting in low credibility being given to outlier years. This methodology produces different weighting schemes across years for each MEG but provides the most consistent and appropriate base dataset.

Program Changes

The State adjusted the data to account for program changes that occurred during the SFY07 – SFY11 data period. All data was normalized to the latest information available. The program changes are further discussed below.

Affordable Care Act Section 1202 - Payment Increase for Medicaid Primary Care Physicians

Certain evaluation and management (E & M) services and immunization administration services provided in calendar years 2013 and 2014 by a physician with a specialty designation of family

medicine, general internal medicine, or pediatric medicine will be paid at a rate no less than 100 percent of Medicare reimbursement. This impact was estimated by applying the latest Medicare rates and July 2009 Medicaid rates to the existing utilization and comparing the resulting change in total cost. This programmatic change impacts the "PCP" category of service.

Graduate Medical Education (GME) Payment Change

The impact of the change in the GME factors from the base to the contract period was estimated by comparing period specific factors to the latest factor effective July 1, 2011.

E2011-131- PRTF Rate Change

The PRTF per diem rates changed effective with dates of service on and after January 1, 2012. The impact of this change to the contract period was estimated by re-pricing the utilization of these facilities at the effective per diems compared to the effective base period rates. This program change primarily impacts the "Residential Treatment Facility" categories of service.

E2011-106 - ICF-MR FY12 Rate Change (Intermediate Care Facility for the Mentally Retarded)

Effective with dates of service on and after October 1, 2011, the rates for the ICF/MR facilities have changed. The impact to the ICF/MR cohort was calculated by comparing utilization at the old contracted rates during the base period to the utilization at the effective rates.

E2011-100 - Rate Change for Codes 90460 and 90461

The reimbursement rate for procedure codes 90460 and 90461 have increased from $7.40 to $10.50 per antigen effective November 1, 2011. The impact of this fee increase was estimated by comparing costs under the new fee to the previous fee applied to the existing utilization.

E2011-099 - Money Follows the Person Frail Elderly Rate Increase for ALF, RHCF, and Home

The reimbursement rate for attendance care services in assisted living settings increased from $3.73 per unit to $4.10 per unit effective November 1, 2011. The impact of this fee increase was estimated by comparing costs under the new fee to the previous fee applied to the existing utilization.

E2011-098 - Home and Community Based Services Frail Elderly Rate Increase for ALF, RHCF, and Home

The reimbursement rate for attendance care services in assisted living, residential health care, and home plus settings will increase from $3.73 per unit to $4.10 per unit effective November 1, 2011. The impact of this fee increase was estimated by comparing costs under the new fee to the previous fee applied to the existing utilization.

E2011-094 - Allow One Unit for Specific Family Planning Service Codes

The following procedure codes were limited to one unit per day per beneficiary effective December 1, 2011: J7300, J7302, J7306, and J7307. The impact to PCP and Other categories of service were calculated by comparing the expenditures at the existing utilization to the utilization adjusted for one unit per day per beneficiary.

E2011-093 - Hospice Payment Rates FFY2012

Hospice service for consumers was reimbursed at the following: T2042 at $157.92, T2043 at $38.41, T2044 at $161.83, and T2045 at $700.39 effective October 1, 2011. The impact to the Home Health/ Hospice category of service was calculated by comparing these rates at existing utilization to the effective base period rates.

E2011-091- NF and NF/MH FY12 Rate Change

Effective July 1, 2011, the rates for each Nursing Facility and Nursing Facility for Mental Health in Kansas were adjusted. The impact was calculated by comparing effective base period rates to FY2012 rates listed at the existing utilization.

E2011-090 - Palivizumab (Synagis®) Pricing Adjustment

The fees for Synagis have increased effective October 1, 2011. The impact of this program change was estimated by comparing the cost of administering the utilization of Synagis under the previous fee and the October 2011 schedule. This impacts the "Pharmacy" category of service.

E2011-065 - Rate Change for Intrauterine Copper Contraceptive (J7300)

The reimbursement rate for HCPCS code J7300 have increased to $633.88 effective August 1, 2011. The impact of this fee increase was estimated by comparing costs under the new fee to the previous fee applied to the existing utilization.

E2011-064 - Kansas University Hospital Inpatient Rate Change 2011

KU is reimbursed according to a percentage of their billed charges, thus we analyzed the difference between the percentages in place during the base period and the August 1, 2011 rate of 42%. Depending on the date of service during our base period, KU was reimbursed using 60%, 44.2%, 35%, 42%, 45%, or 48% of billed charges. The impact of this program change was estimated by comparing the cost of these services with the appropriate factors applied based on date of service.

E2011-047 - Indian Health Services (IHS) Rate Change

Effective with dates of service on and after July 1, 2011, retroactive to dates of service on and after January 1, 2011, the rate for Indian Health Services (IHS) increased from $289 to $294. The impact to the contract period was calculated by comparing utilization at the January 1, 2011 contracted rate. The programmatic change affects the "Other" category of service.

E2011-043 - Money Follows the Person Services Frail Elderly - Self-Directed Attendant Care Rate Reduction

Effective November 1, 2011, the rate for procedure code S5125 UD was reduced to $2.71. This fee schedule change was calculated by comparing this rate and the previous rate of $3.17 to the existing utilization.

E2011-042 - Home and Community Based Services Frail Elderly - Self-Directed Attendant Care Rate Reduction

Effective November 1, 2011, the rate for procedure code S5125 UD was reduced to $2.71. This fee schedule change was calculated by comparing this rate and the previous rate of $3.17 to the existing utilization.

E2011-039 - DRG Weights & Rates

The DRG program change was used to calculate the impact during the contract period of the inpatient DRG schedule changes, including both the rate and outlier fees. The DRG program change was estimated by comparing the effective base period schedule to the new schedule effective October 1, 2011.

E2011-010 - FQHC Rate Change

Rates for the FQHCs listed were adjusted to the amounts identified for each FQHC. The impact was calculated by comparing the previous contracted rates, to the new rate listed effective March 1, 2011.

E2010-052 - RHC/FQHC Prospective Payment System (PPS) Rate Change

The PPS rates for all RHC and FQHCs were increased by the Medicare Economic Index (MEI) rate of 2.1% for 2007, again 1.8% for 2008, 1.6% for 2009, and 1.2% for 2010. The impact of this program change was estimated by comparing the cost of these services with the rate percentage increases applied.

E2009-086 - HCBS/FE Service Coverage Changes

Coverage/reimbursement for the following Home and Community Based Frail Elderly (HCBS/FE) were no longer reimbursed except for crisis exceptions:

- HCBS/FE Oral Health Services
- HCBS/FE Comprehensive Support (Provider and Self-Directed)
- Sleep Cycle Support
- Assistive Technology

The impact of this program change to the Frail Elderly cohort was estimated by calculating expenditures and utilization for these services in the base period, accounting for crisis exceptions.

E2009-083 - Assistive Services Limitation

Effective January, 1, 2010, Assistive Services for the HCBS/PD and HCBS/TBI waivers was limited to crisis situations. The impacts to the Physically Disabled and TBI cohorts were estimated by calculating expenditures and utilization for assistive services in the base period, accounting for crisis exceptions.

E2009-080 - Elimination of HCBS Adult Oral Health Services

HCBS adult beneficiaries covered under Physical Disability (PD), Developmental Disability (MR/DD), and Traumatic Brain Injury (TBI) were no longer eligible for expanded dental services

effective January 1, 2010. The impact to these cohorts was estimated by calculating total dental service expenditures and utilization to remove from the base period.

E2009-078 - Budget Shortfall Payment Reduction (BSR)

Payments issued by KMAP were reduced by 10%, and pharmacy payments were reduced by .5% due to budget shortfall requirements beginning January 1, 2010. The impact of this programmatic change was estimated by comparing expenditures incorporating the BSR amount for dates of service on and after January 1, 2010.

E2008-054 - Reimbursement Changes related to 2008 Congressional changes in DMEPOS

Rate changes for procedure codes A7035, A7046, E0148, E0260-RR, E0310-RR, E0940-RR, E0981, and E0982 were effective January 1, 2009. The impact was calculated by comparing the previous contracted rates, to the new fee schedule. This program changes impacts the "Other" category of service.

E2008-027 - FY09 HCBS-MR/DD Reimbursement Rate Changes

The HCBS-MR/DD services listed increased 2% effective July 1, 2008. The impact of this program change was estimated by comparing the cost of these services with the 2% increase for dates of service prior to the effective date.

E2008-046 - Rate Change for Radiology Codes 72156, 72157, 72158

KHPA has changed the reimbursement rates for procedure codes 72156, 72157, and 72158 effective January 15, 2009. The impact for this program change was calculated by comparing utilization at the previously contracted rates to the utilization at the effective rates.

E2008-036 - FY 2009 HCBS/TBI Waiver Sleep Cycle Support Rate increase

Effective with dates of service on and after July 1, 2008, the rate for the HCBS/TBI Waiver service, Sleep Cycle Support (T2025), changed from $30.00 to $30.60 per unit. The impact to the "Sleep Cycle Support" category of service was calculated by comparing utilization at the old contracted rate during the base period to the new rate of $30.60.

E2008-035 - FY 2009 HCBS/TBI Waiver Transitional Living Skills Rate increase

Effective with dates of service on and after July 1, 2008, the rate for the HCBS/TBI Waiver service Transitional Living Skills (H2014) increased from $6.75 to $6.89 per 15-minute unit. The impact to the "Skills Training" category of service was calculated by comparing utilization at the old contracted rate during the base period to the new rate of $6.89.

E2008-028 - FY 2009 HCBS/TBI Waiver Sleep Cycle Support Rate increase

Effective with dates of service on and after July 1, 2008, the rate for the HCBS/PD Waiver service, Sleep Cycle Support (T2025), changed from $30.00 to $30.60 per unit. The impact to the "Sleep Cycle Support" category of service was calculated by comparing utilization at the old contracted rate during the base period to the new rate of $30.60.

E2008-017 - HCBS/FE Rate Increase

The rates for HCSBS/FE services increased 2% effective July 1, 2008. The impact of this program change was estimated by comparing the cost of these services with the 2% increase for dates of service prior to the effective date.

E2008-013 - Daily Rate Change for Ventilator Dependent Residents/Includes DME

The ventilator rate increased to a daily rate of $485 beginning July 1, 2008, which includes the durable medical equipment for ventilator dependent residents. The base data ventilator claims were identified and the impact was estimated by computing the difference between utilization at the prior fee to the utilization at the effective rate of $485. This program change affects the "Nursing Facility - Skilled Nursing Facility" and "Other" categories of service.

Skilled Nursing Facility (SNF)

Rate changes for SNF effective as of SFY11 applied to each base year.
FY12 SNF rate increases have been removed. SNF supplements have been added to the base data to reflect their inclusion in the managed care benefits package in CY13.

Bariatric Surgery

Effective CY13, costs for Bariatric Surgery have been included, based on the criteria established by KDHE for bariatric services.

Heart Transplants

Effective CY13, costs for Heart Transplants based on Kansas historical experience and national Medicaid experience for heart transplants have been included to reflect their inclusion in the managed care benefits package in CY13.

Targeted Case Management (TCM)

Effective CY13, TCM assessments have been excluded as they are excluded from the managed care benefits package in CY13. Effective CY13, Developmentally Disabled TCM has been removed as it is excluded from the managed care benefits package in CY13.

Critical Access Hospitals (CAH)

Effective CY13, CAH expenses have been added into the managed care base costs, and the CAH pool has been removed.

Without Waiver

The Without Waiver worksheet uses the blended historical data and projects the data to Demonstration Year 00 (DY 00), which translates to calendar year 2012 (CY12). DY 00 PMPMs are then projected to DY 01 – DY 05 (CY13-CY17). This section describes the methodology used to develop the caseload projections and the PMPM trends.

Caseload Projections

Caseload projections were developed by analyzing historical member month changes over time and incorporating known changes in populations going forward. The projections were done at

the rate cohort level and then aggregated into the appropriate MEGs discussed earlier in this document.

PMPM Trends

In order to do the trend analysis, the historical monthly data was first normalized for program changes so that all of the data was on the same basis. The data was also normalized for demographic and regional mix. This was done so that the medical trend could be isolated from the impact of program changes and demographic mix. Trends were developed at the category of service and broad rate cohort level. The services that are currently provided fee-for-service produce a trend that is not impacted by care management and thereby have a higher trend than what would be expected in a managed care environment.

With Waiver

Similar to the Without Waiver worksheet, the With Waiver worksheet uses the blended historical data and projects the data to Demonstration Year 00 (DY 00), which translates to calendar year 2012 (CY12). DY 00 PMPMs are then projected to DY 01 – DY 05 (CY13-CY17). This section describes the methodology used to develop the caseload projections and the PMPM trends.

Caseload Projections

Since the caseload projections are the same as the Without Waiver worksheet, caseload projections were developed by analyzing historical member month changes over time and incorporating known changes in populations going forward. The projections were done at the rate cohort level and then aggregated into the appropriate MEGs discussed earlier in this document.

PMPM Trends and Cost Projections

In order to complete the trend analysis, the historical monthly data was first normalized for program changes so that all of the data was on the same basis. The data was also normalized for demographic and regional mix. This was done so that the medical trend could be isolated from the impact of program changes and demographic mix. Trends were developed at the category of service and broad rate cohort level. These trends are reflective of medical trends under a managed care environment and are slightly lower than the trends developed for the Without Waiver scenario.

The cost projections for DY 01 reflect the capitation rate that will be paid to the MCOs.

APPENDIX F: Budget Neutrality Estimates

5 YEARS OF HISTORIC DATA

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP SERVED:

	HY 1	HY 2	HY 3	HY 4	HY 5	5-YEARS
Medicaid Pop 1	CHIP					
TOTAL EXPENDITURES	$ 31,600,341	$ 46,028,900	$ 48,455,482	$ 50,606,432	$ 64,052,427	$ 240,743,582
Eligible Member Months	436,714	459,163	478,062	482,157	509,649	
PMPM COST	$ 72.36	$ 100.25	$ 101.36	$ 104.96	$ 125.68	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		45.66%	5.27%	4.44%	26.57%	19.32%
ELIGIBLE MEMBER MONTHS		5.14%	4.12%	0.86%	5.70%	3.94%
PMPM COST		38.54%	1.11%	3.55%	19.74%	14.80%

Medicaid Pop 2	Delivery					
TOTAL EXPENDITURES	$ 55,692,781	54,210,523	$ 49,555,231	$ 63,420,147	$ 65,412,016	$ 288,290,698
ELIGIBLE DELIVERIES	10,452	11,386	10,573	12,383	12,143	
PMPD COST	$ 5,328.43	$ 4,761.16	$ 4,686.96	$ 5,121.55	$ 5,386.81	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		-2.66%	-8.59%	27.98%	3.14%	4.10%
ELIGIBLE MEMBER MONTHS		8.94%	-7.14%	17.12%	-1.94%	3.82%
PMPD COST		-10.65%	-1.56%	9.27%	5.18%	0.27%

Medicaid Pop 3	Foster Care					
TOTAL EXPENDITURES	$ 104,248,725	$ 95,396,334	$ 84,134,274	$ 87,934,865	$ 92,419,802	$ 464,134,000
Eligible Member Months	153,683	158,173	154,090	155,565	160,071	
PMPM COST	$ 678.34	$ 603.11	$ 546.01	$ 565.26	$ 577.37	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		-8.49%	-11.81%	4.52%	5.10%	-2.97%
ELIGIBLE MEMBER MONTHS		2.92%	-2.58%	0.96%	2.90%	1.02%
PMPM COST		-11.09%	-9.47%	3.53%	2.14%	-3.95%

Medicaid Pop 4	LTC					
TOTAL EXPENDITURES	$ 781,060,492	$ 870,802,197	$ 930,843,492	$ 924,170,939	$ 971,464,588	$ 4,478,341,709
Eligible Member Months	278,125	285,098	295,461	288,224	284,917	
PMPM COST	$ 2,808.30	$ 3,054.40	$ 3,150.47	$ 3,206.44	$ 3,409.64	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		11.49%	6.89%	-0.72%	5.12%	5.61%
ELIGIBLE MEMBER MONTHS		2.51%	3.64%	-2.45%	-1.15%	0.60%
PMPM COST		8.76%	3.15%	1.78%	6.34%	4.97%

5 YEARS OF HISTORIC DATA

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP SERVED:

	HY 1	HY 2	HY 3	HY 4	HY 5	5-YEARS
Medicaid Pop 5	MN Dual					
TOTAL EXPENDITURES	$ 41,222,236	$ 38,040,734	$ 31,966,764	$ 47,752,072	$ 37,767,023	$ 196,748,829
Eligible Member Months	35,739	31,269	28,620	30,996	27,711	
PMPM COST	$ 1,153.41	$ 1,216.58	$ 1,116.92	$ 1,540.58	$ 1,362.91	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		-7.72%	-15.97%	49.38%	-20.91%	-2.16%
ELIGIBLE MEMBER MONTHS		-12.51%	-8.47%	8.30%	-10.60%	-6.16%
PMPM COST		5.48%	-8.19%	37.93%	-11.53%	4.26%

	HY 1	HY 2	HY 3	HY 4	HY 5	5-YEARS
Medicaid Pop 6	MN Non Dual					
TOTAL EXPENDITURES	$ 22,321,721	$ 27,365,175	$ 28,143,227	$ 28,231,289	$ 29,722,303	$ 135,783,715
Eligible Member Months	21,421	26,080	21,895	19,534	19,602	
PMPM COST	$ 1,042.03	$ 1,049.27	$ 1,285.39	$ 1,445.20	$ 1,516.31	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		22.59%	2.84%	0.31%	5.28%	7.42%
ELIGIBLE MEMBER MONTHS		21.75%	-16.05%	-10.78%	0.34%	-2.19%
PMPM COST		0.69%	22.50%	12.43%	4.92%	9.83%

	HY 1	HY 2	HY 3	HY 4	HY 5	5-YEARS
Medicaid Pop 7	Other					
TOTAL EXPENDITURES	$ 13,589,009	$ 18,317,493	$ 19,723,821	$ 21,643,167	$ 24,148,766	$ 97,422,256
Eligible Member Months	114,685	132,553	149,293	169,517	202,408	
PMPM COST	$ 118.49	$ 138.19	$ 132.12	$ 127.68	$ 119.31	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		34.80%	7.68%	9.73%	11.58%	15.46%
ELIGIBLE MEMBER MONTHS		15.58%	12.63%	13.55%	19.40%	15.26%
PMPM COST		16.63%	-4.40%	-3.36%	-6.55%	0.17%

	HY 1	HY 2	HY 3	HY 4	HY 5	5-YEARS
Medicaid Pop 8	Spend Down Dual					
TOTAL EXPENDITURES	$ 15,255,806	$ 15,517,531	$ 15,206,246	$ 14,347,993	$ 14,629,691	$ 74,957,268
Eligible Member Months	77,308	74,502	73,261	74,545	79,293	
PMPM COST	$ 197.34	$ 208.28	$ 207.56	$ 192.47	$ 184.50	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		1.72%	-2.01%	-5.64%	1.96%	-1.04%
ELIGIBLE MEMBER MONTHS		-3.63%	-1.67%	1.75%	6.37%	0.64%
PMPM COST		5.55%	-0.35%	-7.27%	-4.14%	-1.67%

5 YEARS OF HISTORIC DATA

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP SERVED:

	HY 1	HY 2	HY 3	HY 4	HY 5	5-YEARS
Medicaid Pop 9	Spend Down Non Dual					
TOTAL EXPENDITURES	$ 23,640,770	$ 30,232,117	$ 34,047,937	$ 39,315,693	$ 45,230,660	$ 172,467,177
Eligible Member Months	16,876	19,353	23,282	30,641	35,021	
PMPM COST	$ 1,400.81	$ 1,562.16	$ 1,462.39	$ 1,283.11	$ 1,291.53	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		27.88%	12.62%	15.47%	15.04%	17.61%
ELIGIBLE MEMBER MONTHS		14.67%	20.31%	31.61%	14.29%	20.02%
PMPM COST		11.52%	-6.39%	-12.26%	0.66%	-2.01%

Medicaid Pop 10	SSI Dual					
TOTAL EXPENDITURES	$ 32,093,178	$ 30,426,510	$ 29,068,072	$ 27,860,824	$ 27,306,307	$ 146,754,892
Eligible Member Months	131,443	128,186	125,645	125,589	130,907	
PMPM COST	$ 244.16	$ 237.36	$ 231.35	$ 221.84	$ 208.59	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		-5.19%	-4.46%	-4.15%	-1.99%	-3.96%
ELIGIBLE MEMBER MONTHS		-2.48%	-1.98%	-0.04%	4.23%	-0.10%
PMPM COST		-2.78%	-2.53%	-4.11%	-5.97%	-3.86%

Medicaid Pop 11	SSI Non Dual					
TOTAL EXPENDITURES	$ 229,578,192	$ 252,245,243	$ 255,060,516	$ 267,231,817	$ 280,276,942	$ 1,284,392,710
Eligible Member Months	248,699	255,644	266,049	279,762	292,896	
PMPM COST	$ 923.12	$ 986.71	$ 958.70	$ 955.21	$ 956.92	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		9.87%	1.12%	4.77%	4.88%	5.11%
ELIGIBLE MEMBER MONTHS		2.79%	4.07%	5.15%	4.69%	4.17%
PMPM COST		6.89%	-2.84%	-0.36%	0.18%	0.90%

Medicaid Pop 12	TAF					
TOTAL EXPENDITURES	$ 318,400,262	$ 398,823,822	$ 410,543,827	$ 409,767,334	$ 501,103,557	$ 2,038,638,802
Eligible Member Months	2,027,685	1,948,956	2,003,080	2,257,175	2,517,466	
PMPM COST	$ 157.03	$ 204.63	$ 204.96	$ 181.54	$ 199.05	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		25.26%	2.94%	-0.19%	22.29%	12.01%
ELIGIBLE MEMBER MONTHS		-3.88%	2.78%	12.69%	11.53%	5.56%
PMPM COST		30.32%	0.16%	-11.43%	9.65%	6.11%

Medicaid Pop 13	Waiver					
TOTAL EXPENDITURES	$ 408,020,967	$ 435,267,024	$ 490,047,959	$ 529,614,202	$ 556,398,845	$ 2,419,348,996
Eligible Member Months	122,957	134,836	149,009	161,452	167,883	
PMPM COST	$ 3,318.40	$ 3,228.12	$ 3,288.71	$ 3,280.33	$ 3,314.20	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		6.68%	12.59%	8.07%	5.06%	8.06%
ELIGIBLE MEMBER MONTHS		9.66%	10.51%	8.35%	3.98%	8.10%
PMPM COST		-2.72%	1.88%	-0.25%	1.03%	-0.03%

MEDICAID POPULATIONS: Without Waiver											
ELIGIBILITY GROUP		TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WOW
Medicaid Pop 1	CHIP										
Eligible Member Months			18	557,225		564,537	579,749	594,377	606,621	623,084	
PMPM Cost		2.80%		$ 112.24	3.25%	$ 115.39	$ 119.14	$ 123.01	$ 127.01	$ 131.14	
Total Expenditure				$ 62,542,899		$ 65,141,931	$ 69,071,329	$ 73,114,274	$ 77,046,912	$ 81,711,244	$ 366,085,690
Medicaid Pop 2	Delivery										
ELIGIBLE DELIVERIES			18	13,445		13,745	14,179	14,655	15,146	15,654	
PMPD Cost		1.57%		$ 5,572.15	1.75%	$ 5,659.43	$ 5,758.47	$ 5,859.24	$ 5,961.78	$ 6,066.11	
Total Expenditure				$ 74,915,858		$ 77,786,461	$ 81,652,014	$ 85,865,417	$ 90,295,977	$ 94,958,262	$ 430,558,131
Medicaid Pop 3	Foster Care										
Eligible Member Months			18	165,068		168,553	172,099	175,735	179,450	184,368	
PMPM Cost		2.17%		$ 613.02	2.25%	$ 626.30	$ 640.39	$ 654.80	$ 669.53	$ 684.59	
Total Expenditure				$ 101,190,283		$ 105,564,563	$ 110,210,732	$ 115,071,423	$ 120,147,220	$ 126,216,830	$ 577,210,769
Medicaid Pop 4	LTC										
Eligible Member Months			18	297,417		307,418	316,861	327,459	338,664	350,163	
PMPM Cost		0.80%		$ 3,238.22	0.85%	$ 3,264.13	$ 3,291.88	$ 3,319.86	$ 3,348.08	$ 3,376.54	
Total Expenditure				$ 963,102,818		$ 1,003,452,508	$ 1,043,067,481	$ 1,087,119,200	$ 1,133,875,226	$ 1,182,337,693	$ 5,449,852,108
Medicaid Pop 5	MN Dual										
Eligible Member Months			18	28,145		28,977	29,734	30,619	31,546	32,554	
PMPM Cost		2.24%		$ 1,514.67	2.50%	$ 1,548.57	$ 1,587.28	$ 1,626.96	$ 1,667.63	$ 1,709.32	
Total Expenditure				$ 42,630,057		$ 44,873,384	$ 47,195,543	$ 49,815,614	$ 52,607,606	$ 55,645,251	$ 250,137,399
Medicaid Pop 6	MN Non Dual										
Eligible Member Months			18	19,909		20,498	21,033	21,659	22,315	23,028	
PMPM Cost		1.95%		$ 1,466.71	2.50%	$ 1,495.34	$ 1,532.72	$ 1,571.04	$ 1,610.32	$ 1,650.58	
Total Expenditure				$ 29,200,455		$ 30,651,053	$ 32,237,232	$ 34,026,973	$ 35,934,243	$ 38,009,204	$ 170,858,705
Medicaid Pop 7	Other										
Eligible Member Months			18	206,128		211,512	216,495	222,351	228,462	235,444	
PMPM Cost		1.75%		$ 136.16	2.00%	$ 138.54	$ 141.31	$ 144.14	$ 147.02	$ 149.96	
Total Expenditure				$ 28,066,366		$ 29,302,857	$ 30,592,897	$ 32,049,711	$ 33,588,441	$ 35,307,210	$ 160,841,117
Medicaid Pop 8	Spend Down Dual										
Eligible Member Months			18	80,535		82,917	85,081	87,614	90,268	93,152	
PMPM Cost		2.01%		$ 209.16	2.25%	$ 213.37	$ 218.17	$ 223.08	$ 228.10	$ 233.23	
Total Expenditure				$ 16,844,675		$ 17,692,021	$ 18,562,163	$ 19,544,986	$ 20,590,185	$ 21,725,774	$ 98,115,128
Medicaid Pop 9	Spend Down Non Dual										
Eligible Member Months			18	35,570		36,622	37,578	38,696	39,868	41,142	
PMPM Cost		3.60%		$ 1,471.78	4.00%	$ 1,524.77	$ 1,585.76	$ 1,649.19	$ 1,715.16	$ 1,783.77	
Total Expenditure				$ 52,350,611		$ 55,839,727	$ 59,588,968	$ 63,817,570	$ 68,380,842	$ 73,387,914	$ 321,015,022
Medicaid Pop 10	SSI Dual										
Eligible Member Months			18	139,091		145,773	152,027	159,141	166,702	173,432	
PMPM Cost		2.05%		$ 239.92	2.25%	$ 244.83	$ 250.34	$ 255.97	$ 261.73	$ 267.62	
Total Expenditure				$ 33,370,649		$ 35,689,510	$ 38,058,473	$ 40,735,210	$ 43,630,985	$ 46,413,843	$ 204,528,021
Medicaid Pop 11	SSI Non Dual										
Eligible Member Months			18	311,206		326,156	340,150	356,066	372,984	388,041	
PMPM Cost		1.92%		$ 1,015.12	2.25%	$ 1,034.60	$ 1,057.88	$ 1,081.68	$ 1,106.02	$ 1,130.91	
Total Expenditure				$ 315,910,982		$ 337,440,776	$ 359,837,697	$ 385,149,048	$ 412,528,189	$ 438,839,935	$ 1,933,795,645
Medicaid Pop 12	TAF										
Eligible Member Months			18	2,880,038		2,928,968	3,021,690	3,123,095	3,229,563	3,338,767	
PMPM Cost		1.99%		$ 197.00	2.25%	$ 200.92	$ 205.44	$ 210.06	$ 214.79	$ 219.62	
Total Expenditure				$ 567,367,389		$ 588,488,202	$ 620,776,005	$ 656,037,275	$ 693,677,833	$ 733,260,108	$ 3,292,239,422
Medicaid Pop 13	Waiver										
Eligible Member Months			18	178,378		186,947	194,968	204,091	213,789	222,419	
PMPM Cost		0.85%		$ 3,355.90	0.95%	$ 3,384.43	$ 3,416.58	$ 3,449.04	$ 3,481.81	$ 3,514.89	
Total Expenditure				$ 598,618,443		$ 632,709,516	$ 666,124,778	$ 703,917,889	$ 744,371,027	$ 781,778,241	$ 3,528,901,452

MEDICAID POPULATIONS: With Waiver

ELIGIBILITY GROUP	BASE YEAR DY 00	DEMO TREND RATE	Rate Methodology Adjustment	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
Medicaid Pop 1	CHIP								
Eligible Member Months	557,225			564,537	579,749	594,377	606,621	623,084	
PMPM Cost	$ 112.24	2.36%	-4.84%	$ 109.33	$ 111.80	$ 114.43	$ 120.46	$ 123.30	
Total Expenditure	$ 62,542,899			$ 61,720,195	$ 64,813,085	$ 68,014,522	$ 73,075,246	$ 76,826,265	$ 344,449,313
Medicaid Pop 2	Delivery								
Eligible Deliveries	13,445			13,745	14,179	14,655	15,146	15,654	
PMPD Cost	$ 5,572.15	1.38%	-11.93%	$ 4,975.10	$ 5,038.71	$ 5,108.38	$ 5,326.37	$ 5,400.02	
Total Expenditure	$ 74,915,858			$ 68,380,661	$ 71,446,174	$ 74,861,788	$ 80,672,224	$ 84,531,357	$ 379,892,203
Medicaid Pop 3	Foster Care								
Eligible Member Months	165,068			168,553	172,099	175,735	179,450	184,368	
PMPM Cost	$ 613.02	2.08%	-8.76%	$ 570.99	$ 582.29	$ 594.42	$ 624.07	$ 637.07	
Total Expenditure	$ 101,190,283			$ 96,242,101	$ 100,211,954	$ 104,460,530	$ 111,988,669	$ 117,455,639	$ 530,358,894
Medicaid Pop 4	LTC								
Eligible Member Months	297,417			307,418	316,861	327,459	338,664	350,163	
PMPM Cost	$ 3,238.22	0.75%	-8.87%	$ 2,973.06	$ 2,992.27	$ 3,014.71	$ 3,123.74	$ 3,147.17	
Total Expenditure	$ 963,102,818			$ 913,971,117	$ 948,133,659	$ 987,194,979	$ 1,057,900,483	$ 1,102,020,920	$ 5,009,221,157
Medicaid Pop 5	MN Dual								
Eligible Member Months	28,145			28,977	29,734	30,619	31,546	32,554	
PMPM Cost	$ 1,514.67	1.98%	-11.53%	$ 1,366.48	$ 1,392.06	$ 1,419.57	$ 1,488.82	$ 1,518.25	
Total Expenditure	$ 42,630,057			$ 39,596,966	$ 41,390,901	$ 43,465,574	$ 46,966,829	$ 49,425,153	$ 220,845,423
Medicaid Pop 6	MN Non Dual								
Eligible Member Months	19,909			20,498	21,033	21,659	22,315	23,028	
PMPM Cost	$ 1,466.71	1.40%	-3.38%	$ 1,437.06	$ 1,455.73	$ 1,476.16	$ 1,539.47	$ 1,561.08	
Total Expenditure	$ 29,200,455			$ 29,456,540	$ 30,617,984	$ 31,971,978	$ 34,353,273	$ 35,948,217	$ 162,347,993
Medicaid Pop 7	Other								
Eligible Member Months	206,128			211,512	216,495	222,351	228,462	235,444	
PMPM Cost	$ 136.16	1.49%	-13.45%	$ 119.60	$ 121.27	$ 123.08	$ 128.47	$ 130.39	
Total Expenditure	$ 28,066,366			$ 25,296,932	$ 26,253,318	$ 27,366,994	$ 29,351,496	$ 30,699,567	$ 138,968,307
Medicaid Pop 8	Spend Down Dual								
Eligible Member Months	80,535			82,917	85,081	87,614	90,268	93,152	
PMPM Cost	$ 209.16	1.78%	-8.32%	$ 195.17	$ 198.44	$ 201.96	$ 211.40	$ 215.16	
Total Expenditure	$ 16,844,675			$ 16,183,280	$ 16,883,164	$ 17,694,573	$ 19,082,587	$ 20,042,522	$ 89,886,126
Medicaid Pop 9	Spend Down Non Dual								
Eligible Member Months	35,570			36,622	37,578	38,696	39,868	41,142	
PMPM Cost	$ 1,471.78	3.20%	-6.35%	$ 1,422.45	$ 1,466.48	$ 1,513.43	$ 1,606.32	$ 1,657.74	
Total Expenditure	$ 52,350,611			$ 52,092,715	$ 55,106,786	$ 58,564,159	$ 64,041,618	$ 68,202,785	$ 298,008,062
Medicaid Pop 10	SSI Dual								
Eligible Member Months	139,091			145,773	152,027	159,141	166,702	173,432	
PMPM Cost	$ 239.92	1.84%	-8.36%	$ 223.91	$ 227.80	$ 231.99	$ 242.98	$ 247.46	
Total Expenditure	$ 33,370,649			$ 32,639,490	$ 34,631,131	$ 36,919,019	$ 40,505,737	$ 42,917,456	$ 187,612,834
Medicaid Pop 11	SSI Non Dual								
Eligible Member Months	311,206			326,156	340,150	356,066	372,984	388,041	
PMPM Cost	$ 1,015.12	1.59%	-7.35%	$ 955.45	$ 969.62	$ 985.02	$ 1,029.13	$ 1,045.47	
Total Expenditure	$ 315,910,982			$ 311,624,902	$ 329,817,021	$ 350,731,746	$ 383,850,416	$ 405,685,675	$ 1,781,709,760
Medicaid Pop 12	TAF								
Eligible Member Months	2,880,038			2,928,968	3,021,690	3,123,095	3,229,563	3,338,767	
PMPM Cost	$ 197.00	1.73%	-3.80%	$ 192.80	$ 195.93	$ 199.32	$ 208.54	$ 212.14	
Total Expenditure	$ 567,367,389			$ 564,691,938	$ 592,035,189	$ 622,495,238	$ 673,491,758	$ 708,286,127	$ 3,161,000,250
Medicaid Pop 13	Waiver								
Eligible Member Months	178,378			186,947	194,968	204,091	213,789	222,419	
PMPM Cost*	$ 3,355.90	0.75%	-63.37%	$ 1,238.59	$ 3,219.27	$ 3,243.41	$ 3,360.72	$ 3,385.93	
Total Expenditure	$ 598,618,443			$ 231,551,771	$ 627,655,414	$ 661,950,665	$ 718,483,357	$ 753,095,089	$ 2,992,736,297

*DY01 WW PMPM does not include LTSS for individuals with intellectual and developmental disabilities

BUDGET NEUTRALITY SUMMARY

Without-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY)					TOTAL
		DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Pop 1	CHIP	$ 65,141,931	$ 69,071,329	$ 73,114,274	$ 77,046,912	$ 81,711,244	$ 366,085,690
Medicaid Pop 2	Delivery	$ 77,786,461	$ 81,652,014	$ 85,865,417	$ 90,295,977	$ 94,958,262	$ 430,558,131
Medicaid Pop 3	Foster Care	$ 105,564,563	$ 110,210,732	$ 115,071,423	$ 120,147,220	$ 126,216,830	$ 577,210,769
Medicaid Pop 4	LTC	$ 1,003,452,508	$ 1,043,067,481	$ 1,087,119,200	$ 1,133,875,226	$ 1,182,337,693	$ 5,449,852,108
Medicaid Pop 5	MN Dual	$ 44,873,384	$ 47,195,543	$ 49,815,614	$ 52,607,606	$ 55,645,251	$ 250,137,399
Medicaid Pop 6	MN Non Dual	$ 30,651,053	$ 32,237,232	$ 34,026,973	$ 35,934,243	$ 38,009,204	$ 170,858,705
Medicaid Pop 7	Other	$ 29,302,857	$ 30,592,897	$ 32,049,711	$ 33,588,441	$ 35,307,210	$ 160,841,117
Medicaid Pop 8	Spend Down Dual	$ 17,692,021	$ 18,562,163	$ 19,544,986	$ 20,590,185	$ 21,725,774	$ 98,115,128
Medicaid Pop 9	Spend Down Non Dual	$ 55,839,727	$ 59,588,968	$ 63,817,570	$ 68,380,842	$ 73,387,914	$ 321,015,022
Medicaid Pop 10	SSI Dual	$ 35,689,510	$ 38,058,473	$ 40,735,210	$ 43,630,985	$ 46,413,843	$ 204,528,021
Medicaid Pop 11	SSI Non Dual	$ 337,440,776	$ 359,837,697	$ 385,149,048	$ 412,528,189	$ 438,839,935	$ 1,933,795,645
Medicaid Pop 12	TAF	$ 588,488,202	$ 620,776,005	$ 656,037,275	$ 693,677,833	$ 733,260,108	$ 3,292,239,422
Medicaid Pop 13	Waiver	$ 632,709,516	$ 666,124,778	$ 703,917,889	$ 744,371,027	$ 781,778,241	$ 3,528,901,452
Non Population Expenditures		$ 139,490,386	$ 146,482,651	$ 154,190,922	$ 162,690,479	$ 171,658,416	$ 774,512,853
Excluded WW Populations and Services[1]		$ 142,565,677	$ 149,693,961	$ 157,552,450	$ 166,217,835	$ 175,359,816	$ 791,389,739
Pool 1	Large Public Teaching Hospital	$ 28,995,643	$ 30,508,296	$ 32,189,261	$ 33,983,050	$ 35,807,527	$ 161,483,776
Pool 2	Border City Children's Hospital Program	$ 7,000,000	$ 7,210,000	$ 7,426,300	$ 7,649,089	$ 7,878,562	$ 37,163,951
Pool 3	HCAIP (Health Care Access Improvement Program)	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 205,000,000
Pool 4	CAH						$ -
Pilot 1	Funded Health Account	$ -	$ 1,232,640	$ 1,260,360	$ 1,288,740	$ 1,317,720	$ 5,099,460
Pilot 2	COBRA Pilot	$ -	$ 1,299,203	$ 1,272,964	$ 1,273,275	$ 1,301,907	$ 5,147,349
Pilot 3	Employment Supports Pilot	$ 4,966,080	$ 10,760,736	$ 16,555,392	$ 16,712,688	$ 16,871,472	$ 65,866,368
Pilot 4	SSI Diversion Pilot	$ -	$ 1,269,456	$ 2,596,032	$ 2,654,448	$ 2,714,184	$ 9,234,120
WOW SUBTOTAL		$ 3,388,650,296	$ 3,566,432,256	$ 3,760,308,271	$ 3,960,144,290	$ 4,163,501,111	$ 18,839,036,224

With-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY)					TOTAL
		DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Pop 1	CHIP	$ 61,720,195	$ 64,813,085	$ 68,014,522	$ 73,075,246	$ 76,826,265	$ 344,449,313
Medicaid Pop 2	Delivery	$ 68,380,661	$ 71,446,174	$ 74,861,788	$ 80,672,224	$ 84,531,357	$ 379,892,203
Medicaid Pop 3	Foster Care	$ 96,242,101	$ 100,211,954	$ 104,460,530	$ 111,988,669	$ 117,455,639	$ 530,358,894
Medicaid Pop 4	LTC	$ 913,971,117	$ 948,133,659	$ 987,194,979	$ 1,057,900,483	$ 1,102,020,920	$ 5,009,221,157
Medicaid Pop 5	MN Dual	$ 39,596,966	$ 41,390,901	$ 43,465,574	$ 46,966,829	$ 49,425,153	$ 220,845,423
Medicaid Pop 6	MN Non Dual	$ 29,456,540	$ 30,617,984	$ 31,971,978	$ 34,353,273	$ 35,948,217	$ 162,347,993
Medicaid Pop 7	Other	$ 25,296,932	$ 26,253,318	$ 27,366,994	$ 29,351,496	$ 30,699,567	$ 138,968,307
Medicaid Pop 8	Spend Down Dual	$ 16,183,280	$ 16,883,164	$ 17,694,573	$ 19,082,587	$ 20,042,522	$ 89,886,126
Medicaid Pop 9	Spend Down Non Dual	$ 52,092,715	$ 55,106,786	$ 58,564,159	$ 64,041,618	$ 68,202,785	$ 298,008,062
Medicaid Pop 10	SSI Dual	$ 32,639,490	$ 34,631,131	$ 36,919,019	$ 40,505,737	$ 42,917,456	$ 187,612,834
Medicaid Pop 11	SSI Non Dual	$ 311,624,902	$ 329,817,021	$ 350,731,746	$ 383,850,416	$ 405,685,675	$ 1,781,709,760
Medicaid Pop 12	TAF	$ 564,691,938	$ 592,035,189	$ 622,495,238	$ 673,491,758	$ 708,286,127	$ 3,161,000,250
Medicaid Pop 13	Waiver	$ 231,551,771	$ 627,655,414	$ 661,950,665	$ 718,483,357	$ 753,095,089	$ 2,992,736,297
Non Population Expenditures		$ 139,490,386	$ 146,482,651	$ 154,190,922	$ 162,690,479	$ 171,658,416	$ 774,512,853
Excluded WW Populations and Services[1]		$ 547,240,218	$ 149,693,961	$ 157,552,450	$ 166,217,835	$ 175,359,816	$ 1,196,064,279
Pool 1	Large Public Teaching Hospital	$ 28,856,550	$ 30,216,301	$ 31,727,447	$ 33,332,866	$ 34,949,098	$ 159,082,262
Pool 2	Border City Children's Hospital Program	$ 7,000,000	$ 7,140,000	$ 7,282,800	$ 7,428,456	$ 7,577,025	$ 36,428,281
Pool 3	HCAIP (Health Care Access Improvement Program)	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 205,000,000
Pool 4	CAH						$ -
Pilot 1	Funded Health Account	$ 1,000,000	$ 1,000,000	$ 1,000,000	$ 1,000,000	$ 1,000,000	$ 5,000,000
Pilot 2	COBRA Pilot	$ 955,739	$ 955,189	$ 955,379	$ 989,223	$ 1,000,338	$ 4,855,868
Pilot 3	Employment Supports Pilot	$ 10,415,707	$ 10,526,887	$ 10,641,744	$ 10,826,262	$ 10,944,864	$ 53,355,464
Pilot 4	SSI Diversion Pilot	$ 1,813,075	$ 1,616,208	$ 1,413,036	$ 1,243,699	$ 1,014,564	$ 7,100,582
TOTAL		$ 3,221,220,283	$ 3,327,626,978	$ 3,491,455,543	$ 3,758,492,513	$ 3,939,640,893	$ 17,738,436,211

TOTAL		$ 167,430,013	$ 238,805,278	$ 268,852,727	$ 201,651,777	$ 223,860,218	$ 1,100,600,013

[1]Excluded Services include: LTSS for the Developmentally Disabled, SRS - Physician Services - Psychiatrist, SRS - Psychologist/Psychology Group Practice, SRS - Alcohol/Drug Rehabilitation, NF - Mental Health Age 22-64, Mental Health/MediKan, AIDS Drug Assistance Program, Head Start, LEA/Early Childhood Intervention, ICF/MR Public Providers, and School-based - TCM. Excluded Populations include ADAP, MediKan, PACE, SOBRA and Special Tuberculosis, ICF/MR Public Residents, and 22-64 Year old Residents of Mental Health Nursing Facilities.

APPENDIX G: Implementation Timeline

KanCare Timeline	SFY 2012						SFY 2013											
	Q1	Q2	Q3	Q4			Q1			Q2			Q3			Q4		
				Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
April 2012																		
Expand interagency implementation team - Complete																		
Set timeline for series of town hall meetings/webinars - Complete																		
Face to Face Negotiations - Complete																		
Formalize timeline for MCO readiness reviews - Complete																		
May 2012																		
Advisory Council meets - Complete/continuing																		
Develop format/content/frequency of operational status meetings - Complete																		
Send intent to award - Complete																		
June 2012																		
Complete negotiations - Complete																		
Kickoff meeting re: stakeholder workgroups - Complete																		
Send contracts to CMS - Complete																		
July 2012																		
Educational tour begins: Consumers and Providers, Round 1 - July 30-Aug. 2																		
Weekly MCO standardization/implementation meetings begin - Began July 5																		
Advisory Council meets - Complete/continuing																		
August 2012																		
Launch dedicated website area for implementation activities - In development																		
Educational tour continues: KDADS waiver stakeholders tour																		
Stakeholder workgroups begin meeting - Began in July																		
Start operational status meetings																		
September 2012																		
Advisory Council meets- Continuing																		
Onsite MCO readiness reviews																		
Stakeholder workgroups continue																		
Educational tour continues: Consumers and Providers																		
Consumer and provider notifications																		
Website regularly updated																		
October 2012																		
90% network development 90% implementation activities complete																		
Stakeholder workgroups continue																		
MCO readiness reviews, followup																		
Network certification																		
Go/No Go Decision Milestone																		
Educational tour/open enrollment																		
Operational status meetings continue																		
November 2012																		
Network fully in place																		
Enrollment																		
Advisory Council meets																		
Stakeholder workgroups continue																		
Operational status meetings continue																		
December 2012																		
Enrollment																		
Stakeholder workgroups continue																		
Operational status meetings continue																		
January 2013																		
Go Live																		
Advisory Council meets																		
Stakeholder workgroups continue																		
Operational status meetings continue																		

Appendix H: Tribal Consultation and State Response

On January 11, 2012, the Kansas Department of Health and Environment (KDHE) emailed Tribal government and Indian health care provider contacts in Kansas to begin the process of Tribal Consultation related to the State's intended Section 1115 demonstration application. This initial notification provided information about the program commonly referred to as KanCare and requested comments by March 12, 2012. After the initial notice, a consultation meeting was requested and held with tribal government officials on February 22, 2012, where information about the intended KanCare application was presented and discussed. After the State's submission of an application to the Centers for Medicare and Medicaid Services (CMS) on April 26, 2012, it became apparent that two Indian Health Service (IHS) providers included in the State Plan consultation policy had been excluded from the notification.

Upon learning of the omission, on May 17 KDHE emailed the full contact list detailed in the State Plan, including the two IHS centers that had been omitted, requested comments by June 16, 2012, and offered to organize consultation meetings upon request. A request for face-to-face consultation was received on May 21, and the same day, an email was sent by KDHE to an expanded list, including regional IHS officials and other contacts, providing additional information about KanCare and the requested consultation meeting. On June 5, to ensure compliance with the Tribal Consultation process, KDHE asked CMS to not consider the previously submitted application a formal proposal, allowing the State to continue the Tribal Consultation process. A new email to the expanded contact list was sent that day, June 5, advising contacts of KDHE's request and setting dates for three consultation meetings, June 21, 22, and 26, 2012. Those meetings involved representatives of the four Sovereign Nations located in Kansas, three State agencies, CMS, IHS, I/T/U providers and the National Indian Health Board.

Following those meetings and discussion, the KDHE received written comments and recommendations from the following entities:

1) Prairie Band Potawatomi Nation Letter from Stephen R. Ortiz, "Mon-wah" dated June 27, 2012;
2) Prairie Band Potawatomi Nation Letter from Stephen R. Ortiz, "Mon-wah" dated July 3, 2012 with attached documents:
    a. Prairie Band Potawatomi Nation Recommendations and Comments;
    b. Addendum for Indian Health Care Providers;
    c. Amendments to MCO Contracts;
3) National Council of Urban Indian Health Letter from D'Shane Barnett dated July 3, 2012;
4) Hunter Health Clinic cover letter from Susette M. Schwartz dated July 5, 2012 with attached documents:
    a. Detail letter from Susette M. Schwartz dated July 5, 2012;
    b. Amendments to MCO Contracts;
    c. Addendum for Indian Health Care Providers;

5) Summary of comments and recommendations distributed by KanCare Advisory Council member Susette Schwartz at the Council meeting of July 9, 2012;
6) Sac and Fox Nation of Missouri in Kansas and Nebraska letter from Michael Dougherty dated July 10, 2012 with attached documents:
    a. Sac and Fox Nation of Missouri in Kansas and Nebraska Recommendations and Comments;
    b. Amendments to MCO Contracts;
    c. Addendum for Indian Health Care Providers;
7) Kickapoo Tribe in Kansas letter from Steve Cadue dated July 12, 2012 with attached documents:
    a. Prairie Band Potawatomi Nation Recommendations and Comments;
    b. Amendments to MCO Contracts;
    c. Addendum for Indian Health Care Providers;
8) National Indian Health Board letter from Cathy Abramson dated July 16, 2012.

While each of these groups individualized their comments, their comments have been organized into five (5) issues that include the following: 1) Tribal Consultation, 2) Mandatory Enrollment, 3) American Recovery and Reinvestment Act Protections, 4) Tribal Addendum, and 5) Additional Tribal Review and Comment. These issues will be summarized and addressed in the following paragraphs. At times, Recommendations are republished verbatim as the issue was well articulated and cannot be more sufficiently summarized.

TRIBAL CONSULTATION

Comment Received:

Tribal governments expressed concern about the adequacy of tribal consultation, noting CMS requirements regarding written notification to tribal governments at least 60 days before the anticipated submission date of the State's intent to submit a Medicaid waiver request or waiver renewal to CMS. While commenters recognized the efforts provided by KDHE in the last few months to allow meaningful dialogue through the recent tribal consultations, they raised concerns about the sufficiency of consultation in general.

Commenters noted it is important for Tribes to advocate their own interests and be fully involved at the earliest stages at the State level in the development of the waiver in order to ensure that Tribal health programs are included as an integral part of the State waiver plan and to avoid significant complications post implementation.

Related Recommendations:

1. Draft Tribal consultation policy that allows for adequate time for meaningful dialogue and consultation to ensure Tribes have the opportunity to fully participate in health care reform as it affects Tribes, Indians and Tribal and urban health organizations.

2. Appoint a State Tribal Technical Advisory Group (TTAG) that can provide ongoing assistance to the State going forward to address and facilitate discussion regarding Medicaid and healthcare reform issues involving both state and Tribes.

State Response:
The positive and extensive Tribal Consultation related to KanCare that has occurred this spring and summer, consistent with federal and state policy, has led to productive results, as evidenced by the volume and thoroughness of comments received from participants. Because of that process and the resulting comments, the State has adopted virtually all recommendations offered in those communications. It is the State's desire to continue this dialogue, consultation and cooperation as KanCare progresses, so KDHE has proposed to enhance the existing Tribal Consultation policy by formally creating a permanent State TTAG as recommended.

It is the State's intention that the adoption of virtually all of the recommendations and suggestions from Tribes and I/T/U providers demonstrates that the State of Kansas and KDHE have in fact heard and understood the concerns raised through this consultation. The State of Kansas and KDHE welcome the opportunity to further discuss these recommendations, comments and other issues.

MANDATORY ENROLLMENT

Comment Received:
The draft KanCare Section 1115 Demonstration would have required mandatory enrollment of all Kansas residents, including members of Indian Tribes. Federal law exempts American Indians and Alaskan Natives (AI/ANs) from mandatory enrollment in state managed care plans. Through a waiver, the state can require that AI/ANs be enrolled. Commenters opposed mandatory enrollment of AI/ANs, considering it a violation of tribal sovereignty that undermines the federal trust responsibility to AI/AN people. The provision of health services to AI/AN people stems from the unique trust relationship between the United States and Indian Tribe governments. Commenters said that trust responsibility provides the legal justification and moral foundation for Indian-specific health policymaking with the objectives of enhancing AI/ANs' access to health care and overcoming the chronic health status disparities between AI/ANs and the rest of the American population.

Section 1932(a)(2)(C) of the Social Security Act prohibits states from requiring the enrollment of AI/ANs in managed care. Tribal government officials requested the application be revised to specifically exempt AI/ANs from mandatory enrollment in the managed care organizations in order to receive their care.

Related Recommendations:
1. Revise KanCare Demonstration Application to provide for voluntary enrollment for AI/ANs. Indian Medicaid beneficiaries should be presumptively enrolled as in other States including but not limited to OR, AZ, WA, NY, and MN, but have the option of affirmatively disenrolling from the program or "opting-out". The exemption provision should include the AI/AN definition that is consistent with the definition adopted by the Centers for Medicare and Medicaid Services (CMS) in its implementation of the Medicaid cost-sharing protections enacted in Section 5006 of the American Recovery and Reinvestment Act (Recovery Act) (42 U.S.C.§l396oG). 42 C.P.R.§ 447.50 broadly defines the term "Indian" consistent with the Indian Health Service regulations

on IRS eligibility and should be uniformly adopted to avoid administrative inconsistency and confusion.

2. Provide education and information to the AI/AN population on their right to choose to use managed care organizations and how they can access that care as well as their right to opt out of managed care organizations and the associated procedure for doing so. The enrollment process is crucial to the determination of the type of care AI/ANs receive and the requirement to choose and enroll in a plan will take time and effort to ensure tribal members have sufficient information, education, and time to make an informed choice. Tribal members who customarily receive care from a Tribal or urban Indian health organization may prefer to continue with their provider due to geographical proximity and/or to receive culturally appropriate care and they must be fully informed on their right to choose.

State Response:

The State of Kansas has revised the KanCare Demonstration Application to provide for presumptive but voluntary enrollment for AI/AN populations. Indian Medicaid beneficiaries will be presumptively enrolled, and they will have the option of affirmatively opting-out of the program. The definition of AI/AN will be adopted consistent with the definition adopted by the Centers for Medicare and Medicaid Services (CMS) in the implementation of Medicaid cost-sharing protections under the American Recovery and Reinvestment Act. The term "Indian" will be defined consistent with 42 C.F.R. 447.50.

In partnership with tribal government and I/T/U providers, KDHE will provide education and information to the AI/AN population on their right to choose an MCO and how to access care. The State will also provide education and information to the AI/AN population on the opt-out provisions and the procedures for doing so.

AMERICAN RECOVERY AND REINVESTMENT ACT (RECOVERY ACT) PROTECTIONS

Comment Received:

Commenters noted that the Recovery Act, Public Law 111-5, Section 5006 provides specific protections for Indians under Medicaid and the Children's Health Insurance Program (CHIP). Section 5006(a) prohibits States from imposing Medicaid premiums or any other Medicaid cost sharing on Indian applicants and participants served by Indian health care providers and assures that Indian health providers, and providers of contract health services (CHS) under a referral from an Indian health care provider, will receive full payment. These protections include:

- Indians are exempt from payment of enrollment fees, premiums, or similar charges when they are furnished an item or service by an Indian health care provider; Indian Health Service (IHS); an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U*)* or through referral under CHS.
- Indians are exempt from payment of a deductible, coinsurance, copayment, cost sharing or similar charge for any item or service covered by Medicaid if the Indian is furnished the item or service directly by an Indian health care provider, I/T/U, or through CHS.

- Full Medicaid payment rate due to the IHS, an I/T/U or to a CHS referral health care provider for furnishing a service or item to an Indian. The payments may not be reduced by the amount of any enrollment fee, premium, deduction, copayment, cost sharing or similar charge that otherwise would be due from an Indian person.

Commenters noted the Recovery Act Section 5006(b) requires States to exclude the following types of property from consideration as a "resource" when determining Medicaid or CHIP eligibility for an Indian person:

- Property including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of Interior. For any federally-recognized Tribe not described in paragraph (1), property located within the most recent boundaries of a prior Federal reservation.
- Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally-protected rights.
- Ownership interests in or usage rights to items not covered by paragraphs (1) through (3) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal law or custom.

Recovery Act Section 5006(c) continues protections of certain Indian property from Medicaid Estate Recovery. Certain income, resources, and property are exempt from Medicaid Estate Recovery because of the Federal responsibility for Indian tribes as set forth in Section 1917 of the Social Security Act. 42 U.S.C. 1396p(b)(3).

Recovery Act Section 5006(d) provides that all contracts with Medicaid and CHIP managed care organizations (MCOs) must include the following:

- Permit an Indian who is enrolled in an non-Indian MCO and is eligible to receive services from a participating I/T/U provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a primary provider, to choose that I/T/U as his or her primary care provider, as long as the provider has the capacity to provide the services.
- Require each MCO to demonstrate that the number of I/T/U providers in the network is sufficient to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers;

- Require that I/T/U providers, regardless whether they are a network participant, be paid for covered Medicaid or CHIP managed care services they provide to Indian enrollees who are eligible to receive services from such providers at (1) a rate negotiated between the MCO and the I/T/U provider, or (2) if no negotiated rate exists, at a rate no less than the rate of payment that would be paid if the provider were not an I/T/U provider; and
- Provide that the MCO shall make prompt payment to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under 42 CFR Sections 447.45 and 447.46.

Commenters also noted an Indian health care provider is not required to be designated a Federally Qualified Health Center (FQHC) in order to receive the supplemental payment from the state and the provider does not have to be a contracted participant in the MCO's provider network to receive the rate of pay equal to a participating FQHC that is not an Indian health care provider. The supplemental payment must make up the difference between the amount paid by the MCO and the applicable rate under the State plan.

Related Recommendations:

1. Add specific language reflecting the above cited protections in the Recovery Act to the contracts between the State and the managed care organizations (MCOs). Also, add specific language reflecting the above cited protections through the Tribal Addendum to the agreements between each MCO and its provider network, as applicable, to ensure that the federal legal protections for Indians and I/T/Us are provided.

2. Provide policy and guidance that require the MCO to work closely with the I/T/Us and providers of contract health services to implement the above exemptions, and notify non-I/T/U providers who participate in CHS regarding the cost-sharing prohibition.

3. Add specific language reflecting the above cited exemptions from resource consideration and evaluation as provided in the Recovery Act to the Contracts between the State and the MCOs. Also, add specific language reflecting the above cited protections through the Tribal Addendum to the agreements between each MCO and its provider network, as applicable, to ensure that the federal legal protections for Indians and I/T/Us are provided.

4. Provide policy and guidance to staff involved in Medicaid eligibility evaluations regarding implementation of the above cited exemptions.

5. Ensure the Contracts between the State and MCOs include reference to this specific Recovery Act protection;

6. Add specific language in the agreements between each MCO and its provider network, as applicable, through the Tribal Addendum to reflect Recovery Act Section 5006(c) exemptions of specific income, resources, and property from Medicaid Estate Recovery for Indians; and

7. Provide policy and guidance to staff regarding exemptions from Medicaid Estate Recovery for Indians (State Medicaid Manual Section 381O.A.7).

8. Include specific language and guidance in the contracts between the State and MCOs which reflects each of the above protections as provided in federal law.

9. Add specific language in the agreements between each MCO and its provider network, as applicable, through the Tribal Addendum to reflect Recovery Act Section 5006(d) protections.

State Response:
The State of Kansas and KDHE concurred with the commenters' recommendations related to the Recovery Act protections, including adopting an Addendum for Indian Health Care Providers and Amendments to MCO contracts as outlined in comments.

The State has included language in an Addendum for Indian Health Care Providers and in MCO Contracts to make it clear that no enrollment fee, premium, deduction, copayment, copayments, coinsurance cost sharing or similar charge will be imposed on I/T/Us or CHS provider payments. MCOs will be required to pay Indian Health Service, I/T/U or CHS referral health care providers the Medicaid payment rate for furnishing medical services or goods to an Indian. Under the terms of the State Contract with MCOs, the payment rate must be at least equivalent of fee-for-service Medicaid; for example, the All-Inclusive Rate will be the minimum reimbursement for providers currently reimbursed at that rate. I/T/U providers do not need to be designated Federally Qualified Health Centers to be covered by these protections. Payments will not be reduced by the amount of any enrollment fee, premium, deduction, copayment, cost share, or other charge otherwise due from an Indian person. The State of Kansas and KDHE will provide education and guidance requiring the selected MCOs to work with the I/T/Us and contractors to implement these protections.

KDHE retains the responsibility for Medicaid eligibility determination. For clarity, KDHE has amended the MCO contracts and include an Addendum for Indian Health Care Providers that excludes by reference the property defined in Recovery Act Section 5006(b) from consideration as a "resource" when determining Medicaid or CHIP for and Indian person. That excluded property includes:

1) Property, including real property and improvements, held in trust, subject to Federal restrictions, or otherwise under supervision of the Secretary of Interior, located on a reservation, including former reservations in Oklahoma, Alaska Native regions and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs;

2) All other property, not outlined in paragraph (1), located within the most recent boundaries of a prior Federal reservation;

3) Ownership interests in rents, lease, royalties, or usage rights related to natural resources resulting from the exercise of federally protected rights; and

4) Ownership interest in or usage rights to items not covered above that have religious, spiritual, traditional or cultural significance or rights that support subsistence or a traditional lifestyle according to Tribal law or custom.

The State of Kansas and KDHE recognize the significance of Section 1917 of 42 U.S.C. 1396p(b)(3) relating to exemption of certain Indian property from Medicaid Estate Recovery. As a result, again for clarity, KDHE has amended the contracts to reference and enforce the applicability of this section of the Social Security Act as reiterated by Section 5006(c) of the Recovery Act. The State will also provide guidance to State staff regarding these exemptions as set out in the State Medicaid Manual Section 3810.A.7.

Also included in the MCO contracts and the Tribal Addendum, the State has included specific citations to ensure the protections set out in the Recovery Act section 5006(d), including the following:

1) Allow the Indian participant to receive services from a participating I/T/U provider and choose that I/T/U as his or her primary care provider, as long as the provider has the capacity to provide the service;
2) Ensure that the MCO shows there is sufficient number of I/T/U providers in the network to provide timely access to services;
3) Ensure the I/T/U providers be paid for covered Medicaid or CHIP managed care services they provide to Indian enrollees who are eligible to receive services at a rate negotiated between the MCO and the I/T/U provider or at a rate not less than the rate of payment to be paid to a non-I/T/U provider; and
4) Ensure that the MCO makes prompt payment to the I/T/U providers under 42 CFR Sections 447.45 and 447.46.

TRIBAL ADDENDUM

Comment Received:

Commenters noted that the Affordable Care Act (ACA), inclusive of the expansion and permanent reauthorization of the Indian Health Care Improvement Act (IHCIA), includes provisions governing Indian health care providers and the provision of health care to Indian people. The Recovery Act includes several protections for Indian people and health care providers as set forth above. The State and MCOs must comply with the IHCIA and the Recovery Act, among other federal laws applicable to Indian health care providers and the provision of health care to Indian people.

Commenters requested that the State Contract with MCOs be amended to include the requirement that each MCO contract with an I/T/U provider include a Tribal Addendum ensuring all federal laws are adhered to in the provision of Medicaid and CHIP services to Indian people. The Addendum is modeled on the Indian Addendum that is required by CMS to be used by Medicare Part D providers. Commenters argued that, by setting out all of the existing federal laws that apply to I/T/U providers in one place, the Addendum would reduce the potential for disputes and streamline the negotiation process.

Related Recommendations:

1. Adopt recommended amendments to the State MCO contracts.
2. Ensure that the Tribal Addendum is included and incorporated into each provider contract an MCO enters into with an Indian health care provider.

State Response:

The State of Kansas and KDHE is adopting and implementing the Addendum for Indian Health Care Providers by reference into the contracts with KanCare MCOs. KDHE and KanCare MCOs

also agreed to amend the State Contract in substantially the form and content as suggested in the Tribal Consultation process.

ADDITIONAL TRIBAL REVIEW AND COMMENT

Comment Received:

To ensure Tribes have meaningful consultation with the State on this important matter, several commenters requested that the State discuss its response to these recommendations and allow them to review and comment on any revisions made to the Section 1115 Application and to the MCO contracts prior to their submission to the Centers for Medicare and Medicaid Services. They also sought the opportunity to review and comment on sample provider contracts.

State Response:

The State welcomed review and comment on revisions to the 1115 Demonstration Application, the Addendum for Indian Health Care Providers, and Amendments to MCO Contracts and distributed them to tribal government and I/T/U contacts on July 25, 2012. I/T/U provider contract templates also will be forwarded for review when they are available.