

August 19, 2013

Mr. Ed Francell
Project Officer
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Division of State Demonstrations and Waivers
Mail Stop S2-03-15
7500 Security Boulevard
Baltimore, MD 21244-1850

Mr. James Scott
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Kansas City Regional Office
Division of Medicaid and Children's Health Operations
601 East 12th Street, Suite 235
Kansas City, MO 64106

RE: Amendment to the KanCare Medicaid Section 1115 Demonstration, 11-W-00283/7

Dear Mr. Francell and Mr. Scott:

The State of Kansas, Department of Health and Environment (KDHE) requests approval of an amendment to the KanCare Section 1115 demonstration project (11-W-00283/7), which was approved by the Centers for Medicare & Medicaid Services (CMS) on December 27, 2012. The KanCare demonstration is effective from January 1, 2013, through December 31, 2017.

As required by the KanCare Special Terms and Conditions (STCs), STC 7, this request includes: (i) a detailed description of the proposed amendment, including the impact on beneficiaries, the changes to evaluation design, and the necessary waiver and expenditure authority; (ii) an explanation of the public process used by the State to reach a decision regarding the requested amendment; and (iii) a data analysis that identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Because the proposed changes will not affect children in the CHIP program, KDHE is not including a CHIP Allotment Neutrality Worksheet.

I. Proposed Amendment

The State requests CMS approval to implement three changes to KanCare, effective January 1, 2014: (1) provide long term supports and services (LTSS) for individuals with intellectual or developmental disabilities through KanCare managed care plans; (2) establish three pilot programs to support

employment and alternatives to Medicaid; and (3) change the timeline for the Delivery System Reform Incentive Payment (DSRIP) Pool. Each initiative is detailed below.

A. Long Term Services and Supports for Individuals with Intellectual or Developmental Disabilities

Under the current waiver, specialized services for individuals with intellectual or developmental disabilities are carved out from the Medicaid managed care organization (MCO) benefit package and are paid on a fee-for-service basis. The carved-out services are LTSS authorized through the Intellectual Disabilities/Developmental Disabilities (ID/DD) waiver (KS-0224) and State Plan Targeted Case Management (TCM), screening services, and positive behavioral supports for the ID/DD population.

The current waiver also authorizes the State to operate a voluntary ID/DD Services pilot program in demonstration year (DY) 1. The pilot will help prepare members, providers, and the MCOs transition to the provision of LTSS through KanCare. The pilot, discussed in more detail in Attachment C, Public Comment and State Response, was developed in collaboration with a steering committee of stakeholders, and has the primary objectives of developing relationships and shared understanding between MCOs and the ID/DD system; defining how services and service delivery will look under KanCare on January 1, 2014; and developing and testing billing processes in advance of January 2014. To that end, the state submitted a 1915(c) waiver amendment on June 27, 2013, outlining the pilot's collaborative service planning process and billing test process. Requests to participate in the KanCare ID/DD Pilot Project were accepted until June 30, 2013. More than 550 individuals and approximately 25 service providers have enrolled in the pilot.

The State now requests CMS approval to no longer carve out these specialized services and to provide LTSS to individuals with intellectual or developmental disabilities through the KanCare managed care plans. Inclusion in managed care will provide a more robust set of care management resources and more complete integration of all services (LTSS as well as physical and behavioral health). The State sees great promise in full integration of care coordination for these members, particularly for those who also have behavioral health diagnoses.

Kansas state law provides several protections to ensure a smooth transition for individuals with intellectual or developmental disabilities enrolled in KanCare. These provisions are consistent with terms in the KanCare STCs for other LTSS. Under state law adopted this legislative session for state fiscal years 2014 and 2015:

- Enrollees may keep current LTSS providers on their approved service plans, even if those providers are not in the network, for 180 days from January 1, 2014, or until a service plan is completed and either agreed upon by the enrollee or resolved through the appeals or a fair hearing process and implemented.
- Enrollees may keep their targeted case managers, provided those case managers are employed with community developmental disability organizations (CDDOs) or CDDO subcontractors.
- Enrollees using ID/DD residential providers may access those providers up to one year from January 1, 2014, regardless of contracting status.
- The MCOs must comply with the specific powers and duties of the CDDOs provided in Kansas law. They also must contract with at least two providers serving each county for each covered LTSS in the benefit package for the enrollees with intellectual or developmental disabilities

(unless the county has an insufficient number of providers), and must make at least three contract offers to all LTSS providers serving such enrollees at or above the state-set fee for service rate.

- In 2014, the State will conduct an educational tour to provide information to enrollees with intellectual or developmental disabilities and LTSS providers. The State also will review, in the first 180 days of 2014, each MCO's ID/DD service planning process, and will conduct, in 2014 and 2015, training for each MCO to ensure that they understand the DD services system.
- The Kansas Department for Aging and Disabilities Services (KDADS) will, in fiscal years 2014 and 2015, review and approve all plans of care for ID/DD waiver members for which a reduction, suspension or termination of services is proposed.

The State believes that including these services in KanCare will result in better access to services and improved quality of care for KanCare enrollees with intellectual or developmental disabilities. Moreover, it will result in stable reimbursement rates for providers and will give the MCOs a compelling financial incentive to keep individuals in a home environment rather than a more costly acute-care facility.

The draft KanCare evaluation design submitted to CMS in April incorporated measures related to LTSS for members with intellectual or developmental disabilities. Measures that include stratification by members with intellectual or development disabilities include:

- Care Management Plans of Care
 - Identifying needs
 - Provision of services
 - Satisfaction with integration
- Gained/Maintained Competitive Employment
- Physical Health Measures
 - Emergency Department visits
 - Inpatient Hospitalizations
 - Inpatient Readmissions
- Healthy Life Expectancy
 - Health Literacy
 - Preventive Care and Screenings
 - Treatment/Recovery

B. Pilot Programs to Support Employment and Alternatives to Medicaid

KDHE requests CMS approval to implement three pilot programs designed to support Kansans who might otherwise be enrolled in Medicaid. These programs will aid in the transition from Medicaid to independence, while preserving relationships with providers.

Two of the pilots are focused on increasing opportunities for Kansans with disabilities to work. 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, and 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 program 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. Of *Working Healthy* participants who receive personal assistance services through the ancillary program, *WORK*, 83 percent reported an increased level of independence since enrolling in the program.

Given these results, the State seeks to implement pilots to broaden the availability of these key services. KDHE is collaborating with other State agencies, including KDADS and the Kansas Department for Children and Families, to coordinate existing programs for employment services that will support pilot participants as they seek and obtain employment.

i. Social Security Alternative Pilot

KDHE will establish a pilot program to provide health care coverage and employment support services to individuals who meet Social Security Administration (SSA) criteria for disability, as an alternative to Social Security benefits and Medicaid. The pilot is designed to provide the supports necessary to help these individuals become employed, maintain employment, and avoid long-term dependence on the Social Security system.

Target Population. The Social Security Alternative Pilot will enroll up to 200 individuals 18 and over who meet SSA criteria for disability, but who have not yet been determined eligible for Supplemental Security Income (SSI) or Social Security Disability (SSDI) cash benefits or Medicaid coverage.

Services. The program will offer the following services:

- Benefits planning through the Kansas Medicaid Buy-in program, *Working Healthy*. Benefits Specialists will be available to discuss the pilot and other options, provide individual benefit plans, and explain the impact of employment and participation in the pilot on Social Security and other benefits.
- For individuals with a demonstrated need, funding for personal care and employment support services in the form of a monthly allocation, capped at \$1,500 per month, which will allow participants to directly manage their funds and provide flexibility in purchasing support services that best meet their needs.

- “Medicaid-like” health care coverage for up to 12 months while seeking employment with the same physical, behavioral, and pharmaceutical benefits provided to Medicaid eligible individuals under the Kansas Medicaid State Plan.
- Assistance in obtaining employment, provided by Kansas Rehabilitation Services (Vocational Rehabilitation) and Kansas Workforce Centers.

Eligibility. Participants in the Pilot must be individuals age 18 and above who meet the Social Security disability criteria as determined by a Presumptive Medical Disability Team (PMDT) who are employed or willing to seek employment. Once employed, a participant in the Pilot must earn at least the federal minimum wage or greater, have Federal Insurance Contributions Act (FICA) taxes withheld, and have gross monthly earnings that equal or exceed the SSA Substantial Gainful Activity (SGA) level. Self-employed individuals must have net earnings that equal or exceed the SSA SGA level and demonstrate proof of paying the Self-Employment Contributions Act (SECA) tax. Participants must also be eligible for, or enrolled in, an employer provided health insurance plan or, if self-employed, must be enrolled in a private health insurance plan. They also must be employed in a competitive, integrated work setting, as defined by the State.

Cost sharing. Cost sharing will be consistent with *Working Healthy* monthly premiums (<http://www.kdheks.gov/hcf/workinghealthy/premium.htm>).

Safety Net. Pilot participants who do not meet these minimum employment levels within 12 months will be removed from the pilot and will receive an expedited PMDT determination for other medical program eligibility. Those who become too ill to continue working will also be removed from the pilot and receive an expedited PMDT determination. Participants who become unemployed but intend to return to work may be eligible to remain in the pilot program for four months after the employment ends.

Evaluation. KDHE will evaluate the Social Security Alternative Pilot by measuring income compared to SSI/SSDI cash benefits; cost avoidance to the Social Security and Medicaid systems; improved health and quality of life as reported by participants; and program satisfaction.

ii. SSI Employment Support Pilot

KDHE will establish a pilot program to promote employment for individuals with intellectual disabilities, developmental disabilities, and physical disabilities, by providing personal and employment support services to those individuals who are employed.

Eligibility. The SSI Employment Support Pilot will be available to up to 400 individuals between the ages of 16 and 60 who are currently on the waiting lists for the Home and Community-Based Services (HCBS) ID/DD and the Physical Disability (PD) waivers.

Participants in the program must be employed in a competitive, integrated work setting (as defined by the State) for at least 40 hours per month, earn at least federal minimum wage or better, and have FICA withheld from earnings. Those who are self-employed must have net earnings equal to or greater than the federal minimum wage times 40 hours per month and show proof of paying SECA.

Services. The program will offer the following services (similar to the Social Security Alternative Pilot):

- Benefits planning through the Kansas Medicaid Buy-in program, *Working Healthy*. Benefits Specialists will be available to discuss the pilot and other options, provide individual benefit plans, and explain the impact of employment and pilot participation on benefits.
- Funding for personal care and employment support services in the form of a monthly allocation of \$1,500, which will allow participants to directly manage their funds and provide flexibility in purchasing services that best meet their needs.
- Medicaid services under KanCare or, if eligible for employer-sponsored health insurance, Medicaid wrap-around services as long as the participant remains eligible for Medicaid. Pilot participants whose income results in a loss of SSI benefits will be able to access *Working Healthy* and personal/employment support services through the Work Opportunities Reward Kansans Program (*WORK*).
- Assistance in obtaining employment, which will be provided by Kansas Rehabilitation Services (Vocational Rehabilitation), Community Developmental Disability Organizations, Centers for Independent Living, and Kansas Workforce Centers.

Cost Sharing. Because participants are SSI recipients, there will be no premium, cost-sharing, or spenddown required.

Safety Net. Participants who leave the pilot for any reason will return to the HCBS waiting list with the same request date he or she had prior to joining the pilot. If individuals from the waiting list with the same request date as a pilot participant are later accepted into the waiver, the pilot participant will be offered waiver services. Pilot participants who become unemployed, but intend to return to work, may retain pilot program eligibility for four months after the employment ends.

Evaluation. KDHE will evaluate the SSI Employment Support Pilot by assessing whether the pilot results in lower physical and behavioral health costs; improved health and quality of life as reported by participants; increased earnings and taxes paid; decreased reliance on benefits; and program satisfaction.

iii. Health Account Pilot

KDHE also seeks to implement a pilot program for adult members formerly eligible for Family Medical Assistance that offers an alternative to transitional Medicaid using a Health Account model, to determine whether this model more effectively transitions participants to private health insurance through KanCare MCOs or health benefit exchanges.

Description. The Health Account Pilot will provide up to 500 adults age 19 and older eligible for TransMed, the Kansas transitional Medicaid program, the option of purchasing health care with a pre-loaded account worth \$2,000 instead of enrolling in TransMed. Participants can use the account to purchase qualifying health services or pay health insurance premiums, co-pays, and deductibles. Participants may also purchase basic health coverage through a KanCare MCO.

Eligibility and Enrollment. The option to join the Health Account Pilot would be available at the time of an individual’s Medicaid open enrollment. Only individuals who have lost eligibility for Family Medical Assistance because of an increase in earnings, but who retain eligibility for TransMed, would be able to enroll in the Pilot. Children for whom the TransMed beneficiary is responsible will continue to be eligible for Medicaid or CHIP through KanCare. Participants can renew the accounts annually during open enrollment for up to three years of funding, for a total of \$6,000. Moreover, participants would retain the balance in their accounts even if their income would make them otherwise ineligible for Medicaid during the time they are participating.

Waiver and Safety Net. Individuals who elect this option would waive their right to Medicaid eligibility for one year after their participation in the pilot ends. However, there would be exceptions to the waiver for certain qualifying events, such as loss of employment or change in household composition, including pregnancy. If the participant becomes disabled and receives SSI or SSDI or turns age 65, they may qualify for Medicaid under the Kansas Medicare Savings program.

Evaluation. KDHE will evaluate the Health Account Pilot by assessing whether participants successfully transition to employer-based health insurance.

C. Timeline for Delivery System Reform Incentive Payment (DSRIP) Pool

Under the current waiver, CMS has approved a DSRIP Pool of funds in DY 2 through DY 5 (2014-2017) for the development of a program of activity that supports participating hospitals’ efforts to enhance access to health care, quality of care, and the health of the patients and families they serve. KDHE proposes delaying the implementation of the DSRIP Pool for one year, from DY 2 (2014) to DY 3 (2015), to allow the State and CMS to focus on other critical activities related to the KanCare demonstration. Specifically, Kansas proposes to:

- Delay implementation of DSRIP payments for one year, to begin January 1, 2015 in DY 3;
- Continue Uncompensated Care (UC) pool payments into DY 2 to participating DSRIP hospitals with a total UC payment limit for the Border City Children’s Hospital (BCCH)/Large Public Teaching Hospital (LPTH) pool of \$39,856,550 in DY 2;
- Begin DSRIP pool payments in DY 3, with increasing funds allocated through DSRIP and decreasing funds allocated through UC in DYs 4 and 5. Proposed pool limits are listed below.

	DY 1 (CY 2013)	DY 2 (CY 2014)	DY 3 (CY 2015)	DY 4 (CY 2016)	DY 5 (CY 2017)	Total
UC Pool: HCAIP	\$41,000,000	\$41,000,000	\$41,000,000	\$41,000,000	\$41,000,000	\$205,000,000
UC Pool: BCCH/ LPTH	\$39,856,550	\$39,856,550	\$29,856,550	\$19,856,550	\$9,856,550	\$139,282,750
DSRIP	N/A	N/A	\$10,000,000	\$20,000,000	\$30,000,000	\$60,000,000
% UC Pool	100%	100%	87.6%	75.3%	62.9%	---
% DSRIP	N/A	N/A	12.4%	24.7%	37.1%	---
Total	\$80,856,550	\$80,856,550	\$80,856,550	\$80,856,550	\$80,856,550	\$404,282,750

- Allow the previously submitted required documentation (including proposed focus areas and draft Planning and Funding and Mechanics protocols) to fulfill the requirements of STC 69 (b, e and f).
- Shift reporting and outcome measure requirements by one DY. For example, the previous DSRIP requirements for DY 2 will now be fulfilled in DY3; DY 3 requirements will now be fulfilled in DY 4.
- Eliminate the previously stipulated DY 5 DSRIP requirements. DY 5 will now be devoted to achieving the previous requirements stipulated for DY 4.

D. Waiver and Expenditure Authority

KDHE has not identified any additional waiver or expenditure authority that would be needed to implement the changes regarding LTSS for individuals with developmental or intellectual disabilities and the DSRIP Pool. With respect to the pilot programs to support employment and alternatives to Medicaid, KDHE requests the following additional waivers of provisions of Section 1902 of the Social Security Act and costs not otherwise matchable under Section 1903.

Waivers

- Section 1902(a)(32) (direct payment to providers) to enable Kansas to provide a monthly funding allocation to certain participants in the Social Security Alternative Pilot and all participants in the SSI Employment Support Pilot, to pay for personal and employment support services.
- Section 1902(a)(10)(A) (mandatory eligibility groups) to enable Kansas to require participants in the Health Account Pilot to waive Medicaid eligibility for the 12 months following participation in the pilot. The waiver of eligibility would not apply to certain participants who become disabled and receive SSI or SSDI, or turn age 65.
- Sections 1902(a)(3) and 1902(a)(8) (reasonable promptness) to enable Kansas to not enroll participants in the Health Account Pilot in Medicaid for the 12 months following participation in the pilot.

Costs Not Otherwise Matchable

- Expenditures to provide employment assistance and Medicaid-like coverage to participants in the Social Security Alternative Pilot.
- Expenditures to provide employment assistance and Medicaid coverage and/or wrap-around coverage to participants in the SSI Employment Support Pilot.
- Expenditures to provide pre-loaded debit cards to participants in the Health Account Pilot, which can be used to purchase health services or pay health insurance premiums, co-pays, and deductibles.

Medicaid Requirements Not Applicable

- Sections 1916 and 1916A (premiums and cost sharing) to allow Kansas to charge premiums for the Social Security Alternative Pilot consistent with the *Working Healthy* program.

II. State Public Notice Process

A. Notice Regarding the Proposed Amendment

The State published an abbreviated public notice of this proposed amendment in the June 27, 2013, *Kansas Register* (see Attachment A). The same day, a full public notice and the draft amendment letter were posted on the KanCare website for public comment, and an email notification was sent to stakeholder distribution lists (see Attachment B). Comments on the draft amendment were accepted through July 29, 2013.

In addition, the State scheduled two public meetings specifically for the purpose of seeking comment on the KanCare amendment:

- July 15, 2013, at 2 p.m.
Wichita State University Metroplex, Multipurpose Room
5015 E. 29th St. N
Wichita, KS
- July 16, 2013, at 10 a.m.
Downtown Ramada, Madison Ball Room
420 SE 6th St.
Topeka, KS

The State provided teleconference access for the July 16 meeting and provided an opportunity for individuals with disabilities to request accommodations to participate in either meeting.

A summary of the comments received and the State's responses to the comments is provided as Attachment C.

B. Tribal Notice

The State also distributed an initial notice of its intent to amend the KanCare 1115 demonstration to tribal governments and Indian Health Service, Tribal Organization, and Urban Indian Organization providers (I/T/U providers) on June 7, 2013 (see Attachment D). KDHE and members of the Tribal Technical Advisory Group (TTAG) discussed the amendment at the July 9 TTAG meeting in Topeka. The State, tribal governments and I/T/U providers also held two in-person consultation meetings, on July 17 in White Cloud and on July 23 in Mayetta.

C. Public Discussion Regarding the ID/DD LTSS Initiative

KDADS and KDHE have made a concentrated effort to address concerns about the inclusion of ID/DD LTSS in KanCare voiced by consumers, their families, providers and advocates. In addition to the ID/DD pilot project, the effort has included the development of a KanCare ID/DD Friends and Family Work Group to assist the State in educating consumers and their families. KDADS Secretary Shawn Sullivan and staff have spoken at dozens of ID/DD-specific forums and town meetings, as well as broader HCBS forums across the state.

The Friends and Family Work Group, comprised of consumers and families and friends of consumers, continues to provide guidance and recommendations to KDADS leadership regarding education and policy development for ID/DD LTSS. This group meets bi-weekly and will continue to operate after integration of ID/DD waiver services into KanCare to provide a voice for consumers throughout the implementation process. The Work Group and its education and policy subcommittees will provide valuable consumer insight into how best to address concerns or issues that may impact ID/DD consumers.

Based on input from the Friends and Family Work Group and other work groups, KDADS will host consumer calls to address frequently asked questions as well as provide information directly to consumers, guardians and family members to address their concerns.

The KanCare and KDADS websites also provide information in various formats that reiterates consumers will not be forced to change their providers. The KanCare health plans are hosting education sessions for providers to help them with contracting and credentialing to ensure timely contracting prior to January 1, 2014.

State officials have written and published articles about the inclusion of ID/DD LTSS in KanCare in newspapers around the state. Articles from national experts about providing HCBS services for these consumers have appeared in state newspapers as well.

Family members and guardians with connections to an ID/DD consumer have received an informational letter regarding the inclusion (or carve-in) of LTSS in KanCare and how it will function. In addition, KDADS regularly posts ID/DD information on its agency website, including a lengthy fact sheet and FAQs.

The State has gained constructive experience in providing LTSS through managed care from the inclusion of the other HCBS waivers in managed care since January 2013. During regular Long Term Care and KanCare steering committee meetings, KDADS and KDHE staff have been able to share updates on issues related to LTSS that will aid in the successful integration of ID/DD services into KanCare. KDADS staff also facilitates a weekly Technical Assistance call and Complex Case Staffing call to assist the health plans. These activities continue to inform the State and the health plans, providing valuable insight into the system.

As a result of these ongoing efforts, substantially fewer family members have raised objections regarding the inclusion of ID/DD services in KanCare than before KanCare was launched in January 2013. The State is committed to continuing the dialogue to address remaining concerns.

III. Budget Neutrality

Enclosed are several documents detailing the effect of the proposed amendment on budget neutrality. Per the KanCare STCs, KDHE has included summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment (see Attachment E). Budget neutrality documents submitted last year in the demonstration proposal assumed the inclusion of LTSS for ID/DD consumers beginning January 1, 2014. As a result, the attached budget neutrality amendment summary does not reflect a change in the “with waiver” totals for Medicaid Population 5, “DD Waiver.” An analysis of inclusion of LTSS for ID/DD consumers is provided in Attachment F, “DD LTSS Analysis.”

An update to the safety net care pool table at STC 70 is attached as Attachment G. A similar table is proposed for inclusion in the STCs for the three pilots and is attached for your review as Attachment H.

The State appreciates your consideration of this amendment request, and looks forward to working with CMS to accomplish these changes. If you have any questions or would like to discuss this request, please contact Kari Bruffett, Director of the Division of Health Care Finance, at (785) 296-3512.

Sincerely,



Susan Mosier, MD
Medicaid Director

Enclosures

State of Kansas

Department of Labor

Notice of Maximum and Minimum Weekly
Unemployment Benefit Amounts

Each year, in accordance with K.S.A. 44-704 of the Kansas Employment Security Law, the maximum and minimum weekly benefit amounts payable to unemployment insurance claimants are recalculated. In SFY 2014, for new claims filed on or after July 1, 2013, and before July 1, 2014, the maximum weekly benefit amount will be \$469 and the minimum weekly benefit amount will be \$117.

Lana Gordon
Secretary of Labor

Doc. No. 041666

State of Kansas

Department of Health
and Environment
Division of Health Care FinanceNotice of Meetings on the KanCare
Demonstration Amendment

The state of Kansas, Department of Health and Environment, hereby notifies the public that it intends to seek an amendment to the KanCare Section 1115 demonstration (11-W-00283/7) from the Centers for Medicare & Medicaid Services (CMS). KDHE is providing this abbreviated notice in compliance with CMS requirements in 42 C.F.R. § 431.408(a)(2)(ii).

KDHE plans to request CMS approval for three changes to KanCare, effective January 1, 2014. First, KDHE will ask CMS for approval to provide long-term supports and services (LTSS) to individuals with intellectual or developmental disabilities through the KanCare managed care plans. Under the current waiver, these services are carved out from managed care and paid on a fee-for-service basis. Second, KDHE will ask CMS to approve three new pilot programs designed to support Kansans who might otherwise be enrolled in Medicaid: (1) a Social Security Alternative Pilot; (2) a Supplemental Security Income (SSI) Employment Support Pilot; and (3) a Health Account Pilot. Third, KDHE will ask CMS to postpone implementation of the Delivery System Reform Incentive Payment (DSRIP) Pool of funds by one year, so that it will begin in demonstration year 3 (2015) instead of demonstration year 2 (2014).

The state's full public notice, which describes the proposed amendment in more detail, can be found on the KanCare website at:

http://www.kancare.ks.gov/download/KanCare_1115_Amendment_Public_Notice.pdf

The draft KanCare amendment can be viewed directly in Room 900, Landon State Office Building, 900 S.W. Jackson, Topeka, or at the KanCare website at:

http://www.kancare.ks.gov/download/KanCare_1115_Amendment_Public_Comment.pdf

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

- July 15 at 2 p.m.
Wichita State University Metroplex
Multipurpose Room
5015 E. 29th St. North, Wichita
- July 16 at 10 a.m.
Downtown Ramada, Madison Ball Room
420 S.E. 6th St., Topeka

The state is also making teleconference access available for the July 16 meeting. The participant dial-in number for the event will be 866-491-3158.

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 proposed demonstration amendment can be emailed to KanCare@kdheks.gov or mailed to KDHE-DHCF, Attn: Rita Haverkamp, Room 900, Landon State Office Building, 900 S.W. Jackson, Topeka, 66612. KDHE will be accepting public comments until July 29, 2013.

Kari Bruffett, Director
Division of Health Care Finance

Doc. No. 041673

State of Kansas

Children's Cabinet and Trust Fund

Request for Proposals

The Kansas Children's Cabinet and Trust Fund announces the release of a request for proposals to provide evaluation services. The qualified contract will conduct ongoing, multi-site evaluation of the ECBG program. The Kansas Children's Cabinet and Trust Fund is seeking consultants, consulting firms or organizations with the experience, qualifications and capacity to provide evaluation services of the Kansas Early Childhood Block Grantees. It is anticipated that evaluation activities will include creation of an evaluation plan, data collection and analysis, interpretation of results, report writing and dissemination of results. Preference will be given to those consultants or consulting firms based in Kansas.

The funding period will be from July 30, 2013 to June 30, 2014, with a maximum award amount of \$300,000. These are one-year grants with option of one renewal possible depending on funding and outcomes. Complete proposals include one original and five copies and may be sent to the Kansas Children's Cabinet and Trust Fund, Room 152, Landon State Office Building, 900 S.W. Jackson, Topeka, 66612. Proposals must be received not later than 5 p.m. July 11, 2013. A PDF file of the application also is required by the deadline date and may be emailed to Dyogga Adegbore, program consultant, KCCTF, at dyogga.adegbore@dcf.ks.gov.

Jim Redmon
Executive Director

Doc. No. 041675



**KanCare
Section 1115 Demonstration Amendment**

PUBLIC NOTICE

June 27, 2013

The State of Kansas, Department of Health and Environment (KDHE) hereby notifies the public that it intends to seek an amendment to the KanCare Section 1115 demonstration (11-W-00283/7) from the Centers for Medicare & Medicaid Services (CMS). A copy of the proposed amendment is available at:

http://www.kancare.ks.gov/download/KanCare_1115_Amendment_Public_Comment.pdf

It is also available in person at 900 SW Jackson, Room 900, Topeka, Kansas. KDHE is providing this notice to open a formal public comment period and public consultation process pursuant to CMS requirements in the KanCare Special Terms and Conditions (STCs) and 42 C.F.R § 431.408.

Proposed Amendment Description, Goals, and Objectives

The State will request CMS approval to implement three changes to KanCare, effective January 1, 2014: (1) provide long term supports and services (LTSS) for individuals with intellectual or developmental disabilities through KanCare managed care plans; (2) establish three pilot programs to support employment and alternatives to Medicaid; and (3) change the timeline for the Delivery System Reform Incentive Payment (DSRIP) Pool.

(1) Long Term Services and Supports for Individuals with Intellectual or Developmental Disabilities

Under the current waiver, specialized services for individuals with developmental disabilities are carved out from the Medicaid managed care organization (MCO) benefit package and are paid on a fee-for-service basis. The carved-out services are LTSS authorized through the Intellectual Disabilities/Developmental Disabilities (ID/DD) waiver (KS-0224) and State Plan Targeted Case Management (TCM), screening services, and positive behavioral supports for the ID/DD population. The current waiver also authorizes KDHE to operate a voluntary ID/DD Services pilot program in demonstration year (DY) 1 to help members, providers, and the MCOs transition to providing LTSS through KanCare.

The State will request CMS approval to no longer carve out these specialized services and to provide LTSS to individuals with intellectual or developmental disabilities through the KanCare managed care plans. Inclusion in managed care will provide a more robust set of care management resources and more complete integration of LTSS, physical, and behavioral health services. Under state law for fiscal years 2014 and 2015, enrollees may keep their targeted case managers, and they may keep current LTSS providers on their service plans even if they are not in-network for 6 months, among many other protections.

The State believes that including these services in KanCare will result in better access to services and improved quality of care for KanCare enrollees with intellectual or developmental disabilities, provide stable

reimbursement rates for providers, and incentivize MCOs to keep individuals in a less costly home environment. The draft KanCare evaluation design submitted to CMS in April incorporated measures related to LTSS for members with intellectual or developmental disabilities. For more information, please see the draft evaluation design at http://www.kancare.ks.gov/download/KanCare_Draft_Evaluation_Design.pdf.

(2) *Pilot Programs to Support Employment and Alternatives to Medicaid*

The State will also request CMS approval to implement three pilot programs designed to support Kansans who might otherwise be enrolled in Medicaid.

- **Social Security Alternative Pilot.** This pilot will provide health care coverage and employment support services for up to 200 individuals age 18 and over who meet Social Security Administration (SSA) criteria for disability, but who have not yet applied for Supplemental Security Income (SSI) or Social Security Disability (SSDI) cash benefits or Medicaid coverage. The program will offer services including: benefits planning by Benefits Specialists; funding for personal care and employment support services for individuals with a demonstrated need, capped at \$1,500 per month; “Medicaid-like coverage” until individuals obtain employer-sponsored health insurance; and assistance to obtain employment. Cost sharing will be consistent with the Kansas Medicaid Buy-In Program, *Working Healthy*. The goal of the program is to place individuals with disabilities, particularly young adults, on an employment trajectory to avoid outcomes that result from unemployment and dependence on benefits. The State will evaluate the pilot by measuring income compared to SSI/SSDI cash benefits; cost avoidance to the Social Security system; improved health and quality of life as reported by participants; and program satisfaction.
- **SSI Employment Support Pilot.** This program will promote employment for individuals with disabilities by providing personal and employment support services to those individuals who are employed. The pilot will be available to up to 400 individuals between the ages of 16 and 60 who are currently on the waiting lists for the Home and Community-Based Services (HCBS) ID/DD and the Physical Disability (PD) waivers. It will offer services including: benefits planning by Benefits Specialists; funding for personal care and employment support services, capped at \$1,500 per month; Medicaid services under KanCare or, if eligible for employer-sponsored health insurance, Medicaid wrap-around services as long as the participant remains eligible for Medicaid; and assistance to obtain employment. Because participants are SSI recipients, there will be no premium, cost-sharing or spenddown required. Participants who leave the pilot for any reason will return to the HCBS waiting list with the same request date they had prior to joining the pilot. KDHE will evaluate the SSI Employment Support Pilot by assessing whether the pilot results in lower physical and behavioral health costs; improved health and quality of life as reported by participants; increased earnings and taxes paid; decreased reliance on benefits; and program satisfaction.
- **Health Account Pilot.** This program will offer an alternative to transitional Medicaid, using a Health Account model, to determine whether this model more effectively transitions participants to private health insurance through KanCare MCOs or health benefit exchanges. The program will give to up to 500 individuals eligible for TransMed, the Kansas transitional Medicaid program, the option of purchasing health care with a pre-loaded debit card worth \$2,000 instead of enrolling in TransMed. Participants can use the debit card to purchase qualifying health services or pay health insurance premiums, co-pays, and deductibles. Participants may also purchase basic health coverage through a KanCare MCO. The account may be renewed annually for up to three years, and participants would retain the balance in their accounts even if their incomes would make them otherwise ineligible for Medicaid during the time they are participating. Individuals choosing this option would waive their right to Medicaid eligibility for one year after their participation in the pilot ends, with exceptions for certain qualifying events, including loss of employment or a change in household composition (including pregnancy). Participants who become disabled and receive SSI or SSDI or turn age 65 may

qualify for Medicaid under the Kansas Medicare Savings program. KDHE will evaluate the Health Account Pilot by assessing whether participants successfully transition to employer-based health insurance.

(3) *Changes to Timeline for Delivery system Reform Incentive Payment (DSRIP) Pool*

Under the current waiver, CMS has approved a DSRIP Pool of funds in DY 2 through DY 5 (2014-2017) for the development of a program of activity that supports participating hospitals’ efforts to enhance access to health care, quality of care, and the health of the patients and families they serve. KDHE proposes delaying the implementation of the DSRIP Pool for one year, from DY 2 (2014) to DY 3 (2015), to allow the State and CMS to focus on other critical activities related to the KanCare demonstration. KDHE proposes to maintain Uncompensated Care pool payment limits in DY 2 at the level currently approved for DY 1.

Annual Enrollment and Annual Expenditures

The following table summarizes Kansas Medicaid population expenditures and enrollment for populations included in KanCare, both historically as well as the period of the demonstration. Historical years are shown as State Fiscal Years, while Demonstration years are shown as Calendar Years. LTSS for individuals with ID/DD were not included in managed care in CY 2013, but associated expenditures are included in KanCare budget neutrality and the table below.

Historical	SFY 07	SFY 08	SFY 09	SFY 10	SFY 11	Average Trend
Medicaid Enrollment (member months)	2,850,800	2,790,087	2,853,568	3,114,678	3,388,370	4.41%
Medicaid Population Expenditures	\$ 1,946,968,416	\$ 2,140,606,790	\$ 2,291,098,906	\$ 2,320,065,777	\$ 2,566,076,170	7.15%

KanCare	CY 2013*	CY 2014	CY 2015	CY 2016	CY 2017	Average Trend
Medicaid Enrollment (member months)	4,252,688	4,391,835	4,545,651	4,707,540	4,870,306	3.45%
Medicaid Population Expenditures	\$ 2,756,702,668	\$ 2,857,398,803	\$ 3,002,455,649	\$ 3,246,958,636	\$ 3,405,962,099	5.43%

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

Details of the effects of the inclusion of LTSS, as well as the pilots and change in timeline for the DSRIP pool, are included in the draft amendment at:

http://www.kancare.ks.gov/download/KanCare_1115_Amendment_Public_Comment.pdf

Hypothesis and Evaluation Parameters

The evaluation parameters for each initiative are described above. The State will test the following research hypotheses through these programs:

- Providing LTSS to individuals with intellectual or developmental disabilities through the KanCare managed care plans will result in better access to services and improved quality of care, provide stable reimbursement rates for providers, and incentivize MCOs to keep individuals in a less costly home environment.
- Alternatives to Medicaid will promote employment and self-sufficiency.

Waivers/Costs Not Otherwise Matchable

The State has not identified any additional waiver or expenditure authority necessary for the LTSS and DSRIP initiatives. However, the State will request the following additional authority for the pilot programs to support employment and alternatives to Medicaid.

Waivers

- Section 1902(a)(32) (direct payment to providers) to enable Kansas to provide a monthly funding allocation to participants in the Social Security Alternative Pilot and the SSI Employment Support Pilot, to pay for personal and employment support services.
- Section 1902(a)(10)(A) (mandatory eligibility groups) to enable Kansas to require participants in the Health Account Pilot to waive Medicaid eligibility for the 12 months following participation in the pilot. The waiver of eligibility would not apply to certain participants who become disabled and receive SSI or SSDI, or turn age 65.
- Sections 1902(a)(3) and 1902(a)(8) (reasonable promptness) to enable Kansas to not enroll participants in the Health Account Pilot in Medicaid for the 12 months following participation in the pilot.

Costs Not Otherwise Matchable

- Expenditures to provide employment assistance and Medicaid-like coverage to participants in the Social Security Alternative Pilot.
- Expenditures to provide employment assistance and Medicaid coverage and/or wrap-around coverage to participants in the SSI Employment Support Pilot.
- Expenditures to provide pre-loaded debit cards to participants in the Health Account Pilot, which can be used to purchase health services or pay health insurance premiums, co-pays, and deductibles.

Medicaid Requirements Not Applicable

- Sections 1916 and 1916A (premiums and cost sharing) to allow Kansas to charge premiums for the Social Security Alternative Pilot consistent with the *Working Healthy* program.

Comments and Public Input Process

Please submit any written comments or questions on the proposed amendment to KanCare@kdheks.gov or ATTN: Rita Haverkamp, KDHE-DHCF, 900 SW Jackson, Room 900, Topeka, 66612. Comments will be accepted for consideration until **July 29, 2013**.

KDHE will also hold two public meetings to solicit comments on the proposed amendment:

- **July 15, 2013, at 2 p.m.**
Wichita State University Metroplex, Multipurpose Room
5015 E. 29th St. N
Wichita, KS
- **July 16, 2013, at 10 a.m.**
Downtown Ramada, Madison Ball Room
420 SE 6th St.
Topeka, KS

The State will provide teleconference access for the July 16 meeting. The participant dial-in number for the event will be 866-491-3158.

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.

Miranda Steele

From: KanCare
Sent: Thursday, June 27, 2013 8:58 AM
Cc: KanCare
Subject: Notice of Meetings on KanCare Demonstration Amendment
Attachments: KanCare 1115 Amendment Public Notice.pdf

Notice of Meetings on KanCare Demonstration Amendment

The State of Kansas, Department of Health & Environment (KDHE), intends to seek an amendment to the KanCare Section 1115 demonstration (11-W-00283/7) from the Centers for Medicare & Medicaid Services (CMS). The full public notice, which describes the proposed amendment in more detail, is attached and available on the KanCare website, at www.kancare.ks.gov/download/KanCare_1115_Amendment_Public_Notice.pdf.

KDHE plans to request CMS approval for three changes to KanCare, effective January 1, 2014. First, KDHE will ask CMS for approval to provide long term supports and services (LTSS) to individuals with intellectual or developmental disabilities through the KanCare managed care plans. Under the current waiver, these services are carved out from managed care and paid on a fee-for-service basis. Second, KDHE will ask CMS to approve three new pilot programs designed to support Kansans who might otherwise be enrolled in Medicaid: (1) a Social Security Alternative Pilot; (2) a Supplemental Security Income (SSI) Employment Support Pilot; and (3) a Health Account Pilot. Third, KDHE will ask CMS to postpone implementation of the Delivery System Reform Incentive Payment (DSRIP) Pool of funds by one year, so that it will begin in demonstration year 3 (2015) instead of demonstration year 2 (2014).

The draft KanCare amendment can be viewed directly at 900 S.W. Jackson, Room 900, Topeka, or at the KanCare website, at:

www.kancare.ks.gov/download/KanCare_1115_Amendment_Public_Comment.pdf

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

- July 15 at 2 p.m.
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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 proposed demonstration amendment 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 29, 2013**.

Attachment C: Public Comment and State Response

The State of Kansas solicited public comment on its request for CMS approval of an amendment to the KanCare Section 1115 demonstration project which would enable the State to implement three changes to KanCare, effective January 1, 2014: (1) provide long term supports and services (LTSS) for individual with intellectual or developmental disabilities through KanCare managed care plans; (2) establish three pilot programs to support employment and alternatives to Medicaid; and (3) change the timeline for the Delivery System Reform Incentive Payment (DSRIP) Pool.

In addition to conducting two public forums and two consultations with tribal leaders and I/T/U providers, the State also opened a formal comment period that officially closed on July 29, accepting email and written comments. Those comments can be viewed on the KanCare website, at: http://www.kancare.ks.gov/download/KanCare_1115_Public_Comments_on_Draft_Amendment.pdf.

The feedback received during the public comment timeframe focused on the following themes:

1. ID/DD services and supports: Families of individuals with ID/DD and providers of ID/DD services raised concern about managed care organizations dismantling existing long term services and supports in place for individuals with ID/DD.

State response: The State agrees that maintaining and building upon the service infrastructure that supports members with intellectual or developmental disabilities is key to the successful implementation of managed long term services and supports. The State, in accordance with a 2013 legislative budget proviso, has outlined specific protections for existing service networks, including a 180-day continuity of care window. As outlined in the proposed amendment, those protections provide that:

- Enrollees may keep their targeted case managers, provided those case managers are employed with community developmental disability organizations (CDDOs) or CDDO subcontractors.
- Enrollees may keep current LTSS providers on their approved service plans, even if those providers are not in the network, for 180 days from January 1, 2014, or until a service plan is completed and either agreed upon by the enrollee or resolved through the appeals or a fair hearing process and implemented.
- Enrollees using ID/DD residential providers may access those providers up to one year from January 1, 2014, regardless of contracting status.
- The MCOs must comply with the specific powers and duties of the CDDOs provided in Kansas law. They also must contract with at least two providers serving each county for each covered LTSS in the benefit package for the enrollees with intellectual or developmental disabilities (unless the county has an insufficient number of providers), and must make at least three contract offers to all LTSS providers serving such enrollees at or above the state-set fee for service rate.
- In 2014, the State will conduct an educational tour to provide information for enrollees with intellectual or developmental disabilities and LTSS providers. The State also will review, in the first 180 days of 2014, each MCO's ID/DD service

planning process, and will conduct, in 2014 and 2015, training for each MCO to ensure that they understand the DD services system.

- The Kansas Department for Aging and Disabilities Services (KDADS) will, in fiscal years 2014 and 2015, review and approve all plans of care for ID/DD waiver members for which a reduction, suspension or termination of services is proposed.

2. ID/DD pilot: Some stakeholders from the ID/DD community raised concerns about whether the ID/DD pilot has accomplished its aims.

State response: The three main objectives of the ID/DD pilot, as developed by the blue-ribbon advisory committee of ID/DD stakeholders, are as follows: (1) Develop relationships and shared understanding between MCOs and ID/DD system; (2) define how services and service delivery will look under KanCare on January 1, 2014; and (3) develop and test billing processes for January 1, 2014 inclusion.

Objective (1): The three MCOs were asked by the state to begin meeting regularly with the Pilot Committee in October 2012. For the last ten months, the MCOs have been active participants in every one of the Pilot Committee's bi-weekly meetings, and as a result both the MCOs and the ID/DD community have learned about the roles each play and how they each carry out their separate functions.

In addition to developing shared understanding of how the other operates, the MCOs have each created ID/DD-specific teams. Each team is led by individuals who formerly worked in the Kansas ID/DD system, and who have intimate knowledge and appreciation for the concerns of providers and consumers in Kansas. With this background and insight, each one of the health plans have launched (pilot) participant-specific outreach initiatives designed to collaborate directly with the ID/DD community.

Break-out sessions between MCOs and the Challenging Behaviors and Employment First Work Groups have been ongoing in an effort to increase the MCOs' knowledge of some of the more complex issues facing the ID/DD system. Two rounds of State and MCO ID/DD Pilot training tours have already been conducted, one in the first week of June, and the most recent in July. These sessions were designed with the intention of allowing all active participants (members and providers) an opportunity to ask questions, raise concerns, and get support materials for the transition. The meetings have given providers an opportunity to ask the MCOs questions and to work with providers on completing the contracting and credentialing processes.

The State has also completed an initial survey of participants and their guardians to develop a baseline level of their current knowledge of KanCare. Additionally, the State is ready to pilot a new web application for reporting critical incidents and has asked providers in the pilot to provide feedback on the functionality of the system.

Objective (2): The Pilot Committee, the State, and all three MCOs agree that service delivery and the assessment/tiering for those services should remain in the hands of the

Community Developmental Disability Organizations, their affiliate community service providers, and the targeted case managers.

Objective (3): Establishing and testing billing processes for ID/DD services under KanCare has been one of the key elements that the Pilot Committee added. However, until the close of legislative session, some providers were hesitant to begin detailed discussions regarding IT requirements and synchronization among the MCOs, the state and provider billing mechanisms. Explicit discussions about how the billing procedures would work began the first week of June.

The current emphasis moving ahead is getting the billing component correct the first time. Stakeholders in our workgroups have provided solid guidance on the specific situation of the ID/DD population. The billing process is being developed to minimize impact on the current system while properly testing the billing and payment of claims under the pilot.

3. Payment delays/billing: Several providers of ID/DD services expressed concern about timely claims payment under KanCare, citing delays to providers of other services currently under KanCare.

State response: The KanCare contract holds the MCOs to stringent payment guidelines and timeframes in accordance with state and federal law. This includes performance measures for timely claims processing, credentialing processing, and appeals. The State, along with the three MCOs, has developed multiple avenues of support for providers who are seeking answers to questions about billing, including, but not limited to, rapid response calls, issues logs, and a provider assistance dial-in line.

4. Social Security Alternative Pilot: Some stakeholders expressed concern about the 6-month window for employment in the draft amendment, citing that period of time as being too short. Additional concern was expressed that pilot participants would not be adequately educated about their benefits, and the impact those benefits would have on their Social Security.

State response: Based on this input, “Medicaid-like” coverage will continue for twelve months to allow adequate time for the pilot participant to become employed. Further, language was added in the pilot description specifically outlining the certified Benefits Specialists’ role to include an explanation to the participant of the impact of employment and participation in the pilot on Social Security and other benefits.

Additionally, multiple State agencies (the Kansas Department of Health and Environment, Kansas Department for Aging and Disabilities, and Kansas Department for Children and Families) are collaborating to coordinate existing programs for employment services that will support Social Security Alternative and SSI Employment Support Pilot participants as they seek and obtain employment. KDHE is also exploring private funding to conduct an evaluation of the Social Security Alternative Pilot.

5. Health Account Pilot: A stakeholder group, Kansas Action for Children, pointed out that the draft amendment did not specify whether children would be included in the Health Account Pilot, and recommended that children be excluded from pilot participation.

State response: We agree that it was not clear in the proposal published for public comment that the Health Account Pilot is designed for adults 19 years and older. Children in the household will continue to receive KanCare coverage. This has been clarified in the final version of the proposed amendment.

Attachment D:

**Notice to Tribal Governments, Indian Health Programs and Urban Indian Organizations
Amendment to KanCare Section 1115 Demonstration
June 7, 2013**

The State of Kansas, Department of Health and Environment (KDHE) hereby notifies tribal governments, Indian health programs, and Urban Indian organizations in Kansas that it intends to seek an amendment to the KanCare Section 1115 demonstration (11-W-00283/7) from the Centers for Medicare & Medicaid Services (CMS). The KanCare demonstration was approved by CMS on December 27, 2012, and is effective from January 1, 2013, through December 31, 2017. The State is seeking advice and feedback from federally recognized tribes, Indian health programs, and Urban Indian organizations regarding the intended changes.

Proposed Amendment

As discussed during the Tribal Technical Advisory Group meeting on June 4, KDHE intends to request CMS approval for three changes to KanCare, effective January 1, 2014. As described below, the changes relate to (1) long term supports and services (LTSS) for individuals with intellectual or developmental disabilities; (2) pilot programs to support employment and alternatives to Medicaid; and (3) the timeline for the Delivery System Reform Incentive Payment (DSRIP) Pool.

(1) Long Term Supports and Services for Individuals with Intellectual or Developmental Disabilities

Under the current KanCare Section 1115 demonstration, specialized services for individuals with intellectual or developmental disabilities are carved out from the Medicaid managed care organization (MCO) benefit package and are paid on a fee-for-service basis. The carved-out services are LTSS authorized through the Intellectual Disabilities/Developmental Disabilities (ID/DD) (MR/DD) waiver (KS-0224) and state plan Targeted Case Management (TCM) and screening services. The current waiver also authorizes KDHE to operate a voluntary ID/DD services pilot program in demonstration year 1. The goals of the ID/DD services pilot are to:

- Help ID/DD service providers acclimate to the managed care system before full implementation;
- Help persons served and their family members/guardians learn about and get accustomed to the managed care system before full implementation;
- Help the MCOs gain a deeper understanding of the ID/DD service system before full implementation;
- Demonstrate that including ID/DD services in KanCare with other Medicaid services will improve coordination of, and access to, needed services;
- Assist TCM with care coordination to address behavioral health, employment issues, and other challenges.

Participants in the ID/DD services pilot have access to a number of additional benefits, including: targeted assistance with specific care management issues; a more robust set of care

management resources; individualized training and information about KanCare; and an array of value-added services focused on individuals with developmental disabilities.

In the planned amendment, the State of Kansas intends to request CMS approval to no longer carve out these specialized services and to provide LTSS to individuals with intellectual or developmental disabilities through the KanCare managed care plans. The State believes this will result in better access to services and improved quality of care for KanCare enrollees with intellectual or developmental disabilities.

(2) Pilot Programs to Support Employment and Alternatives to Medicaid

KDHE will ask CMS to approve three new pilot programs designed to support Kansans who might otherwise be enrolled in Medicaid.

- Social Security Alternative Pilot. KDHE will establish a pilot program for up to 200 individuals who meet the Social Security Administration (SSA) criteria for disability, but who have not yet been determined eligible for Social Security (SSI/SSDI) cash benefits or Medicaid coverage. The program will offer services including: benefits planning by Benefits Specialists; personal care and employment support services; Medicaid-like coverage until individuals become employed and obtain employer-sponsored health insurance; and assistance to obtain employment. The goal of the program is to place individuals with disabilities, particularly young adults, on an employment trajectory to avoid outcomes that result from unemployment and dependence on benefits.
- Supplemental Security Income (SSI) Employment Support Pilot. KDHE will establish an employment pilot program for up to 400 individuals between the ages of 16 and 60 who are currently on waiting lists for the Home and Community-Based Services (HCBS) ID/DD or Physical Disability (PD) waivers. The program will offer services necessary to support independent living and employment, including: benefits planning by Benefits Specialists; personal care and employment support services; Medicaid-like coverage until individuals become employed and obtain employer-sponsored health insurance; and assistance to obtain employment. By engaging members in the workforce and providing these services, the program aims to promote increased self-reliance and decreased dependence on federal and state systems, while at the same time improving health outcomes and quality of life.
- Alternatives to Medicaid. KDHE will establish a pilot program for up to 500 people to offer a funded health account for the purpose of purchasing qualifying health services, paying health insurance premiums, co-pays and deductibles, or purchasing basic health coverage from a KanCare MCO. The account may be renewed annually for up to three years. Eligible members include those otherwise initially eligible for transitional Medicaid, and members who choose to participate in the pilot would retain the balance in their accounts even if their incomes would make them otherwise ineligible for Medicaid during the time they are participating. Individuals choosing this option would waive their right to Medicaid eligibility for one year after the pilot ends, with exceptions for certain

qualifying events, including loss of employment or a change in household composition. The pilot will offer an alternative to traditional transitional Medicaid.

(3) Timeline for Delivery System Reform Incentive Payment (DSRIP) Pool

Under the current waiver, CMS has approved a DSRIP Pool of funds in demonstration years 2 through 5 (2014-2017) for the development of a program of activity that supports participating hospitals' efforts to enhance access to health care, quality of care, and the health of the patients and families they serve. KDHE will ask to implement the DSRIP Pool beginning in demonstration year 3 (2015) instead of demonstration year 2 (2014). KDHE proposes to maintain Uncompensated Care pool payment limits in demonstration year 2 at the level currently approved for demonstration year 1.

Anticipated Impact on Tribal Members

KDHE believes that the KanCare waiver and the initiatives proposed in the amendment will lead to improved health care for all Kansans, including American Indians. None of the proposed changes will diminish statutory and regulatory protections for American Indian/Alaska Native members, nor will the changes affect the explicit protections for AI/AN members in the current KanCare Section 1115 demonstration. **For example, AI/AN members will continue to have the option of affirmatively opting out of managed care at the member's discretion.**

Likewise, the State's proposal will not waive other protections for tribal members and I/T/U providers (including Indian Health Service and 638 clinics). **All such protections will remain in place, including:**

- AI/AN members 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 contract health service (CHS);
- AI/AN members are exempt from payment of a deductible, coinsurance, copayment, cost sharing or similar charge for any item or service covered by Medicaid if the item or service is furnished directly by an Indian health care provider, I/T/U, or through CHS;
- Full Medicaid payment rate is due to the IHS, an I/T/U or to a CHS referral health care provider for furnishing a service or item to an AI/AN member. 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 AI/AN person; and
- Exemption of certain income, resources and property from Medicaid Estate Recovery Act rules, as per Recovery Act, Public Law 111-5, Section 5006.

Further, specific to managed care, as per State Medicaid Director Letter 10-001, **KanCare will continue to:**

- Permit any AI/AN member who is enrolled in a non-Indian managed care entity and 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 care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services;

- Require each managed care entity to demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for AI/AN enrollees who are eligible to receive services from such providers;
- Require that I/T/U providers, whether participating in the network or not, be paid for covered Medicaid or CHIP managed care services provided to AI/AN enrollees who are eligible to receive services from such providers either (1) at a rate negotiated between the managed care entity and the I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider; and
- Provide that the managed care entity must make prompt payment to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under federal regulations at 42 CFR sections 447.45 and 447.46.

Timeline and Comments

KDHE welcomes your comments, advice and questions on the proposed amendment. To facilitate discussion, please send comments regarding this Notice by July 9, 2013, the date of the next Tribal Technical Advisory Group (TTAG) meeting, to Rita Haverkamp at the contact information listed below. You can also contact Division Director Kari Bruffett at karibruffett@kdheks.gov with questions. In addition, KDHE anticipates the draft amendment will be available on or around June 27 for public comment, and KDHE will accept written comments on that draft and accompanying public notice for 30 days after its publication.

KDHE and TTAG members plan to discuss the draft amendment at the next TTAG meeting at 10 a.m. on July 9 in Topeka. The State, tribal governments and I/T/U providers also intend to hold two in-person consultation meetings, at 10 a.m. on July 17 in White Cloud, and on July 23 in Mayetta at a time to be determined. **We invite your participation. Please advise us of your interest in participating in any of those meetings, and we will follow up with additional details.** After considering public feedback, including feedback from the tribal consultation process, KDHE intends to submit the amendment to CMS in August 2013.

Rita Haverkamp
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900 SW Jackson, Room 900N
Topeka, KS 66612-1220
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Attachment E: Budget Neutrality Summary

With-Waiver Total Expenditures - Original¹

		DEMONSTRATION YEARS					TOTAL
		CY13	CY14	CY15	CY16	CY17	
Medicaid Pop 1	ABD/SD Dual	\$ 48,579,348	\$ 51,255,157	\$ 54,335,409	\$ 59,281,166	\$ 62,647,147	\$ 276,098,228
Medicaid Pop 2	ABD/SD Non Dual	\$ 376,599,264	\$ 398,697,805	\$ 424,106,447	\$ 464,293,346	\$ 491,292,958	\$ 2,154,989,819
Medicaid Pop 3	Adults	\$ 243,977,526	\$ 255,620,704	\$ 268,592,948	\$ 290,402,295	\$ 305,204,118	\$ 1,363,797,590
Medicaid Pop 4	Children	\$ 495,389,669	\$ 519,244,077	\$ 545,750,301	\$ 590,238,158	\$ 620,772,548	\$ 2,771,394,754
Medicaid Pop 5	DD Waiver	\$ 434,439,279	\$ 433,191,764	\$ 457,088,774	\$ 496,371,206	\$ 520,541,119	\$ 2,341,632,142
Medicaid Pop 6	LTC	\$ 912,768,880	\$ 946,886,510	\$ 985,898,240	\$ 1,056,510,763	\$ 1,100,574,749	\$ 5,002,639,142
Medicaid Pop 7	MN Dual	\$ 39,567,879	\$ 41,360,604	\$ 43,433,731	\$ 46,932,439	\$ 49,389,018	\$ 220,683,670
Medicaid Pop 8	MN Non Dual	\$ 29,241,209	\$ 30,498,011	\$ 31,955,518	\$ 34,452,876	\$ 36,175,501	\$ 162,323,115
Medicaid Pop 9	Waiver	\$ 176,139,615	\$ 185,454,775	\$ 196,191,243	\$ 213,603,074	\$ 224,583,645	\$ 995,972,351
Pool 1	UC Pool : HCAIP	\$ 41,000,000	\$ 41,000,000	\$ 41,000,000	\$ 41,000,000	\$ 41,000,000	\$ 205,000,000
Pool 2	UC Pool : BCCH/LPH	\$ 39,856,550	\$ 29,856,550	\$ 19,856,550	\$ 9,856,550	\$ -	\$ 99,426,200
Pool 3	DSRIP	\$ -	\$ 10,000,000	\$ 20,000,000	\$ 30,000,000	\$ 39,856,550	\$ 99,856,550
Pilot 1	Social Security Alternative Pilot	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Pilot 2	SSI Employment Support Pilot	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Pilot 3	Health Account Pilot	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TOTAL - Original		\$ 2,837,559,218	\$ 2,943,065,958	\$ 3,088,209,159	\$ 3,332,941,872	\$ 3,492,037,353	\$ 15,693,813,561

With-Waiver Total Expenditures - Amendment²

		DEMONSTRATION YEARS					TOTAL
		CY13	CY14	CY15	CY16	CY17	
Medicaid Pop 1	ABD/SD Dual	\$ 48,579,348	\$ 51,255,157	\$ 54,335,409	\$ 59,281,166	\$ 62,647,147	\$ 276,098,228
Medicaid Pop 2	ABD/SD Non Dual	\$ 376,599,264	\$ 393,887,201	\$ 419,209,487	\$ 459,166,659	\$ 486,074,254	\$ 2,134,936,864
Medicaid Pop 3	Adults	\$ 243,977,526	\$ 255,620,704	\$ 268,592,948	\$ 290,402,295	\$ 305,204,118	\$ 1,363,797,590
Medicaid Pop 4	Children	\$ 495,389,669	\$ 519,244,077	\$ 545,750,301	\$ 590,238,158	\$ 620,772,548	\$ 2,771,394,754
Medicaid Pop 5	DD Waiver	\$ 434,439,279	\$ 433,191,764	\$ 457,088,774	\$ 496,371,206	\$ 520,541,119	\$ 2,341,632,142
Medicaid Pop 6	LTC	\$ 912,768,880	\$ 946,886,510	\$ 985,898,240	\$ 1,056,510,763	\$ 1,100,574,749	\$ 5,002,639,142
Medicaid Pop 7	MN Dual	\$ 39,567,879	\$ 41,360,604	\$ 43,433,731	\$ 46,932,439	\$ 49,389,018	\$ 220,683,670
Medicaid Pop 8	MN Non Dual	\$ 29,241,209	\$ 30,498,011	\$ 31,955,518	\$ 34,452,876	\$ 36,175,501	\$ 162,323,115
Medicaid Pop 9	Waiver	\$ 176,139,615	\$ 185,454,775	\$ 196,191,243	\$ 213,603,074	\$ 224,583,645	\$ 995,972,351
Pool 1	UC Pool : HCAIP	\$ 41,000,000	\$ 41,000,000	\$ 41,000,000	\$ 41,000,000	\$ 41,000,000	\$ 205,000,000
Pool 2	UC Pool : BCCH/LPH	\$ 39,856,550	\$ 39,856,550	\$ 29,856,550	\$ 19,856,550	\$ 9,856,550	\$ 139,282,750
Pool 3	DSRIP	\$ -	\$ -	\$ 10,000,000	\$ 20,000,000	\$ 30,000,000	\$ 60,000,000
Pilot 1	Social Security Alternative Pilot	\$ -	\$ 2,198,525	\$ 4,411,358	\$ 4,449,421	\$ 4,464,667	\$ 15,523,971
Pilot 2	SSI Employment Support Pilot	\$ -	\$ 12,010,605	\$ 12,096,960	\$ 12,326,686	\$ 12,418,704	\$ 48,852,955
Pilot 3	Health Account Pilot	\$ -	\$ 600,000	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000	\$ 3,600,000
TOTAL - Amendment		\$ 2,837,559,218	\$ 2,953,064,483	\$ 3,100,820,517	\$ 3,345,591,293	\$ 3,504,702,020	\$ 15,741,737,532

With-Waiver Total Expenditures - Net: Amendment - Original

		DEMONSTRATION YEARS					TOTAL
		CY13	CY14	CY15	CY16	CY17	
Medicaid Pop 1	ABD/SD Dual	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Medicaid Pop 2	ABD/SD Non Dual	\$ -	\$ (4,810,605)	\$ (4,896,960)	\$ (5,126,686)	\$ (5,218,704)	\$ (20,052,955)
Medicaid Pop 3	Adults	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Medicaid Pop 4	Children	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Medicaid Pop 5	DD Waiver	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Medicaid Pop 6	LTC	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Medicaid Pop 7	MN Dual	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Medicaid Pop 8	MN Non Dual	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Medicaid Pop 9	Waiver	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Pool 1	UC Pool : HCAIP	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Pool 2	UC Pool : BCCH/LPH	\$ -	\$ 10,000,000	\$ 10,000,000	\$ 10,000,000	\$ 9,856,550	\$ 39,856,550
Pool 3	DSRIP	\$ -	\$ (10,000,000)	\$ (10,000,000)	\$ (10,000,000)	\$ (9,856,550)	\$ (39,856,550)
Pilot 1	Social Security Alternative Pilot	\$ -	\$ 2,198,525	\$ 4,411,358	\$ 4,449,421	\$ 4,464,667	\$ 15,523,971
Pilot 2	SSI Employment Support Pilot	\$ -	\$ 12,010,605	\$ 12,096,960	\$ 12,326,686	\$ 12,418,704	\$ 48,852,955
Pilot 3	Health Account Pilot	\$ -	\$ 600,000	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000	\$ 3,600,000
TOTAL - Net: Amendment - Original		\$ -	\$ 9,998,525	\$ 12,611,358	\$ 12,649,421	\$ 12,664,667	\$ 47,923,971

Notes

¹ "With-Waiver Total Expenditures - Original" - includes DD LTSS in KanCare for CY14-17.

² "With-Waiver Total Expenditures - Amendment" - SSI Employment Support Pilot includes acute care costs for ABD/SD Non Dual members enrolled in this pilot.

Attachment F: DD LTSS Analysis

	DY1 (CY 2013)	DY2 (CY2014)	DY3 (CY2015)	DY4 (CY2016)	DY5 (CY2017)	Total
DD Without Amendment	\$ 434,439,279	\$ 464,757,090	\$ 490,917,587	\$ 518,910,025	\$ 544,756,492	\$ 2,453,780,475
DD With Amendment	\$ 434,439,279	\$ 433,191,764	\$ 457,088,774	\$ 496,371,206	\$ 520,541,119	\$ 2,341,632,142
Savings	\$ -	\$ 31,565,326	\$ 33,828,814	\$ 22,538,819	\$ 24,215,374	\$ 112,148,332

Attachment G: Pools Summary

	DY1 (CY 2013)	DY2 (CY2014)	DY3 (CY2015)	DY4 (CY2016)	DY5 (CY2017)
UC Pool : HCAIP	\$ 41,000,000	\$ 41,000,000	\$ 41,000,000	\$ 41,000,000	\$ 41,000,000
UC Pool : BCCH/LPH	\$ 39,856,550	\$ 39,856,550	\$ 29,856,550	\$ 19,856,550	\$ 9,856,550
DSRIP	\$ -	\$ -	\$ 10,000,000	\$ 20,000,000	\$ 30,000,000
% UC Pool	100.0%	100.0%	87.6%	75.3%	62.9%
% DSRIP	N/A	N/A	12.4%	24.7%	37.1%
Total	\$ 80,856,550	\$ 80,856,550	\$ 80,856,550	\$ 80,856,550	\$ 80,856,550

Attachment H: Pilots Summary

	DY1 (CY 2013)	DY2 (CY2014)	DY3 (CY2015)	DY4 (CY2016)	DY5 (CY2017)
Social Security Alternative Pilot	\$ -	\$ 2,198,525	\$ 4,411,358	\$ 4,449,421	\$ 4,464,667
SSI Employment Support Pilot	\$ -	\$ 12,010,605	\$ 12,096,960	\$ 12,326,686	\$ 12,418,704
Health Account Pilot	\$ -	\$ 600,000	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000
Total	\$ -	\$ 14,809,130	\$ 17,508,318	\$ 17,776,107	\$ 17,883,371

December 27, 2012

Susan Mosier, M.D.
Medicaid Director
Kansas Department of Health and Environment
900 SW Jackson Ave., Suite 900
Topeka, KS 66612

Dear Dr. Mosier:

This letter is to inform you that Kansas' request for a new section 1115(a) Medicaid demonstration, entitled "KanCare" (Project Number 11-W-00283/7), has been approved by the Centers for Medicare & Medicaid Services (CMS) in accordance with section 1115(a) of the Social Security Act (the Act). This approval is effective from January 1, 2013, through December 31, 2017.

Under this demonstration, Kansas will operate a statewide Medicaid reform effort that expands managed care to most Medicaid state plan populations with physical, behavioral, and long-term care services and support (LTSS). KanCare also provides managed care authority for the state's concurrent section 1915(c) home and community based services (HCBS) waivers, creating the first section 1115(a)/1915(c) combination. KanCare also creates a Safety Net Care Pool in the state, made up of two sub-pools: an Uncompensated Care (UC) Pool and a Delivery System Reform Incentive Payment (DSRIP) Pool.

Below are the primary components of Kansas' comprehensive statewide demonstration request that CMS has approved:

Managed care expansion

Under KanCare, nearly all state plan populations (including some dual eligibles) and individuals eligible through the state's concurrent section 1915(c) waivers will receive all state plan services and home and community-based services (HCBS) (with the exception of the mentally retarded/developmentally disabled (MR/DD) waiver) via a managed care delivery system. The concurrent 1915(c) waivers are: Autism waiver (KS-0476); Physically Disabled waiver (KS-0304); Technology Assisted waiver (KS-4165); Traumatic Brain Injury (KS-4164); Serious Emotional Disturbance waiver (KS-0320); Frail and Elderly waiver (KS-0303); and, Intellectual Disabilities/Developmental Disabilities (ID/DD; MR/DD) waiver (KS-0224). While state plan services for the MR/DD waiver will be provided via managed care beginning with the effective date in this letter, HCBS services for this waiver will continue to be provided on a fee-for-service basis until the state receives approval of section 1115 demonstration and 1915(c) waiver amendments to move these services into managed care. Per the demonstration proposal, CMS does not expect this delivery system change for the ID/DD waiver to occur any sooner than demonstration year 2.

Concurrent section 1115(a)/1915(c) authorities

The CMS is approving this demonstration as a section 1115(a)/1915(c) combination. The 1115(a) demonstration provides the authority to mandate 1915(c) waiver participants into managed care for all services, including HCBS. The concurrent 1915(c) waivers continue to contain eligibility standards, benefit specifications, and reporting requirements; other than the managed care authority provided by the section 1115(a) demonstration, these waivers continue to guide and define the state's HCBS program. Each 1915(c) waiver continues to have its own waiting list (if applicable), defined service package, and expiration date. This letter provides approval only for the section 1115 authority; approval for amendments to the current section 1915(c) waivers is issued separately.

ID/DD Pilot Project

The CMS is approving the request to operate a demonstration year 1 pilot project for individuals on the ID/DD 1915(c) waiver. This pilot project is voluntary, and will allow providers and beneficiaries to become familiar with the benefits of managed care for their HCBS, and will help the MCOs to learn more about the unique needs of this population and program.

Safety Net Care Pool

Beginning January 1, 2013, the state will end its existing supplemental payment programs for hospitals. Under KanCare, the state will operate a safety net care pool, which contains two sub-pools: the UC Pool and the DSRIP Pool. The UC Pool provides support for the uncompensated care costs eligible hospitals experience as a result of providing medical services to Medicaid eligible and uninsured individuals; this pool will operate throughout the demonstration. The DSRIP Pool will provide incentive payments to participating hospitals for the achievement of specified metrics related to reforming the health care delivery system and quality improvement initiatives. The DSRIP Pool will operate in years 2 through 5 of the demonstration.

Program Implementation Beneficiary Protections

Given the significant transition the state is undertaking with the single-day implementation of KanCare (with the exception of HCBS services for the ID/DD 1915(c) waiver), CMS is requiring the state agree to provide a number of beneficiary protections, including:

- Beneficiaries have access to consumer telephone hotlines such as through the enrollment broker, managed care plans, the Ombudsman Program, and choice counseling entities;
- The state will create an Ombudsman Program to assist beneficiaries in the resolution of conflicts with the managed care organizations (MCOs) regarding services, coverage, access, and rights;
- The state will oversee plans of care for beneficiaries in HCBS waiver programs;
- The state has added "good cause" reasons to allow beneficiaries to change managed care plans outside of the open enrollment period;
- The MCO must follow the existing LTSS service plan until the beneficiary either agrees to the revised plan or the issue is resolved through the appeals and fair hearings process;
- The state will conduct a KanCare educational tour during the first 180 days of the demonstration to educate beneficiaries during the transition;
- The state will conduct ride-alongs with each MCO during the first 180 days of implementation to observe the service planning process for each MCO;

- The state is required to maintain and keep current a KanCare website for the lifetime of the demonstration; and,
- The section 1915(c) waivers remain in place and all of the protections in section 1915(c) authority will remain.

In addition to these protections, the state is required to monitor call center statistics and hold regular calls with the MCOs during the first 180 days following implementation. The state must also participate in implementation monitoring calls with CMS for the first 180 days of KanCare, as a supplement to standard demonstration monitoring.

Requests CMS is Not Approving

As CMS staff have discussed with the state, there are also some requests that CMS is not able to approve at this time.

- Kansas requested to include the state's separate title XXI Children's Health Insurance Program (CHIP) in this demonstration. CMS determined that the state could accomplish the changes proposed under KanCare for the CHIP population via amendments to the title XXI state plan. The state agreed to pursue CHIP state plan amendments to implement KanCare for this program.
- The KanCare proposal would have limited the period of time a beneficiary could change plans without cause from the statutory 90 days to 45 days. This proposal raised a number of concerns for CMS, given the movement of vulnerable populations to managed care for the first time, and the state's current lack of a similar 45-day requirement for populations currently in managed care. CMS informed the state that it would not allow the state to limit the choice period to 45 days at this time, but that it might consider such a proposal as a demonstration amendment after the state has experience with the managed care expansion employing the choice period provided for by statute.
- The KanCare proposal included requests for several pilot projects. The state has agreed to pursue these pilot projects as amendments to the demonstration rather than as components of the initial demonstration approval, in order to allow the state and CMS to focus on the managed care implementation at this time.

Our approval of this demonstration is subject to the limitations specified in the enclosed approved expenditure and waiver authorities, and special terms and conditions (STCs). These documents specify the agreement between the Kansas Department of Health and Environment and CMS. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as granted expenditure authority or waived. All requirements of the Medicaid programs as expressed in law, regulation, and policy statement not expressly identified as waived in the waiver authorities shall apply to KanCare.

This approval is also conditioned upon continued compliance with the enclosed STCs which set forth in detail the nature, character, and extent of federal involvement in this demonstration and the state's obligations to CMS, including an evaluation of this demonstration, during the term of

the approval period. This award letter is subject to our receipt of your written acceptance of the award, including the waiver and expenditure authorities and the STCs, within 30 days of the date of this letter.

Your project officer is Ms. Jennifer Sheer, who may be reached at (410) 786-1769 and through e-mail at Jennifer.Sheer@cms.hhs.gov. Ms. Jennifer Sheer is available to answer any questions concerning your section 1115 demonstration. Communications regarding program matters and official correspondence concerning the demonstration should be submitted to Ms. Sheer at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Official communication regarding program matters should be submitted simultaneously to Ms. Jennifer Sheer and Mr. James Scott, Associate Regional Administrator for the Division of Medicaid and Children's Health Operations in the CMS Kansas City Regional Office. Mr. James Scott's contact information is as follows:

Centers for Medicare & Medicaid Services
Kansas City Regional Office
Division of Medicaid and Children's Health Operations
601 East 12th Street
Room 355
Kansas City, MO 64106

We extend our congratulations to you on this award, and we appreciate your cooperation throughout the review process. If you have additional questions, please contact Ms. Jennifer Ryan, Acting Director of the Children and Adults Health Programs Group within the Center for Medicaid and CHIP Services at (410) 786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Marilyn Tavenner
Acting Administrator

Enclosures

Page 5 – Dr. Susan Mosier

cc:

Ms. Cindy Mann, CMCS

Ms. Jennifer Ryan, CMCS

Mr. James Scott, ARA, Kansas City Regional Office

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00283/7

TITLE: KanCare

AWARDEE: Kansas Department of Health and Environment

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

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

I. SERVICE-RELATED EXPENDITURES

1. Expenditures for Additional Services for Individuals with Behavioral Health or Substance Use Disorder Needs. Expenditures for the following services furnished to individuals eligible under the approved state plan and concurrent 1915(c) waivers, pursuant to the limitations and qualifications provided in STC 22 to address behavioral health and substance use disorder needs:

- a. Physician Consultation (Case Conferences);
- b. Personal Care Services; and
- c. Rehabilitation Services.

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

2. Uncompensated Care Pool (UC Pool): Pursuant to STC 68, expenditures for payments to hospitals to defray hospital costs of uncompensated care furnished to Medicaid-eligible or uninsured individuals that meets the definition of "medical assistance" under section 1905(a) of the Act, to the extent that such costs exceed the amounts received by the hospital pursuant to 1923 of the Act.

- 3. Delivery System Reform Incentive Payment (DSRIP) Program:** Expenditures from pool funds for the Delivery System Reform Incentive Payment (DSRIP) Program, pursuant to STC 69, for incentive payments to hospitals for the development and implementation of approved programs that support hospital efforts to enhance access to health care and improve the quality of care. DSRIP incentive payments are not direct reimbursement for service delivery, and may not duplicate other federal funding.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY**

NUMBER: 11-W-00283/7
TITLE: KanCare
AWARDEE: Kansas Department of Health and Environment

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration project beginning the date of the approval letter through December 31, 2017, unless otherwise specified. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

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

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

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

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

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

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00283/7

TITLE: KanCare

AWARDEE: Kansas Department of Health and Environment

I. [PREFACE](#)

The following are the Special Terms and Conditions (STCs) for Kansas' KanCare section 1115(a) Medicaid demonstration (hereinafter "demonstration"). The parties to this agreement are the Kansas Department of Health and Environment (state) and the Centers for Medicare & Medicaid Services (CMS). CMS has granted waivers of requirements under section 1902(a) of the Social Security Act (the Act) which are separately enumerated. These STCs set forth conditions and limitations on those waiver authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. These STCs neither grant additional waiver or expenditure authority, nor expand upon those granted separately. The STCs are effective as of the date of the approval letter unless otherwise specified. This demonstration is approved through December 31, 2017.

The STCs have been arranged into the following subject areas:

- I. [Preface](#)
- II. [Program Description and Objectives](#)
- III. [General Program Requirements](#)
- IV. [Eligibility](#)
- V. [Benefits](#)
- VI. [Cost Sharing](#)
- VII. [KanCare Enrollment](#)
- VIII. [Delivery System](#)
- IX. [Money Follows the Person and HCBS Service Delivery](#)
- X. [Program Implementation Beneficiary Protections](#)
- XI. [Safety Net Care Pool](#)
- XII. [General Reporting Requirements](#)
- XIII. [General Financial Requirements](#)
- XIV. [Monitoring Budget Neutrality](#)
- XV. [Evaluation of the Demonstration](#)
- XVI. [Schedule of State Deliverables](#)
- Attachment A. [Quarterly Report Content and Format](#)
- Attachment B. [Historical Budget Neutrality Data](#)
- Attachment C. [HCAIP Hospitals](#)
- Attachment D. [LPTH/BCCH Hospitals](#)
- Attachment E. [UC Payment Application Template](#)

Attachment F.	<u>DSRIP Planning Protocol</u>
Attachment G.	<u>DSRIP Funding and Mechanics Protocol</u>
Attachment H.	<u>Ombudsman Plan</u>
Attachment I.	<u>Verification of Beneficiary's MCO Enrollment</u>
Attachment J.	<u>UC Pool Uniform Percentages</u>
Attachment K.	<u>DSRIP Pool Focus Areas</u>
Attachment L.	<u>ID/DD Pilot Project</u>

II. PROGRAM DESCRIPTION AND OBJECTIVES

On August 6, 2012, the State of Kansas submitted a Medicaid section 1115 demonstration proposal, entitled KanCare. KanCare will operate concurrently with the state's section 1915(c) Home and Community-Based Services (HCBS) waivers and together provides the authority necessary for the state to require enrollment of almost all Medicaid beneficiaries (including the aged, disabled, and some dual eligibles) across the state into a managed care delivery system to receive state plan and HCBS waiver services. This represents an expansion of the state's previous managed care program, which consisted of HealthWave (managed care organization) and HealthConnect Kansas (primary care case management), and provided services to children, pregnant women, and parents in the state's Medicaid program. KanCare also includes a safety net care pool to support certain hospitals that incur uncompensated care costs for Medicaid beneficiaries and the uninsured, and to provide incentives to hospitals for programs that result in delivery system reforms that enhance access to health care and improve the quality of care.

This five year demonstration will:

- Maintain Medicaid state plan eligibility;
- Maintain Medicaid state plan benefits;
- Allow the state to require eligible individuals to enroll in managed care organizations (MCOs) to receive covered benefits through such MCOs, including individuals on HCBS waivers, except:
 - American Indian/Alaska Natives will be presumptively enrolled in KanCare but will have the option of affirmatively opting-out of managed care.
- Provide benefits, including long-term services and supports (LTSS) and HCBS, via managed care; and
- Create a Safety Net Care Pool to support hospitals that provide uncompensated care to Medicaid beneficiaries and the uninsured.

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

- Provide integration and coordination of care across the whole spectrum of health to include physical health, behavioral health, mental health, substance use disorders and LTSS.
- Improve the quality of care Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes);
- Control Medicaid costs by emphasizing health, wellness, prevention and early detection as well as integration and coordination of care; and
- Establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms as well.

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

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 by providing additional HCBS and supports to beneficiaries that allow them

- to move out of an institutional setting when appropriate and desired;
3. The state will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health, mental health, substance use disorder, and LTSS; and
 4. KanCare will provide integrated care coordination to individuals with developmental disabilities, which will improve access to health services and improve the health of those individuals.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid and Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP for the separate CHIP population, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.
3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly identified as not applicable.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
 - b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** If a population eligible through the Medicaid state plan or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the state plan may be required, except as otherwise noted in these STCs.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
- a. An explanation of the public process used by the state, consistent with the requirements of STC 14, to reach a decision regarding the requested amendment;
 - b. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - c. An up-to-date CHIP allotment neutrality worksheet, if necessary;
 - d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, including a conforming title XIX and/or title XXI state plan amendment, if necessary; and
 - e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.
8. **Extension of the Demonstration.**
- a. States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 12 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of STC 9.
 - b. Compliance with Transparency Requirements 42 CFR Section 431.412: Effective April 27, 2012, as part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in STC 14, as well as include the following supporting documentation:
 - i. Historical Narrative Summary of the Demonstration Project: The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide

evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

- ii. Special Terms and Conditions (STCs): The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.
- iii. Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.
- iv. Quality: The state must provide summaries of: External Quality Review Organization (EQRO) reports; managed care organization (MCO) reports; state quality assurance monitoring; and any other documentation that validates of the quality of care provided or corrective action taken under the demonstration.
- v. Financial Data: The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.
- vi. Evaluation Report: The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.
- vii. Documentation of Public Notice (42 CFR section 431.408): The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

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

- a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment (SPA). Once the 30-day public comment period has ended, the state must provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.
- b. The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.
- c. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- d. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
- e. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the state has materially failed to comply with the terms of the

project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.
12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.
13. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.
14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the state public notice process for Section 1115 demonstrations at 42 C.F.R. §431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC6, are proposed by the state.

In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 C.F.R. §431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **Post Award Forum.** Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a

prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in STC79, associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in STC80.

16. **Federal Financial Participation (FFP).** No federal matching for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY

Under the KanCare demonstration, there is no change to Medicaid eligibility. Standards for eligibility remain set forth under the state plan, and eligibility for the state's HCBS waiver programs is set forth in the concurrent approved 1915(c) waivers. Medicaid state plan services and 1915(c) services are delivered through a statewide comprehensive managed care delivery system through managed care organizations (MCOs). Most beneficiaries eligible under the state plan and all beneficiaries eligible for home and community based services provided through the concurrent 1915(c) waivers are required to enroll in MCOs to obtain covered benefits. The state plan and 1915(c) waiver populations, as identified below, are affected by the demonstration through the requirement to enroll in the Medicaid managed care program under the demonstration in order to receive state plan and, if eligible, 1915(c) waiver services. Full benefit dual eligibles are covered under this demonstration for Medicaid services.

17. Eligibility Groups Affected By the Demonstration. The following charts describe the mandatory and optional state plan populations, and the 1915(c) waiver populations affected by this demonstration. Income and resources standards in the tables in STC 17(a) and (b) are intended to reflect those in the approved state plan; eligibility authority for these state plan populations resides in the state plan. Should the state amend the state plan to make any changes to eligibility for the populations listed in STC 17(a) and (b), upon submission of the state plan amendment, the state must notify CMS demonstration staff in writing of the pending state plan amendment, and request corresponding technical corrections to the tables in STC 17(a) and (b). These corresponding technical corrections would not take effect until the approval of the state plan amendment.

a. Medicaid State Plan Mandatory Populations

State Plan Mandatory Medicaid Eligibility Groups	Description	FPL	Resource Standard	Medicaid Eligibility Group (MEG)
POVERTY LEVEL RELATED PREGNANT WOMEN	1902(a)(10)(A)(i)(IV) 1902(l)(1)(A)	150%	N/A	Adults
POVERTY LEVEL RELATED CHILDREN				
<i>Infants Less than one year old</i>	1902(a)(10)(A)(i)(IV) 1902(l)(1)(B)	150%	N/A	Children
<i>Children ages 1 through 5 years</i>	1902(a)(10)(A)(i)(VI) 1902(l)(1)(C)	133%	N/A	Children
<i>Children ages 6 through 18 years</i>	1902(a)(10)(A)(i)(VII) 1902(l)(1)(D)	100%	N/A	Children
<i>Permanent custodianship subsidy</i>	This program is for children age 14 to 18 years old that are in state custody, are not receiving SSI benefits, and have a permanent qualifying custodian. The child will receive coverage through the Foster Care Medical program.			Children
<i>Deemed Newborns</i>	1902(e)(4)	Children born to a Medicaid mother	N/A	Children
LOW INCOME FAMILIES WITH CHILDREN	1902(a)(10)(A)(i)(I) 1931	Approximately 30% (State's 7/16/1996 AFDC payment standards by family size)	N/A	Children Adults

State Plan Mandatory Medicaid Eligibility Groups	Description	FPL	Resource Standard	Medicaid Eligibility Group (MEG)
TRANSMED – WORK TRANSITION (Transitional Medical Assistance (TMA))	1902(a)(10)(A)(i)(I) 408(a)(11)(A)1925 1931(c)(2)	Coverage for up to 12 months 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, increase in working hours, or loss of time-limited earned income disregard. Income must exceed guidelines for Low Income Families with Children program.	N/A	Children Adults
EXTENDED MEDICAL	1902(a)(10)(A)(i)(I) 408(a)(11)(B) 1931 (c) (1)	Coverage for 4 months 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. Income must exceed guidelines for Low Income Families with Children program.	N/A	Children Adults
FOSTER CARE MEDICAL (IV-E)	1902(a)(10)(A)(i)(I) 473(b)(3)	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 custody, and placed with an individual, family or institution.	N/A	Children
ADOPTION SUPPORT MEDICAL (IV-E)	1902(a)(10)(A)(i)(I) 473(b)(3)	This program is for adopted children with special needs who were in state custody and meet the eligibility criteria for federal participation in the IV-E adoption support program.	N/A	Children

State Plan Mandatory Medicaid Eligibility Groups	Description	FPL	Resource Standard	Medicaid Eligibility Group (MEG)
SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS	1902(a)(10)(A)(i)(II) 1619(a) 1619(b) 1905(q)	\$698/month (single) \$1,048/month(couple)	\$2,000 (single) \$3,000 (couple)	ABD/SD Dual ABD/SD Non Dual
PICKLE AMENDMENT	Section 503 of P.L. 94-566		\$2,000 (single) \$3,000 (couple)	MN Dual MN Non Dual
ADULT DISABLED CHILD	1634(c) Section 1939		\$2,000 (single) \$3,000 (couple)	MN Dual MN Non Dual
EARLY OR DISABLED WIDOWS AND WIDOWERS	1634(b) 1935 (Disabled Widow/ers) 1634(d) 1935 (Early Widow/ers)		\$2,000 (single) \$3,000 (couple)	MN Dual MN Non Dual
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. (1902(a)(10)(A)(ii)(V))	300 % \$62/month Personal Need Allowance	N/A	Children

b. Medicaid State Plan Optional Populations

State Plan Optional Medicaid Eligibility Groups	Description	FPL	Resource Standard	MEG
FOSTER CARE MEDICAL (NON IV-E)	This program is for children under age 21 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 custody, and placed with an individual, family or institution.	State's 7/16/1996 AFDC payment standards by family size	n/a	Children
FOSTER CARE MEDICAL (AGED OUT)	1902(a)(10)(A)(ii)(XVII)	No income test. This program is for children transitioning to adult independent living who are being removed from the Foster Care Medical program because they are turning 18 years old. Medicaid coverage may continue through age 21.	n/a	Children
ADOPTION SUPPORT MEDICAL (NON IV-E)	1902(a)(10)(A)(ii)(VIII)	This program is for adopted children with special needs receiving non-IV-E state adoption assistance who do not meet the eligibility criteria for federal participation in the IV-E adoption support program and met the Medicaid eligibility requirements at the time of adoption and are under age 21.	n/a	Children

State Plan Optional Medicaid Eligibility Groups	Description	FPL	Resource Standard	MEG
MEDICALLY NEEDED	1902(a)(10)(C)	\$475/month (single and couple)	\$2,000 (single) \$3,000 (couple)	MN Dual MN Non Dual ABD/SD Dual ABD/SD Non Dual
BREAST AND CERVICAL CANCER	1902(a)(10)(A)(ii)(XVIII)	N/A	N/A	Adults
WORKING HEALTHY	1902(a)(10)(A)(ii)(XV)	\$2,793/month (single) \$3,783/month (couple)	\$15,000 (single and couple)	ABD/SD Non Dual
WORKING HEALTHY MEDICALLY IMPROVED	1902(a)(10)(A)(ii)(XVI)	\$2,793/month (single) \$3,783/month (couple)	\$15,000 (single and couple)	ABD/SD Non Dual
LONG TERM INSTITUTIONAL CARE	1902(a)(10)(A)(ii)(V) Except for individuals residing in a public ICF/MR	300% SSI \$62/month Personal Needs Allowance	\$2,000	LTC

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

Waiver Eligible Groups	Description	Personal Needs Allowance	Resource Standard	MEG
<i>Autism Waiver</i>	1902(a)(10)(A)(ii)(VI)	\$727/month	\$2,000	Waiver
<i>Intellectual Disabilities/Developmental Disabilities</i>	1902(a)(10)(A)(ii)(VI)	\$727/month	\$2,000	DD Waiver
<i>Frail Elderly</i>	1902(a)(10)(A)(ii)(VI)	\$727/month	\$2,000	LTC
<i>Physically Disabled</i>	1902(a)(10)(A)(ii)(VI)	\$727/month	\$2,000	LTC
<i>Technology Assisted</i>	1902(a)(10)(A)(ii)(VI)	\$727/month	\$2,000	Waiver
<i>Traumatic Brain Injury</i>	1902(a)(10)(A)(ii)(VI)	\$727/month	\$2,000	Waiver
<i>Serious Emotional Disturbance</i>	1902(a)(10)(A)(ii)(VI)	\$727/month	\$2,000	Waiver

- i. Individuals on the section 1915(c) waiver waiting lists who are not otherwise eligible for Medicaid through the approved state plan are excluded from the demonstration.

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

- a. **American Indians/Alaska Natives (AI/AN):** The AI/AN population will be automatically enrolled in managed care under the demonstration. This population will have the ability to opt out of managed care at the beneficiary's discretion. The state will use the definition of Indian provided at 42 CFR 447.50.

19. **Eligibility Exclusions.** Notwithstanding STC 17, the following populations are excluded from this demonstration.

Exclusions from KanCare	Description	FPL	Resource Standard
Aliens eligible for emergency services only	1903(v)(3)	Varies depending on eligibility category.	Varies depending on the specific underlying medical program.
QUALIFIED MEDICARE BENEFICIARY (QMB), not otherwise Medicaid eligible	1902(a)(10)(E)(i) 1905(p)(1)	100%	\$6,940 (single) \$10,410 (couple)
SPECIAL LOW-INCOME MEDICARE BENEFICIARY (LMB) not otherwise Medicaid eligible	1902(a)(10)(E)(iii) 1902(a)(10)(E)(iii)	120%	\$6,940 (single) \$10,410 (couple)
EXPANDED SPECIAL LOW-INCOME MEDICARE BENEFICIARY (E-LMB)	1902(a)(10)(E)(iv)(I)	135%	\$6,940 (single) \$10,410 (couple)
PROGRAM OF ALL-INTENSIVE CARE FOR THE ELDERLY (PACE)	1934	\$62/month (institution) \$727/month (HCBS)	\$2,000
LONG TERM INSTITUTIONAL CARE Individuals residing in a public ICF/MR	1902(a)(10)(A)(ii)(V)	300% SSI \$62/month Personal Needs Allowance	\$2,000

Exclusions from KanCare	Description	FPL	Resource Standard
RESIDENTS OF MENTAL HEALTH NURSING FACILITIES	1902(a)(10)(A)(ii)(V)	\$62/month	\$2,000

20. **Presumptive Eligibility.** The state will operate presumptive eligibility as specified in its approved state plan. The state must notify CMS of any upcoming changes to presumptive eligibility during the bimonthly monitoring calls and in the quarterly reports as required under STCs 78 and 79.

V. **BENEFITS**

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

- a. KanCare Benefits. All populations outlined in STC 17 are entitled to receive all mandatory and optional services under the approved Medicaid state plan, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for children up to age 21. These Medicaid state plan benefits are provided through KanCare MCOs in at least the same amount, duration and scope that services are provided through the state plan. Individuals enrolled in the following 1915(c) waiver programs will also receive 1915(c) waiver services authorized through the waiver program from the KanCare MCO in which they are enrolled:
 - i. Autism waiver KS-0476
 - ii. Physically Disabled waiver KS-0304
 - iii. Technology Assisted waiver KS-4165
 - iv. Traumatic Brain Injury Waiver KS-4164
 - v. Serious Emotional Disturbance Waiver KS 0320
 - vi. Frail and Elderly Waiver KS-0303
- b. KanCare FFS benefits. The waiver services authorized through the Intellectual Disabilities/Developmental Disabilities (ID/DD)(MR/DD) waiver KS-0224 and state plan Targeted Case Management (TCM) and screening services are carved out from the Medicaid MCO benefit package and are paid on a FFS basis. The state must submit, and receive CMS approval of 1115 and 1915(c) amendments to include waiver services in the MCO benefit package.

22. **Additional Services.** In addition to the benefits described in STC 21, KanCare MCOs will provide the following services to certain populations below.

- a. Additional services covered in the demonstration

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

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

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

VI. COST SHARING

24. Co-Payments. No individuals enrolled in managed care under this demonstration (see STC 19) will be required to make any co-payments.

- a. The state may increase KanCare copayments up to the amount authorized under the state plan provided that the state informs CMS in writing at least 60 days prior to the implementation of the revised co-payments. Any changes to co-payments above those authorized under the state plan are subject to the amendment process specified in STC 7 and the public notice process specified in STC 14.

25. Premiums. Premiums will be limited to those authorized under the state plan.

- a. Any changes to the KanCare premiums are subject to the amendment process specified in STC 7 and the public notice process specified in STC 14.

26. AI/AN Cost Sharing Protections. All cost-sharing protections in statute, regulation, and policy apply to the AI/AN population under this demonstration.

VII. KANCARE ENROLLMENT

27. **KanCare Enrollment Process.**

- a. Initial Enrollment for January 1, 2013. The state will pre-select an MCO for each KanCare member. That pre-selection shall be based on the principles set forth in 42 CFR 438.52(f), taking into account the MCO affiliation of the member's historic providers. Once the member is advised of the state's pre-selection, the member will have at least 30 days to choose another MCO prior to the enrollment effective date. If a different MCO is not selected during that time period, the member will be enrolled into the pre-selected MCO where they will then have 90 days to change MCOs without cause.
- b. Enrollment Process after January 1, 2013. All individuals must have the opportunity to make an active selection of a KanCare MCO during the application process. If no MCO is selected, the state will pre-select an MCO for each KanCare member and enroll the individual in that MCO. That pre-selection shall be based on the principles set forth in 42 CFR 438.52(f), taking into account the MCO affiliation of the individual's historic providers, with a prior history with the MCO being taken into account first.
- c. Additional Enrollment Supports for Beneficiaries using LTSS. For individuals residing in a nursing facility or other residential facility, the nursing or residential facility will be used first to determine the selection of a KanCare MCO. For individuals using HCBS providers at the time of enrollment, the selection process must be customized to the specific waiver with specific attention paid to the types of providers critical to positive outcomes of the individuals within each of the waivers. All individuals enrolled in one of the 1915(c) waivers in STC 21 at the time of KanCare enrollment must have the opportunity to receive counseling from an independent options counselor to assist them in making an MCO selection and switching MCOs if desired.
- d. Enrollment Broker. The state will contract with an independent entity to assist beneficiaries with the Medicaid managed care enrollment and plan selection process.

28. **KanCare Disenrollment.** Individuals must be informed at least annually of their opportunity to change MCOs. Within 90 days of their initial enrollment into an MCO, individuals must be permitted to change MCOs without cause. After that time period, MCO changes are permitted for cause only.

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

- a. MLTSS Service Planning Dissatisfaction. Members with an existing LTSS service

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

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

VIII. DELIVERY SYSTEM

30. **Managed Care Requirements.** The state must comply with the managed care regulations published at 42 CFR 438. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR 438.6. The certification shall identify historical utilization of state plan and HCBS services used in the rate development process.
31. **Managed Care Benefit Package.** Individuals enrolled in any managed care program within the state must receive from the managed care program the benefits as identified in Section V of the STCs. Benefits should be delivered and coordinated in an integrated fashion, using an interdisciplinary care team, to coordinate all physical, behavioral, acute and long-term services and supports. The state must require that each MCO refer and/or coordinate enrollees' access to needed services that are excluded from the managed care delivery system but available through a fee-for-service (FFS) delivery system.
32. **Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of such contracts and/or contract amendments. The state shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 45 days to review and approve changes. If changes to contracts are needed based on CMS approval of initial or amended STCs, the state must submit amended contracts within 60 days of approval of the demonstration documents. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.
33. **Public Contracts.** Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).
34. **Network Requirements.** The state must deliver all covered benefits, ensuring high quality care. Services must be delivered in a culturally competent manner, and the MCO network must be sufficient to provide access to covered services. In addition, the MCO must coordinate health care services for demonstration populations. The following requirements must be included in the state's MCO contracts:
- a. Special Health Care Needs. Enrollees with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 CFR 438.208(c)(4).
 - b. Out of Network Requirements. The state, through its contracts with the KanCare MCOs, will require the MCOs to provide out of network benefits in the following situations:
 - i. Each MCO must allow access to non-network providers when services cannot be provided consistent with the timeliness standards required by the

state.

- ii. During the transition of beneficiaries into KanCare MCOs on January 1, 2013, for any provider seen by the beneficiary within the previous 6 months prior to transition, MCOs will allow access to that provider within the first 90 days, even on a non-network basis.
- iii. During the transition of beneficiaries into KanCare MCOs on January 1, 2013, enrollees using LTSS providers will be allowed to see all current providers on their approved service plan, even on a non-network basis, for 180 days or until a service plan is completed and either agreed upon by the enrollee or resolved through the appeals or fair hearing process, and implemented. Enrollees using residential providers will be permitted to access those providers for up to 1 year.

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

36. Demonstrating Network Adequacy. Annually, each MCO must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of preventive, primary, pharmacy, specialty, acute, and HCBS services for the anticipated number of enrollees in the service area.

- a. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:
 - i. The number and types of preventive, primary, pharmacy, specialty, acute, and HCBS providers available to provide covered services to the demonstration population;
 - ii. The number of network providers accepting the new demonstration population; and
 - iii. The geographic location of providers and demonstration populations, as shown through GeoAccess or similar software.

- b. The state must submit the documentation required in subparagraphs i – iii above, to CMS with each contract renewal or renegotiation, or at any time that there is a significant impact to each MCO’s operation, including service area reduction and/or population expansion.

37. Comprehensive State Quality Strategy. The state shall adopt and implement a comprehensive and holistic, continuous Quality Improvement Strategy that focuses on all aspects of quality improvement in KanCare including acute, primary, behavioral and long term services and supports. The Quality Strategy shall meet all the requirements of 42 CFR 438 Subpart D and must include components relating to HCBS that address the following: administrative authority, level of care determinations, person-centered service planning process and outcome of person-centered goals, health and welfare, and qualified providers. The Quality Strategy must include State Medicaid Agency and MCO responsibilities, with the State Medicaid Agency retaining ultimate authority and accountability for ensuring the quality of and overseeing the operations of the program. The Quality strategy must include distinctive components for discovery, remediation, and improvement. The state must revise their Comprehensive Quality Strategy whenever significant changes are made, including changes through this demonstration and consistent with STC 45. The revisions to the Comprehensive Quality Strategy resulting from the section 1915(c) amendments required under STC 45 must be submitted to CMS for review and approval within 90 days of approval of the STC 45 waiver amendments. The state must obtain the input of beneficiaries and other stakeholders in the development of its revised comprehensive Quality Strategy and make the Strategy available for public comment. Pursuant to STC 80, the state must also provide CMS with annual reports on the implementation and effectiveness of their comprehensive Quality Strategy as it impacts the demonstration.

38. Required Monitoring Activities by State and/or External Quality Review Organization (EQRO). The state’s EQRO process shall meet all the requirements of 42 CFR 438 Subpart E. In addition, the state, or its EQRO having sufficient experience and expertise and oversight by the State Medicaid Agency, shall monitor and annually evaluate the MCOs’ and/or contracting entities’ performance on requirements under the 1915(c) waivers in STC 21. These include but are not limited to the following:

- a. Level of care determinations – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with LTSS have been assessed to meet the required level of care for those services.
- b. Person-centered plans – to ensure that MCOs are appropriately creating and implementing person-centered plans based on enrollee’s identified needs.
- c. MCO credentialing and/or verification policies – to ensure that HCBS services are provided by qualified providers.
- d. Health and welfare of enrollees – to ensure that the MCO, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

39. **State Advisory Committee.** The state must maintain for the duration of the demonstration, a public managed care advisory group comprised of individuals, interested parties, and stakeholders impacted by the demonstration's use of managed care, regarding the impact and effective implementation of these changes. Membership on this group should be periodically updated to ensure adequate representation of individuals receiving LTSS as well as other eligibility groups. The state shall maintain minutes from these meetings and use them in evaluating program operations and identifying necessary program changes. Copies of committee meeting minutes must be made available to CMS upon request and the outcomes of the meetings may be discussed on the bimonthly demonstration calls in STC 78.
40. **MCO Participant Advisory Committees.** The state shall require each MCO, through its contracts, to create and maintain participant advisory committees through which the MCO can share information and capture enrollee feedback. The MCOs will be required to support and facilitate participant involvement and submit meeting minutes to the state. Copies of meeting minutes must be made available to CMS upon request.
41. **Independent Ombudsman Program.** For the lifetime of the demonstration, a qualified independent, conflict-free entity will assist KanCare enrollees in the resolution of problems and conflicts between the MCOs and participants regarding services, coverage, access and rights. The independent Ombudsman program must exist outside of the Kansas Department of Health and Environment. The Ombudsman should help participants understand the fair hearing, grievance, and appeal rights and processes at each MCO and proactively assist them through the process if needed. Ombudsman activities are available to all demonstration eligible populations, but specific focus and outreach activities will be directed towards KanCare enrollees utilizing LTSS (institutional, residential and community based). The state will report on the Ombudsman program and activities in the quarterly and annual reports per STCs 79 and 80. The state will share with CMS copies of any Ombudsman reports submitted to the state legislature within 2 weeks of submission to the legislature. Please see Attachment H for additional information on the Ombudsman Plan. Changes to Attachment H must be submitted to CMS for review and approval prior to implementation, but are not subject to the amendment process outlined in STC 7. The state will evaluate the impact of the Ombudsman program in the demonstration evaluation per STC 103.
42. **KanCare Website.** The state must maintain and keep current a KanCare website for the lifetime of the demonstration. The website should include the approved or proposed program design features, descriptions of eligibility and enrollment processes, options for choice counseling, and an area for beneficiaries and stakeholders to provide input on the program design and implementation. The state must also publish information about its program operations and outcomes at least annually. The state must ensure that all information on this website is presented in an easily accessible manner (language, reading level), including for individuals with disabilities, in order to support beneficiaries in making decisions about their plans, providers, and care. The state must make this information available in hard copy upon request. MCO-specific information should be included in the information that is considered public and is regularly published.

IX. MONEY FOLLOWS THE PERSON AND HCBS SERVICE DELIVERY

43. **Money Follows the Person (MFP).** Beneficiaries enrolled in the state's MFP program are included in this demonstration. MFP grant funds must pay for MFP services for MFP-eligible participants. Within 30 days of approval of the demonstration, the state must submit a revised MFP Operational Protocol for CMS approval. This revised protocol must specify how MFP services will be delivered consistent with the demonstration. The protocol must ensure no duplication of federal funds, specify the state's expenditure claiming process for MFP and the demonstration, and outline how the two programs will coordinate to increase opportunities for eligible individuals to access HCBS upon discharge from hospitals, nursing facilities (NFs), and intermediate care facilities for persons with intellectual and developmental disabilities (ICFs/IDD) as an alternative to institutional services.
- a. Expenditure Claiming Process. When submitting the revised operational protocol, the state must describe how the state will determine the percentage of its capitated payment that is for qualified HCBS provided to MFP participants for purposes of the enhanced FMAP. The state must include in the protocol:
 - i. Assurance that the claiming process will be used to report the qualified HCBS expenditures for MFP participants on the ABDC and 64i MFP reports.
 - ii. Will require the MCOs to provide the necessary encounter data for MFP participants to the state.
 - iii. Will submit the information to CMS in the required timeframes in the protocol.
44. **MFP Benchmark Targets.** The state will assure that the MCOs, through their contract requirements, meet the annual transition benchmarks in the Kansas Money Follows the Person grant. The state shall report on the progress of the MCOs meeting these requirements in their annual reports pursuant to STC 80as well as in the MFP semi-annual reports. CMS encourages the state to consider developing policies within the managed care model to incentivize the MCOs to help the state meet or exceed their MFP benchmarks or consumer direction goals.
45. **HCBS Quality.** Within 12 months of implementation, the State Medicaid Agency will submit revisions to the 1915(c) waivers (KS-0476, KS-0304, KS-4165, KS-4164, KS-0320 and KS-0303) to incorporate performance measures that are reflective of services delivered in a managed care delivery system, taking into account a holistic approach to care. The revised performance measures should focus on outcomes, quality of life, effective processes, as well as community integration for those individuals enrolled in the HCBS waivers. The state should ensure that measures in each waiver address each assurance as outlined in the waiver, but also look across the 1915(c) waivers to show consistencies in measures where appropriate. In the interim time period, the state will have flexibility in merging existing quality monitoring practices and protocols into the Comprehensive State Quality Strategy

addressed at STC 37, and reporting the results of that strategy in connection with HCBS waiver service oversight and monitoring. The management of this merger will be included in the quarterly reports addressed at STC 79 during this 12 month period.

46. **Earmarked Cost Savings.** The State Medicaid Agency will designate a portion of savings achieved through the implementation of the KanCare 1115 to increase the number of slots in the 1915(c) waivers to move individuals currently on the waiting list to HCBS, subject to state legislature appropriations. The state shall report to CMS on the progress of individuals receiving HCBS services in their annual report pursuant to STC 77. In this report the state must include: the total number of individuals on the waiting list; the number of people that have moved off the waiting list and the reason; the number of people that are new to the waiting list; and the number of people that are on the waiting list, but receiving community-based services through the managed care delivery system.

47. **Service Planning Firewalls.** The State Medicaid Agency ensures:
 - a. There are clear conflict-free guidelines for contracted entities participating in the service planning process so that these entities offer choices to the participant regarding the services and supports they receive and from available alternatives;
 - b. Includes a method for the participant to request changes to the service plan;
 - c. Records the alternative HCBS and settings that were considered by the participant; and
 - d. Grants beneficiaries the fair hearing and appeal rights provided for under Medicaid statute, regulation, and policy.

48. **Participant-Direction.** The State Medicaid Agency, either directly or through its contracts with its MCOs and level of care enrollment entities, educates LTSS participants about the opportunity to self-direct their services and MCOs will provide adequate supports to help beneficiaries be successful in self-directing their services. Both Level of Care and Service Planning personnel will receive training to ensure they can offer participants sufficient information to make an informed choice on their option to self-direct and/or use MFP as a vehicle to transition into the community.

49. **Critical Incident Management System.** The State Medicaid Agency or the MCO operates a critical incident management system according to the State Medicaid Agency's established policies, procedures and regulations. On an ongoing basis the State Medicaid Agency ensures that all entities, including the MCOs, prevent, detect, report, investigate, and remediate instances of abuse, neglect and exploitation, and ensures participant rights are maintained through policies concerning seclusion, restraint, and medication management. MCOs, providers and participants are educated about this system initially at the start or at hire, and at least annually thereafter. MCO and provider obligations include specific action steps that MCOs and providers must take in the event of suspected or substantiated abuse, neglect or exploitation, including risk mitigation. If the State Medicaid Agency delegates the

responsibility for the critical incident management systems to the participating MCOs, the State Medicaid Agency must collect and analyze the data collected by the MCOs on a regular, periodic basis, and ensure that individual situations are remediated in a timely manner and that system-wide issues are identified and addressed.

50. **HCBS Settings and Community Integration.** Services shall be provided in a setting that has a home-like character by providing full access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas, and visitors at times convenient for the participant. The settings/services support community integration, including facilitation of employment and easy access to resources and activities in the community. HCBS LTSS are not provided in institution-like settings except when such settings are employed to furnish short term respite to participants. The state, either directly or through its MCO contracts, must ensure that:(1) all participants receive appropriate services in the least restrictive and most integrated home and community-based setting, in accordance with CMS community-based setting requirements outlined in the proposed regulatory text at 42 CFR 441.530; and (2) all participants' engagement and community integration is supported and facilitated to the fullest extent desired by each participant and reflected in the member's service plan. The state must ensure that all HCBS settings comply with any revisions to Medicaid regulations.
51. **HCBS Authority.** The 1915(c) waivers of KS-0224, KS-0476, KS-0304, KS-4165, KS-4164, KS-0320 and KS-0303 will continue to be the authority under which HCBS operates until such time the State Medicaid Agency requests and receives approval of an 1115 amendment to incorporate the 1915(c) services into the section 1115 demonstration. The state should follow the section 1915(c) amendment process to make alterations to its HCBS waivers. The state must notify CMS demonstration staff in writing of any proposed amendments to the section 1915(c) waivers concurrently with the submission of the section 1915(c) amendment.
52. **ID/DD Pilot Project.** During demonstration year 1, the state will operate a pilot project for individuals in the section 1915(c) ID/DD waiver (KS-0224). This pilot project is completely voluntary for beneficiaries and their providers. Both the beneficiary and at least one of the beneficiary's providers must elect to participate in this pilot project in order for participation to occur. In accordance with STC 21(b), HCBS services for individuals participating in this pilot project are paid on a FFS basis, and are carved out of managed care. This pilot project will help providers and beneficiaries become more familiar with the MCOs, and will help the MCOs to become more familiar with the needs of individuals served through the ID/DD waiver. This will occur through enhanced communication and care coordination between the beneficiary, the ID/DD providers, and the MCOs. Participating beneficiaries will also receive some value added services from the MCOs that do not meet the waiver definition of HCBS services (see Attachment L). Attachment L provides a more detailed overview of this pilot project. Changes to Attachment L must be submitted to CMS for review and approval prior to implementation, but are not subject to the amendment process outlined in STC 7. The state will report on the ID/DD Pilot Project during the monitoring calls in STC 78, and in the quarterly and annual reports in STCs 79 and 80. The state must also include an evaluation of the DD Pilot Project in the demonstration evaluation design required per STC 103.

X. PROGRAM IMPLEMENTATION BENEFICIARY PROTECTIONS

The KanCare demonstration is a comprehensive reform for the state's Medicaid program. The beneficiary protections below reflect the discussions between CMS and the state regarding continuity of care and ensuring a smooth transition for beneficiaries. To provide for a smooth transition for beneficiaries, the state has assured CMS, through the submission of pre-implementation reports, that: there is a coordinated approach to the call centers serving KanCare beneficiaries; a timely and efficient billing process will be established; and the state will continue education and outreach activities for at least the first 180 days of the demonstration.

- 53. Attempts To Gain an Accurate Beneficiary Address.** The state will complete return mail tracking after first enrollment notification mailing and throughout the first 90 days of implementation. The state will use information gained from return mail to make additional outreach attempts through other methods (phone, email, etc.) or complete other beneficiary address analysis from previous claims to strengthen efforts to obtain a valid address. For LTSS enrollees, the state must deliver such notices to LTSS enrollees through their HCBS provider or residential provider in any case where mailings have not been effective.
- 54. Verification of Beneficiary's MCO Enrollment.** The state shall implement the CMS approved process (see Attachment I) for an MCO, network and non-network providers, or the state to confirm enrollment of enrollees who do not have a card or go to the wrong provider.
- 55. Call Center Availability.** The state must keep the existing (HealthWave) MCO call centers open for the first month of implementation to direct callers to either the state, the enrollment broker, or their new KanCare MCO.
- 56. Sample Notification Letters.** The state must send sample beneficiary notification letters to the existing Medicaid providers, either through direct mailing, posted on the KanCare website, or other widely distributed method, so providers are informed of what is being told to the beneficiaries regarding their transition to KanCare.
- 57. Educational Tour for Beneficiaries and Providers.** The state will conduct an educational tour for beneficiaries and providers during the first 180 days of the demonstration. This educational tour will consist of state and MCO staff traveling to locations throughout the state to provide enrollees and potential enrollees with information about KanCare and the MCOs. The first 90 days should focus on the broader population, and the remainder of the 180 days should focus on the LTSS population, targeting senior centers, nursing facilities and other large HCBS residential or day providers. The educational tour should continue to educate beneficiaries and providers on their MCO enrollment options, rights and responsibilities, and other important program elements. This effort must include participation from the enrollment broker, choice counseling entities, ombudsman, and any other group providing enrollment support for beneficiaries or providers through written notice distribution, outgoing phone calls or other method.
- 58. Care/Service Plan Sharing.** For beneficiaries enrolled in HealthWave that are part of the existing MCO care management program and have an existing care plan, each HealthWave

MCO will send the care plan to the newly assigned KanCare MCO. The HealthWave MCO will also send a report to each of the new KanCare MCOs of each beneficiary who is expected to be using inpatient care at the time of initial transition as well as each beneficiary who is receiving prenatal care. Additionally, the state must send the existing FFS service plan information for all beneficiaries using LTSS as well as the name of the NF that each assignee is in, or expected to be in, at the time of initial transition. These care/service plans will be shared with the KanCare MCOs upon the December 2012 enrollment to allow sufficient time for transition planning.

59. **LTSS Service Planning Timeframe.** The MCOs, through their contracts, will be permitted to complete all service assessments within 180 days of implementation to ensure a person-centered approach to the service planning process. Until such time that the service plan is completed and either agreed upon by the beneficiary or resolved through the appeals or fair hearing process, and implemented, the MCO must ensure that service level and providers used on the existing service plan are available to the member. The MCOs must, through contract requirements, prioritize the service planning process to those individuals whose service plans expire in the first 90 days or whose needs change and necessitate a new service plan. For individuals with a FFS service plan expiring without a new service plan implemented, the MCOs will need to extend their existing service plan (in scope of services and providers) until such time that the new service plan is implemented.
60. **State Review of Service Plan Reductions.** For demonstration year one, the state must review and approve all service plans for individuals using LTSS where the KanCare MCO proposes a reduction, suspension, or termination of services when comparing their existing FFS service plan to the KanCare service plan. In these cases, until such time that the service plan is completed and either agreed upon by the beneficiary or resolved through the appeals or fair hearing process, and implemented, the MCO must ensure that service level and providers used on the existing services plan are available to the member.
61. **State Ride-Alongs.** The state must complete ride-alongs with each MCO during the first 180 days of implementation to observe the service planning process for each MCO. A ride along consists of an experienced state employee who accompanies an MCO employee to observe and assist in the performance of a needs assessment and service plan development for individuals enrolled in the concurrent section 1915(c) HCBS waivers.
62. **State Operated Call Center.** The state must operate a call center independent of the MCOs for the duration of the demonstration. This can be achieved either by providing the call center directly or through the enrollment broker or other state contracted entities. This entity should be able to help enrollees in making independent decisions about MCO choice, and be able to voice complaints about each of the MCOs independent of the MCOs.
63. **Call Center Response Statistics.** During the first 30 days of implementation the state must review all call center response statistics daily to ensure all contracted entities are meeting requirements in their contracts. If deficiencies are found, the state and the entity must determine how they will remedy the deficiency as soon as possible. After the first 30 days, if all entities are consistently meeting requirements, the state can lessen the review of call

center statistics, but must still review all statistics at least weekly for the first 180 days of implementation. Data and information regarding call center statistics, including beneficiary questions and concerns, must be made available to CMS upon request.

64. **Auto-assignment Algorithm Review.** The state must review the outcomes of the auto-assignment algorithm, and if an MCO is found to get a larger number of beneficiaries associated with no match to an existing provider relationship due to a more limited network, that MCO will not be able to receive as many auto-assignees until such time as the network has improved.
65. **Implementation Calls with the MCOs.** During the first 2 weeks of implementation of KanCare, the state must hold daily calls with the MCOs to discuss any issues that arise during that day. The calls should cover all MCO operations and determine plans for correcting any issues as quickly as possible. After the first 2 weeks, if it is found that daily calls are no longer needed then the state can scale back the calls, but must maintain weekly calls for the first 90 days and bi-weekly calls for the next 90 days. After the first 180 days of the program, the state may move to the regular timeframe intended for meeting with each of the MCOs. CMS will require weekly reporting of issues encountered and plans for and status of resolution during the Program Implementation Beneficiary Protection conference calls specified in STC 77.
66. **State Review of Beneficiary Complaints, Grievances, and Appeals.** During the initial implementation of KanCare, the state must review complaint, grievance, and appeal logs for each MCO and data from the state or MCO operated incident management system, to understand what issues beneficiaries and providers are having with each of the MCOs. The state will use this information to implement any immediate corrective actions necessary. The state must review these statistics at least weekly for the first 90 days and then at least bi-weekly for the next 90 days. The state will continue to monitor these statistics throughout the demonstration period and report on them in the quarterly reports as specified in STC 79. Data and information regarding the beneficiary complaints, grievances, and appeals process must be made available to CMS upon request.

XI. SAFETY NET CARE POOL

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

67. Terms and Conditions Applying to Pools Generally.

- a. The non-federal share of pool payments to providers may be funded by state general revenue funds and transfers from units of local government that are compliant with section 1903(w) of the Act. All payments must remain with the provider and may not be transferred back to any unit of government. CMS reserves the right to withhold or reclaim FFP based on a finding that the provisions of this subparagraph have not been followed.
- b. The state must inform CMS of the funding of all payments from the pools to hospitals through a quarterly payment report, in coordination with the quarterly operational report required by STC 79, to be submitted to CMS within 60 days after the end of each quarter. This report must identify and fully disclose all the underlying primary and secondary funding sources of the non-federal share (including health care related taxes, certified public expenditures, intergovernmental transfers, general revenue appropriations, and any other mechanism) for each type of payment received by each provider.
- c. On or before March 31, 2013, the state must submit Medicaid state plan amendments to CMS to remove all supplemental payments(excluding Disproportionate Share Hospital (DSH) payments) for inpatient and outpatient hospital services from its state plan, with an effective date of January 1, 2013 or the approval date for this demonstration, whichever is later. The state may not subsequently amend its Medicaid state plan to authorize supplemental payments for hospitals, so long as the expenditure authorities for pool payments under this demonstration remain in force.
- d. The state will ensure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of services available under the state plan or this demonstration. The preceding sentence is not intended to preclude the state from modifying the Medicaid benefit through the state plan amendment process.
- e. Each quarter the state makes a pools payment (for either pool as described in STCs 68 and 69 below) and claims FFP, appropriate supporting documentation will be made available for CMS to determine the allowability of the payments. Supporting documentation may include, but is not limited to, summary electronic records containing all relevant data fields such as Payee, Program Name, Program ID, Amount, Payment Date, Liability Date, Warrant/Check Number, and Fund Source. Documentation regarding the Funds revenue source for payments will also identify all other funds transferred to such fund making the payment.

68. Uncompensated Care (UC) Pool. The UC Pool is available in DYs 1 through 5 to defray the actual uncompensated cost of medical services that meet the definition of “medical assistance” contained in section 1905(a) of the Act, that are provided to Medicaid eligible or uninsured individuals (defined as individuals who have no source of third party coverage) incurred by hospitals. Expenditures must be claimed in accordance with the methodology described in STC 68(c) below.

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

- i. Hospitals eligible for the HCAIP Pool are listed in Attachment C.
- ii. Hospitals eligible for the LPTH/BCCH Pool are listed in Attachment D.

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

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

Demonstration Year	HCAIP Pool (total computable)	LPTH/BCCH Pool (total computable)	UC Pool (total computable)
DY1	\$41,000,000	\$39,856,550	\$80,856,550
DY2	\$41,000,000	\$29,856,550	\$70,856,550
DY3	\$41,000,000	\$19,856,550	\$60,856,550
DY4	\$41,000,000	\$9,856,550	\$50,856,550
DY5	\$41,000,000	----	\$41,000,000

c. UC Payment Methodology

i. All UC payments are based on uncompensated care costs calculated in accordance with the General DSH Audit and Reporting Protocol, CMS-2198-F. Payments are made each calendar quarter based on a UC Payment Application that contains information reported by each hospital from its Medicare hospital cost report associated with the state's most recent DSH audit collection tool net of any DSH payments received in that fiscal year.

ii. Annual (DY) UC Payment limits are described in STC 68(b) above.

- 1. Within the LPTH/BCCH Pool, 75 percent of the funding is available to the designated LPTHs while the remaining 25 percent is available to the designated BCCHs (see Attachment D for additional information on LPTH/BCCH Pool eligible hospitals).

- iii. HCAIP Pool. The payment structure for the HCAIP UC payments is as follows, subject to the annual limits in STC 68(b):
1. *Uniform Percentage*: The state shall calculate aggregate uncompensated care costs for HCAIP hospitals based on the information identified in STC 68(c)(i) above. Each hospital eligible under the HCAIP UC section shall then receive a uniform percentage of its eligible uncompensated care costs (UCC);
 2. *Specialty Service Uniform Percentage*: Each hospital that furnishes at least 1 of the following specialty services shall receive an additional uniform percentage of its eligible UCC:
 - A. Psychiatric services;
 - B. Level II or Level III Neonatal Intensive Care Unit (NICU) services; or
 - C. Level I or Level II Trauma Services.
 3. *Tri-Level NICU Services Uniform Percentage*: Each hospital system that furnishes all 3 levels of NICU services (Levels I, II, and II) shall receive an additional uniform percentage of its eligible UCC.
 4. *Tri-Specialty Uniform Percentage*: Each hospital that provides all 3 specialty services identified above and has less than \$250 million in net patient revenue shall receive an additional uniform percentage of its eligible UCC.
 5. The uniform percentages for each of the four adjustments for each demonstration year may be found in Attachment J. By April 30, 2013, the state must submit a revised Attachment J for CMS review and approval should the state elect to modify the percentages for DY 1; if the state does not elect to modify the DY 1 percentages, no action is needed. For each of DY 2 through 5, the state will determine the uniform percentages based on the uncompensated care data derived from the updated Medicare cost report to ensure that payments from the HCAIP sub-pool do not exceed the amount authorized in STC 68(b). By February 28th of each year (DY 2 through 5), the state must submit a revised Attachment J to CMS for review and approval. This revision is not subject to the amendment process provided in STC 7.
- iv. LPTH/BCCH Pool. The payment structure for the LPTH/BCCH UC payments will be calculated in accordance with STC 68(c)(i), up to the limits set forth in STCs 68(b) and 68(c)(ii)(1).

- d. UC Payment Application. To qualify for a UC Payment, a hospital must submit to the state an annual UC Payment Application that will collect cost and payment data on services eligible for reimbursement under the UC Pool. The UC Payment Application template must be submitted to CMS for review by March 31, 2013. The UC Payment Application template must be approved by CMS prior to use, and will become Appendix H upon approval. Data collected from the application will form the basis for UC Payments made to individual hospitals. The state must require hospitals to report data in a manner that is consistent with the Medicare 2552-10 cost report.
- i. After CMS has approved the UC Payment Application template, the state may begin accepting applications from hospitals for UC Payments in DY 1. Thereafter, hospitals are required to submit their UC Payment Applications to the state by December 31st of each year, in order to qualify for a UC Payment for the DY that begins on January 1st.
 - ii. Cost and payment data included on the application must be based on the Medicare 2552.10 cost report. The state may trend the data to model costs incurred in the year in which payments are to be made. Subsequent DY application will be used to verify that a hospital's UC Payments, when combined with Disproportionate Share Hospital (DSH) payments under the state plan, did not exceed its actual uncompensated care costs in that year. For example, uncompensated care costs data from a DY 3 application will be used to determine the actual uncompensated care for DY 1 UC Payments for a qualifying hospital and the state will verify that UC Payments plus DSH payments attributable to DY 1 did not exceed the hospital's actual uncompensated care costs. Any overpayments identified in the verification process that occurred in a prior year must be recouped from the provider, with the FFP returned to CMS.
- e. All applicable inpatient and outpatient hospital UC payments received by a hospital count as title XIX revenue, and must be included as offsetting revenue in the state's annual DSH audit reports. Providers receiving both DSH and UC Payments cannot receive total payments under the state plan, DSH, and the UC Pool (related to inpatient and outpatient hospital services) that exceed the hospital's total eligible uncompensated costs. UC Payments for physicians, non-physician professionals, pharmacy, and clinic costs are not considered inpatient or outpatient Medicaid payments for the purpose of annual hospital specific DSH limits and the DSH audit rule. All reimbursement must be made in accordance with CMS approved cost claiming protocols that are consistent with the Medicare 2552-10 cost report.
- f. Annual Reporting Requirements for UC Payments. The state must submit to CMS two reports related to the amount of UC Payments made from the UC Pool per demonstration year. The reporting requirements are as follows:

- i. By March 31st of each demonstration year, beginning in DY 2, the state shall provide the following information to CMS:
 - 1. The UC payment applications submitted by eligible providers; and
 - 2. A chart of estimated UC Payments to each provider for a DY.
 - 3. In DY 1, all UC Payment Applications must be submitted to CMS within 90 days of approval of the UC Payment Application template in order to qualify for DY 1 UC Payments.
- ii. Within ninety (90) days after the end of each demonstration year, beginning with the end of DY 2, the state shall provide the following information to CMS:
 - 1. The UC Payment applications submitted by eligible providers; and
 - 2. A chart of actual UC payments to each provider for the previous DY.

g. UC Pool Timeline

- i. DY 1:
 - 1. By January 4, 2013, the state must submit to CMS the UC Payment Application template for review and approval. CMS and the state agree to a target approval date of February 28, 2013. CMS reserves the right to not approve the template on the target date if the document is not approvable at that time.
 - 2. Following CMS approval of the UC Payment Application template, hospitals may begin to submit the template for DY 1.
 - 3. By April 30, 2013, the state must submit a revised Attachment J should the state elect to revise the uniform percentages for DY 1.
 - 4. Within 90 days of CMS approval of the UC Payment Application, the state must submit all completed UC Payment Applications in order to qualify for DY 1 UC Payments.
 - 5. By December 31st, hospitals must submit the UC Payment Application for DY 2 in order to qualify to DY 2 UC Payments
- ii. DY 2 through 4:
 - 1. By December 31st of each year, hospitals must submit to the state the UC Payment Application for the DY beginning January 1.

iii. DY 2 through 5:

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

69. Delivery System Reform Incentive Payment (DSRIP) Pool. The DSRIP Pool is available in DY 2 through 5 for the development of a program of activity that supports hospitals' efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve. The program of activity funded by the DSRIP will be those activities that are directly responsive to the needs and characteristics of the populations and communities served by each hospital. Under DSRIP, participating hospitals must implement new, or significantly enhance existing, health care initiatives. The state must develop the DSRIP Planning Protocol which will serve as the guiding document for the state's DSRIP Pool. Each participating hospital must develop a Hospital DSRIP Plan, consistent with the DSRIP Planning Protocol, that is rooted in the intensive learning and sharing that will accelerate meaningful improvement. The individual Hospital DSRIP Plan must be consistent with the hospital's mission and quality goals, as well as CMS's overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population, and lower cost through improvement (without any harm whatsoever to individuals, families or communities). In its Hospital DSRIP Plan, each hospital will describe the projects. For each project, the hospital should describe the specific measurable goals for improving the health outcomes of patients and the populations the hospital services, the data analytics that support the selection of these goals, and how it will carry out the project that is designed to achieve these specific goals. Each project must consist of a series of milestones that build on each other, drawn from a predetermined menu of milestones grouped according to four Project Categories. Hospitals may qualify to receive incentive payments (DSRIP Payments) for fully meeting milestones (as specified in the Hospital DSRIP Plan), which represent measurable, incremental steps toward the completion of project activities, or demonstration of their impact on health system performance or quality of care.

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

- b. Project Focus Areas. The state will solicit public input into the development of project focus areas for the DSRIP Pool. These focus areas should target specific care improvements, and may include those based on regional planning needs or state public health initiatives. Each focus area has an explicit connection to the achievement of the three-part aim. Each participating hospital will be required to select at least two projects from the menu of focus areas identified by the state through its public process. The state must develop and submit the list of project focus areas to CMS for review and approval in accordance with the timeline in STC 69(m). The approved focus areas will become Attachment K.
- c. Project Categories. Each hospital project must include Category 1, 2 and 3 milestones. All hospitals must report the common Category 4 milestones and the Category 4 milestones specific to the selected projects:
 - i. *Category 1: Infrastructure Milestones*. These are infrastructure-related milestones a hospital must achieve to move forward with its selected and approved project. These milestones lay the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services. These milestones must support the achievement of quality and outcomes milestones for each project.
 - ii. *Category 2: Process Milestones*. These milestones focus on process changes and improvements. These milestones must support the achievement of quality and outcomes milestones for each project.
 - iii. *Category 3: Quality and Outcomes Milestones*. These milestones address the impact of the project on quality metrics and beneficiary outcomes. This stage involves the broad dissemination of interventions from a list of activities identified by the state, in which major improvements in care can be achieved within four years. These are hospital-specific initiatives and will be jointly developed by hospitals, the state, and CMS and are unlikely to be uniform across all of the hospitals.
 - iv. *Category 4: Population Focused Improvements*. This category evaluates the broader impact of the selected projects through the reporting of Performance Indicators across several domains selected by the state in conjunction with CMS, and may include:
 - 1. Patient experience;
 - 2. Care outcomes; and
 - 3. Population health.

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

- d. DSRIP Performance Indicators. The state will work with CMS to identify performance indicators that are connected to the achievement of providing better care, better access to care, enhanced prevention of chronic medical conditions, and population improvement. The DSRIP Performance Indicators will comprise the list of reporting measures that hospitals will be required to report under Category 4: Population Focused Improvements.
- e. DSRIP Planning Protocol. The state must develop and submit to CMS for approval a DSRIP Planning Protocol, following the timeline specified in STC 69(m) below. During the development of this protocol, the state must seek input from the public, including hospitals, quality of care experts, consumers, and stakeholder groups. Once approved by CMS, this document will be incorporated as Attachment F of these STCs, and once incorporated may be altered only by amending the demonstration through the process described in STC 7. The Protocol must:
 - i. Outline the process of gathering data to support community needs and specific goals and outcomes that the state seeks to achieve through the implementation of individual projects by hospitals, and the analytics for this assessment;
 - ii. Describe the process the state utilized to solicit public input into the development of the DSRIP Planning Protocol;
 - iii. Describe the projects hospitals may select from when designing the Hospital DSRIP Plans;
 - iv. Specify the Project Milestones, as shown in STC 69(c) above, for each project, from which each eligible hospital will select to create its own projects. DY 3 through 5 must include Category 3 milestones that build off of DY 2's Category 1 and 2 milestones;
 - v. Establish a process for rapid cycle evaluation for each plan and for the DSRIP overall (see STC 69(n));
 - vi. Describe the state's plan to conduct an independent evaluation of the DSRIP projects and the program overall, as a component of the overall demonstration evaluation (see Section XV for additional details on demonstration evaluation requirements);
 - vii. Detail the requirements of the Hospital DSRIP Plans, consistent with STC 69(g); and
 - viii. Explain how the state will ensure that selected DSRIP projects do not

duplicate any existing or future federal funding.

- f. DSRIP Funding and Mechanics Protocol. The state must develop a DSRIP Funding and Mechanics Protocol to be submitted to CMS for approval, following the timeline specified in STC 69(m). During the development of this protocol, the state must seek input from the public, including hospitals, quality of care experts, consumers, and stakeholder groups. Once approved by CMS, this document will be incorporated as Attachment G of these STCs, and once incorporated may be altered only by amending the demonstration through the process described in STC 7. DSRIP payments for each participating hospital are contingent on: (1) the hospital fully meeting project milestones defined in the approved hospital-specific Hospital DSRIP Plan; and (2) both the state and CMS certifying the hospital's achievement of a given milestone. In order to receive incentive funding relating to any metric, the hospital must submit all required reporting, as outlined in the DSRIP Program Funding and Mechanics Protocol, and the result must be certified by both the state and CMS. In addition, the DSRIP Program Funding and Mechanics Protocol must:
- i. Describe the process the state utilized to solicit public input into the development of the DSRIP Funding and Mechanics Protocol;
 - ii. Include guidelines requiring hospitals to develop individual Hospital DSRIP Plans, which shall include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance;
 - iii. Specify a state review process and criteria to evaluate each hospital's individual DSRIP plan and develop its recommendation for approval or disapproval prior to submission to CMS for final approval;
 - iv. Allow sufficient time for CMS to conduct its review of the Hospital DSRIP Plans (minimum two (2) months);
 - v. Describe and specify the role and function, of a standardized, hospital-specific application to be submitted to the state on an annual basis for the utilization of DSRIP funds that outlines the hospital's specific DSRIP plan, as well as any data books or reports that hospitals may be required to submit to report baseline information or substantiate progress;
 - vi. Include templates of the hospital-specific application and any data books or reports the hospitals may be required to provide;
 - vii. Specify that hospitals must submit semi-annual reports to the state using a standardized reporting form to document their progress (as measured by the specific metrics applicable to the projects that the hospitals have chosen), and qualify to receive DSRIP Payments if the specified performance levels were achieved;

- viii. Include the template for all annual and semi-annual reports the hospitals will be required to submit under STC 69(f)(vii) above;
- ix. Specify a review process and timeline to evaluate hospital progress on its DSRIP plan metrics in which first the state and then CMS must certify that a hospital has met its approved metrics as a condition for the release of associated DSRIP funds to the hospital (minimum CMS review time: one (1) month);
- x. Specify the penalty if either the state or CMS determines that a hospital has failed to meet its approved metric (see STC 69(i)(i) below);
- xi. Specify an incentive payment formula to determine the total annual amount of DSRIP incentive payments each participating hospital may be eligible to receive in DY 2 through 5, consistent with STCs 69(i) and 69(k) below, and a formula for determining the incentive payment amounts associated with the specific projects and milestones selected by each hospital, such that the amount of incentive payment is commensurate with the value and level of effort required. This formula must place a higher value on quality and outcomes milestones than infrastructure and process milestones;
- xii. Specify that hospital's failure to fully meet a performance metric under its Hospital DSRIP Plan within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment);
- xiii. Include a process that allows for hospital plan modification and an identification of circumstances under which a plan modification may be considered, which shall stipulate that CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved. This process does not allow modification for failure to comply with the STCs, DSRIP Planning Protocol, or DSRIP Program Funding and Mechanics Protocol; and
- xiv. Include a state process for developing an evaluation of DSRIP as a component of the draft evaluation design as required by Section XV. When developing the DSRIP Planning Protocol, the state should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in Section XV of the STCs. The state must select a preferred evaluation plan for the applicable evaluation question, and provide a rationale for its selection. To the extent possible, participating hospitals should use similar metrics for similar projects to enhance evaluation and learning experience between hospitals. To facilitate evaluation, the DSRIP Planning Protocol must identify a core set of

Category 3 metrics that all participating hospitals must be required to report even if the participating hospital chooses not to undertake that project. The intent of this data set is to enable cross hospital comparison even if the hospital did not elect the intervention.

- g. Hospital DSRIP Plans. The hospitals will develop hospital specific Hospital DSRIP Plans in good faith, to leverage hospital and other community resources to best achieve the delivery system transformation goals of the state, established in these STCs, consistent with the demonstration's requirements.
- i. A background section on the hospital system(s) covered by the DSRIP plan that includes an overview of the patients served by the hospital, the challenges the hospital faces, and the goals and objectives of its DSRIP plan;
 - ii. Each hospital's DSRIP plan must identify the project, population-focused objectives, and specific activities and metrics, which must be chosen from the approved DSRIP Planning Protocol, and meet all the requirements pursuant to this waiver. For each project selected, the narrative section of the hospital's DSRIP plan must, at a minimum, include:
 1. A description of the goal(s) of the project, which describes the specific challenges of the hospital system and the major delivery system solution identified to address those challenges by implementing the particular project, including analytics to support these conclusions specific to the hospital;
 2. A description of the target goal over the demonstration approval period and metrics associated with the project and the significance of that goal to the hospital system and its patients;
 3. A narrative on the hospital's rationale for selecting the project, milestones, and metrics based on relevance to the hospital system's population and circumstances, community need, and hospital system priority and starting point with baseline data; and
 4. A narrative describing how this project supports, reinforces, enables and is related to but does not duplicate other projects and interventions within the hospital system.
 - i. Each project must include, over the lifetime of the project, milestones from Categories 1 through 4 in STC 69(c), and require the hospital to report at least two milestones (one of which must be an outcome milestone) in each reporting cycle. Category 1 milestones may be reported on in DY 2. Each project must include Category 2 milestones in DY 2 through 5. Each project must include Category 3 milestones in DY 3 through 5 (note that Category 3

milestones may also be reported in DY 2). Category 4 Performance Indicators must be reported every year.

- ii. For each stated goal or objective of a project, there must be an associated outcome (Category 3) milestone that must be reported on in DY 3 through 5 (note that Category 3 milestone may also be reported on in DY 2). This initially submitted Hospital DSRIP Plan must include baseline data on all Category 3 measures.
 - iii. Hospital DSRIP Plans shall include estimated funding available by year to support DSRIP payments, and specific allocation of funding to DSRIP milestones proposed within the Hospital DSRIP Plan. Category 3 milestones must be of greater value than Category 2 milestones, which in turn must be of greater value than Category 1 milestones. Category 4 common performance indicators receive the lowest level of reimbursement compared to the other categories, and incentive payments must be identical for all Category 4 common performance indicators.
 - iv. Payment of funds allocated in a Hospital DSRIP Plan to Category 4 may be contingent on the hospital reporting DSRIP Performance Indicators to the state and CMS, on the hospital meeting a target level of improvement in the DSRIP Performance Indicator relative to baseline, or both. At least some of the funds so allocated in DY 3 and DY 4, and all such funds allocated in DY 5, must be contingent on meeting a target level of improvement for the Category 4 specific performance indicators.
 - v. Participating hospitals must implement new, or significantly enhance existing health care initiatives; to this end, hospitals must identify the CMS and HHS funded initiatives in which they participate, and explain how their proposed DSRIP activities are not duplicative of activities that are already funded.
 - vi. Each individual Hospital DSRIP Plan must report on progress to receive DSRIP funding. Eligibility for DSRIP Payments will be based on successfully meeting metrics associated with approved activities as outlined in the Hospital DSRIP Plans. Hospitals may not receive credit for metrics achieved prior to CMS approval of their Hospital DSRIP Plans.
- h. CMS Approval of Protocols and Plans. CMS and the state agree to the targeted approval dates specified in STC 69(m). However, if CMS determines that a protocol or plan is not ready for approval on the target date, CMS will notify the state of its determination and the penalties specified in STC 69(j) will apply.
- i. Status of DSRIP Payments. DSRIP payments are not direct reimbursement for expenditures or payments for services. Payments from the DSRIP pool are intended to support and reward hospitals for improvements in their delivery systems that

support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Payments from the DSRIP Pool are not considered patient care revenue, and shall not be offset against DSH expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) as defined under these STCs, and/or under the Medicaid state plan.

- i. A hospital may only receive DSRIP payments following the successful achievement of metrics as reflected in its reports and as approved by both the state and CMS. If either the state or CMS determines that the hospital did not fully and successfully achieve a metric, payment to the hospital for that metric will not be issued.

j. Hospital Plan Review and Approval Process

- i. Hospitals may not submit their Hospital DSRIP Plans until after CMS approval of the Planning Protocol and the Funding and Mechanics Protocol.
- ii. Upon receiving each Hospital DSRIP Plan, the state will conduct a review to determine whether the plan meets the requirements outlined in the DSRIP Planning Protocol, DSRIP Program Funding and Mechanics Protocol, and these STCs.
- iii. Following submission of the state-approved Hospital DSRIP plan, CMS staff will review the Hospital DSRIP plan. CMS will share any feedback and questions with the state, and the state will share CMS' concerns with the hospital and work with the facility to develop a response and amend the plan until it is acceptable to CMS.
- iv. If a hospital's Hospital DSRIP Plan is not accepted by the state, or is accepted by the state but not approved by CMS by December 31, 2013, the state may not claim FFP for DSRIP Payments made to that hospital for any DY, except under the circumstances described in STC 69(j)(v).
- v. If either (A) or (B) below applies, the state may submit a Hospital DSRIP Plan to CMS no later than February 28, 2014 for a hospital that did not receive approval of a plan under subparagraph (iv), which would allow the hospital to qualify for DSRIP Payments in DY 2 through 5 if approved by CMS. The state must notify CMS at least 30 days in advance of its intention to submit a Hospital DSRIP Plan under this provision.
 1. If a hospital failed to submit a DSRIP plan in DY 1 because of a significant adverse unforeseen circumstance, the hospital may submit a DSRIP plan. A significant adverse unforeseen circumstance is one not commonly experienced by hospitals; this determination is subject to

CMS approval. CMS will work with the hospital to reach an acceptable plan by April 30, 2014.

- A. If the Hospital DSRIP Plan is approved by April 30, 2014, the hospital is eligible for DY 2 through 5 payments.
 - i. If the Hospital DSRIP Plan is not approvable on April 30, 2014, CMS will notify the state in writing and the hospital will be unable to participate in DSRIP. This will result in the forfeiture of the payments designated for this hospital.
- B. If a hospital did not receive approval of its Hospital DSRIP Plan by December 31, 2013, the hospital may continue to work with the state and CMS to obtain approval by April 30, 2014.
 - i. If the Hospital DSRIP Plan is approved by April 30, 2014, the hospital is eligible for DY 2 through 5 payments.
 - ii. If the Hospital DSRIP Plan is not approvable on April 30, 2014, CMS will notify the state in writing and the hospital will be unable to participate in DSRIP. This will result in the forfeiture of the payments designated for this hospital.
- k. Demonstration Years 2 through 5 Payments. Each hospital with a Hospital DSRIP Plan approved by the state and CMS by December 31, 2013 (or the target date specified in STC 69(j)(v) above) may receive DSRIP Payments in DY 2, DY 3, DY 4, and DY 5. The total amount of DSRIP Payments available shall be allocated 75 percent to LPTH and 25 percent to BCCH.
- l. Annual DSRIP Payment Limits. Subject to the requirements of STC 69(o), the state may claim FFP for DSRIP Payments in each DY up to the limits (total computable) described in the table in STC 70.
- m. DSRIP Pool Timeline
 - i. DY 1
 - 1. The state will seek public input into the development of the Focus Areas for the DSRIP Pool.

2. By March 31, 2013, the state must submit to CMS for review and approval its list of DSRIP Pool Focus Areas.
3. The state will work with participating hospitals to establish priorities for the DSRIP program.
4. The state will seek public input into the development of the Planning and Funding and Mechanics Protocols.
5. The program application, status reports and data books will be developed. These will be submitted to the state annually as part of the hospitals' formal DSRIP application process.
6. By May 31, 2013, the state must submit to CMS its initial drafts of the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol, and CMS and the state will begin a collaborative process to develop and finalize these documents. The state and CMS agree to a target date of July 31, 2013 for CMS to issue its final approval of these protocols.
7. Hospitals will begin drafting their Hospital DSRIP Plans after the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol are approved by CMS.
8. By September 30, 2013, the hospitals must submit to CMS their initial drafts of their hospital DSRIP plans. CMS, the state, and the hospital will begin a collaborative process to develop and finalize these documents. The state and CMS agree to a target date of December 31, 2013 for CMS to issue its final approval of these protocols.

ii. DY 2

1. Hospitals begin implementing their projects and reporting on infrastructure and process milestones.
 - A. If a hospital does not have an approved DSRIP plan by January 1, 2014, all of its DY 2 DSRIP payment must be withheld pending the approval of the plan.

iii. DY 3 through 5

1. Hospital DSRIP Plan projects are underway and hospitals are focused on achieving quality and outcomes milestones.

iv. DY 5

1. The state reviews the progress hospitals have made on their desired outcomes.
 2. Hospitals will submit a status report on the projected five-year DSRIP plan outcome.
- n. Rapid Cycle Evaluation: The DSRIP will support a process of data-driven, rapid cycle improvement that will gather data in real time and make recommendations to the state, CMS, and hospitals about how to ensure the timely progress in promoting the DSRIP goals. Under DSRIP, hospitals will implement continuous performance improvement in order to improve efficiencies, improve quality, improve experience, reduce inefficiencies, and eliminate waste and redundancies. Hospitals must disseminate their findings to allow other providers to learn from the DSRIP.
- o. Federal Financial Participation (FFP) For DSRIP. The following terms govern the state's eligibility to claim FFP for DSRIP.
- i. The state must not claim FFP for DSRIP until after CMS has approved the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol.
 - ii. The state may not claim FFP for DSRIP Payments in DY 2 through 5 until both the state and CMS have concluded that the hospitals have met the performance indicated for each payment. Hospitals' reports must contain sufficient data and documentation to allow the state and CMS to determine if the hospital has fully met the specified metric, and hospitals must have available for review by the state or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to activities listed in an approved Hospital DSRIP Plan.
 - iii. In addition to the documentation discussed in STC 67(e), the state must use the documentation discussed in STC 69(f)(vi) to support claims made for FFP for DSRIP Payments that are made on the CMS-64.9 Waiver forms.

70. Limits on Pool Payments. The state may claim FFP for the Safety Net Care Pool in each DY up to the limits on total computable listed in the table below. Annual SNCP total computable costs may not exceed \$80,856,550 in any demonstration year. Beginning in DY 2, the percentage of total annual funds allocated to the UC Pool must decrease while the DSRIP Pool correspondingly increases.

	DY 1 (CY 2013)	DY 2 (CY 2014)	DY 3 (CY 2015)	DY 4 (CY 2016)	DY 5 (CY 2017)	Total
UC Pool: HCAIP	\$41,000,000	\$41,000,000	\$41,000,000	\$41,000,000	\$41,000,000	\$205,000,000
UC Pool: BCCH/LPH	\$39,856,550	\$29,856,550	\$19,856,550	\$9,856,550	N/A	\$99,426,200
DSRIP	N/A	\$10,000,000	\$20,000,000	\$30,000,000	\$39,856,550	\$99,856,550
% UC Pool	100%	87.6%	75.3%	62.9%	50.7%	---
% DSRIP	N/A	12.4%	24.7%	37.1%	49.3%	---
Total	\$80,856,550	\$80,856,550	\$80,856,550	\$80,856,550	\$80,856,550	\$404,282,750

71. Assurance of Budget Neutrality.

- a. By October 1 of each year, the state must submit an assessment of budget neutrality to CMS, including a summation of all expenditures and member months already reported to CMS, estimates of expenditures already incurred but not reported, and projections of future expenditures and member months to the end of the demonstration, broken out by DY and Medicaid Eligibility Group (MEG) or other spending category.
- b. Should the report in (a) indicate that the budget neutrality Annual Target for any DY has been exceeded, or is projected to be exceeded, the state must propose adjustments to the limits on UC Pool and DSRIP Pool limits, such that the demonstration will again be budget neutral on an annual basis, and over the lifetime of the demonstration. The new limits will be incorporated through an amendment to the demonstration.

72. Transition Plan for Funding Pools. No later than April 1, 2016, the state shall submit a transition plan to CMS based on the experience with the DSRIP pool, actual uncompensated care trends in the state, and investment in value based purchasing or other payment reform options.

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

XII. GENERAL REPORTING REQUIREMENTS

74. **General Financial Requirements.** The state must comply with all general financial requirements under title XIX of the Social Security Act as set forth in Section XIII of these STCs.
75. **Compliance with Managed Care Reporting Requirements.** The state must comply with all managed care reporting regulations at 42 CFR 438 et. seq.
76. **Reporting Requirements Related to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality as set forth in Section XIII of these STCs, including the submission of corrected budget neutrality data upon request.
77. **Program Implementation Beneficiary Protection Calls.** The state must participate in program implementation beneficiary protection calls with CMS during the first 180 days of the demonstration. These calls will focus on all STCs in Section X of the STCs. During the first 60 days of the demonstration, these calls will be weekly and then both CMS and the state will determine the frequency of calls for the remaining 120 days. The state will provide CMS an update on all the beneficiary protections implemented and any issues that came up during the implementation as well as the plans to address the issues. CMS reserves the right to request documentation of any issues discussed on these calls. Documentation requested must be submitted to CMS within 5 business days of the request.
78. **Bi-Monthly Monitoring Calls.** The state must participate in monitoring calls every other month with CMS. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments, rate certifications, changes in provider qualification standards, on-going monitoring and oversight), health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, proposed changes in payment rates, the Ombudsman program, activities related to the SNCP, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, any changes to state plan presumptive eligibility, any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.
79. **Quarterly Reports:** The state must submit progress reports in the format specified in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas under the demonstration. These quarterly reports must include, but not be limited to:
- a. An updated budget neutrality monitoring spreadsheet;

- b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues, approval and contracting with new plans; benefits; enrollment; presumptive eligibility; grievances; quality of care; changes in provider qualification standards; access; proposed changes to payment rates; health plan financial performance that is relevant to the demonstration; MLTSS implementation and operation; updates on the safety net care pool including DSRIP activities; information on any issues regarding the concurrent 1915(c) waivers and on any upcoming 1915(c) waiver changes (amendments, expirations, renewals); pertinent legislative activity; and other operational issues;
- c. Updates on the post award forums required under STC 15;
- d. Action plans for addressing any policy and administrative issues identified;
- e. The state must address network adequacy reporting from plans including GeoAccess mapping, customer service reporting including average speed of answer at the plans and call abandonment rates; summary of MCO appeals for the quarter including overturn rate and any trends identified; enrollee complaints and grievance reports to determine any trends; summary of ombudsman activities including why people are accessing the ombudsman and outcomes of their assistance; and summary analysis of MCO critical incident report which includes, but is not limited to, incidents of abuse, neglect and exploitation.
- f. Updates on the ID/DD Pilot Project per STC 52;
- g. Updates on the operations, outcomes, and activities of the Ombudsman program per STC 41;
- h. Updates on the managed care and HCBS quality strategies per STCs 37 and 45;
- i. Information on beneficiary complaints, grievances and appeals per STC 66;
- j. Quarterly enrollment reports that include the member months for each demonstration population and the end-of-quarter, point-in-time enrollment for each demonstration population;
- k. Notification of any changes in enrollment and/or participation that fluctuate 10 percent or more in relation to the previous quarter within the same DY and the same quarter in the previous DY;
- l. Activities and planning related to payments made under the Safety Net Care Pool pursuant to the reporting requirements outlined in section XI of the STCs; and
- m. Evaluation activities and interim findings.

80. **Annual Report.** The annual report must, at a minimum, include the requirements outlined below. The state must submit the draft annual report no later than April 1 after the close of each demonstration year (DY). Within 30 days of receipt of comments from CMS, a final annual report must be submitted.
- a. All items included in the quarterly report pursuant to STC 79 must be summarized to reflect the operation/activities throughout the DY;
 - b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
 - c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement, and the total number of unique enrollees within the DY;
 - d. Quality Strategy. Pursuant to STC 37, the state must report on the implementation and effectiveness of the updated Comprehensive Quality Strategy as it impacts the demonstration;
 - e. MFP Benchmarks. Pursuant to STC 43, the state must report on the progress of meeting its MFP benchmarks within the MCOs;
 - f. HCBS waiver waitlists. Pursuant to STC 46, the state must report on the status of individuals receiving community-based services (HCBS-like services) while on a waitlist;
 - g. Ombudsman program. Pursuant to STC 41, the state must report on the operations, outcomes, and activities of the Ombudsman program;
 - h. ID/DD Pilot Project. Pursuant to STC 52, the state must report on the status of the ID/DD Pilot Project; and
 - i. Managed Care Delivery System. The state must document accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy and administrative difficulties in the operation of the demonstration. The state must provide the CAHPS survey, outcomes of any focused studies conducted and what the state intends to do with the results of the focused study, outcomes of any reviews or interviews related to measurement of any disparities by racial or ethnic groups, annual summary of network adequacy by plan including an assessment of the provider network pre and post implementation and MCO compliance with provider 24/7 availability, summary of outcomes of any on-site reviews including EQRO, financial, or other types of reviews conducted by the state or a contractor of the state, summary of performance improvement projects being conducted by the state and any outcomes associated with the interventions, outcomes of performance measure

monitoring, and summary of plan financial performance. The annual report must include an analysis of service reductions that occurred as a result of the assessment within the first 180 days of the transition of 1915(c) HCBS participants into a managed care delivery system, and must also include an analysis of service reductions that occurred through the course of the service planning process.

81. **Final Report.** Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 90 days after receipt of CMS' comments.

XIII. GENERAL FINANCIAL REQUIREMENTS

82. **Quarterly Expenditure Reports (CMS-64).** The state must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XIV of the STCs.
83. **Reporting Expenditures Under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:
- a. Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX and section 1115 of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension which indicates the DY in which services were rendered or for which capitation payments were made).
 - b. Reporting by Demonstration Year (DY) by Date of Service. In each quarter, demonstration expenditures (including prior period adjustments) must be reported separately by DY (as defined in STC 83(g) below). Separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted for each DY for which expenditures are reported. The DY is identified using the Project Number Extension, which is a 2-digit number appended to the Demonstration Project Number. Capitation and premium payments must be reported in the DY that includes the month for which the payment was principally made. Pool payments are subject to annual limits by DY, and must be reported in DY corresponding to the limit under which the payment was made. All other expenditures must be assigned to DYs according to date of service.
 - c. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.
 - d. Premium and Cost Sharing Contributions. Premiums and other applicable cost sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that these collections are

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

- e. Pharmacy Rebates. Pharmacy rebates must be reported on Form CMS-64.9 Base, and not allocated to any Form 64.9 or 64.9P Waiver.
- f. Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to reimburse physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014, with the Federal Government paying 100 percent of the increase. The entire amount of this increase will be excluded from the budget neutrality test for this demonstration. The specifics of separate reporting of these expenditures will be described in guidance to be issued by CMS at a later date.
- g. Demonstration Years. The first Demonstration Year (DY1) will be January 1, 2013 through December 31, 2013, and subsequent DYs will be defined as follows:

Demonstration Year 1 (DY1)	Jan. 1, 2013 to Dec. 31, 2013	12 months
Demonstration Year 2 (DY2)	Jan. 1, 2014 to Dec. 31, 2014	12 months
Demonstration Year 3 (DY3)	Jan. 1, 2015 to Dec. 31, 2015	12 months
Demonstration Year 4 (DY4)	Jan. 1, 2016 to Dec. 31, 2016	12 months
Demonstration Year 5 (DY5)	Jan. 1, 2017 to Dec. 31, 2017	12 months

- h. Use of Waiver Forms. For each quarter of each Demonstration Year, eleven (11) separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the *Category Names* shown in quotation marks below, to report expenditures for the demonstration. Items i through ix below represent *Medicaid Eligibility Groups* (MEGs); STC 17 specifies the populations within each MEG. Items x and xi refer to the SNCP. Expenditures should be allocated to these forms based on the guidance found below.

- i. Aged, Blind, and Disabled/Spend Down Dual ["ABD/SD Dual"]
- ii. Aged, Blind, and Disabled/Spend Down Non Dual ["ABD/SD Non Dual"]
- iii. "Adults"
- iv. "Children"
- v. "DD Waiver"

- vi. Long Term Care [“LTC”]
- vii. Medically Needy Dual [“MN Dual”]
- viii. Medically Needy Non Dual [“MN Non Dual”]
- ix. “Waiver”
- x. Safety Net Care Pool – Uncompensated Care Pool [“UC Pool”]
- xi. Safety Net Care Pool – Delivery System Reform Incentive Payment Pool [“DSRIP Pool”]

84. **Expenditures Subject to the Budget Neutrality Limit.** For purposes of this section, the term “expenditures subject to the budget neutrality limit” must include:

- a. All demonstration medical assistance expenditures (including those authorized through the Medicaid state plan, through the concurrent 1915(c) waivers, and through the section 1115 waiver and expenditures authorities), but excluding the increase expenditures resulting from the mandated increase in payments to physicians per STC 80(f) made on behalf of all demonstration participants listed in the tables in STC 17, with dates of services within the demonstration’s approval period; and
- b. All Safety Net Care Pool payments, including both UC Pool and DSRIP Pool payments.

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

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

86. **Claiming Period.** All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

87. Reporting Member Months. For the purpose of calculating the budget neutrality limit and for other purposes, the state must provide to CMS on a quarterly basis the actual number of eligible member months for the demonstration enrollees. Member-month enrollment information must be provided to CMS in conjunction with the quarterly reports pursuant to STC 79.

- a. The state must report the actual number of member months for Eligibility Groups i through ix as defined in STC 83(h).
- b. The term “eligible member/months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.
- c. To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

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

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

- a. Administrative costs, including those associated with the administration of the demonstration;
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
- c. Net medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration period, including expenditures under the Safety Net Care Pool.

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

- a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.
- c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

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

- a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
- b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
- d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

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

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

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

XIV. MONITORING BUDGET NEUTRALITY

94. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method described in STC 97, and budget neutrality limits are set on a yearly basis with a cumulative budget neutrality limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.
95. **Risk.** The state shall be at risk for the per capita cost (as determined by the method described below) for demonstration eligibles under this budget neutrality limit, but not for the number of demonstration eligibles. By providing FFP for all demonstration eligibles, the state shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have been realized had there been no demonstration.
96. **Expenditures Excluded From Budget Neutrality Limit.** Regular FFP will continue for costs not subject to budget neutrality limit. These exclusions include:
- a. Allowable administrative expenditures;
 - b. Mandated increase in physician payment rates in 2013 and 2014 (as specified in STC 83(f));
 - c. Disproportionate Share Hospital (DSH) payments;
 - d. Graduate Medical Education (GME) payments;
 - e. Pharmacy rebates (see STC 83(e)); and
 - f. Costs for excluded populations (see STC 19).
97. **Calculation of the Budget Neutrality Limit and How It Is Applied.** The following are the PMPM costs for the calculation of the budget neutrality limit for the demonstration enrollees in the MEGs listed in STC 83(h) under this approval period. *The demonstration year is January 1 through December 31.*
- a. The PMPM costs for the calculation of the annual budget neutrality limit for the eligibility groups subject to the budget neutrality limit under this demonstration are specified below.

Demonstration Eligibility Groups	Trend Rate	DY 1 (CY 2013)	DY 2 (CY 2014)	DY 3 (CY 2015)	DY 4 (CY 2016)	DY 5 (CY 2017)
ABD/SD Dual	0.00%	\$192.83	\$192.83	\$192.83	\$192.83	\$192.83
ABD/SD Non Dual	1.92%	\$1,072.16	\$1,092.75	\$1,113.73	\$1,135.11	\$1,156.90
Adults	4.87%	\$631.05	\$661.81	\$694.07	\$727.90	\$763.38
Children	2.67%	\$218.47	\$224.30	\$230.29	\$236.44	\$242.75
DD Waiver	1.11%	\$3,873.00	\$3,915.99	\$3,959.46	\$4,003.41	\$4,047.85
LTC	4.35%	\$3,488.61	\$3,640.34	\$3,798.66	\$3,963.87	\$4,136.26
MN Dual	4.35%	\$1,380.10	\$1,440.12	\$1,502.75	\$1,568.11	\$1,636.31
MN Non Dual	4.35%	\$1,785.86	\$1,863.53	\$1,944.58	\$2,029.15	\$2,117.40
Waiver	4.35%	\$2,590.95	\$2,703.63	\$2,821.22	\$2,943.92	\$3,071.96

- b. For each year of the budget neutrality agreement, an annual budget neutrality expenditure limit is calculated for each MEG. An annual MEG estimate must be calculated as a product of the number of eligible member months reported by the state under STC87 for each MEG, times the appropriate per member per month (PMPM) costs from the table in STC (this item)(a). Historical data used to calculate the budget neutrality limit are provided in Attachment B.
- c. The annual budget neutrality limit for the demonstration as a whole is the sum of the projected annual expenditure caps for each EG calculated in subparagraph (b) above.

98. **Composite Federal Share.** The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported on the forms listed in STC83(h) above, by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the approval period (see STC9), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of the Composite Federal Share may be used.

99. **Lifetime Demonstration Budget Neutrality Limit.** The lifetime (overall) budget neutrality limit for the demonstration is the sum of the annual budget neutrality limits calculated in STC 97(c). The federal share of the overall budget neutrality limit (calculated as the product of the overall budget neutrality limit times the Composite Federal Share) represents the maximum amount of FFP that the state may receive for demonstration expenditures during the demonstration period reported in accordance with STC83.

100. **Future Adjustments to the Budget Neutrality Limit.** CMS reserves the right to adjust the budget neutrality limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

101. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state’s expenditures exceed the calculated cumulative budget neutrality limit by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative target definition	Percentage
DY 1	Cumulative budget neutrality limit plus:	2.0 percent
DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 4	Cumulative budget neutrality limit plus:	0.5 percent
DY 5	Cumulative budget neutrality limit plus:	0 percent

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

XV. EVALUATION OF THE DEMONSTRATION

103. **Submission of Draft Evaluation Design.** The state shall submit to CMS for approval a draft *Evaluation Design* for an overall evaluation of the demonstration within 120 days of CMS approval of the demonstration. At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, and identify outcomes measures that shall be used to evaluate the demonstration's impact. It shall discuss the data sources, including the use of Medicaid encounter data, and sampling methodology for assessing these outcomes. The draft Evaluation Design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The draft design must describe the state's process to contract with an independent evaluator.

- a. Domain of Focus: The Evaluation Design must, at a minimum, address the research questions/topics listed below and the goals of the demonstration as outlined in Section I of the STCs. For questions that cover broad subject areas, the state may propose a more narrow focus of the evaluation.
 - i. What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care, for each demonstration population or relevant population group?
 - ii. What is the impact of including LTSS in the capitated managed care benefit, with a sub-focus on the inclusion of HCBS in capitated managed care?
 - iii. How did the Ombudsman's program assist the KanCare program and its beneficiaries?
 - iv. What did the state learn from the ID/DD Pilot Project that could assist the state in moving ID/DD HCBS services into managed care?
 - v. How did the UC Pool impact care under Medicaid in the state?
 - vi. An assessment of the impact of DSRIP payments to participating providers, including:
 1. Were the participating hospitals able to show statistically significant improvements on measures within Categories 1 through 3 related to the goals of the three part aim as discussed in STC 69?
 2. Were the participating hospitals able to show improvements on measures within Category 4 related to the goals of the three part aim as discussed in STC 69?
 3. What is the impact of health care delivery system and access reform

measures on the quality of care delivered by participating providers?

4. What is the impact of DSRIP on managing short and long term per-capita costs of health care?
5. How did the amount paid in incentives compare with the amount of improvement achieved?

b. Evaluation Design Process: Addressing the research questions listed above will require a mix of quantitative and qualitative research methodologies. When developing the DSRIP Planning Protocol, the state should consider a way to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design. To the extent applicable, the following items must be specified for each design option that is proposed:

- i. Quantitative or qualitative outcome measures;
- ii. Baseline and/or control comparisons;
- iii. Process and improvement outcome measures and specifications;
- iv. Data sources and collection frequency;
- v. Robust sampling designs (i.e. controlled before-and-after studies, interrupted time series design, and comparison group analysis);
- vi. Cost estimate; and
- vii. Timeline for deliverables.

c. Levels of Analysis. The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population or relevant population group stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups. In its review of the draft evaluation plan, CMS reserves the right to request additional levels of analysis.

104. **Final Evaluation Design.** CMS shall provide comments on the draft Evaluation Design described in STC 103 within 60 days of receipt, and the state shall submit a final design within 60 days of receipt of CMS comments. This final evaluation design is subject to review; CMS reserves the right to request additional revisions prior to accepting the final Evaluation Design.

105. **Final Evaluation Design Implementation.** The state must implement the evaluation

design after submission of the final evaluation design, and submit its progress in each of the quarterly and annual progress reports. The evaluation design must be conducted by an independent evaluator.

106. **Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of its request for each subsequent renewal.
107. **Final Evaluation Report.** The state must submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final evaluation report within 90 days after receipt of CMS comments.
108. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the demonstration, the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to the contractor or CMS.

XVI. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION APPROVAL PERIOD

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

Date - Specific	Deliverable	STC Reference
January 4, 2013	Submit UC Payment Application template	Section XI, STC 68
Within 30 days of approval	Submit revised MFP Operational Protocol	Section IX, STC 43
March 31, 2013	Submit DSRIP Pool Focus Areas	Section XI, STC 69
120 days from date of award letter	Submit Draft Evaluation Plan	Section XV, STC 103
April 30, 2013	Submit a revised Attachment J (if the state wishes to revise the DY 1 percentages)	Section XI, STC 68
Within 90 days of UC Payment Application template approval	Submit DY 1 UC Payment Applications	Section XI, STC 68
May 31, 2013	Submit Draft DSRIP Planning Protocol	Section XI, STC 69
May 31, 2013	Submit Draft DSRIP Funding and Mechanics Protocol	Section XI, STC 69
Within 60 days of receipt of CMS comments	Submit a Final Evaluation Plan	Section XV, STC 104
September 30, 2013	Submit Hospital DSRIP Plans	Section XI, STC 69
Within one year of approval	Submit 1915(c) amendments to revise performance measures	Section IX, STC 45
Within 90 days of approval of STC 43 changes	Submit revised Comprehensive State Quality Strategy	Section VII, STC 37
Within 120 days of expiration	Submit a Draft Final Evaluation Report	Section XV, STC 107
Within 120 days of expiration	Submit a Draft Final Report	Section XII, STC 81
90 days of receipt of CMS comments	Submit Final Evaluation Report	Section XV, STC 107
Within 90 days of receipt of CMS comments	Submit Final Report	Section XII, STC 81

	Deliverable	STC Reference
Annual	By April 1 st - Draft Annual Report	Section XII, STC 80
	By February 28 th – Submit revised Attachment J	Section XI, STC 68
	By March 31 st – UC Payment Applications	Section XI, STC 68
	Within 90 days of close of previous DY – UC Payment Applications and a chart of actual UC Payments for the previous DY	Section XI, STC 68
Each Quarter (02/28, 05/31, 08/31, 11/30)		
	Quarterly Operational Reports	Section XII, STC 79
	Quarterly Enrollment Reports	Section XII, STC 79
	CMS-64 Reports	Section XIII, STC 82
	Eligible Member Months	Section XIII, STC 87

[ATTACHMENT A](#)

Quarterly Report Content and Format

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

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

NARRATIVE REPORT FORMAT:

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

Demonstration/Quarter Reporting Period:

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

Introduction

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

Enrollment Information

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

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

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

ATTACHMENT A
Quarterly Report Content and Format

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

Outreach/Innovative Activities

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

Operational Developments/Issues

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

Policy Developments/Issues

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

Financial/Budget Neutrality Development/Issues

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

Member Month Reporting

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

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

ATTACHMENT A
Quarterly Report Content and Format

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

Consumer Issues

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

Quality Assurance/Monitoring Activity

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

Managed Care Reporting Requirements

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

Safety Net Care Pool

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

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

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

State Contact(s)

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT B
Historical Budget Neutrality Data

	SFY07	SFY08	SFY09	SFY10	SFY11	5-YEARS
Medicaid Pop 1	ABD/SD Dual					
TOTAL EXPENDITURES	\$ 44,236,459	\$ 43,025,422	\$42,691,201	\$40,506,394	\$40,532,103	\$210,991,580
Eligible Member Months	208,752	202,688	198,906	200,134	210,200	
PMPM COST	\$ 211.91	\$212.27	\$214.63	\$202.40	\$192.83	
TREND RATES	ANNUAL CHANGE					5-YEAR AVERAGE
TOTAL EXPENDITURE		-2.74%	-0.78%	-5.12%	0.06%	-2.16%
ELIGIBLE MEMBER MONTHS		-2.90%	-1.87%	0.62%	5.03%	0.17%
PMPM COST		0.17%	1.11%	-5.70%	-4.73%	-2.33%

	SFY07	SFY08	SFY09	SFY10	SFY11	5-YEARS
Medicaid Pop 2	ABD/SD Non Dual					
TOTAL EXPENDITURES	\$262,996,600	\$287,521,460	\$302,718,060	\$318,094,717	\$353,270,763	\$1,524,601,599
ELIGIBLE DELIVERIES	277,577	287,295	303,044	325,477	345,539	
PMPM COST	\$947.47	\$1,000.79	\$998.92	\$ 977.32	\$1,022.38	
TREND RATES	ANNUAL CHANGE					5-YEAR AVERAGE
TOTAL EXPENDITURE		9.33%	5.29%	5.08%	11.06%	7.66%
ELIGIBLE MEMBER MONTHS		3.50%	5.48%	7.40%	6.16%	5.63%
PMPM COST		5.63%	-0.19%	-2.16%	4.61%	1.92%

ATTACHMENT B
Historical Budget Neutrality Data

Medicaid Pop 3		Adults				
TOTAL EXPENDITURES	\$145,696,984	\$178,511,453	\$ 182,736,445	\$192,965,697	\$215,135,856	\$915,046,435
Eligible Member Months	341,481	302,194	297,411	327,511	383,991	
PMPM COST	\$426.66	\$590.72	\$614.42	\$589.19	\$560.26	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		22.52%	2.37%	5.60%	11.49%	10.23%
ELIGIBLE MEMBER MONTHS		-11.51%	-1.58%	10.12%	17.25%	2.98%
PMPM COST		38.45%	4.01%	-4.11%	-4.91%	7.05%

Medicaid Pop 4		Children				
TOTAL EXPENDITURES	\$339,146,737	\$391,345,646	\$395,809,865	\$395,188,873	\$469,903,838	\$1,991,394,959
Eligible Member Months	1,842,324	1,807,933	1,862,831	2,088,632	2,297,347	
PMPM COST	\$184.09	\$216.46	\$212.48	\$189.21	\$204.54	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		15.39%	1.14%	-0.16%	18.91%	8.49%
ELIGIBLE MEMBER MONTHS		-1.87%	3.04%	12.12%	9.99%	5.67%
PMPM COST		17.59%	-1.84%	-10.95%	8.10%	2.67%

ATTACHMENT B
Historical Budget Neutrality Data

Medicaid Pop 5	DD Waiver					
TOTAL EXPENDITURES	\$317,272,274	\$333,079,826	\$352,328,338	\$361,930,538	\$378,141,817	\$1,742,752,793
Eligible Member Months	88,021	92,716	94,654	98,443	100,367	
PMPM COST	\$3,604.51	\$3,592.47	\$3,722.28	\$3,676.54	\$3,767.57	
TREND RATES	ANNUAL CHANGE					5-YEAR AVERAGE
TOTAL EXPENDITURE	4.98%	5.78%	2.73%	4.48%	4.49%	
ELIGIBLE MEMBER MONTHS	5.33%	2.09%	4.00%	1.95%	3.34%	
PMPM COST	-0.33%	3.61%	-1.23%	2.48%	1.11%	

Medicaid Pop 6	LTC					
TOTAL EXPENDITURES	\$714,587,999	\$764,736,723	\$837,320,779	\$802,268,440	\$893,612,115	\$4,012,526,055
Eligible Member Months	278,125	285,098	295,461	288,224	284,917	
PMPM COST	\$2,569.30	\$2,682.36	\$2,833.94	\$2,783.49	\$3,136.39	
TREND RATES	ANNUAL CHANGE					5-YEAR AVERAGE
TOTAL EXPENDITURE	7.02%	9.49%	-4.19%	11.39%	5.75%	
ELIGIBLE MEMBER MONTHS	2.51%	3.64%	-2.45%	-1.15%	0.60%	
PMPM COST	4.40%	5.65%	-1.78%	12.68%	5.11%	

ATTACHMENT B
Historical Budget Neutrality Data

Medicaid Pop 7		MN Dual				
TOTAL EXPENDITURES	\$37,210,534	\$34,425,301	\$28,602,622	\$42,253,903	\$34,382,233	\$176,874,594
Eligible Member Months	35,739	31,269	28,620	30,996	27,711	
PMPM COST	\$1,041.17	\$1,100.96	\$999.38	\$1,363.19	\$1,240.76	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE			-7.49%	-16.91%	47.73%	-18.63%
ELIGIBLE MEMBER MONTHS			-12.51%	-8.47%	8.30%	-10.60%
PMPM COST			5.74%	-9.23%	36.40%	-8.98%

Medicaid Pop 8		MN Non Dual				
TOTAL EXPENDITURES	\$24,500,245	\$28,139,319	\$30,191,137	\$28,559,359	\$31,471,604	\$142,861,664
Eligible Member Months	21,421	26,080	21,895	19,534	19,602	
PMPM COST	\$1,143.73	\$1,078.96	\$1,378.92	\$1,462.00	\$1,605.55	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE			14.85%	7.29%	-5.40%	10.20%
ELIGIBLE MEMBER MONTHS			21.75%	-16.05%	-10.78%	0.34%
PMPM COST			-5.66%	27.80%	6.02%	9.82%

ATTACHMENT B
Historical Budget Neutrality Data

Medicaid Pop 9	Waiver					
TOTAL EXPENDITURES	\$61,320,583	\$79,821,639	\$118,700,459	\$138,297,856	\$149,625,842	\$ 547,766,379
Eligible Member Months	34,936	42,109	53,790	61,202	64,235	
PMPM COST	\$1,755.22	\$1,895.60	\$2,206.74	\$2,259.68	\$2,329.36	
TREND RATES	ANNUAL CHANGE					5-YEAR AVERAGE
TOTAL EXPENDITURE		30.17%	48.71%	16.51%	8.19%	24.98%
ELIGIBLE MEMBER MONTHS		20.53%	27.74%	13.78%	4.95%	16.45%
PMPM COST		8.00%	16.41%	2.40%	3.08%	7.33%

ATTACHMENT C
HCAIP Hospitals

Hospital Name	City	County
Blue Valley Hospital Inc.	Overland Park	Johnson
Bob Wilson Memorial Hospital	Ulysses	Grant
Children's Mercy Hospital South	Overland Park	Johnson
Coffey County Hospital	Burlington	Coffey
Coffeyville Regional Medical Center	Coffeyville	Montgomery
Cushing Memorial Hospital	Leavenworth	Leavenworth
Doctors Hospital	Leawood	Johnson
Galichia Heart Hospital	Wichita	Sedgwick
Geary Community Hospital	Junction City	Geary
Great Bend Regional Hospital, LLC	Great Bend	Barton
Hays Medical Center	Hays	Ellis
Heartland Spine & Specialty Hospital	Overland Park	Johnson
Kansas City Orthopaedic Institute	Leawood	Johnson
Kansas Heart Hospital	Wichita	Sedgwick
Kansas Medical Center	Andover	Butler
Kansas Rehabilitation Hospital	Topeka	Shawnee
Kansas Spine Hospital	Wichita	Sedgwick
Kansas Surgery & Recovery Center	Wichita	Sedgwick
Labette County Medical Center	Parsons	Labette
Lawrence Memorial Hospital	Lawrence	Douglas
LTAC Hospital of Wichita	Wichita	Sedgwick
Manhattan Surgical Hospital	Manhattan	Riley
McPherson Memorial Hospital	McPherson	McPherson
Meadowbrook Hospital	Gardner	Johnson
Menorah Medical Center	Overland Park	Johnson
Mercy Health Center - Fort Scott	Fort Scott	Bourbon
Mercy Health Center - Independence	Independence	Montgomery
Mercy Hospital - Moundridge	Moundridge	McPherson
Mercy Regional Health Center	Manhattan	Riley
Miami County Medical Center	Paola	Miami

**ATTACHMENT C
HCAIP Hospitals**

Hospital Name	City	County
Mid-America Rehabilitation Hospital	Overland Park	Johnson
Morton County Health System	Elkhart	Morton
Mount Carmel Regional Medical Center	Pittsburg	Crawford
Newman Regional Health	Emporia	Lyon
Newton Medical Center	Newton	Harvey
Olathe Medical Center	Olathe	Johnson
Overland Park Regional Medical Center	Overland Park	Johnson
Pratt Regional Medical Center	Pratt	Pratt
Promise Regional Medical Center	Hutchinson	Reno
Providence Medical Center	Kansas City	Wyandotte
Ransom Memorial Hospital	Ottawa	Franklin
Saint Catherine Hospital	Garden City	Finney
Saint Francis Health Center	Topeka	Shawnee
Saint John Hospital	Leavenworth	Leavenworth
Saint Luke's South Hospital	Overland Park	Johnson
Salina Regional Health Center	Salina	Saline
Salina Surgical Hospital	Salina	Saline
Select Specialty Hospital Kansas City	Overland Park	Johnson
Select Specialty Hospital Topeka	Topeka	Shawnee
Select Specialty Hospital Wichita	Wichita	Sedgwick
Shawnee Mission Medical Center	Overland Park	Johnson
South Central Kansas RMC	Arkansas City	Cowley
Southwest Medical Center	Liberal	Seward
Specialty Hospital of Mid-America	Overland Park	Johnson
Stormont-Vail Regional Health Center	Topeka	Shawnee
Summit Surgical, LLC	Hutchinson	Reno
Sumner Regional Medical Center	Wellington	Sumner
Susan B. Allen Memorial Hospital	El Dorado	Butler
Via Christi Hospital St. Teresa	Wichita	Sedgwick
Via Christi Regional Medical Center	Wichita	Sedgwick
Via Christi Rehabilitation	Wichita	Sedgwick

**ATTACHMENT C
HCAIP Hospitals**

Hospital Name	City	County
Center		
Wesley Medical Center	Wichita	Sedgwick
Wesley Rehabilitation Hospital	Wichita	Sedgwick
Western Plains Medical Complex	Dodge City	Ford

ATTACHMENT D
LPTH/BCCH Hospitals

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

ATTACHMENT E
UC Payment Application Template

[PLACEHOLDER: Following CMS review and approval, the UC Payment Application Template
(see STC 68) will be placed in this attachment]

ATTACHMENT F
DSRIP Planning Protocol

[PLACEHOLDER: Following CMS review and approval, the DSRIP Planning Protocol (see STC 69) will be placed in this attachment]

ATTACHMENT G
DSRIP Funding and Mechanics Protocol

[PLACEHOLDER: Following CMS review and approval, the DSRIP Funding and Mechanics Protocol (see STC 69) will be placed in this attachment]

ATTACHMENT H
Ombudsman Plan

The following report was submitted by the state of Kansas on November 26, 2012, as a part of CMS' KanCare review. This report describes the qualified independent, conflict-free entity which will assist KanCare enrollees in the resolution of problems and conflicts between the MCOs and participants regarding services, coverage, access and rights. The Ombudsman should help participants understand the fair hearing, grievance, and appeal rights and processes at each MCO and proactively assist them through the process if needed. Ombudsman activities are available to all demonstration eligible populations, but specific focus and outreach activities will be directed towards KanCare enrollees utilizing LTSS (institutional, residential and community based). (see STC 41).

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ATTACHMENT H Ombudsman Plan



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www.kdheks.gov/hcf/

Robert Moser, MD, Secretary
Kari Bruffett, Director

Sam Brownback, Governor

KanCare Implementation Activity: KanCare Consumer Ombudsman

Date Updated: Dec. 5, 2012

Purpose:

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

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

The ombudsman will:

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

ATTACHMENT H

Ombudsman Plan

Organization:

The KanCare Ombudsman will be located in the Kansas Department for Aging and Disability Services (KDADS). The Ombudsman will be organizationally independent from other KDADS commissions which set and direct Medicaid program, and reimbursement policy. The Ombudsman will receive administrative and legal support from the Office of the Secretary division of KDADS.

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

Personnel:

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

Program and Training:

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

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

The Ombudsman will work with consumers and providers in distributing information about the Ombudsman services. Contact information for the Ombudsman will be provided through state processes and contractors such as eligibility offices, KanCare hotline and mailings, Aging and Disability Resource Centers, KanCare member materials, and consumer and provider advocates.

In addition to assisting consumers with the items listed in the overview, the Ombudsman will provide information, assistance, and referrals to consumers with issues not covered in the Ombudsman's scope of work.

Supporting Resources:

The Ombudsman will be presented as a source for assistance when a consumer cannot find an acceptable outcome by speaking directly with their KanCare plan, or through the normal processes. While the Ombudsman will be trained on eligibility criteria and covered benefits, the State does not expect the Ombudsman's office to be the first contact for all such questions. The state's enrollment broker, MCO call centers, State eligibility staff, and the ADRC are

ATTACHMENT H Ombudsman Plan

established resources for member inquiries. Similarly, while the Ombudsman will assist individuals exercise their rights to the grievance and appeals process, the Ombudsman is not expected to file or represent the consumer in the grievance or appeal. The Ombudsman will assist in mediating those cases that cannot be handled by state eligibility case workers, hotline staff, or the ADRC, when assistance is needed in starting a grievance or appeal, and when satisfaction cannot be obtained through the grievance and appeals processes.

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

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

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

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

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

Policy and Advocacy:

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

ATTACHMENT H
Ombudsman Plan

Coordination with Quality Oversight:

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

ATTACHMENT I

Verification of Beneficiary's MCO Enrollment

The following report was submitted by the state of Kansas on November 23, 2012, as a part of CMS' KanCare review. This report describes the approved process for an MCO, network and non-network providers, or the state to confirm enrollment of enrollees who do not have a card or go to the wrong provider(see STC 54).

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ATTACHMENT I
Verification of Beneficiary's MCO Enrollment



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 www.kdheks.gov/hcf/

Robert Moser, MD, Secretary
 Kari Bruffett, Director

Sam Brownback, Governor

KanCare Implementation Activity: Enrollment Verification
Date Posted: Nov. 23, 2012

State:

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

Access Point	Functionality	Availability	MCO	Providers		State	Fiscal Agent
				Network	Non-		
KMAP Secure Web Site	Entities enrolled with KMAP have access to the Secure Web site. Through the site, a user can verify eligibility by keying a valid combination of the following: <ul style="list-style-type: none"> Beneficiary ID and date of birth Social Security No. and date of birth Name and date of birth 	22 hrs/day 7 days/week	X	X		N/A	N/A
State Secure Web Site	Approved users have access to the KMAP Secure Web Site realm used by enrolled MCOs and provider by accessing a dedicated State Secure Web site. Through the site, a user can verify eligibility by keying a valid combination of the following: <ul style="list-style-type: none"> Beneficiary ID and date of birth Social Security No. and date of birth Name and date of birth 	22 hrs/day 7 days/week	N/A	N/A	N/A	X	X
Automated	Entities enrolled with KMAP have access to	22 hrs/day	X	X		N/A	N/A

ATTACHMENT I Verification of Beneficiary's MCO Enrollment

Voice Response System	the Automated Voice Response System by dialing 1-800-933-6593. Through the phone line, a user can verify eligibility by keying a valid combination of the following: <ul style="list-style-type: none"> Beneficiary ID and date of birth Social Security No. and date of birth 	7 days/week					
MMIS	Access to all Medicaid-related information by authorized users. Users would share information verbally with requesting entities.	22 hrs/day 7 days/week		N/A	N/A	X	X
KMAP Customer Service	All entities can reach a KMAP Customer Service agent by calling 1-800-933-6593 (provider) or 1-800-766-9012 (beneficiary).	8 am – 5 pm Monday - Friday	X	X	X	X	N/A
MCO Processes	The MMIS provides each MCO eligibility and enrollment information via the 834 to allow the MCO to share through their own access points.			N/A	X	X	

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

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

In addition, providers have the option of using MCO resources to verify enrollment. Please see below:

MCOs:

► **UnitedHealth care:** There are several options available to members, providers or partners if a member's eligibility requires verification. UnitedHealthcare has developed a secure portal called www.MyUHC.com, available through a link on www.UHCCommunityPlan.com and available only to KanCare members, which includes functionality to check eligibility and view / print an ID card. United also maintains a provider website and provider portal, *UHOnline*, that gives all providers access to critical and timely information through a single source, facilitating better and more responsive care. Providers have round-the-clock access to the portal. Once the provider has completed registration, *UHOnline* provides access to a variety of comprehensive plan information, including functionality that

ATTACHMENT I Verification of Beneficiary's MCO Enrollment

allows providers to verify member eligibility and view member ID cards. Information and training is provided during educational tours.

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

► **Sunflower Health Plan:** Sunflower providers and Non-Par providers can use the following methods to verify enrollees' eligibility if they present for services without an ID card or go to the wrong provider.

Network Providers can confirm eligibility in the following ways:

- Use automated IVR line
- Call Member Services Department
- Use Secure Provider Portal functionality
- Use the KMAP site

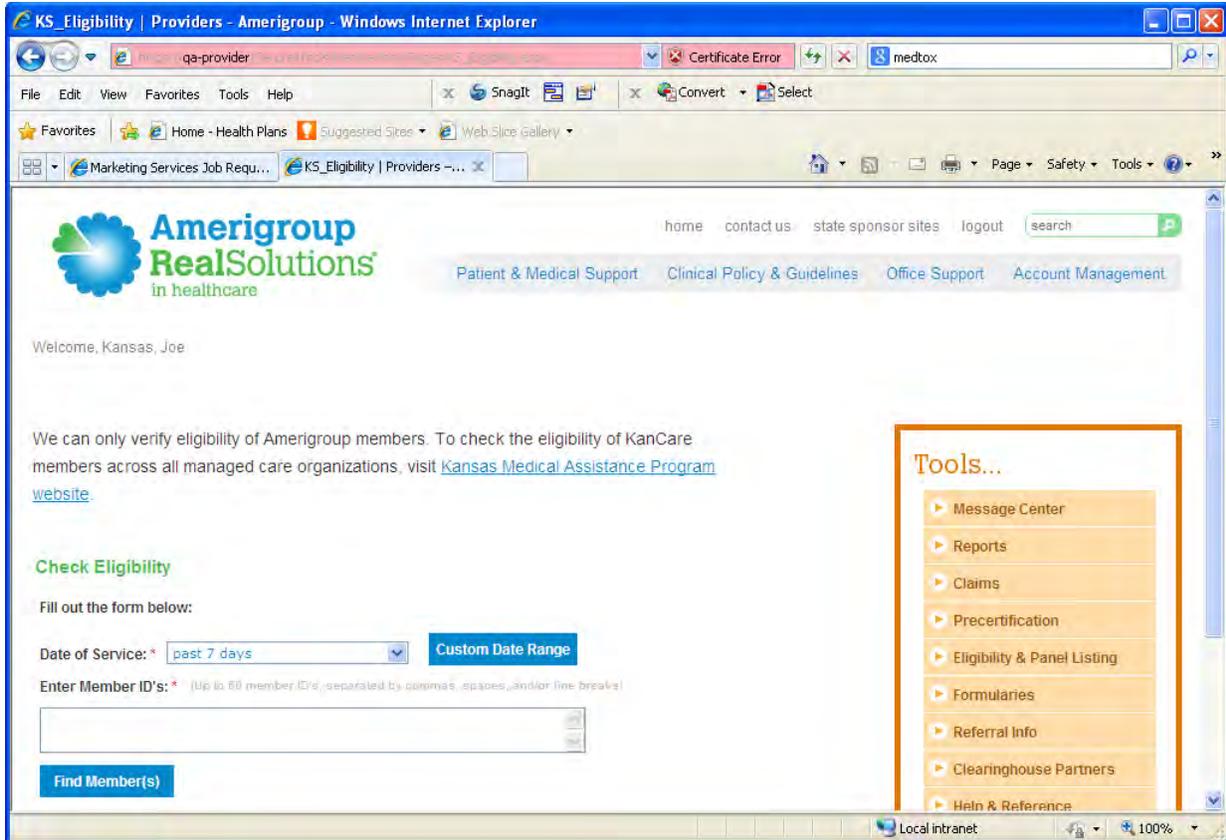
Non-Network Providers:

- Call Member Services Department
- Use IVR line
- Register on secure provider portal as a non-par
- Use the KMAP site

► **Amerigroup:** If the provider is attempting to verify if a member has coverage and the member does not have an ID card, the provider can **a)** contact the Amerigroup Provider Services team at 1-800-454-3730 and/or **b)** check the Amerigroup provider services web portal. To check eligibility on the website at providers.amerigroup.com/ks, providers can use the Amerigroup eligibility lookup tool to get the most up-to-date member information. The provider would log in to the provider self-service site, click on Eligibility & Panel Listings in the Tools menu and select Eligibility. Please see below **Amerigroup Check Eligibility Screen Shot** for a display of how the web page appears.

ATTACHMENT I

Verification of Beneficiary's MCO Enrollment



ATTACHMENT J
UC Pool: HCAIP Uniform Percentages

The table below provides the uniform percentages for the UC HCAIP Pool (STC 68). Should the state elect to revise the uniform percentages for DY 1, the state must submit a revised Attachment J by April 30, 2013. The state must submit a revised version of this attachment to CMS by February 28th of DY 2 through 5 for review and approval.

	DY 1	DY 2	DY 3	DY 4	DY 5
Uniform Percentage	20.35%				
Specialty Service Uniform Percentage	4%				
Tri-Level NICU Services Uniform Percentage	10.92%				
Tri-Specialty Uniform Percentage	11.83%				
Date revised	11/28/2012				

ATTACHMENT K
DSRIP Focus Areas

[PLACEHOLDER: Following CMS review and approval, the DSRIP Focus Areas (see STC 69)
will be placed in this attachment]

ATTACHMENT L
ID/DD Pilot Project

The following report was submitted by the state of Kansas on December 4, 2012, as a part of CMS' KanCare review. This report further describes the demonstration year 1 DD Pilot Project discussed in STC 52. The value-added services referenced in the report below are the result of contract negotiations between the state and its contracted MCOs. These value-added services are funded through MCO overhead and are not expenditures for which the state receives FFP. The charts of value-added services provided by each MCO are illustrative examples, and reflect the anticipated value-added services as of December 4, 2012.

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DD Pilot Project Summary

I. The purposes of the DD services pilot are to:

- a. Help providers acclimate to the managed care system before full implementation
- b. Help persons served and their family members and guardians learn more about and get used to the managed care system before full implementation
- c. Help the MCOs to gain a deeper understanding of the I/DD service system before full implementation
- d. Demonstrate better access and coordination to needed services through full-inclusion of services to demonstrate how the integration of DD services will merge with other Medicaid services in the KanCare program.
- e. Assist TCM with Care Coordination
 - Behavioral health
 - Employment issues
 - Housing options

II. Participation in the project is voluntary. Criteria and process for participation.

- a. Person Centered planning: A member wants to participate *and*
- b. A DD services provider wants to participate with a member (or members) who want to participate. One cannot participate without the other. If one of the member's service providers wants to participate, that is sufficient. For example, if a member receives residential, day services and targeted case management (TCM), any one of those providers participating will be enough for the member to participate.

Once a member and any of the member's providers want to participate, the member's TCM provider and CDDO will be required to support the member's participation by conducting some administrative functions for the State, primarily by providing/collecting information to and from members, providers, and the KanCare managed care organizations (MCOs).

III. Pilot Information and selection process:

Members that want to participate in the DD services pilot will have access to:

**ATTACHMENT L
ID/DD Pilot Project**

- a. Direct collaboration about and improved access to all of the member’s needed services, including about the member’s DD services, between the member’s providers and the KanCare MCOs.
- b. Direct information to each provider participant about how to succeed in the MCO networks, including how to contract with the MCOs, how to become a credentialed member of the MCOs’ provider networks, and how to prepare and submit claims for services provided. Some of these processes will be completed during the pilot project so that the providers will be pre-ready for joining the KanCare program on 1.1.14.
- c. Access for members to some additional value-added services that **are only available for DD services pilot participants**. These additional services are for only people choosing to participate in the DD services pilot, on these conditions:
 - They are for the use of those participants only for the first year of the program. Participation is voluntary
 - The MCOs will review the results of those VAS for those participants, take into account the input of those participants, and consider extending those VAS for year two of the KanCare program, when all DD waiver services are slated to come into KanCare.

The additional value-added services include:

For Amerigroup members:

Service	Overview
Personal Assistance Services	<ul style="list-style-type: none"> • Up to three days of supplemental personal assistance services that do not meet the 1915(c) waiver service definition. This service will not supplant the DD waiver services. For example, an individual in the hospital could be offered personal assistance during the hospital stay.
Transportation	Local community transportation for caregivers to non-provider, community locations with the member as approved by care manager (limit of 48 segments per calendar year) for various health and wellness activities
Caregiver Support Kit	<p>a one-time lifetime benefit that would be mailed to the pilot project participant member upon enrollment, including:</p> <p>Amerigroup communication to caregiver stating importance of role and giving appreciation.</p> <p>Dinner for four or four movie ticket vouchers for use during respite hours.</p> <p>Caregiver support book (link).</p>

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For Sunflower members:

Service	Overview
<p>For each service listed below, the member's Sunflower State care coordinator will assess the need of the member and provide approval on a case-by-case basis. If approved, the member's care coordinator will determine the amount or duration of the service, and it will become a part of the member's overall Plan of Care.</p>	
Hospital companion	<p>Sunflower State will coordinate with the hospital, family/guardian, and direct care provider to provide a companion who is familiar with the member and his/her specific needs while in the hospital. This service will be approved when determined medically necessary to promote comfort and recovery.</p>
Home modifications	<ul style="list-style-type: none"> • Sunflower State will work with the member, the family/guardian, and the DD Targeted Case Manager to identify any supplemental home modifications needed by the member either for health purposes, or to live successfully within the community. Services do not meet the 1915(c) waiver service definition. This service will not supplant the DD waiver service but might be offered to assist individuals in home modification in other instances. Example: For recreational access or a ramp for a family member's home.
Crisis intervention teams	<p>Sunflower State will work with its specialty companies NurseWise and Cenpatico to partner with the State, advocacy work groups, and other MCOs to further develop this important program.</p>
Remote behavioral health supports	<p>Sunflower State's specialty company, Cenpatico, has been involved in offering remote psychiatry through participating network providers. Sunflower will work with stakeholders and Kansas providers to further develop a program, including monitoring protocols for informed consent and protection of individual's rights that offers remote behavioral observation with the person's or guardian's informed consent, behavior support planning, family supports and training, and member monitoring.</p>
Practice visits to ob/gyns and dentists	<p>Sunflower State will offer "practice visits" for members with IDD, when needed to help them feel more comfortable with, and therefore be more likely to participate in, preventative visits to the OB/GYN and/or dentist. Sunflower State's sister companies in other states have found this to be beneficial for members.</p>
Member career development	<p>Sunflower State will work very closely with the developmentally disabled community, including the statewide Employment First Workgroup, in an effort to build a meaningful approach to increasing employment opportunities for persons with IDD. Sunflower will research the effectiveness of current Kansas supported employment programs, help support local programs that increase competitive employment opportunities, and create partnerships to develop further resources where needed. In addition, Sunflower will facilitate access to education of caregivers and consumers about the importance of employment, encourage scheduling of medical appointments that don't conflict with work hours, provide a care plan for HCBS services that supports the person's schedule for employment, and arrange and assist with</p>

**ATTACHMENT L
ID/DD Pilot Project**

	<p>transportation to and from employment settings, if not otherwise available.</p> <p>Sunflower State’s culture is to facilitate employment options, as well as extend employment where there is a fit. Through our national advisory group and other local community advisory groups we will establish additional employment opportunities.</p>
In-home caregiver support	<p>Sunflower State offers resources to caregivers on our website (links to community resources). In addition, our specialty company, Nurtur, has a significant array of articles and helpful information that are disease specific. Rather than providing a caregiver guide we avoid duplication and offer an independent approach by linking caregivers to local support and information groups already in existence. Examples include: CDDOs, Independent Living Centers, Aging and Disability Resource Centers, Families Together, Kansas Council on Developmental Disabilities, and many other local non-profits. We offer additional respite hours so the caregiver can take time to attend support sessions.</p>
Additional value adds for the ABD population	<p>Sunflower will work with local stakeholders and advisory groups to identify and offer additional needed benefits for members with IDD, contingent upon state approval.</p>

For United members:

Service	Overview
Respite	<p>The value add of respite is a temporary service provided on an intermittent basis to provide the beneficiary’s family (unpaid primary caregiver) short, specified periods of relief. Respite must be self-directed and in the beneficiary’s place of residence. It serves the family by:</p> <ul style="list-style-type: none"> · Meeting nonemergency or emergency family needs · Restoring or maintaining the physical and mental well- being of the beneficiary and/or his or her family · Providing supervision, companionship, and personal care to the beneficiary · Beneficiary meets MCO clinical guidelines for utilization of this benefit <p><u>Qualifications for the Value Add:</u></p> <ul style="list-style-type: none"> • Member must be: <ul style="list-style-type: none"> • participating in the DD pilot • be five years of age or older • meet the criteria for ICF/MR level • have a family member who services as the primary caregiver who is not paid to provide any HCBS DD program service for the beneficiary

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	<ul style="list-style-type: none">• Member's benefit is limited to <u>40 hours</u> per year• The cost of transportation to and from the beneficiary's place of residence or places in the community is included in the reimbursement rate paid to the providers of this service.• Financial Management Services (FMS) will be used to administer the self-direction
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Value Added services do not meet the 1915(c) waiver service definition. Personal services and home medication services offered as a Value Added Service will be for situations in which the existing waiver benefit is not available, and the MCO will have the responsibility to ensure that the services are delivered in ways that are responsive to needs of individuals.

- d. Access to information about how the DD services pilot is functioning, and what lessons are being learned from the pilot process. This includes the results of measures related to the pilot that will:
- Demonstrate MCOs working with KDADS, CDDOs and CSPs to understand and access KanCare structure (this measure focuses on providers participating in the pilot)
 - Measure improved access to needed services (this measure focuses on targeted case managers participating in the pilot)
 - Ensure members, families and guardians are aware of service options and how to access services in the KanCare structure, and report an increased understanding of the KanCare program (this measure focuses on members and families/guardians participating in the pilot)
 - Ensure MCOs have demonstrated an understanding of the Kansas DD service system (this measure focuses on the three KanCare MCOs).
 - Employment supports for volunteering members who need additional targeted work around removing barriers and building solutions to support employment options.
 - Behavioral supports for volunteering members who need additional targeted work around accessing needed behavioral supports in order to successfully remain in their home and community.
 - Housing for volunteering members who need additional targeted assistance to identify and explore potential housing supports in order to successfully remain in their home and community and maximize their independence.

IV. Selection process:

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Members or service providers who want to participate in the DD services pilot will be asked to complete *and submit the “Developmental Disabilities Pilot Participation Request” online form at the following*http://www.kdads.ks.gov/CSP/DD_Pilot_Info.html when the pilot is ready.

Members and providers selected to participate will be provided additional information and instructions. Participation in the DD pilot project will not be limited.

V. Measurements:

- a. Number of DD providers who, having requested it, report receiving helpful information and assistance from MCOs about how to enter their provider network.
- b. Number of DD providers submitting a credentialing application to an MCO, who completed the credentialing application to an MCO, who completed the credentialing process within 45 days.
- c. Number of DD providers who, having requested it, report receiving helpful information and assistance from MCOs about how to submit claims for services provided.
- d. Number of providers who, having participated in the DD pilot project, report understanding how to help the members they support understand the services available in the KanCare program and how to access those services.
- e. Improved access to services including physical health, behavioral health, specialists, prevention. Targeted Case Managers participating in the pilot will be the focus of this measurement.
- f. Wichita State University will facilitate the process for determining members and guardians are aware of service options and how to access services in the KanCare structure. Focus will be members, family members, parents and guardians participating in the pilot. Areas covered will include:
 - What is KanCare
 - DD services
 - TCM role
 - Care coordinator role
 - Coordination of DD services and other Medicaid services.
 - Provider network navigation and selecting an MCO
 - How can services are accessed to meet new or changing needs.
- g. MCOs have demonstrated an understanding of the Kansas DD service system.

ATTACHMENT L ID/DD Pilot Project

- MCOs demonstrate a knowledge and understanding of the statutes and regulations that govern the IDD service delivery system.
- MCOs demonstrate a knowledge and understanding of the person-centered planning process and regulations related to the process.
- MCOs demonstrate a knowledge and understanding of the various types of providers and the roles they play in the IDD service system.
- MCOs demonstrate a knowledge and understanding of the tools/strategies used by CDDO/Stakeholder processes.
- MCOs demonstrate a knowledge and understanding of the tools used by CDDOs to implement various local processes (local quality assurance, funding committees, crisis determinations, public school system collaboration, etc.)

The MCO demonstration of knowledge and understanding of these Kansas DD system issues should be reflected in the training and operation of customer service staff, provider relation representatives, member advisory staff, and grievance management staff.

SUMMARY:

Individual in DD Pilot	Individual on HCBS Waiver Only
<ul style="list-style-type: none"> • Voluntary direct and targeted assistance with specific care management issues that engage the spectrum of MCO coordination resources, including those that touch the HCBS waiver services. • Deeper bench of care management resources around specific issues that may be a barrier to successfully remaining in the person’s home/community and/or maximizing the person’s independence • Individualized training, information and focused discussions about the KanCare program, operational details, service details and structural details for volunteering members, their families/guardians and providers. • Additional array of value added services focused on DD pilot participants, including: <ul style="list-style-type: none"> • Extra Personal Assistance service • Transportation for caregivers • Caregiver support kit • Hospital companion • Supplemental home modification • Crisis intervention • Remote behavioral health supports • Practice visits to ob/gyn and dentist • Career development 	<ul style="list-style-type: none"> • Existing TCM and MCO coordination of non-HCBS waiver services • Existing waiver services. • Education about KanCare via existing TCM, outreach activities of the state and MCOs, and website-based or written materials. • Broadly offered value added services, based upon individual eligibility/applicability

ATTACHMENT L
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- In-home caregiver support
- Extra respite service for volunteers self-directing their services

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and CHIP Services
Children and Adults Health Programs Group

Susan Mosier, MD
Medicaid Director
Department of Health and Environment
900 SW Jackson Avenue Suite 900
Topeka, KS 66612

AUG 20 2012

Dear Dr. Mosier:

Thank you for your recent section 1115 demonstration application entitled, "KanCare." The Centers for Medicare & Medicaid Services (CMS) received your application on August 6, 2012. We have completed a preliminary review of the application, and have determined that the State's application has met the requirements for a complete application as specified under section 42 CFR 431.412(a).

In accordance with section 42 CFR 431.416(a), CMS acknowledges receipt of the State's application. The 30-day Federal comment period, as required under 42 CFR 431:416(b), begins on August 21, 2012, and ends on September 20, 2012. The State's application is available at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>.

We look forward to working with you and your staff on the proposed demonstration project. If you have additional questions or concerns, please contact your assigned project officer Ms. Jennifer Sheer, Division of State Demonstrations and Waivers, at (410) 786-1769, or at Jennifer.Sheer@cms.hhs.gov.

Sincerely,

/Angela D. Garner/ for

Allison Orris
Acting Division Director

cc: Victoria Wachino, CMCS
James Scott, ARA, CMS Kansas City Regional Office

August 6, 2012

The Honorable Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Kansas Section 1115 "KanCare" Demonstration Application

Dear Secretary Sebelius:

The State of Kansas (State) is pleased to submit to the Department of Health and Human Services (HHS) a formal application for a section 1115 demonstration waiver that will enable us to fundamentally reform Medicaid in Kansas (KanCare 1115 Demonstration). Our vision is to serve Kansans in need with a transformed, fiscally sustainable Medicaid program that provides high-quality, holistic care and promotes personal responsibility,

This application revises and builds on the proposal outlined in the State's January 26, 2012 concept paper, and the informal application submitted on April 26, 2012, and reflects additional consultation and public comment over the last several months. As laid out in the concept paper, this application is the first step in a two-track process,

The first track focuses on developing and implementing by January 1, 2013, a comprehensive, integrated care coordination program called "KanCare," developed with the input of thousands of Kansans over a year and a half. KanCare will offer vibrant options, including newly covered services such as bariatric surgery and adult heart transplants, and value-added services including adult preventive dental. KanCare offers more choice, does not cut provider rates, and does not reduce eligibility. It is projected to save more than \$1 billion over the next five years and move Kansans towards rewarding health outcomes.

The second track will begin longer-term discussion with CMS regarding future implementation of a global waiver that will administer an outcomes-based Medicaid and CHIP program under a per-capita block grant,

We appreciate the assistance your department has offered thus far and look forward to your continued support in meeting our January 1 timeframe and working with us to develop and implement innovative solutions to improve outcomes, strengthen the safety net, and manage costs,

Sincerely,

/Sam Brownback/

Sam Brownback
Governor of Kansas

Enclosure

cc: Marilyn Tavenner, Acting Administrator, Centers for Medicare and Medicaid Services
Cindy Mann, Director, Center for Medicaid and CHIP Services



STATE OF KANSAS

"KANCARE"

SECTION 1115 DEMONSTRATION

APPLICATION

August 6, 2012

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STATE OF KANSAS
“KANCARE”
SECTION 1115 DEMONSTRATION
APPLICATION
August 6, 2012

The State of Kansas (State), Department of Health and Environment (KDHE), is seeking Section 1115 demonstration waiver authority to fundamentally reform Medicaid in Kansas to improve outcomes and establish financial responsibility. This 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. Create and Support Alternatives to Traditional Medicaid

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 withoutwaiver 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

	<p>contracts to all current providers participating in Medicaid.</p> <p>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.</p>
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.

<p>There were lots of issues with a similar program in another state. How will you keep those problems from happening in Kansas?</p>	<p>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.</p>
<p>Consumers need to fully understand the program. What will you do to educate them?</p>	<p>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.</p>
<p>Where are details behind the savings assumptions?</p>	<p>The formal Section 1115 Demonstration Application contains details of savings estimates <i>Appendix E and F</i>.</p>
<p>The proposed 45-day choice period seems too short. How will the State ensure members are allowed choice among the KanCare plans?</p>	<p>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.</p>
<p>Will my services be cut? Will my hours be cut?</p>	<p>Services will not be cut. There are protections in the KanCare contracts which ensure that all beneficiaries receive the services they need.</p>
<p>How will the health homes program work?</p>	<p>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.</p>
<p>How will the State transition beneficiaries from the HealthWave program and other current programs that are well known?</p>	<p>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.</p>

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 (KPER) 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/KPER, 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

(Published in the Kansas Register June 14, 2012.)

**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	
<p>POVERTY LEVEL PREGNANT WOMEN 1902(a)(10)(A)(i)(IV) 1902(l)(1)(A)</p>	<p>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.</p>	
	<p>Income (150%FPL)</p>	<p>\$1650 two individuals</p>
		<p>\$2075 three individuals</p>
		<p>\$2500 four individuals</p>
<p>Resources</p>	<p>No resource test</p>	
<p>POVERTY LEVEL CHILDREN</p>	<p>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.</p>	
<p><i>NEWBORNS</i> 1902(a)(10)(A)(i)(IV) 1902(l)(1)(A)</p>	<p>Children under the age of 1 with family income equal to or less than 150% FPL</p>	
	<p>Income (150%FPL)</p>	<p>\$1225 one individual</p>
		<p>\$1650 two individuals</p>
		<p>\$2075 three individuals</p>
		<p>\$2500 four individuals</p>
<p>Resources</p>	<p>No resource test</p>	
<p><i>AGES 1-5</i> 1902(a)(10)(A)(i)(VI) 1902(l)(1)(C)</p>	<p>Children age 1 through 5 with family income equal to or less than 133% FPL.</p>	
	<p>Income (133% FPL)</p>	<p>\$1087 one individual</p>
		<p>\$1463 two individuals</p>
		<p>\$1840 three individuals</p>
		<p>\$2217 four individuals</p>
<p>Resources</p>	<p>No resource test</p>	

CATEGORY	CRITERIA	
<p style="text-align: center;"><i>AGES 6-18</i></p> <p>1902(a)(10)(A)(i)(VII) 1902(l)(1)(D)</p>	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	
<p style="text-align: center;"><i>DEEMED NEWBORNS</i></p> <p>1902(e)(4)</p>	Children born to a Medicaid mother are eligible for Medicaid coverage through the month of their first birthday.	
<p>LOW INCOME FAMILIES WITH CHILDREN</p> <p>1902(a)(10)(A)(i)(I) 1931</p>	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	
<p>TRANSMED – WORK TRANSITION</p> <p>1902(a)(10)(A)(i)(I) 402(a)(37) 1925</p>	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 18 th 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	
<p>QUALIFIED WORKING DISABLED (QWD) - if dually eligible for Medicaid</p> <p>1902(a)(10)(E)(ii)</p> <p>1905(s)</p>	<p>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.</p>	
	Income	\$1805/month (single)
		\$2429/month (couple)
	Resources	\$4000 (single)
\$6000 (couple)		
<p>MEDICARE PART D SUBSIDY - if dually eligible for Medicaid</p> <p>1860D-14</p>	<p>This program helps pay the costs associated with Medicare Part D prescription drug coverage for eligible individuals, including premiums and deductibles.</p>	
	Income	\$1354/month (single)
		\$1822/month (couple)
	Resources	\$11,010 (single)
\$22,010 (couple)		
<p>WORKING HEALTHY</p> <p>1902(a)(10)(A)(ii)(XV)</p>	<p>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.</p>	
	Income	\$2708/month (single)
		\$3643/month (couple)
	Resources	\$15,000 (single)
\$15,000 (couple)		
<p>WORKING HEALTHY MEDICALLY IMPROVED</p> <p>1902(a)(10)(A)(ii)(XVI)</p>	<p>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.</p>	
	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	
<p>LONG TERM INSTITUTIONAL CARE 1902(a)(10)(A)(ii)(V) Except for individuals residing in a public ICF/MR</p>	<p>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.</p>	
	Income:	\$62/month
	Resources:	\$2,000
<p>HOME AND COMMUNITY BASED SERVICES (HCBS) 1902(a)(10)(A)(ii)(VI)</p>	<p>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.</p>	
	Income:	\$727/month
	Resources:	\$2,000
<p>MONEY FOLLOWS THE PERSON</p>	<p>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.</p>	
	Income:	\$727/month
	Resources	\$2,000
<p>SPOUSAL IMPROVERISHMENT 1924</p>	<p>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.</p>	
	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/PT 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						5-YEAR
ANNUAL CHANGE						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%
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						5-YEAR
ANNUAL CHANGE						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%
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						5-YEAR
ANNUAL CHANGE						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%
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						5-YEAR
ANNUAL CHANGE						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%

	HY 1	HY 2	HY 3	HY 4	HY 5	5-YEARS
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%

	HY 1	HY 2	HY 3	HY 4	HY 5	5-YEARS
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%

	HY 1	HY 2	HY 3	HY 4	HY 5	5-YEARS
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%

	HY 1	HY 2	HY 3	HY 4	HY 5	5-YEARS
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)					TOTAL WOW
					DY 01	DY 02	DY 03	DY 04	DY 05	
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)					TOTAL WW
				DY 01	DY 02	DY 03	DY 04	DY 05	
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	
PMPM 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 Border City Children's Hospital Program	\$ 28,995,643	\$ 30,508,296	\$ 32,189,261	\$ 33,983,050	\$ 35,807,527	\$ 161,483,776
Pool 2	HCAIP (Health Care Access Improvement Program)	\$ 7,000,000	\$ 7,210,000	\$ 7,426,300	\$ 7,649,089	\$ 7,878,562	\$ 37,163,951
Pool 3	CAH	\$ 41,000,000	\$ 41,000,000	\$ 41,000,000	\$ 41,000,000	\$ 41,000,000	\$ 205,000,000
Pool 4							\$ -
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	\$ 267,655,414	\$ 306,950,665	\$ 351,483,357	\$ 403,095,089	\$ 1,781,709,760
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	\$ 549,693,961	\$ 557,552,450	\$ 566,217,835	\$ 575,359,816	\$ 2,356,064,279
Pool 1	Large Public Teaching Hospital Border City Children's Hospital Program	\$ 28,856,550	\$ 30,216,301	\$ 31,727,447	\$ 33,332,866	\$ 34,949,098	\$ 159,082,262
Pool 2	HCAIP (Health Care Access Improvement Program)	\$ 7,000,000	\$ 7,140,000	\$ 7,282,800	\$ 7,428,456	\$ 7,577,025	\$ 36,428,281
Pool 3	CAH	\$ 41,000,000	\$ 41,000,000	\$ 41,000,000	\$ 41,000,000	\$ 41,000,000	\$ 205,000,000
Pool 4							\$ -
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
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¹Excluded 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 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. §1396oG). 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 3810.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.

June 5, 2012

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attention: Victoria Wachino
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

RE: Kansas 1115 "KanCare" Demonstration Application Dated April 26, 2012

Ms. Wachino:

I am writing regarding the Section 1115 demonstration application that the State of Kansas submitted on April 26, 2012 to implement the "KanCare" program.

The State of Kansas is strongly committed to consultation with tribal governments, Indian Health Services (IHS) providers, and Urban Indian Organizations (I/T/U). Tribal governments and I/T/U providers have been included in broader KanCare stakeholder communications since the summer of 2011, when invitations were extended to Medicaid reform public forums by email. The State also participated in a Feb. 22, 2012, consultation meeting with representatives of four tribal governments. However, it has come to our attention that notice was not issued to the White Cloud Health Station and the Haskell Health Center, and for this reason the tribal consultation process approved under our Medicaid State Plan was not met.

Because of the State's commitment to a thorough consultation with all tribal government and I/T/U providers, and the unique circumstances of American Indians and I/T/U providers, we have concluded that further consultation regarding KanCare is appropriate. At the same time, we will also provide for broader public comment consistent with the transparency process established in the CMS regulations that became effective April 27, 2012. Therefore, we ask that you not consider our April 26, 2012, submission to be a formal proposal; we will send you a formal proposal once our consultation and public comment processes are complete.

We appreciate your openness to working with the State throughout this process and look forward to continuing our conversation as we work towards the January 1, 2013, implementation of KanCare.

Sincerely,

/Kari M. Bruffett/

Kari M. Bruffett
Director, Division of Health Care Finance
Kansas Department of Health and Environment

By email