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

January 29, 2014

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

Dear Dr. Mosier:

I am writing to inform you that the Centers for Medicare & Medicaid Services (CMS) has granted your request to amend Kansas' section 1115(a) demonstration (11-W- 00283/7), entitled "KanCare." Approval of this amendment is under the authority of section 1115(a) of the Social Security Act and is effective from the date of this letter.

This amendment approves the transfer of the Intellectually Disabled/Developmentally Disabled (ID/DD) 1915(c) waiver and related services and supports for the ID/DD population into KanCare managed care. Included in the Special Terms and Conditions (STCs) are specific requirements to remediate the underserved list that exists in the current 1915(c) ID/DD waiver as well as reporting requirements related to tracking the state's progress resolving this issue. With this approval, the ID/DD pilot program approved with the initial KanCare demonstration approval will sunset and Long Term Services and Supports (LTSS) for individuals participating in the pilot as well as other individuals enrolled in the ID/DD 1915(c) waiver will transition to the demonstration and into managed care. In addition improvements to the Kansas' Ombudsman program have been made in the STCs aimed at enhancing the beneficiary experience and reporting requirements.

CMS recognizes that one of the key benefits anticipated by Kansas in pursuing this comprehensive demonstration, including this amendment, is the opportunity to redirect a portion of savings from managed care improvements to increase access to community based long term services and supports. Kansas has already begun to realize this benefit by increasing the availability of slots for individuals who are currently on waiting lists for the section 1915(c) enrollment. CMS is pleased to see this progress and urges the state to assure that the commitment to increase access to services under the 1115 is realized at the same time that the state brings its ID/DD 1915(c) waiver into full compliance by assuring that current needs are fully met for individuals already served on the ID/DD waiver.

At this time, CMS is deferring the state's requests related to establishing three pilot programs to support persons who might otherwise be enrolled in Medicaid.

CMS approval of this amendment is conditioned on continued compliance with the enclosed set of STCs that define the nature, character, and extent of anticipated Federal involvement in the project. The award is subject to your written acknowledgement of the award and acceptance of the STCs within 30 days of the date of this letter.

The existing waiver and expenditure authorities for this demonstration are also enclosed and are unchanged by this amendment, and remain in force.

Your project officer for this demonstration is Ms. Lane Terwilliger. She is available to answer any questions concerning your section 1115 demonstration and this amendment. Ms. Terwilliger's contact information is:

Ms. Lane Terwilliger
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-2059
Fax: (410) 786-5882
E-mail: lane.terwilliger@cms.hhs.gov

Official communications regarding this demonstration should be sent simultaneously to Ms. Terwilliger and Mr. James Scott, Associate Regional Administrator for the Division of Medicaid and Children's Health in our Kansas City Regional Office. Mr. Scott's contact information is as follows:

Mr. James Scott
Centers for Medicare & Medicaid Services
601 E. 12th Street, Suite 235
Kansas City, MO 64106

If you have any questions regarding this approval, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services at (410) 786-5647.

Sincerely,

/s/

Cindy Mann
Director

cc: James Scott, ARA Region VII

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
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
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. DSRIP Planning Protocol
Attachment G. DSRIP Funding and Mechanics Protocol
Attachment H. Ombudsman Plan (moved the body of this attachment with enhanced protections into STC 42 effective February 1, 2014).
Attachment I. Verification of Beneficiary's MCO Enrollment
Attachment J. UC Pool Uniform Percentages
Attachment K. DSRIP Pool Focus Areas
Attachment L. ID/DD Pilot Project

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. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. The approved amended STCs will be effective upon issuance and the state will have an additional 30 days to accept the amended STCs in writing, or to begin an orderly phase-out of the Demonstration, in accordance with STC 9.

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 7below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval 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. <u>Compliance with Transparency Requirements 42 CFR Section 431.412</u>: 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 section 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 section 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 section 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 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. section 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. section 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 6 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 STC77, associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in STC78.

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				
Infants Less than one year old	1902(a)(10)(A)(i)(IV) 1902(l)(1)(B)	150%	N/A	Children
Children ages 1 through 5 years	1902(a)(10)(A)(i)(VI) 1902(l)(1)(C)	133%	N/A	Children
Children ages 6 through 18 years	1902(a)(10)(A)(i)(VII) 1902(l)(1)(D)	100%	N/A	Children
Permanent custodianship subsidy	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
Deemed Newborns	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
TRANSMED – WORK	1902(a)(10)(A)(i)(I)	Coverage for up to 12 months is provided to	N/A	Children

State Plan Mandatory Medicaid Eligibility Groups	Description	FPL	Resource Standard	Medicaid Eligibility Group (MEG)
TRANSITION (Transitional Medical Assistance (TMA))	408(a)(11)(A)1925 1931(c)(2)	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.		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
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

State Plan Mandatory Medicaid Eligibility Groups	Description	FPL	Resource Standard	Medicaid Eligibility Group (MEG)
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 NEEDY	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/ID	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
Autism Waiver	1902(a)(10)(A)(ii)(VI)	$727/month	$2,000	Waiver
Intellectual Disabilities/Developmental Disabilities	1902(a)(10)(A)(ii)(VI)	$727/month	$2,000	DD Waiver
Frail Elderly	1902(a)(10)(A)(ii)(VI)	$727/month	$2,000	LTC
Physically Disabled	1902(a)(10)(A)(ii)(VI)	$727/month	$2,000	LTC
Technology Assisted	1902(a)(10)(A)(ii)(VI)	$727/month	$2,000	Waiver
Traumatic Brain Injury	1902(a)(10)(A)(ii)(VI)	$727/month	$2,000	Waiver
Serious Emotional Disturbance	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 Intermediate Care Facility for Persons with Intellectual or Developmental Disabilities (ICF/ID)	1902(a)(10)(A)(ii)(V)	300% SSI $62/month Personal Needs Allowance	$2,000
RESIDENTS OF MENTAL	1902(a)(10)(A)(ii)(V)	$62/month	$2,000

Exclusions from KanCare	Description	FPL	Resource Standard
HEALTH NURSING FACILITIES			

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 76 and 77.

V. BENEFITS

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

a. KanCare Benefits. All populations outlined in STC 17are 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 receive1915(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; and,

vii. Intellectual Disabilities/Developmental Disabilities KS-0224 (effective February 1, 2014).

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
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	SPMI and SED not receiving personal care under the SED waiver

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

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.

e. Number of enrollees receiving 1915(c) services**.** The state must allow all eligible individuals to enroll into each 1915(c) delivery system until the enrollment cap has been reached in a given year.

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.

a. Additionally, individuals who are temporarily or permanently placed in a public Intermediate Care Facility for Persons with Intellectual or Developmental Disabilities

(ICF/ID) will also be disenrolled from their MCO.

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

33. 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.

34. 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.

35. 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.

iv. During the transition of ID/DD LTSS benefits into KanCare MCOs on February 1, 2014, 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 at full FFS rates. After the transition period, non-participating qualified providers will be reimbursed at 90 percent of the participating provider rate.

36. **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.

37. **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.

38. 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 46. The revisions to the Comprehensive Quality Strategy resulting from the section 1915(c) amendments required under STC 46 must be submitted to CMS for review and approval within 90 days of approval of the STC 456waiver 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 78, the state must also provide CMS with annual reports on the implementation and effectiveness of their comprehensive Quality Strategy as it impacts the demonstration.

39. 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.

40. State Advisory Committee. The state must maintain for the duration of the demonstration, a public managed care advisory group comprised of individuals, family members, interested parties, and stakeholders impacted by the demonstration's use of managed care, regarding the impact and effective implementation of these changes. 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 76.

41. 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.

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

a. <u>Core Elements of the Ombudsman.</u>

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

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

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

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

iv. *Staffing and training*. The Ombudsman must employ individuals who are knowledgeable about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; the health and support needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs, and the community based systems that support them. In addition, the Ombudsman shall ensure that its services are delivered in a culturally competent manner and are accessible to individuals with limited English proficiency and people with disabilities. The state shall develop an access standard to measure the availability and responsiveness of the system to beneficiaries and others seeking support from the Ombudsman, and shall report compliance with this standard to CMS in its quarterly and annual reports, as specified in STC 77 and 78. The system shall be staffed sufficiently to address all

requests for support consistent with this access standard.

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

vi. *Data Collection and Reporting*. The Ombudsman shall include a robust system of data collection and reporting. The state shall include this data in all quarterly and annual reports to CMS as specified in STCs 77 and 78. The state shall also develop a mechanism for public reporting. At a minimum, the state shall collect and report on the following elements:

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

b. The State will evaluate the impact of the Ombudsman program in the demonstration evaluation per STC 101.

43. 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

44. 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 individuals with intellectual and developmental disabilities (ICFs/IID) 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.

45. 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 78 as 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.

46. HCBS Quality. Within 12 months of transition of HCBS waivers into managed care, the State Medicaid Agency will submit revisions to the 1915(c) waivers (KS-0476, KS-0304, KS-4165, KS-4164, KS-0320, KS-0303, and KS 0224 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 38, 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 77 during this 12 month period.

47. **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 78. In this report the state must include: the total number of individuals in nursing facilities, and public ICF/IDs, the total number of people on each of the 1915(c) waiting lists; 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.

48. **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.

49. **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.

50. **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.

51. **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 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.

52. **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.

53. **ID/DD Pilot Project**. During demonstration year 1 and until the transition of, 1915(c) ID/DD waiver (KS-0224) to managed care effective February 1, 2014, 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 76, and in the quarterly and annual reports in STCs 77 and 78. The state must also include an evaluation of the DD Pilot Project in the demonstration evaluation design required per STC 103. Attachment L will sunset upon the transition of 1915(c) ID/DD waiver (KS-0224) to managed care effective February 1, 2014.

54. ID/DD in Managed Care. The ID/DD LTSS scope of services will be provided through managed care effective February 1, 2014, as follows:

a. Enrollees may keep current LTSS providers and services in their approved service plans, even if those providers are not in the network, for 180 days from February 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.
b. Enrollees using ID/DD residential providers may access those providers up to 1 year from February 1, 2014, regardless of contracting status.

c. The State will ensure MCOs comply with Kansas law regarding the duties of the CDDOs, including the provision of Targeted Case Managers. 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.

d. 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, further training for each MCO to ensure that they understand the DD services system.

e. The Kansas Department for Aging and Disabilities Services (KDADS) will, in state 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 process including the criteria utilized for such reviews and approvals/denials shall be publicly available.

f. In 2014, the State will ensure that all individuals who are receiving some but not all requested ID/DD waiver (KS-0224) services will have all assessed service needs met within 6 months of integration into managed care, as detailed in the approved 1915(c) waiver amendment. The state will review capitation rates with the MCOs once all KS-0224 service needs are identified.

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.

55. 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.

56. 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.

57. 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.

58. State Ride-Alongs. The state must complete ride-alongs with each MCO during the first 180 days of incorporation of ID/DD (KS-0224) LTSS benefits into managed care 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.

59. 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.

60. Call Center Response Statistics. During the first 30 days of incorporation ID/DD (KS-0224) LTSS benefits into managed care 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.

61. **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.

62. **Implementation Calls with the MCOs**. During the first 30 days of incorporation of ID/DD (KS-0224) LTSS benefits into managed care, the state must hold calls at least 2 times a week with the MCOs to discuss any issues that arise. The calls should cover all MCO operations and determine plans for correcting any issues as quickly as possible. After the first 30 days, if it is found that the frequency of calls is no longer needed then the state can scale back the calls, but must maintain 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 75.

63. **State Review of Beneficiary Complaints, Grievances, and Appeals.** During the initial implementation of ID/DD (KS-0224) LTSS benefits into managed care, the state must review complaint, grievance, appeal notices, and appeal logs for each MCO and data from the state or MCO operated incident management system. The state will use this information to implement any immediate corrective action necessary including revising notices. The state must review the data at least weekly for the first 90 days and then at least bi-weekly for the next 90 days. The state shall monitor MCO service authorization processes and participant appeals of service authorizations, reductions, or expirations, and intervene if the results of the appeals indicate broader problems in the service authorizations process. The state will continue to monitor these statistics throughout the demonstration period and report on them in the quarterly reports as specified in STC 77. Data and information regarding the beneficiary complaints, grievances, and appeals process must be made available to CMS upon request.

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

XI. SAFETY NET CARE POOL

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

65. 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 77, 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 66 and 67 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.

66. 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 66(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.

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

   b) 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	$39,856,550	$80,856,550
DY3	$41,000,000	$29,856,550	$70,856,550
DY4	$41,000,000	$19,856,550	$60,856,550
DY5	$41,000,000	$9,856,550	$50,856,550

c. UC Payment Methodology

   a) 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.

   b) Annual (DY) UC Payment limits are described in STC 66(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).

   c) HCAIP Pool. The payment structure for the HCAIP UC payments is as follows, subject to the annual limits in STC 66(b):

1) *Uniform Percentage*: The state shall calculate aggregate uncompensated care costs for HCAIP hospitals based on the information identified in STC 66(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 inpatient net patient revenue less than the amount identified in Attachment J shall receive an additional uniform percentage of its eligible UCC. The goal of including an inpatient net patient revenue threshold as a criterion for this adjustment is to recognize the added difficulty in providing access to multi-specialty services in smaller facilities. As such, the threshold must be evaluated annually to ensure smaller facilities that offer such multi-specialty services would not be inadvertently ineligible for such payment merely based on standard industry growth in patient revenues.

5) In addition to the inpatient net patient revenue threshold applicable to the Tri-Specialty adjustment the uniform percentages for each of the four adjustments for each demonstration year may also be found in Attachment J. By April 30, 2013, the state must submit a revised Attachment J for CMS review and approval should the state elect to modify inpatient net patient revenue threshold and/or 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 inpatient net patient revenue threshold based on the normal trend in patient revenues and 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.

   d) <u>LPTH/BCCH Pool</u>. The payment structure for the LPTH/BCCH UC payments will be calculated in accordance with STC 66(c)(i), up to the limits set forth in STCs 66(b) and 66(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.

    a) 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.

    b) 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:

    a) 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.

b) Within 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. <u>UC Pool Timeline</u>

a) 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

b) 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.

c) 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.

67. Delivery System Reform Incentive Payment (DSRIP) Pool. The DSRIP Pool is available in DY 3through 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 67(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:

a) *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.

b) *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.

c) *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 within4 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.

d) *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 697m) 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:

a) 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;

b) Describe the process the state utilized to solicit public input into the development of the DSRIP Planning Protocol;

c) Describe the projects hospitals may select from when designing the Hospital DSRIP Plans;

d) Specify the Project Milestones, as shown in STC 67(c) above, for each project, from which each eligible hospital will select to create its own projects. DY 4 through 5 must include Category 3 milestones that build off of DY 3's Category 1 and 2 milestones;

e) Establish a process for rapid cycle evaluation for each plan and for the DSRIP overall (see STC 67(n));

f) 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);

g) Detail the requirements of the Hospital DSRIP Plans, consistent with STC 67(g); and,

h) 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 67(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:

a) Describe the process the state utilized to solicit public input into the development of the DSRIP Funding and Mechanics Protocol;

b) 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;

c) 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;

d) Allow sufficient time for CMS to conduct its review of the Hospital DSRIP Plans (minimum 2 months);

e) 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;

f) Include templates of the hospital-specific application and any data books or reports the hospitals may be required to provide;

g) 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;

h) Include the template for all annual and semi-annual reports the hospitals will be required to submit under STC 67(f)(vii) above;

i) 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: 1 month);

j) Specify the penalty if either the state or CMS determines that a hospital has failed to meet its approved metric (see STC 67(i)(i) below);

k) 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 3 through 5, consistent with STCs 67(i) and 67(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;

l) 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);

m) 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,

n) 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.

a) 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;

b) 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 67(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 3through 5. Each project must include Category 3 milestones in DY 4 through 5 (note that Category 3 milestones may also be reported in DY 3).Category 4 Performance Indicators must be reported every year. (DY 3 through 5).
   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 4through 5 (note that Category 3 milestone may also be reported on in DY 3). 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 4 and DY 5, and all such funds allocated in any subsequent Demonstration extension years, 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 67(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 697j) 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.

a) 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

a) Hospitals may not submit their Hospital DSRIP Plans until after CMS approval of the Planning Protocol and the Funding and Mechanics Protocol.

b) 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.

c) 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.

d) 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, 2014, the state may not claim FFP for DSRIP Payments made to that hospital for any DY, except under the circumstances described in STC 67(j)(v).

e) If either (A) or (B) below applies, the state may submit a Hospital DSRIP Plan to CMS no later than February 28, 2015 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 3 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 2 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, 2015.

a. If the Hospital DSRIP Plan is approved by April 30, 2015, the hospital is eligible for DY 3 through 5 payments.

i. If the Hospital DSRIP Plan is not approvable on April 30, 2015, 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, 2014, the hospital may continue to work with the state and CMS to obtain approval by April 30, 2015.

i. If the Hospital DSRIP Plan is approved by April 30, 2015, the hospital is eligible for DY 3 through 5 payments.

ii. If the Hospital DSRIP Plan is not approvable on April 30, 2015, 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 3 through 5 Payments**.** Each hospital with a Hospital DSRIP Plan approved by the state and CMS by December 31, 2014 (or the target date specified in STC 67(j)(v) above) may receive DSRIP Payments in 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 67(o), the state may claim FFP for DSRIP Payments in each DY up to the limits (total computable) described in the table in STC 68.

m. DSRIP Pool Timeline

a) DY 1 and 2

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 May 31, 2014 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, 2014, 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, 2014 for CMS to issue its final approval of these protocols.

b) DY 3

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, 2015, all of its DY 3 DSRIP payment must be withheld pending the approval of the plan.

c) DY 4 through 5

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

d) 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 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.

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

b) The state may not claim FFP for DSRIP Payments in DY 3 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.

c) In addition to the documentation discussed in STC 66(e), the state must use the documentation discussed in STC 67(f)(vi) to support claims made for FFP for DSRIP Payments that are made on the CMS-64.9 Waiver forms.

68. 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 3 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	$39,856,550	$29,856,550	$19,856,550	$9,856,550	$139,282,750
DSRIP	N/A	N/A	$	$20,000,000		

			$10,000,000		$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

69. 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.

70. Transition Plan for Funding Pools. No later than April 1, 2017, 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.

71. 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

72. 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.

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

74. 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.

75. 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.

76. 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.

77. 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. Claims adjudication statistics from each of the MCO provider types;

d. Updates on the post award forums required under STC 15;

e. Action plans for addressing any policy and administrative issues identified;

f. 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.

g. Updates on the ID/DD Pilot Project per STC 53;

h. Updates on the operations, outcomes, and activities of the Ombudsman program per STC 42;

i. Updates on the managed care and HCBS quality strategies per STCs 38 and 46;

j. Information on beneficiary complaints, grievances and appeals per STC 63;

k. The number of plans of care subject to the state review and approval or denial for members receiving LTSS under any 1915(c) authority for which a reduction, suspension or termination of services is has been proposed, per STC 54.

l. 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;

m. 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;

n. 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,

o. Evaluation activities and interim findings.

78. 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 77 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 38, 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 45, the state must report on the progress of meeting its MFP benchmarks within the MCOs;

f. HCBS waiver waitlists. Pursuant to STC 47, the state must report on the status of individuals receiving community-based services (HCBS-like services) while on a waitlist;

g. Number of institutional days and number of admissions for nursing facility and ICF/IIDs. These numbers should include those admitted from the MCOs HCBS delivery system into each institutional setting and those who are not KanCare HCBS recipients admitted from the community into each institutional type as specified in STC 47.

h. Ombudsman program. Pursuant to STC 42, the state must report on the operations, outcomes, data collected, and activities of the Ombudsman program;

i. ID/DD Pilot Project. Pursuant to STC 53, the state must report close out activities following the sunsetting of the pilot on January 31, 2014, on the status of the ID/DD Pilot

Project; and,

j. 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.

79. 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

80. 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.

81. 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 81(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, 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 though ix below represent *Medicaid Eligibility Groups* (MEGs); STC 17specifies 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"]

82. **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 81f) 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.

83. **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.

84. **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.

85. **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 797

a. The state must report the actual number of member months for Eligibility Groups i though ix as defined in STC 81(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 4 eligible member/months.

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

86. 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.

87. 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.

88. 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.

89. 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.

90. **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.

91. **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

92. 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.

93. 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.

94. 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 81(f));

c. Disproportionate Share Hospital (DSH) payments;

d. Graduate Medical Education (GME) payments;

e. Pharmacy rebates (see STC 81(e)); and

f. Costs for excluded populations (see STC 19).

95. 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 81(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 STC85 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.

96. 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 STC 81(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 STC 9), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of the Composite Federal Share may be used.

97. 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 95(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 STC 81.

98. 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.

99. 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

100. 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

101. 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.

a) 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?

b) 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?

c) How did the Ombudsman's program assist the KanCare program and its beneficiaries?

d) 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?

e) How did the UC Pool impact care under Medicaid in the state?

f) 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 67?

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.

102. Final Evaluation Design. CMS shall provide comments on the draft Evaluation Design described in STC 101 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.

103. 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.

104. 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.

105. 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.

106. 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 66
Within 30 days of approval	Submit revised MFP Operational Protocol	Section IX, STC 44
March 31,2013	Submit DSRIP Pool Focus Areas	Section XI, STC 67
120 days from date of award letter	Submit Draft Evaluation Plan	Section XV, STC 101
April 30, 2013	Submit a revised Attachment J (if the state wishes to revise the DY 1 percentages)	Section XI, STC 66
Within 90 days of UC Payment Application template approval	Submit DY 1 UC Payment Applications	Section XI, STC 66
May 31, 2013	Submit Draft DSRIP Planning Protocol	Section XI, STC 67
May 31, 2013	Submit Draft DSRIP Funding and Mechanics Protocol	Section XI, STC 67
Within 60 days of receipt of CMS comments	Submit a Final Evaluation Plan	Section XV, STC 102
September 30, 2013	Submit Hospital DSRIP Plans	Section XI, STC 67
Within one year of approval	Submit 1915(c) amendments to revise performance measures	Section IX, STC 46
Within 90 days of approval of STC 43 changes	Submit revised Comprehensive State Quality Strategy	Section VII, STC 38
Within 120 days of expiration	Submit a Draft Final Evaluation Report	Section XV, STC 105
Within 120 days of expiration	Submit a Draft Final Report	Section XII, STC 79
90 days of receipt of CMS comments	Submit Final Evaluation Report	Section XV, STC 105
Within 90 days of receipt of CMS comments	Submit Final Report	Section XII, STC 79

	Deliverable	STC Reference
Annual	By April 1st - Draft Annual Report	Section XII, STC 78
	By February 28th – Submit revised Attachment J	Section XI, STC 67
	By March 31st – UC Payment Applications	Section XI, STC 67
	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 67
Each Quarter (02/28, 05/31, 08/31, 11/30)		
	Quarterly Operational Reports	Section XII, STC 77
	Quarterly Enrollment Reports	Section XII, STC 77
	CMS-64 Reports	Section XIII, STC 80
	Eligible Member Months	Section XIII, STC 85

ATTACHMENT A

Quarterly Report Content and Format

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

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

NARRATIVE REPORT FORMAT:

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

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

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

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

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

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

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						**5-YEAR AVERAGE**
			ANNUAL CHANGE			
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%

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						**5-YEAR AVERAGE**
			ANNUAL CHANGE			
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%

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						**5-YEAR**

ATTACHMENT B
Historical Budget Neutrality Data

	ANNUAL CHANGE				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						**5-YEAR**
			ANNUAL CHANGE			**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%

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**

ATTACHMENT B
Historical Budget Neutrality Data

	ANNUAL CHANGE				AVERAGE
TOTAL EXPENDITURE	-7.49%	-16.91%	47.73%	-18.63%	-1.96%
ELIGIBLE MEMBER MONTHS	-12.51%	-8.47%	8.30%	-10.60%	-6.16%
PMPM COST	5.74%	-9.23%	36.40%	-8.98%	4.48%

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	ANNUAL CHANGE				5-YEAR AVERAGE
TOTAL EXPENDITURE	14.85%	7.29%	-5.40%	10.20%	6.46%
ELIGIBLE MEMBER MONTHS	21.75%	-16.05%	-10.78%	0.34%	-2.19%
PMPM COST	-5.66%	27.80%	6.02%	9.82%	8.85%

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	

ATTACHMENT B
Historical Budget Neutrality Data

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
Geary Community Hospital	Junction City	Geary
Great Bend Regional Hospital, LLC	Great Bend	Barton
Hays Medical Center	Hays	Ellis
Kansas City Orthopedic 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
Mid-America Rehabilitation Hospital	Overland Park	Johnson
Morton County Health System	Elkhart	Morton

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

Hospital Name	City	County
Complex		
Marillac Center Inc	Overland Park	Johnson
Prairie View Hospital	Newton	Harvey

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]

ATTACHMENTS F and G
DSRIP Planning Protocol

Section 1. Preface

Section XI of the Kansas KanCare Section 1115 Demonstration authorizes a Delivery System Reform Incentive Payment (DSRIP) pool available in DY 3 (CY 2015) through DY 5 (CY 2017) 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.

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

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

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

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

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

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

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

a. Background

The DSRIP pool program will be implemented in Kansas as part of a major delivery system overhaul that converted nearly all Kansas Medicaid and CHIP populations and services into a risk-based capitated managed care program. That program is known as KanCare and represents one of the largest reform efforts for the Kansas Medicaid and CHIP programs in recent years.

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

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

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

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

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

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

c. DSRIP Goals and Focus Areas

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

- Access to services
- Healthy living, and
- Healthy communities

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

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

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

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

Section 2. DSRIP Projects and Project Metrics

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

a. Projects

Participating DSRIP hospitals will design and implement at least 2 DSRIP projects, selected from the list below.

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

1. Focus area 1: Access to integrated delivery systems
   - Project 1.a: Expansion of Patient Centered Medical Homes and Neighborhood

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

b. Metrics

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

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

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

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

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

2. ***Process milestones (Category 2):*** Metrics associated with these milestones focus on process changes and improvements. All providers must include a measure of the quantifiable patient impact of each project on the Medicaid and low-income uninsured population. In addition, as part of the ongoing monitoring of DSRIP

projects (as described in section 6 below), the state or CMS may add category 2 metrics to a project prospectively in order to address implementation concerns with "at risk" projects.

i. Number of Medicaid/ CHIP beneficiaries served by the project (P4P)
ii. Project specific metrics selected by hospitals and approved by the state for each project, as specified in Appendix A (P4P)
iii. Additional project-specific metrics, established by the state or CMS for a particular project, especially "at risk" projects (P4P)

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

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

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

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

c. Metric Targets

All participating hospitals must have a target for all pay-for-performance metrics, which will be used to determine whether or not the associated milestone was achieved (and whether the

participating hospital is eligible for DSRIP payments, based on the mechanism described in section 6 below).
To assist participating hospitals in setting targets, the state will specify a high performance level for all category 3 pay-for-performance metrics in Appendix B. Performance targets should be based on the higher of top decile of performance for state or national data, or an alternative method approved by CMS.

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

d. Metric attribution method

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

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

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

specific measure specification for continuous enrollment criteria. It will also allow for the addition of new Medicaid beneficiaries attributed to the DSRIP Project during the year, and any other adjustments necessary to assure a proper measurement denominator.

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

1. Beneficiaries who do not receive qualifying services from the DSRIP hospital or project associated community partners will be excluded from the attribution.

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

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

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

   i. Matching Goal – the goal is to make the best assignment to the DSRIP hospital based on the beneficiary's current utilization patterns and assigned providers. If the project specifically targets IPPs that have a responsibility for beneficiaries due to assignment through an enrollment process (PCPs, HHs, and NFs), the provider with the current assignment will be matched regardless of past utilization of services. Otherwise, the DSRIP hospital and its IPPs that have provided a higher proportion of qualifying services for the beneficiary will be assigned the beneficiary.
   ii. Service Groupings – To meet this goal, the methodology will aggregate beneficiary service volume across four different groups of services (depending upon the identified project) and assign attribution using a defined hierarchy such as:
      - 1st priority – assigned providers (PCPs, HHs, NFs)
      - 2nd priority – other outpatient providers (specialists, behavioral health)
      - 3rd priority – emergency department (ED);
      - 4th priority – inpatient hospitalization.
   iii. Attribution Method – Once the identified project's network of providers (DSRIP hospital and associated IPPs) is finalized, the network will be loaded into the attribution system for beneficiaries to be assigned based on the above matching methods and service groupings. Depending on the specific project's hierarchical

prioritization, the first step may be to try to assign a beneficiary to a DSRIP provider network based on enrollment/assignment to any of the project's IPPs. If no beneficiary assignments with the IPPs exist, the algorithm would move on to tally the number of services received by the beneficiary from IPPs that are other outpatient providers (specialists, behavioral health). The beneficiary would be assigned to the provider network with the most IPP services provided. If no outpatient provider visits, the algorithm would proceed to look for ED visits at EDs within the project network. If no ED visits, the algorithm would look for hospitalizations at hospitals within the project network.

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

Section 3. Hospital DSRIP Plan Requirements

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

a. Executive Summary

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

b. Background Section

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

Specifically, the background section will include the following components:

1) **Provider Demographics** including:
   a) Name, Address, Senior level person responsible for the DSRIP project and to whom all correspondence should be addressed
   b) The name of community partners participating in each project

c) Definition of service area and the name of the community partners participating in the project that will be used for the purpose of attributing members for calculating metrics, according to the method described in 2.d above.

2) **Identification of Need for Project:**
The participating hospital will need to provide objective data-driven evidence that this is a relevant goal for the participating hospital and its service area. The participating hospital must demonstrate that all relevant Category 3 metrics for the projects selected align with community needs and that these areas have room for improvement by submitting baseline data on its Category 3 metrics at the time of application. If the participating hospital's baseline performance on the majority of any chosen Category 3 metric set is within 10 percentage points or 1.5 standard deviations to the high performance goal (whichever is greater) , the project would not be approved.

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

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

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

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

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

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

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

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

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

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

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

8) **Data sharing and confidentiality**: Metrics will be collected in a uniform and valid fashion across the participating hospital and its community partners. As a result, the plan must include provisions for appropriate data sharing arrangements that permit this and appropriately address all HIPPA privacy provisions.

9) **Expectation of Sustainability:** Participating hospitals are asked to explain how the outcomes of this project will be sustained at the end of DSRIP and how gains can be continued after the conclusion of the project period.

d. Project Milestones and Performance Indicators Table

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

e. Funding Estimates

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

Section 4. Project Valuation

a. Valuation for each project

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

Step 1: Base Valuation

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

Project Base Valuation					
DSRIP Hospital	Base Value Proportion	DY 3	DY 4	DY 5	Total
LPTH Pool	75%	5,625,000	11,250,000	16,875,000	33,750,000
BCCH Pool		1,875,000	3,750,000	5,625,000	11,250,000
	Total	7,500,000	15,000,000	22,500,000	45,000,000

Step 2: Secondary Valuation

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

The secondary valuation will be applied as follows:

- Partner valuation payments: 15 percent secondary payment valuation if at least 20 percent of the patients served through the project are affiliated with external community partners.

- Trailblazer valuation payments: 10 percent secondary payment valuation for including outreach and capacity-building components that disseminate the project's outcomes and methods to rural and underserved areas of Kansas in order to expand access to best practices.

Secondary Project Valuation					
DSRIP Hospital	**"Partner" Secondary Value Proportion**	**DY 3**	**DY 4**	**DY 5**	**"Partner" Total**
LPTH Pool	15%	1,125,000	2,250,000	3,375,000	6,750,000
BCCH Pool		375,000	750,000	1,125,000	2,250,000
	Subtotal	1,500,000	3,000,000	4,500,000	9,000,000
DSRIP Hospital	**"Trailblazer" Secondary Value Proportion**	**DY 3**	**DY 4**	**DY 5**	**"Trailblazer" Total**
LPTH Pool	10%	750,000	1,500,000	2,250,000	4,500,000
BCCH Pool		250,000	500,000	750,000	1,500,000
	Subtotal	1,000,000	2,000,000	3,000,000	6,000,000
	Total	2,500,000	5,000,000	7,500,000	15,000,000

Step 3 Calculation of Total Value

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

b. DSRIP Allocation

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

DSRIP Allocation (All Funds)

	Funding Allocation	DY 3	DY 4	DY 5	Total
LPTH (KU Hospital)	75%	7,500,000	15,000,000	22,500,000	45,000,000
BCCH (Children's Mercy Hospital)	25%	2,500,000	5,000,000	7,500,000	15,000,000
	100%	10,000,000	20,000,000	30,000,000	60,000,000

c. Milestone Valuation

Once the overall project valuation is set, incentive payment values will be calculated for each metric/milestone category in the DSRIP project plan by multiplying the total valuation of the project in a given year by the milestone percentages specified below. Within each metric category and pay for performance grouping, and within each milestone category for pay for reporting grouping, the value for each metric and milestone will be equally divided between all metrics in a given grouping.

Metric Milestone Categories	Payment Type	DY 3 2015	DY 4 2016	DY 5 2017
Project Category 1 (Infastrusture Milestones)	Performance / Reporting	45%	25%	10%
Project Category 2 (Process Milestones)	Performance / Reporting	30%	25%	20%
Project Category 3 (Quality and Outcome Milestones)	Performance	5%	25%	45%
	Reporting	10%	10%	5%
Project Category 4 (Population Focused Improvement Milestones)	Performance	0%	5%	15%
	Reporting	10%	10%	5%

Section 5. Hospital Plan Review Process

a. Overview of Review Responsibilities

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

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

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

b. <u>State Review Process</u>

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

- The plan is in the format and contains all required elements outlined in the Kansas DSRIP Planning, Funding and Mechanics Protocols and is consistent with STC 69.
- All projects clearly identify Category 1, 2 and 3 milestones as described in STC 69 (c)(i-iii)
- All projects clearly identify the population focused health improvement measures (Category 4) to be reported.

- The description of the project is coherent and comprehensive and includes a logic model clearly representing the relationship between the goals, the interventions and the measures of progress and outcome
- The project selection is grounded in a demonstrated need for improvement at the time that the project is submitted and is sufficiently comprehensive to meaningfully contribute to the CMS three part aim for better care for individuals, better health for the population, lower costs through improvement (i.e. Triple Aim), and while at the same time charting a path towards future sustainability.
- The likelihood for success of this intervention is based on, where available, accurate and robust citations to the evidence base.
- The plan includes an approach to rapid cycle evaluation that informs the system of progress in a timely fashion, and how that information will be consumed by the system to drive transformation and who will be accountable for results, including the organizational structure and process to oversee and manage this process. The plan must also indicate how it will tie into the state's requirement to report to CMS on a rapid cycle basis.
- The goals are mapped to a robust and appropriate set of research hypotheses to support the evaluation.
- The amount and distribution of funding is in accordance with STC 69 (g)(iii) , STC 70 and Section 8 of this combined protocols document
- The proposed projects are new or significantly enhance existing health care initiatives and do not duplicate other CMS and Department of Health and Human Services (HHS) funded initiatives in which the hospital participates
- The plan and all of the projects proposed are consistent with the overall goals of the DSRIP program

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

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

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

c. CMS Review

The State will submit hospital DSRIP plans to CMS no later than September 30, 2014 for CMS

review with a target date for final approval by CMS of December 31, 2014.

In addition to approving the review protocol, CMS will review the plans to determine whether the protocol was followed, will identify any systematic gaps between the protocol and the actual reviews, and will provide such findings to the state to address these gaps in reviews by the independent assessor and by the state. Assuming that CMS finds that the reviews are consistent with the review protocol, CMS will accept the state's recommendations for approval with the following possible exceptions which will be applied at CMS's discretion:

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

CMS will complete its review by no later than December 31, 2014. CMS reserves the right to conditionally approve plans, and to allow modifications to plans to resolve issues it identifies in its review provided that the modifications are made to the plan and found acceptable by CMS according to the timeline provided by CMS.

Section 6. Reporting Requirements and Ongoing Monitoring

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

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

a. Semi-annual reports

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

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

The state and CMS must certify that a hospital has met its approved metrics as a condition for the release of associated DSRIP funds to the hospital. A hospital may only receive DSRIP payments following the successful achievement of metrics as reflected in its reports and as approved by both the state and CMS. If either the state or CMS determines the hospital did not fully and successfully achieve a metric, payment to the hospital for that metric will not be issued. DSRIP hospitals will have all supporting documentation available for review by the state and CMS, if requested.

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

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

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

b. Rapid Cycle Evaluation

The DSRIP program will support a process of data-driven, rapid cycle improvement that will gather data in real time and make recommendations to the State, CMS and hospitals about how to ensure timely progress in promoting the overall goals of the DSRIP program. As previously

noted, these goals are: healthy living; healthy communities; and access to services. Each Hospital DSRIP Plan will address their process for continuous performance improvement in order to improve efficiencies, quality and experience while reducing or eliminating inefficiencies, waste and redundancies. Upon completion and approval of the Hospital Plans, the State and the external evaluator will further develop the process for rapid cycle evaluation for the DSRIP program overall by submitting a learning collaborative plan to CMS by March 1, 2015.

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

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

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

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

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

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

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

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

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

c. Independent Evaluation of DSRIP Program and Projects

The DSRIP evaluation will include review of process and outcome measures related to milestones identified in Categories 1 through 4. Quantitative and qualitative data sources will be used in calculation of the process and outcome measures. The DSRIP evaluation plan (see table below) will be more fully designed once specific DSRIP project documents are further developed. The Kansas Foundation for Medical Care, Inc has been contracted with as the external evaluator, in accordance with STC 69 (e) vi.

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

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

Section 7. Disbursement of DSRIP funds

a. General principles

Aggregate incentive payments available over the 3 year demonstration period will be based on the project valuation approved by the state, subject to the limits set forth in section 4.c. above. DSRIP payments for each participating hospital are contingent on:

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

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

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

b. Incentive Payment Formula

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

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

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

Hospital improvement metric targets will be established annually using baseline data for DY 3 and then annually thereafter for DY 4-5, as described in section 2.c above. The Achievement Value for Pay for Performance metrics will be established by comparing the hospital results for the reporting period with the improvement target for the hospital. If the hospital meets the improvement target for the metric, the hospital will receive an AV of 1.

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

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

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

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

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

c. Non-Duplication of Federal Funds

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

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

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

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

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

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

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

Section 8. DSRIP Plan Modifications in Limited Circumstances

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

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

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

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

ATTACHMENT H

Ombudsman Plan

This attachment excluding the report from Kansas referenced below has been moved to STC 42 , which modified and supersedes this attachment..

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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900 SW Jackson Street, Room 900-N
Topeka, KS 66612

Kansas Department of Health and Environment
Division of Health Care Finance

Phone: 785-296-3981
Fax: 785-296-4813
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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ATTACHMENT 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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Phone: 785-296-3981
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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-Network		
KMAP Secure Web Site	Entities enrolled with KMAP have access to the Secure Web site. Through the site, a user can verify eligibility by keying a valid combination of the following: • Beneficiary ID and date of birth • Social Security No. and date of birth • Name and date of birth	22 hrs/day 7 days/week	X	X		N/A	N/A
State Secure Web Site	Approved users have access to the KMAP Secure Web Site realm used by enrolled MCOs and provider by accessing a dedicated State Secure Web site. Through the site, a user can verify eligibility by keying a valid combination of the following: • Beneficiary ID and date of birth • Social Security No. and date of birth • Name and date of birth	22 hrs/day 7 days/week	N/A	N/A	N/A	X	X
Automated Voice Response	Entities enrolled with KMAP have access to the Automated Voice Response System by	22 hrs/day 7 days/week	X	X		N/A	N/A

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

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

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

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, *UHCOnline,* 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, *UHCOnline*provides access to a variety of comprehensive plan information, including functionality that allows providers to verify member eligibility and view member ID cards. Information and training is provided during educational tours.

ATTACHMENT I
Verification of Beneficiary's MCO Enrollment

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

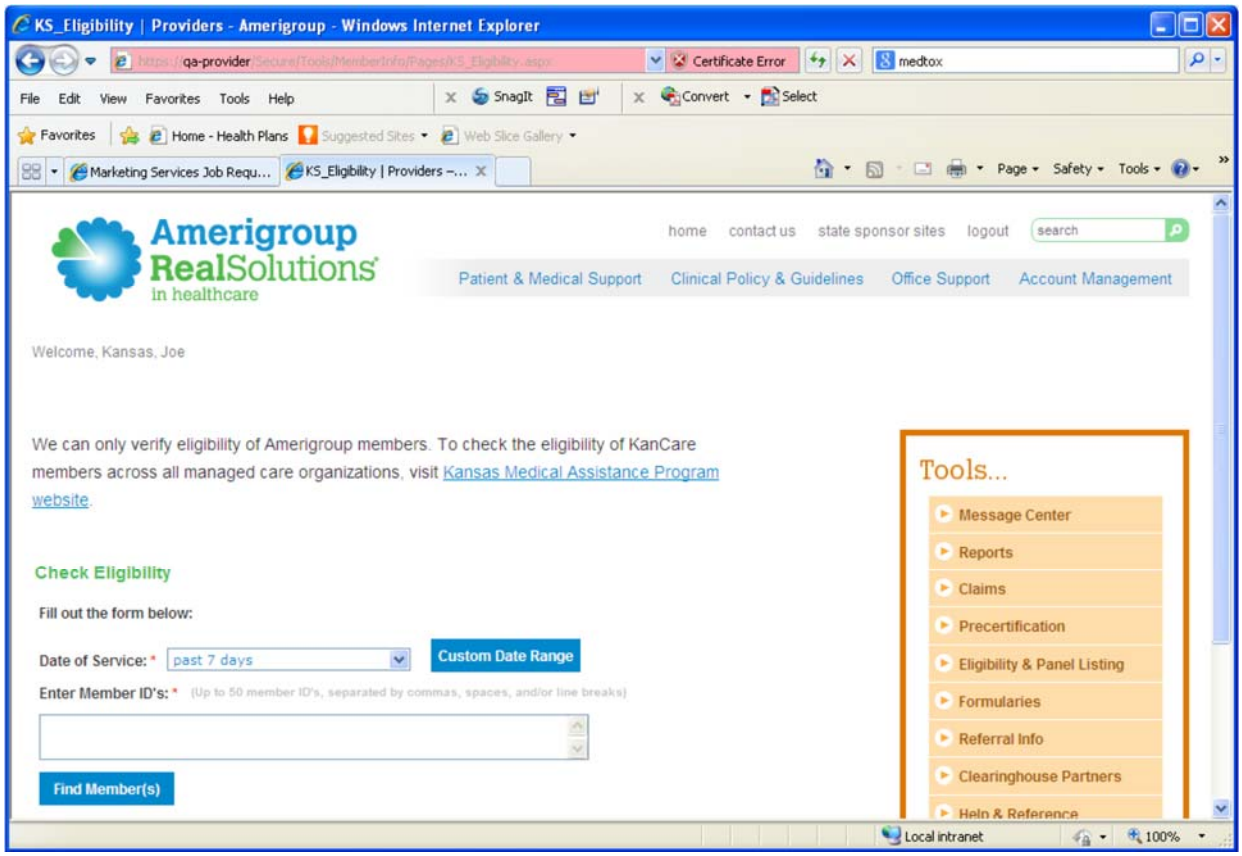
► **Sunflower Health Plan:** Sunflower providers and Non-Par providers can use the following methods to verify enrollees' eligibility if they present for services without an ID card or go to the wrong provider.

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: CAIP 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 and the inpatient net patient revenue threshold, the state must submit a revised Attachment J by April 30, 2013. The state must submit a revised version of this attachment to CMS by February 28th of DY 2 through 5 for review and approval.

	DY 1	**DY 2**	**DY 3**	**DY 4**	**DY 5**
Uniform Percentage	18.55%	14.65%	12.67%	11.13%	
Specialty Service Uniform Percentage	3.72%	3.72%	3.72%	3.72%	
Tri-Level NICU Services Uniform Percentage	10.92%	10.92%	10.92%	10.92%	
Tri-Specialty Uniform Percentage	11.83%	11.83%	11.83%	11.83%	
Tri-Specialty Inpatient Net Patient Revenue Threshold	$250,000,000	$300,000,000	$300,000,000	$300,000,000	
Date revised	3/31/2013	3/31/2014	3/31/2015	5/27/2016	

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

This Pilot Project sunsets on January 31, 2014 with the incorporation of ID/DD (KS-0224) LTSS benefits into managed care effective February 1, 2014.

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:

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	• 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	a one-time lifetime benefit that would be mailed to the pilot project participant member upon enrollment, including: Amerigroup communication to caregiver stating importance of role and giving appreciation. Dinner for four or four movie ticket vouchers for use during respite hours. Caregiver support book (link).

For Sunflower members:

Service	Overview
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**.	
Hospital companion	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.
Home modifications	• 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	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.
Remote behavioral health supports	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.
Practice visits to ob/gyns and dentists	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.
Member career development	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 transportation to and from employment settings, if not otherwise available. 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.
In-home caregiver support	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.
Additional value adds for the ABD population	Sunflower will work with local stakeholders and advisory groups to identify and offer additional needed benefits for members with IDD, contingent upon state approval.

For United members:

Service	Overview
Respite	**The value add of respite** is a temporary service provided on an intermittent basis to provide the beneficiary's family (unpaid primary care-giver) short, specified periods of relief. Respite must be **self-directed** and in the beneficiary's place of residence. It serves the family by: 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 **Qualifications for the Value Add:** • Member must be: participating in the DD pilot be 5 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 Member's benefit is limited to 40 hours 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

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:

e.

- 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:

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.
- 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
• 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: • 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 • In-home caregiver support • Extra respite service for volunteers self-directing their services	• 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