STATE PLAN UNDER, TITLE XIX OF THE SOCIAL SECURITY ACT

State: **Kansas**

Kansas Medical Assistance Program (KMAP),
MCO, PCCM programs

Citation: Section 1932 of the Social Security Act

A. General Description of the Program

1. This program is called Kansas Kansas Medical Assistance Program (KMAP). All Medicaid beneficiaries as described in Section C are required to enroll in either a managed care organization (MCO), or a primary care case management (PCCM) program.

2. The objectives of these programs are to reduce costs, reduce inappropriate utilization, and ensure adequate access to care for Medicaid recipients.

3. This MCO program is intended to enroll Medicaid recipients in MCOs, which will provide or authorize all primary care services and all necessary specialty services, where the assigned medical practitioner will authorize all primary care services and all necessary specialty services. The MCO/PCCM assigned practitioner will act as the PCP. The PCP is responsible for monitoring the care and utilization of non-emergency services. Neither emergency nor family planning services are restricted under these programs.

4. The PCP will assist the participant in gaining access to the health care system and will monitor the participant's condition, health care needs, and service delivery on an ongoing basis. The PCP will be responsible for locating, coordinating, and monitoring all primary care and other covered medical and rehabilitation services on behalf of recipients enrolled in the program. In the PCCM program, the PCP will receive a per member per month payment for case management services.

5. Recipients enrolled under this program will be restricted to receive covered services from the PCP or upon referral and authorization of the PCP or MCO. The PCP will manage the recipient's health care delivery. The KMAP program is intended to enhance existing provider-patient relationships and to establish a relationship where there has been none. It will enhance continuity of care and efficient and effective service delivery. This is accomplished by providing the recipient with a choice between at least two PCCM PCPs or a combination of one MCO and the PCCM program. Recipients will have a minimum of 15 days to make the selection but may change the initial selection at any time.

6. Non-MCO contractors will act as enrollment brokers in assisting eligible recipients in choosing among competing health plans in order to provide recipients with more information about the range of health care options open to them.

7. The state will share cost savings with recipients resulting from the use of more cost-effective medical care with recipients by eliminating co-payments for those who enroll into an MCO. Co-payments will apply for those services provided under the PCCM program.

8. The state requires recipients in PCCM to obtain services only from their assigned PCP or through referral to a Medicaid-participating provider who provides such services. Providers must meet reimbursement, quality, and utilization standards that are consistent with access, quality, and efficient and economic provisions of covered care and services. Recipients enrolled in MCO plans may be referred to any MCO-credentialed provider. The plan may also choose to allow non-emergency care to be provided by other practitioners on a case-by-case basis if it benefits the enrollee.

9. PCCM may operate in all counties of the state except in those geographical areas without an adequate number of primary care case managers participating in a PCCM. The MCO and PCCM programs may operate in the same counties where MCOs have contracted with the state. Mandatory assignment will only occur if the recipient has a choice between at least two PCCM PCPs or a combination of one MCO and the PCCM program. Recipients will have the option to select from a PCCM PCP and MCO where available. The Medicaid recipient must choose one of these options for the delivery of health care services.

10. Public Process for proposed changes in the Kansas Medical Assistance Program (KMAP) MCO and PCCM program. The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act for proposed changes in KMAP programs. Public notice will be published in the Kansas Register which is available to the public on a weekly basis.

B. Assurances and Compliance

1. Consistent with this description, the state assures that all the requirements of Sections 1932, 1903(m), and 1905(t) of the Social Security Act will be met.

2. The KMAP program is available in selected counties in Kansas. Mandatory enrollment provisions will not be implemented unless a choice of at least two PCCM PCPs or a combination of MCO and the PCCM program is available.

3. Kansas has safeguards in effect to guard against conflict of interest on the part of employees of the state and its agents.

4. Kansas will monitor and oversee the operation of the mandatory/voluntary managed care program, ensuring compliance with all federal program requirements, federal and state laws and regulations, and the requirements of the contracts agreed upon by Medicaid and its contractors.

5. Kansas will evaluate compliance by review and analysis of reports prepared and sent to the Kansas Medicaid agency by the contractors. Deficiencies in one or more areas will result in the contractor being required to prepare a corrective action plan, which will be monitored by the Kansas Medicaid agency.

h. All enrollees of HCBS waivers are excluded

i. Clients who have excess income (i.e. spenddown - met or unmet)

j. Clients participating in the Subsidized Adoption Program, including those receiving subsidy from another state

k. Clients having other insurance

l. Clients enrolled in another Medicaid Managed Care Program

m. Clients who have an eligibility program that is only retro-active.

n. Clients under the custody of the Juvenile Justice Authority

o. Clients residing in a State institution

p. Clients designated as participants in the administrative lock in program.

q. Indians who are members of Federally recognized tribes when the MCO or PCCM is:

(i) The Indian Health Service; or
(ii) An Indian Health Program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with Indian Health Service.

r. Children under 19 years of age who are:

(i) Eligible for SSI under Title XVI; or
(ii) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.

E. Target Groups of Recipients for Voluntary Enrollment

The state must provide assurances that, in implementing the state plan managed care option, it will not require the following groups to enroll in an MCO or PCCM:

1. Indians who are members of Federally recognized tribes, except when the MCO or PCCM:

a. The Indian Health Service; or
b. An Indian Health Program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service.

2. Children under 19 years of age who are:

   a. Eligible for SSI under Title XVI; or
   b. Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.

F. Enrollment and Disenrollment

1. All recipients will be given the opportunity to choose from at least two KMAP providers. This will be multiple PCCM providers or a combination of PCCM providers and an MCO option or a choice of MCOs if two or more are available in a county. If a recipient has a prior provider relationship they wish to maintain, the enrollment broker will assist the recipient in choosing a managed care entity that will maintain this relationship.

   Kansas contracts with an independent contractor to conduct the enrollment process and related activities. The enrollment broker performs services and supplies information as follows to facilitate the enrollment process:

   a. Review provider access for each county quarterly to assure appropriate primary care access for the enrollees. (EQRO performs this function).

   b. Answer KMAP-related questions from recipients and providers.

   c. Prepare enrollment materials for KMAP program, for Department approval, and store KMAP materials (MCO, PCCM and KMAP in general).

   d. Process new enrollments and transfers for those KMAP eligibles identified by the Department.

   e. Process the recipient's choice and assign to the provider. (PCCM only receives a monthly card).

   f. Log grievances and requests for special authorization from KMAP enrollees.

   g. Perform various quality assurance activities for the KMAP program. This is inclusive of the QAT process.

   h. Supply an enrollment packet to the recipients that includes MCO andPCCM materials and information supplied by the state and plans.

   i. Provides enrollment counseling which includes:

      1. Inquiring about patient/provider experience and preference.

      2. Providing information on which MCOs or PCCM PCPs are available to maintain a prior patient-provider relationship.

3. Facilitating direct contact with individual PCPs, PCCM and MCOs, as necessary.

4. Providing any information and education concerning the enrollment process, individuals', benefits offered, the enrollment packet, client rights' and responsibilities and any of the other information provided for in this section.

2. If the mandatory recipient fails to choose an MCO or PCCM PCP within a minimum of 15 calendar days after receiving enrollment materials, the Department assigns the recipient to a PCP in a PCCM or to a MCO. Kansas enrollment system can identify the voluntary recipients from data available to the system and will insure that these populations are not autoassigned. If a voluntary recipient does not choose to enroll with the PCCM or MCO, they will receive services on a fee-for-service basis.

3. Mandatory default enrollment will be based upon maintaining prior provider-patient relationships, proximity and prior familial/provider relationships or, where this is not possible, on maintaining an equitable distribution among managed care entities.

4. Information in an easily understood format will be provided to beneficiaries on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement, and comparative information among managed care entities regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).

5. Any selection or assignment of an PCP, MCO or PCCM may be changed at any time.

6. PCPs, MCOs and PCCM will not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of services.

7. The MCO and PCCM will not terminate enrollment because of an adverse change in the recipient's health.

8. An enrollee who is terminated from an MCO or PCCM solely because the enrollee has lost Medicaid eligibility for a period of two months or less will automatically be re-enrolled into the same MCO or PCCM upon regaining eligibility to the extent possible.

9. The recipient will be informed at the time of enrollment of the right to disenroll.

10. An enrollee will be allowed to choose his or her health professional in the MCO to the extent possible and appropriate and will be allowed to change his or her health professional as often as requested per the policy of the MCO.

11. Enrollees will have access to specialists to the extent possible and appropriate and female enrollees will have direct access to women's health services.

12. A general explanation of terms regarding enrollment and disenrollments (lock-in and referrals).

13. A description of the delivery system.

14. The responsibilities of the providers.

15. Enrollment procedures.

16. Provide information on services outside the MCO contract including the access to emergency services.

G. Process for Enrollment in an MCO/PCCM

The following process is in effect for recipient enrollment in the KMAP Program:

1. The Department shall provide beneficiaries with information in an easily understood format on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement, and comparative information among Managed Care Entities (MCEs) regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).

2. All materials will be in an easily understood format (6th grade reading level or less). Materials will be translated into Spanish and other languages upon request, including Braille.

3. Recipients will be able to select an MCO or PCCM from a list of available managed care entities in their service area. If the recipient wishes to remain with a PCP or plan with whom a patient/physician relationship is already established, the recipient is allowed to do so to the extent possible. Each recipient shall notify the Department by mail, telephone or in person, of his or her choice of plans. If voluntary selection for the mandatory poplulation is not made within the 15 day period describe above, the Medicaid program shall assign a MCO or PCCM in accordance with the procedures outlined in F above.

4. The MCO and PCCM will be informed electronically or in writing of the recipient's enrollment in that plan.

5. The recipient will be notified of enrollment and issued an identification card.

6. Additionally, each MCO will provide recipients the following information as soon as practical after activation of enrollment:

   a. Benefits offered, the amount, duration, and scope of benefits and services available.

   b. Procedures for obtaining services.

c. Names, locations, telephone numbers of, and non-English languages spoken by currently contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients to be provided.

d. Any restrictions on freedom of choice.

e. The extent to which there are any restrictions concerning out-of-network providers.

f. Policies for specialty care and services not furnished by the primary care providers.

g. Grievance and appeal process.

h. Member rights and responsibilities.

H. Maximum Payments

The contract with the actuary requires that calculated rates shall be actuarially sound and consistent with generally accepted actuarial principles and practices as required by 42 CFR 438.6(c). State payments to contractors will comply with actuarial soundness in 42 CFR 438.6(c).

I. Covered Services

1. Services not covered by the KMAP program will be provided under the Medicaid fee-for-service program. Medicaid recipients will be informed of the services not covered under the KMAP Program and the process for obtaining such services. The State assures that the services provided within the managed care network and out-of plan and excluded services will be coordinated. The required coordination is specified in the state contract with MCOs and PCCM and is specific to the service type and service provider.

2. MCOs are encouraged to develop subcontracts or memoranda of understanding with federally qualified health centers (FQHCs) and rural health clinics (RHCs) as well as family planning clinics and Indian Health Clinics.

3. Preauthorization of emergency services and emergency post stabilization services and family planning services by the recipient's MCO is prohibited. Recipients will be informed that emergency and family planning services are not restricted under the KMAP Program. "Emergency services" are defined in the MCO contract.

4. The PCCM shall be responsible for managing the services marked below in column (7). The MCO capitated contract will contain the services marked below in Column (4). All Medicaid-covered services not marked in those columns will be provided by Medicaid fee-for-service (without referral).

Service (1)	State Plan Approved (2)	MCO/PHP Capitated Reimbursement (4)	Fee-for-Service Reimbursement impacted by MCO/PHO (5)	Fee-for-Service Reimbursement for MCO/PHO (6)	PCCM Referral/Prior Auth. Required (7)
Medical Supplies/DME	X	X			X
Vision Care	X	X			
FFS Wrap-Around Svcs. provided to waiver members and controlled by MCO or affected by PCCM					
Inpatient Hospital – Psych	X		X		X
Inpatient Hosp- heart, liver & bone marrow transplant	X		X		X
Psychiatrist	X		X		X
Family Planning	X	X			
Sterilization	X	X			
Abortion	X		X		
Psychologist	X				X
Prescription drugs - Psychiatric	X	X			
Prescription drugs - Family Planning	X	X			
Prescription drugs – Factor VIII	X		X		
Dental	X				
Mental Health - State Psychi. Hospital	X				
Mental Health – Nursing Facility	X				

Service (1)	State Plan Approved (2)	MCO/PHP Capitated Reimbursement (4)	Fee-for-Service Reimbursement impacted by MCO/PHO (5)	Fee-for-Service Reimbursement for MCO/PHO (6)	PCCM Referral/Prior Auth. Required (7)
Mental Health – CMHC	X		X		X
Mental Health - Non CMHC	X		X		X
Mental Health - Behavior Management	X		X		X
Alcohol & Drug Addiction Treatment	X		X		X
Education Agency Services	X				

J. Mandate

1. In the KMAP program, Kansas will enter into contracts with State licensed MCOs. Kansas will enter into comprehensive risk contracts with the MCOs. These organizations will arrange for comprehensive services, including inpatient or outpatient hospital, laboratory, x-ray, physician, home health, early periodic screening, diagnosis and treatment, family planning services (excluding abortions), RHC, and FQHC except for those described in Section H.1.

   All contracts will comply with Sections 1932 and 1903(m) of the Act. Kansas has used and will continue to use a competitive procurement process. The Department sets the capitation rates by region in the state and any participating MCO must accept those rates for the respective Medicaid covered services.

2. With respect to the PCCM, the contracts Kansas enters into with PCPs will contain (at a minimum) all terms required under section 1905(t)(3). Reimbursement will be made on a fee-for-service basis, with a $2.00 monthly case management fee for each PCCM recipient assigned except for those recipients assigned to FQHCs and RHCs. The following is a list of the types of providers that qualify to be primary care providers under the KMAP program: physicians (pediatricians, family practitioners, internists, general practitioners, obstetrician/gynecologists physician assistants), and certified nurse practitioners, certified nurse midwives, IHS, FQHCs, and RHCs.

3. All participating PCPs in the PCCM shall be required to sign a PCCM participation agreement in addition to the standard Medicaid provider agreement and shall be bound by its terms and conditions. Each PCP shall be required to specify the number of recipients the PCP is willing to serve as a primary care case manager. Unless circumstances exist which require the Department to authorize a higher quota for a PCP to ensure adequate coverage in an area, the maximum shall be 1,800 recipients per primary care physician.

4. PCP under the KMAP program must:

   a. Be Medicaid-qualified providers and agree to comply with all applicable federal statutory and regulatory requirements, including those in Section 1932 of the Act and 42 CFR 434 (and new requirements in 42 CFR 438 when final) and all State plan standards regarding access to care and quality of service;

   b. If participating in a PCCM, sign a contract or addendum for enrollment as a PCP which explains the PCPs responsibilities and complies with the PCCM contract requirements in Section 1905(t)(3) of the Act including: an answering machine which will immediately direct an enrollee as to how to contact an on-call medical professional, so that referrals can be made for non-emergency services and information can be given about accessing services or how to handle medical problems during non-office hours.

   c. Provide or arrange for the provision of comprehensive primary health care services to all eligible Medicaid beneficiaries who choose or are assigned to the PCP's practice;

   d. Refer or have arrangements for sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

   e. Have hours of operations that are reasonable and adequate. The Department requires all PCPs to have 24-hour access via telephone. This does allow for another provider to be on-call for the PCP provider during non-office hours.

   f. Not refuse an assignment or disenroll an enrollee or otherwise discriminate against an enrollee solely on the basis of age, sex, race, physical or mental handicap, national origin, or health status or need for health services, except when that illness or condition can be better treated by another provider type;

   g. Not have an affiliation with person debarred, suspended, or otherwise excluded from federal procurement activities per Section 1932(d)(1) of the Act;

   h. Assign clients in the order in which they enroll.

5. Qualifications and requirements for PCPs are noted in the provider agreements. MCOs and PCCM shall meet all of the following requirements as applicable:

   a. An MCO shall be a Medicaid-qualified provider and agree to comply with all pertinent Medicaid regulations and state plan standards regarding access to care and quality of services.

   b. The MCO shall sign a contract that explains the responsibilities in which the MCOs must comply.

   c. The MCO shall have a state-approved grievance and appeal process.

   d. The MCO or PCP shall provide comprehensive primary health care services to all eligible Medicaid recipients who choose, or are assigned to, the MCO.

   e. The MCO or PCCM and PCP shall refer enrollees for specialty care, hospital care, or other services when medically necessary.

   f. The MCO or PCCM shall make available 24-hour, 7-day-a-week access by telephone to a live voice (an employee of the MCO or a representative or a representative of the PCCM) or an answering machine which will immediately direct an enrollee as to how to contact an on-call medical professional, so that referrals can be made for non-emergency services and information can be given about accessing services or how to handle medical problems during non-office hours.

   g. The MCO or PCCM shall not refuse an assignment, disenroll a participant, or otherwise discriminate against a participant solely on the basis of age, sex, physical or mental disability, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider type.

   h. The MCO or PCCM may request reassignment of the participant to another MCO or PCCM only with the approval of the state. Disenrollment may be allowed in certain situations, such as: abusive behavior; PCCM or MCO left the program; or noncompliance with medical orders.

      The Department reviews all reasons for transfer on a quarterly basis via the reports from the enrollment broker. The Department meets with the enrollment broker and MCO as needed to review all current issues, including any requests for disenrollment by any PCCM or MCO.

i. All MCO and PCCM subcontractors shall be required to meet the same requirements as those that are in effect for the contractor.

j. The MCO shall be licensed by the Kansas Department of Insurance in order to ensure financial stability (solvency) and compliance with regulations.

k. Access to medically necessary emergency services shall not be restricted as set forth in the prudent layperson guidelines (Section 1932(b)(2) of the Act). "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

l. Kansas ensures enrollee access to emergency services by requiring the MCO or PCCM to provide adequate information to all enrollees regarding emergency service access.

m. Kansas ensures enrollee access to emergency services by including in the contract requirements for MCOs or PCCMs to cover the following:

1. The screening or evaluation and all medically necessary emergency services, when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,

2. The screening or evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

3. Both the screening or evaluation and stabilization services, when a clinical emergency is determined,

N. Access to Care

Kansas assures that recipients will have a choice between at least two PCCM PCPs or a combination of one MCO and the PCCM. When fewer than two choices are available in the geographic area, the managed care program is voluntary. In addition to this process, the KMAP program is not likely to substantially impair access because of the following:

1. Recipients may choose any of the participating MCOs or PCCM PCPs in the service areas. In addition, as per 42 CFR 434.29, within an MCO each Medicaid enrollee has a choice of health professional to the extent possible and feasible.

2. The same range and amount of services that are available under the Medicaid fee-for-service program are available for enrollees covered under the KMAP Program.

3. Access standards for distances and travel miles to obtain services for recipients under the KMAP program have been established.

   The Department utilizes 30 minutes for urban counties and 30 miles for all other areas in the MCO and PCCM programs. This is applied to the MCOs at the time they request service to a new county, as well as quarterly thereafter. The Department will review each county for PCP access on a yearly basis in the MCO program.

   The PCCM option allows the PCP to give a referral to any Kansas Medicaid provider, thus the panel of specialists would be the entire Kansas Medicaid provider network. This allows any PCCM enrollee to see any specialist that accepts Kansas Medicaid. Therefore, this network is no less than the network available to a person not in the KMAP program.

   The Department realizes that there are some counties in the state that do not have a hospital. While the normal guideline is to have at least one hospital in the county being served, consideration is given to those counties without a hospital.

   Additionally, if a county has multiple hospitals, the Department expects to see a fair representation on the provider network.

4. Primary care and health education are provided to enrollees by a chosen or assigned MCO or PCCM PCP. This fosters continuity of care and improved provider/patient relationships.

5. Pre-authorization is precluded for emergency care and family planning services under the KMAP Program.

6. Recipients have the right to change plans at any time.