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State/Territory Name: KS

State Plan Amendment (SPA) #: 13-11

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

June 12, 2013

Susan Mosier, M.D.
Medicaid Director
Kansas Department of Health and Environment
Division of Health Care Finance
Landon State Office Building
900 SW Jackson, Room 900-N
Topeka, Kansas 66612-1220

Dear Dr. Mosier:

On March 25, 2013, the Centers for Medicare & Medicaid Services (CMS) received Kansas's State Plan Amendment (SPA), transmittal #13-011, to discontinue the enrollment cap and change the rate methodology used for the Program of All-inclusive Care for the Elderly (PACE) calculation of capitation rates for CY2013 for the state's program effective January 1, 2013.

Based on the information provided, this SPA is approved as of June 11, 2013, with an effective date of January 1, 2013, as requested by the state. Enclosed is a copy of the CMS 179 form, as well as, the approved pages for incorporation into the Kansas State Plan.

If you have any questions regarding this amendment, please contact Narinder Singh at (816) 426-5925 Narinder.Singh@cms.hhs.gov.

Sincerely,

//s//

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

cc: Rita Haverkamp

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: SPA #KS 13-11	2. STATE Kansas
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE January 1, 2013	
5. TYPE OF PLAN MATERIAL *(Check One)*: ☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT		
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*		
6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT: a. FFY 2013 $1,100,000 b. FFY 2014 $1,200,000	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 3 to Attachment 3.1-A, Pages 1, 6 & 7	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Supplement 3 to Attachment 3.1-A, Pages 1, 6 & 7	
10. SUBJECT OF AMENDMENT: Program of All-Inclusive Care for the Elderly (PACE)		
11. GOVERNOR'S REVIEW *(Check One)*: ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL X OTHER, AS SPECIFIED: Kari Bruffett is the Governor's Designee		
12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: Kari Bruffett KDHE; Division of Health Care Finance Landon State Office Building 900 SW Jackson, Room 900-N Topeka, KS 66612-1220	
13. TYPED NAME: for Kari Bruffett		
14. TITLE: Director, Division of Health Care Finance		
15. DATE SUBMITTED: March 25, 2013		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED: March 25, 2013	18. DATE APPROVED: June 11, 2013	
PLAN APPROVED – ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2013	20. SIGNATURE OF REGIONAL OFFICIAL: /s/	
21. TYPED NAME: James G. Scott	22. TITLE: Associate Regional Administrator for Medicaid and Children's Health Operations	
23. REMARKS:		

Revised Submission 5.30.13

KANSAS MEDICAID STATE PLAN

State of Kansas
PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency:

The State Medicaid Agency, the Kansas Department of Health and Environment (KDHE), is the Administering Agency, and under the authority of state statute and an interagency cooperative agreement, KDHE delegates the administration of the PACE program to the Kansas Department for Aging and Disability Services (KDADS), 503 S. Kansas Avenue, Topeka, Kansas 66603.

I. Eligibility

A. _X__ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

The Special Income Level Group for Institutionalized Persons [1902(a)(10)(A)(ii)(V)]. Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the PACE participant groups.

B. ____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C. _X__ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

Revised Submission 6.11.13

II. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1. _X_ Rates are set at a percent of fee-for-service costs
2. ___ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. ___ Adjusted Community Rate (please describe)
4. ___ Other (please describe)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

Optumas

The PACE rates for Medicaid are established based upon services rendered to the SSI and Medically Needy populations residing in the service area. The upper payment limits (UPLs) include the aged, blind, and disabled populations that are age 55 and older, meet the state's criteria for nursing home level of care, live in an area that offers PACE, and have the ability to live safely in the community. The most recent claims data is used for all services including targeted case management, with the exception of Medicare Part A and Part B premiums (Medicare buy-in). No data is used for individuals that are eligible for any current capitated managed care program. Data for persons in a ICF/MR, HCBS/MR, NF-MH, or state hospital setting are excluded. Only data for persons in a Nursing Facility (NF) or in the Physically Disabled (PD) or Frail Elderly (FE) waivers are included. The costs in the base period are inflated to the present for rate setting purposes and adjusted for any applicable program changes. Inflation is based on state historical costs.

Beneficiary eligibility data for the same time period as the claims data and with the same exclusions as above is used. This data was analyzed in a manner similar to that used for capitated managed care rate setting. UPLs on a per member per month basis are computed byseveral dimensions: Dual vs. Non-Dual, age groups 55-74 vs. 75+, and the four regions (JO, NE, SE, and SG).

Revised Submission 6.11.13

Actual fee for service expenditures by Medicaid are used to calculate the UPL with the exceptions noted below. The claims completion factor was completed for the missing months of the last year used. The data was further adjusted for Graduate Medical Education (GME) payments not included in the historical Fee For Service (FFS) data the State provided as the capitated payment to PACE providers includes these costs. The PACE provider shall be responsible for collection of and reporting of third party liability. No adjustment is necessary to payments because claims do not reflect any receipts of third party liability by Medicaid. Adjustments to expenditures are made equal to the amount of average Medicaid pharmacy rebates received. The percentage is based upon the aggregate receipt of pharmacy rebates versus aggregate pharmacy payments as rebates cannot readily be identified to a particular population or county of residence. Co-payment, which is a reduction in actual payment, is added back into the UPLs as the provider will not be allowed to charge co-payment. Certified match expenditures are added to the UPLs. There may be instances when the provider certifies that state funds are available and the State will not pay for these funds. Medicare Part D medication drugs were deducted from the UPL. In addition, an administrative cost consistent with existing administrative levels in FFS was included in the UPL development.

Disproportionate share payments are not included in any claims data as they cannot be identified to a particular beneficiary, nor will they be the responsibility of the PACE provider.

For those individuals who have client participation for cost of care requirements, the actual rate paid will be the applicable rate less the client participation for that particular person.

In order to set UPLs for a future time period, trend factors will be completed at least every 5 years. Separate trends for the following are computed using the same methodology that is used for the KHPA budget process:

- SSI Aged regular medical expenditures (all expenditures except for long term care and HCBS related),
- SSI Blind and Disabled regular medical expenditures,
- Medically Needy Aged regular medical expenditures,
- Medically Needy Blind and Disabled regular medical expenditures,
- HCBS/FE expenditures,
- HCBS/PD expenditures,
- FE targeted case management expenditures, and
- Nursing facility expenditures.

The rates are made prospectively to the PACE organization and are less than what would have been paid under the State Plan if the participants were not enrolled in PACE.