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

September 16, 2024

Christine Osterlund
Medicaid Director and Interim Division Director
State of Kansas, Division of Health Care Finance
Department of Health and Environment
900 SW Jackson Avenue
Suite 900
Topeka, KS 66612

Dear Christine Osterlund:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Kansas' submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The proposal was received by CMS on March 19, 2024, and has a control name of KS_VBP_IPH.OPH_Renewal_20240101-20251231.

CMS has completed our review of the following Medicaid managed care state directed payment(s):

- Value Based Payment to meet or exceed the performance measure benchmarks on specific provider quality metrics for the inpatient and outpatient services to receive incentive payments for the rating period covering January 1, 2024 through December 31, 2025 for a multi-year period, incorporated in the capitation rates through a separate payment term of up to $60,000,000.

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for state directed payments described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations. The state is required to submit contract action(s) and related capitation rates that include all state directed payments.

All state directed payments must be addressed in the applicable rate certifications. CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all state directed payments must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification will cause delays in CMS review. The Medicaid Managed Care Rate Development Guide includes specific requirements associated with the use of separate payment terms. If the total amount of the separate payment term is exceeded from what is documented in the preprint or the payment methodology changes, CMS requires the state to submit a state directed payment preprint amendment. If the separate payment

term amount documented within the rate certification exceeds the separate payment term amount documented in the preprint, the state is required to submit a rate certification amendment.

If you have any questions concerning this letter, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

Laura M. Snyder -S

Digitally signed by Laura M. Snyder -S
Date: 2024.09.16 15:54:33 -04'00'

Laura Snyder
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   January 1, 2024 - December 31, 2025
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* January 1, 2024
3. Identify the managed care program(s) to which this payment arrangement will apply:
   KanCare
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $60 million
   a. Identify the estimated federal share of this state directed payment: $36,919,500
   b. Identify the estimated non-federal share of this state directed payment: $23,080,500

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted: January 1, 2022 to December 31, 2023

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☐ Quality Metric(s) / Benchmark(s) Change
☐ Other; please describe:

☒ X No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

The provider classes must meet performance targets related to delivery of services covered under the MCO contract as identified in response to Question 12, Table 1. The University of Kansas Hospital System (TUKHS) and Children's Mercy Hospital (CMH) will be paid for performance, and they will receive the amount specific to each measure if they perform at the level identified in this preprint. There is $30 million annually in the incentive pool. TUKHS is eligible for $22.5 million in annual incentive payments. CMH is eligible for $7.5 million annually. To the extent the provider classes do not receive money in one year, no amount of the annual pool of funding will be transferred to the following year.

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

At the end of this document, SPA pages are attached for inpatient and outpatient services (Attachment 3.1-A; pages 1-2a) and the definitions for inpatient hospital care (Attachment 4.19-A, pages 3-4).

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☒ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ☐ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☒ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

TUKHS and CMH need to meet or exceed the performance measure benchmarks on the provider quality metrics in question 12, Table 1, in order to be eligible to receive the incentive payment.

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a. UKHS: Screening for Depression and FollowUp Plan: Ages 12-17 (CDF-CH) and Age 18 and Older (CDF-AD) and NQF #0418/0418e	NCQA	CY2023	57.43	CY2024	59.43	
b. UKHS: Screening for Depression and Follow-upNCQA Plan: Ages 12-17 (CDF-CH) and Age 18 and Older (CDF-AD) and NQF #0418/0418e	NCQA	CY2023	59.72	CY2024	69.72	
c. Breast Cancer Screening (BCS-AD) and NQF #2372	NCQA	CY2023	58.84	CY2024	78.84	
d. Flu Vaccination for all Ages (ages 6 months and older)	State - Developed; HEDIS Like	CY2023	61.10	CY2024	70	
e. Lung Cancer Screening using low dose CT scans	State - Developed	CY2023	113	CY2024	124	

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

The methodology used to set performance targets for each measure was done collaboratively between the State, TUKHS, and CMH. The methodology for each is outlined below:
Breast Cancer Screening: 10% gap to goal for each year of the APM (target 77%)
Screening for Depression and Follow-up: Screening would be measure maintenance in 2022 and 10% gap to goal in 2023; Follow-up is 20% gap to goal each year
TUKHS Flu Vaccination: 10% annual gap to goal increase (target 70%)
Low Dose CT Scan: 10% increase each year (baseline 92, 102 in 2022, 113 in 2023)
CMH Flu Vaccination: Target rate of 72%, which is goal each year
Chlamydia Screening: Measure maintenance in 2022 with 5% relative increase in 2023
Diabetes protocols: In 2022, the hospitals will work with interested participants from hospitals statewide to develop standardized diabetes protocols for adults and children, with particular focus in meeting any special needs of communities in rural areas of the state. Diabetes protocols will be implemented in 2023. Due to implementation the addition of a Hemoglobin A1c Control for Patients with Diabetes (HBD) was added with a reasonable expectation of increase per the protocols established in prior time frame.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

TUKHS and CMH do not need to meet performance targets in all measures. There will be an annual subpool for each individual measure from the entire pool of money and, to the extent they meet a performance target in one measure, they will be eligible for that annual subpool.
TUKHS: Breast Cancer Screening ($4.5 m), Screening for Depression ($1.8 m), Depression Follow-Up Plan documentation ($2.7 m), Flu vaccine ($4.5 m), Low Dose CT Scan ($4.5 m), Diabetes Protocols ($2.25 m); Hemoglobin A1cControl for patients with Diabetes (HBD) ($2.25m).
Children's Mercy: Flu Vaccine ($2.5 m), Chlamydia Screening ($2.5 m), Diabetes Protocols ($1.25 m); Hemoglobin A1cControl for patients with Diabetes (HBD) ($1.25m).

c. For state-developed measures, please briefly describe how the measure was developed?

There are two state-developed measures included in the APM. The measures are Flu vaccinations and lung cancer screening. The flu vaccinations measure is expanded to all ages. The Low Dose CT Scan measure was developed to increase counseling and screening for lung cancer.

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☒ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

Calendar years 2024 and 2025.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ☐ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ■ inpatient hospital service
- ■ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

The two provider classes identified as Large Public Kansas Teaching Hospital and Border City Children's Hospital align with the Kansas State Plan. The definitions for these two provider classes are located in the inpatient hospital care definitions and are attached the the end of this document (Attachment 4.19-A, pages 3-4).

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

The providers in each provider class will receive payments in accordance with the performance targets in Question 12, Table 1.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Border City Children's Hospital Inpatient	63.90%	4.10%	1.30%		69.30%
b. Large Public Kansas Teaching Hospital Inpatient	57.40%	11.10%	3.70%		72.20%
c. Border City Children's Hospital Outpatient	16.30%	1.00%	0.30%		17.70%
d. Large Public Kansas Teaching Hospital Outpatient	11.30%	2.20%	0.70%		14.20%
e.	0.00%	0.00%	0.00%		0.00%
f.	0.00%	0.00%	0.00%		0.00%
g.	0.00%	0.00%	0.00%		0.00%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☒ Other; Please define: Average Commercial Rate

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☒ Yes ☐ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

The data sources and methodology used for the analysis provided in Question 23 are based on the Medicare cost reports from 2022.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

The State determined the directed payment is appropriate and reasonable because it was below the average commercial rate. The State believes this would provide stronger incentives for providers to decrease costs while maintaining or improving quality of care.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☒ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

Kansas_KanCare_20240101-20241231_Certification_20231229

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

Actuarial Certification, Page 38.

b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☒ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i. Kansas_KanCare_20240101-20241231_Certification_20231229	12/29/2023	Yes	Page 38
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☒ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

Hospitals are only paid if they meet a specific goal for an objective. The hospital is not required to meet all goals for all objectives in order to receive a payment.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☒ State general revenue
- **b.** ☒ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ☐ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i. The Univeristy of Kansas Hospital System	State	$ 17,310,375.00	No	No	Yes
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☑ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

The IGT agreement is attached.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i.						
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ■ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ■ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https//kancare.ks.gov/quality-measurement/QMS
- **b.** The effective date of quality strategy. January 1, 2022

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Improve overall Health and Safety for KanCare members.	5.7 Increase rates of selected Adult and Child Core mesures by 5% annually.	18
b.		
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

This payment arrangement advances the goal above by setting performance targets over a multi-year approach that focuses on preventive services in adults and children. The depression screening, breast cancer screening, lung cancer screening, and diabetes protocols all focus on preventative screenings, like in this payment arrangement, will allow for quicker detection and treatment of issues an individual may have.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes**[1]
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. See attached table.				
ii.				
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

The state will receive the CY2023 results on April 3, 2024. This delay is due to billing lag. The current data is related to CY2022 and CY2021. It should be noted that this APM set a baseline year of CY2019, successive years were during the COVID-19 pandemic which caused a great deal of stress on the Kansas healthcare system. The PHE impacted every metric. There were difficulties with the flu vaccine measures in CY2022 due to a nationwide shortage of vaccines. The state reviews the raw information for HEDIS related measures via reports from the fiscal agent's data warehouse system.

The latest CY2023 data has shown improvement across the board compared to the CY2019 baseline. KU Screening for Depression rose a total of 32.9 points between our baseline and CY2023. Screening went from 77.9 in CY2022 to 85.6 in CY2023. Screening for Depression and Follow up Plan rose 37.7 points.

Breast cancer screening had a marginal increase between the baseline CY2019 at 54.6 and CY2022 at 61.0 with a minor decrease in CY2023 to 58.7.

Flu Vaccination mirrored the rates across the nation by not increasing in CY2022 due to the PHE. The increase from baseline was 59.0 to 60.3. In CY2023 the increase went to 65.1.

Lung Cancer Screening is a state measure. The baseline was 92 in CY 2019 and increased to 145 in CY2022.

Chlamydia screening for Children's Mercy Hospital CY 2019 baseline rate was 50.3% and increased to 63% for CY 2022.

Inpatient Hospital Services Limitations

1. Services shall be ordered by a physician and shall be related specifically to the present diagnosis of the Consumer.

2. Rehabilitation therapy is limited to that which is restorative in nature and provided following physical debilitation due to acute physical trauma or physical illness.

3. Prosthetic devices provided by a hospital are limited to those that replace all or part of an internal body organ, including replacement of these devices.

4. Elective surgery is noncovered with the exception of elective sterilization procedures.

5. Transplant surgery is limited to corneal, kidney, bone marrow, pancreas, liver, heart, heart-lung, lung transplants and related services. Procurement of the organ is covered.

6. Inpatient acute care related to psychiatric services is limited to stays in which the psychiatric plan of care is directed by a psychiatrist and in which psychotherapy is provided on a daily basis. Individuals admitted to psychiatric care must have received an assessment to determine appropriate care level before services are reimbursed.

7. Sterilization and abortions are covered in accordance with current federal regulation.

8. Discharge days are noncovered.

9. Long-Term Head Injury Rehabilitation Services:

Services include, but are not limited to, inpatient restorative and rehabilitative therapies designed to prevent physical or mental deterioration, achieve and maintain maximum use of physical or cognitive capabilities and health, and/or restore and retain self-help and adaptive skills necessary to achieve the recipient's discharge from inpatient status at the earliest possible time

These programs are intended to provide active treatment for the purpose of relearning independent living skills for those individuals who have experienced a Traumatic Brain Injury (TBI) and choose to receive services in a Traumatic Brain Injury Rehabilitation Facility. "Active Treatment" is defined as an aggressive and organized effort to fulfill each person's optimal functional capacity.

Recipients of these services must be assessed prior to admission and once admitted must be re-assessed for the need of continued services on a regularly scheduled basis as defined by state law, regulation, and/or policy. Services must be provided in accordance with an individualized treatment plan under the direction of a physician. The activities included in the service must be intended to achieve identified treatment plan goals and measurable, behaviorally-stated objectives.

The need for services is evidenced by:

- The recipient has a diagnosis of Traumatic Brain Injury, defined as a traumatically-acquired, non-degenerative, structural brain injury resulting in residual deficits and disability;
- The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed; and
- The individual with TBI requires the provision of services in an institutional setting because of the intensity, duration, or frequency of the need for the services, the lack of appropriate community services to meet those needs, or both.

Service furnished in a Long-Term Head Injury Rehabilitation Facility must satisfy all requirements of subpart G of 42 CFR 483 governing the use of restraint and seclusion.

Provider Qualifications: A Long-Term Head Injury Rehabilitation Facility must meet the requirements and standards of state certification or licensure, and national accreditation by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or by any other accrediting organization, with comparable standards, that is recognized by the State.

Services must be furnished by or under the direction of a physician and all staff must meet applicable licensure and certification requirements and adhere to scope of practice definitions of licensure boards.

Outpatient Hospital Services Limitations

1. Non-emergency services are covered. Outpatient hospital assessment of the need for emergency service is non-covered.

2. Emergency services are covered.

3. Elective surgery is non-covered with the exception of elective sterilization procedures.

4. Partial hospitalization for psychiatric illness is limited to programs which have been licensed by SRS (Social and Rehabilitation Services).

5. Sterilization and abortions are covered in accordance with current federal regulations.

6. Rehabilitation therapy is limited to that which is restorative in nature and provided following physical debilitation due to acute physical trauma or physical illness. Therapy services must be prescribed by the attending physician. Therapy services are limited to 6 months for participants over the age of 20 (except the provision of therapy under HCBS) per injury, to begin at the discretion of the provider. There are no time limits for participants from birth through age 20.

7. Prosthetic devices provided by a hospital are limited to those that replace all or part of an internal body organ, including replacement of these devices.

8. Ambulance services billed as outpatient services are non-covered.

9. See Attachment 3.1-A, #4.b. for outpatient hospital service limitations for children from birth through age 20.

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

1.0000 continued

t. "General hospital inpatient beds" means the number of beds as reported by the general hospital on the hospital and hospital health care complex cost report form excluding those beds designated as skilled nursing facility or intermediate care facility beds. For hospitals not filing the hospital and hospital health care complex cost report form the number of beds shall be obtained from the provider application for participation in the Kansas Medicaid/Medikan Program form.

u. "Group reimbursement rate" means the dollar value assigned by the Department to each general hospital group for a diagnosis related group weight of one.

v. "Large Public Kansas Teaching Hospital" is a public hospital located within the State of Kansas with a minimum of 200 inpatient beds and a minimum of 100 interns and residents.

w. "Length of stay as an inpatient in a general hospital" means the number of days an individual remains for treatment as an inpatient in a general hospital from and including the day of admission, to and excluding the day of discharge.

x. "Low income utilization rate" means the sum of (1) the fraction expressed as a percentage, the numerator of which is the sum for a period of the total revenues paid by Medicaid to the hospital for patient services and the amount of the cash subsidies for patient services received directly from state and local governments, and the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and (2) a fraction expressed as a percentage, the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies (as referred to above in [1]) in the period reasonably attributable to inpatient hospital services, not including contractual allowances and discounts other than for indigent patients not eligible for Medicaid and the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period. Medicaid revenue shall include payment made to the hospital from managed care entities on behalf of Medicaid beneficiaries.

y. "Medicaid inpatient utilization rate" means a fraction expressed as a percentage, the numerator of which is the hospital's number of inpatient days attributable to patients who for such days were eligible for Medicaid in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. The numerator shall include managed care patient days for Medicaid eligible beneficiaries.

z. "Metropolitan statistical area (MSA)" means a geographic area designated as such by the United States executive office of management and budget.

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

1.0000 continued

z. "Readmission" means the subsequent admission of a recipient as an inpatient into a hospital within 15 days of discharge as an inpatient from the same or another hospital participating in the DRG reimbursement system.

aa. "Recalibration" means the adjustment of all DRG weights to reflect changes in relative resource use associated with all existing DRG categories and/or the creation or elimination of DRG categories.

bb. "Standard diagnosis related group DRG) amount" means the amount computed by multiplying the group reimbursement rate for the general hospital by the diagnosis related group weight.

cc. State-operated hospital' means an establishment operated by the State of Kansas with an organized medical staff of physicians, with permanent facilities that include inpatient beds, with medical services, including physician services and continuous registered professional nursing services for not less than 24 hours of every day, and which provides diagnosis and treatment for nonrelated patients.

dd. "Stay as an inpatient in a general hospital" means the period of time spent in a general hospital from admission to discharge.

ee. "Transfer" means the movement of an individual receiving hospital inpatient services from one hospital to another hospital, or different units within the same hospital, for additional related inpatient care after admission to the previous hospital, hospitals, or hospital units.

ff. "Transferring hospital" means the hospital which transfers a recipient to another hospital. There may be more than one transferring hospital for the same recipient until discharge.

gg. "Critical Access Hospital": Hospitals that are certified as critical access hospitals by Medicare.

hh. "Border city children's hospital" is defined as a comprehensive pediatric medical center with 200 beds or more, a level I pediatric trauma center, and at least a level IIIc intensive care nursery. The border city children's hospital must be located in a Kansas border city. A Kansas border city means those communities outside of the state of Kansas, but within a 50-mile range of the state border.

ii. "Hospital located in a frontier county": A hospital located within a county where the population is fewer than 6.90 persons/sq. mi. The population density is taken from the 2010 Census.

jj. "Hospital located in a rural county": A hospital located within a county where the population is 6.0 – 19.9 person/sq. mi. The population density is taken from the 2010 Census.

kk. "Hospital located in a densely-settled rural county": A hospital located within a county where the population is 20.0 - 39.9 persons/sq. mi. The population density is taken from the 2010 Census.

ll. "Large Hospital" is defined as any hospital in the State of Kansas with 500 or more available beds, as reported on the Medicare cost report, defined in Section 6.2000 B.

mm. "State Institutional Alternatives (SIA)" are defined as facilities that provide inpatient psychiatric treatment and are authorized by the Kansas Department of Aging and Disability Services (KDADS) to serve as an alternative to placement in a state mental health institution.