

## Executive Summary

### KanCare: Reinventing Medicaid for Kansas

#### Background

In January, Governor Sam Brownback charged Lt. Governor Jeff Colyer, MD, and a working group of cabinet members with the task of fundamentally reforming Medicaid to improve outcomes and establish financial sustainability in the face of mounting uncertainty.

Kansas faces major challenges in its Medicaid program that require swift and effective policy changes to continue serving vulnerable Kansans. The Governor's FY 2012 budget sustained Medicaid through the current fiscal year and provided Kansas the time to reinvent its Medicaid program to better serve Kansans in need and maintain fiscal responsibility.

Lt. Governor Colyer and the Working Group reached out to thousands of Kansans to help in the effort. The Administration sought public input through an open process that included a Request for Information, public forums in each congressional district, a web survey, stakeholder workgroups and countless individual meetings with consumers, advocates, and providers. (See [Deloitte summary report.](#))

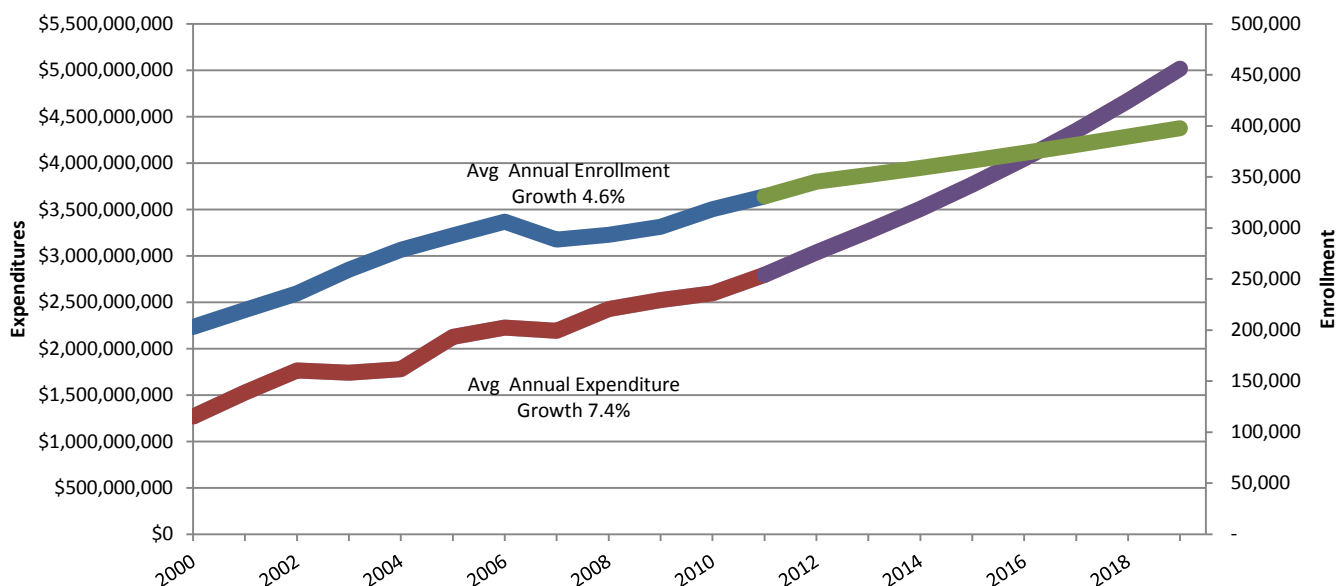
The vision statement outlined at the beginning of the process remains and was confirmed by the participation of Kansans from every corner of the state:

*To serve Kansans in need with a transformed, fiscally sustainable Medicaid program that provides high-quality, holistic care and promotes personal responsibility.*

#### The Problem

Kansas Medicaid costs have grown at an annual rate of 7.4 percent over the last decade. Long-run trends in Medicaid are driven by widespread increases in enrollment and spending per person. While exacerbated by the economic downturn, Medicaid growth is not just tied to the economy. Kansas is in the midst of a sustained period of accelerated growth as baby boomers reach the age of acquired disability.

**Figure 1: Historic Medicaid Growth, without expansion**



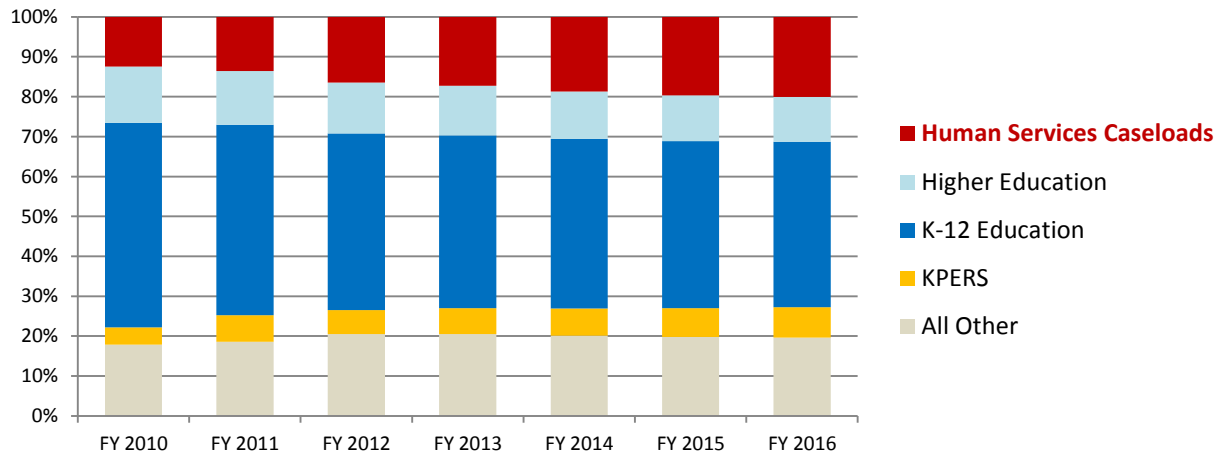
Yet the cost drivers in Medicaid are not confined to one service area or population. As Figure 2 illustrates, the projected sources of growth in Kansas Medicaid spending cut across populations. Tackling the structural deficit facing Medicaid cannot be accomplished by excluding or focusing solely on one population or service.

**Figure 2: Projected sources of growth in Medicaid spending FY 2012-2017, without reforms**

Percent of total growth	Aged Non-Waiver Population	Disabled Non-Waiver Population	Aged and Disabled HCBS Waiver Populations	Children and Families	Foster, MediKan and other populations	TOTAL by Service
Medical and misc. services	1%	14%	7%	22%	4%	48%
HCBS waiver services	0%	0%	25%	0%	0%	25%
Behavioral Health and Substance Abuse	0%	2%	3%	2%	1%	9%
Institutional care/PACE LTC services	11%	6%	1%	0%	0%	18%
TOTAL by Population	13%	22%	36%	24%	5%	100%

Through the reform process, the Administration quickly concluded that no short-term solutions – provider rate cuts, tweaks of eligibility requirements – could address the scale of the issue over time. Without intervention, projected Medicaid growth will continue to put downward pressure on other critical state priorities, including education and transportation.

**Figure 3: The Crowd-Out Effect, Expenses as Percentage of State General Fund**



FY 12-16 projected; illustrates impact on other programs if Medicaid growth continues unabated. Assumes projected deficits would be offset in other programs.

The fiscal picture for Medicaid is further clouded by uncertainty from Washington DC, where federal policies drive costs to the states. Whether via the mandated expansion in the Affordable Care Act, or in President Obama's proposals to cut the federal share of Medicaid by \$72 billion over 10 years, these policies and the uncertainty surrounding them only increase the pressure on state budgets.

Just as important, Kansas Medicaid historically has not been outcomes-oriented. Focusing only on costs, to the exclusion of quality and outcomes, would be counterproductive. The public input and stakeholder consultation process validated the need for increased accountability in the services the state provides, and for a new level of investment in prevention, care coordination, and evidence-based practice.

## The Kansas Solution

**Global Waiver:** Kansas will seek a global waiver from the federal government to maximize flexibility in administering the Medicaid program for the benefit of all Kansans. The waiver request will mirror the broad flexibility sought by many other states facing challenges similar to Kansas’.

In addition, Kansas will implement reforms in the current Medicaid program to improve outcomes and reduce costs. As highlighted in the Deloitte report on the public input and stakeholder consultation process, the Kansas approach will be based on the themes of:

- Integrated, whole-person care
- Preserving or creating a path to independence
- Alternative access models and an emphasis on home and community based services.

**Person-Centered Care Coordination:** The clear message of the reform process has been to align the financial incentives for the payers, providers and consumers to best serve the needs of the whole person and the taxpayer, without adding to the administrative burden of the program. That message, combined with the themes that emerged from the process, led the Working Group toward a comprehensive, integrated, person-centered care coordination program to be named “**KanCare**” that includes all major populations and services (including those currently provided in fee-for-service, existing managed care, home and community based services, and long-term and institutional care).

- The state will leverage private sector innovation to achieve public goals by issuing a Request for Proposal (RFP) targeting three statewide KanCare contracts.
- Population-specific and statewide outcomes measures will be integral to the contracts and will be paired with meaningful financial incentives.
- The reforms explicitly call for creation of health homes, with an initial focus on individuals with a mental illness, diabetes, or both.
- The KanCare RFP encourages contractors to use established community partners, including hospitals, physicians, community mental health centers (CMHCs), primary care and safety net clinics, centers for independent living (CILs), area agencies on aging (AAAs), and community developmental disability organizations (CDDOs).
- Safeguards for provider reimbursement and quality are included.
- The state will create a contractual obligation to maintain existing services and beneficiary protections.
- Services for individuals residing in state ICF-MR facilities will continue to be provided outside these contracts.

**Off-ramps:** Reforms include transition to private insurance coverage for Kansans currently on Medicaid, including a COBRA-like option, and health savings accounts that can be used to pay private-sector health insurance premiums. These reforms will aid in the transition from Medicaid to independence while preserving relationships with providers.

**Medicaid to Work:** Increasing opportunities to work, particularly for the more than 2,000 disabled Kansans on Medicaid who have told SRS they want to find employment, is a key element of reform. An enhanced Medicaid to Work program will include collaboration with the Department of Commerce to match potential workers with employers. Other elements include:

- Reducing disincentives to work by enhancing Working Healthy and WORK program.
- Creating a disability preference for state employment.
- Leveraging state purchasing and incentive policies to encourage contractors to hire people with disabilities.

- Establishing cash incentives for businesses that hire people with disabilities who are currently receiving state services.
- Increasing awareness of the Use Law.

**Home and Community Based Services:** The Kansas solution includes long-range changes to the delivery system by aiding the transition away from institutional care and toward services that can be provided in individuals' homes and communities. Kansas currently has the sixth highest percentage of seniors living in nursing homes in the country. Including institutional and long-term care in person-centered care coordination means KanCare contractors will take on the risk and responsibility for ensuring that individuals are receiving services in the most appropriate setting. Outcome measures will include lessening reliance on institutional care. The reforms also include helping nursing facilities build alternative HCBS capacity.

**Collaboration:** The solution encourages providers to practice at the highest level of their licensed training, while reducing isolated, narrowly focused care provision. An example is engaging pharmacists to actively collaborate in managing patient education, compliance and self-management, particularly for patients with medications from multiple prescribers.

**Inclusiveness:** Services for Kansans with developmental disabilities will continue to utilize the statutory role of CDDOs, but their inclusion in KanCare means the benefits of care coordination will be available to them. Contractors will be accountable for functional as well as physical and behavioral health outcomes. Providing Kansans with developmental disabilities enhanced care coordination will improve access to health services and continue to reduce disparities in life expectancy while preserving services that improve quality of life.

**Consumer Voice:** Because these reforms were driven by Kansans, the Administration also proposes to form an advisory group of persons with disabilities, seniors, advocates, providers and other interested Kansans to provide ongoing counsel on implementation of KanCare. Additionally, managed care organizations will be required to create member advisory committee to receive regular feedback, include stakeholders on the required Quality Assessment and Performance Improvement Committee, and have member advocates to assist other members who have complaints or grievances.

**Realign State Agencies:** Public interaction with the Medicaid program will be streamlined by an agency realignment that will consolidate Medicaid fiscal and contractual management in the Kansas Department of Health and Environment and HCBS waivers and mental health program management in a reconfigured Kansas Department on Aging, to be renamed the Kansas Department for Aging and Human Services. Social and Rehabilitation Services will add select family preservation, social and prevention programs from KDHE and the Juvenile Justice Authority to strengthen its targeted focus as a renamed Department for Children and Families.

**Savings:** Based on a conservative baseline of 6.6% growth in Medicaid without reforms (the actual historic growth rate over the past decade was 7.4%), the outcomes-focused, person-centered care coordination model executed under the RFP is expected to achieve savings of **\$853 million** (all funds) over the next five years.

Savings	FY 13	FY 14	FY 15	FY 16	FY 17	5-year Total
All Funds	29,060,260	113,513,129	198,041,997	235,439,877	277,004,864	853,060,127
SGF	12,522,066	48,912,807	85,336,296	101,451,043	119,361,396	367,583,609

## Select Policy Highlights

- Ensure statewide services by each KanCare contractor so that every eligible Kansan on Medicaid or the Children's Health Insurance Program will have access to comparable services throughout the state.
- Expand provider-based systems such as PACE and PACE-like programs as a dual enrollment option.
- Require the completion of a health risk appraisal to identify health and service needs in order to develop care coordination and integration plans for each member.
- Require the provision of health homes to members with complex needs, starting with members who have a mental illness or diabetes, or both.
- Require efforts to improve members' health literacy in order to make effective use of services and to share responsibility for their health.
- Request value-added services, at no additional cost to the state, to incentivize members to lose weight, quit smoking, participate in chronic condition management programs, and other health and wellness initiatives.
- Promote continuity by establishing one-year enrollment lock after the choice period for individuals in plans.
- Require contractors to create member Advisory Committees to receive regular feedback and to have Member Advocates to help members who have complaints and grievances.
- Establish contractual obligation to maintain existing services and beneficiary protections.
- Require contractors to work with existing and additional provider networks and stakeholders.
- CDDOs maintain statutory role; CMHCs continue key role for SED and SPMI.
- Establish significant monetary incentives and penalties linked to quality and performance:
  - 3-5% of total payments will be used as performance incentives to motivate continuous quality improvement.
  - Additional penalties are associated with low quality and insufficient reporting.
  - Measures include prevention, health and social outcomes.
- Minimize conflicts across assessment, case management and service provision.
- Utilize Aging and Disability Resource Centers (ADRCs) to determine functional eligibility determination and provide information and assistance and options counseling.
- Solicit innovative solutions to incentivize healthy behavior – including obesity prevention, smoking cessation, and benefits for annual health screenings.
- Implement Medication Therapy Management to engage pharmacists in a bridging and collaborative role in patient education, compliance and self-management.
- Develop and implement evidence-based guidelines for pharmaceuticals, including behavioral health medications; enhance academic detailing and retrospective reviews.
- Strengthen anti-fraud efforts – including implementation of the Kansas Eligibility Enforcement System (KEES).
- Use uniform provider credentialing form and timeline to reduce administrative burdens on providers.
- Set provider reimbursement floor at 100% of fee for service rates inclusive of options for quality and outcomes incentive payments.
- The state reserves the right to set rates for nursing facilities.
- Preserve the benefit of existing add-on payments such as the hospital and nursing home provider assessment, Disproportionate Share Hospital (DSH), and Graduate Medical Education (GME).
- Enforce prompt payment requirements.
- Establish tiered functional eligibility system for the Frail and Elderly that restricts access to the highest cost institutional settings only to those with the highest level of need in order to utilize appropriate alternative home and community based settings.

- Incentivize nursing facilities through a focused shared savings programs to diversify and build alternative HCBS capacity.
- Ensure access to mid-levels such as physician assistants and advanced practice nurses through integrated care model.
- Align financial incentives for integrated care systems through blended rates to re-balance and prevent premature nursing facility placement.
- Integrated care systems will be expected to effectively integrate Medicaid and Medicare.