

KanCare
Frequently Asked Questions
March 5, 2012

What are the major changes with Kansas Medicaid?

- Person-centered care coordination
- Clearer accountability
- Agency streamlining
- Financing consolidation
- Name change to KanCare

When will these changes take effect?

The state issued the Request for Proposal on Nov. 9, 2011. The deadline for technical proposals to be submitted was Jan. 31, 2012, and the deadline for bidders to submit the fiscal component was Feb. 22, 2012. Five companies submitted complete bids, and KanCare will take effect in January 2013.

The plan is for all Medicaid beneficiaries to be enrolled in a KanCare plan starting fall 2012. While beneficiaries initially will be auto-assigned, they will be able to choose the plan they prefer during a 45-day enrollment period. After the initial enrollment of current beneficiaries in January 2013, new beneficiaries will be able to select which of the three health plans in which they want to be enrolled.

KanCare will bring partnerships, engagement, and even new business relationships in the Medicaid provider community. These innovations at the ground level will be KanCare's true legacy. The RFP anticipates a steady but intense period of change over the next three years, with corresponding increases in expected patient outcomes and savings.

How will improved health outcomes be achieved?

The State of Kansas Medicaid program will provide superior service by implementing an integrated model of care that focuses on the whole person. Through the contracting process, the state will require KanCare companies to create health homes revolving around our consumers' core provider and to undergird these health homes with technology, funding, person centered care coordination and communication required to engage the consumer and improve their care.

The Administration has identified specific outcomes to be achieved for various population groups within Kansas Medicaid. The state is also looking for the best ideas in the industry, so we announced to the bidders that we expect them to put forth additional ideas on how to achieve meaningful improvements to consumer health.

We are crafting ironclad agreements with integrated care companies. This began with the development of the RFP, and it will culminate with signed contracts that establish enforceable outcomes. These reforms create the first-ever set of comprehensive goals and targeted outcomes in Kansas Medicaid. These new standards exceed Federal requirements and set Kansas on a path to historic improvement and efficiency.

Have other states moved forward with similar program models?

Kansas is drawing from the best examples from around the country and expects to become a national leader in performance-oriented strategic purchasing of Medicaid services. Other states have used similar models: Texas, Tennessee, Michigan and Pennsylvania.

Kansas expects to be on the leading edge when it comes to implementing a whole-person centered model of care that looks at all aspects of the program and the needs of Medicaid consumers.

Why is it important that all populations be “carved in”?

Services for all Kansans served by Medicaid will be incorporated into the KanCare system so that 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 this enhanced care coordination will improve access to services supporting independence as well as health services and continue to reduce the disparity in life expectancy while preserving services that improve quality of life.

Will the state continue to contract with existing providers?

The KanCare RFP mandates contractors 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).

The state will continue to use CDDOs and other provider groups in their statutorily established role.

With these changes, will consumers be partnered with the same care manager they have today?

Person-centered care coordination is not something that currently happens in Kansas. Care managers should have the social service, behavioral health and physical health background to coordinate all these providers to best serve Kansans.

Health plans are being mandated in the RFP to partner with established community partners, so some case managers may become “care managers” under KanCare. However, even if a consumer’s case manager changes, the care manager will meet with the consumer and their family and provide services that meet the needs of the consumer. All care managers will be held to the highest standard.

Will KanCare result in cost savings?

Over five years, the state expects to reduce growth in Kansas Medicaid spending by 8-10%, which equates to 1/3 reduction in total Medicaid growth.

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.

| | 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 |

With the planned agency streamlining, what functions and programs are moving to other agencies/entities?

Public interaction with the Medicaid program will be streamlined by a realignment of state agencies. Medicaid fiscal and contractual management will be consolidated within the Kansas Department of Health and Environment’s Division of Health Care Finance.

Home and Community Based Service waivers and mental health program management will be housed in a reconfigured Kansas Department on Aging, to be renamed the *Kansas Department for Aging and Disability Services (KDADS)*. Social and Rehabilitation Services will strengthen its targeted focus as a renamed *Department for Children and Families*, thus making Medicaid more efficient by the program being managed by two agencies—KDHE and KDADS—instead of three.

Will the Reorganization result in cost savings?

While the primary purpose for reorganizing state agencies is to increase coordination for programs, the state does expect to achieve some administrative cost savings. Any administrative savings will be reinvested to reduce waiting lists for waiver services.

We are restructuring to increase coordination and are focused on the efficient use of administrative resources to assure quality of care and contract oversight.

How can the State guarantee that the health plans will achieve the measureable outcomes identified under KanCare and improve the care of consumers?

The State will ensure performance by establishing significant monetary incentives and penalties for the plans that are linked to quality and performance, including:

- 3-5% of total payments will be withheld and used as performance incentives to motivate continuous quality improvement.
- Additional penalties are associated with low quality and insufficient reporting.
- Measures of plan performance will include prevention, health and social outcomes.

Since these reforms were driven by Kansans, the State will form an advisory group of persons with disabilities, seniors, advocates, providers and other interested Kansans to provide ongoing counsel on implementation of KanCare. Additionally, KanCare health plan companies 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.

What approval process with Centers for Medicare and Medicaid Services (CMS) is necessary for Kansas to implement KanCare?

The Section 1115 demonstration project Kansas submitted in the form of a concept paper on Jan. 26, 2012, was developed after a year's worth of consultation with advocates, consumers and providers, highlighted by an extensive public input process over the summer and fall of 2011, with a high level of interest throughout. That public input has continued into 2012, as we have made the concept paper and other supporting documents publicly and widely available, solicited public comments, and consulted with stakeholders, legislative committees, and constituents, and will continue to do so throughout the process leading to implementation.

Kansas has started conversations with CMS around the 1115 proposal. We purposefully asked for a two-track process to separate the global waiver issues from those authorities that have been granted in other states. There is nothing precluding our federal partners from approving the waiver authority necessary to implement KanCare in the time available. We're encouraged by our ongoing conversations with CMS, and we look forward to continuing the KanCare dialogue with stakeholders, legislators and other interested Kansans.