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Jeff Colyer, M.D., Lieutenant Governor

Sam Brownback, Governor

December 26, 2017

Mr. Eric D. Hargan
Acting Secretary and Deputy Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Acting Secretary Hargan:

On behalf of the State of Kansas, I am pleased to submit our request for a Section 1115 demonstration waiver renewal application to implement the KanCare 2.0 program from January 1, 2019 to December 31, 2023. Building on the success of the current KanCare demonstration, the goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by providing services and supports for social determinants of health and independence in addition to traditional Medicaid benefits.

The State of Kansas appreciates your consideration of this Section 1115 demonstration waiver renewal application and looks forward to working with CMS to improve the health and independence of KanCare members.

Please let me know if you have any questions or need additional information.

Sincerely,

Jeffrey Colyer, M.D.
Lieutenant Governor

State of Kansas

KanCare 2.0
Section 1115 Demonstration Renewal Application

Final Submission to CMS

December 20, 2017

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I. Introduction

The Kansas Department of Health & Environment (KDHE), in partnership with the Kansas Department for Aging and Disability Services (KDADS) is pleased to submit this Section 1115 demonstration renewal application for the KanCare program. KanCare, Kansas' statewide mandatory Medicaid managed care program, was implemented on January 1, 2013, under authority of a waiver through Section 1115 of the Social Security Act. The initial demonstration was approved for five years, and the Centers for Medicare and Medicaid Services (CMS) approved a one-year extension on October 13, 2017.

The original goals of the KanCare demonstration focused on providing integrated and whole-person care, creating health homes, preserving or creating a path to independence, and establishing alternative access models with an emphasis on home and community-based services (HCBS). Building on the success of the current KanCare demonstration, the goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid benefits. The State of Kansas (the State) seeks a five-year Section 1115 demonstration renewal from CMS to further improve health outcomes, coordinate care and social services, address social determinants of health, facilitate achievement of member independence, and advance fiscal responsibility.

II. Historical Narrative Summary of KanCare and Requested Changes

This section provides an overview of the State's current KanCare demonstration and requested changes under KanCare 2.0.

Historical Narrative Summary of KanCare

KanCare is a Medicaid managed care program which serves the State through a coordinated approach. The State determined that partnerships with managed care organizations (MCOs) will result in more efficient and effective provision of health care services to the populations covered by the Medicaid and Children's Health Insurance Program (CHIP) in Kansas. Three MCOs currently serve the KanCare program – Amerigroup, Sunflower Health Plan, and UnitedHealthcare. The State will begin the reprocurement process for new MCO contracts in November 2017 to implement KanCare 2.0.

Prior to the implementation of KanCare, the State operated a managed care program which provided services to children, pregnant women, and parents in the State's Medicaid program, as well as carved out mental health and substance use disorder (SUD) services to separate managed care entities. On August 6, 2012, the State submitted a Medicaid Section 1115 demonstration proposal, entitled KanCare. CMS approved that proposal on December 27, 2012, effective from January 1, 2013 through December 31, 2017. On August 19, 2013, the State submitted a letter to CMS requesting approval of an amendment to the KanCare demonstration, detailing three changes to KanCare:

Figure 1. Previously Requested KanCare Demonstration Amendments Approval Status

Proposed Change	CMS Approval Date
Provide Long-Term Supports and Services (LTSS) for individuals with intellectual and developmental disabilities (I/DD) through KanCare managed care plans	CMS approved the LTSS integration of I/DD population in a letter dated January 29, 2014, and approved amendments to the HCBS I/DD waiver in a letter dated February 3, 2014
Establish a supplemental security income pilot program to support employment and alternatives to Medicaid	State withdrew this proposed change on July 24, 2017
Change the timeline for the Delivery System Reform Incentive Payment (DSRIP) Pool	CMS approved the DSRIP delay amendment on September 20, 2013

KanCare is operating concurrently with the State's section 1915(c) HCBS waivers, which together provide the authority necessary for the State to require enrollment of almost all Medicaid beneficiaries across the State into a managed care delivery system to receive State Plan and waiver services. Appendix A lists the groups included in KanCare under the current 1115 demonstration Special Terms and Conditions (STC). Although most of the populations within the demonstration renewal will remain the same, the State is considering the addition of certain MediKan enrollees who voluntarily discontinue pursuit of a disability determination in exchange for Medicaid benefits with employment support for a duration of 18 months.

The KanCare program integrates medical, behavioral, and long-term care health delivery systems and covers mandatory and optional services under the approved Medicaid State Plan. Kansas is not requesting any changes in covered benefits for this renewal.

Currently, KanCare includes a Delivery System Reform Incentive Payment (DSRIP) Pool, which aims to advance the goals of access to services and healthy living by specifically focusing on incentivizing projects that increase access to integrated delivery systems and projects that expand successful models for prevention and management of chronic and complex diseases. Participating hospitals work with community partners statewide to implement projects that have measurable milestones for improvements in infrastructure, processes, and healthcare quality.

The DSRIP program in Kansas includes two major hospitals: Children's Mercy Hospital and The University of Kansas Hospital. The two hospital systems are major medical service providers to Kansas and Missouri residents. Each hospital system is implementing two projects selected from a catalog of five projects approved by CMS and the State that target specific needs of Kansas residents who are receiving Medicaid services or are uninsured. The Kansas DSRIP projects were originally planned to be implemented as four-year projects from 2014 through 2017. In 2013, the State amended the 1115 demonstration to change the projects to begin in 2015. Then in 2017, the State received approval to extend the projects through December 21, 2018. Under KanCare 2.0, the State proposes to extend the DSRIP program for two additional years through December 31, 2020. Subsequently, the State will propose a design for an alternative payment model (APM) approach that replaces the DSRIP program beginning in January 2021. In developing the design for the DSRIP replacement, the State will work closely with CMS and will seek input from key stakeholders. The State will consider the lessons learned from the current DSRIP program, including data collection and reporting practices, and intends to align performance measures with KanCare 2.0 objectives.

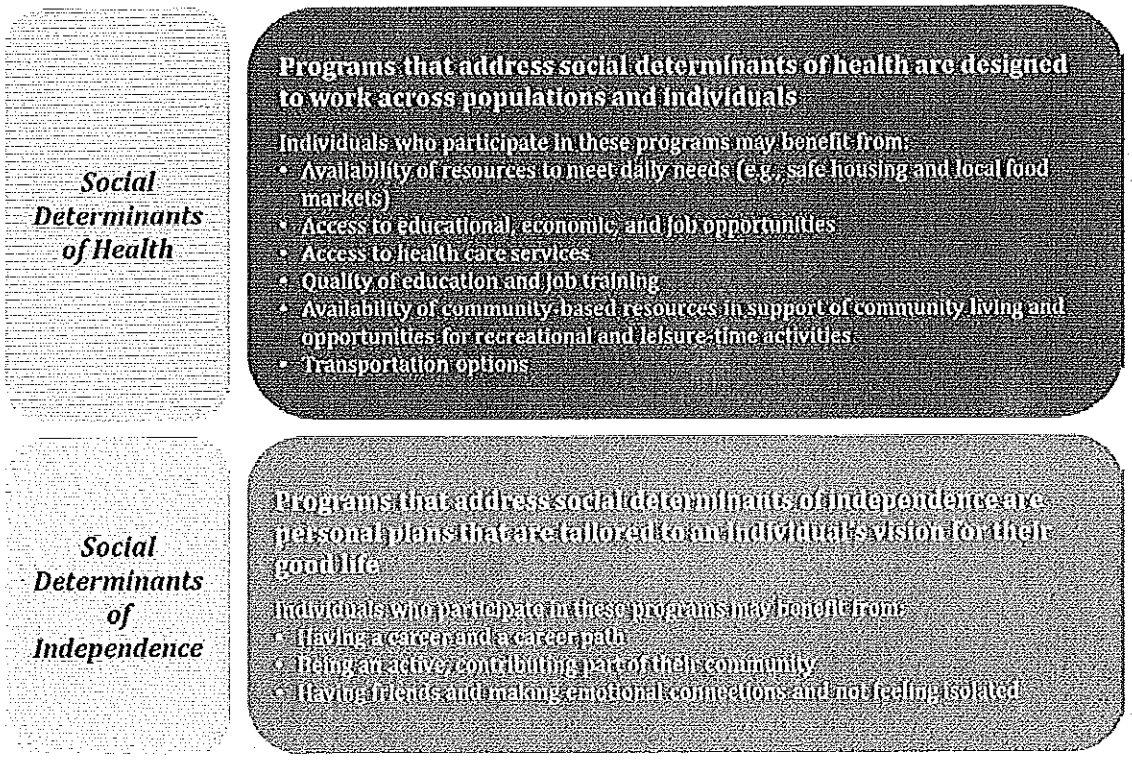
KanCare also includes an Uncompensated Care (UC) Pool (also referred to as a Safety Net Care Pool). The UC Pool provides payments to hospitals to defray hospital costs of uncompensated care provided to Medicaid-eligible or uninsured individuals. The UC Pool consists of two sub-pools, the Health Care Access Improvement Program (HCAIP) Pool and the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool. Under KanCare 2.0, the State proposes to increase the size of the UC Pool as discussed further below.

Finally, refer to Section IV, Quality Reporting and Section VI, Evaluation Design, for additional information regarding performance of the current KanCare program.

Requested Changes

Building on the success of the current KanCare program, the goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid and CHIP benefits. Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[1] Social determinants of independence are an individual's goals that help them achieve sustainable improvements and advancement in their lives. Addressing social determinants of independence in conjunction with social determinants of health accelerates an individual's path to higher levels of independence and attainment of their vision for a good life.

Figure 2. Examples of Social Determinants of Health and Independence



[1] Healthy People 2020, 2017. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Kansas will test the following hypotheses in KanCare 2.0 to accomplish the goal of helping Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid benefits:

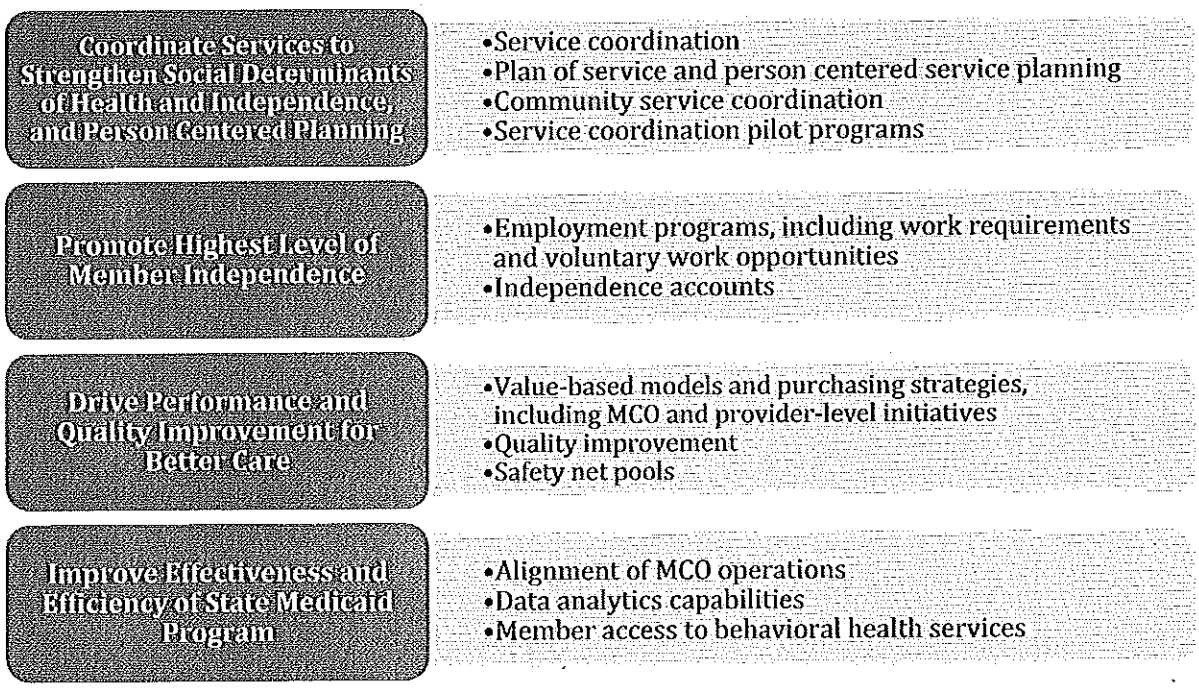
1. Expanding service coordination to include assisting members with accessing affordable housing, food security, employment, and other social determinants of health and independence will increase independence, stability, and resilience and improve health outcomes;

2. Increasing employment and independent living supports for members with behavioral health needs, or who have intellectual, developmental or physical disabilities or traumatic brain injuries will increase independence and improve health outcomes; and

3. Providing service coordination for all youth in foster care will decrease the number of placements, reduce psychotropic medication use, and improve health outcomes for these youth.

The State will not continue to test hypotheses previously included under KanCare. The vision for KanCare 2.0 includes enhancements, advancements, and innovations focusing on areas below.

Figure 3. Key Themes and Initiatives Under KanCare 2.0

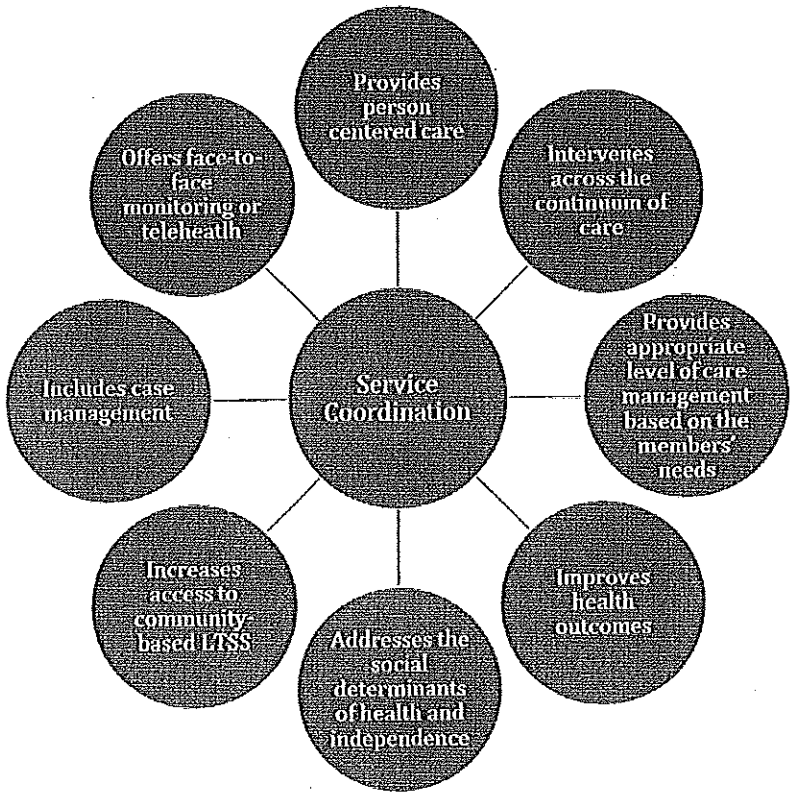


Each of the key themes and selected initiatives is described in further detail below.

Coordinate Services to Strengthen Social Determinants of Health and Independence, and Person Centered Planning

KanCare 2.0 will expand upon care coordination to provide service coordination, which is a comprehensive, holistic, integrated approach to person centered care. Service coordination is a foundational component to improving the health and well-being of members. It allows for maximum access to supports by coordinating and monitoring all of an individual's care (acute, behavioral health, and LTSS) through direct interventions, provider referrals, and linkages to community resources. Case management, disease management, discharge planning, and transition planning are also elements of service coordination for members across all providers and settings.

Figure 4. Key Elements of the KanCare 2.0 Service Coordination Model



The State will require MCOs to provide service coordination to groups such as:

- Individuals enrolled in a 1915(c) waiver or on a waiver waiting list,
- Youth (birth up through age 21) who have intensive behavioral health needs,
- Youth who are in an out-of-home placement through the foster care system,
- Individuals who are institutionalized in a nursing facility, intermediate care facility for individuals who have intellectual disabilities or hospital, psychiatric residential treatment facility, psychiatric hospital or other institution,
- Adults who have behavioral health needs,
- Individuals who have chronic and/or complex physical and/or mental health conditions, and
- Individuals participating in the Work Opportunities Reward Kansans (WORK) program or other employment programs.

Plans of Service and Person Centered Service Plans

To support our hypotheses, KanCare 2.0 service coordination enhancements and advancements include tools for assessing initial and ongoing member needs and other systematic efforts to identify the health and social resources required to meet the member's needs and confirm coordination across settings and during transitions of care.

MCOs will complete health screenings for members using a screening tool that contains State-prescribed questions and fields. For all members whose health screen results indicate the need for a health risk assessment (HRA), MCOs will use a State-developed tool for members who have behavioral health conditions or enrolled in a HCBS waiver program to determine the type of needs assessment warranted by the member's health status and next steps in the process. MCOs will conduct health screenings and HRAs in a centralized information system that is capable of interfacing with the State's Kansas Medicaid Modular System (KMMS).

Following the assessment, MCOs will develop plans of service and person centered service plans (PCSP), based on their needs shown in the figure below.

Figure 5. Plan of Service and Person Centered Service Plan

Plan of Service

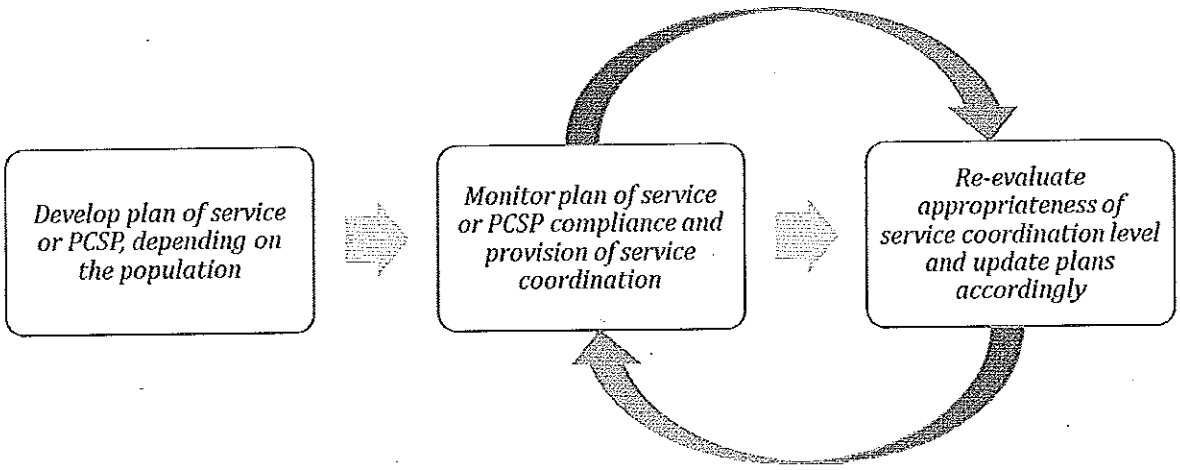
Members receiving service coordination are encouraged to participate in their individualized plan of service development process. The plan of service is a written document that describes the member's goals and service needs in accordance with State policy. The plan of service records the strategies to meet goals and interventions selected by the member and the team that will support

the member's health and well-being and address social determinants of health and independence. The plan of service will accurately document the member's strengths, needs, goals, lifestyle preferences, and other preferences, and will outline the services and supports that will be provided to meet member needs. MCOs will also consider the availability and role of unpaid supports provided by family members and other natural supports.

Person Centered Service Planning

For all members enrolled in HCBS waiver services, children in foster care, and members who have behavioral health needs, MCOs will ensure that members participate in the person centered service planning process that is compliant with federal requirements, (e.g., 42 C.F.R 441.301(c)), State law, and the State's PCSP policy. The PCSP will involve an interdisciplinary team of professionals including individuals chosen by the member. These professionals must have adequate knowledge, training and expertise around community living and person centered service delivery. The PCSP process will promote self-determination and actively engage the member and individuals of their choice.

Figure 6. KanCare 2.0 Service Planning Process



Community Service Coordination

KanCare 2.0's service coordination will feature:

- Person and family-centeredness,
- Timely and proactive communication,
- Promotion of self-care and independence,
- Cross continuum and system collaboration,
- Comprehensive consideration of physical, behavioral, and social determinants of health and independence, and
- Promotion of community access and participation in community activities.

KanCare 2.0 will create linkages to allow for sharing information through KMMS (discussed further below), tracking referrals, obtaining the appropriate approvals or member consent to share health and care information, and maintain ongoing coordination efforts with community agencies important to the health and well-being of members.

The State will require MCOs to work with local entities to perform community service coordination activities. These activities may include items such as:

- Development, implementation, monitoring, and approval of the plan of service or PCSP,
- Choice counseling,
- Member contacts and home visits,
- Linkage and referral to community resources and non-Medicaid supports,
- Referrals for education, employment, and housing, and
- Education to the member regarding self-direction and the WORK program and other employment programs.

Service Coordination Pilots

Finally, the State is considering the implementation of potential pilots to further improve services coordination for members. We describe the goals of these initiatives below.

Figure 7. Potential Service Coordination Pilots

Target Population	Goals
Individuals with Disabilities & Behavioral Health Condition	• Help members obtain and maintain competitive integrated employment • Help members achieve their highest level of independence
Children in Foster Care	• Increase stability at home and school • Support the child and foster family to reduce adverse childhood experiences • Ease transitions
Adults with Chronic Conditions	• Improve outcomes for people with chronic conditions through direct primary care • Lower emergency room visits and hospital admissions
Members Living in Rural & Frontier Areas	• Expand services delivered through telehealth • Increase provider capacity through tele-mentoring • Promote and expand the rural workforce

Promote Highest Level of Member Independence

The goal of Medicaid long-term supports and services (LTSS) initiatives is to "create a person-driven, long-term support system that offers people who have disabilities and chronic conditions choice, control and access to services that help them achieve independence, good health and quality of life."[2] Individuals who have disabilities comprise 14.5 percent of Kansas' Medicaid and CHIP enrollment but represent 47.5 percent of Kansas' Medicaid and CHIP spending in State Fiscal Year 2016.[3] Many KanCare members who have disabilities wish to remain within the community and complete activities of daily life on their own, to the extent possible. The State is considering the following initiatives to promote the highest level of member independence, as defined by the member. The State is also interested in promoting member-driven health care decisions by supporting health care quality and cost transparency, and will work with MCOs to help members identify high quality, high value providers who can best meet their specific needs.

Employment Programs

Stakeholders in Kansas and the rest of the nation have identified a number of barriers impacting individuals' abilities to achieve employment. Among these are low expectations for youth and adults who have disabilities, medical and service providers who discourage employment, lack of work experience for transition age youth, a Social Security system that defines disability as the inability to work, state and federal systems that incentivize unemployment, and inconsistency across systems in terms of their approach to employment.

Unemployed Americans face numerous health challenges beyond loss of income. Workers who are laid-off are "54 percent more likely than those continuously employed to have fair or poor health, and 83 percent more likely to develop a stress-related condition, such as stroke, heart attack, heart disease, or arthritis." [4] With respect to behavioral health, a 2013 Gallup Poll found that "the longer Americans are unemployed, the more likely they are to report signs of poor psychological well-being."[5] Employment plays a major role in adult life, frequently bringing with it a sense of accomplishment, personal satisfaction, self-reliance, social interaction, and integration into the community, which can ultimately impact an individual's social determinants of health and independence. Steady employment can provide the income, benefits, and stability necessary for good health.

The Temporary Assistance to Needy Families (TANF) program in Kansas has been successful in increasing the number of Kansans with new jobs: from January 2011 through June 2017, 43,975 new employments were reported for TANF clients. As the State builds on its TANF program and KanCare successes to further promote member independence, the State will institute work requirements for only some able-bodied adults and offer work opportunities for other KanCare members who wish to work.

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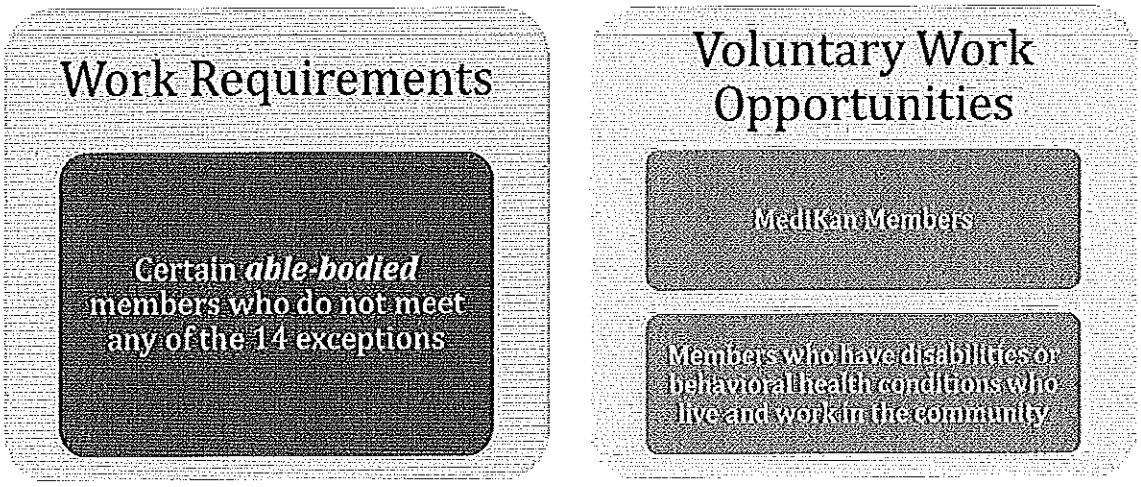
[2] Centers for Medicare & Medicaid Services, 2017. Available at: https://www.medicaid.gov/medicaid/ltss/balancing/index.html

[3] Kansas Health Institute, 2017. Available at: http://www.khi.org/assets/uploads/news/14738/kansasmedicaidprimer2017.pdf

[4] Robert Wood Johnson Foundation, 2013. Available at: https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf403360

[5] Gallup News, 2014. Available at: http://news.gallup.com/poll/171044/depression-rates-higher-among-long-term-unemployed.aspx

Figure 8. KanCare 2.0 Employment Programs



Work Requirements

As part of the State's broader effort to encourage member independence, the State will require only some able-bodied adults to meet work requirements under KanCare 2.0. Work requirements will be implemented as soon as possible on or after January 1, 2019, and no later than July 1, 2020. This policy aligns with Kansas' initiative across public programs to promote the highest level of member independence. Work requirements will build on requirements already in place for the Temporary Assistance to Needy Families (TANF) program. Therefore, if the KanCare member is receiving TANF benefits and complies with work participation requirements for TANF, he or she will also meet KanCare 2.0 work requirements. Training and employment support resources available via TANF will also be available to KanCare members required to comply with this requirement.

Population

Only some KanCare able-bodied adults will be required to comply with work requirements.

The following KanCare members will **not** be subject to work requirements:

1. Members receiving long-term care, including institutional care and Money Follows the Person;
2. Members enrolled in or on the waiting list for the following Home- and Community-Based Services (HCBS) waiver programs: Autism, Serious Emotional Disturbance (SED), Technology Assisted (TA), Frail Elderly (FE), Traumatic Brain Injury (TBI), Intellectual and Developmental Disabilities (I/DD), and Physical Disability (PD);
3. Children;
4. Women who are pregnant;
5. Members who have disabilities and are receiving Supplemental Security Income (SSI);
6. Caretakers for dependent children under six years or those caring for a household member who has a disability;
7. Medicaid beneficiaries who have an eligibility period that is only retroactive;
8. Members enrolled in the MediKan program;
9. Members presumptively eligible for Medicaid;
10. Persons whose only coverage is under a Medicare Savings Program;

11. Persons enrolled in Programs of All-inclusive Care for the Elderly (PACE);
12. Members with TBI, human immunodeficiency virus (HIV), or in the Breast and Cervical Cancer Program;
13. Members who are over the age of 65 years; and
14. Certain caretakers of KanCare members 65 years and older who meet criteria specified by the State.

The State may consider an exceptions process for members who have certain behavioral health conditions.

Eligibility

The State will assess Kansas Medicaid beneficiaries at the point of application or redetermination to determine if they are required to meet the KanCare work requirements. Members will be able to request exemptions throughout their eligibility. Members who must comply with these work requirements can receive a grace period of up to three months of KanCare coverage in a 36-month period. The State may authorize an additional month of eligibility for coverage beyond the three months in exceptional circumstances (e.g., natural disasters). The following table provides an overview of members' eligibility and the maximum length of KanCare coverage they may receive based on proof of meeting work requirements.

Figure 9. KanCare Member Eligibility and Maximum Coverage under Work Requirements

Eligibility	Maximum Length of KanCare Coverage
Members who are subject to work requirements but **do not meet** work requirements	3 months of KanCare coverage in a 36-month period
Members who are subject to work requirements **who meet** work requirements	36 months

Participation

The State will align KanCare work requirements with TANF program requirements. Minimum weekly requirements are 20 or 30 hours in a one-adult household, depending on whether there is a child under the age of six. Minimum weekly requirements are 35 or 55 hours in two-adult households.[6] For any given individual, the maximum requirement is 40 hours per week per individual. Applicants are required to complete a self-assessment and an orientation.

Consistent with Section 407 of the Social Security Act and the TANF program, the following

[6] Some two-adult households do not meet the two-parent definition. For instance, there may not be a mutual child or they are cohabiting partners. For TANF, effective May 1, 2017, two-adult households are required to participate 30 hours per week. If there is a child under the age of six, at least 20 of those hours are to be completed by one adult. If there is no child under the age of six, all 30 hours must be completed by one adult. http://content.dcf.ks.gov/ees/KEESM/SOC_Rev_82_05-17.html

activities will meet the State's definition of work:

- Unsubsidized Employment: This activity includes employment that is full or part-time including self-employment, apprenticeship, and internship/practicum that pays a wage or salary.
- Subsidized Public Employment: Contracted employment such as temporary staffing in the public sector, federal work study, Job Corps, or Workforce Innovation and Opportunity Act (WIOA)-paid work experience in which the wages are subsidized by TANF or other public funds.
- Subsidized Private Employment: Employment in the private sector in which the wages are subsidized by TANF or other public funds. This could include, but is not limited to, work study, WIOA work experience, temporary staffing, and other work experience opportunities.
- Work Experience: An unpaid, supervised assignment to help the member develop work history, improve work habits and increase self-confidence and esteem. Work experience may occur in the public or private sector.
- On-the-Job Training: Paid employment that provides significant and/or additional training in the knowledge and skills necessary to perform one's job. Training would be based on a well-defined plan and may be subsidized or unsubsidized, in either the public or private sector.
- Supervised Community Service: Work that is performed for the direct benefit of the community and the member in a variety of capacities while under supervision. This includes, but is not limited to AmeriCorps, Volunteers in Service to America (VISTA), faith-based organizations, probation conditions, substance abuse recovery centers, and animal shelters.
- Vocational Education: Employment training that prepares members for employment in current or emerging occupations. This includes, but is not limited to skill specific certificate programs, work towards an Associate Baccalaureate Degree, language instruction, or online distance learning.
- Job Search/Job Readiness: The following are considered job search/job readiness for those who are otherwise employable:
    - Individual or Group Job Search: Supervised individual job search or workshops designed to build job search competency and support the individual in searching and interviewing for job openings.
    - Job readiness: This includes, but is not limited to community or agency workshops and/or support groups designated to enhance life skills and remove barriers that may prevent obtaining and retaining employment including rehabilitation activities such as short-term physical therapy.
- Job Readiness Case Management: One-on-one services to help remove employment barriers and assist the participant in learning and adhering to employers' general expectations.
- Job Skills Training Directly Related to Employment: Training or education that is customized to job specific skills required by an employer to obtain employment or to adapt to the changing demands of the workplace.
- Education related to Employment: Education activities that include Adult Basic Education, English as a Second Language, and other courses designed to provide knowledge and skills for a specific job.

- Secondary School Attendance: This activity includes a member's efforts toward General Educational Development (GED) and/or completing a high school degree, particularly those under 20 years of age.

Tracking

The State will track countable months for members who are required to comply with work requirements. Members who fail to comply with the work requirements and who have exhausted their three-month grace period will be removed from KanCare until compliance is achieved. The start date of the disenrollment shall be the first of the month after normal procedures for closing or removal of the member have taken place. Should a fair hearing delay the disenrollment process, the period shall start the first of the month following the decision upholding the State's determination. The disqualification period shall continue until the disqualified member complies with all work requirements. Members will be afforded the usual grievance and appeal rights and existing Medicaid protections.

Voluntary Work Opportunities

The State will also offer two programs to support voluntary work opportunities for KanCare members who wish to or elect to work. KanCare 2.0 will include voluntary work opportunities for the following members:

- Members in the MediKan program, and
- Members who have disabilities or behavioral health conditions living and working in the community.

Work Opportunities for MediKan Members

The initiative focuses on individuals who apply for a disability determination through the Kansas Presumptive Medical Disability process who do not meet the Social Security Administration (SSA) guidelines for a disability determination. These individuals tend to have a combination of physical and behavioral conditions that do not meet SSA criteria for a disability, as well as socio-economic issues that may be a barrier to a stable lifestyle. Approximately 35 percent of individuals in this population have mental illness as one of their disabilities. The higher rate of mental illness and health problems, combined with education and socioeconomic issues, likely result in a greatly reduced capacity to obtain and/or maintain gainful employment, and highlight the need for vocational supports and other interventions in order for them to leave the general assistance rolls and become employed. As of June 2017, there were 2,101 individuals eligible to receive the MediKan benefit.

Under KanCare 2.0, beginning in 2020, the State will provide a voluntary choice to MediKan members who are under the age of 65 years to pursue a disability determination from the SSA and be eligible for 12 months of MediKan, or they may discontinue pursuit of a disability determination. Subsequently, they would receive a broader array of health care and social support services than the traditional MediKan program with employment support. These individuals will be a new population under the KanCare demonstration. MediKan members who discontinue pursuit of a disability determination will receive Medicaid benefits through a KanCare MCO and will receive employment support such as job skills training for a duration of 18 months.

The goal is to provide a comprehensive benefit package to these individuals to:

- Decrease the likelihood of a future disability determination by stabilizing their immediate health care needs and providing preventive care,
- Support their employment pursuits and assist in maintaining employment, and
- Promote greater independence and self-sufficiency.

The State will require MCOs to contract with community partners that have trained staff to provide employment supports. These partners will have strong ties with the State's vocational and rehabilitation and workforce systems. To further increase work opportunities for members who have disabilities, the State is also considering requiring MCOs to adopt recruitment strategies that establish a hiring preference for Kansans who have disabilities.

Work Opportunities for Members who have Disabilities or Behavioral Health Conditions

The State is also considering a pilot program for individuals who have disabilities or behavioral health conditions, and who are living and working in the community. The State may provide services such as:

- Employment support,
- Independent living skills training,
- Personal assistance, and
- Transportation.

KanCare members who have disabilities or behavioral health conditions and who are at risk for institutionalization would have the option to receive services under the demonstration program.

This pilot program would allow the State to test whether offering supported employment, combined with supportive housing, independent living skills training and personal assistance services, results in a significant increase in the number of members who have disabilities or behavioral health conditions who gain and maintain competitive employment. The pilot supports the goals of KanCare 2.0, and if it demonstrates positive results, the State can expand the pilot.

Independence Accounts

The TransMed program is a transitional Medicaid program which is designed to provide temporary health coverage to families moving from welfare to economic self-sufficiency. The TransMed program provides an additional 12 months of coverage for families who were previously eligible for Medicaid and lost financial eligibility due to increased earnings. The State is considering the creation of Independence Accounts, also known as health savings accounts, for adults enrolled in the TransMed program to encourage them to:

- Maintain employment, and
- Transition out of Medicaid and onto the health insurance exchange or other commercial insurance plans.

Each TransMed member will have the option to sign up for an Independence Account. The State will deposit funds into the Independence Account for the member for the 12 months of TransMed coverage, contingent upon the member's continued employment for all 12 months. At the end of the TransMed eligibility period, members will receive a debit card with which they can access funds from their Independence Account use for items specified by the State and approved by CMS. These

funds do not expire. Members who choose to participate in this initiative would be prohibited from re-enrolling in Medicaid for a period of time determined by the State.

The State will conduct a pilot of the Independence Accounts in a limited geographic area for TransMed members before determining whether to make them available on a statewide basis. The State may require MCOs to manage the Independence Accounts for enrolled members and support members in transitioning to commercial health insurance alternatives.

Drive Performance and Quality Improvement for Better Care

Demand for health care services continues to increase, and health care costs represent a large proportion of corporate and governmental budgets, with Medicaid comprising 21 percent of the State's General Fund expenditures in State Fiscal Year 2015.[7] Policymakers and payers alike recognize the need to transform the health care delivery system into one that aligns financial incentives to reward high quality services and improve outcomes, rather than a system that drives volume. Value-based models and purchasing strategies focus on those innovative programs that will drive better value for members and increase quality and outcomes with provider payment incentives, while reducing costs.

With the goal of driving performance and quality improvement for better care, KanCare 2.0 will leverage value-based models and purchasing strategies, use of data to drive quality improvement, and safety net pools.

Value-Based Models and Purchasing Strategies

KanCare 2.0 promotes two different types of value-based models and purchasing strategies:

1. Provider payment and/or innovative delivery system design strategies between MCOs and their contracted providers, and
2. A pay-for-performance (P4P) program between the State and contracted MCOs.

Value-based models incorporate performance and quality initiatives into service delivery. Such initiatives will be critical to helping Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence.

The first value-based model and purchasing strategy will incentivize providers. MCOs will implement provider payment and/or innovative delivery system design strategies that incorporate performance and quality initiatives in service delivery models. The State is considering both types of strategies so long as they support the goals and objectives of KanCare 2.0. The State will offer MCOs flexibility to design strategies to support the goals and objectives of KanCare 2.0, with the State reserving the ultimate authority for approval. MCOs will submit proposals that utilize strategic approaches, such as those outlined below.

[7] Kaiser State Health Facts, State Fiscal Year 2015.

Figure 10. Examples of Value-Based Model and Purchasing Strategies

Approach	Description
Alternative Payment Models (APM)	• Includes quality and/or outcome measures as a part of the reimbursement strategy
Social Determinants of Health and Independence	• Uses direct interventions that address social determinants that impact the overall health and well-being of members and result in decreased medical expenditures
Behavioral Health Services	• Reduces total cost of care, addresses gaps and improvement in access to services, quality of providers, incentives for transitions from institutions to community based programs and services, seamless follow-up care, diversion from institutions, and reduces inpatient admissions
Long-Term Supports and Services (LTSS)	• Addresses gaps and improvement in access to services, quality of providers, incentives for transitions from institutions to community based programs and services, reductions in reliance of institutions for treatment, ensuring choice of in-home versus residential services
Physical and Behavioral Health Integration Strategies	• Identifies, treats, and transitions members to appropriate behavioral health services and providers when presenting at the hospital with an emergent medical condition
Telehealth Projects	• Uses telemedicine, telemonitoring, and telementoring to enhance access to services for rural areas, access to behavioral health services, and support chronic pain management interventions

The State will make available the registries, tools, and resources to the MCOs to assist in the implementation of value-based purchasing models targeting providers. Some of these resources will include:

- Defined condition registries currently under consideration for inclusion by the State in its KMMS development,
- Reports available through the State enterprise data warehouse,
- Public health registries,
- Health information exchanges (HIE),
- Kansas Medical Assistance Program (KMAP) website containing updated eligibility information, and
- KMAP provider registry.

The second value-based model and purchasing strategy will continue the P4P program, rewarding MCOs that meet measures and targets under KanCare 2.0 goals. The basis behind the P4P program is a payment withhold, where the State withholds a portion of the payments due to MCOs each month. At the end of the year, the State assesses whether or not each MCO has met the required performance targets and distributes or withholds payments based on level of achievement. The State aims to improve health care quality and reduce costs by holding MCOs accountable to outcomes and performance measures and tying measures to meaningful financial incentives. Example monetary incentives and penalties include:

- A percent of total payments used as performance incentives to motivate continuous quality improvement, and
- Penalties associated with low quality and insufficient reporting.

Quality Improvement

The State will update its Quality Strategy to incorporate performance measures and reporting to support KanCare 2.0 initiatives, and will include a variety of performance measures derived from sources such as the Healthcare Effectiveness Data and Information Set® (HEDIS®), Consumer Assessment of Healthcare Providers and Systems® (CAHPS®), and a survey of KanCare members receiving mental health services. Quality assessments and performance improvement programs will continue to include performance improvement projects (PIP) that focus on clinical and non-clinical areas.

The State will require MCOs to implement at least three clinical and two non-clinical PIPs. Clinical PIPs may include, but are not limited to projects focusing on prevention and care of acute and chronic conditions, high-risk populations, high-volume services, high-risk services, and continuity and coordination of care. Non-clinical PIPs may include, but are not limited to projects focusing on availability, accessibility, and cultural competency of services, claims payment timeliness, interpersonal aspects of care, grievances and appeals, and other complaints. Each of the PIPs will have benchmarks and achievable performance goals. The State may link PIP outcome requirements to P4P indicators in efforts to hold MCOs accountable for improvement standards.

Use of Data to Drive Quality Improvement

The State will continue to require each MCO to submit reports for all KanCare populations and identify key metrics to drive program improvement, which we describe in more detail in Section IV, Quality Reporting Summary. Additionally, the State will conduct its own analysis of MCO claims data and work with each individual MCO to strengthen network adequacy and improve quality of care.

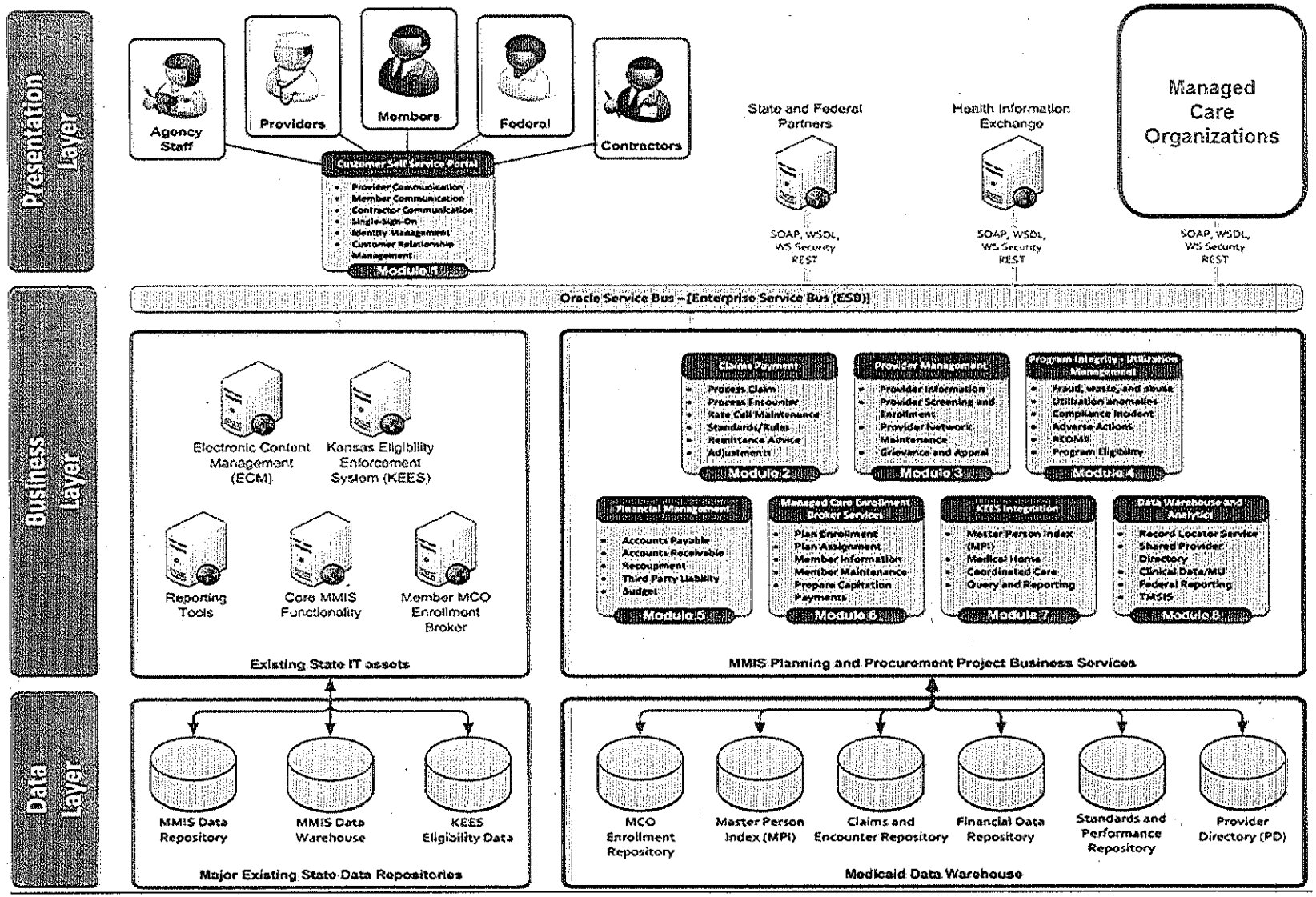
Under KanCare 2.0, the State will continue its current strategies for data collection and use of data to drive quality improvement. The State is in the process of enhancing its data analytics capabilities to streamline all data sources into one central location for a more comprehensive review of MCO performance. The new Kansas Modular Medicaid System (KMMS) will be based on Medicaid Information Technology Architecture (MITA) 3.0 standards. KMMS will allow the State to evaluate MCO performance against benchmarks and trend MCO data over time, providing a more robust analysis to all stakeholders regarding the performance of the KanCare program.

KMMS is a service-oriented architecture platform with transactions brokered through an enterprise service bus (ESB) operating in a virtual private cloud, making data more accessible to the State and MCOs. KMMS includes eight modules:

1. Customer Self Service Portal
2. Claims Payment/Encounter Processing
3. Provider Management
4. Program Integrity/Utilization Management
5. Financial Management
6. Managed Care Enrollment Broker Services
7. Kansas Eligibility Enforcement System Integration
8. Data Warehouse and Analytics

KMMS facilitates innovative collaborations by connecting modules across agencies for better monitoring and oversight. It allows individual and population needs to be assessed holistically, and not only programmatically. KMMS provides a 360-degree view of a member's care and plan of service or PCSP to identify where improved coordination and integration of services is needed. Data is collected from various sources for State, federal, health information exchange (HIE), and MCO use. KMMS will allow the State to move from a disparate set of systems to an integrated system architecture with modules linking member and provider data within the Medicaid data warehouse, as shown in the figure on the next page.

Figure 11. Medicaid Enterprise Diagram



Safety Net Pools

DSRIP History

The State operates a DSRIP Pool authorized under the current KanCare demonstration, which aims to advance the goals of access to services and healthy living by focusing on projects that increase access to integrated delivery systems and expand successful models for prevention and management of chronic and complex diseases. Two hospitals are eligible to participate in the DSRIP program: The University of Kansas Hospital and Children's Mercy Hospital.

Each hospital was required to implement at least two projects from the following list:

- Access to integrated delivery systems
  - Expansion of Patient Centered Medical Homes (PCMH) and Neighborhoods
- Prevention and management of chronic and complex diseases
  - Self-Management and Care/Resiliency
  - HeartSafe Community
  - Improving Coordinated Care for Medically Complex Patients
  - Statewide Expansion of Sepsis Early-Warning and Escalation Process

For each selected project, each hospital was required to create a Hospital DSRIP Plan, which was approved by CMS and the State.

The University of Kansas Hospital is engaged in two DSRIP projects:

- ***STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis.*** The objective of this project is to expand internal quality programs to reduce the prevalence of sepsis in rural nursing facilities and hospitals in Kansas.
- ***Supporting Personal Accountability and Resiliency for Chronic Conditions.*** The objective of this project is to improve heart failure patients' ability to self-manage their condition.

Children's Mercy Hospital is also engaged in two DSRIP projects:

- ***Expansion of PCMH and Neighborhoods.*** The objective of this project is to promote PCMH to improve pediatric primary care in Kansas, including increasing access to primary care services and the use of health information technology.
- ***Improving Coordinated Care for Medically Complex Patients.*** The objective of this project is to improve care coordination and provide primary care provider consultations for children living in rural areas.

To date, these DSRIP projects have achieved key measurable outcomes for the target populations, including a reduction in the number of septic patients transferred to a higher-level facility, reduction in the patient-reported heart failure admission rate, increased percentage of adolescent patients that receive well-care visits, and increased immunization rates for patients diagnosed with asthma.[8]

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[8] 2016 Delivery System Reform Incentive Payment Pool (DSRIP) Hospitals Annual Report Prepared for KanCare (February 28, 2017).

In demonstration year (DY) 3 and DY 4, the KanCare DSRIP program paid $22,848,750 to eligible providers related to specific performance metrics associated with the DSRIP projects.[9] Providers will be eligible to receive an additional $30,000,000 in DY 5, and the State's one-year waiver extension application includes $30,000,000 in DSRIP funding for DY 6.

DSRIP Under KanCare 2.0

Under the KanCare 2.0 demonstration, the State proposes to extend the DSRIP program by two additional years, through December 31, 2020 (DY 7 and DY 8). For each additional year, the State proposes annual DSRIP funding of $30,000,000. During this two-year period, the current DSRIP providers, The University of Kansas Hospital and Children's Mercy Hospital, will continue their current DSRIP projects. The State intends to continue the momentum with these DSRIP projects, while leveraging the infrastructure and processes that have been set up by the State and the participating hospitals to maximize results.

Because a number of the population-focused metrics across the four DSRIP projects are based on HEDIS® metrics, the cycle to obtain and evaluate data follows a longer trajectory (e.g., due to data collection and validation), particularly since it can take years to realize improvements in quality and outcome metrics and achieve a return on investment. Therefore, extending the DSRIP program through December 31, 2020 will provide the State the opportunity to have a more complete picture of DSRIP program performance and accomplishments. It will also allow each hospital to build upon the successes they have achieved to date, and increase the impact of their selected projects.

For the two-year DSRIP extension period, the State will review the current DSRIP metrics used to evaluate project performance and examine whether any of the metrics should be modified to create a stronger link between payment and performance and increase the accountability of the participating providers. The State will also consider introducing additional project metrics that better reflect the more advanced implementation stage of the DSRIP projects, and incorporate lessons learned from data collection exercises to date.

The State will also use the two-year DSRIP extension period to design and implement an APM approach that will replace the DSRIP program beginning in January 2021. APMs are one of the value-based model and purchasing strategies listed in Figure 10 that the State expects MCOs to continue to employ under KanCare 2.0. The transition from the DSRIP model to the APM approach will shift reporting from DSRIP project-based metrics to APM provider-based quality and outcome metrics. Similar to the DSRIP program, the APM approach will require that providers meet or exceed pre-determined quality and outcome improvements to receive incentive payments.

The State will designate additional funding for MCO capitation payments to be used as APM incentive payments, under which MCOs will make additional payments to qualifying providers for meeting or exceeding the pre-determined quality and outcome improvement benchmarks. It is also anticipated that additional providers beyond The University of Kansas Hospital and Children's Mercy Hospital will be eligible to participate in these APMs.

The State will define in its contracts with MCOs the additional requirements necessary to execute APMs with specified groups of providers. The State will use the period through Summer 2020 to

[9] Evaluation of Uncompensated Care Pool and Delivery System Reform Incentive Payment Program Funding for Kansas Medicaid 1115 Waiver. Prepared for Kansas Department of Health and Environment. (September 2017).

develop and finalize the roadmap and approach for these additional APMs, including defining the following:

- Types of APMs that the State will require MCOs to implement with contracted providers (e.g., pay-for-performance (P4P) arrangements),
- Performance measures and related benchmarks to evaluate value and outcomes,
- Terms of performance for participation and measurement periods,
- Classes of providers eligible to participate in APMs,
- Total funds available for incentive payments to specified providers and methodology for disbursing those funds, and
- Plan for evaluating the impact of the APMs on the State's quality objectives.

In developing the design for the DSRIP replacement, the State will work closely with CMS and will seek input from key stakeholders. The State will consider the lessons learned from the current DSRIP program, including data collection and reporting practices, and intends to align performance measures with KanCare 2.0 objectives.

UC Pool

The original KanCare demonstration included a UC Pool. Historically, the UC Pool consisted of two sub-pools, the HCAIP and the LPTH/BCCH Pool. The objective of the UC Pool was to provide payments to hospitals to defray hospital costs of uncompensated care provided to Medicaid-eligible or uninsured individuals.

Under KanCare 2.0, the State will maintain the HCAIP Pool for the five-year KanCare 2.0 demonstration period. The State proposes to increase the size of the Pool by $20 million each year, for a total of $61 million annually. The increase in the Pool amount will allow both of the hospitals currently in the HCAIP Pool plus critical access hospitals to benefit from the UC Pool helping defray their uncompensated care costs. It is important that this Pool continues in order to help mitigate uncompensated care costs and support access to care among vulnerable populations, including those served by critical access hospitals.

Under KanCare 2.0, the State proposes to maintain the LPTH/BCCH Pool for the five-year KanCare 2.0 demonstration period, at $9,856,550 each year.

Improve Effectiveness and Efficiency of State Medicaid Program

The State contracts with multiple MCOs to provide services to KanCare members. Based on this program design, KanCare providers contracting with more than one MCO must understand each MCO's policies and procedures in key areas, such as prior authorizations, service coordination, and contracting and credentialing. The State understands that providers have expressed concerns with perceived administrative complexities built into the current KanCare program, most recently through KanCare public input sessions held in June 2017.

To improve administrative effectiveness and simplicity for both providers and members, KanCare 2.0 will improve the effectiveness and efficiency of the State's Medicaid program through the following methods:

- Alignment of MCO operations,
- Improved data analytics capabilities, and
- Member access to inpatient behavioral health services.

Alignment of MCO Operations

Medicaid providers spend a significant amount of time and resources understanding, complying with, and executing each MCO's individual processes for credentialing, service coordination, utilization management, and grievances and appeals, among others. Although MCOs make every effort to simplify their processes, interfacing with multiple MCOs in lieu of the single state Medicaid agency presents some additional administrative burden for providers.

With the goal of enhancing the member and provider experience, the State will establish standardized tools and processes across MCOs to reduce the challenges providers face in contracting with multiple MCOs. Some of these areas may include:

- **Health screenings:** MCOs must conduct initial health screenings for all members using a State-developed health screening and algorithm. MCOs will store health screening data within a centralized information system that will be capable of interfacing with KMMS.

- **Health risk assessment tool tailored with sections for specific populations:** Contracted MCOs will use the State-prescribed tool for the assessment of behavioral health needs and for each waiver program for the assessment of HCBS needs.

- **Prior authorizations for selected services:** MCOs will use the State's preferred drug list to authorize the use of prescription drugs. MCOs will also have the capability for providers to submit prior authorizations electronically by July 2019.

- **Grievances and appeals:** Contracted MCOs will use the same grievance and appeals process for members and providers.

- **Provider credentialing:** KanCare 2.0 will implement a standardized provider application and enrollment process for all providers applying for network status. The State will eventually automate this process to streamline credentialing activities for providers, allow for more accurate tracking of the enrollment application process, and permit monitoring of time frames for MCOs to complete provider credentialing activities.

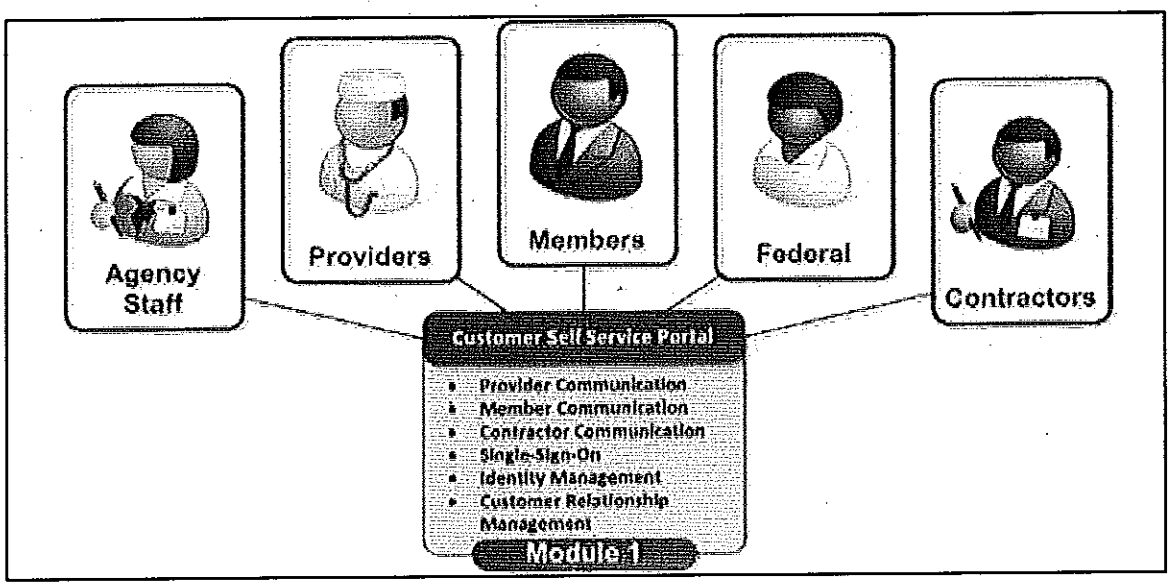
The State's intention through these efforts is to reduce member and provider administrative burden and ultimately support MCO provider network recruitment and retention efforts and allow providers to focus more on patient care.

Data Analytics Capabilities

The State is in the process of implementing the new KMMS, a new information technology infrastructure which will allow the State to better connect with each other and with other state agencies and organizations to share information, including data to support initiatives addressing social determinants of health and independence.

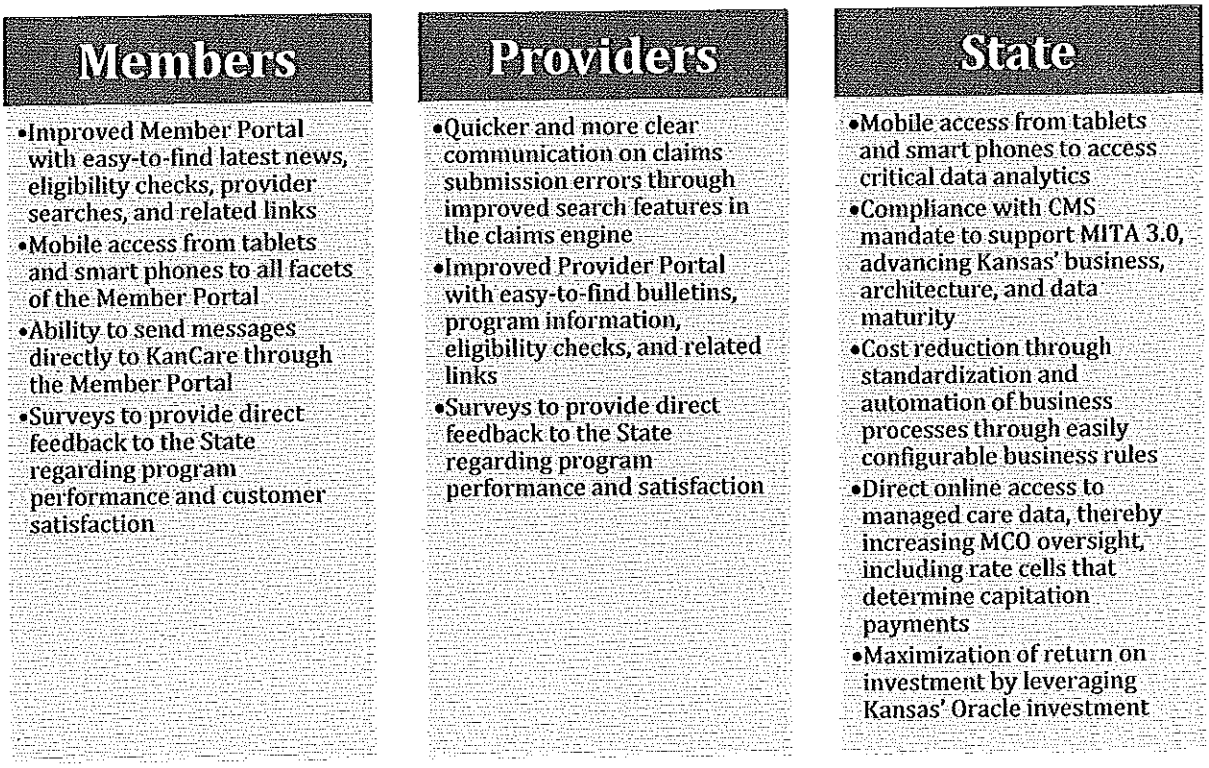
KMMS will provide a 360-degree view of a Medicaid beneficiary to meet that individual's needs holistically and address social determinants of health and independence. KMMS will collect a wide range of information not available currently, such as the results of the functional assessment for HCBS waiver programs. As a result, KMMS will facilitate increased and improved service coordination and integration of services by breaking down silos of behavioral and physical health, and agencies and organizations.

Figure 12. KMMS Customer Service Portal



KMMS will provide an enhanced user approach to members, providers, and the State, shown in the figure below.

Figure 13. Enhanced User Experience



<u>Member Access to Inpatient Behavioral Health Services</u>

CMS's July 2016 regulation (Federal Rule 42 C.F.R. 438.6(e) as amended) prohibits the State from claiming federal financial participation for a monthly payment made by the State to a member's MCO responsible for all care of the member when the member's stay in an Institution for Mental Disease (IMD) is longer than 15 days during any given month. This exclusion causes a loss of Medicaid coverage for members requiring inpatient psychiatric care and limits provider innovation.

The State is seeking a waiver of this authority to provide coverage under KanCare 2.0 for otherwise-covered services provided to Medicaid-eligible individuals aged 21 through 64 who are enrolled in a Medicaid MCO and who are receiving services in a publicly-owned or non-public IMD.

III. Requested Waiver and Expenditure Authorities

The State is requesting all of the same waiver and expenditure authorities as those approved in the current demonstration, which are restated below. The State is also requesting a new waiver authority related to eligibility and new waiver expenditure authority for Institutions for Mental Disease.

Waiver Authorities

1. **Amount, Duration, and Scope of Services – Section 1902(a)(10)(B)**

To the extent necessary to enable Kansas to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, by providing additional services to individuals who are enrollees in certain managed care arrangements.

2. **Freedom of Choice – Section 1902(a)(23)(A)**

To the extent necessary to enable Kansas to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services. No waiver of freedom of choice is authorized for family planning providers.

3. **Eligibility – Section 1902(a)(10)(A)**

State requests new authority to require able-bodied KanCare 2.0 adults, as a condition of eligibility, to meet work requirements.

Expenditure Authorities

Service-Related Expenditures

1. **Expenditures for Additional Services for Individuals with Behavioral Health or Substance Use Disorder Needs**

Expenditures for the following services furnished to individuals eligible under the approved State Plan and concurrent 1915(c) waivers, pursuant to the limitations and qualifications provided in STC 22 to address behavioral health and SUD needs:

- Physician Consultation (Case Conferences),
- Personal Care Services, and
- Rehabilitation Services.

2. **Expenditures for Institution for Mental Disease (IMD)**

State requests new expenditure authority for otherwise-covered services provided to Medicaid-eligible individuals aged 21 through 64 years who are enrolled in a Medicaid managed care organization and who are receiving services in a publicly-owned or non-public IMD.

Safety Net Care Pool (SNCP) Expenditures

Expenditures for the following categories of expenditures, subject to overall SNCP limits and category-specific limits set forth in the STCs.

1. **Uncompensated Care Pool**

Pursuant to STC 68, expenditures for payments to hospitals to defray hospital costs of uncompensated care furnished to Medicaid-eligible or uninsured individuals that meets the definition of "medical assistance" under section 1905(a) of the Act, to the extent that such costs exceed the amounts received by the hospital pursuant to 1923 of the Act.

2. **Delivery System Reform Incentive Payment Program**

Expenditures from Pool funds for the DSRIP Program, pursuant to STC 69, for incentive payments to hospitals for the development and implementation of approved programs that support hospital efforts to enhance access to health care and improve the quality of care. DSRIP incentive payments are not direct reimbursement for service delivery, and may not duplicate other federal funding. The State requests this expenditure authority for DY 7 and DY 8.

IV. Quality Reporting Summary

The State contracts with the Kansas Foundation for Medical Care (KFMC) to develop external quality review organization (EQRO) reports. Covered topics may include:

- Performance measure validation,
- Performance improvement project (PIP) validation,
- Balanced Budget Act (BBA) compliance review, and
- Survey validation, including the Mental Health Survey and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®).

Quality reporting topics will remain similar under KanCare 2.0. However, the State will update measures, surveys, and compliance review areas to reflect KanCare 2.0 priorities and goals.

Performance Measures

The State relies on various types of quantitative performance measure reports using medical/case record information, which include the following:

- HEDIS®,
- Mental health measures, including Serious Emotional Disturbance (SED) waiver reports and National Outcome Measures,
- Nursing facility measures,
- Substance use disorder (SUD) measures,
- HCBS waiver reports,
- Case record reviews,
- Access reports, and
- Financial reports.

Kansas evaluates MCO performance on HEDIS® measures on an annual basis, and compares MCO performance to national benchmarks. HEDIS® is a tool used by most health plans to measure performance on important dimensions of care and service. MCOs will include performance measure requirements for medical, behavioral health and LTSS in the quality assessment and performance

improvement methodology. See Appendix B for more detailed information on statewide HEDIS® performance from CY 2013 – CY 2015.

The Final Evaluation Design for the current KanCare demonstration is available at: https://www.kancare.ks.gov/docs/default-source/policies-and-reports/quality-measurement/kancare-final-evaluation-design-march-2015.pdf?sfvrsn=2.

Performance Improvement Projects

To achieve safe, effective, patient centered, timely, and equitable care, the State encourages MCOs to develop and implement PIPs that focus on assessing the impact of improvement initiatives on health outcomes or quality of care. Two of the three KanCare MCOs – Amerigroup and UnitedHealthcare - initiated PIPs in July 2013, followed by Sunflower in January 2014. The current collaborative PIP started in August 2016, focusing upon the HEDIS® measure for Human Papillomavirus vaccination.

Amerigroup, Sunflower, and UnitedHealthcare are completing the following individual PIPs:

- Amerigroup chose to improve well-child visit rates in the third, fourth, fifth and sixth years of life.
- UnitedHealthcare chose to improve follow-up after hospitalization for mental illness.
- Sunflower chose to increase the rate of initiation and engagement of alcohol and other drug dependence treatment.

The State reviews all PIP methodology and revises it to ensure clear interventions, outcomes, tracking, and measurement methods are identified. Representatives of each MCO report PIP progress at regular KanCare interagency meetings. Written updates are also provided post-implementation of each PIP. MCOs must also submit monthly PIP progress reports, including how lessons learned will be used to improve the outcomes of PIPs. Under KanCare 2.0, the State will continue to support MCOs in attaining PIP results. Each PIP will utilize principles of rapid cycle process improvement and be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and will include some of the following elements:

- Measurement of performance using objective quality indicators,
- Implementation of interventions to achieve improvement in the access and quality of care,
- Evaluation of the effectiveness of interventions based on established performance measures, and
- Planning and initiation of activities for increasing or sustaining improvement.

Balanced Budget Act Compliance Review

On an ongoing basis and as part of the State's readiness review process, the State assesses MCO compliance with managed care-related federal regulations associated with the Balanced Budget Act (BBA) including:

- Enrollee rights and protections;
- Quality assessment and performance improvement, including:
    - Access standards,
    - Structure and operation standards,
    - Measurement and improvement standards; and
- Grievance system.

Within the regulatory areas there are approximately 312 individual requirements for which the MCOs will submit supporting evidence and documentation to demonstrate compliance with the federal regulations and state contract requirements. For each MCO, the State reviews approximately 60 cases for provider credentialing (including individual, institutional, initial credentialing, recredentialing, and denied credentialing) and 300 cases for physical health records, behavioral health records, grievances, appeals, and denied claims.

KFMC conducted full reviews in 2013 and 2016. In 2014 and 2015, KFMC reviewed and reported on MCO follow-up efforts to address recommendations made in the full review. MCOs' overall compliance ratings from the 2013 full review, and follow-up improvements from 2014 and 2015 were:

- **Amerigroup:** 82% Fully Met, 15% Substantially Met, 3% Partially Met, 1% Minimally Met, and 0% Not Met. (Of 71 areas identified for improvement in the 2013 full review, Amerigroup brought 92% into full or substantial compliance.)

- **UnitedHealthcare:** 76% Fully Met, 16% Substantially Met, 5% Partially Met, 3% Minimally Met, and 0% Not Met. (Of 100 areas identified for improvement in the 2013 full review, UnitedHealthcare brought 98% into full or substantial compliance.)

- **Sunflower:** 69% Fully Met, 24% Substantially Met, 4% Partially Met, 2% Minimally Met, and 1% Not Met. (Of 151 areas identified for improvement in the 2013 full review, Sunflower brought 93% areas into full or substantial compliance.)

Section VII, Compliance with STCs, further describes the State's efforts to continue to improve its MCO oversight based on analysis of MCOs' submitted data, and to apply this information in decision making at the programmatic level.

Under KanCare 2.0, the State will continue to review compliance with the BBA on an ongoing basis and during readiness reviews.

Mental Health Survey

Since 2010, the State has administered and analyzed results of surveys of Kansas Medicaid members receiving mental health services. Survey results are reported by adults, youth (family members completing the survey, with separate questions completed by youth ages 12-17), and youth and young adults receiving SED Waiver services. The State analyzes survey results annually for statistical significance and to identify trends over time, including comparison of survey results in 2011 and 2012 (pre-KanCare) with current survey results. Members have consistently expressed high levels of satisfaction with services provided in both pre-KanCare and KanCare years. Questions are related to the perception of care coordination for members receiving mental health services. See Appendix C for detailed survey results.

KanCare 2.0 will continue its efforts to ensure high level of quality of care in mental health services. In addition to continuing administration of a survey to assess feedback from members receiving mental health services, MCOs will develop and implement a comprehensive service coordination program that emphasizes the integration of treatment for co-occurring mental health and SUDs. The State will develop time and distance standards and timeframes to receive mental health services, and ensure MCOs maintain a comprehensive behavioral health crisis response network.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey

CAHPS® is a survey tool developed to assess consumer satisfaction and member experiences with their health plan. It is a nationally standardized survey tool sponsored by the Agency for Health Care Research and Quality (AHRQ), and co-developed with National Committee for Quality Assurance (NCQA). The survey measures how well MCOs are meeting their members' expectations and goals to determine which areas of service have the greatest effect on members' overall satisfaction and to identify areas for improvement which could aid plans in increasing the quality of care provided to members. Detailed specifications are provided by NCQA to be used by health plans in conducting the survey. In order for a health plan's CAHPS® survey to be a dependable source of information, it must be administered according to the published CAHPS® technical specifications.

When administered properly, CAHPS® surveys provide information regarding the access, timeliness and/or quality of health care services provided to health care consumers. Since the launch of KanCare in January of 2013, KanCare MCOs have conducted CAHPS® surveys annually and have them validated by KFMC. KanCare members rate their experiences positively with key aspects of KanCare services, which ranked above 2016 national benchmarks. The figure below highlights select survey responses over the past three years from across all population members that rated their satisfaction with a 9 or 10, in a scale that ranged 0-10. See Appendix D for detailed CAHPS® survey quality of care results.

Figure 14. KanCare CAHPS® Results

	Adult			General Child			Children with Chronic Conditions		
Measure *(Scale of 0-10, Responses of 9, 10)*	2014	2015	2016	2014	2015	2016	2014	2015	2016
Rating of Health Care	53%	51%	54%	69%	69%	71%	65%	65%	66%
Rating of Personal Doctor	64%	67%	68%	73%	73%	76%	72%	73%	74%
Rating of Specialist	65%	66%	67%	70%	69%	70%	69%	68%	73%
Rating of Health Plan	55%	58%	61%	71%	72%	74%	63%	67%	67%

The State will continue to use CAHPS® surveys in KanCare 2.0 as an integral instrument for assessing consumer satisfaction and KanCare member experiences.

MCO and State Quality Assurance Reporting

The State requires MCOs to submit a number of reports and facilitates monthly meetings with each MCO to discuss operational issues, data discrepancies, and areas for MCO improvement. Below, we summarize selected aspects of MCO reporting. For more information, please see KanCare quarterly and annual reports, which further highlight successes and areas for improvement in the KanCare program. These reports are available at the following webpage: http://www.kancare.ks.gov/policies-and-reports/annual-and-quarterly-reports.

Section VII, Compliance with STCs, further describes the State's efforts to continue to improve its MCO oversight based on analysis of MCOs' submitted data and to apply this information in decision making at the programmatic level.

KanCare 2.0 will continue to collect monthly, quarterly, and annual reports from MCOs to confirm compliance with State requirements and to identify areas for program improvement, lessons learned, and promising practices.

Utilization

The State measures utilization of different services, such as preventive/ambulatory health services, dental visits, and emergency department visits. KanCare places a greater emphasis on health, wellness, prevention, earlier detection, and earlier intervention with members. Under the current KanCare demonstration, the frequency of inpatient services, nursing home stays, and outpatient emergency room treatment declined. This is partly attributed to the upward movement of the community-based, local, outpatient office visits and ancillary services that KanCare provides to members. The figure below compares utilization data from KanCare DY 4 with pre-KanCare measurements.

Figure 15. KanCare Aggregate Utilization Report

Aggregate Utilization Report	Comparison of CY 2016 to CY 2012 (Pre-KanCare)
Type of Service	**% Difference**
Primary Care Physician	18%
Transportation	58%
Outpatient (Non-Emergency Room (ER))	10%
Inpatient	-30%
Emergency Room	-7%
Dental	25%
Pharmacy	2%
Vision	16%

Under KanCare 2.0, the State will continue to analyze and report utilization data for all MCOs, separately addressing physical health, behavioral health, nursing facility, and HCBS services by demonstration quarter. The State will continue to monitor and manage utilization, in effort to detect under-utilization, over-utilization, and mis-utilization and assess the quality and appropriateness of care furnished. Utilization reports are one component of the State's initiative to move toward the primary goal of controlling Medicaid costs by emphasizing health, wellness, prevention, and early detection.

Network Adequacy

The State evaluates recruitment and retention of network providers through MCOs' monthly submission of GeoAccess reports that identify gaps in coverage. MCOs also report strategies for

closing any gaps in coverage. The following table presents the average number of unique contracting providers under each MCO since 2014.

Figure 16. Average Number of Unique Providers Enrolled in KanCare by Year and MCO

KanCare MCO	Average # of Unique Providers in 2014	Average # of Unique Providers in 2015	Average # of Unique Providers in 2016
Amerigroup	14,200	14,918	16,430
Sunflower	17,007	19,912	20,790
UnitedHealthcare	19,752	19,245	22,881

Providers for the figure above were de-duplicated by National Provider Identifier; however, the table does not account for providers covering multiple specialties or areas. In addition to continuing to recruit pre-KanCare Medicaid providers and any newly identified providers, the MCOs have demonstrated their commitment to working with providers in adjacent cities and counties in adjacent states to provide services to members.

Under KanCare 2.0, MCOs will continue to develop, maintain, and monitor their network of providers. MCOs will report any gaps in network adequacy coverage (e.g., provider ratios, distance and time standards, appointment availability, timely access, etc.) each month, using Geo Access Reports and other provider network reports. Both the State and MCOs will perform analyses of network adequacy data with the goal of offering members a choice of providers to the extent possible and ensuring covered services are reasonably accessible. See Section VII, Compliance with Special Terms and Conditions for additional steps the State is taking under the current KanCare demonstration to improve network adequacy.

Dental Care

KanCare and partner agencies emphasize the importance of regular dental care for members and are committed to increasing utilization of these important services. Dental services data show significant improvement from 2014 to 2015, as illustrated in the figure below.

Figure 17. Total Eligibles Receiving Dental Services in 2014 to 2015

	SFY 2014	SFY 2015
Total eligible receiving dental treatment	125,413	129,720
Total eligible receiving preventative services	116,526	122,724

Under KanCare 2.0, the State will continue to collaborate with MCOs in increasing dental health and wellness service utilization. The State will monitor dental services through HEDIS® measures and Geo Access Reports. KanCare 2.0 aims to close gaps in access to dental primary care for members in frontier, rural, or densely-settled rural counties.

MCO Financial Performance

MCOs are responsible for monthly, quarterly, and annual financial reports, and must report any profits. As of December 31, 2016, all three MCOs are in a sound and solvent financial standing. All

three KanCare MCOs reported profits in 2016. Statutory filings for the KanCare MCOs are available on the National Association of Insurance Commissioner's (NAIC) "Company Search for Compliant and Financial Information" website: https://eapps.naic.org/cis/.

Under KanCare 2.0, the State will continue to submit financial reports and track medical loss ratio (MLR), detailing the percent of claims incurred related to activities that improve health care quality and fraud prevention. MCOs will owe remittance for the difference between the MLR for the reporting year and the minimum MLR percentage of 85 percent.

KanCare MCO Contract Annual Audit Process

In addition to routine ongoing monitoring activities, the State and KFMC conduct an MCO contract review process each year. One of the purposes of the audit process is to evaluate compliance with State contract requirements and MCO policies and procedures that the State has previously approved. The State and KFMC conduct planning meetings to prepare for the reviews and establish the desk review and on-site review tools. The MCOs submit documentation prior to the desk and on-site reviews. For the on-site review, a three-day time block is scheduled with each MCO. Examples of focus areas for the on-site review include appeals, grievances, finance, coordination of care, customer service, and provider credentialing. Following the conclusion of the desk and on-site reviews, the State works with KFMC to develop an executive report and individual reports for each MCO.

V. Financial Data

Kansas does not anticipate a significant change in enrollment or aggregated expenditure trends for the renewal period. The following table summarizes the annual enrollment and aggregated expenditures for KanCare, by demonstration year (DY). Kansas projects continued savings under the KanCare program as compared to the absence of the KanCare program.

Appendix E includes required financing and budget neutrality forms. Appendix F includes the budget neutrality workbook.

Figure 18. Projected KanCare 2.0 Enrollment and Expenditures*

	DY1 (actual)	DY2 (actual)	DY3 (actual)	DY4 (actual)	DY5 (projected)	DY6 (projected)
Total Member Months	3,954,724	4,206,474	4,240,388	4,553,224	4,373,929	4,383,052
Total Expenditures	$ 2,614,464,846	$ 2,837,185,334	$ 3,066,579,865	$ 3,212,952,243	$ 3,179,290,798	$ 3,577,978,363

	DY7 (projected)	DY8 (projected)	DY9 (projected)	DY10 (projected)	DY11 (projected)
Total Member Months	4,469,538	4,558,290	4,649,371	4,742,845	4,838,778
Total Expenditures	$ 3,827,708,851	$ 4,058,572,138	$ 4,282,596,858	$ 4,520,616,672	$ 4,773,562,737

*Notes:

1. The State updated member month enrollment from prior demonstration years to reflect retroactive membership. As a result, enrollment may vary slightly from previous submissions to CMS.
2. The State updated prior total expenditure amounts submitted to CMS. Specifically:
    a. DY1 (CY13) – DY6 (CY18) include Share of Cost to be consistent with the Without Waiver per member per month (PMPM) estimates, which also include Share of Cost.
    b. The Health Insurer Provider Fee (HIPF) amounts are included for DY3 (CY15) and DY4 (CY16).
    c. Previously DY5 (CY17) and DY6 (CY18) were projected amounts. DY5 (CY17) includes the most recent actual expenditures, and DY6 (CY18) has been updated with the most recent capitation rates for that period.

VI. Evaluation Design

On April 26, 2013, Kansas submitted to CMS for approval a draft Evaluation Design for overall evaluation of the current KanCare demonstration. CMS provided comments on the draft KanCare Evaluation Design on June 25, 2013. After discussing the comments with CMS and gathering additional input from stakeholders, Kansas submitted the final KanCare Evaluation Design to CMS on August 24, 2013. CMS approved the KanCare Evaluation Design on September 11, 2013.

After submission of the Final KanCare Evaluation Design, Kansas began implementation as described in the approved document. Kansas contracted with KFMC to serve as the independent evaluator for the KanCare demonstration. Kansas has submitted updates on the progress related to the implementation design of the KanCare Evaluation Design in each of the quarterly and annual reports. Kansas also submitted to CMS a revised KanCare Evaluation Design in March 2015, and CMS did not identify any concerns with this revised KanCare Evaluation Design. The approved Final Evaluation Design for the current KanCare demonstration is available at: https://www.kancare.ks.gov/docs/default-source/policies-and-reports/quality-measurement/kancare-final-evaluation-design-march-2015.pdf?sfvrsn=2.

The original goals of the KanCare demonstration focused on providing integrated, whole-person care, creating health homes, preserving or creating a path to independence, and establishing alternative access models with an emphasis on HCBS. Building on the success of KanCare, the goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by providing services and supports for social determinants of health and independence in addition to traditional Medicaid benefits. The State will modify and strengthen evaluation activities under KanCare 2.0 to measure progress in meeting this goal. The State will also prepare a detailed KanCare 2.0 Evaluation Design after receiving approval of the demonstration renewal application from CMS.

Below we summarize previous evaluation findings and our proposed approach for evaluation activities under KanCare 2.0.

Previous Evaluation Findings

In the KanCare annual and quarterly evaluation reports, KFMC, the State's external quality review organization, reports on performance metrics related to the following categories:

- Quality of care,
- Coordination of care and integration,
- Cost of care,
- Access to care, and
- Efficiency.

The evaluation reports also include findings regarding the UC and DSRIP Pools. Below, we include selected findings from the 2016 KanCare Evaluation Annual Report. See Appendix G for the full 2016 KanCare Evaluation Annual Report.

1. **Quality of Care:** The baseline data submitted by the MCOs, including results by age group, revealed a mixed performance with areas of strength, where performance metric results were above the 50th or 75th percentile nationwide, and several measures below the 50th percentile. Many of these low-performing metrics have been persistently low for several years. Quality of care in mental health and SUD services improved over the duration of the demonstration.

2. **Coordination of Care (and Integration):** Members receiving waiver services had more primary care and annual dental visits over the course of the demonstration. These members also decreased their count of emergency department visits.

3. **Cost of Care:** KanCare placed a greater emphasis on health, wellness, prevention, earlier detection and earlier intervention with members, which helped control Medicaid costs. Furthermore, the frequency of inpatient services, nursing home stays and outpatient emergency room treatment declined. This is partly attributed to the upward movement of the community-based, local, outpatient office visits and ancillary services that KanCare provides to members. The figure below compares utilization data from KanCare DY 4 with pre-KanCare data.

Figure 19. Comparison of KanCare Utilization Data

Aggregate Utilization Report	Comparison of Pre-Care to CY 2016
Type of Service	**% Difference Between CY 2012 and 2016**
Primary Care Physician	↑ +18%
Transportation	↑ +58%
Outpatient (Non-Emergency Room (ER))	↑ +10%
Inpatient	↓ -30%
Emergency Room	↓ -7%
Dental	↑ +25%
Pharmacy	↑ +2%
Vision	↑ +16%

4. **Access to Care:** As shown in Figure 16 under Section IV, Quality Reporting Summary, the average number of unique contracting providers under each MCO since 2014 has increased under KanCare.

   In addition to continuing to recruit pre-KanCare Medicaid providers and any newly identified providers, the MCOs have demonstrated their commitment to working with providers in cities and counties in adjacent states to provide services to members. In calendar year 2016, each of the KanCare MCOs achieved 100 percent of the required State behavioral health access standards for each county type:

   - Urban/semi-urban: One provider within 30 miles,
   - Densely-settled rural: One provider within 45 miles, and
   - Rural/frontier: One provider within 60 miles.

5. **Efficiency:** Emergency department visit rates for HCBS were much lower in 2013-2015 compared to rates in 2012 pre-KanCare. However, inpatient hospitalization rates were higher in 2015 for some waiver participants, including members who have I/DD, and lower for other waiver participants than inpatient admission rates in 2012, pre-KanCare.

The successes and accomplishments of the current KanCare demonstration serve as a foundation for KanCare 2.0. The State will modify and strengthen evaluation activities under KanCare 2.0 to build on lessons learned and address challenges.

Proposed KanCare 2.0 Evaluation Approach

Under KanCare 2.0, the KanCare Evaluation Design will utilize KMMS, discussed in more detail under Section II, Historical Narrative Summary of KanCare and Requested Changes, and continue to include quantitative and qualitative sources such as:

- Administrative data (e.g., financial data, claims, encounters, Automated Information Management Systems (AIMS)),
- Medical and case records, and
- Consumer and provider feedback (e.g., surveys, grievances, Ombudsman Reports).

Building on the original KanCare Evaluation Design, Kansas will test the hypotheses listed in the figure below under KanCare 2.0 while maintaining many of current evaluation measures. The figure also includes potential measures that the State may use to test the KanCare 2.0 hypotheses. However, the State will select and finalize specific measures to test under the KanCare 2.0 Evaluation Design after receiving approval of the demonstration renewal application from CMS. The State will work with other State agencies and stakeholders in developing the KanCare 2.0 Quality Strategy which will inform the KanCare 2.0 Evaluation Design.

Figure 20. Example Measures for KanCare 2.0 Evaluation

#	Example Measures	Applicable Population(s)*	Data Source
Hypothesis 1. Expanding service coordination to include assisting members with accessing affordable housing, food security, employment and other social determinants of health and independence will increase independence, stability and resilience and improve health outcomes.			
1.1	Percentage of members receiving service coordination who move from unemployed (actively seeking employment) to employed.	All KanCare members ages 18 and older receiving service coordination	Medical and Case Records; Administrative Data
1.2	Percentage of members receiving service coordination utilizing services (e.g., inpatient, ER, preventive) compared to members who are not receiving service coordination.	All KanCare members	Administrative Data; Medical and Case Records
1.3	Percentage of members who can perform instrumental activities of daily living (IADL) (e.g., meal preparation, taking prescribed medications, home maintenance) who are receiving service coordination to those who are not receiving service coordination.	HCBS waiver populations	Consumer and Provider Survey

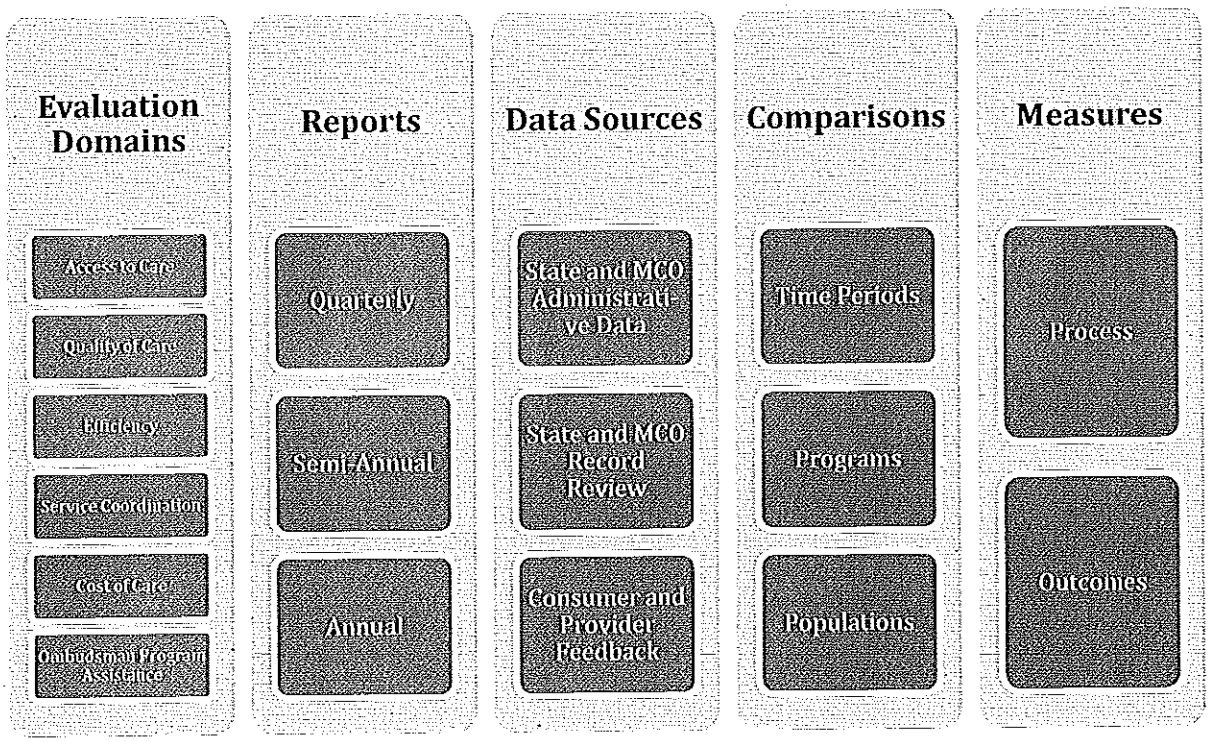
#	Example Measures	Applicable Population(s)*	Data Source
1.4	Percentage of members reporting the following: - As a direct result of services I received, I am better able to control my life. - As a direct result of services I received, I am better able to deal with crisis. - As a direct result of services I received, I am better able to do things that I want to do.	All KanCare members receiving behavioral health services	Consumer Survey
1.5	Percentage of deliveries that received a prenatal care visit in the first trimester.	Pregnant women	Administrative Data; Medical and Case Records
1.6	Percentage of members 3-6 years of age who had one or more well-child visits with a primary care provider (PCP).	Children ages 3-6	Administrative Data
Hypothesis 2. Increasing employment and independent living supports for members with behavioral health needs, or who have intellectual, developmental or physical disabilities or traumatic brain injuries will increase independence and improve health outcomes.			
2.1	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.	Members ages 12 years and older	Administrative Data; Medical and Case Records
2.2	Percentage of inpatient visits by members with behavioral health, I/DD, physical disability, SPMI, or TBI who are employed to those who are not employed.	All KanCare members who have a behavioral health diagnosis	Administrative Data; Medical and Case Records
2.3	Percentage of KanCare members, receiving HCBS PD, I/DD, or TBI waiver services eligible for the WORK program who have increased competitive employment.	HCBS waiver population	Medical and Case Records; Consumer Survey
2.4	Percentage of KanCare members who report: - Having a place to live that is comfortable for them - Having a job or volunteer opportunities - Having a job they want	All KanCare members	Consumer Survey

#	Example Measures	Applicable Population(s)*	Data Source
Hypothesis 3. Providing service coordination for all youth in foster care will decrease the number of placements, reduce psychotropic medication use, and improve health outcomes for these youths.			
3.1	Percentage of youths in foster care obtaining permanency (e.g., guardianship, adoption, kinship, etc.).	Children in foster care	Administrative Data
3.2	Percentage of foster care members receiving an antipsychotic medication *without* evidence of a psychotic disorder or related condition.	Children in foster care	Administrative Data; Medical and Case Records
3.3	Percentage of foster care members receiving an antipsychotic medication *with* evidence of a psychotic disorder or related condition.	Children in foster care	Administrative Data; Medical and Case Records
*The State will track measures by subpopulation (e.g., adults, children, pregnant women, children in foster care, HCBS waiver population) as appropriate.			

Evaluation Components

KanCare 2.0 evaluation components will continue to consider a number of evaluation designs, reports, data sources, comparisons, and measures, as shown in the figure below.

Figure 21. KanCare 2.0 Evaluation Activities



The reports and data sources also consist of elements that are quantitative and qualitative in nature, to provide the State and KFMC a wide range of information to be considered as part of the overall evaluation. These quantitative and qualitative elements include those in the figure below and will pertain to all KanCare members.

Figure 22. Quantitative and Qualitative Reports

Report Type	Elements
Quantitative	• HEDIS®; • Mental Health measures, including Serious Emotional Disturbance (SED) Waiver reports and National Outcome Measures; • Nursing Facility measures; • Substance Use Disorder (SUD) measures; • HCBS Waiver reports; • Case Record reviews; • Access reports; and • Financial reports.
Qualitative	• CAHPS®; • Mental Health Statistical Improvement Program consumer survey; • SUD consumer survey; • Provider survey; • Kansas Client Placement Criteria database, which contains member self-reported data; • Automated Information Management System database, which includes some self-reported data; • Care manager feedback and surveys; and • Grievance reports.

VII. Compliance with Special Terms and Conditions

Kansas has successfully completed, or discussed with CMS modified due dates, for the deliverables required by the current KanCare demonstration STCs. In a letter dated January 13, 2017, CMS identified needed improvements in KanCare program implementation. Kansas has developed correction action plans corresponding to CMS' findings and continues to work diligently to assure compliance with all STCs.

During the current demonstration period, Kansas implemented changes to comply with modifications in such requirements, including the *Affordable Care Act* and the *Medicaid and CHIP Managed Care Final Rule* as published in the Federal Register on April 25, 2016. Under KanCare 2.0, the State will continue compliance with these STCs and others as required by CMS.

KanCare Demonstration Benefits and Coordination

KanCare maintains benefits that were available before implementation of the current KanCare demonstration in at least the same amount, duration, and scope that services are provided in the State Plan. MCOs also offer value-added benefits at no cost to the State.

MCOs are contractually responsible for the management, coordination, and continuity of care for all members and are additionally required to maintain policies and procedures to address this responsibility. MCOs must also coordinate access to needed services excluded from KanCare and

make every effort to permit members to continue, if they so desire, with previously established providers who meet the same qualifications and financial agreements as others in the network.

Compliance with DSRIP and UC Pool Terms

The Kansas DSRIP projects were originally planned to be implemented as four-year projects from 2014 through 2017. In 2013, the State amended the 1115 demonstration to change the projects to begin in 2015. Then in 2017, the State received approval to extend the projects through December 21, 2018.

Kansas has implemented the following under the current waiver demonstration:

- The University of Kansas Hospital and Children's Mercy Hospital and Clinics are eligible to participate in the DSRIP program.
- Kansas convened the Healthy Kansas 2020 Steering Committee to receive input on the proposed DSRIP focus areas and to provide the Steering Committee with an example of how their priority strategies were being put into practice in the State. CMS approved the DSRIP projects on February 5, 2015. Each hospital participating in the DSRIP program was required to select at least two projects.
- Each DSRIP project has milestones from each of the following four categories: Category 1 (infrastructure milestones), 2 (process milestones), 3 (quality and outcome milestones), and 4 (population focused improvements).
- Kansas completes annual reports regarding the progress and outcomes associated with the DSRIP Pool.

In addition to the DSRIP Pool, CMS also authorized a UC Pool that consists of two sub-pools: the HCAIP Pool and the LPTH/BCCH Pool. Kansas has only made payments to the hospitals listed in the STC as eligible for the HCAIP sub-pool and the LPTH/BCCH sub-pool.

Please see Section II, Historical Narrative of Summary of KanCare and Requested Changes, for more information on planned changes to safety net pools.

Compliance with Quality and Reporting Requirements

Kansas has submitted progress reports to CMS following the end of each quarter and each DY since the start of the current KanCare demonstration period. Kansas posts all reports on its publicly available webpage. Each report includes details of compliance with STCs, including engaging the public through post award forums. Reports are additionally accompanied by demonstrations of network adequacy, documenting assurances that MCOs have sufficient capacity to serve the expected enrollment in their service area and offer an adequate range of preventive, primary, pharmacy, specialty, acute, and HCBS services for the anticipated number of enrollees in the service area. These reports are also publicly available on the KanCare website.

The KanCare annual reports also describe the implementation and effectiveness of the comprehensive Quality Strategy as it impacts the demonstration. The Medicaid State Quality Strategy was finalized in September 2014, and contains specific provisions for assessment of care quality and appropriateness as well as improvement following such an assessment. The State Quality Strategy is regularly reviewed and operational details continually evaluated, adjusted, and put into use. The Quality Strategy includes the KanCare Evaluation Design, approved by CMS on September 11, 2013, and updated in March 2015.

Kansas also submits quarterly expenditure reports using Form CMS-64 to separately report expenditures provided through the current KanCare demonstration.

Continuing to Ensure Compliance with KanCare Program Requirements through a Corrective Action Plan

On January 13, 2017, CMS identified needed improvements in KanCare program implementation. In response to this letter, the State developed a corrective action plan (CAP), sent to CMS on February 17, 2017. The CAP outlines the State's responses to the CMS findings, and the actions the State is taking to address those findings.

CMS approved the CAP for LTSS services on May 22, 2017 and the CAP for annual HCBS reporting (Form CMS-372) on August 24, 2017. To implement the CAP, the State is working to address key areas such as:

- Monitoring and reporting,
- Standard operating procedures (SOPs),
- Training,
- Roles and responsibilities, including interagency coordination, and
- Stakeholder engagement.

Below, we provide a sample of the State's responses contained in the CAPs:

- The State will continue to improve its MCO oversight based on analysis of MCOs' submitted data, and use this information to inform decision-making at the programmatic level. Beyond its current efforts, the State will develop and implement SOPs regarding MCO data analysis and communication, focusing on MCO data verification and performance review.
- The State has been consistent in its monitoring operations since the implementation of KanCare and continues to facilitate monthly meetings with MCOs to discuss operational issues, data discrepancies, and areas for MCO improvement. In addition to its current efforts, the State will develop and distribute internal policies and procedures and train staff responsible for the state contract review annual report development.
- In 2015, the State worked with individual MCOs to perform a provider access and network adequacy data clean up as a result of onsite audits the State conducted in 2013 and 2014. The State will continue its efforts in monitoring provider network adequacy by conducting a comprehensive review of network adequacy reporting templates as compared to the Medicaid Managed Care Final Rule. The State will also update internal policies and procedures to guide agency staff in the review and monitoring of State provider network access and adequacy reports. In addition, the State will develop internal analysis tools to begin trending and comparing MCO data with each report submission based on the newly implemented MCO reporting templates.
- As it pertains to tracking critical incidents, Kansas has rigid and effective statutes surrounding the reporting and investigation of abuse, neglect, and exploitation (ANE). Continuing this process, the State and the MCOs have collectively charged a critical incidents workgroup with overseeing the development and implementation of enhanced reporting, tracking, and trending of critical incidents. In addition, the State has made programmatic updates to data collection and reporting processes through its real-time, web-based Adverse Incident Reporting system (AIR).
- The State is updating policies regarding the integrated person centered planning processes for all three MCOs to comply with federal regulations at 42 C.F.R. § 441.301 and the 1915(c) HCBS waivers. In addition, the State has reviewed the audit findings and will establish

internal procedures regarding staff responsibilities in the HCBS quality review process. The State will implement effective oversight to ensure the level of care and provision of services are provided to beneficiaries as indicated in their plan of care.

- The State has an Interagency Agreement, which is an evergreen agreement that is automatically renewed every year. The latest agreement is from 2012, and the State will update this agreement with criteria for interagency evaluation. The State will also update position descriptions that describe specific roles and responsibilities of each agency and procedural documentation, such as SOPs.
- The State uses multiple methods for disseminating information and gathering stakeholder feedback including, but not limited to, website postings, memos to beneficiaries and providers, and public meetings and forums. To promote continued information sharing following standard procedures, the State will implement policies and procedures for programmatic communications to MCOs and stakeholders, as well as processes for collecting public and stakeholder feedback. The State will also train agency staff on proper procedures.
- The State will standardize requirements across 1915(c) waivers, where there were prior inconsistencies to allow for streamlined operations and monitoring efforts (e.g., reporting and documentation of critical incidents). The State will work with CMS to identify what requirement changes meet the criteria of a "substantive change", thus requiring a formal amendment to the waiver, subject to the public comment process.
- The State will identify an ongoing process for systemic remediation to issues identified through the quarterly quality monitoring process. Appropriate representatives in each agency will deliver findings to the established Long-Term Care committee to review remediation steps and identify if any CAPs are warranted.

To keep CMS apprised of the status of our CAP, the State facilitates a bi-weekly status call to review each CAP activity and respond to any CMS questions or requests for clarification. Below is a sampling of the State's accomplishments as a result of the CAPs actions to date:

- The State formalized processes and procedures for the annual MCO contract review process, detailing key steps, responsible parties, and associated timeframes. The State implemented the new processes in time for upcoming reviews on site at MCO locations in Fall 2017.
- The State developed internal analysis tools for purposes of monitoring MCO provider network adequacy. The tools allow the State to track key provider types and whether KanCare members have an appropriate provider network to meet their unique needs.
- The State updated position descriptions for staff responsible for all CAP-related activities. Updates including more accurate descriptions of task responsibilities and allows the State to hold staff accountable for monitoring for MCO compliance.
- The State formalized its processes and procedures for oversight of enrollment broker activities to monitor whether enrollees seeking to become KanCare members have adequate support through the enrollment process. Procedures also detail how the State reviews member materials and enrollment broker publications against state requirements.
- The State developed procedures governing the new Medical Care Advisory Committee and is in the process of recruiting members to join the committee. The purpose of the committee is to advise the Medicaid agency about health and medical care services through providing input on policy development and program administration, including furthering the participation of beneficiaries in Kansas Medicaid.

VIII. Public Notice Process

The State facilitates meaningful dialogue with stakeholders and collects detailed feedback. We conducted formal public input meetings on KanCare in June 2017 and asked questions such as:

- How has care coordination worked for you?
- What would you like to improve about your care coordination experience?
- Which extra services have been or would be most helpful to you?
- Do you understand information your MCO sends you?
- Is it easy to get questions answered when you call your MCO?
- How can your MCO better communicate with you?

A summary of feedback the State received is available at the following webpage: http://www.kancare.ks.gov/docs/default-source/about-kancare/kancare-renewal-forums/kancare-2-0-public-input-report.pdf?sfvrsn=2. We incorporated the feedback from these public input meetings into the KanCare 2.0 Demonstration Renewal Application.

The State facilitated a Medicaid public input and stakeholder consultation process from October 27, 2017 to November 26, 2017. Twelve public hearings were held in-person, while two public hearings took place by conference call, described in the figure below. Because it can be difficult for call-in participants to hear the presentation and comments, there were no telephonic or web conference capabilities at the in-person hearings. Instead, the State offered a dedicated public hearing for call-in participants on November 20, 2017 so that participants could better hear and provide comments. The same information and opportunity for feedback was shared at each session. The State used the following methods to notify the public of the KanCare renewal application and public hearings opportunities:

- Published an abbreviated public notice in the *Kansas Register* on October 26, 2017; please see Appendix H for the abbreviated public notice;
- Emailed a notice to tribal government officials to ensure compliance with the Tribal Consultation process; please see Appendix I for the e-mail documentation of this notice; and
- Posted a full public notice on the KanCare website; please see Appendix J for the full public notice.

Figure 23. KanCare 2.0 Public Hearing Schedule

Day/Date	Location	Time	Audience
Tuesday, November 14, 2017	Pittsburg State University, Overman Student Center, Ballroom A, 1701 S, Broadway St, Pittsburg, KS, 66762	2:00pm to 4:00pm	Providers
		6:00pm to 8:00pm	Members
	Dodge House Hotel & Convention Center 2408 West Wyatt Earp Blvd., Dodge City, KS, 67801	2:00pm to 4:00pm	Providers
		6:00pm to 8:00pm	Members

Day/Date	Location	Time	Audience
Wednesday, November 15, 2017	Kansas State University Olathe, Great Plains A & B, 22201 W. Innovation Drive, Olathe, KS, 66061	2:00pm to 4:00pm	Providers
		6:00pm to 8:00pm	Members
	Perkins Restaurant & Bakery, Meeting Room, 2920 10th Street, Great Bend, KS, 67530	2:00pm to 4:00pm	Providers
		6:00pm to 8:00pm	Members
Thursday, November 16, 2017	Ramada Topeka Downtown, Jefferson Hall, 420 SE 6th St., Topeka, KS, 66607	2:00pm to 4:00pm	Providers
		6:00pm to 8:00pm	Members
	Wichita Marriott, Corporate Hills Ballroom, 9100 Corporate Hills Drive, Wichita, KS, 67207	2:00pm to 4:00pm	Providers
		6:00pm to 8:00pm	Members
Monday, November 20, 2017	Conference Call Option: 1-833-791-5968 and Enter Code: 871 777 85	12:00pm to 1:30pm	Providers
		6:00pm to 7:30pm	Members

The resulting comments and recommendations received, public hearing testimonies, and State responses were summarized and are included in Appendix K. The State received approximately 619 comments at the public hearings, illustrated in the figure below and grouped by theme. The State also received approximately 47 written comments through mail or email.

Figure 24. Public Hearing Comments by Theme