

KanCare

Robert G. Bethell Joint Committee on
Home and Community Based Services and
KanCare Oversight

October 7, 2013

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Overview

Dr. Robert Moser, Secretary, KDHE

Overview

January 1, 2011 we were facing:

- \$200 million funding deficit for Kansas Medicaid
- Rising trend of increasing enrollments and costs
 - Baby boomers
 - Medicaid is countercyclical
- Low emphasis on patient outcomes
 - Fee-for-service models, volume over outcomes
- Fragmentation/Zero Accountability
 - No uniform benchmark for providers and programs to measure outcome performance
 - Widespread spending; across service types, state agencies, funding streams and providers

Medicaid Populations and Key Concerns

MEDICAID POPULATION FOCUS	KEY CONCERNS
Children, Families, and Pregnant Women Enrolled: 210,000 (SFY 2010)	Mobile populations: move in and out of eligibility
Aged Enrolled: 36,000 (SFY 2010)	Higher-than-average proportion of Kansas seniors in nursing homes
Disabled Enrolled: 57,000 (SFY 2010)	Fragmented service provision

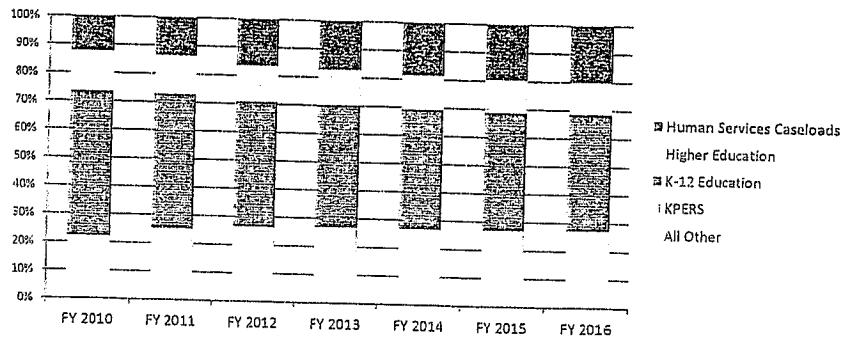
Cost Reality

- 25% consume 75% of funds
- Many of these patients require long-term care
- Most do not have choices of plans designed for them
- Transitions between care settings is major source of cost.
- No overall responsibility so lots of cost shifting

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The Crowd-Out Effect

Expenses as % of State General Fund



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

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Options

CUT PROVIDER PAYMENTS

REDUCE ENROLLMENTS

REDUCE SERVICES

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Overview

KanCare went live January 1, 2013, making the State's Medicaid managed care program available for nearly all Medicaid populations (370,000 individuals):

- Pregnant Women and Children
- Aged
- Disabled

American Indian/Alaska Native (AI/AN) members have the ability to opt out of KanCare.

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Goals

- Integrate and coordinate care across the whole spectrum of health
- Improve quality of care Kansas Medicaid beneficiaries receive
- Control Medicaid costs
- Establish sustainable long-term reforms

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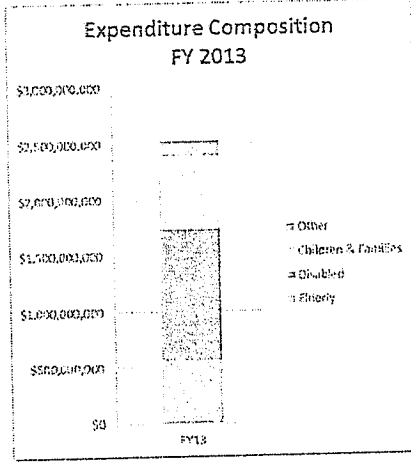
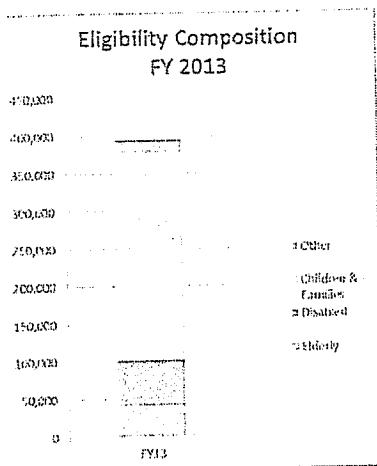
KanCare Composition

Eligibility (FY13)		Expenditures (FY13)
Elderly	41,368	\$556,518,053
Disabled	60,624	\$1,185,985,310
Children/Fam	276,307	\$648,026,331
Other	17,062	\$139,152,462

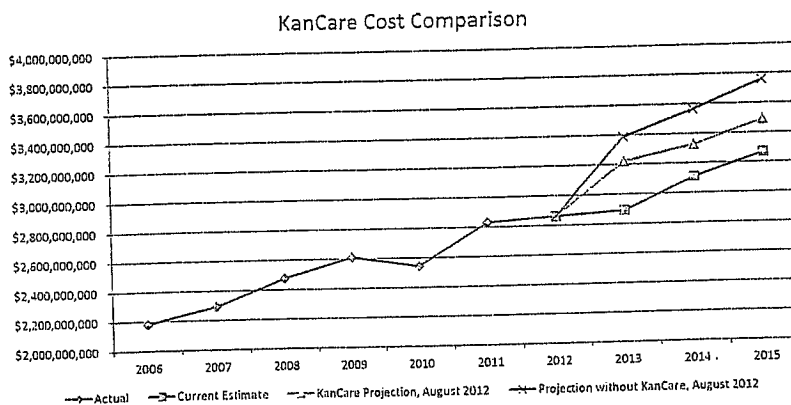
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KanCare Composition



Cost Growth Comparison



Provider Payment Comparison

Provider Payment Comparison—2012 and 2013

Type of Service	Jan through September 2012	Jan through September 2013
HCBS	\$423,493,362	\$422,947,769
Behavioral Health	\$175,350,203	\$152,345,302
Pharmacy	\$202,957,332	\$222,122,037
Dental	\$37,702,353	\$42,319,406
Nursing Facility	\$356,166,038	\$331,017,671
Medical/Al Other	\$704,939,079	\$666,637,734
Total	\$1,801,168,968	\$1,856,811,520

Payer	Jan through September 2012	Jan through September 2013
KMAP	\$1,436,509,978	\$154,045,510
Pror MCOs	\$464,353,959	\$51,395,935
Amerigroup	\$0	\$423,638,557
Sunflower	\$0	\$470,124,311
United Healthcare Community Plan	\$0	\$417,566,156
Total	\$1,901,168,968	\$1,856,811,520

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KDHE-DHCF Update:

Kari Bruffett, Director, DHCF

Network Access

As of 9/3/2013:	Urban/Semi-Urban	Rural
Amerigroup		
PCP	100%	100%
Hospitals	100%	100%
Pharmacy	99.1%	100%
Sunflower		
PCP	100%	100%
Hospitals	100%	99%
Pharmacy	98.3%	99.8%
United HealthCare		
PCP	100%	100%
Hospitals	100%	99.2%
Pharmacy	98.7%	100%

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Denial Rate Comparison

A comparison between Jan-Sept 2012 (pre-KanCare) and Jan-Sept 2013 (KanCare) denial rates

Jan-Sept 2012:	
UNICARE	17.56% claim denial rate
COVENTRY	16.27% claim denial rate
KMAP	28.39% claim denial rate
Jan-Sept 2013:	
KanCare MCOs	16.68% claim denial rate

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Quality Measurement and Oversight

Pay for Performance

- Portion of payment withheld from MCOs
- Performance targets above and beyond required contract standard

Quality Assessment and Performance Improvements (QAPI), MCOs

- Performance improvement projects
- Detection of over/under utilization
- Quality and Appropriateness of care

KanCare Interagency Monitoring Team (IMT)

- KDHE and KDADS

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Quality Measurement and Oversight

External Quality Review Organization – KFMC

KanCare Key Management Activities Reporting (KKMAR)

July Targeted Onsite Reviews:

Customer Service; Provider Credentialing; Grievances and Appeals;
Prior Authorizations; Third Party Liability, Spend Down and Client
Obligation

Annual Onsite Reviews (Nov/Dec/Jan):

KFMC -- 27 federal managed care regulatory requirements.
KDHE and KDADS staff -- 105 state requirements.

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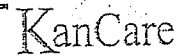
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Issues & Resolutions

- Timely and accurate information in EVV system
- Adjustment of prior claims when errors corrected prospectively
- Eligibility confirmation at pharmacy/prior authorization
- Access after choice period/change "for cause"
- Accuracy of information provided by customer service
- Application of spenddown and client obligation
- Critical issues tracking
- MCO-specific rapid response calls

See Summary for Details on Consumer Issues

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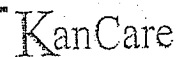


1115 Amendment

Kansas requested CMS approval to implement three changes to KanCare, effective January 1, 2014:

1. LTSS for individuals with intellectual/developmental disabilities inclusion into KanCare
2. Establishment of three pilot programs to support employment and alternatives to Medicaid
3. Change the timeline for the Delivery System Reform Incentive Program (DSRIP) pool.

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Health Homes

Not a physical place or building, a Health Home is the new Medicaid option to provide coordinated care for people with chronic conditions

Initial implementation date was 1/1/14 → 7/1/14

- Ensures optimal success during implementation
- Appropriate technology and systems will be in place
- Allows full focus on successful 1/1/14 inclusion of I/DD services

Health Home Focus group

- 70+ stakeholders
- Provides input on the development and review of health home design and implementation

A large, stylized version of the KanCare logo, with the word "KanCare" in a serif font and a decorative, starburst-like graphic above the letters.

KDADS Update:

Shawn Sullivan, Secretary, KDADS

I/DD Pilot Update

Participant Levels:

28 Providers

548 I/DD Kansans

Goals of the pilot program

Relationship building/shared understanding between MCOs and I/DD system

Define how services/service delivery will look under KanCare

Develop/Test billing processes for January 1, 2014 inclusion

The pilot project advisory group has focused on pre-implementation activities.

The pre-implementation focus has been on training and education for stakeholders and providers in the I/DD system.

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I/DD Pilot Billing

October 1, 2013-Participating pilot providers started to receive payments for services provided to I/DD pilot participants from the MCOs.

Providers will provide feedback on process to allow MCOs ability to improve their systems before implementation.

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I/DD Pilot Education

Educational Tours across the State to work with consumers, families, friends, and providers

National experts brought in to work with State employees, MCO employees, and with the Pilot Advisory Group, pilot providers, and the Friends and Family group.

October training sessions for providers.

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HCBS Quality Improvement

Several amendments submitted to CMS that include more comprehensive quality measures for the HCBS waivers that are coordinated with KanCare's quality measure

Quality amendments include improvements to statistical analysis and data collection.

KDADS Quality Management Specialists rode along with MCO Care Coordinators during the first half of 2013 to observe the Care Coordinators as they conducted face-to-face visits with individuals being served by the HCBS programs.

These ride-alongs will resume in January 2014 until new MCO Care Coordinators have completed the process.

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National Core Indicators

National Core Indicators developed out of the ADA

NCI standardizes quality data and consumer satisfaction across the country

Will provide a more accurate picture of where Kansas stands on the national level.

Kansas is participating in the development of the NCI-AD (aging and disability) tool