Overview

January 23, 2013

Overview of Medicaid and CHIP

Medicaid and the State Children's Health Insurance Program (CHIP):

- **Are joint programs between state and federal government**
- **Are major payers in our health care system**
- **Are tailored by each state to meet the needs of the vulnerable populations of the state**
- **Are growing**

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Overview of Medicaid Nationally

Medicaid:

- **Created in 1965 through an amendment to the Social Security Act**
- **Provides coverage for a broad range of health care services**
- **Serves children, pregnant women, the frail elderly, physically disabled individuals and individuals with intellectual or developmental disabilities**
- **Nationally, Medicaid state and federal expenditures in FY 2010 were over $400 billion**

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Overview of CHIP Nationally

Children's Health Insurance Program (CHIP):

- **Created in 1997, reauthorized in 2009**
- **Provides coverage for health care services**
- **Serves children in families who have too much income to qualify for Medicaid**
- **Nationally, CHIP state and federal expenditures in FY 2010 were $11 billion**

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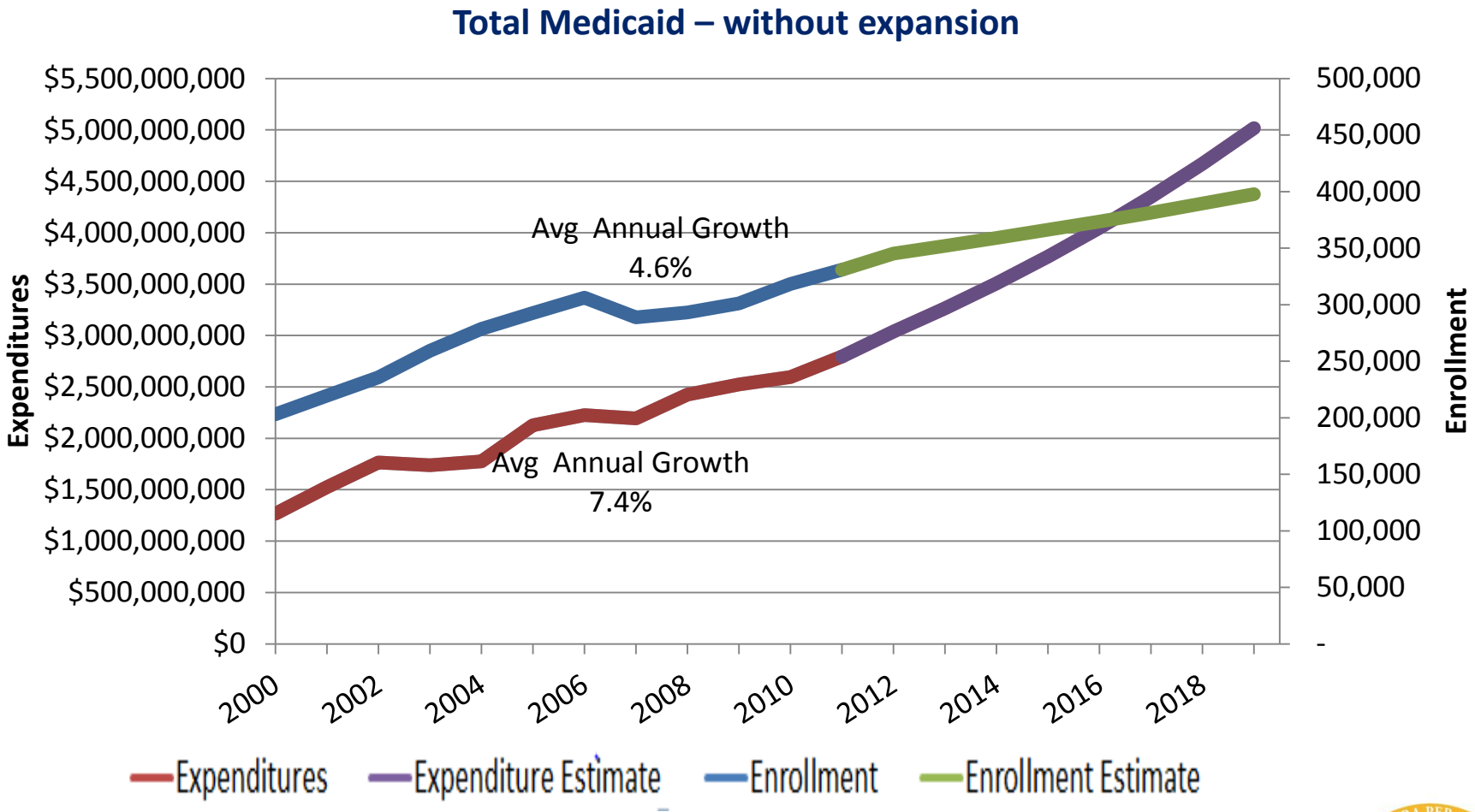
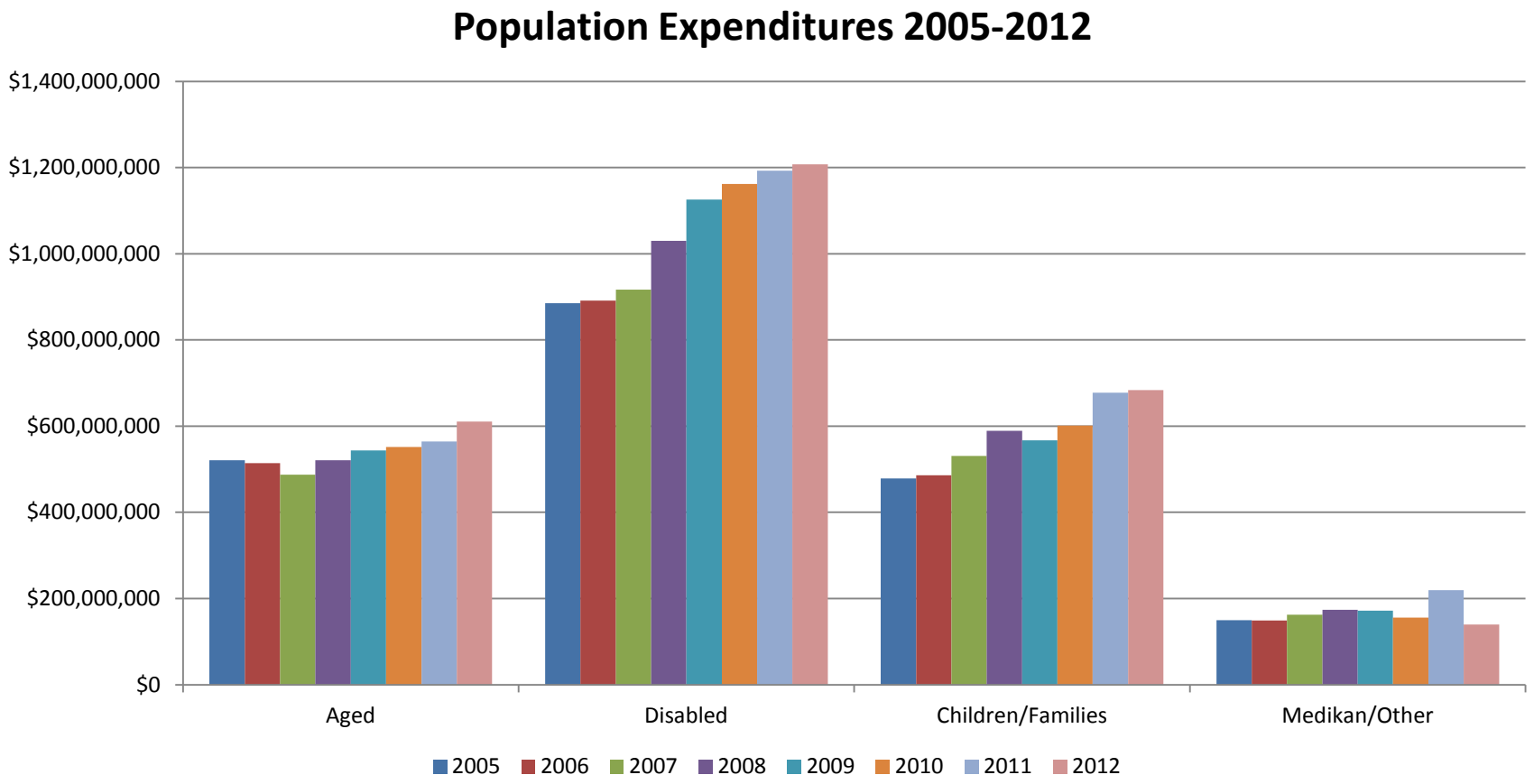
Issues in Kansas Medicaid

- Long-run trends in Medicaid are driven by widespread increases in enrollment and spending per person.
- It is not —just the economy –Kansas is in the midst of a sustained period of accelerated growth as baby boomers reach age of acquired disability.
- Enhanced federal match rate partially –and temporarily –disguised the scale of the deficit.

Sustained Medicaid Growth



Growth by Population



Medicaid Components

SFY 2012 , in $millions	Children/ Families	Disabled	Aged	MediKan/ Other	TOTAL
Physical Health	630	469	107	77	1283
Behavioral Health	46	126	15	48	235
Substance Abuse	8	7	0	4	19
Nursing Facilities	0	121	375	1	497
Home and Community Based Services	0	475	115	9	599
TOTAL	684	1198	612	139	**2633**

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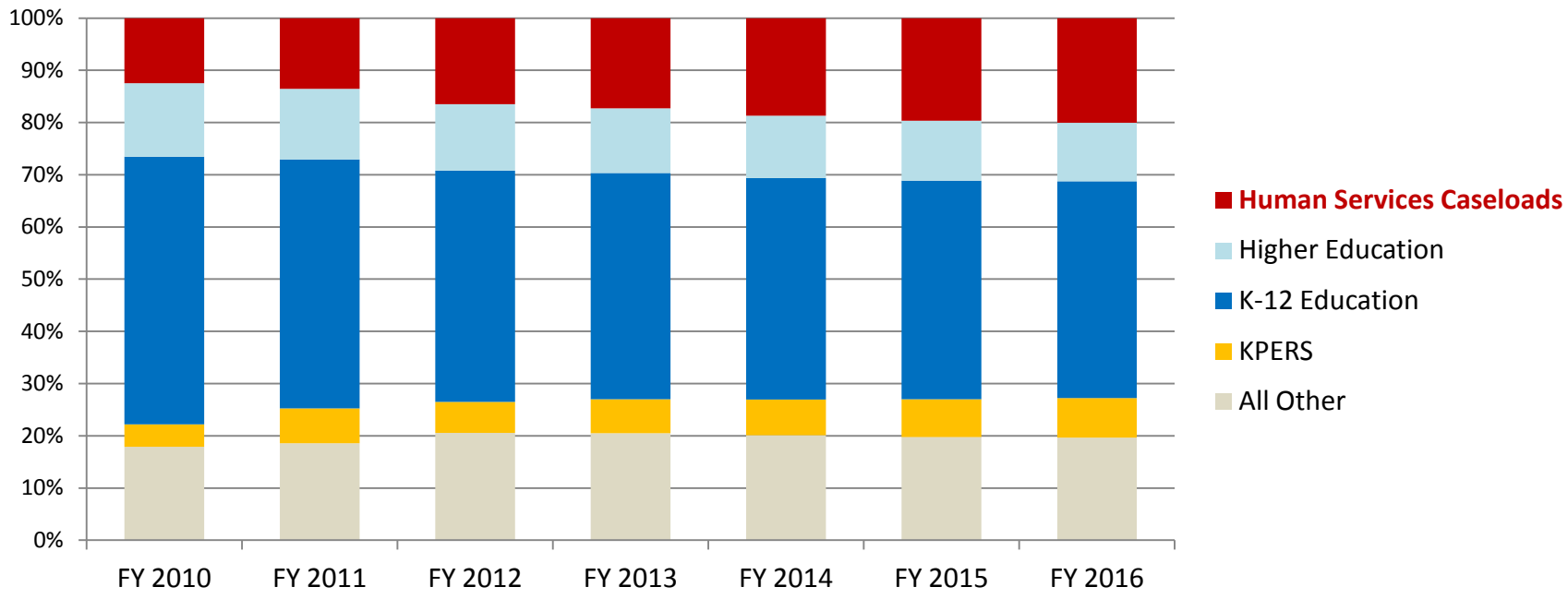
The Crowd-Out Effect

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.

Implementing the Solution:

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Transition to KanCare

On January 1, 2013

became

Person-Centered Care Coordination

- No reduction in current levels of Medicaid services and reimbursements
- New services include:
  - Heart and lung transplants for adults
  - Weight-loss surgery
  - Valued-added services
- Health homes
- Options counseling
- Safeguards for provider reimbursement and quality

Clear Accountability

- Firm protections with a strong emphasis on data and outcomes
- Each contractor is required to:
  - Maintain a Health Information System (HIS)
  - Report data to State of Kansas and Centers for Medicare and Medical Services (CMS)
  - Submit to an External Quality Review (EQR)
- Performance benchmarks
- KanCare Advisory Council

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Improved Outcomes

One of the main focuses of the contracts with managed care companies.

- **Lessening reliance on institutional care**
- **Decreasing re-hospitalizations**
- **Managing chronic conditions**
- **Improving access to health services**

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Financing Consolidation

- **Move the entirety of Medicaid into a capitated risk-based managed care system.**
  - **Coordinate each individual's care along providers**
  - **Decrease repeated hospitalizations**
  - **Better manage chronic conditions**
  - **Lesson reliance on institutional settings**

- **KanCare contractors will be rewarded for paying for preventive care that keeps people healthy**

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1115 Waiver

- Move nearly all Medicaid populations into managed care
- Cover nearly all Medicaid services through managed care, including long-term services and supports
- Establish safety net care pools for hospitals

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Transition Protections

- **CONTINUITY OF CARE**
- **90 day choice period**

Home & Community Based Services (HCBS)

High percentage of seniors living in nursing homes.

Transition from institutional care toward services in individuals' homes and communities.

MCOs risk and responsibility for ensuring that individuals are receiving services in the most appropriate setting.

Outcome measures will include lessening reliance on institutional care.

Home and Community Based Services (HCBS) Protections

- Education opportunities for beneficiaries and providers
- Stakeholder engagement
- MCO accountability to the State
- Ongoing completion of functional assessments
- Continuation of plans of care
- State oversight of plans of care
- Ride-alongs with state staff

Home and Community Based Services (HCBS) Protections

- Rights of grievance and appeals
- Right to a State Fair Hearing
- KanCare Ombudsman
- Eligibility is determined by the State or contractors for the State, not by the MCOs
- Quality assessment and performance improvement
- I/DD waiver services delay and pilots
- Front-end billing (FEB) solution
- Inclusion of current 1915(c) waiver structures and protections

Consumer Voice

- Administration formed an advisory group of advocates, providers, and other interested Kansans.
- MCOs are required to:
  - Create member advisory committee to receive regular feedback
  - Include stakeholders on the required Quality Assessment and Performance Improvement Committee,
  - Have member advocates to assist other members who have complaints or grievances.

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Health Outcomes

- **KanCare provides the first-ever set of comprehensive goals and targeted results in Kansas Medicaid. The new standards exceed federal requirements and set Kansas on a path to historic improvement and efficiency.**
  - KanCare clearly provides performance expectations and penalties if expectations are not met.
  - The State will require KanCare companies to create health homes.

Pay for Performance (P4P)

- **The State will withhold three to five % of the total payments MCOs until certain quality thresholds are met.**
  - Quality thresholds will increase each year to encourage continuous quality improvement.

- **There will be six operational outcome measures in the first contract year, and 15 quality of care measures in Years two and three.**

Pay for Performance (P4P)

- **The measures chosen for the P4P program will allow the State to place new emphasis on key areas:**
  - Employment rates for people with disabilities
  - Person-centered care in nursing facilities
  - Resources to community-based care and services

Timely Claims Payment

The State has included stringent prompt payment requirements among its Year 1 pay for performance measures for managed care organizations.

- Includes a benchmark to process 100% of all clean claims within 20 days
- For nursing facilities, require processing of 90% of clean claims within 14 days

Timely Claims Payment

- While a large portion of Kansas Medicaid and CHIP are already provided through managed care, there are large groups of providers accustomed to fee-for-service Medicaid only.

- **Front-End Billing Solution**

Pharmacy Benefit Managers

- KanCare Managed Care Organizations (MCOs) and their Pharmacy Benefit Managers (PBMs):
  - Amerigroup — CVS/Caremark
  - Sunflower — U.S. Script
  - United — OptumRX

Pharmacy

- The state has one Preferred Drug List (PDL) that all MCOs are required to follow
- The state has a centralized Pharmacy provider website that will serve as a hub for links to each MCOs information/forms/etc.
- MCOs have agreed to the state's dispensing fee of $3.40 per claim

Pharmacy

- **MCOs agreed to language regarding Maximum Allowable Cost (MAC) pricing that requires a grievance process to providers, timely updating of MAC prices, and an annual disclosure of MAC methodology and sources**

Provider Networks

The State received a new set of Geo Access Provider Network reports from each of the MCOs on January 10th.

Summaries and detail information is available on the KanCare website, www.kancare.ks.gov, on the Readiness Activities page under Policies and Reports .

Next report will be posted in mid-February.

Questions?