KanCare
Consumer Frequently Asked Questions
1/25/12

- **Why privatize Medicaid to out-of-state insurance companies?**
  - Insurance companies are profit-driven. The KanCare system will ensure the only way a KanCare vendor can make a profit is by coordinating and integrating care better than the current Medicaid system. KanCare companies will not be allowed to cut rates of providers or the scope of services provided to you.

- **How will savings be achieved without provider cuts or cuts in services?**
  - Savings to Kansas will be achieved by reducing the number of people unnecessarily in institutional settings, decreasing rehospitalizations, managing chronic conditions and coordinating the overall care of all Kansans on Medicaid. KanCare companies are incentivized to pay for preventative care services that keep people out of the higher-cost services. These things will help bend the cost curve of Medicaid down over time.

- **What has been the process for public input?**
  - The Administration spent the past year studying the Medicaid system and soliciting ideas from stakeholders, legislators, and the general public. Lieutenant Governor Jeff Colyer and the Secretaries of Health and Environment, Aging and Social and Rehabilitation Services toured the state having public forums discussing ideas for Medicaid reform. The Administration continued to engage stakeholders through telephone town hall meetings, idea solicitation online and meeting regularly with interested parties. The Lieutenant Governor and the Secretaries of Health and Environment and Aging have also testified several times to interim committees related to KanCare.

- **Is KanCare being implemented too fast?**
  - The KanCare RFP process will take more than one year to implement. The Administration purposefully allowed ample time to implement this change.

    Kansas also will conduct readiness reviews on all three KanCare companies with the supervision of the Centers for Medicare and Medicaid Services to ensure that consumers will be properly supported and served by this new system.

    With that said, there is widespread agreement with the need to move quickly to transform Medicaid into a system that is sustainable in the long term. The average annual growth in expenditures is 7.4%, while the average annual growth in enrollment only accounts for 4.6% growth per year. If this trend continues, Medicaid expenditures will start to crowd-out other state general fund expenses, such as; K-12 education, higher education and KPERS. It is important to start these reforms now, so we can bend the cost curve down over time.

- **Are any other states going to a system like KanCare?**
  - While Kansas has looked and learned from other state models, there is no singular state that KanCare is modeled after. No other state has put assurances into the request for proposal like Kansas has. The assurances are to safeguard the scope of services and providers rates at or above the current rate of pay.

Senate Ways and Means
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- **Will I be able to keep my case manager?**
  - Yes. KanCare will help a person's Care Manager/Care Coordination Team better manage their care, however the manner in which they receive care will not change. The KanCare RFP specifically states that the statutory language that established CDDOs must be followed. The statute ensures the CDDOs do – either directly or by subcontract – the functional waiver eligibility assessment, case management, and service provision. Case management will stay constant for people with Developmental Disabilities.

- **Why not carve all long-term care and services out of KanCare?**
  - Carving out all long-term care and services from KanCare would maintain the current siloed Home and Community Based Services system. It is integral for improving the health outcomes of Kansans to coordinate and integrate all care, including long-term services.

    Kansas Medicaid along with KU Medical Center in 2010 studied the health outcomes of persons with intellectual and developmental disabilities and persons with physical disabilities. The findings of the study stated that "while agencies recognize that health promotion is important for persons with disabilities, health promotion needs are often inadequately addressed." You can learn more about this study on the Kansas Department on Aging website at www.agingkansas.org.

    We feel the best way to break down these traditional silos of care is by integrating and coordinating care for the whole person. This means integrating behavioral care, medical care and long-term services and supports.

    The KanCare RFP mandates the preservation of the social support systems that are already in place and work at the community level. Bidders are required to contract with current community providers including CDDOs.

    Bidders will be able to add their expertise at identifying complex needs of individuals and coordinating and integrating their care to improve health outcomes. This expertise includes:
    - Care coordination and management
    - Wellness and prevention programs
    - Member education in use of health care and managing chronic conditions
    - Incentive programs to engage members in their own health and wellness

Health Promotion for Kansans with Disabilities
Medicaid Transformation Grant Project Summary
January 31, 2012

Full Study can be found at
http://www.agingkansas.org/KUMCHealthStudy.pdf

Overview

In January 2008, the Kansas Health Policy Authority (KHPA) was awarded over $900,000 to pilot a project designed to improve preventive health care for Kansans with developmental or physical disabilities (DD or PD). The grant award, distributed over fiscal years 2007 and 2008, was part of the $150 million Congress approved for Medicaid Transformation Grants in the Deficit Reduction Act of 2005. Kansas was one of 27 states to receive funding to examine new ways of improving Medicaid efficiency, economy and quality of care.

The Kansas project provided an electronic tool, along with Medicaid claims data, to targeted case managers (TCM) and independent living counselors (ILC) that allowed them to review the history of, and need for, preventive health care services for the consumers they served. Specifically, the tool used the claims data to flag instances when consumers needed preventive age and gender appropriate screenings (e.g., mammograms, colonoscopies) or other monitoring procedures for chronic conditions. Using the preventive health care opportunities identified, TCMs and ILCs could have discussions with their clients about the importance and necessity of the screenings and monitoring. The overall goal of the project was to improve the provisions of quality preventive health care services and the quality of monitoring for chronic conditions.

Four Community Developmental Disability Organizations (CDDOs) and three Centers for Independent Living (CILs) served as the project pilot sites. Approximately 1,700 adult consumers were served by about 90 TCMs and ILCs. TCMs and ILCs were surveyed pre- and post-intervention about their understanding and need to learn more about health care prevention and management of chronic conditions. Training was provided on both the tool and on basic preventive care. Monthly newsletters were also developed and distributed to the pilot sites that discussed a particular health topic each month.

The University of Kansas Medical Center Schools of Medicine and Pharmacy provided principle research, data analysis, training of TCMs and ILCs and production of the newsletters. Ingenix Public Sector Solutions, Inc. provided the ImpactPro tool and managed the claims data behind the tool.

Findings

The results from examining claims data pre-, during- and post-intervention demonstrate that the quality of chronic disease management and preventive health care services for persons with developmental and physical disabilities fails to meet national standards for cancer screening, cholesterol monitoring, osteoporosis screening, influenza vaccination, and diabetes care. Disappointingly, there were very few gains in these benchmarks during the course of the project.

Key findings are summarized below:

- Diabetes care
  - 55% of adults with developmental disabilities and 59% of adults with physical disabilities had their HbA1C measured in any 12-month period
  - Annual eye exams were only conducted in <33% of either disability group
  - Cholesterol levels were checked in only one-half of those with either disability in any given year
  - These rates were discouragingly low even in the face of broad access to primary care: 93% of persons with developmental disabilities and ~90% of persons with physical disabilities had at least one visit with a primary care provider during each one year period.

These findings are particularly troubling as national HbA1c rates in 2006 for Medicaid, Medicare, and commercial plans were 72%, 86%, and 81%, respectively (NCQA, 2008; Shireman, Reichard, Nazir, Backes, & Greiner, 2010). Cholesterol screening rates for persons with developmental disabilities and diabetes also fell far below national standards: 67% (Medicaid), 86% (Medicare) and 81% (commercial plans)(NCQA, 2008; Shireman, et al., 2010).

- Cancer screening
  - Women with developmental disabilities actually had higher rates of breast cancer screening than women with physical disabilities (roughly 40% versus 25%) during the one year periods
  - Rates varied slightly from year to year suggesting little effect from the project

- Lipid Management
  - There were vast improvements in general lipid monitoring for adults with development disabilities across the state, increasing from 29.5% to 42.7%. These increases were seen across both subgroups, however, and therefore cannot be attributed to the intervention.
  - There was a smaller rate increase in lipid monitoring for adults with physical disabilities, again seen across the MTG and non-MTG cohorts and apparently not driven by the intervention project.
  - Among both disability groups, there were statewide increases in lipid monitoring for those who were taking second generation antipsychotics, though the increases could not be attributed to the intervention.

These apparent secular trends are promising for the overall health of persons with disabilities as the management of cardiovascular risk factors is extremely important. The overall rates, however, are still only ~50% suggesting significant opportunity for improvement.

- Osteoporosis screening
  - Osteoporosis screening was generally low and stayed low across time, ~10% of either disability group screening statewide. The rates were highest for the MTG cohort with developmental disabilities (10.7-14.6%, over time) and may have been a result of the project.

- Flu vaccination
  - Influenza vaccination rates were highest in the baseline year for both groups and declined substantially over time.

References

NCQA (2008). The State of Health Care Quality 2008. Retrieved from http://www.ncqa.org/tabid/836/Default.aspx

Shireman, T. I., Reichard, A., Nazir, N., Backes, J. M., & Greiner, K. A. (2010). Quality of diabetes care for adults with developmental disabilities. *Disability Health J, 3 (2010) 179-185.*

Kansas

Sam Brownback, Governor

Date: January 25, 2012

To: All Members of the Legislature

From: Wm. Jeff Kahrs, Interim Acting Secretary
Department of Social and Rehabilitation Services
Shawn Sullivan, Secretary
Department on Aging

Re: Background Information on FMS and Electronic Visit Verification

The purpose of this information is to answer questions posed by the Senate Ways and Means and the Public Health and Welfare Committees and to address concerns by the Centers for Independent Living.

Since 2002, Kansas has been allowed to offer self-directed services with the 1915 (c) Home and Community Based Services Medicaid waiver type approved by Centers for Medicaid and Medicare Services (CMS). This waiver does not permit making payments for service directly to a waiver consumer; instead payments must be made through an intermediary organization that performs financial transactions on behalf of the participant. This is called an FMS provider.

While there is no specific federal regulation mandating the change in Kansas to FMS, Kansas has decided to maintain self-directed opportunities in our waivers. (Other states would not be required to implement FMS if they do not opt to provide self-direction in their waivers.) Kansas originally "rolled up" the FMS services rate as part of the personal care service rate. As a result, Kansas was claiming administrative activities as part of the direct service rate of personal care, which does not comply with guidance in the CMS Version 3.5 HCBS Waiver Application. The Medicaid payment, previous to FMS implementation, would go to the FMS provider who would then determine how much to pay each direct service worker and how much of the administrative supports fee they would keep. Due to CMS's guidance in the waiver application, administrative supports could not continue to be claimed under personal care services as they had previously been in Kansas.

CMS directed that the State needed to make this a uniform process and function by separating FMS services from the personal care service rate. Additionally, CMS requested that the State describe the method for procuring FMS services, method of compensation and percent of FMS costs relative to the service costs estimate and scope of supports furnished by the FMS entity. As a result CMS instructed the state to designate FMS as a separate waiver service or provide FMS as an administrative activity. The State then solicited the assistance of a consultant, Sue Flanagan, to calculate a monthly rate per participant for Kansas' specific model of FMS services.

change from one provider to another for a nickel or dime. The system was meant to help consumers find and maintain their DSW with a consistent wage.

Electronic Visit Verification

Kansas (KDOA and SRS) requested proposals to develop, implement and manage an electronic visit verification and monitoring system. The system is designed to verify the in-home visit of a service worker at the customer's home who is providing the service. The system uses an interactive voice response authentication telephone system to track time and location of direct care providers (caregivers) during service delivery. Data gathered provides information for electronic billing and claim submission with the intent of being able to accurately track and record the time spent in the home by the caregiver and verify that services were provided as authorized prior to reimbursement. The system interfaces with the State's Medicaid Management Information System (MMIS) to authorize payment of claims on verified service delivery and provide exception reports. The State covers the cost of the system with no cost to the providers. In addition to the electronic visit verification, there is a scheduling component the provider can use. Though not required, many have indicated this will be helpful. Numerous reports are available in the system to assist both providers and the state in monitoring and managing in-home services for Kansas customers.

The system is in real-time so providers and the state know when a caregiver is in the home and when they leave. Also, a missed visit would be flagged so an alternate caregiver could be sent to the home. This system replaces paper timesheets and will correct rounding errors, saving state dollars.

The KDOA implemented the system with First Data as the Contractor for both Agency and self-directed participants. SRS elected to begin with their self- directed workers but will soon include Agency directed.

The Administration talked to providers about the system beginning in May of 2011. This information was published in a bulletin for providers on the Kansas Medicaid Assistance Program website. An email address was established for any questions or concerns for KS AuthentiCare and providers notified of the email address. This email is open to providers, consumers, case managers, personal attendants, caregivers and the general public with any questions or concerns. This site is monitored daily.

Providers were contacted by phone and in writing informing them of the upcoming system implementation. First Data, SRS and KDOA staff spent two weeks in the field completing face to face trainings to providers. Following the trainings, provider calls were held on a daily basis and continue today. All providers are invited to call in and discuss any issues. Participating in the calls are staff from KDOA, SRS and First Data.

On December 29, an email went to providers explaining many expressed concerns about implementing the system by January 9 and since our "soft go live" date was delayed one day and with the holiday schedule, KDOA and SRS decided to delay implementation of KS AuthentiCare by one week to a new implementation of 6:00 a.m. on January 16, 2012. Input received from

We hope that this information is helpful to you in responding to constituent concerns. Please feel free to contact Sara Arif, Director of Public Affairs at sara.arif@aging.ks.gov if you have any other questions.