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Issue Brief

KANSAS HEALTH INSTITUTE

KanCare: Key Elements of the Medicaid Managed Care Proposal

Introduction

In November 2011, Gov. Sam Brownback announced significant structural and operational changes in the Kansas Medicaid program. The administration has two stated goals for the KanCare initiative: to slow the growth of Medicaid costs and to improve health outcomes by requiring all 350,000 Kansans in Medicaid and the Children's Health Insurance Program (CHIP) to enroll in private managed care plans.

The Kansas Medicaid program costs more than $2.8 billion a year, including more than $1 billion from the state. The Brownback administration estimates KanCare will reduce projected increases in Medicaid spending by $853.1 million during its first five years. Officials say this will be achieved by coordinating and improving the quality of health care for people with chronic illnesses.

If KanCare is implemented, Kansas would be the only state with managed care companies providing care statewide to all people enrolled in Medicaid.

This issue brief describes key aspects of the KanCare proposal, including how:

- Three private companies known as managed care organizations (MCOs) will have financial responsibility for improving health outcomes and controlling the costs of medical care for all Kansans in Medicaid or CHIP.
- KanCare will require all Kansans in Medicaid to be assigned to one of three MCOs after January 2013.
- The MCOs that receive KanCare contracts will be responsible for all Medicaid services currently available and required to pay at least the current Medicaid rates.
- Implementing KanCare will require federal approval to waive Medicaid rules.

What is Managed Care?

Payments to health care providers based on the type and number of services they provide make up the majority of current Kansas Medicaid spending. This is called fee-for-service. The Kansas Medicaid program sets payment rates for health care providers who treat patients based on their contract with the state.

Under managed care, the state works with private companies that recruit and pay health care providers. These MCOs are financially responsible for ensuring timely, appropriate access to health care and for maintaining networks of providers capable of meeting the demand for services.

The MCOs also must meet standards for quality of care, access to care and health outcomes. This is typically done by monitoring the health of Medicaid enrollees to identify their risk factors for chronic illnesses and managing their care. For example, based on a routine physical examination, the MCO could identify a person with high blood pressure and provide services to help that person reduce the risks of the condition, such as taking prescription medication, making dietary changes or encouraging regular exercise. By managing the conditions of enrollees, the MCO reduces the need for more expensive treatment in the future.

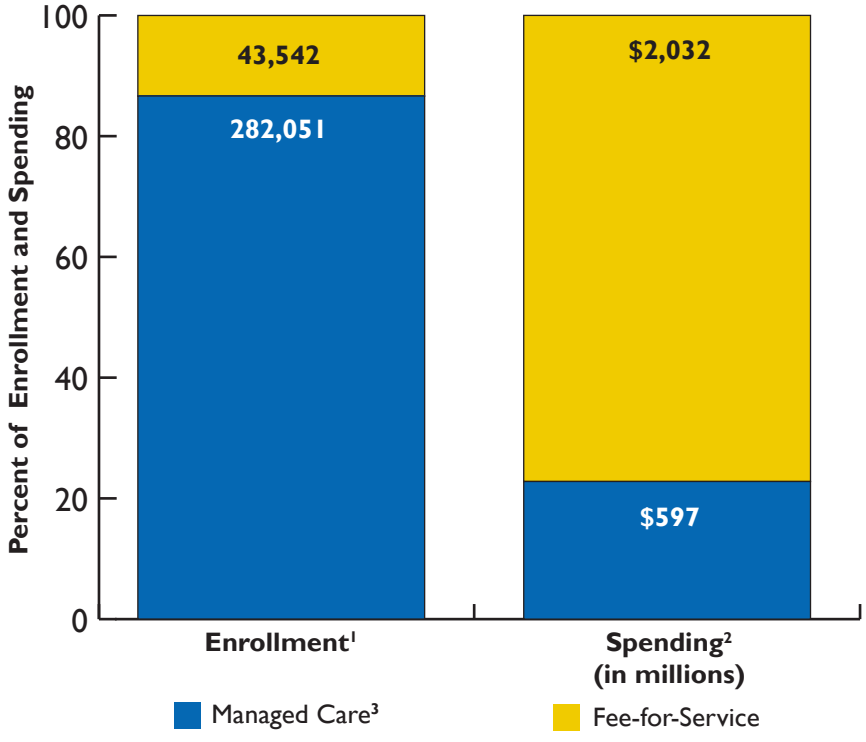
Managed Care in Kansas Medicaid

More than 85 percent of Kansans in Medicaid receive managed care services. These include managed care arrangements for physical health needs or for services such as behavioral health and substance abuse treatment. About half of all Kansas enrollees — around 164,000 people — can only access services through MCOs. However, as Figure 1 shows, only a quarter of Kansas Medicaid spending goes to managed care. This is because most Medicaid enrollees with chronic and other types of costly conditions — primarily the elderly and disabled — receive fee-for-service care.

Who's Included in KanCare?

Under KanCare, Medicaid and CHIP spending will be directed into managed care for all eligible groups, including children, pregnant women, low-income adults, people with disabilities and people with both Medicare and Medicaid.

Figure 1. **Kansas Medicaid Enrollment and Spending by Plan (Fiscal Year 2011)**



Notes:

1. Enrollment accounts for the unduplicated number of Medicaid enrollees as of July 1, 2010, according to the Centers for Medicare and Medicaid Services *Medicaid Managed Care Enrollment Report.*
2. Spending totals are from the KDHE *FY 2011 Kansas Medical Assistance Report.* CHIP spending ($71.6 million) is subtracted from the managed care amount.
3. Managed care includes health plans responsible for enrollees' physical and behavioral health and substance abuse treatment needs.

About a third of Kansans in Medicaid are elderly or have a disability, but they account for 65 percent of the program's cost, as shown in Figure 2. Conversely, children, families and pregnant women account for slightly more than a fourth of Medicaid and CHIP's cost while making up two-thirds of the enrollees.

On January 1, 2013, current Medicaid and CHIP enrollees will be automatically assigned to one of three MCOs to achieve a fair distribution of age, health needs and geographic location. They can choose another MCO within 45 days but must stay with the selected MCO for 12 months or until the next open enrollment period.

What Services are Covered?

The MCOs must provide all services currently available through Medicaid. This includes prenatal care, well-child visits, preventive services, hospital care, in-home care, community-based services and nursing facility care. They also must ensure services are available statewide and at Medicaid-required levels. The benefits also must include health literacy and prevention training for enrollees and health risk assessment examinations to identify chronic conditions.

MCOs may give enrollees gift cards and vouchers for services that Medicaid does not currently cover — such as dental care for adults or weight management programs — if they meet health and wellness goals. These are known as "value-added" benefits.

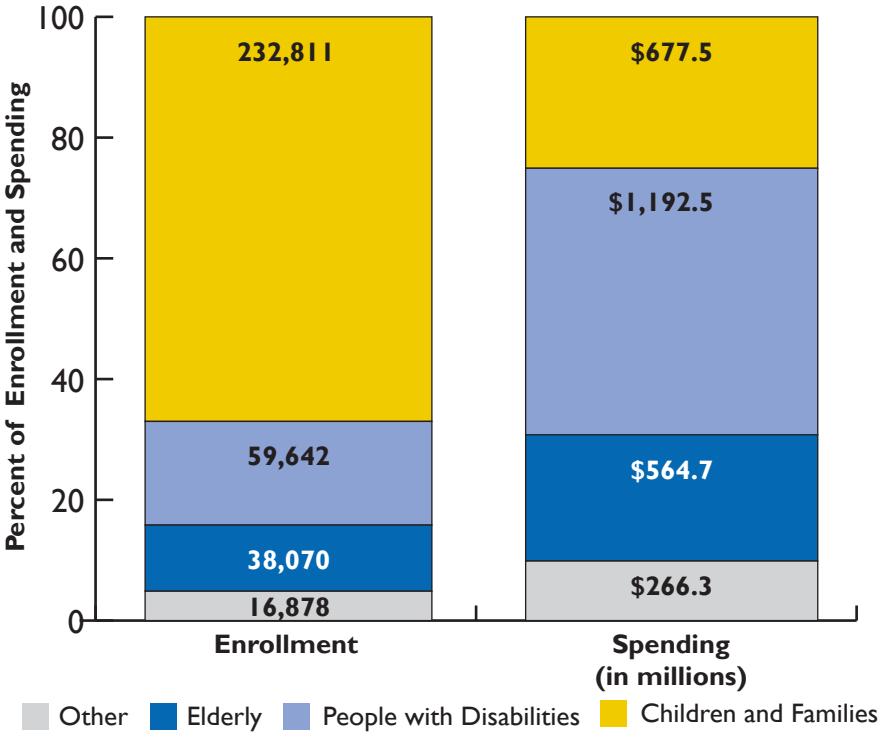
Within a year after MCOs receive the contract, they must make health homes available to help enrollees with mental illness or diabetes manage their conditions. A health home model helps coordinate medical, behavioral health and social supports for enrollees. Health homes also can be used to help people with other chronic illnesses like substance abuse, asthma, heart disease and obesity.

Who Provides the Services?

MCOs must enroll providers with locations that meet access standards for covered services, including primary and specialty care, pharmacy, mental health care, emergency and long-term care. The MCOs must certify that providers are enrolled before services begin on January 1, 2013. There are financial penalties for not meeting access standards.

MCOs are encouraged to use existing resources, including hospitals, physicians, community mental health centers, safety net

Figure 2. **Kansas Medicaid/CHIP Enrollment and Spending by Group (Fiscal Year 2011)**



Source: KDHE FY 2011 Kansas Medical Assistance Report.

About This Brief

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clinics, Centers for Independent Living, Area Agencies on Aging and Community Developmental Disability Organizations. Providers will be able to join one, two or all three MCO provider networks.

How Will This Affect Health Care Providers?

Currently in Medicaid, providers submit bills for the fee-for-service treatment they provide and receive payment from the state. With KanCare, the state will pay MCOs an amount for each person enrolled and MCOs will pay health care providers for services delivered. The MCOs must pay current Medicaid rates for each service to providers in their networks.

How Does KanCare Save Money?

KanCare is expected to reduce projected spending on the Medicaid program by $853.1 million over five years. The contract says that savings should be achieved by coordinating care and improving the health of people in Medicaid and CHIP. In their bids for the KanCare contract, the MCOs described their programs and plans to reduce the unnecessary use of medical services and improve health. Those care management tools are designed to reduce costs compared to the fee-for-service model. The per-person, per-month rate that the state negotiates with each MCO will be less than the historical cost of Medicaid.

The state also will withhold 3 percent of the MCO payments for performance incentives. In the first year of the contract, MCOs must meet six performance standards to receive the full payments. The number of performance measures and required level of performance increase in the second and third years of the contract. The MCOs must show improvement in the quality and efficiency of care or the state will keep the performance incentives.

Federal Approval Required

To implement KanCare, the state has requested a waiver from Medicaid rules from the U.S. Department of Health and Human Services. The waiver allows states to use federal funding for innovative activities or demonstration projects that would otherwise not be allowed under federal Medicaid.

States use this waiver authority for a variety of changes to Medicaid programs. Of the 34 states with approved waivers, 11 are using them to implement broader use of managed care in Medicaid as proposed in KanCare. However, Kansas' request is more extensive because it includes more Medicaid populations and service systems and covers the whole state. Several elements of KanCare, including the mandatory enrollment of all Medicaid enrollee groups in managed care, cannot be implemented without federal approval.

Conclusion

KanCare will shift more than three-fourths of Medicaid spending in the state to private managed care companies that will coordinate services. It also will introduce managed care to almost a third of Medicaid beneficiaries. The plan, subject to federal approval, has ambitious goals for achieving cost savings while significantly changing the way Medicaid services are delivered and paid for in Kansas.

KANSAS HEALTH INSTITUTE

The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multi-year grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

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