



# KANCARE: MANAGED CARE CONTRACTS AIM TO ACHIEVE SAVINGS AND QUALITY IMPROVEMENT

In 2013, Kansas moved most of its Medicaid beneficiaries to a managed care model known as KanCare. Kansas contracted with three companies — Amerigroup Kansas Inc., Sunflower State Health Plan Inc. and UnitedHealthcare of the Midwest — to act as managed care organizations (MCOs) for Medicaid beneficiaries. The MCOs are required to deliver all current Medicaid services without reducing payment rates to providers that agree to work with the MCOs.

The Kansas Department of Health and Environment (KDHE) estimates that KanCare will save more than \$1 billion over the next five years by providing more efficient care and administration. Some have questioned how these substantial savings can be achieved while allowing the MCOs to make a modest profit. This issue brief examines the financial structure for KanCare MCOs, including contract provisions that aim to maintain access to quality services while saving money.

## Quality Care and Cost Savings

So how does managed care control spending? The managed care industry suggests that by

coordinating care for people with multiple or complex medical conditions, health resources are used more efficiently. This includes eliminating unnecessary duplication of services, such as repetitive tests for the same condition, and providing assistance to manage chronic conditions, which can help avoid more expensive treatments caused by delayed care. For example, studies have shown that people who manage their diabetes through routine maintenance, such as frequent blood sugar testing, avoid more costly treatment related to more complicated conditions. KanCare also provides incentives to increase the use of community-based care instead of nursing facilities, a transition that some studies have shown can reduce Medicaid long-term care spending in the long run. These and other efforts presume that improving the coordination of care can lead to lower costs through a more efficient delivery of health care.

The other way MCOs can slow the growth of Medicaid costs is by lowering reimbursement to providers, denying access to medically necessary treatment or placing administrative burdens on providers delivering care. This could be done

### KEY POINTS

- KanCare — the state’s new Medicaid managed care model — aims to ensure savings through contracts that require improved quality and coordination of health care.
- The majority of the projected \$1 billion in Medicaid savings through KanCare will come from services for the elderly and people with disabilities. Care coordination likely will have the greatest impact on these Kansans as they move into managed care.
- KanCare includes risk-sharing and pay-for-performance requirements to ensure that managed care contractors maintain access to services and payment rates to Medicaid providers.

by requiring additional levels of authorization before a service can be delivered or delaying payment of claims by requiring additional documentation. However, Kansas contractually prohibits KanCare MCOs from engaging in these practices. Additionally, Kansas has created financial incentives, known as pay-for-performance, to encourage MCOs to improve quality of care.

## Saving \$1 Billion Through KanCare

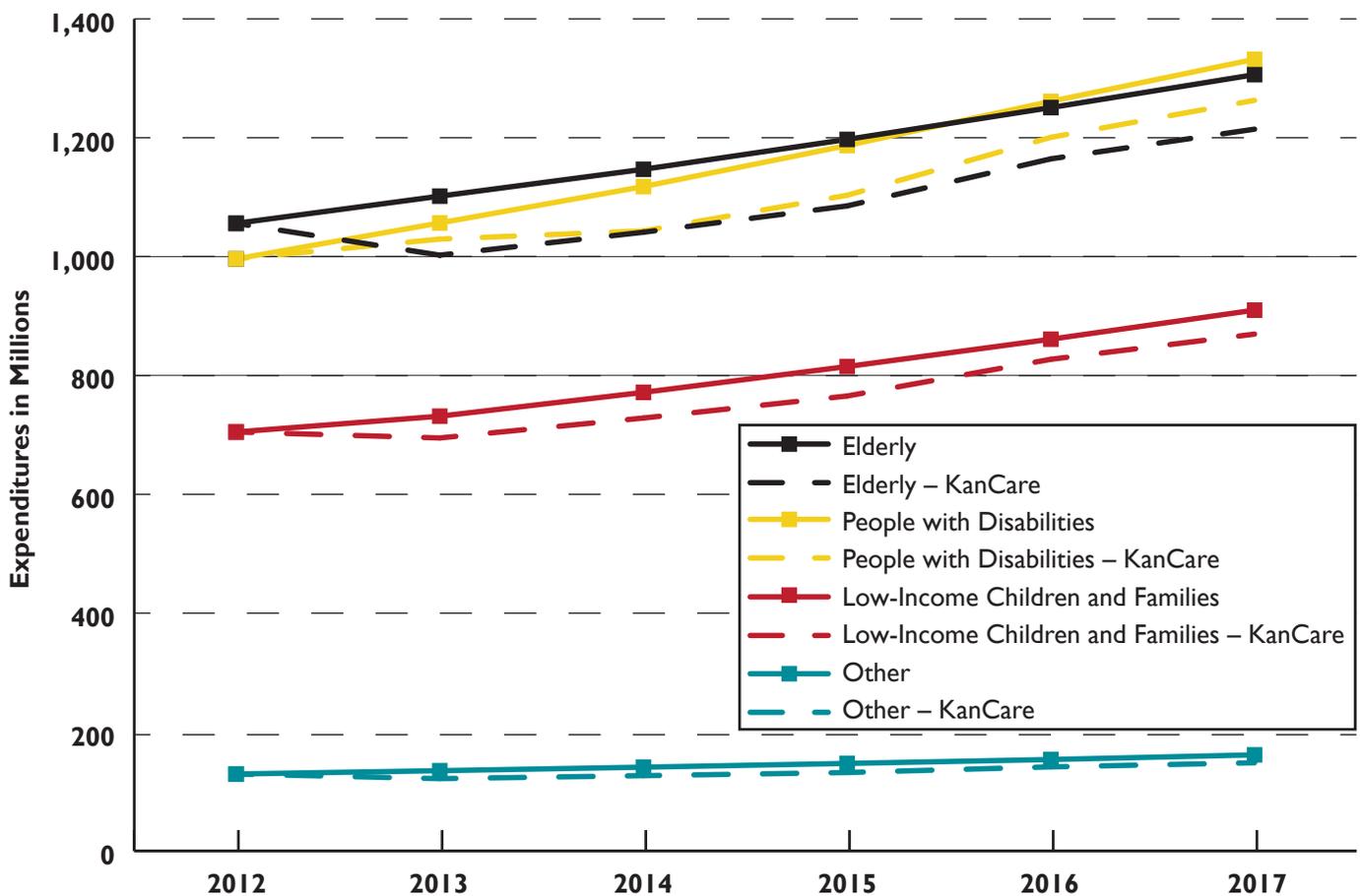
Because KanCare prohibits MCOs from withholding payment or medically necessary care, the \$1 billion projected savings must come from better coordination and more efficient delivery of care. KDHE presented these savings projections in its application to the Centers for Medicare and Medicaid Services for approval of KanCare.

Figure I shows the costs that KDHE projected through 2017 — with and without KanCare — for low-income

children and families, people with disabilities and the elderly. The solid line shows the expected spending if KanCare was not implemented, and the dashed line shows the expected spending through KanCare for the same population. The difference between the two lines is the savings that KDHE anticipates from implementing the managed care model. The projections estimate savings during five years of KanCare will total \$1.1 billion, including approximately \$470 million from the State General Fund.

According to KDHE’s projections, most of the savings should be seen in the first two years of KanCare, when the MCOs introduce administrative and service delivery efficiencies. KDHE predicts the largest savings will be in care for the elderly and people with disabilities. Unlike low-income children and families who previously were in managed care, these populations were not subject to managed care for the medical services they received. KanCare will introduce comprehensive care coordination

**Figure I. KDHE Projections: Annual Costs for Medicaid Population Groups With and Without KanCare**



Note: Other includes children in foster care, breast and cervical cancer patients, children in institutions, qualified Medicare beneficiaries, working disabled and refugees.

Source: Kansas Department of Health and Environment | 115 Waiver Submission, Budget Neutrality Summary, August 6, 2012.

to eliminate redundant services and improve patient outcomes, which KDHE expects will reduce the rate of spending growth over time.

## Payment Structure

The state pays the MCOs a fixed amount for all covered services and benefits, known as a per member per month payment. Each KanCare contractor is paid at a rate bid by the contractor and negotiated with the state. Some members will not use services equal to the rate, while others might use more services. The MCOs have to balance spending for care and their administrative costs with the revenue received from the state.

## Risk Sharing

Because it is likely that an MCO will experience medical costs that will be higher or lower than the total payments

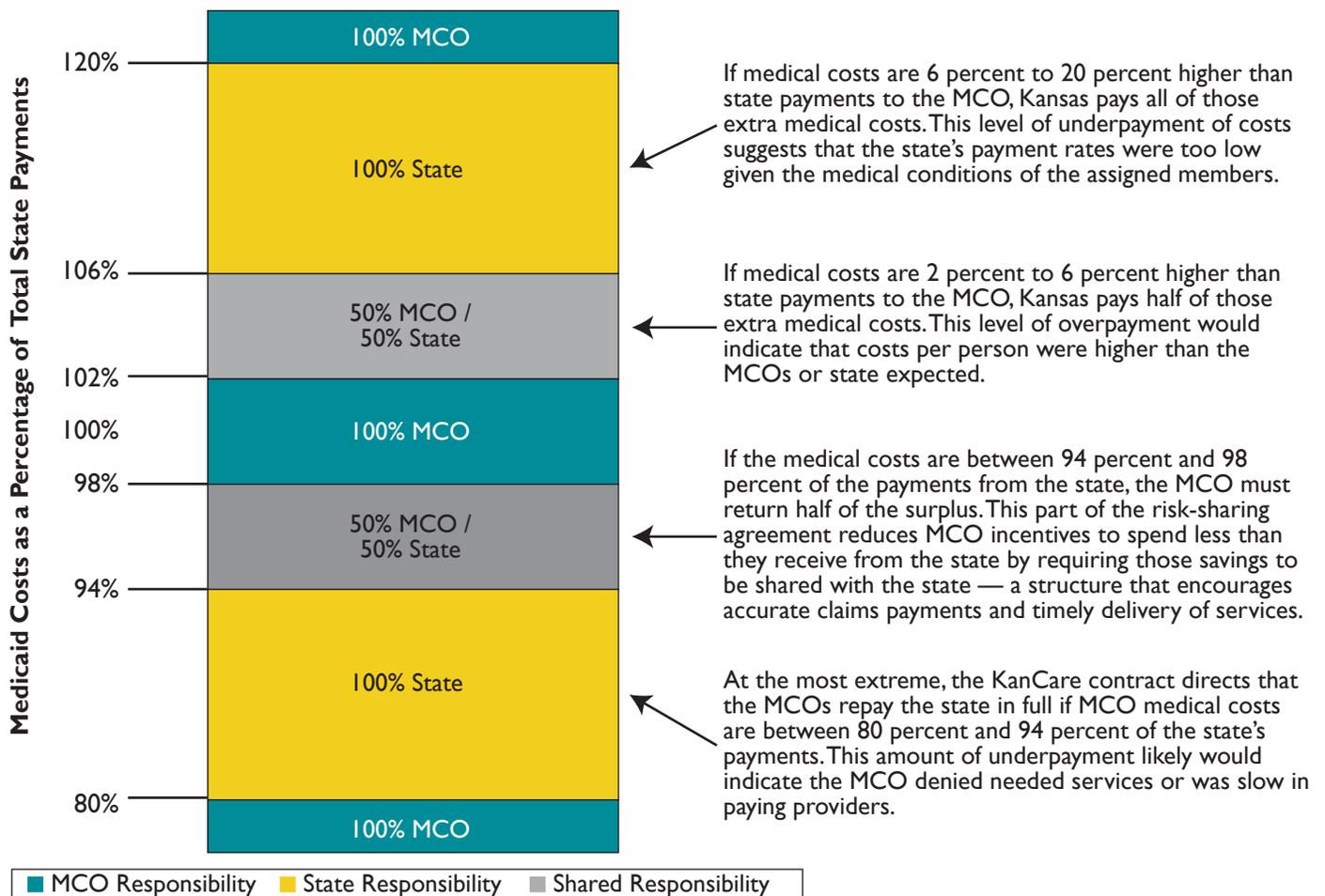
from the state, the KanCare contracts include a risk-sharing requirement, shown in Figure 2. At 100 percent, MCO medical costs are equal to the state payments.

At the end of each contract year, the state will compare the MCO medical costs with the payments. Any adjustment, such as a return of funds to the state or additional state payment to the MCOs, must be made within 10 months of the end of the contract year.

## Pay for Performance

One of the ways KanCare may ensure that Medicaid members receive high-quality health care is through financial incentives tied to improved health outcomes, a provision known as Pay for Performance (P4P). In KanCare, P4P withholds a portion of the state payments for release to the MCO when the contract quality terms are met. While P4P is a common mechanism to encourage quality care, there is little evidence about how P4P works

**Figure 2. Cost Sharing for Contract Year, 2013**



Source: State of Kansas Bid Event EVT 0001028 KanCare Medicaid and CHIP Capitated Managed Care Services; Section 2.3.6.3.2 (page 107).

when the incentives are directed to an MCO instead of health care providers.

In 2013, the first year of the KanCare contracts, the P4P withholding is 3 percent of the annual state payments. MCOs can earn this 3 percent by meeting higher performance standards for six administrative practices: timely claims processing, provider payment and service information submissions, credentialing process, grievances, appeals and customer service.

In 2014 and 2015, MCOs will have 5 percent of their state payments withheld under P4P. To earn these funds, MCOs must meet benchmarks for 15 health care quality indicators in three areas: physical health, behavioral health and long-term care. These indicators, shown in Table I, will use each contractor’s performance in 2013 as a baseline, with increased performance required in 2014

and 2015. In addition to receiving reduced payments, contractors that fail to meet standards can be required to participate in performance improvement projects or corrective action plans.

## Conclusion

Kansas has ambitious goals to improve the quality of care in its Medicaid program and reduce the rate of cost growth over time through managed care. The state’s contracts with MCOs attempt to address this balance of care and cost savings by including financial and performance guidelines as well as incentives to improve quality. Because achieving both quality and savings is an ambitious goal, it is yet to be seen how this will work in practice. However, if contractors are successful, the state may save money while also improving the Medicaid program and the health of its members.

**Table I. Year Two and Three KanCare Pay for Performance Measures**

Measure
Comprehensive diabetes care
Well-child visits in the first 15 months of life
Preterm births
Annual monitoring for patients on persistent medications
Follow-up after hospitalization for mental illness
Competitive employment for people with disabilities
Meet benchmarks for National Outcome Measures for people with substance abuse disorders or severe mental illness
Decreased use of inpatient services for people with mental illness
Increased life expectancy for people with disabilities
Increased integration of care for people with mental illness and disabilities
Nursing facility claim denials
Fall risk management
Decreased hospital admissions 30 days after a nursing facility discharge
Decreased number of nursing facility days of care
Increased use of Promoting Excellent Alternatives in Kansas (PEAK) certified facilities

Source: KanCare Request for Proposals, Attachment J, November 2011.

## About the Issue Brief

This brief is based on work done by Scott C. Brunner, M.A., and Cori Ast, M.H.S.A. It is available online at [www.khi.org/managedcare](http://www.khi.org/managedcare).

### KANSAS HEALTH INSTITUTE

The Kansas Health Institute is a nonprofit, nonpartisan, independent health policy and research organization based in Topeka, Kansas. Established in 1995 with a multiyear 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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