MEDICAID REFORM:

Is Kansas on the right track?

THE SECOND BRIEF IN A SERIES

Medicaid serves an important role in our health care system by providing a safety net for our most vulnerable populations – low-income children, pregnant women, seniors and people with disabilities. Any attempt to redesign the Medicaid program in Kansas must be carried out in a thoughtful and transparent manner, with a timeframe that allows for ample public input and review.

In late January 2012, the Kansas Department of Health and Environment released a concept paper for the proposed overhaul of Medicaid into KanCare. This paper was also submitted to the Centers for Medicare and Medicaid Services and represents the beginning of the waiver application process. At the time of this publication, the waiver application itself has not been submitted by Kansas to the Centers for Medicare and Medicaid Services.

KANSAS IS PROPOSING TO MOVE FORWARD WITH KANCARE IN TWO TRACKS:

Track 1: Implementing managed care for all Medicaid populations
Track 2: Requesting broad authority from the federal government to change the Medicaid program in Kansas

This brief will focus on track 1.

Why is Kansas changing its Medicaid program?

Kansas has cited increasing costs and enrollment as reasons for the change to KanCare. However, compared to the country as a whole and our neighboring Plains states, Kansas spends a smaller percentage of its overall health care spending on Medicaid. And the majority of the Medicaid population in Kansas, children and pregnant women, is already in managed care through the HealthWave program. Populations that would be added to managed care under KanCare include the most costly per-capita populations – primarily the elderly and those with disabilities.

As noted widely across Kansas by advocates, legislators and the media, the timeline for KanCare is fast-moving. The state is aggressively aiming to implement the first track (managed care for all populations) on Jan. 1, 2013. It is highly unusual for a state to successfully negotiate with Centers for Medicare and Medicaid Services and receive the necessary approval on the kind of timeline that has been outlined in Kansas. With the high stakes involved in providing health care to vulnerable populations, the timeline in Kansas should be closely evaluated and adjusted accordingly to ensure a full vetting of the proposal and appropriate transparency throughout the process.

What is a waiver?

Simply put, a waiver allows states to waive certain federal requirements in their Medicaid programs. Waivers are often utilized for a specific population, such as the elderly or disabled. Kansas currently has seven waivers – one allows HealthWave mental health services to be provided through managed care and the other six are population-specific. The intent of waivers is to further the purpose of Medicaid, not restrict eligibility or services.

KanCare proposal has two tracks:

- TRACK 1 proposes managed care for all populations, establishing safety-net care pools for hospitals, and creating and supporting alternatives to traditional Medicaid.
- TRACK 2 proposes seeking broad authority from the federal government through a Global Waiver to turn Medicaid in Kansas into a block grant.

PUBLIC INPUT AND TRANSPARENCY ARE CRITICAL

NEW RULES FROM HEALTH & HUMAN SERVICES STIPULATE A 30-DAY COMMENT PERIOD FOR STATE WAIVERS SUBMITTED AFTER APRIL 27, 2012.

As the KanCare process moves forward, a commitment to transparency and opportunity for public input will best serve Kansans. Fortunately, a format for public input has recently been outlined by U.S. Department of Health and Human Services.

Health and Human Services recently announced new guidelines that states and the Centers for Medicaid and Medicare Services must follow after a state submits a waiver application. These new rules – effective April 27, 2012 – create a uniform process for all states that will, for the first time, guarantee public input. These rules stipulate that the state will be required to accept public comment on its waiver application and demonstrate how those comments have been incorporated into the final application; hold public hearings or meetings; and provide specific detail about how populations could be affected by the waiver (i.e., increase or decrease in enrollment). The rules specifically say that states must provide "sufficient level of detail to ensure meaningful input." These rules were issued Feb. 22, 2012, and become effective April 27, 2012.

An advisory panel for KanCare began meeting in late March 2012. Members of the panel include legislators, consumer advocates and providers. Bringing this group together is a key step toward ensuring public input throughout the KanCare transition process.

AREAS OF CONCERN IN THE KANCARE CONCEPT PAPER

The goals of KanCare – reducing costs and better coordinated care – are laudable, but information released in the concept paper raise some concerns about some of the ways these goals will be accomplished.

- AUTO-ASSIGNMENT: The concept paper states, "All beneficiaries will be auto-assigned to an MCO upon enrollment, but may change plans for any reason for 45 days after assignment." The use of auto-assignment is concerning because it reduces consumer choice and places an additional burden on the beneficiaries to change MCOs if they believe a different provider is in their best interest. Notably, the federal standard for a timeframe to change MCOs is 90 days. The reason behind Kansas' decision to cut this time frame in half is not stated in the concept paper. Shortening the time for consumer choice from 90 days to 45 days will require specific approval from Centers for Medicare and Medicaid Services.

- OFF-RAMP PROPOSAL: Outlined in the concept paper and included in the governor's Fiscal Year 2013 budget is a proposal to offer Health Savings Accounts as an alternative to traditional Medicaid benefits. The budget proposal specifies that Medicaid beneficiaries could choose a one-time payment of $2,000 in return for not applying for Medicaid for three years. Beneficiaries would need to fund all of their health needs with this $2,000 payment, including health plan premiums and cost sharing when they need care. This proposal raises many questions, including whether $2,000 is enough to provide health care for three years, the health-literacy level of Medicaid beneficiaries and their ability to navigate a complex HSA-like program and options for beneficiaries if they develop a need for greater medical care. It is highly unlikely that $2,000 would be sufficient to cover premiums, deductibles and other cost-sharing for three years.

During Fiscal Year 2011, Kansas' Medicaid program served an average of 346,694 people. In Kansas, Medicaid primarily serves poor children and pregnant women, poor elderly and disabled populations.

For more information on the basics of Medicaid in Kansas, see the brief "Medicaid Reform: What does it mean for Kansas kids?" at kac.org/publications.

A PLAN FOR TRANSITIONING HEALTHWAVE TO KANCARE IS LACKING

About 230,000 children in Kansas receive health insurance through Medicaid and CHIP, collectively known as HealthWave. Without a detailed plan for transitioning HealthWave beneficiaries to KanCare, children in Kansas are at risk of losing their health insurance coverage or experiencing a disruption in their care. Two specific concerns regarding this transition are the loss of the HealthWave brand and the education of current HealthWave beneficiaries regarding the potential change to KanCare.

The HealthWave name was created in Kansas when our CHIP program was established in the late 1990s. Families, medical providers and many social service providers are familiar with the name and recognize it as a low- or no-cost health insurance option for many Kansas children. Ensuring a smooth transition between HealthWave and KanCare will require that the name change is clearly and repeatedly communicated to beneficiaries.

IS THIS A REASONABLE TIMELINE?

The KanCare proposal will require significant waiver authority from the Centers for Medicare and Medicaid Services. The likelihood of the state receiving federal waiver approval and conducting a thoughtful RFP process in time for a January 2013 implementation has been questioned by national experts. As stated in Kansas' concept paper, for implementation of track one of KanCare, Kansas will seek waivers to allow the state to make significant changes, including:

- Placing all populations into managed care, including the elderly and disabled populations.
- Modifying benefit packages for certain populations, such as those currently on the waiting list who seek employment.
- Shortening the time consumers have to choose between MCO plans.
- Providing home- and community-based services to individuals who meet an institutional level of care requirement.

NEXT STEPS

On Feb. 22, 2012, the state announced that five companies placed bids to become KanCare contractors. As outlined in public documents regarding KanCare, three MCO companies will be chosen as statewide contractors for KanCare. The state plans to announce the KanCare MCOs in summer 2012.

In the coming months, the state will submit an official waiver application to the Centers for Medicare and Medicaid Services and will begin negotiations for the final terms of the waiver. Once an agreement has been reached, KanCare implementation can begin with the negotiated provisions. Policy provisions outlined in the concept paper, such as auto-assignment or Medicaid transition programs, may or may not be included in a final waiver approved by Centers for Medicare and Medicaid Services. KanCare is slated to be implemented on Jan. 1, 2013.

Companies that have placed bids

- WellCare
- Sunflower State Health Plan
- United Health Care
- Coventry Health Care
- Amerigroup

POLICY RECOMMENDATIONS

As the KanCare proposal continues to unfold, policy changes can be incorporated that will ease the transition for HealthWave beneficiaries, increase consumer choice and guarantee public input throughout the process.

- CO-BRAND HEALTHWAVE AND KANCARE FOR ONE YEAR: If materials used for KanCare include the HealthWave logo, confusion about the change will be mitigated.

- CREATE HEALTHWAVE TRANSITION PLAN: A comprehensive plan to help families enroll in a KanCare MCO is essential to ensuring that children do not experience disruptions or loss of coverage.

- ALLOW BENEFICIARIES TO CHOOSE MCO BEFORE AUTO-ASSIGNMENT: Public documents about KanCare state that beneficiaries will be auto-assigned to an MCO and then have 45 days to choose a different MCO if they wish. Currently, HealthWave beneficiaries are able to choose an MCO upon enrollment and are only auto-assigned if they do not select an MCO. Following the procedure that HealthWave uses will provide KanCare beneficiaries with the most choice and reduce paperwork.

- FOLLOW WAIVER TRANSPARENCY RULES: Kansas will be held to new public input rules if the KanCare waiver is submitted after April 27, 2012. If the waiver is submitted before April 27, Kansas would best serve children and families by abiding by the spirit of the law and adhering to the new regulations, which require the waiver application to be publicly posted and allow for a 30-day public comment period.

- EXCLUDE CHILDREN FROM OFF-RAMPS: Children's eligibility for HealthWave is currently on a sliding-scale – its own version of an off-ramp. Including children in a pilot program will risk their comprehensive care and potentially leave them without access to affordable care.

MEDICAID SERVES AN IMPORTANT ROLE IN OUR HEALTH CARE SYSTEM

Any attempt to overhaul the Medicaid program in Kansas must be carried out in a thoughtful and transparent manner, with a timeframe that allows for careful vetting. Without sufficient time for implementation, the transition for consumers will be unnecessarily cumbersome and confusing, which may place the health of children and other vulnerable Kansans at risk.

TIMELINE

(based on documents provided to the KanCare Advisory Council)

APRIL-JUNE

- The state will reach out to stakeholders about participation in workgroups
- Advisory council has second meeting
- Complete negotiations with MCOs and send contracts to the Centers for Medicare and Medicaid Services
- Kickoff meeting for stakeholder workgroups

JULY-SEPTEMBER

- Town hall meetings begin (consumer and provider focus)
- Advisory Council has third meeting
- Stakeholder workgroups begin meeting
- Centers for Medicare and Medicaid Services approves contracts with MCOs
- Consumer and provider notifications

OCTOBER-DECEMBER

- Stakeholder workgroups continue to meet
- Network established
- Member enrollment education tour/town halls
- Enrollment

JANUARY 2013

- Go live
- Advisory council meets

KANSAS ACTION FOR CHILDREN

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