



**State of Kansas**

**KanCare**

**Section 1115 Demonstration Renewal  
Application**

**DRAFT**

**December 30, 2022**

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## I. Introduction

KanCare is the State of Kansas' statewide mandatory Medicaid/Children's Health Insurance Program (CHIP) managed care program providing integrated services to most Medicaid/CHIP beneficiaries. KanCare operates under the authority of a Section 1115 demonstration concurrently with the State's Section 1915(c) home and community-based services (HCBS) waivers. The current KanCare Section 1115 demonstration expires on December 31, 2023. Pursuant to 42 CFR 431.412(c), the Kansas Department of Health & Environment (KDHE), in partnership with the Kansas Department for Aging and Disability Services (KDADS), is pleased to submit this five-year extension and amendment request.

Since the initial implementation of KanCare, Kansas has sought to improve the health and well-being of KanCare members through integrated, whole person care and to facilitate member independence. These goals are reflected in the State's Quality Management Strategy (QMS), which outlines the goals, objectives, and performance measures to determine if KanCare is providing quality care for its members. In addition to incorporating KanCare goals into the QMS, Kansas has worked over the past demonstration period to reduce the reliance on the 1115 demonstration by successfully transitioning the Delivery System Reform Incentive Payments to a managed care state directed payment.

Given the success and stability of the KanCare program, Kansas proposes to transition features of the Section 1115 demonstration that do not require expenditure authority to more permanent federal authorities. While this transition will impact the way KDHE and KDADS interact with the Centers for Medicare & Medicaid Services (CMS), the goal of this amendment is to ensure people have access to the care and services they have come to expect through the demonstration. This amendment seeks to change only the federal authority under which Kansas operates its current KanCare managed care program. It does not propose any significant changes to the KanCare program, and CMS approval of the application does not seek to change KanCare eligibility, enrollment, costs, provider rates, covered services, or the State's existing HCBS waivers.

In the coming months, Kansas will be developing the following additional authorities to support the KanCare program:

- 1932(a) state plan amendment (SPA)
- 1915(b) freedom of choice waiver
- Alternative Benefit Plan (ABP) SPA

These authorities, coupled with the seven Section 1915(c) HCBS waivers and the amended Section 1115 demonstration, will seek to preserve needed flexibilities for the KanCare program, while providing certainty to KanCare members that the program will continue for years to come.

## II. Historical Summary

Kansas has a long history of using Medicaid managed care as a service delivery mechanism. Prior to KanCare (pre-2013), the State operated a risk-based managed care program “HealthWave” under the authority of a Section 1932(a) SPA that provided a limited set of state plan services to Medicaid/CHIP children, pregnant women, and parents. In addition, under the authority of a Section 1915(b)/(c) waiver, the State contracted with a prepaid ambulatory health plan (PAHP) for mental health services and a prepaid inpatient health plan (PIHP) for substance use disorder (SUD) services. All other services and populations were fee-for-service (FFS).

Kansas submitted its Section 1115 demonstration proposal for KanCare on August 6, 2012 to reform its Medicaid program starting January 1, 2013. The major KanCare initiatives included: (1) moving most Medicaid populations into mandatory managed care; (2) covering all Medicaid services, including long-term services and supports, through managed care; and (3) establishing safety net care pools to reimburse uncompensated hospital costs and to provide payments to essential hospitals. The KanCare demonstration was approved by the Centers for Medicare & Medicaid Services (CMS) on December 27, 2012 for a five-year period effective from January 1, 2013 through December 31, 2017.

The State submitted a 12-month temporary extension request of KanCare to CMS on July 31, 2017 that made no changes to the waiver. The 12-month temporary extension was approved on October 13, 2017 giving Kansas the necessary time to fully incorporate updated goals, objectives and interventions for the extension period. On December 20, 2017, the State submitted a renewal request entitled KanCare 2.0, and on December 18, 2018 CMS approved the extension to authorize KanCare 2.0 for the period of January 1, 2019 through December 31, 2023.

### Post-Award Forums

The State of Kansas has continuously given the public an opportunity to provide meaningful comment on the progress of the KanCare 2.0 demonstration during post-award and annual public forums. Due to the pandemic, the annual forums held in 2020 and 2021 were virtual with videoconferencing information provided to interested parties. The dates and times for each public forum sessions are below:

- KanCare 2019 Public Forum (post-award)
  - December 11, 2019 from 3:30–4:30pm
- KanCare 2020 Public Forum (annual)
  - December 16, 2020 from 3:00–4:00pm
- KanCare 2021 Public Forum (annual)
  - December 7, 2021 from 2:00–3:00pm
- KanCare 2022 Public Form (annual)
  - December 14, 2022 from 3:00–4:00pm (details still to be finalized)

Information regarding meeting web postings, number of meeting attendees and materials used in each of the forums can be found on the KanCare Public Annual Forum webpage located at <http://kancare.ks.gov/about-kancare/annual-forum>. KDHE will remain in compliance with post-award public input processes and will conduct the post-award forum for the KanCare demonstration no more than six months after CMS approval of this renewal. For those interested in

opportunities to provide public input, including the upcoming 2022 public form, can find information on the following webpage located at <http://kancare.ks.gov/home>.

## KanCare 2.0

Since implementation of KanCare 2.0, the State has submitted a few demonstration amendments. Below is a summary of each amendment and the current status of CMS approval.

**Table 1: KanCare Amendments**

<b>Amendment</b>	<b>Submission Date</b>	<b>CMS Approval Status</b>
<b>Implement a change to the Health Care Access Improvement Program (HCAIP) portion of the Uncompensated Care (UC) Pool</b>	July 26, 2019	Approved June 17, 2022
<b>Implement 12 months continuous eligibility for parents and other caretaker relatives</b>	August 13, 2021	Approved September 29, 2022
<b>Address the COVID-19 PHE and promote continuity of coverage during the unwinding for CHIP enrollees</b>	May 20, 2022	Approved August 15, 2022, retroactive to March 1, 2020

The State currently contracts with three managed care organizations (MCOs) to serve KanCare 2.0 members: Aetna Better Health of Kansas, Inc. (Aetna); Sunflower State Health Plan, Inc. (Sunflower); and UnitedHealthcare Community Plan, Inc. (UnitedHealthcare). As a result of legislation prohibiting the State from issuing a request for proposal (RFP) for new MCOs before February 1, 2023, the State will extend the current contracts through December 31, 2024. The State anticipates issuing the RFP for new MCO contracts in 2023 to be effective January 1, 2025.

The original goals of the KanCare demonstration focused on providing integrated and whole-person care, creating health homes, preserving or creating a path to independence, and establishing alternative access models with an emphasis on HCBS. Building on the success of KanCare, the primary goal for KanCare 2.0 was to help Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence (SDOHI) in addition to traditional Medicaid/CHIP benefits. Strategies to achieve this goal included service coordination, the OneCare Kansas (OCK) program, value-based models and purchasing strategies, increasing employment and independent living supports, expanding access to telehealth (e.g., telemedicine, telemonitoring, and telementoring) services, and increasing access to SUD treatment services.

KanCare 2.0 expanded upon care coordination to provide service coordination, which is a comprehensive, holistic, integrated approach to person-centered care. It allows for maximum access to supports by coordinating and monitoring all of an individual's care (acute, behavioral health, and LTSS) through direct interventions, provider referrals, and linkages to community

resources. Case management, disease management, discharge planning, and transition planning are also elements of service coordination. Service coordination was implemented by the MCOs as part of the implementation of KanCare 2.0 on January 1, 2019. The first evaluation question in the evaluation of KanCare 2.0 examined the effectiveness of the overall service coordination strategy. The interim evaluation findings support that service coordination had a positive impact on outcomes of one of the measures evaluated, although additional work may be needed to determine the overall impact of the public health emergency on all of the quality measure outcomes.

OneCare Kansas (OCK) is a care management service model, based on the health home model, where all professionals involved in a member's care communicate with one another so that the member's medical and behavioral health and social service needs are addressed in a comprehensive manner. The coordination of a member's care is done through a dedicated care manager who oversees and coordinates access to all of the services a member requires in order to optimize member health. OneCare Kansas was implemented in June of 2020 and expanded as of April 1, 2021. The second evaluation question examined the effectiveness of the OneCare Kansas program. Results of the interim evaluation found that the OCK program had a positive impact on access to preventive and well-care visits for adults and adolescents along with positive outcomes for annual dental visit rates. Other successes of the OCK program included improved member trust and engagement and increased partner collaboration.

KanCare 2.0 promoted two types of value-based models and purchasing strategies: provider payment and/or innovative delivery system design methods between MCOs and their contracted providers and a pay-for-performance (P4P) program between the State and contracted MCOs. The KanCare 2.0 evaluation includes the evaluation of hypothesis 1: Value-based models and purchasing strategies will further integrate services and eliminate the current silos between physical health services and behavioral health services, leading to improvements in quality, outcomes, and cost-effectiveness. The MCOs each designed their own value based provider incentive program focusing on behavioral health or pediatric care and are in the process of implementing and evaluating the effectiveness of their individual programs.

In addition, as part of KanCare 2.0, the State proposed to replace the Delivery System Reform Incentive Payment (DSRIP) program with an Alternative Payment Model (APM) approach, shifting from DSRIP project-based metrics to APM provider-based quality and outcome metrics. This transition was originally scheduled to occur by January 1, 2021, but due to the COVID-19 public health emergency (PHE), the DSRIP funds initially transitioned to a uniform increase payment for 2021 and the transition to the APM approach occurred January 1, 2022. Similar to the DSRIP program, the APM approach requires that providers meet or exceed predetermined quality and outcome improvements to receive incentive payments. As part of the APM development process, Kansas worked with the participating hospitals to determine priority measures for each hospital and develop baseline metrics and hospital-specific performance targets. In 2023, KDHE will receive reports from each hospital detailing their 2022 performance outcomes and the State will determine each hospital's 2022 performance payments based on their outcomes. The directed payment evaluation of the APM will be consistent with the measures used to determine payment amounts to each hospital, which are intended to measure improvements in quality outcomes as a result of better access to care for both adults and children.

KanCare 2.0 included authorization for an employment support pilot. The Supports and Training for Employing People Successfully (STEPS) program was implemented July 1, 2021. STEPS is a

program through which people with disabilities and/or behavioral health conditions may seek a path to employment without jeopardizing their Social Security benefits or losing medical insurance coverage. STEPS services include Pre-Vocational Services, Independent Living Skills Training, Personal Assistant Services, Transportation, Supported Employment, Assistive Technology, and Community Service Coordination. To receive STEPS services, a participant must be interested in finding and maintaining employment and meet eligibility criteria, including the Social Security Administration definition of disability. The KanCare 2.0 evaluation includes the evaluation of hypothesis 2: Increasing employment and independent living supports for members with behavioral health needs, or who have intellectual, developmental or physical disabilities or traumatic brain injuries will increase independence and improve health outcomes. Over the course of the demonstration, Kansas was able to serve 42 individuals on this pilot program with 37 currently enrolled and 3 who have achieved employment.

The State also expanded the use of telehealth services to enhance access to care for KanCare members living in rural and semi-rural areas. These interventions were particularly important during the COVID-19 PHE to provide access to care when members were unable or uncomfortable leaving their residence. Hypothesis 3 in the evaluation design is that the use of telehealth (e.g., telemedicine, telemonitoring, and telementoring) services will enhance access to care for KanCare members living in rural and semi-urban areas.

Specifically: (a) telemedicine will improve access to services such as speech therapy; (b) telemonitoring will help members more easily monitor health indicators such as blood pressure or glucose levels, leading to improved outcomes for members who have chronic conditions; and (c) telementoring can pair rural and semi-urban health care providers with remote specialists to increase the capacity for treatment of chronic, complex conditions. KanCare experienced increases in use of telemedicine across all measures reviewed along with positive outcomes from provider surveys on the use of telemedicine and member engagement in making progress on their treatment goals.

In its renewal application for KanCare 2.0, the State requested and received approval from CMS for a waiver of the authority to provide coverage for covered services provided to Medicaid-eligible individuals aged 21 through 64 who are enrolled in an MCO and who are receiving services in a publicly-owned or non-public institution for mental diseases (IMD). Under this authority, members ages 19 through 64 have access to additional covered SUD services, authorized under section 1115(a)(2) of the Social Security Act, including SUD treatment services provided to individuals with SUD who are short-term residents in residential treatment facilities that meet the definition of an IMD. These new services were implemented as part of the implementation of KanCare 2.0 on January 1, 2019. As required by CMS, Kansas conducted a separate 1115 SUD demonstration evaluation to examine whether the demonstration achieved its goals. In the interim evaluation of the five goals of the SUD demonstration, the primary drivers for Goals #1 through #4 showed improvements or mixed results and the primary drivers for Goal #5 did not provide evidence of improvements specific to the SUD demonstration, but did experience improvements to some of outcomes overall. Four of the six secondary drivers showed evidence that they contributed to improvements to Goals #2 through #5.

In addition to the strategies described above and the demonstration evaluation, Kansas updated its QMS to incorporate performance measures and reporting to support KanCare 2.0 initiatives. This included establishing goals that align with the KanCare 2.0 hypotheses (e.g., Goal #2 in the QMS is

“Increasing employment and independent living supports to increase independence and health outcomes,” Goal #3 is related to increasing telehealth usage, and Goal #4 is related to removing barriers to services provided in IMDs for members with SUD) and defining objectives for specific initiatives such as STEPS and OneCare Kansas. Even in the absence of a demonstration, the QMS is a necessary and governing document for every Medicaid managed care program. The changes to the demonstration will not impact Kansas’ continued focus on the goals described above, and those goals will remain part of the KanCare program even though the goals of the demonstration will change.

### **The Future Goals of KanCare**

The original goals of the KanCare program include providing integrated and whole-person care to KanCare members and that continues to be a priority for the State as it transitions authorities to more permanent Medicaid authorities. While that may not be a specific goal in this 1115 demonstration waiver renewal due to the more limited scope of populations and services, the 1115 demonstration will maintain the critical goal of ensuring people still have access to the care and services they have come to expect through the demonstration. This will be achieved through providing continuous eligibility for eligible adults and access to SUD services that cannot be authorized elsewhere. Greater detail on the specific goal and objectives of this renewal is shared in Section III.

### III. Requested Changes to the Demonstration and Expenditure Authorities

#### Overview

In 2013, KDHE implemented the KanCare 1115 Demonstration Waiver to reform its Medicaid delivery system with the goal of integrating the full array of services including acute care, behavioral health and LTSS to focus on whole person care. The 1115 Demonstration provided the opportunity for consolidation of the respective MCO, FFS, PAHP and PIHP delivery systems into a single comprehensive MCO delivery system, thus creating KanCare (and subsequently KanCare 2.0). Evaluation findings of KanCare 2.0 demonstrated successes across demonstration goals, including service coordination, health homes, access to services such as SUD services, employment supports and telemedicine, and the transition from DSRIP to a managed care state directed payment.

While these successes are notable, Kansas recognizes that these achievements can be maintained and improved upon through the use of more permanent federal Medicaid authorities. Kansas' program stability, achieved with nearly a decade of KanCare experience, reduced reliance on demonstration expenditure authority for provider payment and incorporating KanCare goals in the QMS has led Kansas to pursue a strategy to leverage more permanent federal authorities and use the 1115 authority only where necessary. All programs currently authorized by the KanCare 2.0 waiver will be continued via 1115 or alternate authority, with no additional programs, cost sharing or eligibility groups to be added at this time. This renewal coupled with the other authorities to be developed aims to maintain the eligibility, benefits, and services that are currently provided to KanCare beneficiaries, along with the managed care delivery system currently operating.

Kansas's vision for the 1115 renewal is to embed successful waiver programs within more permanent Medicaid authorities, thus creating a stable and supportive safety net for KanCare beneficiaries. The 1115 waiver extension will provide continuity for continuous eligibility and SUD services that cannot be authorized elsewhere and therefore has a goal of providing enhanced access to services for Kansas Medicaid beneficiaries.

#### KanCare Today

Today, KanCare 2.0, under the 1115 authority, consists of the following approved and pending components:

- Mandatory managed care enrollment of:
  - Adults and Children
  - Elderly and Disabled
  - Foster Children
  - Adoption Assistance Children
  - Pregnant Women
  - Individuals enrolled in an HCBS waiver
- Authorization of the STEPS Employment Support Pilot Program for individuals with specific behavioral health conditions or who are on the waitlist or leave the I/DD, PD, or BI 1915(c) waivers
- Authorization of services not available under the state plan for individuals with behavioral health needs

- Expenditures for services provided to an individual with a SUD who are short-term residents in an IMD
- Expenditures for payments to hospitals for uncompensated care (uncompensated care pool)
- Expenditures for Delivery System Reform Incentive Payment (DSRIP) Program
- 12-month continuous Eligibility for Parents/Other Caretaker Relatives
- Continuous eligibility for CHIP enrollees who turn 19 during the PHE

### Requested Changes to the Demonstration

Table 2 below provides a snapshot of the elements of the current KanCare demonstration and the authority Kansas proposes to authorize those elements starting January 1, 2024.

**Table 2: KanCare Renewal Snapshot**

<b>Program Name/Eligibility group</b>	<b>Included in 1115 renewal?</b>	<b>New Authority</b>
<b>Specific SUD services and the SUD IMD Exclusion</b>	Yes – the services and population will be included in the 1115 renewal	N/A
<b>Twelve-month continuous eligibility coverage for parents and other caretaker relatives</b>	Yes – the population will be included in the 1115 renewal	N/A
<b>Continuous eligibility for individuals enrolled in CHIP who turn 19 during the PHE</b>	Yes – the population will be included in the 1115 renewal	N/A
<b>Mandatory managed care for most Medicaid and CHIP beneficiaries</b>	No – the services and population will be removed from the 1115	Section 1932(a) state plan managed care authority
<b>Mandatory managed care for members dually eligible for Medicare and Medicaid and children with special health care needs</b>	No – the services and population will be removed from the 1115	1915(b) mandatory managed care authority
<b>Section 1915(c) authorities</b>	No – the services will continue to be authorized through 1915(c) waivers and the population will be removed from the 1115	1915(b)/1915(c) concurrent waiver
<b>Disability and behavioral health employment support pilot (STEPS) program</b>	No – the services and population will be removed from the 1115	ABP SPA
<b>Uncompensated Care Pool and DSRIP</b>	No – expenditures will be removed from the 1115	State Directed Payment

Program Name/Eligibility group	Included in 1115 renewal?	New Authority
<b>Other non-SUD services for BH members (personal care and physician consultation)</b>	No – services will be removed from the 1115	SPA or 1915(b) waiver

As shown in Table 2 above, while many of the items evaluated as part of KanCare are proposed to move to other authorities, this 1115 Demonstration Renewal application seeks authorization for the following:

- Specific SUD services and the SUD IMD Exclusion to continue the success of enhanced access to care for members with a SUD, in order to maintain access to necessary SUD services.
- Renews the 12-month continuous eligibility coverage for parents and other caretaker relatives using Modified Adjusted Gross Income (MAGI), in order to support continued access to Medicaid services and reduce churn in the Medicaid program, providing better opportunities to access care.
- Maintain access to federal financial participation for continuous eligibility for individuals enrolled in CHIP who turn 19 during the PHE in order to reduce gaps in coverage immediately after the PHE.

To further expand upon Table 2 above, Kansas is not proposing any new waivers or expenditure authorities in this extension request. The extension seeks to maintain those program design features that require 1115 expenditure authority or move programs and payment features currently authorized as an expenditure authority into other authorities. As such, below is a more detailed description of each KanCare component listed above that will transition out of the current 1115 waiver.

- Mandatory managed care enrollment will be authorized through a combination of Section 1932(a) state plan authority and 1915(b) waiver authority and will no longer be included in the 1115.
- The STEPS employment support pilot will be authorized through an ABP SPA and will be limited to those individuals who are enrolled in Medicaid and who:
  - Have a qualifying behavioral health condition of Schizophrenia; Bipolar and major depression; Delusional disorders; Personality disorders; Psychosis not otherwise specified; Obsessive-compulsive disorder; Post-traumatic stress disorder; or SUD or co-occurring SUD;
  - Are waitlisted for the I/DD, physical disability (PD), or Brain Injury HCBS waiver 1915(c) waiver; or
  - Are on the I/DD, physical disability (PD), or Brain Injury HCBS waiver who are willing to leave their HCBS waiver and would not lose Medicaid eligibility by doing so.
- The current 1115 does allow some expanded access to Medicaid eligibility for participation on the STEPS program if the person becomes employed and gains assets above the Medicaid limit. Upon review of the membership who are receiving services through STEPS, there are currently only 9 people who would have the possible outcome that were they to gain employment, they could lose eligibility if

their assets go above Medicaid limits. In any instance where a person's assets and income would be above the Medicaid limit (and they lose STEPS eligibility), there is extensive counseling on other programs and asset options in order to maintain their Medicaid eligibility. Kansas would develop individualized counseling plans for each person in order to determine if they should move to the ABP SPA or the Working Healthy Medicaid Buy-In program prior January 1, 2024. Kansas believes that moving the program to a state plan authority will ensure Medicaid members can continue to have access to employment support services without significantly impacting eligibility for the Medicaid program while providing some permanency for members who access the ABP SPA.

- Authorization of services not available under the state plan for individuals with behavioral health needs including physician consultation, personal care services and rehabilitation services. These services will be covered under a combination of authorities including either a SPA authority or 1915(b) waiver for physician consultation, ABP SPA for personal care services for those not on a 1915(c) waiver, and 1115 SUD demonstration authority for rehabilitation services.
- The uncompensated care pool will transition to a Medicaid managed care state directed payment to hospitals and can be accomplished through any managed care authority.
- The DSRIP program has already been transitioned to an APM, so expenditure authority is no longer needed.

As noted previously, there are no additional programs, delivery systems, cost sharing or eligibility groups to be added to the renewal. With the number of changes proposed, Kansas recognizes the need to refresh the goals for the 1115 demonstration. The refreshed goals focus on access to care and services in order to reduce inefficient care or reduce the reliance on higher levels of care in the Medicaid and CHIP program. The specific goals and objectives are detailed in the Evaluation, Outcomes and Design section of this proposal.

## **Eligibility and Benefits in the Renewal**

### *Continuous Eligibility for Parents and Caretaker Relatives*

#### **Eligibility**

The continuous eligibility for adults program authorizes a 12-month continuous coverage period for parents and other caretaker relatives using MAGI eligibility. The medical coverage for parents and caregivers of children program is available to families with children. To qualify, there must be children in the home under the age of 19. This program may cover parents or caretaker relatives of Medicaid or CHIP covered children where the adult qualifies under existing Kansas Medicaid rules.

Per sections 1902(a)(10)(A)(i)(I) and 1931(b) and (d) of the Social Security Act, individuals are eligible under the mandatory group for parents and other caretaker relatives for continued benefits during any periods within a 12-month eligibility period when these individuals would be found ineligible if subject to redetermination, as described in Special Term and Condition (STC) 19.

This eligibility would not change under the renewal.

## **Benefits**

Individuals eligible for this program have access to the full suite of KanCare benefits covered under the state plan. Instead of being periodically reviewed, eligibility determinations will not be made more than once per year.

These covered benefits will remain during the renewal period with no changes.

### *Specific SUD Services and the SUD IMD exclusion*

## **Eligibility**

Currently, the Kansas section 1115 waiver permits Medicaid coverage of expenditures for otherwise covered services furnished to eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an IMD.

This eligibility would not change under the renewal.

## **Benefits**

Currently, the SUD program covers beneficiary access to high quality, evidence-based opioid use disorder (OUD) and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. Pursuant to the Section 1115 waiver, the State must establish requirements or guidance that meet program standards in the ASAM criteria or other nationally recognized, SUD-specific program standards regarding the types of services and hours of clinical care for residential treatment settings. The State must establish a requirement that residential treatment providers offer medication-assisted treatment (MAT) on-site or facilitate access to MAT off-site. The State must guarantee establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities.

These covered benefits and system enhancements will remain during the renewal period with no changes, outside from the State continuing to enhance and transform the SUD delivery system.

### *Continuous Eligibility for Individuals Enrolled in CHIP*

The eligibility and benefits for the continuous eligibility for individuals enrolled in CHIP who turn 19 during the PHE will continue with the approval found at the following link: [ks-kancare-covid19-amndmnt-aprvl-ca.pdf \(medicaid.gov\)](#).

## **Expenditure Authority Requests for the Renewal**

Kansas is not proposing any new waivers or expenditure authorities in this extension request and seeks to maintain those program design features that require 1115 expenditure authority or move programs and payment features currently authorized as an expenditure authority into other authorities. The authorities that will be maintained include:

Expenditures for Additional Services for Individuals with Substance Use Disorder Needs

Kansas requests continuing expenditure authority for rehabilitation services furnished to individuals eligible under the approved State Plan to address SUD needs in the community.

Residential Treatment for Individuals with Substance Use Disorder

Kansas requests continuing expenditure authority for otherwise-covered services provided to Medicaid eligible individuals aged 21 through 64 years who are enrolled in a Medicaid MCO and who are receiving services in a publicly-owned or non-public IMD.

12-Month Continuous Eligibility Period for Parents and Other Caretaker Relatives

Kansas requests continuing expenditure authority for continued benefits during any periods within a twelve-month eligibility period when these individuals would be found ineligible if subject to redetermination.

Continuous Coverage for Individuals Aging Out of CHIP

Kansas requests continuing expenditure authority pursuant to attachment T of the August 15, 2022 KanCare approval letter. These expenditures are to provide continued eligibility for CHIP enrollees who turn 19 during the public health emergency (and therefore lost eligibility for CHIP due to age) and who are otherwise ineligible for Medicaid due to income above 0 percent of the federal poverty level (FPL).

## IV. Quality Reporting Summary

In accordance with federal requirements, KDHE conducts annual reviews of MCO quality through the use of an External Quality Review Organization (EQRO). KDHE currently contracts with the Kansas Foundation for Medical Care, now known as KFMC Health Improvement Partners, (KFMC) to serve as the EQRO for KanCare. In addition to performing the federally required external quality reviews, KFMC assists the State with assessing the success of KanCare in meeting its goals and objectives.

Below is a summary of the three most recent annual EQR technical reports, including findings for Aetna, Sunflower, and UnitedHealthcare related to the following:

- Information Systems Capabilities Assessment (ISCA)
- Performance Measure Validation (PMV)
- Performance Improvement Project (PIP) Validation
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Validation
- Provider Survey Validation
- Review of Compliance with Medicaid and CHIP Managed Care Regulations (Compliance Review)
- Quality Assessment and Performance Improvement (QAPI)
- Network Adequacy Validation

### **KanCare Program Annual External Quality Review Technical Report — 2021–2022 Reporting Cycle**

[Click here for full report](#)

#### *ISCA and PMV*

The ISCA/PMV process had five main objectives:

- Assess the potential impact of the MCOs' information systems on their ability to:
  - Conduct quality assessment and improvement initiatives
  - Calculate valid performance measures
  - Collect and submit complete and accurate encounter data to the State
  - Oversee and manage the delivery of health care to the MCOs' members
- Evaluate the policies, procedures, documentation, and methods the MCOs used to calculate the measures
- Determine the extent to which reported rates are accurate, reliable, free of bias, and in accordance with standards for data collection and analysis
- Verify measure specifications are consistent with the State's requirements
- Ensure measurement rates are produced with methods and source data that parallel the baseline rates

All three MCOs are required to register with NCQA and report their Healthcare Effectiveness Data and Information Set (HEDIS) measures through the NCQA data submission portal. HEDIS measures are NCQA developed measure specifications with strict requirements of validation and auditing to ensure accurate and reporting of measure outcomes between MCOs. MCOs have improved their HEDIS measures over the past three to five years and KanCare rates for four Adult and five Child Core Set measure<sup>1</sup> indicators were above the 75<sup>th</sup> percentile. Furthermore, no issues were found with the information systems review performed as part of the evaluation. MCO-specific findings are noted below.

### **Aetna**

No Adult Core Set measure indicators were below the 10<sup>th</sup> percentile; nine were below the 25<sup>th</sup> percentile. Ten Child Core Set measure indicators were below the 25<sup>th</sup> percentile, one of which was below the 10<sup>th</sup> percentile.

Aetna improved its measures in the following areas:

- Adult cervical cancer screening
- Adult follow-up after emergency department (ED) visit for mental illness
- Adult initiation of AOD (opioid abuse or dependence)
- Adult postpartum care
- Child weight assessment and counseling for nutrition and physical activity

Aetna experienced declines in the following measures:

- Adult chlamydia screening in women
- Adult follow-up after hospitalization for mental illness
- Adult medical assistance with smoking and tobacco use cessation (advising smokers to quit)
- Adult diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications
- Metabolic monitoring for children and adolescents on antipsychotics
- Use of first-line psychosocial care for children and adolescents on antipsychotics
- Childhood immunization status
- Immunizations for adolescents

### **Sunflower**

No Adult Core Set measure indicators were below the 10<sup>th</sup> percentile; five were below the 25<sup>th</sup> percentile. Three Child Core Measure Set indicators were below the 25<sup>th</sup> percentile, one of which was below the 10<sup>th</sup> percentile.

Sunflower improved its measures in the following areas:

- Adult asthma medication ratio

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<sup>1</sup> Adult and Child core set measures are sets of core measures showing the quality of care and health outcomes for adults participating in Medicaid, and children enrolled in Medicaid and the Children's Health Insurance Program (CHIP) selected by CMS on an annual basis.

- Adult cervical cancer screening
- Adult comprehensive diabetes care
- Adult initiation of AOD
- Adult medical assistance with smoking and tobacco use cessation (total current smoker discussing cessation medication)
- Adult postpartum care
- Child asthma medication ratio

Sunflower experienced declines in the following areas:

- Adult follow-up after hospitalization for mental illness (30 days)
- Adult medical assistance with smoking and tobacco use cessation (advising smokers to quit)
- Adult diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications
- Metabolic monitoring for children and adolescents on antipsychotics
- Childhood immunization status (hepatitis B)
- Child follow-up after hospitalization for mental illness (30 days)
- Immunizations for adolescents (tetanus-diphtheria-pertussis)
- Child prenatal and postpartum care (timeliness of prenatal care)

### **UnitedHealthcare**

One Adult Core Set measure indicator ranked below the 10<sup>th</sup> percentile, seven more ranged below the 25<sup>th</sup> percentile. No Child Core Set indicator rates were below the 10<sup>th</sup> percentile, four ranked below the 25<sup>th</sup> percentile.

UnitedHealthcare improved its measures in the following areas:

- Adult antidepressant medication management
- Adult asthma medication ratio
- Adult comprehensive diabetes care
- Adult follow-up after ED visit for mental illness
- Adult initiation of AOD
- Adult postpartum care
- Child asthma medication ratio
- Immunizations for adolescents

UnitedHealthcare experienced declines in the following areas:

- Adult chlamydia screening in women
- Adult flu vaccinations
- Adult medical assistance with smoking and tobacco use cessation (advising smokers to quit, discussing cessation medications, discussing cessation strategies)
- Adult adherence to antipsychotic medications for individuals with schizophrenia
- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications

- Metabolic monitoring for children and adolescents on antipsychotics
- Use of first-line psychosocial care for children and adolescents on antipsychotics
- Childhood immunization status (measles-mumps-rubella, varicella-zoster virus)
- Weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for nutrition)

### *Performance Improvement Project Validation*

The objectives of KFMC’s PIP validation review are to determine if the design of the improvement project is methodologically sound, to validate the annual PIP results, and to evaluate the overall validity and reliability of the methods and findings. KFMC uses a numerical rating system for the evaluation of PIP activities to determine a level of overall confidence: High Confidence: 95% to 100%, Confidence: 90% to <95%, Low Confidence: 80% to <90%, and Little Confidence: below 80%.

- **Aetna** implemented the following PIPs: EPSDT, Pregnancy: Prenatal Care, Food Insecurity, LTSS ED Visits, and Influenza Vaccination. The only PIP that received a validation rating of Confidence (92.6%) is Food Insecurity.
- **Sunflower** implemented the following PIPs: EPSDT, Cervical Cancer Screening, Increasing the Rate of Diabetic Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SMD), Waiver Employment, and Mental Health Services for Foster Care. The only PIP that received a validation rating of Confidence (91.2%) is Cervical Cancer Screening.
- **UnitedHealthcare** implemented the following PIPs: EPSDT, Prenatal Care, SMD, Advanced Directives, and Housing. EPSDT and Advanced Directives both received a validation rating of Confidence (91.3% and 92.0%) and Housing received a validation rating of High Confidence (97.1%).

### *CAHPS Survey Validation*

The CAHPS is a nationally standardized survey tool sponsored by the Agency for Healthcare Research and Quality (AHRQ) and co-developed with the National Committee for Quality Assurance (NCQA). The overall objective of the CAHPS survey is to capture accurate and complete information about consumer-reported experiences with health care. The State requires MCOs to survey representative samples of the adult, general child, and children with chronic conditions populations.

Overall, the CAHPS annual satisfaction results for access, timeliness, and quality of care display a positive trend. With a few exceptions, the ratings were at or above the 50<sup>th</sup> percentile.

**Table 3: Global Rating for KanCare – 2021**

	<b>Adult</b>	<b>General Child</b>	<b>Children with Chronic Conditions</b>
<b>Health Plan</b>	80.0%	89.9%	87.1%
<b>Health Care</b>	76.9%	89.5%	87.3%
<b>Personal Doctor</b>	85.4%	89.5%	89.3%

	Adult	General Child	Children with Chronic Conditions
<b>Specialist</b>	86.4%	84.9%	85.6%

### *Provider Satisfaction Survey Validation*

The three MCOs conducted provider satisfaction surveys in 2021 to assess how well each MCO is meeting its providers' expectations and needs, and to identify strengths and opportunities for improvement. KFMC completed a review of these surveys to validate the methodological soundness of the surveys based on the Validating Survey Protocol worksheet provided by CMS. Table 4 below highlights the sample size and response rate for each of the MCOs.

**Table 4: Information on Fielding the Provider Satisfaction Surveys**

MCO	Sample Size	Completed Surveys	Response Rate
<b>Aetna</b>	1,894	207	10.9%
<b>Sunflower</b>	2,500	315	12.6%
<b>UnitedHealthcare</b>	1,982	35	1.0%

KFMC concluded that the provider satisfaction surveys conducted by the three MCOs were limited in providing results that could be generalizable to their KanCare provider network. The information from the MCOs' survey findings could not be compared to each other due to incomplete methodology information, issues with generalizability of findings, and differences in sample compositions and survey questionnaires. Therefore, the results of the surveys were not included in this summary.

### *Review of Compliance with Medicaid and CHIP Managed Care Regulations*

KFMC reviewed the three MCOs for compliance with federal standards. A comprehensive review is required at least once every three years for each MCO. The comprehensive review for Aetna occurred in 2019 and the subject areas by federal requirement were broken up by topic for Sunflower and UnitedHealthcare between 2019 and 2022. Findings below are limited to the areas reviewed for each year or any areas found non-compliant in a prior review.

- **Aetna, Year 2 Review:** Overall, Aetna was 81% compliant with §438.207 (Assurances of adequate capacity and services), the only regulatory area KFMC reviewed for Aetna in Year 2 (since the comprehensive review for Aetna occurred in 2019).
  - Opportunities for improvement: §438.207(a-b) (Basic rule and Nature of supporting documentation).
- **Sunflower, Year 2 Review:** Overall, Sunflower was 92% compliant with the federal regulatory requirements reviewed for Sunflower in Year 2. Sunflower was 97% compliant with the two regulatory areas reviewed in Subpart D — MCO, PIHP and PAHP Standards and 89% compliant with the seven regulatory areas reviewed in

Subpart F — Grievance and Appeal System.

- Opportunities for improvement: §438.207 (Assurances of adequate capacity and services in Subpart D — MCO, PIHP and PAHP Standards) and §438.424 (Effectuation of reversed appeal resolutions in Subpart F — Grievance and Appeal System).
- **Sunflower, Year 3 Review:** Overall, Sunflower was 95% compliant with federal regulatory requirements reviewed in Year 3. Sunflower was 97% compliant in Subpart C — Enrollee Rights and Protections and 91% compliant in Subpart D — MCO, PIHP and PAHP Standards.
  - Opportunities for improvement: §438.404(a) (Timely and adequate notice of adverse benefit determination – Notice); §438.10 (Information Requirements (Subpart C — Enrollee Rights and Protections))
- **UnitedHealthcare, Year 2 Review:** Overall, UnitedHealthcare was 94% compliant with federal regulatory requirements reviewed for UnitedHealthcare in Year 2.
  - Opportunities for improvement: §438.207 (Assurances of adequate capacity and services in Subpart D — MCO, PIHP and PAHP Standards); §438.406 (Handling of grievances and appeals) in Subpart F — Grievance System.
- **UnitedHealthcare, Year 2 Review:** Overall, UnitedHealthcare was 91% compliant with the federal regulatory requirements reviewed in Year 3.
  - Opportunities for improvement: §438.10 (Information requirements) in Subpart C — Enrollee Rights and Protections.

#### *Quality Assessment and Performance Improvement Review*

A QAPI program is a federal requirement of any Medicaid MCO. The QAPI requires the MCO to describe its quality improvement efforts and how it will measure and maintain quality and access. KFMC's objectives were to review completeness of each MCO's 2021 QAPI design, examine strengths, identify opportunities for improvement, and provide recommendations.

#### **State Contract QAPI Requirements**

KFMC determined that each MCO partially met or did not meet the contract requirement for MCOs to tracking the reason for disenrollment as part of their QAPI. KFMC made the following recommendation — for future QAPI work plans, program descriptions, and evaluations, all three MCOs should include information related to the review, monitoring, tracking, and trending of member disenrollment patterns.

All three MCOs partially met or did not meet the contract requirement for MCOs to review all reports submitted to the State as part of their QAPI. KFMC recommends all MCOs include information related to the MCO's review of all reports submitted to the State in future QAPI work plans, program descriptions, and evaluations.

#### **Annual QAPI Evaluation**

All MCOs fully met all requirements related to Summary of Overall Effectiveness.

KFMC identified the following opportunities for all MCOs related to improving quality, timeliness and access to health care services:

- The MCOs' 2020 QAPI Evaluation did not address all of the activities identified by the MCOs in the 2020 QAPI Program Description and 2020 QAPI Work Plan, including, but not limited to:
  - **Aetna:** Maintain systems for monitoring and tracking practitioner and provider medical recordkeeping practices
  - **Sunflower:** Five interventions that were scheduled for launch in 2020 or results of the PIP for the evaluation year
  - **UnitedHealthcare:** Member notification of continuity of care for specialty care physician (SPC)/PCP termination
- There were opportunities for improvement identified by each MCO in the 2020 QAPI Evaluation that were not addressed in either the 2021 QAPI Program Description or 2021 QAPI Work Plan, including, but not limited to:
  - **Aetna:** Intervention to improve performance:
    - HEDIS manager hired/assigned to Plan
    - Provide further targeted approach to HEDIS measures/activities
  - **Sunflower:** Efforts to promote provider and specialist communication to improve coordination of care
  - **UnitedHealthcare:** Reinforcing/reeducating other departments on the quality of care internal referral mechanism

### *Network Adequacy Validation*

KFMC assessed after-hours availability of a sample of adult and pediatric PCPs to determine, from a member's perspective, the after-hours availability of each provider and the accuracy of provider information that is supplied by the MCOs. Overall, KFMC concluded that many contracted providers may not offer sufficient after-hours availability to members and many issues exist with respect to the quality of responses available to members. Of the eligible records, 159 records (13.1%) were Fully Met, with the caller reaching the intended provider, the on-call provider, or a person who indicated the provider could return a call within one hour. Of the eligible records, 298 records (24.6%) were Not Met and clearly failed meeting study standards for PCP access.

### *Recommendations*

Please see a few of the recommendations highlighted below. For the full list of recommendations, please visit the [report](#).

- HEDIS: MCOs should prioritize improvement efforts towards the following HEDIS measures: metabolic monitoring for children and adolescents on antipsychotics; child and adolescent well-care visits; chlamydia screening in women.
- PIPs: MCOs should follow the analysis plan from the approved PIP methodology; ensure the described analysis results are accurate, clear; and that the interpretations are supported by the presented data.
- CAHPS: MCOs should further review their processes for encouraging providers to assess and respond to members' mental health and emotional health issues, and encouraging members to access mental health or SUD services.
- Provider satisfaction survey: MCOs should ensure data analysis results are

appropriately interpreted:

- Interpret the results within the context of the study population represented by the survey sample.
  - Ensure tables presenting survey results include numerator and denominator counts for each survey question.
  - Conduct non-response analysis.
- QAPI: MCOs should include assessment of all interventions outlined in the QAPI program description and/or QAPI work plan in the annual QAPI evaluation.
  - Network adequacy: MCOs should establish internal processes to review provider information available through multiple data streams to provide the most up-to-date provider information to members (e.g., correct phone, currently practicing providers). MCOs should also work to standardize data fields shared between databases (e.g., provider name and address fields) so providers may be uniquely distinguished.

## **KanCare Program Annual External Quality Review Technical Report — 2020–2021 Reporting Cycle**

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### *ISCA and PMV*

Generally, the KanCare MCOs have improved their HEDIS performance rates over the past three to five years. Rates were above the 75<sup>th</sup> percentile for five Adult and three Child Core Set measure indicators.

The following HEDIS measures improved for KanCare between all three MCOs:

- Adult cervical cancer screening
- Adult comprehensive diabetes care (poor HbA1c control)
- Adult flu vaccinations for adults
- Adult initiation and engagement of alcohol and other drug abuse or dependent treatment (alcohol abuse or dependence, other drug abuse or dependence, total, engagement of AOD – other drug abuse or dependence)
- Adult medical assistance with smoking and tobacco use cessation (advising smokers to quit, discussing cessation medications)
- Child use of first-line psychosocial care for children and adolescents on antipsychotics
- Adolescent well-care visits
- Children and adolescents' access to primary care practitioner
- Childhood immunization status (haemophilus influenza B, hepatitis A, measles-mumps-rubella, pneumococcal conjugate, rotavirus, varicella-zoster virus)
- Immunizations for adolescents (human papillomavirus, meningococcal, tetanus-diphtheria-pertussis, combination 1, combination 2)
- Well-child visits in the first 15 months of life
- Well-child visits in the third, fourth, fifth and sixth years of life
- Child weight assessment and counseling for nutrition and physical activity for

children/adolescents (BMI percentile, counseling for nutrition, counseling for physical activity)

The following HEDIS measures experienced declines for KanCare overall:

- Adult BMI assessment
- Adult controlling high blood pressure
- Childhood immunization status (diphtheria-tetanus-acellular pertussis)

### *Performance Improvement Project Validation*

KFMC uses a numerical rating system for the evaluation of PIP activities to determine a level of overall confidence: High Confidence: 95% to 100%, Confidence: 90% to <95%, Low Confidence: 80% to <90%, and Little Confidence: below 80%. For this reporting cycle, all MCOs implemented one individual PIP and had a collaborative PIP.

- **Aetna:** Increasing influenza vaccination rates for children ages 6 months to 17 years PIP was rated as having Low Confidence (89.7%).
- **Sunflower:** Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications PIP was rated as having High Confidence (99.0%).
- **UnitedHealthcare:** Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications PIP was rated as having High Confidence (96.0%).
- **Collaborative among all MCOs:** Increasing compliance with Human Papillomavirus (HPV) vaccination administration in adolescents PIP was rated as having Confidence (91.2%).

### *CAHPS Survey Validation*

Generally, KanCare and MCO-level survey results are showing that members positively rate their quality, timeliness, and access to health care provided by the MCOs. Overall, global ratings, composite scores and question percentages were at or above the 50<sup>th</sup> percentile. In Table 5 below, the ratings are the percentage responding 8, 9, or 10 out of 10.

**Table 5: Global Rating for KanCare – 2020**

	<b>Adult</b>	<b>General Child</b>	<b>Children with Chronic Conditions</b>
<b>Health Plan</b>	80.1%	89.9%	87.3%
<b>Health Care</b>	78.4%	89.2%	88.1%
<b>Personal Doctor</b>	86.3%	91.2%	90.0%
<b>Specialist</b>	86.3%	87.4%	89.6%

### *Provider Satisfaction Survey Validation*

The three MCOs conducted provider satisfaction surveys in 2020. KFMC conducted a review to validate the methodological soundness of the completed surveys.

KFMC concluded that the surveys conducted by the MCOs were limited in providing results that could be generalized to their Kansas provider network, and the results from the three different surveys could not be compared to each other. Therefore, the results of the surveys are not included in this summary.

### *Review of Compliance with Medicaid and CHIP Managed Care Regulations*

KFMC reviewed the three MCOs for compliance with federal standards. For each of the MCOs, Subpart F – Grievance and Appeal System, had the greatest opportunity for improvement.

- **Aetna** was 71% fully compliant with federal regulatory requirements reviewed for Aetna, including Subpart C – Enrollee Rights and Protections, Subpart D – Quality Assessment and Performance Improvement, Subpart E – Quality Measurement and Improvement, and Subpart F – Grievance and Appeal System.
  - Opportunities for improvement: §438.114 Emergency and Poststabilization Services (Subpart C), §438.214 Provider Selection (Subpart D), §438.224 Confidentiality (Subpart D), §438.228 Grievance Systems (Subpart D), §438.404 Timely and Adequate Notice of Adverse Benefit Determination (Subpart F), §438.406 Handling of Grievances and Appeals (Subpart F), §438.408 Resolution and Notification (Subpart F), and §438.414 Information about Grievance and Appeal System to Providers/Subcontractors (Subpart F).
- **Sunflower** was 83% fully compliant with federal regulatory requirements reviewed for Sunflower, including Subpart D, Subpart E, and Subpart F.
  - Opportunities for improvement: §438.214 Provider Selection (Subpart D) and §438.402 General Requirements (Subpart F).
- **UnitedHealthcare** was 86% fully compliant with federal regulatory requirements.
  - Opportunities for improvement: §438.214 Provider Selection and §438.402 General Requirements (Grievance and Appeal System).

### *Quality Assessment and Performance Improvement Review*

All MCOs fully met all requirements related to Summary of Overall Effectiveness. Among all MCOs, there is a common trend of collaboration across departments to maximize quality assessment and coordination of quality improvement.

However, KFMC did identify a number of opportunities for each MCO. Some of them are highlighted below:

- **Aetna:** The opportunities for improvement identified in the 2019 Evaluation generally connect to the 2020 Program Description and Work plan. However, there were opportunities for improvement identified in the 2019 Evaluation that were not included in either the 2020 Program Description or 2020 Work plan. Examples include:
  - Engage and educate providers regarding authorization request requirements

- Improve quality of communication and coordination between primary care and specialists
- Create incentives for high risk providers regarding notifying Aetna of pregnant members
- Increase awareness of appointment availability standards
- Reconstruct the LTSS service plan to meet State requirements
- **Sunflower:** The opportunities for improvement identified in the 2019 Evaluation generally connect to the 2020 Program Description and Work plan. However, there were opportunities for improvement identified in the 2019 Evaluation that were not included in either the 2020 Program Description or 2020 Work plan. Examples include:
  - Member survey opportunities for improvement
  - Provider survey opportunities for improvement
  - Continuity of care between medical and behavioral health care
  - Appropriate diagnosis, treatment, and referral of behavioral health disorders
  - Treatment access and follow-up for member with coexisting medical and behavioral health disorders
- **UnitedHealthcare:** The opportunities for improvement identified in the 2019 Evaluation generally connect to the 2020 Program Description and Work plan. However, there were opportunities for improvement identified in the 2019 Evaluation that were not included in either the 2020 Program Description or 2020 Work plan.
  - The evaluation reported most of the grievances regarding access issues were related to non-emergent transportation. Neither the Program Description nor the Work plan describes how this opportunity for improvement will be addressed.

### *Network Adequacy Validation*

KFMC completed provider network validation for the three MCOs by assessing member access to PCP after-hours. Some of the objectives of this activity were, but are not limited to:

- Verify the accuracy of the provider phone number sourced from MCO provider directory
- Categorize the call by result (intended/on-call provider, triage/nurse line, answering service, answering machine, other respondent, or no answer)
- Determine whether the provider was practicing and contracted by the MCO at that location

Findings from the study indicated 54% of sampled PCP records (719/1,334) were considered to be fully or substantially meeting KanCare requirements and the study's performance standards. A subset of sampled records (200/1,334; 15%) had minor issues, such as incomplete recordings or respondents unable to tell members when or if a provider could be contacted. Another subset of records (258/1,334; 19%) clearly did not meet requirements. Of those not met, 60% (155/258) were due to poor answering machine recordings, with no or unclear instructions, and 40% (103/258) were where the respondent indicated the provider could not be contacted after hours.

## *Recommendations*

Please see a few of the recommendations highlighted below. For full list of recommendations, please visit the [report](#).

- HEDIS: MCOs should continue efforts to further improve assistance with smoking and tobacco use cessation.
- CAHPS: MCOs should continue to expand their care coordination efforts, particularly for children with chronic conditions, including primary care physicians being informed and up-to-date about the care children receive from other doctors and health providers.
- Provider satisfaction survey: MCOs should ensure generalizability of the survey findings to the intended study population.
- QAPI: All MCOs should include assessment of all interventions outlined in the Program Description and/or Work plan in the annual Evaluation.
- Network adequacy: All MCOs should maintain standardization of data fields that may be shared between databases, such as name, address, and provider specialty fields.

## **KanCare Program Annual External Quality Review Technical Report — 2019-2020 Reporting Cycle**

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The following is a summary of KFMC's external quality review of Aetna, contract effective January 1, 2019, Sunflower and UnitedHealthcare, both contracted since January 2013, and Amerigroup Kansas, Inc. whose contract ended December 21, 2018. Only the final Performance Measure Validation report is reflected in this report for Amerigroup, as all other reports were included in the previous reporting cycle.

### *ISCA and PMV*

KFMC conducted a combined performance measure validation and ISCA of Sunflower and UnitedHealthcare and performed the ISCA for the new MCO, Aetna (contract effective January 1, 2019).

The following conclusions were made:

- MCO information systems are configured to capture complete and accurate data. Each source system utilizes comprehensive edits to ensure fields are populated with valid and reasonable characters. In addition, comprehensive methods exist to ensure data accuracy throughout the data integration process in the areas of claims, encounters, eligibility and enrollment, provider, vendor and ancillary systems. The MCOs use software certified by NCQA to calculate rates for the HEDIS measures.
- Overall, KanCare's 2018 rates for Adult Core Set measures (33 measures) showed five measures ranked above the 75<sup>th</sup> percentile, two measures showed statistically significant improvement from 2017, and 10 measures showed statistically significant trending for improvement since 2014. One of the measures that had a

significant improvement was adult BMI assessment.

- KanCare rates for Adult Core Set measures (33 measures) showed a total of eight measures ranked below the 25<sup>th</sup> percentile. Three measures had five-year average rates of change indicating significant declining performance. One of the measures that had a significant decline from 2017 measures was antidepressant medication management (effective continuation phase treatment).
- KanCare overall 2018 performance for Child Core Set measures (38 measures) showed a total of four measures ranked above the 75<sup>th</sup> percentile, six measures showed statistically significant improvement from 2017. One of the measures that showed significant improvement was asthma medication ratio.
- KanCare overall 2018 performance for Child Core Set measures (38 measures) showed a total of 11 measures ranked below the 25<sup>th</sup> percentile, five measures showed statistically significant declining performance from 2017, and two measures showed statistically significant declining performance since 2014. One of the measures that showed a worsening trend was chlamydia screening in women (16–20).

#### *Performance Improvement Projects Validation*

For this reporting cycle, the following are PIPs that were validated by KFMC. Note that Aetna only participated in the collaborative PIP as that was Aetna's first contract year.

- **Sunflower:** Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications PIP was rated as having Confidence (92.9%).
- **UnitedHealthcare:** Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications PIP was rated as having Confidence (90.0%).
- **Collaborative among all MCOs:** Increasing compliance with Human Papillomavirus (HPV) vaccination administration in adolescents PIP was rated as having Low Confidence (84.7%).

#### *CAHPS Survey Validation*

The 2019 CAHPS surveys were conducted by Sunflower and UnitedHealthcare (not applicable to Aetna as a new MCO). CAHPS survey data for both Sunflower and UnitedHealthcare continue to show a positive trend in member satisfaction with quality, timeliness, and access to health care.

**Table 6: Global Rating for KanCare – 2019**

	Adult	General Child	Children with Chronic Conditions
<b>Health Plan</b>	78.8%	88.4%	85.2%
<b>Health Care</b>	79.0%	87.7%	86.8%
<b>Personal Doctor</b>	84.3%	89.5%	88.7%
<b>Specialist</b>	85.2%	87.8%	88.2%

### *2019 KanCare Consumer Assessment of Healthcare Providers and Systems Home and Community-Based Services (HCBS CAHPS) Survey*

KFMC subcontracted with Vital Research, LLC to conduct a CAHPS Home and Community-Based Services (HCBS) Survey on behalf of KDADS.

The survey objective was to gain member and guardian feedback about the services and supports members across the four waiver programs receive so that Kansas can better understand how well they are serving their clients' needs.

Overall, respondents expressed a high level of satisfaction of the services and supports they received. For example, between 86%–97% of respondents indicated members always received help when needed in getting dressed, taking a shower, or bathing, in getting something to eat when hungry, and in taking their medicine.

### *Provider Survey Validation*

The three MCOs (Aetna, Sunflower, and UnitedHealthcare) conducted provider satisfaction surveys in 2019. KFMC conducted a review to validate the methodological soundness of the completed surveys.

KFMC concluded that the 2019 provider satisfaction surveys conducted by the three MCOs were limited in providing results that could be generalizable to their KanCare provider network and the information from the MCO survey findings could not be compared across MCOs. Therefore, the results of the surveys are not included in this summary.

### *Review of Compliance with Medicaid and CHIP Managed Care Regulations*

For the 2018 review year, KFMC conducted a partial compliance review of Sunflower and UnitedHealth Care (the two contracted MCOs at that time) to evaluate the degree to which recommendations from previous reviews were addressed.

KFMC concluded that Sunflower and UnitedHealthcare continued to work on addressing issues that were found to be less than fully met in previous reviews.

Some of the strengths that were identified by KFMC were:

- Both MCOs are forward-looking, innovative, and have a proactive approach to improvement.
- Throughout the process leading up to and during the follow-up review, both MCOs were organized and responsive.

Some of the opportunities for improvement that KFMC identified for both MCOs were:

- Availability of Services — Delivery Network (§438.206[b][1][iv-v])
- Provider Selection (§438.214[b][2])

### *Quality Assessment and Performance Improvement Assessment*

KFMC's objectives were to review completeness of the MCOs' 2019 QAPI designs, examining strengths, identifying opportunities for improvement, and providing recommendations.

KFMC identified the following conclusions for all three MCOs (Aetna, Sunflower, and UnitedHealthcare):

- Of the 102 total requirements from Section 5.9 (QAPI) of the KanCare 2.0 contract, KFMC identified three requirements that were partially met across all three MCOs:
  - Identifying members enrolled in an LTSS waiver but not receiving any waiver services
  - Telehealth and e-visits
  - Retention of clinical and medical records
- There were two requirements that were not met by Aetna and UnitedHealthcare, and partially met by Sunflower:
  - Education on the peer review process
  - Sampling methodology for HCBS and behavioral health providers for provider satisfaction surveys

### *Recommendations*

Please see a few of the recommendations highlighted below. For a full list of recommendations, please visit the [report](#).

- HEDIS: MCOs should continue and expand their care coordination efforts and enhance service access for adult and child behavioral health services.
- Collaborative PIP: MCOs should include, with their findings, the interpretations and lessons learned regarding comparisons among measurement years and among MCOs.
- CAHPS survey: For the child surveys, each MCO should continue complying with NCQA Children with Chronic Conditions survey protocols to ensure adequate numbers of complete surveys in each subgroup to obtain generalizable results that meet NCQA requirements.
- HCBS CAHPS: Personal assistance/behavioral health staff may benefit from training that specifically addresses arriving to work on time, always treating the members the way they want to be treated, and always listening carefully to members, as those areas received the lowest satisfaction. Improvements in these areas may also further increase overall ratings of staff performance.
- Provider survey: MCOs should include questions with the same language in the survey instrument to provide comparative results to assess how well the MCOs are meeting their providers' expectations and needs, and to identify common and unique strengths and opportunities for improvement across the MCOs.
- Medicaid and CHIP regulations: §438.206(b)(1)(iv) Availability of Services — Delivery Network (Providers not accepting new patients and Network Adequacy):
  - Continue to review and ensure consistency in provider classification, and continue to monitor network adequacy reports for errors.

- Incorporate network adequacy report corrections into the geoaccess report to ensure mapping of access correctly reflects network adequacy.
- QAPI: 5.9.1(G) Mechanisms to identify LTSS Members not receiving any services:
  - Include a description of the process to identify members enrolled in LTSS waivers but not receiving any waiver services.

## V. Finance and Budget Neutrality

### SUD IMD

#### *Overview*

The State is submitting a SUD IMD 1115 demonstration waiver to allow members who are admitted to a SUD IMD for more than 15 days to remain in the KanCare managed care program instead of being moved to the Fee-for-Service (FFS) program. CBIZ Optumas (Optumas) is providing the calculations of the required Budget Neutrality (BN) per member per month (PMPM) amounts that the program will be measured against per CMS requirements of an 1115 waiver. The BN PMPM that this population will be measured against is intended to reflect the PMPM cost of this population in the absence of the SUD IMD 1115 waiver, otherwise known as the Without Waiver (WOW) PMPM. The 1115 demonstration waiver will cover the CY24 to CY28 time period for this population.

#### *Data*

CMS requires the use of recent historic data to develop the projection for this population to be measured against their actual expenditures from CY24 to CY28. Optumas is using monthly enrollment data from CY18 and CY19 for SUD IMD population and the most recent CY22 capitation data. Optumas is selecting to use the average of the CY18 and CY19 enrollment as the most recent snapshot of enrollment mix for the projection to reflect membership mix prior to the COVID-19 pandemic, and specifically the impact of the Federal PHE continuous enrollment policy. Optumas' is applying that to the most recently developed capitation rates for CY22 to reflect recent the most recent policy adjustments for the benefit package for these members. Optumas did adjust the CY22 capitation rates to remove the impact of acuity changes to the population due to the PHE in anticipation of that policy being discontinued prior to CY24. This adjustment is discussed further below.

The enrollment data was provided by KDHE's data vendor from the State's MMIS system, and the capitation data is based on the most recent capitation rates for CY22 that Optumas developed as the State's actuarial vendor. The SUD IMD population used for this analysis was identified using SUD IMD National Provider IDs (NPIs) that are associated with each facility. The members that were admitted to each SUD IMD were analyzed to determine their length of stay for each distinct admission. Any member that was admitted for more than fifteen (15) days is included in the historic enrollment that will be used for the projection.

#### *Methodology*

The historic enrollment by rate cell for the members admitted to a SUD IMD for more than fifteen (15) days was applied to the CY22 capitation rates across all rate cells to calculate an aggregate WOW PMPM. The following adjustments were applied to the historic data to ensure that the WOW PMPM reflect comparable expenses as the actual PMPM during CY24 to CY28.

## **Adjustments**

### **Directed Payments**

KDHE makes multiple directed payments to providers via the KanCare managed care program. There are currently two directed payments, which are paid as a Separate Payment Term (SPT) through KanCare with at least one additional directed payment to be developed in place of the UCC pool. Currently, the SPTs are paid outside of the capitation rates. The directed payments that are being accounted for are the Health Care Access and Improvement Program (HCAIP), and Alternative Payment Methodology (APM). The current directed payments have been approved by CMS for the KanCare program with the new directed payment to be developed in CY23. Adjustments for approved and planned directed payments are included within the current WOW PMPMs.

The portion of these directed payments related to SUD IMD population will ultimately be reflected in the actual expenses for this population for reporting and federal matching purposes, and therefore Optumas is including an adjustment to the historic capitation data to reflect these expenses in the WOW PMPM as well. The impact of these adjustments is a 9.1% increase to the historic capitation data.

### **Acuity**

The CY22 capitation rates used by Optumas reflects the impact of the Federal PHE policy, which has resulted in reduced average PMPM cost due to change in overall acuity of the KanCare population. Optumas anticipates that this policy may end prior to the CY24 to CY28 demonstration period, and would not be appropriate to include in the projection of WOW PMPM expenditures. Therefore, an adjustment has been included to remove the impact of the PHE policy that was included within the CY22 capitation rates. The impact of this adjustments is a 1.4% increase to the aggregate PMPM based on the rate cell mix for SUD IMD members.

### **Projection**

The base period of CY22 is projected forward to each calendar year for the demonstration from CY24 to CY28. The projection factor that will be used will be the President's Budget (PB) Trend once that is available. The PB Trend is not yet available from CMS, so an estimated projection factor of 6.0% is being used for the initial projection. When the actual PB Trend becomes available then Optumas will update the projection.

### *Budget Neutrality Tables*

The final projected WOW PMPMs, along with projected enrollment and total expenditures, are shown below. Please note that enrollment levels may vary in the future due to changes in the Federal PHE continuous enrollment policy.

**Table 7: SUD IMD Without Waiver Projection**

ELIGIBILITY GROUP	Demonstration Years					TOTAL WOW
	DY12 (CY24)	DY13 (CY25)	DY14 (CY26)	DY16 (CY27)	DY16 (CY28)	
<b>SUD IMD</b>						
<b>Total Enrollment</b>	1,545	1,576	1,607	1,639	1,672	<b>8,039</b>
<b>Member months (MMS)</b>	4,439	4,528	4,618	4,711	4,805	<b>23,101</b>
<b>PMPM</b>	\$1,241	\$1,315	\$1,394	\$1,477	\$1,566	<b>\$1,401.81</b>
<b>Total Dollars</b>	\$5,506,668	\$5,953,804	\$6,437,267	\$6,959,968	\$7,525,124	<b>\$32,382,832</b>

### Caretaker Medical Continuous Enrollment

#### Overview

KDHE is also including in their 1115 demonstration expenditure authority to provide 12 months of continuous enrollment for Caretaker Medical Parents. Optumas is providing the calculations of the required BN PMPM amounts that the program will be measured against per CMS requirements of an 1115 waiver. The BN PMPM that this population will be measured against is intended to reflect the PMPM cost of this population in the absence of the 1115 waiver for continuous enrollment, otherwise known as the WOW PMPM. The 1115 demonstration waiver will cover the CY24 to CY28 time period for this population.

#### Data

CMS requires the use of five years of recent historic data to develop the projection for this population to be measured against their actual expenditures from CY24 to CY28. Optumas is using monthly enrollment and capitation payment data from CY16 through CY20 for the Caretaker Medical population projection for the five years of required historic data. This data was provided by KDHE’s data vendor from the State’s MMIS system. The Caretaker Medical population was identified using Population Codes that are assigned to each member each month, which are based on the member’s reason for being eligible for Medicaid benefits, during that time period.

Optumas is selecting to use CY20 as the most recent year for the projection to reflect expenditures prior to the COVID-19 pandemic, as the CY20 capitation rates were developed in the fall of CY19 using CY17-CY18 data prior to the pandemic. Optumas’ approach will ensure that the actual PMPM expenses during the CY24 to CY28 demonstration time period, which are not anticipated to be largely impacted by COVID-19 at this time, will be measured against an appropriate and comparable WOW PMPM.

#### Methodology

The historic enrollment and capitation data was first compiled by calendar year across all rate cells that the members in the Caretaker Medical population were in for the five historic years. The

following adjustments were applied to the historic data to ensure that the WOW PMPM reflect comparable expenses as the actual PMPM during CY24 to CY28.

## **Adjustments**

### **Directed Payments**

KDHE makes multiple directed payments to providers via the KanCare managed care program. There are currently two directed payments, which are paid as a Separate Payment Term (SPT) through KanCare with at least one additional directed payment to be developed in place of the UCC pool. Currently, the SPTs are paid outside of the capitation rates. The directed payments that are being accounted for are the Health Care Access and Improvement Program (HCAIP), and Alternative Payment Methodology (APM). The current directed payments have been approved by CMS with the new directed payment to be developed in CY23. Adjustments for approved and planned directed payments are included within the current WOW PMPMs.

The portion of these directed payments related to Caretaker Medical will ultimately be reflected in the actual expenses for this population for reporting and federal matching purposes, and therefore Optumas is including an adjustment to the historic capitation data to reflect these expenses in the WOW PMPM as well. The impact of these adjustments is a 15.4% increase to the historic capitation data.

### **Avoidable Costs**

The historic capitation data used by Optumas already reflects the impact of the 12 month continuous enrollment policy. Optumas is therefore including an additional adjustment to the historic data to reflect the cost of the population in the absence of this policy. This adjustment is an estimate, as actual data absent this program is not readily available due to the duration this policy has been in effect.

To estimate the impact of the removal of this policy, Optumas compiled a durational analysis which reviewed the PMPM costs for each month of enrollment (first, second, third, etc.). It was observed that the first month of enrollment was much higher cost due to higher inpatient utilization, and the months thereafter were lower cost through the end of the member's enrollment period. It is likely that the first month was higher due to inpatient because member's who are not enrolled in Medicaid may seek Medicaid enrollment if they have an inpatient admission.

The result of this analysis is that if the member was not enrolled continuously for 12 months, but was instead enrolled for a shorter amount of time due to potential change in circumstance that would result in them not being eligible for Medicaid, then the higher cost of the first month of enrollment would be spread across a shorter time period resulting in a higher average PMPM. The impact of this adjustment is a 5% increase to the historic capitation data.

### **Projection**

The final adjusted historic capitation data was used to calculate an annual PMPM, which is the basis for the projection factor calculated via the CMS waiver template. The projection factor is based on the average annual change in PMPM costs over the five years of PMPM data. This calculation is fixed and is not able to be adjusted. The final projection factor is applied to the most recent year of the five years of data, which is CY20. The CY20 data was projected forward to each of the calendar

years covered by this demonstration from CY24 to CY28. The current projection factor is being calculated as 5.8%.

It should be noted that the final projection factor may change, as it is required that the projection factor be the lesser of the average annual change in historic PMPM and the President’s Budget (PB) Trend. The PB Trend is not yet available from CMS. When that becomes available, Optumas will update the projection.

*Budget Neutrality Tables*

The final projected WOW PMPMs, along with projected enrollment and total expenditures, are shown below. Please note that enrollment levels may vary in the future due to changes in the Federal Public Health Emergency (PHE) continuous enrollment policy.

**Table 8: Continuous Enrollment Without Waiver Projection**

ELIGIBILITY GROUP	Demonstration Years					TOTAL WOW
	DY6 (CY24)	DY7 (CY25)	DY8 (CY26)	DY9 (CY27)	DY10 (CY28)	
<b>Caretaker Medical</b>						
<b>Total Enrollment</b>	40,144	40,946	41,765	42,601	43,453	<b>208,909</b>
<b>MMS</b>	481,722	491,357	501,184	511,208	521,432	<b>2,506,903</b>
<b>PMPM</b>	\$792.28	\$838.31	\$887.02	\$938.56	\$993.09	<b>\$891.84</b>
<b>Total Dollars</b>	\$381,658,992	\$411,909,326	\$444,560,183	\$479,799,027	\$517,828,682	<b>\$2,235,756,210</b>

**Budget Neutrality Total**

Table 9 below shows the combined projection of the SUD IMD and Caretaker Medical populations.

**Table 9: Total Without Waiver Projection**

ELIGIBILITY GROUP	Demonstration Years					TOTAL WOW
	DY6 (CY24)	DY7 (CY25)	DY8 (CY26)	DY9 (CY27)	DY10 (CY28)	
<b>All 1115 Populations</b>						
<b>Total Enrollment</b>	41,688	42,522	43,373	44,240	45,125	<b>216,948</b>
<b>MMS</b>	486,161	495,885	505,802	515,918	526,237	<b>2,530,003</b>
<b>PMPM</b>	\$796.37	\$842.66	\$891.65	\$943.48	\$998.32	<b>\$896.50</b>
<b>Total Dollars</b>	\$387,165,661	\$417,863,130	\$450,997,450	\$486,758,996	\$525,353,806	<b>\$2,268,139,042</b>

## VI. Evaluation Outcomes and Design

### Introduction

Per STC 97 for the 1115 demonstration, an independent external evaluator is tasked with evaluating the KanCare demonstration, including data collection and analysis to research, the approved demonstration hypotheses and the development of an interim evaluation report and a final evaluation report.

KDHE contracted with KFMC, as the independent external evaluator. KFMC worked with KDHE to develop a draft evaluation design that was approved by CMS on February 26, 2020. The following parts of this section discuss the draft interim evaluation reports for KanCare 2.0 and the SUD demonstration, followed by preliminary plans to evaluate the impact of the demonstration renewal.

### Evaluation design and key findings to-date

#### *KanCare 2.0*

The original goals of the KanCare demonstration focused on providing integrated and whole-person care, creating health homes, preserving or creating a path to independence, and establishing alternative access models with an emphasis on HCBS. Building on the success of the original KanCare demonstration, the goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by coordinating services and supports for SDOHI in addition to traditional Medicaid/CHIP benefits.

KanCare 2.0 aims to improve integration and coordination of care across the health care spectrum. Services related to social determinants of health include addressing safe housing; food sources; educational, economic, and job opportunities; access to health care services; transportation options; community-based resources in support of community living; and opportunities for recreational and leisure-time activities. Services that address social determinants of independence are tailored to an individual's vision for their life, including areas such as career, community participation and contribution, and social/emotional connections. Strategies to achieve the enhanced goals of KanCare 2.0 include service coordination, the OneCare Kansas (OCK) program, value-based models and purchasing strategies, increasing employment and independent living supports, and telehealth (e.g., telemedicine, telemonitoring, and telementoring) services.

The State's demonstration evaluation will include an assessment of the following hypotheses:

- Value-based models and purchasing strategies will further integrate services and eliminate the current silos between physical health services and behavioral health services, leading to improvements in quality, outcomes, and cost-effectiveness.
- Increasing employment and independent living supports for members who have disabilities or behavioral health conditions, and who are living and working in the community, will increase independence and improve health outcomes.
- Use of telehealth (e.g., telemedicine, telemonitoring, and telementoring) services will enhance access to care for KanCare members living in rural and semi-urban areas. Specifically:
  - Telemedicine will improve access to services such as speech therapy

- Telemonitoring will help members more easily monitor health indicators such as blood pressure or glucose levels, leading to improved outcomes for members who have chronic conditions
- Telementoring can pair rural and semi-urban health care providers with remote specialists to increase the capacity for treatment of chronic, complex conditions

As described above, KanCare experienced improvements across several of the measures reviewed and had at least one measure show improvement in each of the hypotheses analyzed in the draft interim evaluation report. The full draft interim report can be found [KanCare.ks.gov](http://KanCare.ks.gov).

### *SUD Demonstration*

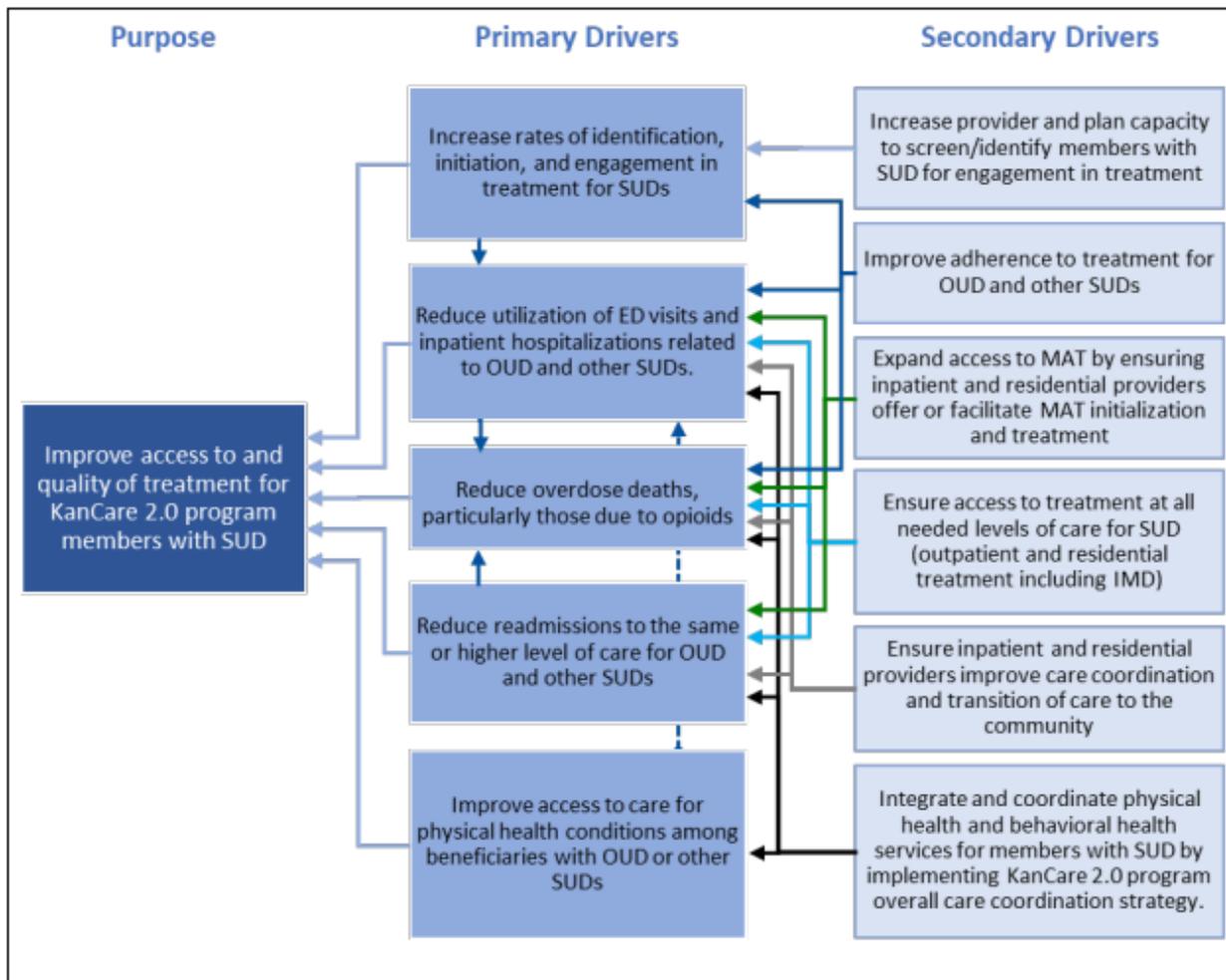
In its renewal application for KanCare 2.0, the State requested and received approval from CMS to provide coverage under KanCare 2.0 for otherwise-covered services provided to Medicaid-eligible individuals aged 21 through 64 who are enrolled in a Medicaid MCO and who are receiving services in a publicly-owned or non-public IMD.

This approval enabled the State to better address OUD and other SUDs and to improve access to high-quality addiction services.

SUD demonstration goals include the following:

1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.
2. Reduced utilization of EDs and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.
3. Reduction in overdose deaths, particularly those due to opioids.
4. Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.
5. Improved access to care for physical health conditions among members with OUD or other SUDs.

**Figure 1: KanCare 2.0 Section 1115 SUD Demonstration Driver Diagram**



The State’s SUD demonstration evaluation will include an assessment of the following hypotheses:

1. The demonstration will increase the percentage of members who are referred and engaged in treatment for SUDs.
2. The demonstration will decrease the rate of ED visits and inpatient hospitalizations related to SUD within the member population.
3. The demonstration will decrease the rate of overdose deaths due to opioids.
4. Among members receiving care for SUD, the demonstration will reduce readmissions to SUD treatment.
5. The demonstration will increase the percentage of members with SUD who access care for physical health conditions.

The interim evaluation showed the following results:

- Goal 1 primary drivers showed demonstrated some improvements to the goal, but rates are still low and further improvement is still needed.

- Goal 2 primary drivers showed some improvements but more effort may be needed to achieve the goal.
- Goal 3 primary drivers showed mixed results with improvements in the rates of use of Opioids at high dosage in persons without cancer, but lacked improvements in overdose death rates.
- Goal 4 primary drivers indicated progress towards reducing preventable admissions.
- Goal 5 primary drivers did not demonstrate evidence of improvements specific to the SUD demonstration, but there were improvements to some of the measures overall.
- Secondary drivers 2, 3, 5, and 6 were shown to contribute to Goals 2 through 5, but there was not enough evidence to demonstrate secondary drivers 1 and 4 helped improve outcomes.

A draft of the interim evaluation for the SUD demonstration can be found at [KanCare.ks.gov](http://KanCare.ks.gov).

*Proposed evaluation hypotheses and methodology for the KanCare renewal*

Because Kansas intends to transition features of KanCare that do not require expenditure authority to more permanent federal authorities, this renewal only requests the following expenditure authorities:

- 12-month continuous eligibility for parents and caretakers
- Continuation of the SUD demonstration including authorization of additional rehabilitation services
- Continuous eligibility for CHIP members who turned 19 during the PHE

The continuation of only these elements will result in the majority of the hypotheses from KanCare 2.0 being discontinued, as they will be evaluated through ongoing quality reviews and evaluation of the QMS. See Table 9 below for a comprehensive list of new and continuing hypotheses, as well as hypotheses set to expire after this demonstration period. As the 12-month continuous eligibility for parents and caretakers has recently been approved and does not have an approved evaluation plan, the hypotheses included in Table 9 are proposed and subject to change during the evaluation design.

Refreshed goals for the continuing 1115 waiver elements include:

- Provide better access to services and reduce ineffective or more costly care
  - Reduce churn or inefficient disenrollment with continuous eligibility for parents/caretakers and CHIP members who turned 19 during the PHE
  - Improve access to appropriate SUD services including:
    - Increase rates of identification, initiation, and engagement in treatment for OUD and other SUDs.
    - Reduce utilization of EDs and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.
    - Reduce overdose deaths, particularly those due to opioids.
    - Reduce readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.
    - Improve access to care for physical health conditions among members with OUD or other SUDs.

**Table 10: KanCare Renewal and SUD Demonstration Hypotheses**

<b>Hypothesis</b>	<b>Methodology</b>	<b>Data Sources</b>	<b>New or Continuing</b>
<b>12-month continuous eligibility for parents and caretaker relatives is associated with decreased emergency room visits, and potentially preventable admissions/readmissions.</b>	Analyze reductions in ED visits or potentially preventable admissions/readmissions compared to rates in another state, a control group, or other probability model.	Medicaid eligibility data, managed care enrollment, and encounter and payment data.	New
<b>Extending eligibility for CHIP enrollees who turn 19 during the PHE, and are otherwise ineligible for Medicaid, will provide continued medical assistance to help protect their health, safety, and welfare during the COVID-19 PHE.</b>	Analyze patterns in health and health care before and during the period of extended CHIP coverage to evaluate if continued health care protects the health, safety, and welfare of individuals.	Medicaid eligibility data and managed care enrollment.	Continuing
<b>The demonstration will increase the percentage of members who are referred and engaged in treatment for SUDs.</b>	Analyze and compare referral and treatment penetration compared to a control group or other probability model.	See table 11	Continuing
<b>The demonstration will decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population.</b>	Analyze and compare ED use and inpatient hospitalizations compared to a control group or other probability model.	See table 11	Continuing
<b>The demonstration will decrease the rate of overdose deaths due to opioids.</b>	Analyze and compare overdose death rates compared to a control group or other probability model.	See table 11	Continuing
<b>Among members receiving care for SUD, the demonstration will reduce</b>	Analyze and compare SUD treatment	See table 11	Continuing

Hypothesis	Methodology	Data Sources	New or Continuing
<b>readmissions to SUD treatment.</b>	readmissions compared to a control group or other probability model.		
<b>The demonstration will increase the percentage of members with SUD who access care for physical health conditions.</b>	Analyze and compare claims for physical health conditions compared to a control group or other probability model.	See table 11	Continuing
<b>Value-based models and purchasing strategies will further integrate services and eliminate the current silos between physical health services and behavioral health services, leading to improvements in quality, outcomes, and cost-effectiveness.</b>	N/A	N/A	Discontinued – moved to other authorities
<b>Increasing employment and independent living supports for members who have disabilities or behavioral health conditions, and who are living and working in the community, will increase independence and improve health outcomes.</b>	N/A	N/A	Discontinued – moved to other authorities
<b>Use of telehealth (e.g., telemedicine, telemonitoring, and telementoring) services will enhance access to care for KanCare members living in rural and semi-urban areas. Specifically: a. Telemedicine will improve access to services such as speech therapy. b. Telemonitoring will help members more easily monitor health indicators such as blood pressure or glucose levels,</b>	N/A	N/A	Discontinued – moved to other authorities

Hypothesis	Methodology	Data Sources	New or Continuing
leading to improved outcomes for members who have chronic conditions. c. Telementoring can pair rural and semi-urban health care providers with remote specialists to increase the capacity for treatment of chronic, complex conditions			

**Table 11: Data Sources for Evaluation of the SUD Demonstration**

Data Source	Owner/Steward	Brief Description
Healthcare Effectiveness Data and Information Set (HEDIS)	KanCare MCOs	Member-level detail tables for HEDIS measures submitted by the MCOs.
Managed care administrative data	KanCare MCOs	Administrative overhead, contractual, and other costs unique to the SUD demonstration.
Managed care case management data	KanCare MCOs	Member-level data maintained by MCOs within their specific case management data systems.
Medicaid Managed Information System (MMIS) encounter data	KanCare MCOs	Encounter/claims data submitted to the State by MCOs used to support HEDIS® and HEDIS®-like performance, Medication-Assisted Treatment, service utilization, and cost metrics for all enrollees.
Member survey data	KanCare MCOs	Member responses to questions within MCO-fielded SUD surveys. Survey objectives and questions to be determined.
Medicaid eligibility and enrollment files (“834 files”)	State of Kansas	Eligibility and enrollment detail for KanCare members used to determine enrollee aid category and stratify data into subgroups.
Mortality data	State of Kansas	Public health birth, death and other vital records used to track overdose deaths attributed to Kansas residents.
State administrative data	State of Kansas	Administrative overhead, contractual, and other costs unique to the SUD demonstration.
Key informant/focus group responses	TBD	Feedback resulting from key informant interviews and/or focus group sessions. Qualitative topics, objectives, and participants/settings to be determined.

## **Plan for evaluation for the KanCare renewal**

### *Who will conduct the evaluation*

KDHE will continue the contract with KFMC to conduct the evaluation of the KanCare 1115 waiver, at the level of detail needed to research the approved hypotheses. KFMC will conduct the demonstration evaluation in an independent manner in accord with the forthcoming draft evaluation design, to be developed and submitted to CMS after the renewal is approved.

KFMC has over 45 years of demonstrated success in carrying out both federal and State health care quality related contracts. They have provided health care quality improvement, program evaluation and review including the following:

- Kansas Medicaid Managed Care EQRO since 1995 (27 years).
- CMS quality improvement organization (QIO) or QIO-Like entity since 1982 (40 years).
- Utilization Review/Independent Review Organization for the Kansas Insurance Department since 2000 (22 years) and for five other states.

### *Timeline for evaluation design*

KDHE will partner with KDADS and KFMC to develop a draft evaluation design, to be submitted to CMS on or before the deadline noted in the finalized extension STCs. Data collection and analysis will begin shortly thereafter, in anticipation of the interim and final evaluation deliverable due dates during and after the extension period.

## **VII. Public Notice**

Reserved for documentation of compliance with the public notice requirements per 42 CFR §431.408 and §431.420(c).

## **Attachment A. KanCare Interim Evaluation**

[See following page.]



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Topeka, Kansas 66612  
Phone 785-273-2552  
Fax: 785-273-0237  
[www.kfmc.org](http://www.kfmc.org)



October 20, 2022

Shirley Norris  
Director of Managed Care  
KDHE Kansas Department of Health & Environment  
Division of Health Care Finance  
900 SW Jackson St., Room 900  
Topeka, KS 66612

RE: Evaluation of the State of Kansas Medicaid Section 1115(a) Demonstration – KanCare 2.0 Interim Evaluation Report – Final

Dear Ms. Norris:

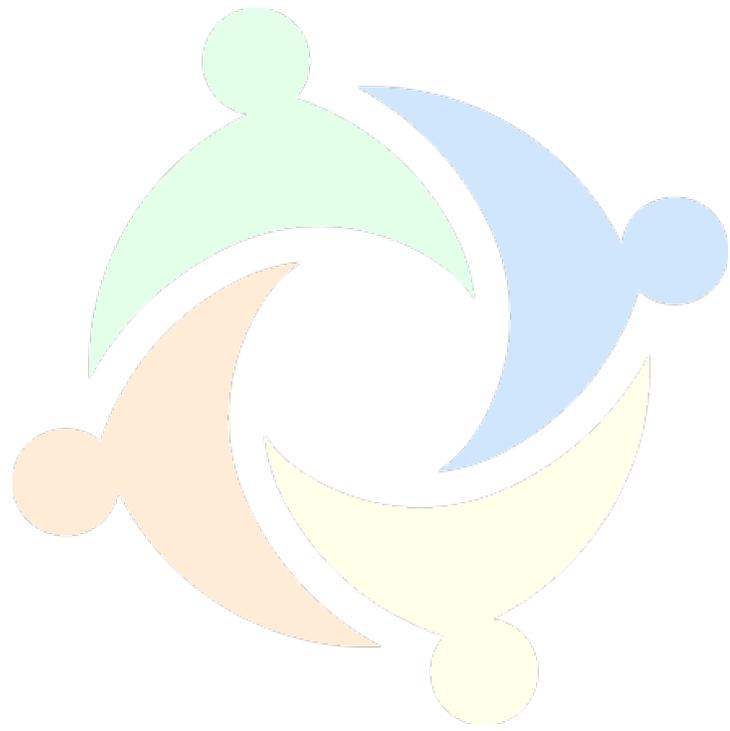
Enclosed is KFMC's final State of Kansas Medicaid Section 1115(a) Demonstration – KanCare 2.0 Interim Evaluation Report. Please contact me, [bnech@kfmc.org](mailto:bnech@kfmc.org), if you have any questions or concerns.

Sincerely,

Beth Nech, MA  
EQRO Manager

Electronic Version: Ryan Gonzales, EQR Audit Manager/Supervisor, KDHE

Enclosure(s)



# ***KanCare 2.0 Interim Evaluation Report***

## ***Evaluation of the State of Kansas Medicaid***

### ***Section 1115(a) Demonstration***

#### ***Reporting Period – January 2019 – September 2022***

**Contract Number:** 46100

**Final Submission Date:** October 20, 2022

**Review Team:**

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Prepared for:



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***KanCare 2.0 Interim Evaluation Report  
Evaluation of the State of Kansas Medicaid Section 1115(a)  
Demonstration – KanCare 2.0  
January 2019 – September 2022  
Final Submission Date: October 20, 2022***

***Executive Summary***

**KanCare 2.0 Demonstration Overview**

KanCare, the Kansas statewide mandatory Medicaid managed care program, was implemented January 1, 2013, under authority of a waiver through Section 1115 of the Social Security Act. The initial demonstration was approved for five years, with a subsequent one year extension. CMS approved the demonstration renewal titled, “KanCare 2.0” for the period of January 1, 2019, through December 31, 2023.

KanCare is operating concurrently with the State’s Section 1915(c) Home and Community Based Services (HCBS) waivers, and together they provide the authority necessary for the State to require enrollment of almost all Medicaid members (including the aging, people with disabilities, and some individuals who are dually eligible).

The original goals of the KanCare demonstration focused on providing integrated and whole-person care, creating health homes, preserving or creating a path to independence, and establishing alternative access models with an emphasis on home and community-based services. Building on the success of the previous KanCare demonstration, the goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid and Children’s Health Insurance Program (CHIP) benefits. KanCare 2.0 aims to improve integration and coordination of care across the healthcare spectrum. Services related to social determinants of health include addressing safe housing; food sources; educational, economic, and job opportunities; access to health care services; transportation options; community-based resources in support of community living; and opportunities for recreational and leisure-time activities. Services that address social determinants of independence are tailored to an individual’s vision for their life, including areas such as career, community participation and contribution, and social/emotional connections. Strategies to achieve the enhanced goals of KanCare 2.0 include service coordination, the OneCare Kansas (OCK) program, value-based models and purchasing strategies, increasing employment and independent living supports, and telehealth (i.e., telemedicine, telemonitoring, and telementoring) services.

KanCare 2.0 expands upon care coordination to provide service coordination, which is a comprehensive, holistic, integrated approach to person centered care. It allows for maximum access to supports by coordinating and monitoring all of an individual’s care (acute, behavioral health, and Long Term Services and Supports [LTSS]) through direct interventions, provider referrals, and linkages to community

resources. Case management, disease management, discharge planning, and transition planning are also elements of service coordination.

KDHE-DHCF developed the OneCare Kansas (OCK) program that is “offered to KanCare 2.0 members with chronic conditions and is designed to apply a comprehensive and intense method of care coordination that integrates and coordinates all services and supports to treat the ‘whole person’ across the life span.” The focus is on members with certain chronic conditions involving mental health and asthma. Eligible members are invited to opt-in to the program. Care coordination is provided by OCK Partners (OCKPs), who are KanCare providers throughout Kansas that contracted to be OCKPs.

Value-based models and purchasing strategies include provider payment and/or innovative delivery system design methods between MCOs and their contracted providers, as well as the pay-for-performance (P4P) program between the State and contracted MCOs.

KanCare 2.0 includes telehealth solutions in designing, establishing, and maintaining provider networks and expanding the use and effectiveness of telehealth strategies, including telemedicine, telemonitoring, and telementoring, with a focus on enhancing access to services.

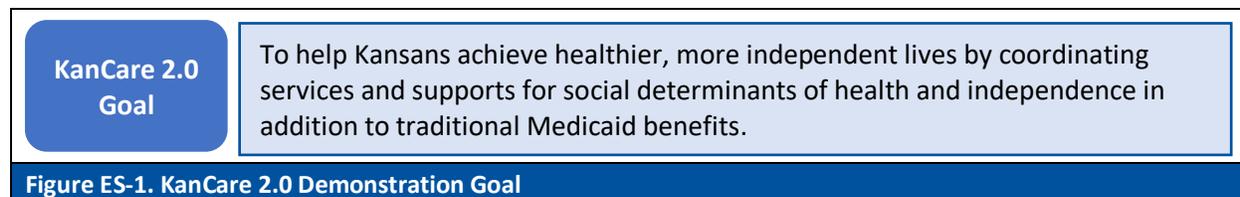
It must be highlighted, much of the interim evaluation measurement period overlapped with the COVID-19 public health emergency (PHE). KanCare 2.0 activities were drastically affected during the onset of the PHE (pandemic). Initially, the MCOs were instructed to pause many activities with members and providers in order to address the public health emergency. For instance, completion of Health Screening Tools (HSTs) was briefly waived. Some changes continued throughout the interim evaluation time period. For example:

- The State obtained an HCBS waiver amendment from CMS, effective January 27, 2020. This amendment remains effective through six months after the end of the public health emergency; the end date is yet to be determined. A couple elements of the amendment that could more directly impact this evaluation of service coordination included
  - suspending the requirement for an HCBS waiver participant to use at least one service every 30 days;
  - allowing telephonic services for case management and monthly monitoring;
  - allowing an extension for reassessments and reevaluations for up to one year past the due date; and,
  - allowing the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
- In March 2020 a State moratorium on member face to face visits was implemented, and the MCOs and members needed to re-adjust to telephonic or tele-video visits. The moratorium was lifted in April 2021, with judgement allowed related to the particular case or need, while there were some continued limitations on in-person group meetings (e.g., wrap-around team meetings) and nursing home visits. Through at least January 2022, there was variation in the MCOs’ and members’ resumption of face-to-face visits, due to continued fluctuations in COVID-19 rates.

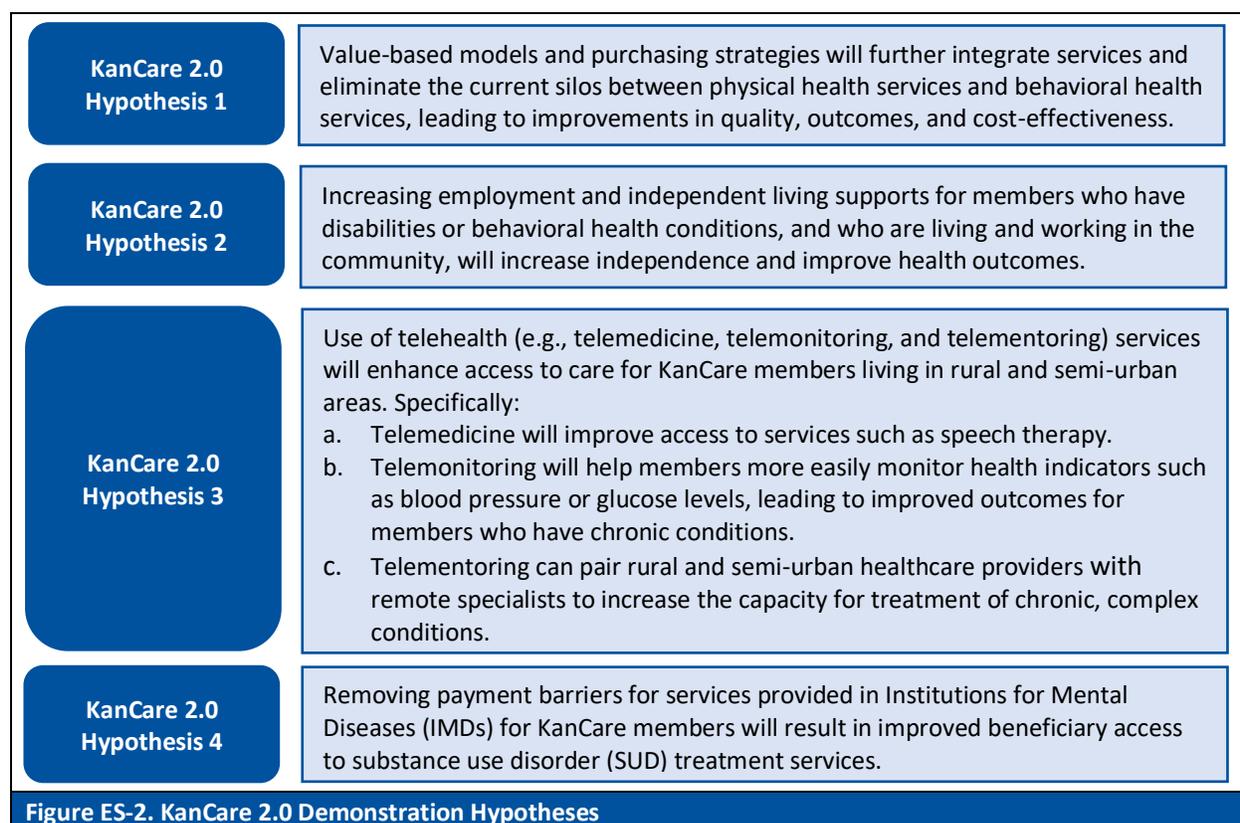
Furthermore, the pandemic affected the overall utilization of health care services throughout the state. It is not yet known how much the COVID-19 pandemic will influence the impact of the KanCare 2.0 program overall. It will take more years to assess the impact of the KanCare 2.0 program outside of the context of the pandemic. Thus, the results presented here should be interpreted with strong caution.

## KanCare 2.0 Demonstration Goal and Hypotheses

The KanCare 2.0 demonstration goal is described in Figure ES-1.



The four hypotheses of the KanCare 2.0 demonstration are described in Figures ES-2.



## Interim Evaluation of KanCare 2.0 Demonstration

In accordance with the CMS guidelines, the KanCare 2.0 evaluation design for the period of January 1, 2019, through December 31, 2023, was submitted for CMS approval. An updated evaluation design as per CMS guidance and feedback was approved by CMS on February 19, 2020.

KFMC Health Improvement Partners (KFMC), under contract with the Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF), serves as the External Quality Review Organization (EQRO) for KanCare. As the EQRO, KFMC is conducting the required KanCare 2.0 evaluation, and has prepared this interim evaluation report to reflect evaluation progress and present findings to date. Measurement data are provided, as available, for the time period of January 1, 2019,

through December 31, 2021, while updates and qualitative data are provided for the time period through September 30, 2022.

### **KanCare 2.0 Demonstration Evaluation Questions**

The evaluation questions were developed in alignment with the demonstration’s goal and four hypotheses (Figure ES-3).

<b>Overall Care Coordination Among KanCare 2.0 Members</b>	<ol style="list-style-type: none"> <li>1. Did the Service Coordination Strategy of integrating physical and behavioral health services provided to KanCare members improve quality of care, health and cost outcomes?</li> <li>2. Did the OneCare Kansas program that implements comprehensive and intense method of care coordination improve the quality of care, health and cost outcomes?</li> </ol>
<b>KanCare 2.0 Hypothesis 1</b>	<ol style="list-style-type: none"> <li>1. Did the Value-Based Provider Incentive Program increase integration and reduce silos between physical and behavioral health services provided to KanCare members?</li> <li>2. Did the Value-Based Provider Incentive Program for integration between physical and behavioral health services improve quality of care, health, and cost outcomes?</li> </ol>
<b>KanCare 2.0 Hypothesis 2</b>	<ol style="list-style-type: none"> <li>1. Did provision of supports for employment and independent living to the KanCare 2.0 members with disabilities and behavioral health conditions who are living in the community improve their independence and health outcomes?</li> </ol>
<b>KanCare 2.0 Hypothesis 3</b>	<ol style="list-style-type: none"> <li>1. Did use of telemedicine services increase over the five-year period for KanCare members living in rural or semi-urban areas?</li> <li>2. Did use of the tele-monitoring services increase over the five-year period for KanCare members with chronic conditions living in rural or semi-urban areas?</li> <li>3. Evaluation question related to telementoring: Data sources for describing the baseline and five-year status of the use of telementoring to pair rural and semi-urban healthcare providers with remote specialists are currently not known; therefore, the related evaluation question and design will be developed later.</li> <li>4. Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?</li> </ol>
<b>KanCare 2.0 Hypothesis 4</b>	<ol style="list-style-type: none"> <li>1. Did removing payment barriers for services provided in IMDs for KanCare members improve members’ access to substance use disorder (SUD) treatment services. (As per CMS guidance, evaluation of Hypothesis 4 was conducted as a part of the SUD Demonstration Evaluation).</li> </ol>

**Figure ES-3. KanCare 2.0 Demonstration Evaluation Questions**

### **KanCare 2.0 Demonstration Interim Evaluation Results**

The interim evaluation included the assessment of performance measures for the KanCare 2.0 Service Coordination Strategy, OCK program, Hypothesis 3, and the monitoring of overall KanCare 2.0 performance measure during 2019–2021.

The performance outcome data are not currently available for the evaluation of KanCare 2.0 Hypothesis 1 and Hypothesis 2. Therefore, the evaluation of these hypotheses will be conducted as part of the summative evaluation of KanCare 2.0.

Per CMS recommendation, KanCare 2.0 Hypothesis 4 evaluation results are included as a part of a separate report prepared for the evaluation of KanCare 2.0 Section 1115 Substance Use Disorder (SUD) Demonstration.

As noted earlier, the interim evaluation includes the time period that encompasses the onset and continuation of the COVID-19 public health emergency (PHE). The PHE was a very strong confounding variable that impacted almost all aspects of the evaluation. As an emergency measure, disenrollment from KanCare was suspended for many members who would otherwise have become ineligible for benefits (e.g., CHIP members turning 19 years old and 60 days after delivery for women receiving benefits due to pregnancy). Consequently, the number of KanCare members increased in 2020 and 2021 (impacting utilization rates) and the homogeneity of the population changed (impacting statewide outcome measures). Also, many types of health care utilization decreased during this time period due to stay-at-home and isolation processes, while telehealth for applicable services was implemented statewide.

Thus, the results presented here should be interpreted with caution. Where feasible, adjustments were made to the analytic plans to account for the pandemic's impact on measurement outcomes. The data and analytic results for 2022 and 2023 may provide a better assessment of the impact of KanCare 2.0 efforts.

#### **a. Evaluation of the KanCare 2.0 Service Coordination Strategy**

To examine whether the Service Coordination Strategy of integrating physical and behavioral health services provided to KanCare members improves quality of care, and health and cost outcomes, the evaluation methodology included assessment of the performance measures in the following comparison populations.

- **Intervention Group:** Members who had a Health Risk Assessment (HRA) and Person Centered Service Plan (PCSP) during 2019 to 2021
- **Comparison Group 1:** Intervention Group members from 2016 to 2018 (pre-intervention period).
- **Comparison Group 2:**
  - Members who had a Health Screen Assessment (HSA) that met an HRA threshold and received traditional care (i.e., did not receive a PCSP).
  - Members who had an HSA total score from 18 to 22 and did not meet an HRA threshold and received traditional care.

Under the assumption that the pandemic and other external influences would equally impact rates for intervention and comparison groups, better relative improvements for the intervention group than for the comparison group would support the assertion that the service coordination strategy was effective. However, as previously noted, the COVID-19 pandemic impeded the MCOs' abilities to fully administer the service coordination strategy as designed, for much of the intervention period. While data is provided for the service coordination evaluation measures, conclusions regarding the effectiveness of the strategy are not possible at this time. The performance measures examined are listed in Figure ES-4.

<b>Measure 1</b>	Adults’ Adults’ Access to Preventive/Ambulatory Health Services (AAP)
<b>Measure 2</b>	Annual Dental Visit (ADV)
<b>Measure 3</b>	Adolescent Well-Care Visit (AWC)
<b>Measure 4</b>	ED Visits, Observation Stays, or Inpatient Admissions for Diabetic Ketoacidosis/ Hyperglycemia, Acute Severe Asthma, Hypertensive Crisis, Fall Injuries, SUD, or Mental Health Issues
<b>Measure 5</b>	Outpatient or Professional Claims for Diabetic Retinopathy, Influenza, Pneumonia or Shingles
<b>Measure 6</b>	Emergency Department Visits (Overall)

**Figure ES-4. Performance Outcome Measures KanCare 2.0 Service Coordination Strategy Evaluation**

Since all HCBS waiver participants are eligible for service coordination, they represent a higher percentage of members participating in service coordination than non-HCBS participants. Examples of non-HCBS participants in service coordination may include members with behavioral health needs or complex/chronic conditions, members in nursing or residential facilities, hospitals or members in foster care. The ratio of HCBS waiver participants to non-HCBS participants was different between the intervention and control groups: 82% of the 23,807 members in the Intervention Group were members receiving HCBS services compared to 26% of the 26,712 members in Control Group 2. Of the 4,366 non-HCBS recipients in the Intervention Group, 77% were from one MCO; the reason for this difference is unknown.

A lack of standardization of the HST, HRA, Needs Assessment and PCSP variable fields, in the datasets provided by the MCOs, created limitations in compiling the Intervention and Comparison Groups needed for the interim evaluation measurement period. Through a contract amendment, the HST and HRA have been standardized, with implementation of the standardized tools occurring in early 2022.

*Key Results and Conclusions*

- Assessment results support the assertion that KanCare 2.0 Service Coordination Strategy had a positive impact on rates of the following measure:
  - Outpatient or Professional Claims (for diabetic retinopathy, influenza, pneumonia or shingles)
- While improvements were not seen in the other measures, no conclusions can be determined due to the changes in healthcare utilization during the pandemic.
- The MCOs’ challenges in implementing the strategy as intended (e.g., contacting members, completing screenings and needs assessments) and the impacts of the COVID-19 pandemic must be considered before judging the success or failure of the strategy.

**Figure ES-5. Key Conclusions from KanCare 2.0 Service Coordination Strategy Evaluation Results**

The main findings related to the outcome measures are summarized below:

- The results for one measure (Outpatient or Professional Claims, for diabetic retinopathy, influenza, pneumonia or shingles) supports the assertion that the KanCare 2.0 Service Coordination Strategy had a positive impact on its rates. It should be noted, instead of improving, this measure's rates increased for both the Intervention Group and Comparison Group 2. Since the Intervention Group's rates changed less, relative to Comparison Group 2, the Intervention Group's performance was deemed better under the circumstances.
- The 2019–2021 rates for ED Visits, Observation Stays, or Inpatient Admissions (for diabetic ketoacidosis/hyperglycemia, acute severe asthma, hypertensive crisis, fall injuries, SUD, or mental health issues), Annual Dental Visits, and Adolescent Well-Care Visits, worsened for both groups from 2016–2018, with the Intervention Group having poorer performance than Comparison Group 2.
- The relative improvements in both groups were about the same for the Access to Preventive/ Ambulatory Health Services and Emergency Department Visits (overall) measures.

#### *Opportunities for Improvement*

- It was not clear from the MCOs' data whether all members eligible for participation in the Service Coordination Strategy received an HRA and Needs Assessment, along with a PCSP if applicable.

#### *Recommendations*

- As the State completes the PHE winding down period, review and improve the steps applied by the three MCOs to ensure all members eligible for participation in the Service Coordination Strategy receive an HRA and Needs Assessment, along with a PCSP and coordinated care, as appropriate during the remaining years of the KanCare 2.0 demonstration. Application of the Service Coordination Strategy to all eligible members will assist in achieving its impact on the performance outcomes.

## **b. Evaluation of the OneCare Kansas Program**

### Quantitative Evaluation of OCK Program

KDHE-DHCF developed the OneCare Kansas (OCK) program that is offered to KanCare 2.0 members with chronic conditions and is designed to apply a comprehensive and intense method of care coordination that integrates and coordinates all services and supports to treat the 'whole person' across the life span. The focus is on members with certain chronic conditions involving mental health and asthma. Initially, eligibility was limited to members diagnosed with Severe Bipolar Disorder, Paranoid Schizophrenia, or Asthma (plus one other qualifying health condition). Effective April 1, 2021, qualifying diagnoses were expanded to additional severe mental illnesses and/or expanded types of asthma which increased the eligible population. Eligible members are invited to opt-in to the program. Care coordination is provided by contracted providers, OCK Partners (OCKPs), including primarily Community Mental Health Centers, as well as Federally Qualified Health Centers, individual primary care practices, providers who serve individuals with developmental disabilities, and other community-based mental health providers (CBMH). As of April 1, 2022, OCK had 3,272 enrolled members.

To examine whether the OCK program (that implements comprehensive and an intense method of care coordination) improves the quality of care, health and cost outcomes, the evaluation assessment of the performance outcome measures in the following comparison populations.

- **Intervention Group** – KanCare 2.0 members eligible for participation in OCK who were enrolled in

the program for at least 3 months of the measurement year (2020 and 2021).

- **Comparison Group 1** – Members of Intervention Group with their outcome data abstracted for the pre-intervention period (2016–2019).
- **Comparison Group 2** – KanCare 2.0 members who met OCK eligibility criteria based on MMIS encounter data but did not enter into OCK and received traditional care (2020–2021).

Under the assumption that the pandemic and other external influences would equally impact rates for intervention and comparison groups, better relative improvements for the intervention group than for the comparison group would support the assertion that the program was effective. However, the COVID-19 pandemic presented challenges for the MCOs’ and OCKPs’ implementation and ongoing administration of OCK, for much of the intervention period. While data is provided for the OCK evaluation measures, conclusions regarding the effectiveness of the strategy are not possible at this time.

The performance outcome measures examined are listed in Figure ES-6.

<b>Measure 1</b>	Adults’ Access to Preventive/Ambulatory Health Services (AAP)
<b>Measure 2</b>	Annual Dental Visit (ADV)
<b>Measure 3</b>	Adolescent Well-Care Visit (AWC)
<b>Measure 4</b>	ED Visits, Observation Stays, or Inpatient Admissions for Diabetic Ketoacidosis/ Hyperglycemia, Acute Severe Asthma, Hypertensive Crisis, Fall Injuries, SUD, or Mental Health Issues
<b>Measure 5</b>	Outpatient or Professional Claims for Diabetic Retinopathy, Influenza, Pneumonia or Shingles
<b>Measure 6</b>	Emergency Department Visits (Overall)

**Figure ES-6. Performance Outcome Measures for OCK Program Evaluation**

### *Key Results and Conclusions*

<ul style="list-style-type: none"> <li>• Results support the assertion that OCK had a positive impact on rates of the following measures: <ul style="list-style-type: none"> <li>○ Adults’ Access to Preventive/Ambulatory Health Services</li> <li>○ Adolescent Well-Care Visits</li> <li>○ Annual Dental Visit – had a positive impact on Annual Dental Visits rates, but less definitively.</li> </ul> </li> <li>• There is potential for the other measures to improve during the remainder of the demonstration, as multiple measures showed relative improvements but were not statistically significant.</li> <li>• While data is provided for the OCK evaluation measures, conclusions regarding the effectiveness of the strategy is not possible at this time.</li> </ul>
---

**Figure ES-7. Key Conclusions from OneCare Kansas Program Evaluation Results**

### Qualitative Evaluation of OCK Program

Information from the OCK Learning Collaborative meetings summary reports from April 2020 through March 2022 was abstracted for qualitative evaluation. Information was also abstracted from the OCK Program’s June 2021 online survey of OCK partners (OCKPs), six regional virtual meetings with OCKPs in

July 2021, and a virtual polling session in March 2022. The six items examined are listed in Figure ES-8.

<b>Item 1</b>	Learning needs identified and discussed by the OCK Learning Collaborative participants
<b>Item 2</b>	Factors that facilitated the OCK implementation to achieve its goals, April 2020–March 2022
<b>Item 3</b>	Barriers/challenges seen in the implementation of the OCK program
<b>Item 4</b>	Observations related to the OneCare Kansas program success in achieving its goals
<b>Item 5</b>	Assistance needed by the OCK Partners from Partners’ Network and State/MCO Implementation Team to assure quality services
<b>Item 6</b>	Recommendations and Potential Next Steps for the OCK program

**Figure ES-8. Qualitative Items for OneCare Kansas Program Evaluation**

*Key Results and Conclusions*

- Identified key factors that facilitated OCK implementation include the availability of program information, resources, and trainings; staffing strategies and support; collaboration among OCK partners; collaboration with community and provider entities; and diagnostic code expansion.
- Key themes of identified barriers and challenges in OCK implementation included
  - Issues with program structure, including labor and time-intensive processes and unclear expectations
  - Access to member information, financial concerns, member enrollment, roster and engagement, opt-in/opt-out process, collaborations with partners/providers, staffing, and access to care in rural areas
- Key observations regarding OCK program successes included the following:
  - Improved care coordination
  - Improved support of members and increase in member trust and engagement
  - Increased partner collaboration
  - Sharing information about the program with community partners
- One learning need theme, identified by Learning Collaborative participants, that did not appear to be addressed pertained to trainings on OCK focused conditions, such as asthma, behavioral health, motivational interviewing and health literacy.
- OCK partners emphasized a need of continued peer learning and support for program implementation, sharing guidance and strategies to address barriers/challenges.
- OCK partners made the following key recommendations and suggestions for potential next steps.
  - Increase access to medical care among non-compliant patients by allowing initial in-person appointment and virtual appointments for follow-up visits.
  - OCKPs across the state could build their professional networks and provide mutual support outside of the formal opportunities offered by the State.
  - Development and use of the provider directory to assist in communication and collaboration across the network of OCK partners.
  - Improve program processes and systems.

- Develop connections with local foster care contractors, child placing agencies, local hospitals, and emergency departments.
- Identification of the opportunities to obtain hospital data and provision of organizational data.

#### *Opportunities for Improvement*

- Review of the MCOs' data files indicated the MCOs' processes to determine members' OCK eligibility, per the State's criteria, had some variability. Differences were also seen between KFMC's identification of eligible members from encounters (using the State's OCK program eligibility criteria), and the dataset provided by one of the MCOs, with KFMC identifying more eligible members.
- Potential unmet OCK partners' learning needs include topics specific to working with OCK members, such as asthma, behavioral health, motivational interviewing, and health literacy.

#### *Recommendations*

- Ensure standardization of the MCOs' processes to determine members' eligibility for the OCK program, per the State's criteria.
- Determine OCK partners' continued learning needs specific to working with OCK members and their diagnoses, and provide related Learning Collaborative training or other resources.

#### **c. Evaluation of KanCare 2.0 Hypothesis 1 – MCOs' Value-Based Provider Incentive Programs**

Each of the three MCOs designed a value-based provider incentive program (VBPs) to address KanCare 2.0 Hypothesis 1:

- Aetna VBP – CARE and CARE+ Programs with Community Mental Health Centers.
- Sunflower Health Plan VBP – Behavioral Health Project.
- UnitedHealthcare VBP – Pediatric Care Network Project.

The three MCOs are in the process of initiating their VBPs. Therefore, data are not currently available from these projects. The evaluation of Hypothesis 1 will be conducted as a part of summative evaluation of KanCare 2.0.

#### **d. Evaluation of KanCare 2.0 Hypothesis – Employment and Independent Living Supports for KanCare 2.0 Members With Disabilities**

Outcome measures data for the evaluation of Hypothesis 2 were not collected by two MCOs as a part of their Health Risk Assessment (HRA) tool. In 2021, the State and MCOs revised the HST to include the questions required for data collection of the Hypothesis 2 evaluation measures. The HST was then incorporated by each MCO into their health assessment processes, and each of the MCOs started using this standardized HST for all members in 2022 (Sunflower Health Plan started in January 2022, UnitedHealthcare started in March 2022, and Aetna started in May 2022). As the standardized HST was not fully implemented until May 2022, data for Hypothesis 2 outcome measures are not currently available. The evaluation of Hypothesis 2 will be conducted as a part of the summative evaluation of KanCare 2.0.

#### **e. Evaluation of KanCare 2.0 Hypothesis 3 – Use of Telehealth Services**

The evaluation of Hypothesis 3, comprised of quantitative and qualitative components, examined whether the use of telehealth services (telemedicine, telemonitoring, and telementoring) enhanced access to care for KanCare members living in rural and semi-urban areas.

- **Telemedicine:** connecting participating providers with members at distant sites for purposes of evaluation, diagnosis, and treatment through two-way, real time interactive communication.
- **Telemonitoring:** technologies that measure health indicators of patients in their homes and transmit the data to an overseeing Provider.
- **Telementoring:** technologies to connect community providers with specialists for consultations, grand rounds, education, and to fully extend the range of care available within a community practice.

**Quantitative Evaluation of KanCare 2.0 Hypothesis 3**

The use of telemedicine services and use of telemonitoring services were examined for the period of January 2018 through December 2021, with cross-year comparisons. The members who received telehealth strategies (telemedicine and telemonitoring strategies) constituted the Intervention Group. The evaluation measures regarding telemedicine services are listed in Figure ES-9.

<b>Measure 1</b>	Percentage of telemedicine services received by the members living in the rural or semi-urban (Non-Urban) areas
<b>Measure 2</b>	Number of receiving sites for telemedicine services in the rural and semi-urban (Non-Urban) areas
<b>Measure 3</b>	Percentage of members living in the rural or semi-urban areas (Non-Urban) who received telemedicine services
<b>Measure 4 &amp; Measure 5</b>	Speech Therapy Analysis; Individual Psychotherapy Analysis; Family and Group Psychotherapy Analysis; and Community Psychiatric Supportive Treatment Analysis: <ul style="list-style-type: none"> <li>• Measure 4: Number of paid claims with selected procedure codes</li> <li>• Measure 5: Number of members with selected diagnosis per 1,000 members</li> <li>• Percentage of KanCare members receiving speech therapy who had a diagnosis in category F80</li> <li>• Percentage of KanCare members with diagnosis in category F80 who received speech therapy</li> <li>• Percentage of KanCare members receiving individual psychotherapy who had an indicating diagnosis</li> <li>• Percentage of KanCare members with an indicating diagnosis who received individual psychotherapy</li> <li>• Percentage of KanCare members receiving family or group psychotherapy who had an indicating diagnosis</li> <li>• Percentage of KanCare members with an indicating diagnosis who received family or group psychotherapy</li> <li>• Percentage of KanCare members receiving community psychiatric supportive treatment</li> </ul>

**Figure ES-9. Performance Outcome Measures for the Evaluation of Use of Telemedicine Services**

The evaluation measures regarding telemonitoring are listed in Figure ES-10.

<b>Measure 1</b>	Percentage of members living in the rural and semi-urban (Non-Urban) areas who received telemonitoring services
<b>Measure 2</b>	Number of telemonitoring services provided to members living in the rural and semi-urban (Non-Urban) areas
<b>Measure 3</b>	Number of providers monitoring health indicator data transmitted to them by members receiving telemonitoring services

**Figure ES-10. Performance Outcome Measures for the Evaluation of Use of Telemonitoring Services**

*Key Results and Conclusions*

**Use of Telemedicine Services**

- Results for all measures examined support the assertion that the use of telemedicine services increased among KanCare 2.0 members (Non-Urban and Urban).
- The ability of these results to show improvement was overshadowed by the impact of the COVID-19 PHE. It should be noted, the increases in usage were higher among Urban members compared to Non-Urban members in these years. These increases corresponded to the onset of the PHE and may be due to changes related to the provision of services by providers and their usage by members made during these years.
- It should also be noted, though still above the pre-COVID-19 PHE years, usage of telemedicine services among members started showing decline in 2021 compared to 2020.
- Thus, the results seen should be interpreted with caution. The data and analytic results for 2022 and 2023 may provide a better assessment of the impact of State interventions on telemedicine services in Non-Urban areas of Kansas.

**Figure ES-11. Key Conclusions Based on the Use of Telemedicine Services Evaluation Results (Hypothesis 3 Component)**

Other main findings are summarized below:

- Telemedicine services for Non-Urban members were used most frequently for Mental, Behavioral and Neurodevelopmental Disorders throughout the time period, specifically Mood [affective] disorders ranked first.
- Analysis related to speech therapy supports the assertion that telehealth enhanced access to care for KanCare members.

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## Use of Telemonitoring Services

- Results for all telemonitoring evaluation measures support the assertion of increased use of telemonitoring services among Non-Urban KanCare 2.0 members
  - Percentage of members living in the rural and semi-urban (Non-Urban) areas who received telemonitoring services
  - Number of telemonitoring services provided to members living in the rural and semi-urban (Non-Urban) areas
  - Number of providers monitoring health indicator data transmitted to them by members receiving telemonitoring services

**Figure ES-12. Key Conclusions Based on the Use of Telemonitoring Services Evaluation Results (Hypothesis 3 Component)**

The main finding related to the outcome measures is summarized below:

- The three telemonitoring evaluation measures showed low utilization of telemonitoring services. However, all three showed an improvement in counts/percentages from 2019 to 2020 and 2021. These improvements corresponded to the onset of the pandemic and may be due to its impact.

### Qualitative Evaluation of Hypothesis 3

#### **Use of Telemonitoring Services**

The data sources are not currently available to describe the status of the use of Telemonitoring; therefore, quantitative evaluation was not conducted. The focused on summarizing the telemonitoring efforts implemented by Sunflower Health Plan, the University of Kansas, and the University of Missouri, using the Project ECHO (Extension for Community Healthcare Outcomes) Model.

#### *Key Results and Conclusions*

- From March 2019 through November 2021, there were twelve Project ECHO series comprised of fifty-one sessions, with an average of 42 participants per session. Following are the Project ECHO topics.
  - Behavioral health (3 of the 4 series focused on Substance Use Disorders)
  - Social Determinants of Health
  - Intellectual and Developmental Disabilities
  - Foster Care
  - Aging
  - Cancer
  - Care Coordination
  - Preventive Health
- The sessions were attended by providers from multiple disciplines, including medical and behavioral clinicians, nurses, pharmacists, and social workers. Participants were from non-urban and urban counties.
- Evaluation results (obtained after each session by the Project ECHO host) indicated participants' knowledge of the topic improved, and they obtained helpful skills and techniques to improve professional practice.

### *Recommendations*

- Continue to expand the use of telementoring, ensuring all MCOs develop and implement plans for this.

### **Telehealth Provider Survey**

Qualitative information was also collected, through a short online survey, from KanCare providers who offered telehealth services to KanCare members in 2020 or 2021. The survey was designed to gain an understanding of providers' telehealth experiences, perceptions regarding telehealth and access to care, and to identify providers' recommendations regarding telehealth. The survey was conducted in August and September 2022.

### *Key Results and Conclusions*

Seventy-three providers from urban and non-urban counties completed the survey, with the majority from behavioral health care providers. Other respondents were from primary care, specialty health care and home and community based services. The key points based on the survey results are summarized below:

- Most respondents “strongly agree” or “agree” that telehealth has improved access to care for KanCare members. It expands their ability to see clients/patients over a greater geographic distance, and it is important to the success of their organization. About two-thirds of the respondents “strongly agree” or “agree” that telehealth increases their ability to see more clients/patients, it fills an essential practitioner gap in their organization, improves workflow efficiencies in their practice, and it improves the quality of care for clients/patients.
- Most respondents noted being “very comfortable” or “moderately comfortable” delivering telehealth services.
- Most of the survey respondents “strongly agree” or “agree” clients are just as engaged and make as much progress on their treatment goals using telehealth visits as in using face-to-face visits.
- Three-fourths of respondents noted the effectiveness of services delivered by telehealth is “about the same” or “better” than services delivered in-person.
- Following are key barriers in providing telehealth services, identified by survey respondents, with the first two bullets being the most frequently noted.
  - Clients lack the technology and resources for telehealth services (mobile phones, computers, internet access).
  - Lack of client familiarity or comfort with using telehealth services.
  - Lack of reliable internet for providers; and
  - Do not consider telehealth services as effective as in-person services.
- Following are key recommendations (themes) by survey respondents.
  - Provide consistency in application of rules and systems.
  - Increase and improve technology and resources for the members and providers.
  - Continued coverage by insurance companies.
  - Provide education, resources (such as searchable databases for identifying providers for needed services), and trainings to members to assist in the understanding benefits of telehealth and using it with ease.
  - Increase reimbursement rate for telehealth services.
  - Ensure opportunities for telehealth services are available for all members.

- Provide trainings for providers, including easy to understand training for everyone on how to bill that providers can access at any time and can reach an expert who can answer specific situational questions.
- Telehealth is a valuable source for members and providers.
- Only 6% of respondents indicated their usage of telehealth visits would decrease in the future, with 50% anticipating the number of telehealth visits for KanCare members will “Increase somewhat.”

#### *Opportunities for Improvement*

- KanCare 2.0 Hypothesis 3’s focus is to enhance access to care for KanCare members living in rural and semi-urban areas. The results for the evaluation of telemonitoring service usage showed low utilization of the telemonitoring services. Although, some increases were seen in 2020 and 2021 among Non-Urban and Urban members, the increases seen were higher for Urban members than the Non-Urban members. Similarly, the increases seen in the telemedicine service usage were higher for the Urban members.
- Though still above pre-pandemic years, the results for the measures assessing the telemedicine and telemonitoring usage started showing a decline in 2021 compared to 2020, which may indicate the increases are due to COVID–19 pandemic.
- The focus of KanCare 2.0 Hypothesis 3, related to telementoring, is to pair rural and semi-urban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions. A data warehouse is not in place to collect detailed information on telementoring sessions offered to providers and to assess their impact in increasing the capacity rural and semi-urban healthcare providers have for the treatment of chronic, complex conditions among Non-Urban members.

#### *Recommendations*

- Ensure application of the strategies to improve the usage of telemedicine and telemonitoring services among Non-Urban members to increase their access to appropriate care.
- Ensure increased provision and utilization of telementoring sessions to increase the capacity of rural and semi-urban healthcare providers for the treatment of chronic, complex conditions among Non-Urban members.
- Assist the University partners and Health Plans providing telementoring sessions in developing a standardized evaluation component to assess the impact of these sessions in improving the capacity of providers in rural and semi-urban areas.
- Develop a data warehouse to collect the information on the telementoring sessions offered to providers and to assess their impact in increasing the capacity rural and semi-urban healthcare providers have for the treatment of chronic, complex conditions among Non-Urban members.

#### **f. The Evaluation of KanCare 2.0 Hypothesis 4 – Removal of Payment Barriers for Services Provided in Institutions for Mental Diseases for KanCare Members with SUD**

A separate report is prepared describing the results for the evaluation of KanCare 2.0 Section 1115 SUD Demonstration.

#### **h. Monitoring of the Overall KanCare 2.0 Performance Measures**

The Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of the Healthcare Providers and Systems (CAHPS) Survey, National Core Indicators (NCI) survey, and National Core

Indicators—Aging and Disabilities (NCI-AD) Survey measures related to the areas for improvement from the prior evaluation of the KanCare Demonstration (2013–2018) were assessed. The measures examined are listed in Figure ES-13.

<b>HEDIS Measures</b>	Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care Postpartum Care Comprehensive Diabetes Care Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Control (<8.0%) Poor Control HbA1c (>9.0%) Eye Exam Performed for Patients with Diabetes (EED)
<b>CAHPS Survey Measures</b>	Medical Assistance with Smoking and Tobacco Use Cessation (MSC) Advising Smokers and Tobacco Users to Quit Discussing Cessation Medications Discussing Cessation Strategies
<b>NCI Survey Measures</b>	Social and Community Engagement Among Adult KanCare Members Receiving At Least One Intellectual/Developmental Disability (I/DD) Waiver Service Can see and communicate with their family when they want (if not living with family) Has friends (may be staff or family) and can see them when wants Able to go out and do the things they like to do in the community as often as they want Services and Supports help person live a good life Decides or has input in deciding how to spend free time Decides or has input in deciding daily schedule
<b>NCI -AD Survey Measures</b>	Social and Community Engagement Among Adults and Seniors Participating in the FE, PD, and BI Waiver Programs to Receive LTSS Percentage of people who are always able to see or talk to friends and family when they want to (if have friends and family who do not live with person) Percentage of people who are able to do things they enjoy outside of home as much as they want to Percentage of people whose services help them live a better life Percentage of people who like how they spend their time during the day Proportion of people who get up and go to bed when they want to Percentage of people who can eat their meals when they want to

**Figure ES-13. Performance Measures for the Overall Monitoring of KanCare 2.0**

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*Key Results and Conclusions*

- Results for following measures support the assertion that an improvement was seen in the overall performance of KanCare 2.0.
  - HEDIS Measure improvement
    - Postpartum Care
  - NCI Survey Measures–improvement
    - Able to go out and do the things they like to do in the community as often as they want
    - Services and Supports help person live a good life
  - NCI Survey Measures–high percentages (≥80%) though no improvement
    - Can see and communicate with their family when they want (if not living with family)
    - Decides or has input in deciding how to spend free time
    - Decides or has input in deciding daily schedule
  - NCI-AD Survey Measures–improvement
    - Percentage of people whose services help them live a better life
  - NCI-AD Survey Measures–high percentages (≥80%) though no improvement
    - Always able to see or talk to friends and family when they want to
    - Get up and go to bed when they want to
    - Can eat their meals when they want to
- Results for the following measures did not support the assertion that an improvement was seen in the overall performance of KanCare 2.0.
  - HEDIS Measure
    - Timeliness of Prenatal Care
    - Hemoglobin A1c Control for Patients with Diabetes (HBD)
    - HbA1c Control (<8.0%)
    - Poor Control HbA1c (>9.0%)
    - Eye Exam Performed for Patients with Diabetes (EED)
  - CAHPS Survey Measures
    - Medical Assistance with Smoking and Tobacco Use Cessation (MSC)
    - Advising Smokers and Tobacco Users to Quit
    - Discussing Cessation Medications
    - Discussing Cessation Strategies
  - NCI-AD Survey Measures
    - Has friends (may be staff or family) and can see them when wants
  - NCI-AD Survey Measures
    - Able to do things they enjoy outside of home as much as they want to
    - Like how they spend their time during the day

**Figure ES-14. Key Conclusions Based on the Monitoring of Overall KanCare 2.0 Performance Measures**

The results for one HEDIS measure, two NCI Survey measures, and one NCI-AD Survey measure supported the assertion that an improvement was seen in the overall performance of KanCare 2.0.

The main findings related to the outcome measures are summarized below:

#### **HEDIS Measures**

- The Prenatal and Postpartum Care (PPC) measure includes Timeliness of Prenatal Care and Postpartum Care. An improvement in the Postpartum Care rate and its QC ranking was seen from Measurement year (MY) 2019 to MY 2020. The QC ranking for Postpartum Care rate also increased from <25<sup>th</sup> to <50<sup>th</sup> percentile.
- The rest of the HEDIS measures did not show improvement from 2019 to 2020.
- A statistically significant decline in the Timeliness of Prenatal Care rate was seen in MY 2020 from MY 2019, with rates for both years below 33.33<sup>rd</sup> percentile.
- The Eye Exam Performed for Patients with Diabetes (EED) rate had a statistically significant declining trend from My 2016 to MY 2020.
- However, the QC rankings increased to >75<sup>th</sup> for 2020 for all three comprehensive diabetes care measures, which indicates KanCare members fared relatively well in the first year of the pandemic compared to members in other health plans.

#### **CAHPS Survey Measures**

- The three indicators of the Medical Assistance with Smoking and Tobacco Use Cessation (MSC) measure — Advising Smokers and Tobacco Users to Quit; Discussing Cessation Medications; and Discussing Cessation Strategies — did not show improvement (with some declines), and had QC rankings less than the 50<sup>th</sup> percentile, suggesting a need for improvement.

#### **Kansas NCI Survey Measures for Social and Community Engagement (2016–2017, 2017–2018, and 2018–2019)**

- The percentage of members whose services and supports help them live a good life, was 90% or above in all three years.
- The percentages for three out of six measures—Can see and communicate with their family when they want (if not living with family); Decides or has input in deciding how to spend free time; and Decides or has input in deciding daily schedule—were above 80% in all three years.
- The percentage of members with the ability to go out and do things they like in the community increased from 79% to 85% in the most recent year.
- The percentage of members with the ability to see friends when they want declined from 83% in 2016-17 to 78% in 2017-18 and 2018-19.

#### **Kansas NCI-AD Survey Measures for Social and Community Engagement (2018–2019, and 2019–2020):**

- The percentages for three out of six measures—Percentage of people whose services help them live a better life; Proportion of people who get up and go to bed when they want to; and Percentage of people who can eat their meals when they want to— were above 90% in both years.
- The percentage of members with the ability to go out and do things they like to in the community as often as they want was above 90% in 2018-19, however it decreased to 87% in recent year.
- The percentages for the measure assessing members' ability to do things they enjoy outside of home as much as they want remained same in both years.
- The percentage of people who like how they spend their time during the day was low in 2018-19, and it further declined in 2019-20.

### **Recommendations**

- Review and ensure strategies are applied by the MCOs and health care providers to improve provision of timely prenatal care, comprehensive diabetes care, and medical assistance for smoking and tobacco use cessation to KanCare 2.0 members.
- As the State completes the PHE winding down period, ensure MCOs and health care providers implement strategies to improve the social wellbeing of members receiving I/DD waiver services. Ensure the PCSPs of these members include the provision of assistance for them to engage socially, with friends and family, when they want.
- As the State completes the PHE winding down period, ensure MCOs and health care providers implement strategies to improve social and community engagement among adults and senior members obtain long term services and supports through the Frail Elderly, Physical Disability and Brain Injury waiver programs. Ensure the PCSPs of these members include provision of assistance for them to engage in activities of their interest outside their home when they want and to decide their daily activities.

### **Interpretations, and Policy Implication and Interactions with Other State Initiatives**

KFMC will address the policy implications and interactions with other state initiatives in the summative KanCare 2.0 evaluation. For this interim evaluation, the following interpretations could be made.

- It is not yet known how much the COVID-19 pandemic will influence the impact of the KanCare 2.0 program overall. It will take more years to assess the impact of the program, overall, outside of the context of the pandemic.
- It is difficult to interpret the interactions with other Medicaid and State programs due to the pandemic, as well. KanCare 2.0 activities were drastically affected during the onset of the pandemic. The MCOs were instructed to pause many initiatives with members and providers in order to address the public health emergency. As a result, many of the projects that would have provided data for this evaluation were on hold for a considerable amount of time. Also, the Service Coordination Strategy could not be fully administered as designed, during much of the evaluation time period, due to limitations in face-to-face visits.

### **Lessons Learned and Recommendations for States**

There were a few lessons learned as a result of this interim evaluation. These lessons learned are also recommendations to State Medicaid agencies for future demonstrations, as well as for the State of Kansas for the remainder of KanCare 2.0.

- There were additional delays in the implementation of KanCare 2.0 strategies that appeared unrelated to the delays due to the COVID-19 pandemic, such as the MCOs' Value Based Provider Incentive Program delays. These delays will impact the ability to evaluate the efficacy of the KanCare 2.0 program, as a whole. KFMC recommends State Medicaid agencies evaluate MCO delays to determine whether they are unavoidable or whether stronger enforcement of timelines is warranted.
- Some of the programs that began (or were intended to begin) during the evaluation timeframe proved to be more time-intensive to implement than anticipated. KFMC recommends State

Medicaid agencies and MCOs explore ways to accelerate the time to implementation of the programs, as designed. This will help to ensure adequate time is allowed for fully conducting the strategy activities, collecting data, and fully testing the hypotheses.

- Lessons learned and recommendations for other State Medicaid agencies will be further addressed in the summative KanCare 2.0 evaluation report.

## ***Summary of Opportunities for Improvement and Recommendations***

- **MCO care coordination assessment:** As the public health emergency completes its winding down period, all members eligible for participation in the Service Coordination Strategy should receive the appropriate assessments.
- **OneCare Kansas capacity and provider training:** The State should ensure the MCOs have a standardized process to determine member eligibility for OCK. The State and MCOs should continue to support the OCK Learning Collaborative, and address providers' training needs regarding working with OCK members (e.g., motivational interviewing, health literacy) and specific diagnoses.
- **Increase telemedicine and telemonitoring utilization:** The State and MCOs should review and implement, as feasible, the provider recommendations for how to improve telehealth services. The State and MCOs should also seek ways to increase the use of telemonitoring services.
- **Improve telementoring opportunities and capacity:** The State should ensure all MCOs develop and implement plans to increase telementoring opportunities targeted towards providers in rural and semi-urban areas of the state, as well as continue to support current telementoring efforts. Standardized methods should also be developed and implemented to collect information on telementoring opportunities across the state and to evaluate the impact for KanCare 2.0 providers, especially those in rural and semi-urban parts of Kansas.
- **Strategies to improve quality and timeliness of care:** The MCOs should evaluate their Quality Assurance and Performance Improvement Programs to ensure they and contracted providers are developing and applying strategies to improve identified KanCare 2.0 performance measures (prenatal, comprehensive diabetes care, medical assistance for smoking and tobacco use cessation).
- **Strategies to improve member social and community engagement:** As the public health emergency completes its winding down period, the State should ensure the MCOs are working through their own care management processes (specifically using the PCSP), as well as with contracted providers, to improve social and community engagement for members on waiver services (I/DD, FE, PD, and BI).

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***KanCare 2.0 Interim Evaluation Report  
Evaluation of the State of Kansas Medicaid Section 1115(a)  
Demonstration  
January 2019 – September 2022  
Final Submission Date: October 20, 2022***

***General Background Information***

KanCare, the Kansas statewide mandatory Medicaid managed care program, was implemented January 1, 2013, under authority of a waiver through Section 1115 of the Social Security Act. The initial demonstration was approved for five years, and the Centers for Medicare and Medicaid Services (CMS) approved a one-year extension on October 13, 2017. The State submitted the Section 1115 demonstration renewal application for the KanCare program, titled “KanCare 2.0,” in December 2018.<sup>1</sup> CMS approved the renewal of the KanCare 2.0 demonstration for the period of January 1, 2019, through December 31, 2023.<sup>2</sup>

In accordance with CMS guidelines, the KanCare 2.0 evaluation design for the period of January 1, 2019, through December 31, 2023, was submitted for CMS approval. The CMS review of the evaluation design was received November 18, 2019. An updated evaluation design as per CMS guidance and feedback was submitted, and it was approved by CMS on February 19, 2020.<sup>3</sup>

KFMC Health Improvement Partners (KFMC), under contract with the Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF), serves as the External Quality Review Organization (EQRO) for KanCare. As the EQRO, KFMC is conducting the required KanCare 2.0 evaluation, and has prepared this interim evaluation report to reflect evaluation progress and present findings to date. Measurement data are provided, as available, for the time period of January 1, 2019, through December 31, 2021, while updates and qualitative data are provided for the time period through September 30, 2022.

KanCare 2.0 is an integrated Medicaid managed care program that serves the State of Kansas through a coordinated approach. KanCare is operating concurrently with the State’s Section 1915(c) Home and Community Based Services (HCBS) waivers, and together they provide the authority necessary for the State to require enrollment of almost all Medicaid members (including the aging, people with disabilities, and some individuals who are dually eligible). The KanCare managed care delivery system provides state plan and HCBS waiver services to Medicaid recipients statewide.<sup>4</sup>

The original goals of the KanCare demonstration focused on providing integrated and whole-person care, creating health homes, preserving, or creating a path to independence, and establishing alternative access models with an emphasis on home and community based services. Building on the success of the current KanCare demonstration, the goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of

health and independence in addition to traditional Medicaid and Children’s Health Insurance Program (CHIP) benefits.<sup>1</sup> KanCare 2.0 aims to improve integration and coordination of care across the healthcare spectrum. Services related to social determinants of health include addressing safe housing; food sources; educational, economic, and job opportunities; access to health care services; transportation options; community-based resources in support of community living; and opportunities for recreational and leisure-time activities. Services that address social determinants of independence are tailored to an individual’s vision for their life, including areas such as career, community participation and contribution, and social/emotional connections. Strategies to achieve the enhanced goals of KanCare 2.0 include service coordination, the OneCare Kansas (OCK) program, value-based models and purchasing strategies, increasing employment and independent living supports, and telehealth (i.e., telemedicine, telemonitoring, and telementoring) services.

KanCare 2.0 expands upon care coordination to provide service coordination, which is a comprehensive, holistic, integrated approach to person centered care.<sup>1</sup> It allows for maximum access to supports by coordinating and monitoring all of an individual’s care (acute, behavioral health, and long term services and supports [LTSS]) through direct interventions, provider referrals, and linkages to community resources. Case management, disease management, discharge planning, and transition planning are also elements of service coordination. All professionals involved in a member’s care communicate with one another so that the member’s medical and behavioral health and social service needs are addressed in a comprehensive manner. The coordination of a member’s care is done through a dedicated care manager who oversees and coordinates access to all of the services a member requires to optimize their health.<sup>5</sup>

KDHE-DHCF developed the OneCare Kansas (OCK) program that is “offered to KanCare 2.0 members with chronic conditions and is designed to apply a comprehensive and intense method of care coordination that integrates and coordinates all services and supports to treat the ‘whole person’ across the life span.” The focus is on members with certain chronic conditions involving mental health and asthma. Initially, eligibility was limited to members diagnosed with Severe Bipolar Disorder, Paranoid Schizophrenia, or Asthma (plus one other qualifying health condition). Effective April 1, 2021, qualifying diagnoses were expanded to additional severe mental illnesses and/or expanded types of asthma which increased the eligible population. Eligible members are invited to opt-in to the program.<sup>5</sup> Care coordination is provided by contracted providers, OCK Partners (OCKPs), including primarily Community Mental Health Centers, as well as Federally Qualified Health Centers, individual primary care practices, providers who serve individuals with developmental disabilities, and other community-based mental health providers (CBMH).<sup>6</sup> All professionals involved in a member’s care communicate with one another so that the member’s medical and behavioral health and social service needs are addressed in a comprehensive manner. The coordination of a member’s care is done through a dedicated care manager who oversees and coordinates access to all of the services a member requires to optimize their health.<sup>5</sup> The OCKPs are required by KDHE policy to participate in the OCK Learning Collaborative, a peer-to-peer learning activity.<sup>6</sup> As of April 1, 2022, OCK had 3,272 enrolled members.

Value-based purchasing (VBP) strategies include provider payment and/or innovative delivery system design methods between managed care organizations (MCOs) and their contracted providers, as well as the pay-for-performance (P4P) program between the State and contracted MCOs.

The State has asked KanCare 2.0 MCOs to utilize telehealth solutions in designing, establishing, and maintaining provider networks and to develop models to expand use and effectiveness of telehealth strategies, including telemedicine, telemonitoring, and telementoring, with a focus on enhancing access

to services in rural or semi-urban areas, access to behavioral health services, and support chronic pain management interventions.<sup>1</sup> The State document for MCOs titled “Kansas Medicaid Managed Care Request for Proposal for KanCare 2.0” has described telemedicine, telemonitoring, and telementoring as follows (pp. 106–107):<sup>7</sup>

- a) **“Telemedicine:** *The State is interested in positively impacting member access by exploring telemedicine strategies that expand the full scope of practice by connecting network providers with members at distant sites for purposes of evaluation, diagnosis, and treatment through two-way, real time interactive communication. such projects can greatly enhance access, save time, money and improve outcomes in communities with limited access to health care.” The state has defined telemedicine as “connecting participating providers with members at distant sites for purposes of evaluation, diagnosis, and treatment through two-way, real time interactive communication.”*
- b) **“Telemonitoring:** *Technologies that target specific disease type (i.e. congestive heart failure) or high utilizers of health services, particularly ER services and medication regimen management. Technologies are available that measure health indicators of patients in their homes and transmit the data to an overseeing Provider. The provider, who might be a physician, nurse, social worker, or even a non-clinical staff member, can filter patient questions and report to a clinical team as necessary. The goal would be to reduce admission, ER utilization and improve overall health of the member.”*
- c) **“Telementoring:** *Technologies such as the Project ECHO model to connect community PCPs with specialists remotely located to provide consultations, grand rounds, education, and to fully extend the range of care available within a community practice. The State is also interested in ways that the use of telementoring can attract and retain providers in rural health shortage areas. This could include creating learning and joint consultation strategies that may make working in more isolated environments or practices more attractive.”*

It must be highlighted, much of the interim evaluation measurement period overlapped with the COVID-19 public health emergency (PHE). KanCare 2.0 activities were drastically affected during the onset of the PHE (pandemic). Initially, the MCOs were instructed to pause many activities with members and providers in order to address the public health emergency. For instance, completion of Health Screening Tools (HSTs) were briefly waived. Some changes continued throughout the interim evaluation time period. For example:

- The State obtained an HCBS waiver amendment from CMS, effective January 27, 2020. This amendment remains effective through six months after the end of the public health emergency; the end date is yet to be determined. A couple elements of the amendment that could more directly impact this evaluation included
  - o suspending the requirement for an HCBS waiver participant to use at least one service every 30 days;
  - o allowing telephonic services for case management and monthly monitoring;
  - o allowing an extension for reassessments and reevaluations for up to one year past the due date; and,
  - o allowing the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
- In March 2020 a State moratorium on member face to face visits was implemented, and the MCOs and members needed to re-adjust to telephonic or tele-video visits. The moratorium was lifted in April 2021, with judgement allowed related to the particular case or need, while there were some continued limitations on in-person group meetings (e.g., wrap-around team meetings) and nursing

home visits. Through at least January 2022, there was variation in the MCOs' and members' resumption of face-to-face visits, due to continued fluctuations in COVID-19 rates.

Furthermore, the pandemic affected the overall utilization of health care services throughout the state. It is not yet known how much the COVID-19 pandemic will influence the impact of the KanCare 2.0 program overall. It will take more years to assess the impact of the KanCare 2.0 program outside of the context of the pandemic. Thus, the results presented here should be interpreted with strong caution.

## ***Evaluation Question and Hypotheses***

### **KanCare 2.0 Demonstration Goal**

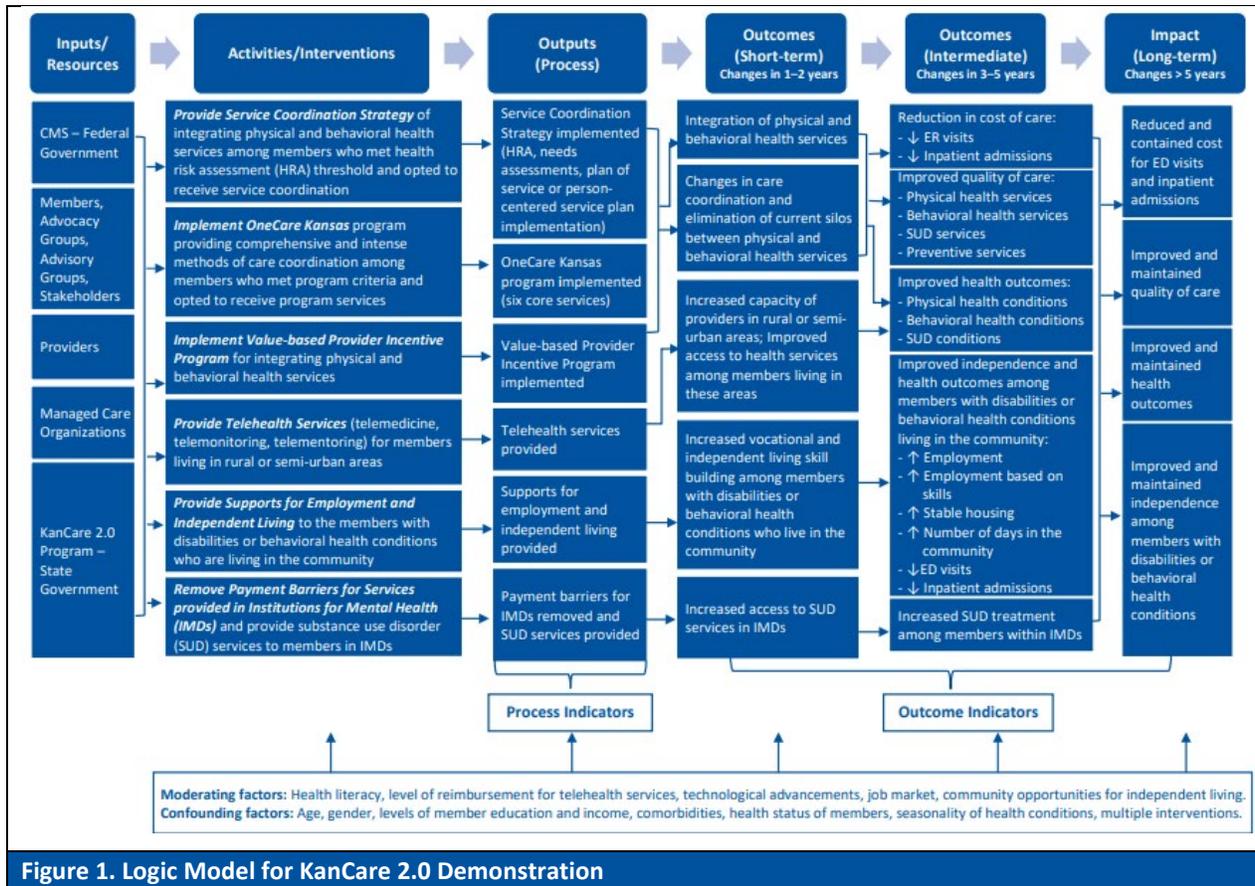
The goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid benefits.<sup>4</sup>

### **KanCare 2.0 Demonstration Hypotheses**

1. Value-based models and purchasing strategies will further integrate services and eliminate the current silos between physical health services and behavioral health services, leading to improvements in quality, outcomes, and cost-effectiveness.
2. Increasing employment and independent living supports for members who have disabilities or behavioral health conditions, and who are living and working in the community, will increase independence and improve health outcomes.
3. Use of telehealth (e.g., telemedicine, telemonitoring, and telementoring) services will enhance access to care for KanCare members living in rural and semi-urban areas. Specifically:
  - a. Telemedicine will improve access to services such as speech therapy.
  - b. Telemonitoring will help members more easily monitor health indicators such as blood pressure or glucose levels, leading to improved outcomes for members who have chronic conditions.
  - c. Telementoring can pair rural and semi-urban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions.
4. Removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members will result in improved beneficiary access to substance use disorder (SUD) treatment services.

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As described in the KanCare 2.0 Evaluation Design document (Attachment A), the logic model for the demonstration is as follows:



### KanCare 2.0 Demonstration Evaluation Questions

As the focus of the evaluation is to examine whether the KanCare 2.0 Demonstration achieved its objectives, the following evaluation questions were developed in alignment with the demonstration’s goal and four hypotheses (Tables 1 and 2). Table 1 describes two evaluation questions related to the KanCare 2.0 service coordination and OCK program strategies. The first examines the effectiveness of the Service Coordination Strategy that was designed to enhance the quality of care and health outcomes, as well as reduce costs of care. The second question evaluates the effectiveness of the OneCare Kansas program.

Table 1. Evaluation Questions for Examination of Overall Care Coordination Among KanCare 2.0 Demonstration Members	
1)	Did the Service Coordination Strategy of integrating physical and behavioral health services provided to KanCare members improve quality of care, health and cost outcomes?
2)	Did the OneCare Kansas program that implements comprehensive and intense method of care coordination improve the quality of care, health and cost outcomes?

Table 2 describes evaluation questions related to four hypotheses of the KanCare 2.0 demonstration.

Table 2. Evaluation Questions for Examination of the KanCare 2.0 Demonstration Hypotheses	
KanCare 2.0 Hypotheses	Evaluation Questions
<b>Hypothesis 1:</b> Value-based models and purchasing strategies will further integrate services and eliminate the current silos between physical health services and behavioral health services, leading to improvements in quality, outcomes, and cost-effectiveness.	1) Did the Value-Based Provider Incentive Program increase integration and reduce silos between physical and behavioral health services provided to KanCare members?
	2) Did the Value-Based Provider Incentive Program for integration between physical and behavioral health services improve quality of care, health, and cost outcomes?
<b>Hypothesis 2:</b> Increasing employment and independent living supports for members who have disabilities or behavioral health conditions, and who are living and working in the community, will increase independence and improve health outcomes.	1) Did provision of supports for employment and independent living to the KanCare 2.0 members with disabilities and behavioral health conditions who are living in the community improve their independence and health outcomes?
<b>Hypothesis 3:</b> The use of telehealth (e.g., telemedicine, telemonitoring, and telementoring) services will enhance access to care for KanCare members living in rural and semi-urban areas. Specifically: a. Telemedicine will improve access to services such as speech therapy. b. Telemonitoring will help members more easily monitor health indicators such as blood pressure or glucose levels, leading to improved outcomes for members who have chronic conditions. c. Telementoring can pair rural and semiurban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions. a. Telemedicine will improve access to services such as speech therapy.	1) Did use of telemedicine services increase over the five-year period for KanCare members living in rural or semi-urban areas?
	2) Did use of the tele-monitoring services increase over the five-year period for KanCare members with chronic conditions living in rural or semi-urban areas?
	3) Evaluation question related to telementoring: Data sources for describing the baseline and five-year status of the use of telementoring to pair rural and semi-urban healthcare providers with remote specialists are currently not known; therefore, the related evaluation question and design will be developed later.
	4) Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?
<b>Hypothesis 4:</b> Removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members will result in improved beneficiary access to substance use disorder (SUD) treatment services.	1) Did removing payment barriers for services provided in IMDs for KanCare members improve members’ access to substance use disorder (SUD) treatment services. (As per CMS guidance, evaluation of Hypothesis 4 was conducted as a part of the SUD Demonstration Evaluation). <sup>5,6</sup>

## Methodology

The evaluation methodology presented in the KanCare 2.0 Evaluation Design (Attachment A) was designed to meet the standards of scientific rigor that will assist in obtaining statistically valid and reliable evaluation results. Where possible, measures were developed according to recognized measures from sources such as Adult Core Set<sup>8</sup> and Healthcare Effectiveness Data and Information Set<sup>®</sup> (HEDIS),<sup>9</sup> which is stewarded by the National Committee for Quality Assurance (NCQA) and endorsed by the National Quality Forum (NQF).

The detailed methodologies for the interim evaluation of the KanCare 2.0 Service Coordination Strategy, the OneCare Kansas program, and three KanCare 2.0 hypotheses are described in this section. As per a CMS recommendation, the evaluation of Hypothesis 4 was included as a part of the SUD Evaluation

Design.<sup>10</sup> The interim evaluation methodology for the KanCare 2.0 Hypothesis 4 is described in a separate interim evaluation report for the KanCare 2.0 Section 1115 SUD Demonstration.

### **a. Methodology for the Evaluation of KanCare 2.0 Service Coordination Strategy**

The KanCare 2.0 Service Coordination Strategy incorporates health risk assessments (HRA), needs assessments, and the development and implementation of person-centered service plans (PCSP) among KanCare 2.0 members who meet HRA thresholds based on health screening tool (HST) scores.

As described in the KanCare 2.0 Evaluation Design (Attachment A), the interim evaluation of KanCare 2.0 Service Coordination Strategy is comprised of a quantitative component.

#### *Evaluation Design:*

The KanCare 2.0 Evaluation Design was created before the onset of the COVID-19 pandemic and public health emergency. Consequently, an alternate approach was taken for the interim evaluation of the KanCare 2.0 Service Coordination Strategy. Relative improvements in measurement rates from a pre-KanCare 2.0 baseline period (2016–2018) to a KanCare 2.0 remeasurement period (2019–2021) were compared. Under the assumption that the pandemic and other external influences would equally impact rates for intervention and comparison groups, better relative improvements for the intervention group than for the comparison group would support the assertion that the service coordination strategy was effective. However, the previously noted changes that were implemented to address the COVID-19 pandemic substantially impacted service coordination. The KanCare 2.0 Service Coordination Strategy could not be fully administered, as designed, during the pandemic. This impacted most of the of the evaluation remeasurement period. While data is provided for the service coordination evaluation measures, conclusions regarding the effectiveness of the strategy are not possible at this time.

The comparative interrupted time series (CITS) evaluation design proposed in the KanCare 2.0 Evaluation Design (Attachment A) was not performed for the interim evaluation because the number of data points available for the analysis was insufficient. The CITS analysis will be performed for the summative evaluation to compare the selected performance outcomes in intervention and comparison groups from 2016 through 2023 (Pre-Intervention Period: 2016–2018; and Post-Intervention Period: 2019–2023).

Instead of reporting utilization rates used for evaluation of the service coordination strategy using units “per 1,000 member-months,” these rate are reported as “per 1,200 member-months” for easier interpretation. For example, “141.5 claims per 1,200 member-months” is equivalent to “on average, there were 141.5 claims per year for every 100 members.”

#### *Target and Comparison Populations:*

**Target Population:** The target population for the interim evaluation of KanCare 2.0 Service Coordination Strategy was comprised of

- Members who had an HST total score of 23 or higher or had an HRA threshold score for any of the four sections of the HST,
- Members who had an HST total score from 18 to 22 and did not meet any other HRA threshold, and
- Members who received an HRA.

The HRA thresholds are as follows:

- A total HST Score  $\geq 23$
- Within the four sections of the HST (even if the total score was less than 23) –
  - Health Status Section Score  $\geq 9$
  - Health Conditions Section Score  $\geq 5$
  - Health Lifestyle Section Score  $\geq 6$
  - Home/ Employment Section Score  $\geq 4$
- An activated automatic trigger of HST

The following members were excluded from the target population:

- Members who did not receive an HST and did not receive an HRA.
- Members with a total HST score less than 18 without meeting a section threshold and who did not receive an HRA.
- Members participating in OneCare Kansas program.

**Comparison Populations:** Comparison populations were comprised of an Intervention Group, Comparison Group 1, and Comparison Group 2.

- **Intervention Group:** Members who had an HRA and PCSP during 2019 to 2021
- **Comparison Group 1:** Intervention Group members from 2016 to 2018 (pre-intervention period).
- **Comparison Group 2:** This group included the following KanCare 2.0 members:
  - Members who had an HST that met an HRA threshold and received traditional care (i.e., did not receive a PCSP).
  - Members who had an HST total score from 18 to 22 and did not meet an HRA threshold and received traditional care.

Note: Intervention and comparison groups exclude members enrolled in OCK during 2020 or 2021. Members with an HST and HRA who did not meet sectional or total score thresholds are assumed to have met the trigger and will be in the intervention group if not receiving a PCSP. Members with an HRA but no HST and no PCSP are not in either the control or intervention group.

#### *Evaluation Period:*

Data were collected from January 1, 2019 – December 31, 2021.

#### *Evaluation Measures:*

The following outcome measures were assessed to examine the evaluation question:

- Adults' Access to Preventive/Ambulatory Health Services (HEDIS)
- Annual Dental Visit (HEDIS)
- Adolescent Well-Care Visits (HEDIS)
- ED visits, observation stays, or inpatient admissions for the following conditions (Administrative):
  - Diabetic Ketoacidosis/Hyperglycemia,
  - Acute severe asthma,
  - Hypertensive crisis,
  - Fall injuries,
  - SUD, or
  - Mental health issues
- Outpatient or professional claims for the following conditions (Administrative):

- Diabetic retinopathy, or
- Influenza,
- Pneumonia, or
- Shingles
- Emergency department visits overall (Administrative)

*Data Sources:*

Data for the interim evaluation of KanCare 2.0 Service Coordination Strategy were obtained from the following sources:

- Data files containing member-level HRA, Needs Assessment, and PCSP data abstracted from each MCO's data system
- The encounter, demographic, eligibility, and enrollment records from the State's Medicaid Management Information System (MMIS) reporting warehouse
- Files containing member-level HEDIS data for selected measures, 2019 and 2020

*Analytic Methods:*

The following analytical steps were applied to examine the outcome measures for the evaluation of the KanCare 2.0 Service Coordination Strategy:

- 1) Each MCO submitted data files containing member-level HRA, Needs Assessment, and PCSP data.
- 2) Member-level HRA, Needs Assessment, and PCSP data abstracted from the MCOs data files were reviewed for missing values, inconsistent patterns, and outliers.
- 3) KanCare 2.0 members constituting the target and comparison populations (intervention and comparison groups) were identified from member-level HRA, Needs Assessment, and PCSP data abstracted from the MCOs' data files.
- 4) Demographic characteristics of the members in the intervention and comparison groups were examined for homogeneity.
- 5) MMIS encounter records related to the outcome measures for the intervention and comparison groups were reviewed for missing values, inconsistent patterns, and outliers.
- 6) Outcome measures rates were calculated.
- 7) For HEDIS measures, measurement year (MY) 2019–2020 rates calculated by KFMC were compared to rates calculated from member-level data submitted by the MCOs.
- 8) Testing for statistically significant differences in rates between baseline (2016 to 2018) and remeasurement (2019 to 2021) periods was conducted for Intervention Group and Comparison Group 2.
- 9) Relative improvement from baseline to remeasurement was calculated for the Intervention Group and Comparison Group 2. A statistical test for equality of relative improvements was conducted with  $p$  less than 0.05 indicating statistical significance.

Because member-level HEDIS data were not available for measurement years 2016 through 2021, HEDIS rates were calculated from encounter data. If technical specifications changed between measurement years that required a break in trending, then the more current version of the specifications were applied to the earlier measurement years to allow trending. Rates calculated from encounter records are not to be considered HEDIS Health Plan rates; calculation of HEDIS rates by the MCOs incorporates supplemental data not available through encounters, such as data extracted from medical records and claims from other lines of business. HEDIS rates calculated from encounter data are Uncertified, Unaudited HEDIS rates. In addition to the three HEDIS rates listed above, 2016–2021 rates were calculated for Prenatal and Postpartum Care (PPC), Initiation and Engagement of Alcohol and Other Drug

Abuse or Dependence Treatment (IET), and Follow-Up After Hospitalization for Mental Illness (FUH). PPC and FUH rates were not included in the evaluation of the Service Coordination Strategy due to low numerator or denominator counts for the Intervention Group; IET rates were excluded due to poor comparisons to rates calculated from MCO member-level detail records.

Emergency department (ED) visits, observation stays, inpatient admissions, and outpatient claims were identified for the utilization measures using HEDIS value sets: ED, Observation Stay, Inpatient Stay, and Outpatient. The alcohol or other drug (AOD) Abuse and Dependence value set, and the Mental Illness value set were used to identify diagnosis of SUD and mental health issues. Other diagnoses specified for the utilization measures were identified by the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis category codes: E08–E12 (diabetic ketoacidosis/hyperglycemia), J45 (acute severe asthma), I16 (hypertensive crisis), W00–W19 (fall injuries), E10 (diabetic retinopathy), J09–J11 (influenza), J12–J18 (pneumonia), and B02 (shingles). Encounters were deduplicated to one claim per member, per billing provider national provider identifier (NPI), per last date of service.

Testing for statistically significant differences between two HEDIS rates was conducted using Pearson’s chi-square tests. Testing for differences in service utilization rates, which have Poisson distribution, used a large-sample z-test.<sup>11</sup>

*Reduction in the failure rate* (RFR) was used for relative improvement. RFR is the amount of improvement relative to the amount of potential improvement. The formula is:

$$RFR = (Remeasurement\ Rate\ minus\ Initial\ Rate) / (Goal\ minus\ Initial\ Rate).$$

For HEDIS rates with a rate increase as an improvement, the goal was set to 100%. The goal was set to 0 for the service utilization rate because the aim of service coordination was to reduce the number of emergency department visits and visits for the selected diagnosis at other care settings. When the goal is 0, the RFR is equal to the *relative decrease* in rates.

The tests for equality of relative improvement between the Intervention Group and Comparison Group 2 followed these steps:

1. Comparison Group 2’s RFR was calculated.
2. The rate the Intervention Group would have had for 2019–2020 if the RFR from the group’s 2016–2018 to the projected rate equaled Comparison Group 2’s RFR (a.k.a., the *projected rate*) was calculated. The denominator of the projected rate was set equal to the denominator of 2016–2018 rate for the Intervention Group.
3. The statistical significance of the difference between the projected rate and the 2019–2021 rate for the Intervention Group was tested using either Pearson’s chi-square test or the small sample z-test, depending on the type of measure.

## **b. Methodology for the Evaluation of OneCare Kansas Program**

The OneCare Kansas (OCK) program started April 1, 2020. As described in the KanCare 2.0 Evaluation Design (Attachment A), the interim evaluation of the OCK program is comprised of quantitative and qualitative components.

## Quantitative Evaluation

### *Evaluation Design:*

The KanCare 2.0 Evaluation Design was created before the onset of the COVID 19 pandemic. Consequently, an alternate approach was taken for the interim evaluation of the OneCare Kansas Program. Relative improvements in measurement rates from a pre-KanCare 2.0 baseline period (2016–2019) to a KanCare 2.0 remeasurement period (2020–2021) were compared. Under the assumption that the pandemic and other external influences would equally impact rates for intervention and comparison groups, better relative improvements for the intervention group than for the comparison group would support the assertion that the program was effective. However, as previously noted, COVID-19 substantially impacted service coordination. While data is provided for the OCK evaluation measures, strong caution must be applied in making conclusions regarding the effectiveness of the strategy.

For the evaluation of OCK, a comparative interrupted time series (CITS) evaluation design was proposed in the KanCare 2.0 Evaluation Design (Attachment A) to compare the selected performance outcomes in intervention and comparison groups over the period of 2016 through 2023 (Pre-Intervention Period: 2016–2019; and Post-Intervention Period: 2020–2023). The CITS analysis was not performed for the interim evaluation because the number of data points available for the analysis was insufficient.

The KanCare 2.0 Evaluation Design indicated utilization rates used for evaluation of the OCK program would be reported “per 1,000 member-months.” However, they are reported as “1,200 member-months” for easier interpretation. For example, “141.5 claims per 1,200 member-months” is equivalent to “on average, there were 141.5 claims per year for every 100 members.”

### *Target and Comparison Populations:*

**Target Population:** The target population for the interim evaluation of OCK was comprised of KanCare 2.0 members eligible for participation in OCK.

- Members having one of the following diagnoses for Severe Mental Illness (SMI):
  - Bipolar disorders
  - Schizophrenia
  - Major depressive disorders
- Members with chronic physical conditions identified as members with asthma and one “at risk” diagnosis listed below.
  - Substance use disorders
    - Alcohol related disorders
    - Opioid related disorders
    - Cannabis related disorders
    - Sedative, hypnotic or anxiolytic related disorders
    - Cocaine related disorders
    - Amphetamine or other stimulant related disorders
    - Hallucinogen related disorders
    - Inhalant related disorders
    - Other psychoactive substance related disorders
  - Mental illness disorders
    - Schizophrenia (excluding paranoid schizophrenia codes)
    - Schizotypal disorder
    - Delusional disorders
    - Shared psychotic disorder

- Schizoaffective disorders
- Psychosis
- Manic episode
- Bipolar disorder (excluding severe bipolar disorder codes)
- Major depression, recurrent
- Persistent mood (affective) disorders
- Unspecified mood (affective) disorder
- Other anxiety disorders
- OCD (obsessive compulsive disorder)
- Reaction to severe stress, and adjustment disorders
- Dissociative and conversion disorders
- Somatoform disorders
- Other nonpsychotic mental disorders
- Eating disorders
- Specific personality disorders
- Impulse disorders
- Attention-deficit hyperactivity disorders
- Conduct disorders
- Emotional disorders with onset specific to childhood
- Disorders of social functioning with onset specific to childhood and adolescence
- Tic disorder
- Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence
- Mental disorder, not otherwise specified
- Chronic Physical Conditions
  - Type 1 diabetes mellitus
  - Type 2 diabetes mellitus
  - Morbid (severe) obesity due to excess calories
  - Metabolic syndrome
  - Essential (primary) hypertension
  - Hypertensive heart disease
  - Hypertensive chronic kidney disease
  - Hypertensive heart and chronic kidney disease
  - Secondary hypertension
  - Chronic ischemic heart disease
  - Pulmonary heart disease, unspecified
  - Chronic lower respiratory diseases
  - Chronic kidney disease (Stage 1–3)
  - Kidney failure
  - Tobacco use or nicotine dependence
  - Contact with and (suspected) exposure to environmental tobacco smoke (acute or chronic)

KanCare 2.0 members who are in nursing facilities, Title XXI (CHIP), or hospice were excluded from the target population.

**Comparison Populations:** Comparison populations were comprised of an intervention group and two comparison groups.

- **Intervention Group** – KanCare 2.0 members eligible for participation in OCK who were enrolled in the program for at least 3 months of the measurement year (2020 and 2021).
- **Comparison Group 1** – Members of Intervention Group with their outcome data abstracted for the pre-intervention period (2016–2019).
- **Comparison Group 2** – KanCare 2.0 members who met eligibility criteria for participation in OCK based on MMIS encounter data but did not enter into OCK and received traditional care (2020–2021)

#### *Evaluation Period:*

Data were collected from April 1, 2020 – December 31, 2021.

#### *Evaluation Measures:*

The following outcome measures were assessed to examine the evaluation question:

- Annual Dental Visit (HEDIS)
- Adults' Access to Preventive/ Ambulatory Health Services (HEDIS)
- Adolescent Well-Care Visits (HEDIS)
- ED visits, observation stays, or inpatient admissions for following conditions (Administrative):
  - Diabetic Ketoacidosis/ Hyperglycemia,
  - Acute severe asthma,
  - Hypertensive crisis,
  - Fall injuries,
  - SUD, or
  - Mental health issues
- Outpatient or professional claims for following conditions (Administrative):
  - Diabetic retinopathy,
  - Influenza,
  - Pneumonia, or
  - Shingles
- Emergency department visits overall (Administrative)

#### *Data Sources:*

Data for interim evaluation of OCK were obtained from the following data sources:

- Data files containing member-level OCK eligibility data abstracted from each MCO's data system.
- Data files containing member-level OCK participation data abstracted from OCK's data system.
- Encounter, demographic, eligibility, and enrollment records from the State's Medicaid Management Information System (MMIS) reporting warehouse.

#### *Analytic Methods:*

The following analytical steps were applied to examine the outcome measures for the evaluation:

- 1) Each MCO submitted data files containing member-level OCK eligibility data.
- 2) Member-level OCK eligibility data abstracted from the MCOs data files and MMIS were reviewed for missing values, inconsistent patterns, and outliers.
- 3) KanCare 2.0 members constituting the target and comparison populations (intervention and comparison groups) were identified from member-level OCK eligibility and enrollment data abstracted from the MCOs' data files, OCK program data system files, and MMIS data files.

- 4) Demographic characteristics of the members in the intervention and comparison groups were examined for homogeneity.
- 5) MMIS encounter records related to the outcome measures for the intervention and comparison groups were reviewed for missing values, inconsistent patterns, and outliers.
- 6) Outcome measures rates were calculated.
- 7) Testing for statistically significant differences between 2020 and 2021 rates was conducted using a weighted Pearson chi-square test with  $p$  less than 0.05 indicating statistical significance. In addition, a chi-square test for equality of relative improvement of the intervention and comparison groups was conducted with  $p$  less than 0.05 indicating statistical significance.

## Qualitative Evaluation

### *Evaluation Design:*

Information from OCK Learning Collaborative meetings conducted from April 2020 through March 2022 was abstracted from summary reports for the qualitative evaluation of the OCK program. As described in these reports, meetings were attended by KDHE, MCOs, state organizations, provider network, and contracted OCK partners (OCKPs). These meetings were focused on identifying and addressing evolving learning needs, which allowed for continual quality improvement of the OCK program. In June 2021, the Wichita State University Community Engagement Institute (WSU CEI) launched a brief online survey of OCKPs on behalf of KDHE. This survey was intended to obtain a point-in-time impression of program success in achieving its goal from the perspective of contracted OCKPs. In July 2021, KDHE conducted six regional virtual meetings with OCK partners. In addition, the information regarding challenges encountered by providers in staffing their programs, and strategies used to address those challenges, was collected using a virtual polling platform during the March 22, 2022, OneCare Kansas Learning Collaborative session.

The qualitative information was abstracted as written in WSU CEI's Learning Collaborative meeting summaries, survey report, and six regional virtual meeting summaries. The information was reviewed for key themes as summarized in Appendix A, Tables A1–A8. These key themes are described in the Results section (Tables 5–11).

The qualitative evaluation focused on six items:

- Learning needs identified and discussed by OneCare Kansas Learning Collaborative participants
- Factors that facilitated the implementation of the OneCare Kansas program to achieve its goals
- Barriers/challenges seen in the implementation of the OneCare Kansas program
- Observations related to the OneCare Kansas program success in achieving its goals
- Assistance needed by OCK partners from the OCK Partners' Network and the State/MCO Implementation Team to assure quality services
- Recommendations and potential next steps for the OneCare Kansas program

## **c. Methodology for the Evaluation of Hypothesis 1 – MCOs' Value-Based Provider Incentive Programs**

As per the State's guidance and approval, each MCO designed a value-based provider incentive program (VBP) to address KanCare 2.0 Hypothesis 1. These VBPs will be evaluated to examine two questions included in the KanCare 2.0 Evaluation Design (Attachment A) by applying quantitative and qualitative evaluation methods (Table 2).

The three MCOs are in the process of initiating their VBPs. Aetna’s project is in the early stages of development, whereas Sunflower and UnitedHealthcare have recently started implementing their projects. Therefore, data are not currently available, and an interim evaluation of Hypothesis 1 was not conducted. At the end of 2023, data for at least two years will be available and examined as a part of the summative evaluation of KanCare 2.0. The MCOs’ VBPs are described below.

### Aetna VBP – CARE and CARE+ Programs with Community Mental Health Centers

#### *Proposed Launch Date of the Program:*

This project was targeted to launch in the first quarter of 2022.

#### *Program Details:*

Aetna provided the following details of the CARE and CARE+ programs with Community Mental Health Centers (CMHCs) program.

*“The CARE and CARE+ programs are a tiered pay-for-quality project designed to create integrated health care, bridging the gap between mental and physical health care for people diagnosed with mental illness (MI) or severe emotional disturbance (SED). A core assumption of the project is that people served within the public mental health system frequently experience silos within that system – a tendency to approach the person’s health through a psychiatric lens, and difficulty accessing physical health resources. Our project leverages the ability of CMHC providers to influence the course of care for those they serve, incentivizing specific outcomes and activities that we believe will result in overall improvements to quality of life and better health outcomes. We are approaching all CMHCs as potential participants. In addition, six CMHCs well-positioned to provide supportive housing and employment services will be approached for participation in the CARE+ program, which provides a second suite of measures and incentives targeted toward housing and employment.*

*Number of providers participating in the CMHC project: We are approaching each of Kansas’ community mental health centers as potential participants. As these discussions are ongoing, the final count is not yet determined.*

*There are two tiers of outcomes for this program. Outcomes are measured based on the total number of Aetna members served at each participating provider. The basic CARE program will measure:*

- *Provider follow-up after emergency department usage*
- *Provider follow-up after inpatient admission/discharge*
- *Usage of the Aetna Better Health of Kansas crisis notification system*
- *Usage of SBIRT screens for potential substance/addiction needs*
- *Provision of tobacco cessation services*
- *Diabetes Screening for people with Schizophrenia, Schizoaffective Disorder or Bipolar Disorder who are using antipsychotic medications*
- *Increase in number of members receiving peer support services (H0038, H0038-HQ).*
- *Use of Z-codes from a provided list, targeted toward social determinants of health, including but not limited to:*
  - *Homelessness*
  - *Inadequate housing*
  - *Food/Water insecurity*
  - *Unemployment*
  - *Tobacco Use*

In addition to the above, The CARE+ program will measure:

- Utilization of Operation: Community Integration (OCI) supported housing services
- Housing status change
- Employment status change

VBP Data Availability for Hypothesis 1 Evaluation: Aetna will be able to provide data needed for the evaluation to KFMC for at least two years. Provider data will be submitted at the onset of each CMHC agreement. Member data will be provided on an ongoing basis throughout the life of the program, with a 180-day delay to account for claims submission and processing.”

### Sunflower Health Plan VBP – Behavioral Health Project

*Proposed Launch Date of the Project:*

VBP Start Date: October 1, 2021

#### *Project Details:*

Sunflower provided the following details regarding the Behavioral Health Project.

“Sunflower Health Plan is just entering into a contract with Wheat State IPA to administer a Value Based Program with all 26 CMHCs (all currently contracted with Sunflower Health Plan). This is the first Behavioral Health VBP of its kind for Sunflower Health Plan but is rolling out to all Centene plans and live in CA as of April. This VBP is an all upside pay for performance contract for our CMHC providers who support our members on Medicaid. This program will encompass members who qualify for the VBP in the Children’s Health Insurance Program; on Autism Waiver, foster care, intellectual or developmental disability waiver, severe emotional disturbance waiver, Supplemental Security Income (SSI Non-Dual), and Temporary Assistance for Needy Families. This model focuses on three main objectives aligned with provider incentives:

- Engage moderate to high risk behavioral health members in appropriate levels of outpatient and community based treatment
- Measurement of member-reported improvement and outcomes
- Appropriate maintenance of members in the community

*Participating provider type: Clinic/Center: Mental Health (Including Community Mental Health Center)*

*Number of Providers: All TIN level providers (CMHCs) 26 have been invited to participate. One CMHC decided not to participate. They serve children.*

*Type of Medicaid Members Population:*

- We utilize machine-learned predictive modeling algorithms, to stratify members’ risk for behavioral health issues, inpatient admissions, and emergency room admissions.
- For our VBC, we are focusing on members with moderate to high BH risk:
  - From this population, the goal of the model is to engage members who receiving OP BH treatment (which inherently means they are using a lot of higher levels of BH treatment)

*Number of Medicaid Members: Our starting membership level is 4,500 Medicaid members but this potentially change month over month with new members and existing members who might enter into the stratification guidelines based on needs. We continuously stratify all members BH risk, regardless of*

*provider. All age groups are included. We utilize Optum Impact Pro software to stratify members by BH risk, emergency room risk, and inpatient admission risk. The algorithms are proprietary to the software.*

*Outcomes and the Measures that will be assessed by Sunflower: The measures we will be monitoring and paying incentives on are by stratified risk levels for the following:*

- *Treatment Initiation*
- *Speed to Care*
- *Member engagement in services*
- *Conducting baseline assessments*
- *Improvement in assessment scores*
- *Maintenance assessments*
- *Reduction of Emergency Room and Inpatient Utilization*
- *Outpatient follow-up from IP stay (timeliness to services)*

*Our baseline measures for this program are utilization on ED/IP/OP/RX for current “non-engaged” members. Members in the catchment area of the CMHC who do not currently utilize their services or the services of other Behavioral Health professionals. We are also using predictive modeling algorithms for identification of moderate/high risk members, even if they don’t yet have significant higher level of care utilization. “Non-engaged” is the member in risk group 1 to 5 who has not received more than three behavioral health care visits within the six-month period prior to being seen by the VBC provider. we continuously re-calculated every member status at time of their first visit with the VBC provider to determine if that member is eligible for the program.*

*The Wheat State IPA will monitor the data by CMHC, pay out the incentives based upon the agreed upon outcomes and coach/train during the initiation of the program as well as throughout the program implementation. For any participating CMHC who is struggling, the IPA will utilize behavioral health best practices and best practices of successful providers in the network to assist with their growth and ultimate success.*

*Number of providers are participating in the CMHC project: We are approaching each of Kansas’ community mental health centers as potential participants. As these discussions are ongoing, the final count is not yet determined.”*

### [UnitedHealthcare VBP – Pediatric Care Network Project](#)

#### [Project Details:](#)

UnitedHealthcare provided the following details regarding their Pediatric Care Network Project.

*“UnitedHealthcare Community Plan of Kansas has contracted with the Pediatric Care Network (PCN) in a value-based arrangement which incentivizes the PCN network to care for all aspects of our members, their patients, needs. We annually review specific quality metrics and pay for performance measures that if PCN achieves the target, they can earn extra dollars above a normal fee-for-service arrangement.*

*We propose in 2021, this arrangement include an incentive to meet and exceed PCN’s previous year’s attainment of the Follow-up Care for Children Prescribed ADHD Medication (ADD) measure. This proposal was based on feedback from State staff and KFMC staff in response to a previous proposal.*

*Since we do not finalize our annual contract with PCN until after the mid-year rates are completed, it is still timely for us to add this incentive to our PCN contract for CY 2021.*

*UHC proposes to address Hypothesis 1 by augmenting our value-based agreement with PCN to include meeting and improving their 2020 performance in the ADD HEDIS measure. This will incentivize PCN to meet the requirements of the ADD HEDIS measure which include 1 follow up visit with a practitioner with prescribing authority within 30 days of their first prescription (Initiation phase), and at least two follow-up visits with a practitioner in the 9 months after the Initiation Phase (Continuation and Maintenance Phase).*

*This intervention is more about the members included and the way they are managed and identified than the providers that are providing the service. Members are identified based on their rate cell and geographic location. Providers are included because they are part of the UHC network and serve members in this population. Outcomes will be determined based on the results of specific HEDIS measures.*

*The individuals in the intervention group and the comparison group are the same individuals, the time period is what provides the comparison point. This pre-post research design which will measure the effect of the intervention, i.e., the ADD HEDIS measure being added to the value-based contract. Per the UHC proposal, HEDIS measure ADD was added to the PCN contract effective 01/01/2021 so the period before the intervention is the pre period and the period after the intervention will be the post period.*

*UHC can provide the requested data points. Any of provider data will be based on the date the provider joined the UHC network.”*

#### **d. Methodology for the Evaluation of Hypothesis 2 – Employment and Independent Living Supports for KanCare 2.0 Members with Disabilities**

Outcome measures data for the evaluation of Hypothesis 2 were not collected by two MCOs as a part of their HRA tool. In 2021, the State and MCOs decided to revise the Health Screening Tool (HST) to include the questions required for data collection of the Hypothesis 2 evaluation measures. The HST was then incorporated by each MCO into their health assessment processes, and each of the MCOs started using this standardized HST for all members in 2022 (Sunflower Health Plan started in January 2022, UnitedHealthcare started in March 2022, and Aetna started in May 2022). As the standardized HST was not fully implemented until May 2022, data for Hypothesis 2 outcome measures are not currently available. The evaluation of Hypothesis 2 will be conducted as a part of the summative evaluation of KanCare 2.0.

#### **e. Methodology for the Evaluation of Hypothesis 3 – Use of Telehealth Services**

As described in the KanCare 2.0 Evaluation Design (Attachment A), the interim evaluation of Hypothesis 3 has quantitative and qualitative components.

##### Quantitative Evaluation

###### *Evaluation Design:*

The non-experimental One-Group Pretest–Posttest Design method was used to examine the evaluation questions of two components of Hypothesis 3, use of telemedicine services and use of telemonitoring services. The cross-year comparisons of the outcome measures among the Non-Urban members (living

in rural or semi-urban areas) who received telehealth were examined across 2019, 2020 and 2021. In addition, trend analysis over the three-year period (2019 through 2021) and comparisons to measures of Urban members were conducted.

*Target and Comparison Populations:*

- **Target Population:** KanCare 2.0 members living in the Non-Urban areas (rural or semi-urban areas) constituted the target population.
- **Intervention Group:** The members who received telehealth strategies (telemedicine and telemonitoring strategies) constituted the Intervention Group.
- **Comparison Population:** KanCare 2.0 members living in the Urban area was the comparison group for some measures.

*Evaluation Period:*

Data were collected from January 1, 2018 – December 31, 2021.

*Evaluation Measures:*

Since the evaluation measures are focused on the use of telehealth services among KanCare members living in the rural or semi-urban areas, data were examined in two geographic areas, Non-Urban and Urban. KDHE's grouping of counties into frontier, rural, densely rural, semi-urban and urban population density groups was used in defining the areas.<sup>12</sup> The Urban area contains the urban counties, as defined by KDHE: Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte counties. The Non-Urban area contained the frontier, rural, densely rural, and semi-urban counties.

The following outcome measures were assessed to examine the evaluation questions:

Telemedicine

- Percentage of telemedicine services received by members living in the rural or semi-urban areas. Subgroup analyses by age, primary diagnosis type, and primary diagnosis classification strata of diagnosis types.
- Number and percentage of receiving sites for telemedicine services (in the rural and semi-urban areas. Subgroup analyses by age.
- Number and percentage of members living in the rural or semi-urban areas who received telemedicine services. Subgroup analyses by age.
- Number of paid claims with selected procedure codes, stratified by area, mode of delivery, provider specialty, and selected diagnosis categories.
- Number of members with selected diagnosis (e.g., speech-language pathology) per 1,000 members, stratified by area.

The age strata used in analyzing the first three measures were 0–17 years, 18–45 years, and 46 years and older at the time of service received. These strata were selected to ensure adequate representation within each stratum. Also, the chronic diseases that can benefit from telemedicine services are more prevalent among 46 years and older adults.<sup>13</sup> In addition to age strata, counts by primary diagnosis were stratified by ICD-10-CM chapters and blocks, and strata with the highest counts are reported.

The stratified results for the two measures addressing fourth evaluation question (Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or

semi-urban areas?) were combined to form eight additional measures:

- Percentage of KanCare Members Receiving Speech Therapy Who Had a Diagnosis in Category F80
- Percentage of KanCare Members with Diagnosis in Category F80 Who Received Speech Therapy
- Percentage of KanCare Members Receiving Individual Psychotherapy Who Had an Indicating Diagnosis (categories F34, F40, F43, F60, F91, and F93)
- Percentage of KanCare Members with an Indicating Diagnosis Who Received Individual Psychotherapy
- Percentage of KanCare Members Receiving Family or Group Psychotherapy Who Had an Indicating Diagnosis (categories F34, F91, F93, T74, and T76)
- Percentage of KanCare Members with Indicating Diagnosis Who Received Family or Group Psychotherapy
- Percentage of KanCare Members Receiving Community Psychiatric Supportive Treatment Who Had an Indicating Diagnosis (F20, F25, F34, F60, and F91)

#### Telemonitoring

- Number and percentage of members living in the rural and semi-urban areas (Non-Urban) who received telemonitoring services.
- Number of telemonitoring services provided to members living in the rural and semi-urban areas (Non-Urban).
- Number of providers monitoring health indicator data transmitted to them by the members receiving telemonitoring services.

#### *Data Sources:*

Data for the interim evaluation of KanCare 2.0 Hypothesis 3 was obtained from the following source:

- The encounter, demographics, eligibility, and enrollment records from the State’s Medicaid Management Information System (MMIS) reporting warehouse.

#### *Analytic Methods:*

The following analytical steps were applied to examine the outcome measures for the evaluation of use of telemedicine and telemonitoring services.

- 1) Variables including member Medicaid ID, telehealth codes, and county codes from encounter, demographic, eligibility, and enrollment records from the State’s Medicaid Management Information System (MMIS) reporting warehouse were used to identify the target and intervention populations.
- 2) From encounter records, data for outcome measures were abstracted for the members identified for inclusion in the intervention and comparison populations.
- 3) Data abstracted in Steps 1 and 2 were reviewed for missing values, inconsistent patterns, and outliers to ensure quality and appropriateness of data for analyses required by the evaluation design.
- 4) The denominator and numerator counts and the rates or percentages of the outcome measures were calculated and stratified.
- 5) Appropriate statistical tests were applied. Statistical testing of differences in percentages between two consecutive years (2018 to 2019, 2019 to 2020, and 2020 to 2021) was conducted using a weighted Pearson chi-square test with  $p$  less than 0.05 indicating statistical significance. Weighted Mantel-Haenszel chi-square tests were applied to determine whether the slopes of 3-year trend lines were statistically significantly different from horizontal (trend analysis: 2019 to 2021) with  $p$

less than 0.05 indicating statistical significance.

- 6) Key outcome measure results and interpretations were described in narrative, tables, and figures (see Results section and Appendix B).

### Qualitative Evaluation

#### *Use of Telementoring Services:*

As mentioned above, data sources are not currently available to describe the status of the use of telementoring; therefore, quantitative evaluation was not conducted. The evaluation of the use of telementoring services focused on summarizing the telementoring efforts implemented by Sunflower Health Plan, the University of Kansas, and the University of Missouri.

The Project ECHO (Extension for Community Healthcare Outcomes) Model is used by Sunflower Health Plan, the University of Kansas, and the University of Missouri to provide telementoring services to providers. These efforts are summarized in Results section of this report.

#### Project ECHO Sunflower Health Plan

In response to the telementoring component of the KanCare 2.0 Hypothesis 3, Sunflower Health Plan served as a Project ECHO hub. A Project ECHO hub refers to “a regional center where a team of subject matter experts is located, replicates the ECHO Model™ and runs their own ECHO program.”<sup>14</sup> Sunflower Health Plan collaborated initially with the University of Kansas and later with the University of Missouri’s Office of Continuing Education, School of Medicine, and Sinclair School of Nursing to conduct this program. The information summarized in the Results section was abstracted from the report provided by Sunflower Health Plan titled “Project ECHO®. Sunflower Health Plan Kansas. 2019–Present.”<sup>15</sup>

#### KUMC Project ECHO® Series

In April 2021, the University of Kansas Medical Center (KUMC) conducted the KUMC Project ECHO® Series titled “Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders” for physicians, advanced practice clinicians, nurses, behavioral health providers, and other providers.<sup>16</sup> The purpose of the series was to improve healthcare providers’ capacity to implement evidence-based practices related to substance use disorder (SUD) prevention, screening, early intervention, referral to treatment, and risk reduction. The information summarized in the Results section is abstracted from the report, titled “Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders. KUMC Project ECHO® Series Summary Report”, provided by the KUMC Project ECHO®.<sup>16</sup>

#### *Telehealth Provider Survey:*

In addition to the assessment of quantitative outcome measures to examine the use of telemedicine and telemonitoring services, a qualitative evaluation was also conducted.

The qualitative information was collected, through a short online survey, from KanCare providers who offered telehealth services to KanCare members in 2020 or 2021. The survey was designed to gain an understanding of their experiences providing telehealth services to KanCare members, including facilitators and barriers related to the use telemedicine and telemonitoring services, and whether the use of these services improved access to care among KanCare members. In addition, providers were asked to provide recommendations for removing barriers to increasing the use of these services and improving access to care among KanCare members.

### Survey Population

The survey population was defined as KanCare providers who offered telehealth services to KanCare members in 2020 or 2021. These providers were identified through encounter records from the MMIS reporting warehouse. A total of 9,710 providers constitute the survey population.

### Survey Sample Frame

KanCare providers from the survey population with an email address were included in the survey frame. The contact information of the providers, obtained from the Kansas Medicaid Modular System (KMMS) database, was examined for the availability of an email address. A provider-specific or a group/organization email address was identified for 3,307 providers. A list of these 3,307 providers was compiled to serve as the sample frame.

### Survey Sample

A sample of 843 providers who offered telehealth services to KanCare members in 2020 and 2021, with a unique or group/organization email address, was selected from the sample frame to send an invitation to participate in the Telehealth Provider Survey. The survey sample included all the providers for whom unique email addresses were available. The selection of providers with a group/organization email was done by examining the number of providers with that email. If the organization had a small number of providers, then all providers with that group/organization email address were included in the sample. For the large organizations with several providers with the same group/organization email address, 5 to 10 providers with 201 or more claims, 5 to 10 providers with 100 to 200 claims, and 5 to 10 providers with less than 100 claims were selected for the sample. Though these providers were selected randomly, a rigorous probability sampling methodology was not applied as the purpose of this survey is to collect qualitative information from providers regarding their experience with telehealth services for KanCare members.

### Survey Questionnaire

The survey questionnaire had an introductory paragraph describing the purpose of the survey and twelve questions. The initial two questions were designed to collect information on primary locations of the respondents and the type of healthcare service they provide. The third question was directed toward confirming whether they provided telehealth services to KanCare members. For the respondents selecting “Yes” to the third question, nine subsequent questions were designed using a close-ended question format for eight of these questions, and an open-ended format for one question. For the respondents selecting “No” to the third question, before directing them to end the survey, an open-ended question was asked regarding the reasons for not providing telehealth services. To conduct the survey using the SurveyMonkey software platform, the survey questionnaire was formatted using the Software’s online survey building features.

### Survey Implementation

SurveyMonkey was used to conduct the survey. The email invitation with an online survey link was sent directly to the providers with provider-specific email addresses. For the providers using the same group/organization email address, the emailed invitation included a list of the selected providers’ names and a request for the recipient to forward the survey link to all listed providers. If the recipient was a provider, the email also included a request to complete the survey as well as forward it to others. These emails were sent to 96 group/organization addresses to reach these providers.

### Analytic Method

SurveyMonkey analysis and reporting features were used to collect the responses provided by the

survey respondents. Respondents were kept anonymous. The responses to survey questions abstracted from SurveyMonkey were reviewed and categorized into key themes to summarize the providers' experiences related to use of telehealth services for providing healthcare to KanCare members.

#### **f. Methodology for the Evaluation of Hypothesis 4**

As per a recommendation from CMS, the KanCare 2.0 Hypothesis 4 evaluation methodology description is included in a separate report prepared for the interim evaluation of the KanCare 2.0 Section 1115 SUD Demonstration.

#### **g. Monitoring of the Overall KanCare 2.0 Performance Measures**

The final evaluation of the KanCare Demonstration conducted for the first six years of the program (2013–2018) identified areas for improvement. The KanCare 2.0 Evaluation design (Attachment A) proposed monitoring of thirteen performance measures related to a few of these areas during the period of 2019 through 2023. Changing circumstances made deviations from the proposal necessary. The changes will be explained below. The interim evaluation of overall performance measures was conducted using quantitative methods.

As proposed in the KanCare 2.0 Evaluation Design (Attachment A), two HEDIS measures and a Consumer Assessment of the Healthcare Providers and Systems (CAHPS) adult survey measure were examined for inclusion in the interim evaluation.

For the HEDIS measure Prenatal and Postpartum Care (PPC), only measurement years (MY) 2019 and 2020 rates were included in the evaluation. Because of specification changes, NCQA indicated a break in trending from prior rates. A break in trending was indicated for the HEDIS Comprehensive Diabetes Care (CDC) indicator Blood Pressure Control between MY 2019 and MY 2020; because only one data point remained, the indicator was excluded from the evaluation.

The comprehensive diabetes care HEDIS measures were reorganized by NCQA since the KanCare 2.0 Evaluation Design was written. Three indicators were discontinued: Medical Attention for Nephropathy, HbA1C Testing, and HbA1c Control (<7.0%). The remaining four indicators were separated into three independent measures that are percentages of members 18–75 years of age with diabetes (types 1 and 2).<sup>17</sup>

- Hemoglobin A1c Control for Patients with Diabetes (HBD) – Percentage whose hemoglobin A1c (HbA1c) was at the following levels:
  - HbA1c Control (<8.0%)
  - Poor Control HbA1c (>9.0%)
- Eye Exam Performed for Patients with Diabetes (EED) – Percentage who had a retinal eye exam
- Blood Pressure Control for Patients with Diabetes (BPD) – Percentage whose blood pressure was adequately controlled (<140/90 mm Hg)

The KanCare 2.0 Evaluation Design proposed monitoring of four mental health measures using data from the Kansas Medicaid Mental Health Consumer Perception Survey reports. However, that survey was replaced in 2021 with the Experience of Care and Health Outcomes (ECHO) Survey. Because the questions related to the selected measures from the Kansas Medicaid Mental Health Consumer Perception Survey were not available in the ECHO Survey, data from Kansas ECHO survey for three years (2021, 2022, 2023) will be examined for the KanCare 2.0 Evaluation. Currently, ECHO Survey data for the mental health measures are available for only on year (2021); therefore, the measures were not

included in the interim evaluation but are expected to be included in the KanCare 2.0 summative evaluation.

Also, the KanCare 2.0 Evaluation Design proposed monitoring of six measures related to social and community engagement among KanCare members receiving HCBS services by using data from the Kansas Consumer Assessment of Healthcare Providers and Systems Home and Community Based Services (HCBS CAHPS) Survey. The Kansas HCBS CAHPS survey was conducted only in 2019. The Kansas Department of Aging and Disability Services (KDADS) decided not to repeat this survey. Instead, Kansas data from the National Core Indicators (NCI) survey and National Core Indicators—Aging and Disabilities (NCI-AD) Survey will be used to monitor measures related to Social and Community Engagement among KanCare members receiving HCBS services. The measures from 2016-2017, 2017-2018 and 2018-2019 Kansas NCI surveys,<sup>16,19,20</sup> and from 2018-2019 and 2019-2020 Kansas NCI-AD surveys<sup>21,22</sup> were examined for the interim evaluation.

#### *Target and Comparison Populations:*

The HEDIS measures included in the evaluation assessed performance of adult and infant KanCare 2.0 members. The CAHPS adult surveys were distributed to adult KanCare 2.0 members aged 18 years or older.<sup>23,24</sup> The Kansas NCI surveys were conducted among members who are Medicaid eligible, 18 years and older, receiving at least one Intellectual/Developmental Disability (I/DD) waiver service (waiver services to not include services from Intermediate Care Facilities for Individuals with Intellectual Disabilities). The Kansas NCI-AD surveys were conducted among adults who are Medicaid eligible and receive long term services and supports (LTSS) through the Frail Elderly (FE), Physical Disability (PD) and Brain Injury (BI) waiver programs.

#### *Evaluation Periods:*

HEDIS measures – Measurement Years 2019–2020

CAHPS survey measure – Survey Years 2019–2021 (MY 2019–2020)

Kansas NCI Survey measures – Survey Years 2016-2017, 2017-2018, and 2018-2019

Kansas NCI-AD Survey measures – Survey Years 2018-2019 and 2019-2020

#### *Evaluation Measures:*

The following outcome measures were assessed.

- Prenatal and Postpartum Care (PPC) [HEDIS measure]
  - Timeliness of Prenatal Care – Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization
  - Postpartum Care – Percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery
- Comprehensive Diabetes Care [HEDIS measures; percentage of members 18–75 years of age with diabetes (types 1 and 2)]
  - Hemoglobin A1c Control for Patients with Diabetes (HBD) – Percentage whose hemoglobin A1c (HbA1c) was at the following levels:
    - HbA1c Control (<8.0%)
    - Poor Control HbA1c (>9.0%)
  - Eye Exam Performed for Patients with Diabetes (EED) – Percentage who had a retinal eye exam.
- Blood Pressure Control for Patients with Diabetes (BPD) – Percentage whose blood pressure was adequately controlled (<140/90 mm Hg)

- Medical Assistance with Smoking and Tobacco Use Cessation (MSC) [CAHPS survey HEDIS measure]
  - Advising Smokers and Tobacco Users to Quit – Percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the prior six months
  - Discussing Cessation Medications – Percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medication in the prior six months
  - Discussing Cessation Strategies – Percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies in the prior six months.
- Social and Community Engagement [Kansas NCI Survey and Kansas NCI-AD Survey Measures]
  - Kansas NCI Survey Measures
    - Can see and communicate with their family when they want (if not living with family)
    - Has friends (may be staff or family) and can see them when wants
    - Able to go out and do the things they like to do in the community as often as they want
    - Services and Supports help person live a good life
    - Decides or has input in deciding how to spend free time
    - Decides or has input in deciding daily schedule
  - Kansas NCI-AD Survey Measures
    - Percentage of people who are always able to see or talk to friends and family when they want to (if have friends and family who do not live with person)
    - Percentage of people who are able to do things they enjoy outside of home as much as they want to
    - Percentage of people whose services help them live a better life
    - Percentage of people who like how they spend their time during the day
    - Percentage of people who get up and go to bed when they want to
    - Percentage of people who can eat their meals when they want to

*Data Sources:*

- HEDIS measure data submitted by the MCOs for measurement years 2016 to 2020
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, 2018 to 2021<sup>23,24</sup>
- NCI In-Person Surveys, 2016-2017, 2017-2018, and 2018-2019 Kansas State Reports<sup>16,19,20</sup>
- NCI-AD Adult Consumer Surveys, 2018-2019 and 2019-2020 Kansas Results<sup>21,22</sup>

*Analytic Methods:*

The following analytical steps were applied to examine the monitoring of overall KanCare 2.0 performance measures.

- HEDIS and CAHPS Survey Measures:
  - The Prenatal and Postpartum Care (PPC) and Comprehensive Diabetes Care indicator rates were calculated from Certified, Audited HEDIS Health Plan rates that were calculated by the MCOs using administrative and medical record data for samples of members meeting administrative criteria. KanCare rates are weighted averages of the MCOs' rates, weighted by the measures' administrative denominators.
  - Four CAHPS questions on the adult survey questionnaire addressed smoking and tobacco use and cessation strategies among adult members. Respondents indicated whether or not they smoked or used tobacco. If respondents replied "everyday" or "some days" to the smoking and tobacco use question, they were asked three questions about cessation strategies that form

indicators of the HEDIS measure Medical Assistance with Smoking and Tobacco Use Cessation (MSC). KanCare rates for the MSC indicators were calculated from CAHPS survey responses. These rates represented the combined membership of each MCO's indicated populations. KanCare rates were averages weighted by the counts of members meeting survey eligibility criteria. MSC rates are reported as one-year rates, as opposed to two-year rolling averages, to accommodate statistical testing of differences between years.

- KanCare rates were compared to national percentiles for all Medicaid and CHIP health plans made available through Quality Compass (QC). KanCare rates were ranked using the QC percentiles. The ranks are denoted, in order of worst to best performance: <5<sup>th</sup>, <10<sup>th</sup>, <25<sup>th</sup>, <33.33<sup>rd</sup>, <50<sup>th</sup>, ≥50<sup>th</sup>, >66.67<sup>th</sup>, >75<sup>th</sup>, >90<sup>th</sup>, and >95<sup>th</sup>. For example, a rate ranked <10<sup>th</sup> will be less than the 10<sup>th</sup> percentile but not less than the 5<sup>th</sup> percentile.
- Statistical testing to assess statistically significant differences between two consecutive years (2019 to 2020, and 2020 to 2021) was conducted using a weighted Pearson chi-square test with *p* less than 0.05 indicating statistical significance.
- Kansas NCI Survey Measures:
  - The percentages for the NCI Survey measures were abstracted from the 2016-17, 2017-18, and 2018-19 National Core Indicators (NCI®) In-Person Surveys, Kansas State Reports.
  - Absolute improvement was examined by comparing percentages across the three survey years.
- Kansas NCI-AD Survey Measures:
  - The percentages for the NCI-AD Survey measures were abstracted from the 2018–2019 and 2019–2020 survey reports.
  - Absolute improvement was examined by comparing percentages across the three survey years.

## **Methodological Limitations**

Due to state-wide implementation of the KanCare 2.0 Demonstration, the evaluation of overall strategies (Service Coordination Strategy and OneCare Kansas program) and four hypotheses is limited by the lack of true comparison groups. All Medicaid clients in the state are subject to participation in the Demonstration. As a result, the evaluation design included comparisons among members in the Intervention and Comparison Groups (without true external comparison groups); therefore, the pre- and post-test evaluation design or comparisons to baselines may suggest overall improvements in outcomes due to the demonstration and observed associations may not imply causality due to a specific intervention.

The use of administrative claims and encounters data sources can be a limitation. These data sources are designed and collected for billing purposes but will be used in the evaluation to determine changes in access to services, quality of care, and health outcomes. However, most of the measures selected for assessment of the evaluation questions are validated and widely used for this purpose. While administrative data might be able to identify key cases and statistical trends, these are usually limited in providing detailed health and health behavior information, thus making it difficult to obtain information on possible covariates. Also, due to the use of population-level data, the effect size of measured differences represents true differences; however, this may or may not correspond to meaningful changes at the intervention or program levels.

Because MCO member-level HEDIS data were not available for measurement years 2016 through 2021, HEDIS rates were calculated from encounter data. Rates calculated from encounter records do not match the MCOs' rates and are not to be considered HEDIS Health Plan rates; calculation of HEDIS rates

by the MCOs incorporates supplemental data not available through encounters, such as data extracted from medical records and claims from other lines of business. HEDIS rates calculated from encounter data are Uncertified, Unaudited HEDIS rates. Not all HEDIS rates could be adequately produced from encounter data; Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) rates were excluded from the evaluation due to poor comparisons to rates calculated from MCO member-level detail records.

Data lag also causes a challenge in measuring and reporting change in a timely manner. Analysis from encounter data was limited to dates of service occurring in 2016 through 2021 and further limited to encounters received into the State's system within 3 months of the measurement year. The latest HEDIS data from the MCOs available for analysis was measurement year 2020.

As the evaluation covers multiple years, definitions and specifications of the evaluation measures, policies for data collection, and infrastructure of the data sources were subject to change during the evaluation period. Adjustments were made to analytic plans, where possible. These include adjusting HEDIS measure calculations to reflect more current technical specifications and modifying inclusion criteria for the Service Coordination Strategy intervention and comparison groups due to missing data.

Comparison group options using members who are the members of the intervention's target population will be applied, therefore, there is a possibility of encountering methodological issues (such as selection bias due to differences in the characteristics of members opting-in for the participation in the intervention and those not opting-in, multiple treatment threats due to other interventions, effect of confounding variables, inadequate statistical power, and multiple comparisons issues) that will require application of appropriate techniques.

A lack of standardization of the HST, HRA, Needs Assessment and PCSP variable fields, in the datasets provided by the MCOs, created limitations in compiling the Intervention and Comparison Groups needed for the interim evaluation measurement period. Through a contract amendment, the HST and HRA have been standardized, with implementation of the standardized tools occurring in early 2022.

Issues with comparability of intervention and control groups, time periods, or strata were encountered. Appropriate techniques were applied to address these issues as much as possible.

- The COVID-19 public health emergency was a very strong confounding variable that impacted almost all aspects of the evaluation.
- As an emergency measure, disenrollment from KanCare was suspended for many members who would otherwise have become ineligible for benefits (e.g., CHIP members turning 19 years old and 60 days after delivery for women receiving benefits due to pregnancy). Consequently, the number of KanCare members increased in 2020 and 2021 (impacting utilization rates) and the homogeneity of the population changed (impacting statewide outcome measures).
- The intervention and control groups for evaluation of the Service Coordination Strategy and OneCare Kansas groups were subject to self-selection bias due to differences in the characteristics of members opting-in for the participation in the intervention and those not opting-in.
- Telehealth was implemented statewide, which creates spillover effects.
- Differences in the type of providers available to offer services differed between regions of the state, which made it a confounding variable for evaluation of telehealth.

- Some measures (e.g., Prenatal and Postpartum Care and Follow-Up After Hospitalization for Mental Illness for evaluation of the Service Coordination Strategy and OneCare Kansas groups) were not reported for due to inadequate statistical power (too few members met denominator criteria).
- Statistical testing results on measures with large denominators frequently produced *p*-values less than 0.001. If confounding variables were known, test results may not have been meaningful for evaluation of the hypotheses.

## **Results**

### **a. KanCare 2.0 Service Coordination Strategy**

#### Quantitative Evaluation

For the interim evaluation of the KanCare 2.0 Service Coordination Strategy, the six selected performance outcome measures were examined for the Intervention Group and Comparison Group 2 for the pre-intervention period (2016–2018) and intervention period (2019–2021). The Intervention Group rates calculated for the pre-intervention period (2016–2018) constituted the rates for Comparison Group 1. The results are summarized in Table 3.

#### *Demographic Analysis:*

Demographic analysis included stratifying the Intervention Group and Control Group 2 by MCO and by whether or not they received HCBS services. Since all HCBS waiver participants are eligible for service coordination, they represent a higher percentage of members participating in service coordination than non-HCBS participants. Examples of non-HCBS participants in service coordination may include members with behavioral health needs or complex/chronic conditions, members in nursing or residential facilities, hospitals or members in foster care. The ratio of HCBS waiver participants to non-HCBS participants was different between the intervention and control groups: 82% of the 23,807 members in the Intervention Group were HCBS recipients compared to 26% of the 26,712 members in Control Group 2. At the MCO-level, the percentages of HCBS recipients in the Intervention Group were 57%, 93%, and 95%; the percentages of HCBS recipients in Control Group 2 were 4%, 16%, and 44%. Because service coordination was available through HCBS services prior to KanCare 2.0, inclusion of HCBS recipients will dampen the planned analysis to measure the impact of extending service coordination to non-HCBS recipients. Of the 4,366 non-HCBS recipients in the Intervention Group, 77% were from one MCO; the reason for this difference is unknown.

As noted in the evaluation methodology for the service coordination strategy, the COVID-19 pandemic impeded the MCOs' abilities to fully administer the service coordination strategy as designed, for much of the intervention period. While data is provided for the service coordination evaluation measures, conclusions regarding the effectiveness of the strategy are not possible at this time.

#### *Measure 1: Adults' Access to Preventive/Ambulatory Health Services (AAP):*

The Intervention Group's RFR improvement was not statistically different from that of Comparison Group 2. The RFR, which measures improvement relative to the amount of possible improvement, should be higher for the intervention group to show effectiveness. The following results were seen for the AAP measure:

- The 2016–2018 AAP rates were high for both Intervention Group (95.8%) and Comparison Group 2 (94.3%). Since the Intervention Group has less potential for improvement, equal percentage point increases would result in larger RFRs for the Intervention Group than for Comparison Group 2.
- For both groups, the 2019–2021 AAP rates were about 1 percentage point lower than the 2016–2018 AAP rates, which is shown in Table 3 as a difference of –1 percentage points. The Intervention Group’s rate decreased to 94.8%; the AAP rate for Comparison Group 2 decreased to 93.2%.
- The RFR improvements were also about the same. The RFR for the Intervention group was –22.9%; the formula is  $RFR = (94.8\% - 95.8\%) / (100\% - 95.8\%)$ . The RFR for Comparison Group 2 was –19.1%.
- The difference in RFRs was not statistically significant ( $p=.27$ ). Statistical significance of the differences between 2016–2018 and 2019–2021 rates was expected; it was assumed the COVID-19 pandemic would impact AAP rates. Also, the denominators are large, so small changes in rates would yield significant findings.
- The differences between Intervention Group and Comparison Group 2 rates are indications of comparability of the two groups. The significance of the differences was not surprising since members who elect to receive service coordination may be more likely have medical conditions requiring preventive or ambulatory health services. These differences are accounted for by comparing RFRs instead of percentage point differences between years.

*Measure 2: Annual Dental Visit (ADV):*

For Intervention Group and Comparison Group 2, negative RFRs for ADV measure were seen. For the Intervention Group, a statistically significant lower RFR was seen. The RFR should be higher for the intervention group to show effectiveness. The following results were seen for the ADV measure:

- The 2016–2018 ADV rates for the Intervention Group and the Comparison Group 2 were 54.4% and 63.9%, respectively. A statistically significant difference of 9.5 percentage points was seen between the rates for the two groups ( $p<.001$ ).
- The 2019–2021 ADV rates for both groups were lower than the 2016–2018 rates. The Intervention Group’s rate decreased to 47.9%, showing a difference of 6.5 percentage points. The rate for the Comparison Group 2 decreased to 62.3%, showing a difference of 1.6 percentage points.
- For both groups, negative values of RFRs were seen. The RFR for the Intervention group was –14.2%. The RFR for Comparison Group 2 was –4.5%. The difference in RFRs for the two groups was statistically significant ( $p<.001$ ), showing the decrease was larger for the Intervention Group than for the Comparison Group 2.

*Measure 3. Adolescent Well-Care Visit (AWC):*

For Intervention Group and Comparison Group 2, negative RFRs for the AWC measure were seen. For the Intervention Group, a statistically significant lower RFR was seen. The RFR should be higher for the Intervention Group to show effectiveness. The following results were seen for AWC measure:

- The 2016–2018 AWC rates for the Intervention Group and the Comparison Group 2 were 47.2% and 52.3%, respectively. A statistically significant difference of 5.1 percentage points was seen between the rates for the two groups ( $p<.001$ ).
- The 2019–2021 AWC rates for both groups were lower than the 2016–2018 rates. The Intervention Group’s rate decreased to 42.4%, showing a difference of 4.8 percentage points. The rate for Comparison Group 2 decreased slightly to 52.0%, showing a difference of 0.2 percentage points.
- For both groups, negative values of RFRs were seen. The RFR for the Intervention group was –9.1%. The RFR for Comparison Group 2 was –0.5%. The difference in RFRs for the two groups was statistically significant ( $p<.001$ ), showing the decrease was larger for the Intervention Group than for

the Comparison Group 2.

*Measure 4: ED Visits, Observation Stays, or Inpatient Admissions for Following Conditions:*

- *Diabetic Ketoacidosis/Hyperglycemia,*
- *Acute Severe Asthma,*
- *Hypertensive Crisis,*
- *Fall Injuries,*
- *SUD, or*
- *Mental Health Issues*

Rates for Intervention Group and Comparison Group 2 increased instead of improving. The relative increase was greater for the Intervention Group (i.e., the difference in RFRs was statistically significant), which indicates poorer performance. The following results were seen for the measure:

- The 2016–2018 ED Visits, Observation Stays, or Inpatient Admissions for Diabetic Ketoacidosis/Hyperglycemia, Acute Severe Asthma, Hypertensive Crisis, Fall Injuries, SUD, or Mental Health Issues rates for the Intervention Group and the Comparison Group 2 were 52.6 occurrences (visits, stays, or admissions) per 1,200 member-months and 86.4 occurrences (visits, stays, or admissions) per 1,200 member-months, respectively.
- The Intervention Group’s rate increased 9.4 occurrences per 1,200 member-months. The rate for the Comparison Group 2 increased only 3.7 occurrences per 1,200 member-months.
- The RFR for the Intervention Group was –17.9%, which indicates worse performance than the RFR of –4.3% for Comparison Group 2. The difference in RFRs for the two groups was statistically significant ( $p < .001$ ).
- The difference between rates of 33.9 occurrences per 1,200 member-months indicates an underlying difference in health status between the two groups, which may have contributed to their differing performance under this measure.

*Measure 5: Outpatient or Professional Claims for Following Conditions:*

- *Diabetic retinopathy*
- *Influenza*
- *Pneumonia or*
- *Shingles*

Results support the assertion that the KanCare 2.0 Service Coordination Strategy had a positive impact on the Outpatient or Professional Claims, for Diabetic Retinopathy, Influenza, Pneumonia or Shingles rates. Instead of decreasing, which would indicate improvement, rates for both the Intervention Group and Comparison Group 2 increased. However, the increase was greater for Comparison Group 2. The difference in RFRs was statistically significant, which indicates the Intervention Group performed better than Comparison Group 2 under the circumstances. The following results were seen for the measure:

- The 2016–2018 rates for Outpatient or Professional Claims for Diabetic Retinopathy, Influenza, Pneumonia or Shingles for the Intervention Group and Comparison Group 2 were 66.9 claims per 1,200 member-months and 56.6 claims per 1,200 member-months, respectively. The 10.3 claims per 1,200 member-months difference in these rates was statistically significant but was considered acceptable for the analysis.
- The 2019–2021 rates for both groups were higher than the 2016–2018 rates. The Intervention Group’s rate increased 11.5 claims per 1,200 member-months. The rate for Comparison Group 2

increased 18.6 claims per 1,200 member-months.

- For both groups, negative values of RFRs were seen. The RFR for the Intervention group was –17.3%, which was “less worse” than RFR of –32.8% for Comparison Group 2. The difference in RFRs for the two groups was statistically significant ( $p<.001$ ).

**Measure 6: Emergency Department Visits Overall (Administrative):**

Neither intervention and comparison group’s rate changed statistically significantly between time periods, and the difference in RFRs was not statistically significant. The following results were seen for the measure:

- The 2016–2018 Emergency Department Visits (Overall) rate was 141.5 claims per 1,200 member-months for the Intervention Group and 192.7 claims per 1,200 member-months for Comparison Group 2.
- For both groups, the 2019–2021 Emergency Department Visits (Overall) rates were lower than the 2016–2018 rates. The Intervention Group’s rate decreased 2.3 claims per 1,200 member-months. The rate for the Comparison Group 2 slightly decreased 1.4 claims per 1,200 member-months. The decreases were not statistically significant ( $p=.13$  and  $p=.48$ , respectively).
- The RFR for the Intervention Group (1.6%) and RFR for Comparison Group 2 (0.8%) were not statistically significantly different ( $p=.41$ ).

Table 3. KanCare 2.0 Service Coordination Strategy Evaluation Measures						
	Intervention Group		Comparison Group 2		Statistics	
	Rate	Denominator	Rate	Denominator	Difference	Significance
<b>Adults’ Access to Preventive/Ambulatory Health Services (AAP)*</b>						
<b>2016–2018</b>	95.8%	42,267	94.3%	26,770	1.5 pp	$p<.001$
<b>2019–2021</b>	94.8%	47,722	93.2%	37,684	1.6 pp	$p<.001$
Difference, $p$ -value	-1.0 pp	$p<.001$	-1.1 pp	$p<.001$		
RFR Improvement	-22.9%		-19.1%			$p=.27$
<b>Annual Dental Visit (ADV)*</b>						
<b>2016–2018</b>	54.4%	10,280	63.9%	11,310	-9.5 pp	$p<.001$
<b>2019–2021</b>	47.9%	11,371	62.3%	13,766	-14.4 pp	$p<.001$
Difference, $p$ -value	-6.5 pp	$p<.001$	-1.6 pp	$p=.01$		
RFR Improvement	-14.2%		-4.5%			$p<.001$
<b>Adolescent Well-Care Visit (AWC)*</b>						
<b>2016–2018</b>	47.2%	10,070	52.3%	10,780	-5.1 pp	$p<.001$
<b>2019–2021</b>	42.4%	11,176	52.0%	13,004	-9.6 pp	$p<.001$
Difference, $p$ -value	-4.8 pp	$p<.001$	-0.2 pp	$p=.70$		
RFR Improvement	-9.1%		-0.5%			$p<.001$
<b>ED Visits, Observation Stays, or Inpatient Admissions for Following Conditions:                      Diabetic Ketoacidosis/Hyperglycemia, Acute Severe Asthma, Hypertensive Crisis, Fall Injuries, SUD, or Mental Health Issues^</b>						
<b>2016–2018</b>	52.6	44,132	86.4	30,447	-33.9	$p<.001$
<b>2019–2021</b>	62.0	51,549	90.2	45,367	-28.2	$p<.001$
Difference, $p$ -value	-9.4	$p<.001$	-3.7	$p=.01$		
RFR Improvement	-17.9%		-4.3%			$p<.001$

Table 3. KanCare 2.0 Service Coordination Strategy Evaluation Measures (Continued)						
	Intervention Group		Comparison Group 2		Statistics	
	Rate	Denominator	Rate	Denominator	Difference	Significance
<b>Outpatient or Professional Claims for Following Conditions:</b> Diabetic Retinopathy, Influenza, Pneumonia, or Shingles <sup>^</sup>						
<b>2016–2018</b>	66.9	44,132	56.6	30,447	10.3	<i>p</i> <.001
<b>2019–2021</b>	78.4	51,549	75.2	45,367	3.3	<i>p</i> <.01
Difference, <i>p</i> -value	-11.5	<i>p</i> <.001	-18.6	<i>p</i> <.001		
RFR Improvement	-17.3%		-32.8%			<i>p</i> <.001
<b>Emergency Department Visits Overall<sup>^</sup></b>						
<b>2016–2018</b>	141.5	44,132	192.7	30,447	-51.2	<i>p</i> <.001
<b>2019–2021</b>	139.2	51,549	191.2	45,367	-52.1	<i>p</i> <.001
Difference, <i>p</i> -value	2.3	<i>p</i> =.13	1.4	<i>p</i> =.48		
RFR Improvement	1.6%		0.8%			<i>p</i> =.41
Reduction in failure rate (RFR) measures improvement relative to the amount of possible improvement. The formula is: $RFR = \frac{\text{Final Rate} - \text{Initial Rate}}{\text{Goal} - \text{Initial Rate}}$ where Goal = 100% or 0%, depending on the measure. *Measures were calculated from MMIS encounter data based on specifications for HEDIS Health Plan measures. Rates differ from Certified, Audited HEDIS health plan rates calculated by MCOs due to differences in available source data. To calculate RFR, the goal was 100%. Differences in rates are shown in percentage points (pp) and were tested for statistical significance using a Pearson chi-square test. A chi-square test was used to test for equality of RFR improvements. ^Measures were calculated from MMIS encounter data that was deduplicated to count one claim per member, per billing provider NPI, per last date of service. Rates are the number of claims in the measurement period per 1,200 member-month, which may be interpreted as the average number of claims in a year for 100 members. The denominator shown is the total member-months divided by 12 (i.e., the total of the average number of members in each year within the measurement period). Large sample z-tests were used to test for differences between rates and RFR improvements.						

## b. OneCare Kansas program

### Quantitative Evaluation

For the interim evaluation of the OneCare Kansas (OCK) program, the six selected performance outcome measures were examined in the Intervention Group and Comparison Group 2 for the pre-intervention period (2016–2019) and intervention period (2020–2021). The rates calculated for the pre-intervention period (2016–2019) constituted the rates for the Comparison Group 1. The results are summarized in Table 4. As noted in the evaluation methodology, the COVID-19 pandemic impeded the MCOs’ abilities to fully administer the service coordination strategy as designed, for much of the intervention period. While data is provided for the OCK evaluation measures, conclusions regarding the effectiveness of the strategy are not possible at this time.

Review of the MCOs’ data files indicated the MCOs’ processes to determine members’ OCK eligibility, per the State’s criteria, had some variability. Differences were also seen between KFMC’s identification of eligible members from encounters (using the State’s OCK program eligibility criteria), and the dataset provided by one of the MCOs, with KFMC identifying more eligible members.

#### Measure 1: Adults’ Access to Preventive/Ambulatory Health Services (AAP):

Results supports the assertion that the OCK program had a positive impact on Adult’s Access to Preventive/Ambulatory Health Services rates. The Intervention Group’s rate improved while Comparison Group 2’s rate declined. The difference in the relative improvements was statistically significant. The following results were seen for the AAP measure:

- The 2016–2019 AAP rates were high for both the Intervention Group (97.5%) and Comparison Group 2 (94.6%). Since the Intervention Group has less potential for improvement, equal percentage point increases would result in larger RFRs for the Intervention Group than for Comparison Group 2.

- For the Intervention Group, the 2020–2021 AAP rate was 0.2 percentage points higher than the 2016–2019 AAP rate; the AAP rate for Comparison Group 2 decreased 2.4 percentage points.
- The increase in the Intervention Group’s AAP rates was a 7.4% relative improvement. The RFR for Comparison Group 2 was –44.2%. The difference in RFRs was statistically significant ( $p < .001$ ).
- Statistically significant differences between 2016–2019 and 2020–2021 rates were expected; it was assumed the COVID-19 pandemic would impact AAP rates. Also, the denominators are large, so small changes in rates can yield significant findings.
- The differences between the Intervention Group and Comparison Group 2 rates are indications of comparability of the two groups. The significance of the differences was not surprising since members who elect to receive OCK program services may be more likely have medical conditions requiring preventive or ambulatory health services. These differences are accounted for by comparing RFRs instead of percentage point differences between years.

*Measure 2: Annual Dental Visit (ADV):*

Results suggest the OCK program may have had a positive impact on Annual Dental Visit rates. Although ADV rates for both groups decreased, the Intervention Group’s rate did not decrease as badly as the Comparison Group 2’s rate did, based on the RFRs—the Intervention Group’s RFR was closer to positive than Comparison Group 2’s RFR, and the difference was statistically significant. The following results were seen for the ADV measure:

- The 2016–2019 ADV rates for the Intervention Group and the Comparison Group 2 were 72.2% and 66.3%, respectively.
- The 2020–2021 ADV rates for both groups were lower than the 2016–2019 rates; 3.0 percentage points for the Intervention Group and 9.5 percentage points for Comparison Group 2.
- The RFR for the Intervention Group was –10.7%. The RFR for Comparison Group 2 was –28.3%. The difference in RFRs for the two groups was statistically significant, showing the Intervention Group fared relatively better in the last two years than Comparison Group 2.
- The differences between groups within each period are large enough to warrant comparison of RFRs, but not so large as to indicate Comparison Group 2 is not suitable to be a comparison group for the analysis.

*Measure 3. Adolescent Well-Care Visit (AWC):*

Results support the assertion that the OCK program had a positive impact on Adolescent Well-Care Visit rates. As with the AAP rates, the AWC rate for the Intervention Group increased (non-significantly) while the AWC rate for Comparison Group 2 decreased. The difference in RFRs was statistically significant. The following results were seen for the AWC measure:

- The 2016–2019 AWC rates for the Intervention Group and the Comparison Group 2 were 59.1% and 51.4%, respectively. The difference of 7.7 percentage points was acceptable for the analysis.
- For Intervention Group, the 2020–2021 AWC rate was 0.8 percentage points higher than the 2016–2019 rate. The Comparison Group 2 AWC rate decreased 6.5 percentage points.
- The RFR for the Intervention Group was 2.0% and the RFR for Comparison Group 2 was -13.3%. The difference in RFRs was statistically significant.

*Measure 4: ED Visits, Observation Stays, or Inpatient Admissions for Following Conditions:*

- *Diabetic Ketoacidosis/Hyperglycemia,*
- *Acute Severe Asthma,*
- *Hypertensive Crisis,*
- *Fall Injuries,*
- *SUD, or*
- *Mental Health Issues*

The Intervention Group's RFR improvement was not statistically different from that of Comparison Group 2. The following results were seen for the measure:

- The 2016–2019 rates for the ED Visits, Observation Stays, or Inpatient Admissions for Diabetic Ketoacidosis/ Hyperglycemia, Acute Severe Asthma, Hypertensive Crisis, Fall Injuries, SUD, or Mental Health Issues rates for the Intervention Group and the Comparison Group 2 were 61.1 and 32.7 occurrences (visits, stays, or admissions) per 1,200 member-months, respectively.
- For the Intervention Group, the 2020–2021 rate was 1.2 occurrences per 1,200 member-months higher than the 2016–2019 rate (shown in Table X as –1.2 since it is not an improvement). The rate for Comparison Group 2 increased 1.7 occurrences per 1,200 member-months from 2016 to 2019.
- The RFRs were –2.0% for the Intervention Group and –5.1% for Comparison Group 2; the difference was not statistically significant ( $p=.49$ ).
- The difference between the Intervention Group and Comparison Group 2 rates was relatively large for both time periods. For 2016–2019, the difference was 28.4; the Intervention Group's rate was almost double Comparison Group 2's rate. This makes the comparability of the two groups questionable, and the results of the analysis should be interpreted with caution.

*Measure 5: Outpatient or Professional Claims for Following Conditions:*

- *Diabetic retinopathy*
- *Influenza*
- *Pneumonia or*
- *Shingles*

For both the Intervention Group and Comparison Group 2, the RFR was –14%. The following results were seen for the measure:

- The 2016–2019 rates for the Outpatient or Professional Claims for the diabetic retinopathy, influenza, pneumonia or shingles for the Intervention Group and the Comparison Group 2 were 62.5 and 43.9 claims per 1,200 member-months, respectively.
- For the Intervention Group, the 2020–2021 rate was 8.8 claims per 1,200 member-months higher than the 2016–2019 rate. The Comparison Group 2 rate increased 6.1 claims per 1,200 member-months from 2016–2019.
- The RFRs (–14.1% for the Intervention Group, –14.0% for Comparison Group 2) were not statistically significantly different ( $p=.98$ )
- The difference between the groups' rates was relatively large for both time periods; Comparison Group 2's rates were about one and a half times the Intervention Group's rates. This makes the comparability of the two groups questionable, and the results of the analysis should be interpreted with caution.

**Measure 6: Emergency Department Visits Overall (Administrative):**

The rates improved for both groups, but the RFR improvement was statistically significantly greater for Comparison Group 2 than the Intervention Group. The following results were seen for the measure:

- The 2016–2019 Emergency Department Visits (Overall) rate for the Intervention Group was 310.3 and 212.5 claims per 1,200 member-months for Comparison Group 2.
- For both groups, the 2020–2021 Emergency Department Visits (Overall) rates were about 37 claims per 1,200 member-month lower than the 2016–2019 rates.
- The RFR for the Intervention Group was 11.6%, but the RFR for Comparison Group 2 (17.6%) was statistically significantly greater ( $p<.01$ ).
- The difference between the groups’ rates was relatively large for both time periods; Comparison Group 2’s rates were about one and a half times the Intervention Group’s rates. This makes the comparability of the two groups questionable, and the results of the analysis should be interpreted with caution.

Table 4. OneCare Kansas Program Evaluation Measures						
	Intervention Group		Comparison Group 2		Statistics	
	Rate	Denominator	Rate	Denominator	Difference	Significance
<b>Adults’ Access to Preventive/Ambulatory Health Services (AAP)*</b>						
2016–2019	97.5%	7,125	94.6%	143,237	2.9 pp	$p<.001$
2020–2021	97.7%	5,012	92.2%	103,627	5.5 pp	$p<.001$
Difference, p-value	0.2 pp	$p=.52$	-2.4 pp	$p<.001$		
RFR Improvement	7.4%		-44.2%			$p<.001$
<b>Annual Dental Visit (ADV)*</b>						
2016–2019	72.2%	2,727	66.3%	139,906	5.9 pp	$p<.001$
2020–2021	69.2%	1,606	56.8%	81,137	12.5 pp	$p<.001$
Difference, p-value	-3.0 pp	$p=.04$	-9.5 pp	$p<.001$		
RFR Improvement	-10.7		-28.3%			$p<.01$
<b>Adolescent Well-Care Visit (AWC)*</b>						
2016–2019	59.1%	2,687	51.4%	135,928	7.7 pp	$p<.001$
2020–2021	59.9%	1,603	44.9%	80,084	15.0 pp	$p<.001$
Difference, p-value	0.8 pp	$p=.59$	-6.5 pp	$p<.001$		
RFR Improvement	2.0%		-13.3%			$p<.001$
<b>ED Visits, Observation Stays, or Inpatient Admissions for Following Conditions: Diabetic Ketoacidosis/Hyperglycemia, Acute Severe Asthma, Hypertensive Crisis, Fall Injuries, SUD, or Mental Health Issues^</b>						
2016–2019	61.1	7,936	32.7	168,872	28.4	$p<.001$
2020–2021	62.3	5,517	34.3	124,563	28.0	$p<.001$
Difference, p-value	-1.2	$p=.66$	-1.7	$p<.001$		
RFR Improvement	-2.0%		-5.1%			$p=.49$
<b>Outpatient or Professional Claims for Following Conditions: Diabetic Retinopathy, Influenza, Pneumonia, or Shingles^</b>						
2016–2019	62.5	7,936	43.9	168,872	18.5	$p<.001$
2020–2021	71.3	5,517	50.1	124,563	21.2	$p<.001$
Difference, p-value	-8.8	$p<.01$	-6.1	$p<.001$		
RFR Improvement	-14.1%		-14.0%			$p=.98$

Table 4. OneCare Kansas Program Evaluation Measures (Continued)						
	Intervention Group		Comparison Group 2		Statistics	
	Rate	Denominator	Rate	Denominator	Difference	Significance
<b>Emergency Department Visits Overall<sup>^</sup></b>						
<b>2016–2019</b>	310.3	7,936	212.5	168,872	97.8	<i>p</i> <.001
<b>2020–2021</b>	273.5	5,517	175.2	124,563	98.4	<i>p</i> <.001
Difference, <i>p</i> -value	36.8	<i>p</i> <.001	37.3	<i>p</i> <.001		
RFR Improvement	11.9%		17.6%			<i>p</i> <.01
Reduction in failure rate (RFR) measures improvement relative to the amount of possible improvement. The formula is: $RFR = \frac{\text{Final Rate} - \text{Initial Rate}}{\text{Goal} - \text{Initial Rate}}$ where Goal = 100% or 0%, depending on the measure. *Measures were calculated from MMIS encounter data based on specifications for HEDIS Health Plan measures. Rates differ from Certified, Audited HEDIS health plan rates calculated by MCOs due to differences in available source data. To calculate RFR, the goal was 100%. Differences in rates are shown in percentage points (pp) and were tested for statistical significance using a Pearson chi-square test. A chi-square test was used to test for equality of RFR improvements. <sup>^</sup> Measures were calculated from MMIS encounter data that was deduplicated to count one claim per member, per billing provider NPI, per last date of service. Rates are the number of claims in the measurement period per 1,200 member-month, which may be interpreted as the average number of claims in a year for 100 members. The denominator shown is the total member-months divided by 12 (i.e., the total of the average number of members in each year within the measurement period). Large sample z-tests were used to test for differences between rates and RFR improvements.						

## Qualitative Evaluation

### Learning Needs Identified:

The learning needs identified by OCK Learning Collaborative participants were collected from information available from April 2020 through March 2022, including the virtual regional meetings and survey. An overview of participants’ responses and related key themes are described in Appendix A, Table A.1. These key themes are summarized below (Table 5).

Table 5. Learning Needs Identified by OneCare Kansas Learning Collaborative Participants, April 2020 – March 2022 Key Themes
<ul style="list-style-type: none"> <li>• Health assessment tools and trainings for use of different types of health assessment tools including those for the comprehensive care</li> <li>• Trainings for setting and writing goals and use of health assessment tools to identify goals</li> <li>• Tracking outcomes and improvement of goals</li> <li>• Ways to build program and engage members during COVID-19 pandemic</li> <li>• MCO resources and benefits, tools, and portals</li> <li>• Staff recruitment, retention, and engagement</li> <li>• Provider engagement, networking, and peer learning</li> <li>• Member engagement, recruitment, retention, and outreach tips</li> <li>• Finance and billing</li> <li>• Information and guidance on program processes and protocols:                             <ul style="list-style-type: none"> <li>○ Service codes</li> <li>○ Use of same protocols by MCOs</li> <li>○ Simplifying inclusion process</li> <li>○ Patient transfers and referrals</li> <li>○ Staff-to-member ratios</li> <li>○ Required staff</li> <li>○ HIPAA</li> <li>○ Foster care system</li> <li>○ Advanced directives</li> <li>○ Program manual, including demonstrating compliance</li> </ul> </li> </ul>

**Table 5. Learning Needs Identified by OneCare Kansas Learning Collaborative Participants, April 2020 – March 2022 Key Themes (Continued)**

<ul style="list-style-type: none"> <li>• Trainings on OCK focused conditions:                             <ul style="list-style-type: none"> <li>○ Asthma</li> <li>○ Asthma and mental health issues</li> <li>○ Addiction (SBIRT, etc.)</li> <li>○ Motivational interviewing</li> <li>○ Health literacy</li> </ul> </li> <li>• Health promotion resources for members</li> </ul>
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A variety of topics were identified by the participants to be discussed in Learning Collaborative meetings to gain information and guidance on various aspects of OCK program, including member and provider resources, program processes and protocols, provider and member engagement and strategies, staffing, and trainings on program focused conditions.

*OCK Learning Collaborative Discussions and Sessions:*

The main focus of the Learning Collaborative meetings was to identify and address evolving learning needs of OCK partners, which allows for continual quality improvement of the OCK program. To achieve this objective, fourteen virtual meetings were conducted from April 2020 through March 2022, providing information and guidance to participants on various aspects of the program. These meetings were attended by KDHE, MCOs, state organizations, provider network and contracted OCKPs. KDHE and other state agencies’ staff, WSU CEI staff, and OCK partners presented information on various topics identified by participants as learning needs. These sessions also included interactive discussions among the participants using small and large group discussion formats. The approximate number of participants attending these meetings ranged from forty-five to seventy. Feedback was also collected after each session. Detailed information on these sessions is provided in Appendix A, Table A2. An overall summary of the topics presented in these meetings is provided below (Table 6). One identified learning need theme, that did not appear to be addressed, pertained to working with OCK members and their conditions, such as asthma, behavioral health, motivational interviewing, and health literacy.

**Table 6. Topics Discussed in OneCare Kansas Learning Collaborative Meetings, April 2020 – March 2022**

<b>April 2020 through November 2020: Eight Learning Collaborative meetings presented eleven topics.</b>
<ul style="list-style-type: none"> <li>• Information about adjustments to OCK policy during the COVID-19 emergency; Information regarding recommended and mandatory learning opportunities that impact OCK providers</li> <li>• Recruitment and engagement of potential OCK members</li> <li>• Quality measures for the OneCare Kansas program</li> <li>• Information on the difference between a Health Risk Assessment conducted by the MCOs (KanCare care coordination strategy) and an OCK Health Assessment; Model for providing services to OCK members (including the Health Assessment process) shared by partners from the Community Health Centers; and strategies for engaging other providers in the process</li> <li>• Programs available to support OCK partners for health promotion activities</li> <li>• Challenges and opportunities that the partners have experienced in the first six months of the program’s implementation</li> <li>• Promoting staff resilience</li> <li>• Recruitment of potential OCK members</li> </ul>

<b>Table 6. Topics Discussed in OneCare Kansas Learning Collaborative Meetings, April 2020 – March 2022 (Continued)</b>
<b>January 2021 through November 2021: Five Learning Collaborative meetings presenting thirteen topics, one online survey, and six regional virtual meetings with OCK partners were conducted.</b>
<ul style="list-style-type: none"> <li>• Use and benefits of GIS map; use of map for collaboration; barriers in its use; and strategies to overcome these barriers</li> <li>• A review of the first year; introduction of a data dashboard posted by KDHE to the OCK website; a review of aggregate results of the first OCK audit; OCK partner’s experience in achieving financial sustainability for their program; expectations for the 2<sup>nd</sup> year of the program; and description on the expanded eligibility criteria</li> <li>• Experiences of three OCK partners related to engagement of the members in their OCK program</li> <li>• Online survey to obtain a point-in-time impression of program success in achieving its goal from the perspective of contracted OCKPs (June 2021)</li> <li>• Six regional virtual meetings with OCKPs – program success, concerns, needs and offers and potential next steps for the program (July 2021)</li> <li>• OCK quality goals and partner expectations related to monitoring program quality; processes applied by the participant for gathering member feedback and challenges encountered</li> <li>• Collaborations with local healthcare partners in the community</li> </ul>
<b>March 2022: One Learning Collaborative meeting presented three topics.</b>
<ul style="list-style-type: none"> <li>• Challenges and potential opportunities to hire support level staff to complete certain tasks; organizational changes need to allow for hiring additional support staff such as CNA/CMAs in their programs; and consideration of an option of adding community health workers as a potential support role for the OCK program</li> </ul>

*Factors that Facilitated the Implementation of the OneCare Kansas Program to Achieve Its Goals, April 2020–March 2022:*

During discussions in the OCK Collaborative meetings, participants identified factors that facilitated their efforts to implement the OCK program and achieve its goals. An overview of participants’ responses and related key themes are described in Appendix A, Table A3. Those key themes are summarized below (Table 7).

<b>Table 7. Factors that Facilitated the Implementation of the OneCare Kansas Program to Achieve Its Goals, April 2020 – March 2022 Key Themes</b>
<ul style="list-style-type: none"> <li>• Getting familiar with the program, its processes, and benefits</li> <li>• Provision of trainings and re-trainings for the OCK providers for increasing their knowledge base to support their efforts, readily available information about the trainings and their time frames</li> <li>• Availability of resources, variety of tools, OCK dashboard and GIS maps from State, MCOs and other agencies</li> <li>• Diagnostic codes expansion and updates</li> <li>• Tracking and reporting of quality measures and focus on outcomes</li> </ul>

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Table 7. Factors that Facilitated the Implementation of the OneCare Kansas Program to Achieve Its Goals, April 2020 – March 2022 Key Themes (Continued)
<ul style="list-style-type: none"> <li>• Staffing options and expertise; Staff support</li> </ul>
<ul style="list-style-type: none"> <li>• Incorporation of the health promotion and risk factor prevention and control as the provision of care options; submission of separate claims for these options; and sharing of health promotion resources with clients</li> </ul>
<ul style="list-style-type: none"> <li>• Discussing challenges encountered in member recruitment and engagement; and application of strategies, methods and processes for member recruitment, enrollment, engagement, and outreach</li> </ul>
<ul style="list-style-type: none"> <li>• Referral processes and assistance from MCOs</li> </ul>
<ul style="list-style-type: none"> <li>• Collaboration with other entities such as psychosocial groups, hospitals, clinics, PCPs, and pharmacies to recruit clients</li> <li>• Use of prescription program to recruit clients</li> </ul>
<ul style="list-style-type: none"> <li>• Applying strategies for building and improving collaboration with other local health partners/providers who work with the members</li> </ul>
<ul style="list-style-type: none"> <li>• Collaboration, peer learning, and support among OCK partners to address similar challenges and implement OCK program</li> </ul>
<ul style="list-style-type: none"> <li>• Ensuring documentation fully reflects all activities and interactions for purposes of ongoing work with the client, billing, getting credit for work completed, and identification of successes</li> </ul>
<ul style="list-style-type: none"> <li>• Strategies applied to address OCK program staffing challenges:                             <ul style="list-style-type: none"> <li>○ Hiring and recruiting staff</li> <li>○ Hiring of staff to work in two roles</li> <li>○ Providing more support to staff by regular debriefing</li> <li>○ Contracting with other agencies</li> <li>○ Financial strategies such as increasing pay/wages, sign on bonus, staff bonuses, cross training of staff for OCK to bill the program</li> <li>○ Reducing staff turnover rates</li> </ul> </li> </ul>

OCK Learning Collaborative participants noted several factors that facilitated their efforts for the implementation of the OCK program to achieve its goals. Fourteen overall themes described these factors. These themes could be further grouped into five broad categories: availability of program information, resources, and trainings; staffing strategies and support; collaboration among OCK partners; collaboration with community and provider entities; and diagnostic codes expansion, health promotion options, and outcome focused program processes and systems.

*Barriers/Challenges Seen in the Implementation of the OneCare Kansas Program:*

During the discussions conducted in the OCK Collaborative meetings, participants identified the barriers and challenges they encountered in the implementation of the OCK program. An overview of participants’ responses and related key themes are described in Appendix A, Table A4. Those key themes are summarized below (Table 8).

Table 8. Barriers/Challenges Encountered by OneCare Kansas Partners in the Implementation of the Program, April 2020 – March 2022 Key Themes
<ul style="list-style-type: none"> <li>• Issues with program structure and processes:                             <ul style="list-style-type: none"> <li>○ Labor intensive and time-consuming Health Assessment Plans</li> <li>○ Multiple levels of bureaucracy and their requirements</li> <li>○ Unclear or inconsistent expectations</li> <li>○ Inadequate time to incorporate audit feedback</li> <li>○ Limited diagnostic criteria (identified in 2020)</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Unclear information on outcome and process measures gathering, and role OCK partners in collection of the measures</li> </ul>
<ul style="list-style-type: none"> <li>• Financial concerns                             <ul style="list-style-type: none"> <li>○ Payment structure</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Issues with access to member information</li> </ul>
<ul style="list-style-type: none"> <li>• Member enrollment, roster, and engagement issues</li> </ul>
<ul style="list-style-type: none"> <li>• Issues related to opt-in/opt-out process</li> </ul>
<ul style="list-style-type: none"> <li>• Training, education, and support needed for employees, providers, and members</li> </ul>

**Table 8. Barriers/Challenges Encountered by OneCare Kansas Partners in the Implementation of the Program, April 2020 – March 2022 Key Themes (Continued)**

<ul style="list-style-type: none"> <li>• Barriers in collaborating with other health partners/providers who work with the members:                             <ul style="list-style-type: none"> <li>○ Time consuming</li> <li>○ COVID-19 pandemic</li> <li>○ Providers are not readily available or do not have buy in for the collaboration.</li> <li>○ Members not ready to join OCK</li> <li>○ Members not wanting to share their information with all of their providers</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Challenges for staffing OCK program:                             <ul style="list-style-type: none"> <li>○ Unavailability of professionals and recruiting staff needed for the program</li> <li>○ Adequate number of staff not available</li> <li>○ Inadequate staffing and time constraints (staff with multiple roles, covering multiple counties, and increased enrollment)</li> <li>○ Getting medical staff</li> <li>○ Staff retention</li> <li>○ Financial issues as competitive wages and justifying the costs</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Issues related to access to care in rural areas</li> </ul>

Learning Collaborative participants noted barriers and challenges in the implementation of OCK. Ten overall themes summarized these barriers and challenges. Participants noted certain issues related to program structure and processes had created challenges in program implementation. Participants also noted some aspects of these processes are labor-intensive and time consuming, and often expectations were unclear and inconsistent. In earlier stages of program implementation, participants identified use of limited diagnostic criteria for members’ eligibility to participate in the program as a barrier. The expansion of the criteria by the state addressed this issue, and participants have noted it as a facilitating factor. Other barriers and challenges, including those related to access to member information, financial concerns, member enrollment, roster, and engagement, opt-in/opt-out process, collaborations with partners and providers, staffing and access to care in rural areas, were noted by the participants throughout the interim evaluation period (April 2020 through March 2022).

*Observations Related to the OneCare Kansas Program Success in Achieving its Goals:*

The information on the impressions of OCK partners regarding major successes related to individual members, organization and systems, connecting with other community partners and marketing of the program to the community was collected through an online survey and the virtual meetings conducted in June 2021 and July 2021. Participants’ responses and related key themes are described in Appendix A, Table A5. Those themes are summarized below (Table 9).

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<b>Table 9. Impressions of the OCK Program Partners Regarding Major Successes of the Program, June and July 2021 – Key Themes</b>
<b>Individual Member Successes</b>
<ul style="list-style-type: none"> <li>• Coordination of care to assist members with their multiple health and social issues</li> <li>• Provision of resources to the members for morbid conditions, and pre-surgical education and support</li> <li>• Provision of health promotion resources and support to the members to assist them with their disease prevention efforts</li> </ul>
<b>Organization/System Successes</b>
<ul style="list-style-type: none"> <li>• Engaging with the members and their families to support them with their health improvement efforts</li> <li>• Provision of information on program services available for the members</li> <li>• Growth and sustainability of the program due to increased number of members, member engagement and trust, and hiring of staff dedicated to OCK</li> <li>• Collaboration between providers such as PCPs, dental providers, other medical providers, hospitals, and MCOs that connect members to medical, dental, and community resources</li> </ul>
<b>Program Successes in Connecting with Other Community Providers</b>
<ul style="list-style-type: none"> <li>• Utilizing collaborative strategies with community providers, such as PCPs, hospitals, and FQHCs for member recruitment and referral to the OCK program</li> <li>• Using EHR global alert technology to assist providers in sending member enrollment information to the OCK program and in making referrals to the program</li> </ul>
<b>Successes Related to the Marketing of the Program to the Community</b>
<ul style="list-style-type: none"> <li>• Use of a variety of marketing strategies for community and provider outreach                         <ul style="list-style-type: none"> <li>○ Program presentations and discussions at the Community Coalitions’ and community agencies’ meetings and at community events conducted at public venues</li> <li>○ Communication of program information to PCPs and other internal and external partners using word of mouth, packages with tailored information, and presentations</li> </ul> </li> <li>• Direct communication with the new clients attending various clinics and use of organization’s mass text alert system to provide information and to encourage them to join the OCK program and make appointments</li> </ul>

Learning Collaborative participants made several observations regarding the successes achieved by the OCK program. These successes were noted at the individual member level, as well as at organization and system levels. Successes were also seen in the program’s efforts to connect with other community providers and to market the program to the community.

At the individual member level, noted successes were related to care coordination and provision of resources to members for medical and surgical care and for health promotion. Participants noted several achievements at their organization or system that led to the program success. These achievements were related to providing support to members and their families with their health improvement efforts, provision of program information to members, growth and sustainability of the program with increases in member trust and engagement, appropriate staffing for the program, and collaboration with providers, provider entities and MCOs to connect members with appropriate medical and community resources.

Additionally, participants shared their observations related to OCK successes in connecting with other community providers, such as Primary Care Providers (PCPs), hospitals, and Federally Qualified Health Centers (FQHCs), for member recruitment and referral. They noted these successes were achieved using multiple collaborative strategies with these providers for member recruitment and referral to OCK and by using electronic health record (EHR) global alert technology to exchange member enrollment and referral information with these providers.

Participants noted several successes in the marketing of the program to the community. These successes included use of variety of marketing strategies for community and provider outreach, direct communication with new clients attending various clinics, and use of a text alert system that encouraged clients to join the program.

**Assistance Needed by the OCK Partners from OCK Partners’ Network and State/MCO Implementation Team to Assure Quality Services:**

During the July 2021 virtual meetings, participants were asked what their needs were that other partners within the OCK network or the State-MCO implementation team could address to assure quality services are provided to members participating in the OCK program. The participants’ responses and related key themes are described in Appendix A, Table A6 and A7. Those themes are summarized below (Tables 10 and 11).

Table 10. Needs to be Addressed Among OCK Partners, July 2021
<ul style="list-style-type: none"> <li>• Peer learning and support                             <ul style="list-style-type: none"> <li>○ Peer mentoring</li> <li>○ Conducting joint trainings</li> <li>○ Sharing ideas and successes</li> </ul> </li> <li>• Making provider and community connections to identify resources.                             <ul style="list-style-type: none"> <li>○ Connections between CMHCs and FQHCs</li> <li>○ Community business donations</li> <li>○ Hospital discharge planners</li> <li>○ Dental resources</li> <li>○ Listserv for clinics to contact all the other participating FQHCs</li> <li>○ Communication between partners sharing clients</li> </ul> </li> </ul>

OCK partners emphasized a need for continued peer learning and support for program implementation, sharing guidance and strategies to address barriers/challenges encountered and to improve quality of program efforts to achieve its goals. The partners showed their willingness to share contact information for their teams, to pair up with new and small programs to offer them advice and support related to program operations and resource sharing, and to offer joint training to their communities.

Table 11. Assistance Needed from the State/MCO Implementation Team, July 2021
<ul style="list-style-type: none"> <li>• Information needed:                             <ul style="list-style-type: none"> <li>○ Each program’s demographics</li> <li>○ Contacts within OCK partners</li> <li>○ Clarification on new federal Certified Community Behavioral Health Clinics initiative</li> <li>○ Diagnosis/qualifying information on clients</li> <li>○ Organizational data on trends in clinical outcomes, cost benefits, etc.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Improvement in program processes and systems for member recruitment, engagement, discharge, and transition:                             <ul style="list-style-type: none"> <li>○ Add OCK flag and service start date to KMAP</li> <li>○ Notification of member’s OCK enrollment with another provider</li> <li>○ Electronic system in place for easier access and transfers of the records</li> <li>○ Improved process to remove from the roster the members who opt-out</li> <li>○ Improved education of members and providers regarding opt-in process, including need for active participation in client invitation letter</li> <li>○ Access to ER and hospital data for better follow-up and transition planning for members</li> <li>○ Attention to organizational capacity of OCKPs</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• State assistance needed to provide education about the program to hospitals, foster care agencies, and foster parents; and in locating children in the foster care system.</li> </ul>
<ul style="list-style-type: none"> <li>• Timely provision of audit results to implement changes; agreement on audit results; bypassing the subsequent audit depending on audit results</li> </ul>
<ul style="list-style-type: none"> <li>• MCO communications and systems                             <ul style="list-style-type: none"> <li>○ Regular meetings with MCOs and review of information on their provider portals</li> <li>○ Consistency in MCOs’ systems and improvement in timely communication by MCO staff</li> </ul> </li> </ul>

OCK partners discussed the assistance they needed from State and MCOs' teams to implement the program. They asked the State to provide information related to program processes and program outcomes. They also requested the State's assistance in improving program processes and systems for member recruitment, engagement, discharge, and transition. They asked for the State's assistance in reaching children in the foster care system and timely provision of audit results. OCK partners also asked the MCOs for regular communication and consistency between their systems.

*OCK Partner Recommendations and Potential Next Steps for the OneCare Kansas Program:*

During the July 2021 virtual meetings, OCK partners made the following recommendations and suggested potential next steps for the program.

- Increase access to medical care among non-compliant patients by allowing initial in-person appointment and virtual appointments for follow-up visits.
  - To overcome the challenge of patients in rural areas who were dismissed from the clinic for non-compliance and were unable to access medical care, determine if patients are able to make an initial "meet" appointment with a specialist and have virtual appointments after that.
- OCKPs across the state could build their professional networks and provide mutual support outside of the formal opportunities offered by the State.
  - Overall, OCKPs across the state indicated a desire to build their professional networks and provide mutual support outside of the formal opportunities offered by the KDHE-DHCF and WSU CEI. All partners recognized that this would take intentional time and effort that they sometimes feel they do not have due to staffing shortages and high workload, but many regions reported that this investment would be beneficial to their programs.
- Development and use of the provider directory to assist in communication and collaboration across the network of OCK partners.
  - Discussion between MCO representatives and WSU CEI staff to develop a provider directory to be distributed across the network (not publicly).
  - OCK partners will utilize the directory to reach out to one another to establish local and regional opportunities for connection and information sharing to enhance professional relationships across the network. This may be through email or regularly scheduled virtual or in-person meetings.
- Improve program processes and systems.
  - OCKPs promote services within other programs to help boost their referrals as well.
  - KDHE-DHCF will continue to work with Gainwell Technologies to assure timely entry of information into the Kansas Medical Assistance Program (KMAP).
  - KDHE-DHCF and the MCOs will review opportunities to improve processes related to member invitations, program audits, notice of enrollment when there are multiple potential providers and the Health Action Plan portal.
- Develop connections with local foster care contractors, child placing agencies, local hospitals, and emergency departments.
  - OCKPs will reach out to local foster care contractors and child placing agencies to offer education about their local programs and the benefits to youth in foster care.
  - OCKPs will continue to develop connections with local hospitals and emergency departments.
  - KDHE-DHCF will continue to research the relationship between Certified Community Behavioral Health Clinics and OCK.
- Identify opportunities to obtain hospital data and provision of organizational data.
  - The State team will work to identify opportunities to obtain data from the hospital systems in Kansas.

- KDHE-DHCF opportunities to provide organizational level data for quality improvement efforts.

**c. Hypothesis 1 – MCOs’ Value-Based Provider Incentive Programs**

As mentioned in the Methodology section, the three MCOs are in the process of initiating their VBPs. Therefore, data are not currently available from these projects and an interim evaluation of Hypothesis 1 was not conducted. The evaluation of Hypothesis 1 will be conducted as part of the summative evaluation of KanCare 2.0.

**d. Hypothesis 2 – Employment and Independent Living Supports for KanCare 2.0 Members With Disabilities**

As mentioned in the Methodology section, data for the Hypothesis 2 outcome measures are not currently available. Therefore, the interim evaluation of Hypothesis 2 was not conducted. The evaluation of Hypothesis 2 will be conducted as part of the summative evaluation of KanCare 2.0.

**e. Hypothesis 3 – Use of Telehealth Services**

Quantitative Evaluation

The quantitative outcome measures for the evaluation of KanCare 2.0 Hypothesis 3 components—use of telemedicine services and use of telemonitoring services—were examined for January 2018 through December 2021 for the interim evaluation.

Results of the Evaluation of Use of Telemedicine Services

The results of the evaluation of the outcome measures to assess the use of telemedicine services are summarized here. Detailed information, including denominator and numerator counts and statistical analysis results, is provided in Appendix B.

*Measure 1: Percentage of telemedicine services received by the members living in the rural or semi-urban (Non-Urban) areas:*

<b>Table 12. Telemedicine Services Received by KanCare Member Location</b>						
<b>Measure 1: Percentage of KanCare telemedicine services that were received by members living in rural or semi-urban areas (Non-Urban) of Kansas.</b>						
Geographic Group	Pre-KanCare 2.0	KanCare 2.0			Statistical Analysis: Percent Non-Urban	
	2018	2019	2020	2021	Comparison Periods	p-value
Non-Urban	24,034	26,844	355,386	251,844	2018 & 2019	p<.01
Urban	4,550	5,429	341,522	269,302	2019 & 2020	p<.001
Total	28,584	32,273	696,908	521,146	2020 & 2021	p<.001
<b>Percent Non-Urban</b>	84.08%	83.18%	50.99%	48.33%	Trend: 2019 to 2021	p<.001

Counts of telemedicine services were stratified by member’s county of residence; Urban counties were Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte. Testing for statistically significant differences in Non-Urban percentages between two years used a weighted Pearson chi-square test, and testing whether the slopes of the 3-year trend lines were statistically significantly different from horizontal used a weighted Mantel-Haenszel chi-square test (p<.05 was considered statistically significant).

The number of telemedicine services increased from 2018 to 2019 for Non-Urban and Urban members. This pattern was also seen for each age stratum except for Urban members aged 46 years or older. The considerably large increases from 2019 to 2020 corresponded to the onset of the COVID-19 public health emergency. Counts for Non-Urban and Urban members decreased from 2020 to 2021 but remained well above pre-public health emergency levels. The increases were relatively greater in Urban areas than Non-Urban areas. Consequently, the percentage of telemedicine services received by Non-Urban members decreased each year.

**Subgroup Analyses:**

The data and statistical results for subgroup analyses are shown in Appendix B, Tables B1–B3.

**Stratification by Age (0–17 years, 18–45 years, and 46 years and older)**

The number of telemedicine services increased from 2018 to 2019 for Non-Urban and Urban members for each age stratum except for Urban members aged 46 years or older. With regard to counts for Non-Urban and Urban members, a pattern similar to the overall measure was seen for each age stratum. The percentage of the telemedicine services received by Non-Urban members decreased each year, except for the increase from 2018 to 2019 for members aged 46 years or older.

**Stratification of Primary Diagnosis Codes by ICD-10-CM Chapter**

The chapter Mental, Behavioral and Neurodevelopmental Disorders (Codes F01–F99) had the highest ranking for Non-Urban members in both time periods. For 2018–2019, the number of claims with codes F01–F99 was over 60 times the number of claims in the second ranked chapter (Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified). In 2021, the number of claims was 17 times the number of claims in the second ranked chapter (Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified). The next five highest ranked chapters were the same in 2018–2019 as in 2021, but the rankings were slightly different. Similar patterns were seen for Urban members. (Appendix B, Table B2).

<b>Table 13. Telemedicine Services Ranked by ICD-10 CM Diagnosis Chapter</b>			
<b>Area of Member Residence: Non-Urban</b>	<b>Code Range</b>	<b>2018+2019 Rank</b>	<b>2021 Rank</b>
ICD-10-CM Chapter of Primary Diagnosis Code			
Mental, Behavioral and Neurodevelopmental Disorders	F01–F99	1	1
Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified	R00–R99	2	2
Diseases of the Respiratory System	J00–J99	4	3
Diseases of the Nervous System	G00–G99	3	4
Factors Influencing Health Status and Contact with Health Services	E00–E89	6	5
Endocrine, Nutritional and Metabolic Diseases	Z00–Z99	5	6
Counts of telemedicine services were stratified by the ICD-10-CM chapter of the primary diagnosis code and by member’s county of residence; Non-Urban counties are all Kansas counties except Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte. The six top ranked chapters for 2018–2019 and 2021 are shown in order of 2021 rank.			

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**Stratification of Primary Diagnosis Codes by ICD-10-CM Block**

The top four blocks of primary codes for Non-Urban members were the same in 2018–2019 and in 2021, although the rankings had changed. Each of the five blocks were from the Mental, Behavioral and Neurodevelopmental Disorders chapter. Mood [affective] disorders (Codes F30–F39) ranked first in both years. Mental and behavioral disorders due to psychoactive substance use (Codes F10–F19), which ranked 8<sup>th</sup> for 2018–2019, rose to 5<sup>th</sup> for 2021—displacing Mental disorders due to known physiological conditions (F01–F09). Similar patterns were seen for Urban areas. (Appendix B, Table B3).

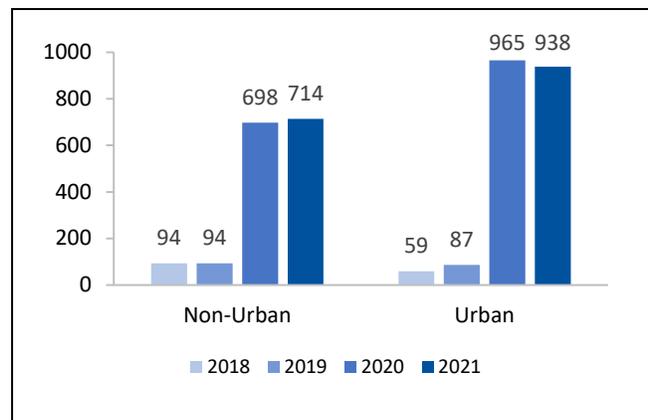
Area of Member Residence: Non-Urban	Code Range	2018+2019 Rank	2021 Rank
Mood [affective] disorders	F30–F39	1	1
Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	F40–F48	4	2
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	F90–F98	2	3
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	F20–F29	3	4
Mental and behavioral disorders due to psychoactive substance use	F10–F19	8	5
Mental disorders due to known physiological conditions	F01–F09	5	16

Counts of telemedicine services were stratified by the ICD-10-CM chapter block of the primary diagnosis code and by member’s county of residence; Non-Urban counties are all Kansas counties except Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte. Blocks shown were in the top 5 ranked blocks for either 2018–2019 or 2021 and are shown in order of 2021 rank.

**Measure 2: Number of receiving sites for telemedicine services in the rural and semi-urban (Non-Urban) areas:**

Figure 2 shows the number of receiving sites, i.e., billing provider locations providing telehealth services to KanCare members. Stratification into Non-Urban and Urban areas was based on the member’s county of residence.

The number of receiving sites providing telemedicine services to Non-Urban KanCare members were relatively unchanged from 2018 to 2019, but increased considerably for 2020 and 2021, which were the initial years of the pandemic. The number of receiving sites providing telemedicine services to Urban KanCare members increased slightly between 2018 and 2019 and then increased considerably for 2020 and 2021.



**Figure 2. Receiving Sites for Telemedicine Services by KanCare Member Location**

**Subgroup Analyses:**

**Stratification by Age (0–17 years, 18–45 years, and 46 years and older)**

The data and statistical results for subgroup analyses by three age strata are shown in Appendix B, Table B4. The number of receiving sites providing telehealth services to Non-Urban and Urban members increased slightly from 2018 to 2019 for all age strata, except for Non-Urban members 46 years and older. The numbers increased considerably for all age strata for 2020 and 2021.

**Measure 3: Percentage of members living in the rural or semi-urban areas (Non-Urban) who received telemedicine services:**

The percentages of Non-Urban KanCare members who received telemedicine services increased from 2018 to 2019 and from 2019 to 2020. However, percentages decreased from 2020 to 2021 but remained well above pre-pandemic levels. Similar patterns were seen for Urban members. (Appendix B, Table B.5).

Table 15: KanCare Members Receiving Telemedicine Services						
Measure 1: Percentage of members living in the rural or semi-urban areas (Non-Urban) who received telemedicine services.						
	Pre-KanCare 2.0	KanCare 2.0			Statistical Analysis	
	2018	2019	2020	2021	Comparison Periods	p-value
Non-Urban	3.94%	4.45%	24.73%	20.49%	2018 & 2019 2019 & 2020 2020 & 2021 Trend: 2019 to 2021	p<.001 p<.001 p<.001 p<.001
Non-Urban counties are all Kansas counties except Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte (Urban counties). Testing for statistically significant differences between two consecutive years used a weighted Pearson chi-square test and testing of the 2019–2021 trend line used a weighted Mantel-Haenszel chi-square test (p<.05 was considered statistically significant).						

**Subgroup Analyses:**

**Stratification by Age (0–17 years, 18–45 years, and 46 years and older)**

Similar patterns were seen for the three age strata for Non-Urban members. Tests showed p<.001 except from 2018 to 2019 for members aged 45 or older (p=.02). (Appendix B, Table B.5).

**Speech Therapy Analysis:**

- Measure 4: Number of paid claims with selected procedure codes
- Measure 5: Number of members with selected diagnosis per 1,000 members
- Percentage of KanCare members receiving speech therapy who had a diagnosis in category F80
- Percentage of KanCare members with diagnosis in category F80 who received speech therapy

The State approved a set of speech-language pathology or audiology codes for telemedicine delivery effective January 1, 2019.<sup>25</sup> Two new current procedural terminology (CPT) codes were added effective January 1, 2020. With the onset of the COVID-19 public health emergency, additional codes were authorized for telemedicine, including codes for diagnostic evaluations and HCBS procedures related to speech, language, and hearing. Services by speech-language pathologists (SLPs) and audiologists were tabulated from paid claims, and the percentages of those services provided via telemedicine were calculated. (Appendix B, Table B6.) Procedures related to speech and language billed by HCBS providers were also summarized. (Appendix B, Table B7.)

**Measure 4**

Very few services related to speech and language were provided by SLPs, audiologists, or HCBS providers in 2019. Services with the most paid claims in 2020 and 2021 were as follows (with counts of paid claims via telemedicine in 2020 and 2021, respectively, in parentheses):

- By speech-language pathologists and audiologists
  - 92507 – Treatment of speech, language, voice, communication, and/or hearing processing disorder (5,273 and 3,966)
  - 92526 – Treatment of swallowing dysfunction and/or oral function for feeding (658 and 446)
- By Home and Community Based Service providers
  - 97129 – Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes (4,296 and 3,309)
  - 97130 – Therapeutic interventions that focus on cognitive function; each additional 15 minutes (4,022 and 3,141)
  - G0153 – Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes (3,119 and 3,567)

The number of diagnostic evaluations performed via telemedicine was considered too small to address the hypothesis, “diagnostic evaluations via telemedicine would increase the number of members receiving diagnosis indicating services performed by SLPs and audiologists would be beneficial.”

Based on Tables B6 and B7, procedure codes 92507 and G0153 were chosen for the next steps of the analysis. Although technically inaccurate, for this analysis *speech therapy* will refer to services billed with codes 92507 and G0153. The statewide utilization rate (i.e., the number of members who received speech therapy per 1,000 KanCare members) increased each year from 2018 to 2021. The statewide rate increases from 2018 to 2019 (from 5.34 to 6.56) suggest factors unrelated to telemedicine or the pandemic are impacting utilization; therefore the results of this analysis should be interpreted with caution. (Appendix B. Table B8.) Stratifying the count of paid services by billing provider type (e.g., therapist, hospital, HCBS provider) and by primary diagnosis showed differences between the Non-Urban and Urban areas. (Appendix B. Table B9.) Because these differences did not provide insight for answering the study question, discussion of these results are presented in Appendix B.

#### Percentage of KanCare members receiving speech therapy who had a diagnosis in category F80

The most frequently used category of primary diagnoses on claims for speech therapy was F80, specific developmental disorders of speech and language. About two-thirds of the members receiving speech therapy had an F80 diagnosis. The statewide percentage of KanCare members receiving speech therapy who had a diagnosis in category F80 was relatively stable (61% in 2018, 2020, and 2021; 64% in 2019, corresponding to a bump in the Urban percentage). The Non-Urban percentages were about 4 percentage points below the Urban percentages, which may be related to differences in the billing provider strata observed in Table B9.

#### Measure 5

The Measure 5 rate for F80 diagnoses (the number of members diagnosed with an F80 category diagnosis per 1,000 KanCare members) is shown in Appendix B, Table B10. The rates for both areas alternately increased and decreased with a generally upward trend; the statewide rates for 2018 to 2021 were 17.6, 19.8, 18.0, and 20.3 members with F80 diagnosis per 1,000 KanCare members, respectively. Rates were greater for the Urban area. The dip in 2020 may be pandemic related.

Percentage of KanCare members with diagnosis in category F80 who received speech therapy

Table B10 also shows the percentages of Non-Urban members with a diagnosis in category F80 who received speech therapy were greater for 2020 (20.4%) and 2021 (19.7%) than for 2018 (17.1%) and 2019 (19.0%), which supports the hypothesis that telemedicine will enhance access to services such as speech therapy for KanCare members living in rural or semi-urban counties. Access to speech therapy services also appears to have been enhanced for Urban members (percentages from 2018 to 2021 were 17.7%, 20.3%, 23.7%, and 23.9%, respectively).

*Telemedicine Services by Mental Health Providers – Background:*

Telemedicine services were provided to KanCare members prior to KanCare 2.0. A KDHE provider bulletin lists 59 procedure codes approved for telemedicine as of January 1, 2018 (some codes had earlier approval dates).<sup>26</sup> The list included codes for services offered by mental health providers, such as, psychotherapies, psychiatric diagnostic evaluations, adaptive behavior treatments, office visits for evaluation and management (E&M), and medical consultations. With the onset of the pandemic, additional services were approved for telemedicine.

*Measure 4: Number of Paid Claims with Selected Procedure Codes Billed by Mental Health Providers:*

Telemedicine services commonly offered from 2019 to 2021 by mental health providers are summarized in Appendix B, Table B11. The table includes counts of paid claims by procedure code (Measure 4) and the number and percentage of those that were for telemedicine services. The following trends were observed in Table B11:

- Over 50% of services in 2020 were provided via telehealth for 30-minute psychotherapy sessions and evaluation and management (E&M) office visits for established patients (15-, 25-, and 40-minute sessions).
- The number of family and group psychotherapy sessions in 2020 and 2021 were below 2019 levels; the decreases are offset by increases in 30-minute psychotherapy sessions.
- The percentages decreased for most services from 2020 to 2021, which may indicate members' or providers' preference for face-to-face visits.
- Percentages increased from 2020 to 2021 for short E&M visits; psychiatric diagnostic evaluation with medical services; medical team conference with patient and/or family, and nonphysician health care professionals; and comprehensive management and care coordination for advanced illness. The increases could indicate members' and providers' experiences with telemedicine were positive.

Based on these and other analytic results, three areas were chosen for continued analysis: individual psychotherapy, family and group psychotherapy, and community psychiatric supportive treatment.

*Individual Psychotherapy Analysis:*

- *Measure 5: Number of members with selected diagnosis per 1,000 members*
- *Percentage of KanCare members receiving individual psychotherapy who had an indicating diagnosis*
- *Percentage of KanCare members with an indicating diagnosis who received individual psychotherapy*

The number of members who received individual psychotherapy per 1,000 KanCare members for 2018 to 2021 is displayed in Appendix B, Table B12. The statewide rate increased from 2018 to 2019 (from 125.1 to 132.3), but statewide rates for 2020 (116.3) and (117.9) were lower than the 2018 level. The pattern was the same for Non-Urban and Urban rates.

Per 1,000 members, use of individual psychotherapy was greater in Non-Urban areas than Urban areas.

From 2018 to 2021, the average difference was 36.6 psychotherapy recipients per 1,000 KanCare members. The difference was lowest in 2020 (35.4 recipients per 1,000 KanCare members).

Individual psychotherapy is billed using CPT procedure codes (90832 through 90838). Coding depends on the length of the session and whether or not evaluation and management was included. To compare utilization between strata, hours of service was used as the unit of analysis instead of the number of claims. The number of hours was stratified by area and sub-stratified by mode of delivery, provider type, and primary diagnosis category. (Appendix B. Table B13.) Key observations were made:

- There was a near 50-50 split between Non-Urban and Urban areas; Non-Urban’s share was lower.
- The percentage of hours by telemedicine was slightly lower for Non-Urban members (37% for 2020 and 25% for 2021) than for Urban members (38% for 2020 and 32% for 2021).
- The percentages stratified by provider type and primary diagnosis varied slightly between years.
- Although fewer members received individual psychotherapy in 2020 than 2019 or 2021, the number of hours per person receiving psychotherapy was highest in 2021.

#### Percentage of KanCare members receiving individual psychotherapy who had an indicating diagnosis

About two-thirds of claims for individual psychotherapy contained one or more diagnosis in the six diagnosis categories. (Appendix B. Table B14.) The six categories were chosen as the indicating diagnoses for the individual psychotherapy measures:

- F34 – Persistent mood [affective] disorders
- F40 – Phobic anxiety disorders
- F43 – Reaction to severe stress, and adjustment disorders
- F60 – Specific personality disorders
- F91 – Conduct disorders
- F93 – Emotional disorders with onset specific to childhood

#### Measure 5

The numbers of members with an indicating diagnosis per 1,000 KanCare members were greater in Non-Urban areas than in Urban areas (e.g., 142.8 to 128.2 for 2020). These differences correspond to the Non-Urban areas having higher rates of members receiving individual psychotherapy (see Table B12).

The trend in the numbers of members with an indicating diagnosis per 1,000 KanCare members from 2018 to 2021 follows a similar trend seen in the numbers of members who received individual psychotherapy per 1,000 KanCare—rates increased from 2018 to 2019, decreased in 2020, and increased again in 2021 but remained below the 2018 level. There are at least three likely factors.

- During the COVID-19 public health emergency, the State suspended disenrollment of members from KanCare under most circumstances. For example, KanCare members covered under the CHIP program were not disenrolled when they turned 19, and women with coverage due to pregnancy were not disenrolled 60 days postpartum.
- Reduced access to diagnostic evaluations and treatments while stay at home orders were in effect may have led to fewer members receiving the indicating diagnoses.
- Members’ mental health may have improved, thus decreasing the need for psychotherapy; however, this seems unlikely during the pandemic.

Percentage of KanCare members with an indicating diagnosis who received individual psychotherapy

Percentage of KanCare members with an indicating diagnosis who received individual psychotherapy slightly increased from 2018 to 2019 but declined for 2020 and 2021. The declines were greater in Non-Urban areas than Urban areas. These results do not support an affirmative response to the study question, “Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?” This conclusion does not mean telemedicine was not integral for members accessing care; telemedicine was just not able to override the barriers presented by the pandemic.

*Family and Group Psychotherapy Analysis:*

- *Measure 5: Number of members with selected diagnosis per 1,000 members*
- *Percentage of KanCare members receiving family or group psychotherapy who had an indicating diagnosis*
- *Percentage of KanCare members with an indicating diagnosis who received family or group psychotherapy*

Table B15 shows the number of members who received family or group psychotherapy per 1,000 KanCare members for 2018 to 2021. The statewide rate decreased each year from 2018 to 2021 (from 36.0 to 34.3, to 25.3, to 22.0). Per 1,000 members, use of group and family psychotherapy was greater in the Non-Urban area than the Urban area. From 2018 to 2021, the average difference was 4.2 recipients per 1,000 KanCare members. The difference was greatest in 2020 (4.5 recipients per 1,000 KanCare members).

For comparisons, rates were also calculated using hours of service as the unit of analysis instead of the number of claims. The number of hours was stratified by area and sub-stratified by mode of delivery, provider type, and primary diagnosis category (see Table B16). Key observations were made:

- There was a near 50-50 split between Non-Urban and Urban areas. Non-Urban’s share was slightly lower.
- The percentage of hours that were by telemedicine was lower for Non-Urban members (28% for 2020 and 18% for 2021) than for Urban areas (36% for 2020 and 32% for 2021).
- The Non-Urban area’s use of telemedicine declined faster from 2020 to 2021 (10 percentage points) than the Urban area’s did (4 percentage points).
- About 80% of family and group psychotherapy was provided by mental health providers and about 15% by “other providers” in Non-Urban areas from 2019 to 2021. In contrast, the Urban area’s percentages were about 93% and 1%, respectively.

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Percentage of KanCare members receiving family or group psychotherapy who had an indicating diagnosis

Analysis of primary and secondary diagnosis codes on paid claims identified five categories for which the percentage of members receiving family or group psychotherapy for whom there was a paid claim with at least one of diagnosis from the five categories was about 43%. (Appendix B. Table B17.) Those five diagnosis categories were chosen as the indicating diagnosis for the family and group psychotherapy measures:

- F34 – Persistent mood [affective] disorders
- F91 – Conduct disorders
- F93 – Emotional disorders with onset specific to childhood
- T74 – Adult and child abuse, neglect, and other maltreatment, confirmed
- T76 – Adult and child abuse, neglect, and other maltreatment, suspected

Measure 5

The prevalence rates, the number of members with an indicating diagnosis per 1,000 KanCare members, were considerably greater in Non-Urban areas than in Urban areas (e.g., 55.7 to 39.5 for 2020). These differences correspond to Non-Urban areas having higher rates of members receiving individual psychotherapy (see Table B15), but the difference is much wider.

The general trend in the rates of members with an indicating diagnosis per 1,000 KanCare members from 2018 to 2021 follows a similar trend seen in the rates of members who received family or group psychotherapy per 1,000 KanCare members—rates were stable from 2018 to 2019, decreased in 2020, and decreased again in 2021. The same factors listed for individual psychotherapy may have contributed to the rate declines.

Percentage of KanCare members with an indicating diagnosis who received family or group psychotherapy

Percentages of KanCare members with an indicating diagnosis who received family or group psychotherapy slightly decreased each year, from 27% in 2018 to 19% in 2021 for Non-Urban areas and from 29% for 2018 to 21% for 2021 for Urban areas. These results do not support an affirmative response to the study question, “Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?” This conclusion does not mean telemedicine was not integral for members accessing care; telemedicine was just not able to override the barriers presented by the pandemic.

*Community Psychiatric Supportive Treatment Analysis:*

- *Measure 4: Number of paid claims with selected procedure codes*
- *Measure 5: Number of members with selected diagnosis per 1,000 members*
- *Percentage of KanCare members receiving community psychiatric supportive treatment who had an indicating diagnosis*
- *Percentage of KanCare members with an indicating diagnosis who received community psychiatric supportive treatment*

Statewide, the number of members who received community psychiatric supportive treatment per 1,000 KanCare members was 47.8 in 2018, increased to 49.5 in 2019, decreased to 42.3 in 2020, and decreased again in 2021 to 40.9). Rates for Non-Urban and Urban areas did likewise. Per 1,000 member months, use of group and family psychotherapy was greater in Non-Urban areas than Urban areas. From

2018 to 2021, the difference increased each year (from 17.5 to 20.6 recipients per 1,000 KanCare members).

For comparisons, rates were calculated based on hours of service, stratified by Non-Urban and Urban area, and sub-stratified by mode of delivery, provider type, and primary diagnosis category. (Appendix B. Table B19.)

- There was roughly a 60 to 40 ratio of total hours of treatment between Non-Urban and Urban areas. The difference widened each year. The difference in hours of treatment per recipient also widened.
- The service was not approved for telehealth by KDHE until the public health emergency. In the Non-Urban area, the percent by telemedicine was 18.5% in 2020 but only 5.0% in 2021; the percentages for the Urban area were greater and had a smaller relative decrease (25.1% in 2020 and 12.1% in 2021).
- At least 99% of the hours of treatment were provided by mental health providers.

#### Percentage of KanCare members receiving community psychiatric supportive treatment who had an indicating diagnosis

Five diagnosis categories were chosen as indicating diagnosis from among the categories with the highest ranked categories when ranked by the measure “percentage of claims for community psychiatric supportive treatment having a primary or secondary diagnosis in a given category.” About three-fifths of claims for community psychiatric supportive treatment contained one or more diagnosis in the five categories. (Appendix B. Table B20.)

- F20 – Schizophrenia
- F25 – Schizoaffective disorders
- F34 – Persistent mood [affective] disorders
- F60 – Specific personality disorders
- F91 – Conduct disorders

#### Measure 5

The numbers of members with an indicating diagnosis per 1,000 KanCare members were greater in Non-Urban areas than in Urban areas (e.g., 72.7 and to 58.9 in 2020). The rates were also greater in Non-Urban areas than Urban areas for individual psychotherapy and family and group psychotherapy (Appendix A. Tables B14 and B17.) The general trend in the rates from 2018 to 2021 follows a similar trend seen in the rates for two types of psychotherapy—rates were stable from 2018 to 2019, decreased in 2020, and decreased again in 2021. The same factors listed for individual psychotherapy may have contributed to the rate declines.

#### Percentage of KanCare members with an indicating diagnosis who received community psychiatric supportive treatment

Percentages of KanCare members with an indicating diagnosis who received individual psychotherapy were about the same in 2018 and 2019 (36.6% and 36.7%, respectively), but in the last two years, decreased to 36.1% in 2020 and 35.1% in 2021. The pattern was the same for both areas. These results do not support an affirmative response to the study question, “Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?” This conclusion does not mean telemedicine was not integral for members accessing care; telemedicine was just not able to override the barriers presented by the pandemic.

### Results of the Evaluation of Use of Telemonitoring Services

The results of the evaluation of three outcome measures to assess the use of telemonitoring services are summarized here. Detailed information, including denominator and numerator counts and statistical results, is provided in the Appendix B.

Telemonitoring of KanCare members’ health indicator data kicked off with the onset of the COVID-19 pandemic in 2020. (Table 16; Figure 3).

Table 16. KanCare Telemonitoring Service Utilization						
Area of Member Residence	Measure 1: Percentage of members living in rural or semi-urban areas (Non-Urban) who received telemonitoring services.			Measure 2: Number of telemonitoring services provided to members living in rural and semi-urban (Non-Urban) areas.		
	KanCare 2.0			2019	2020	2021
Non-Urban	*	0.01%	0.02%	*	84	132
Urban	*	0.01%	0.04%	*	90	738

Non-Urban area was defined as all counties except Urban counties.  
 Urban area was defined as Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte counties.  
 \*The number of members receiving telemonitoring services in 2019 was insufficient for analysis.

#### Measure 1: Percentage of members living in the rural and semi-urban areas who received telemonitoring services:

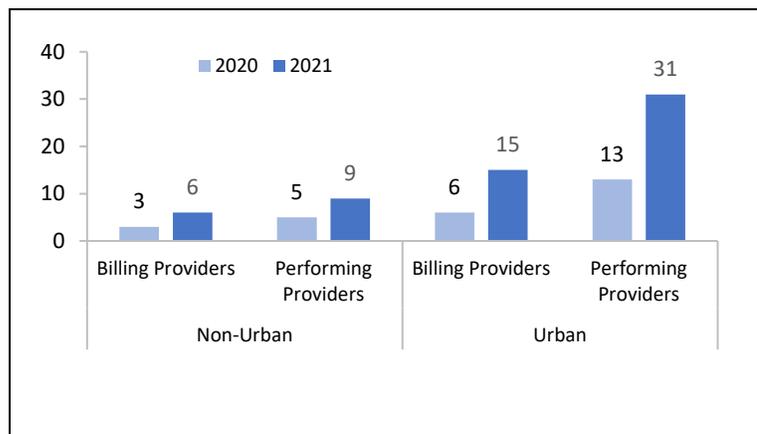
The percentage of Non-Urban and Urban members receiving telemonitoring services in 2019 was very low (less than 0.001%). However, the percentages of Non-Urban and Urban members who received telemonitoring services increased from 2019 to 2020 and 2021. Statistically significant increases from 2020 to 2021 for Non-Urban ( $p < .01$ ) and Urban members ( $p < .001$ ) occurred.

#### Measure 2: Number of telemonitoring services provided to members living in rural and semi-urban (Non-Urban) areas:

In 2020 and 2021, the number of telemonitoring Services provided to Non-Urban and Urban members increased from 2019. Compared to 2020, the number of telemonitoring services provided in 2021 was 1.6 times higher for Non-Urban members and 8.2 times higher for Urban members.

#### Measure 3: Number of providers monitoring health indicator data transmitted to them by members receiving telemonitoring services:

The number of billing and performing providers monitoring health indicator data transmitted to them by members receiving telemonitoring services in both Non-Urban and Urban areas of the state was small, however, the number roughly doubled from 2020 to 2021.



**Figure 3. Providers Monitoring Health Indicator Data from Members Receiving Telemonitoring Services**

## Qualitative Evaluation

### Results of the Evaluation of Use of Telementoring Services:

#### Project ECHO Sunflower Health Plan

The telementoring efforts implemented by Sunflower Health Plan’s Project ECHO are summarized here. Detailed information on the goals and sessions of each series is provided in Appendix B, Tables B16, B17, and B18.

From March 2019 through November 2021, eleven series comprised of forty-six sessions were conducted. Each series had four sessions, except the series for “Care Coordination” topic, which had six. The sessions were attended by staff from Centene (parent company of Sunflower Health Plan) and providers from multiple

disciplines, including medical and behavioral clinicians, nurses, pharmacists, and social workers. The participants were from Non-Urban and Urban areas. On average, the four 2019 sessions had 52 participants. In 2020, the average number of participants per session ranged from 21 to 67. In 2021, the average number of participants per session ranged from 18 to 52.

Year	ECHO Series Title	Number of Sessions	Average Number of Participants Per Session
2019	Fundamentals of Addiction Treatment	4	52
2020	Supporting and Integrated Life for Members with Intellectual and Developmental Disabilities	4	41
	Social Determinants of Health	4	29
	Foster Care	4	43
	Cancer	4	21
	Behavioral Health	4	67
	Aging	4	36
	Preventative Health	4	38
2021	Behavioral Health and Addiction	4	52
	Preventative Care	4	18
	Care Coordination	6	28

An evaluation survey was conducted at the end of each session in the October-November 2021 Series titled “Care Coordination.” The survey responses provide further insights on the effectiveness of the sessions’ improving participant understanding of care coordination and knowledge on different care coordination supports related to unique needs of members, patients, and clients. The results are summarized in Table 18.

Session Topic	Participants’ Responses After Attending the Session		
	Total Number of Survey Participants	Number of Participants Indicating Improvement in Understanding of Care Coordination	Number of Participants Indicating Improvement in Knowledge on Different Care Coordination Supports in Relation to Unique Needs of the Members/Patients/Clients
Week 1: Case Management Overview	17	10	11
Week 2: OneCare Kansas	12	8	10
Week 3: Behavioral Health	15	2	10
Week 4: Physical Health	5	5	5
Week 5: HCBS and Care Coordination	6	3	4
Week 6: Transitions to Employment	6	4	4

Insights were also gained with regard to the learning points from the sessions that survey participants indicated they will apply to their practice. Key themes based on their responses are as summarized in Figure 4.

Week 1: Case Management Overview	<ul style="list-style-type: none"> <li>Coordination of care and services for members</li> <li>Case management and care coordination benefits managing member care and getting resources</li> <li>Resources/ways to access more coordination</li> <li>Networking and communication</li> </ul>
Week 2: OneCare Kansas	<ul style="list-style-type: none"> <li>Information on benefits of OneCare Kansas program</li> <li>Access to increased resources to assist members with services</li> <li>Utilization of CMHCs for in-person help, and in coordination of medical services for members with dual diagnoses</li> </ul>
Week 3: Behavioral Health	<ul style="list-style-type: none"> <li>Information on benefits of and resources available through Smart Start for Babies program for pregnant women</li> <li>Referring pregnant women to Smart Start for Babies program for better outcomes</li> <li>Several resources available for members</li> </ul>
Week 4: Physical Health	<ul style="list-style-type: none"> <li>Information on benefits of coordinating behavioral health and medical care</li> <li>Resources and services available for members</li> </ul>
Week 5: HCBS and Care Coordination	<ul style="list-style-type: none"> <li>Importance of coordination with other agencies</li> <li>Better understanding of final rule and KDADS expectations</li> <li>Importance of communication</li> </ul>
Week 6: Transition of Employment	<ul style="list-style-type: none"> <li>Continue member-centered work</li> <li>Communications and giving choices</li> <li>The dynamics that can occur with I/DD waiver and how to get other resources/departments involved</li> </ul>

**Figure 4. Project ECHO Sunflower Health Plan October-November 2021 Series Survey: Continuation Education Learning Points Applicable to Practice – Key Themes from Participants’ Insights**

**KUMC Project ECHO® Series**

The telementoring efforts implemented by the KUMC Project ECHO® Series titled “Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders” are summarized here. Detailed information on series sessions is provided in Appendix B, Tables B19-B22.

The series was conducted during April 2021 and was comprised of five sessions. A total of 383 attendees participated, with an average of 77 attendees per session. Through this ECHO series, 240 hours of Continuing Education (CE) Credit were awarded; on average, nearly 50 hours CE credit was claimed during each session. Out of 383 attendees, 240 attendees (63%) claimed CE credit. There were 212 unique registrants for the series. Out of these 212 registrants, 158 (75%) were target learners, including 33 physicians (21%), 49 advanced practice clinicians (31%), 42 nurses (27%), and 34 behavioral health providers (21%). Out of the 212 registrants, 172 (81%) were Kansas providers, whereas 40 registrants (19%) were from other states. The Kansas registrants were from both Non-Urban and Urban counties. Out of 172 Kansas registrants, 77 (45%) were from Non-Urban counties, and 95 (55%) were from Urban counties.

Attendees' knowledge was assessed through pre-test and post-test evaluations, and 46 attendees completed the evaluations. The post-test percentages for the correct response rates for three of the four evaluation items were improved.

About 89% of the attendees agreed that “complex care circumstances were mastered through case-based learning.” The evaluation of three clinical practices for screening and treating SUDs was conducted at registration and again post-series to determine changes regarding screening for SUD, use of medication assisted treatment (MAT) waivers, and partnerships with local pharmacist related to opioid use disorder (OUD) care. The post-series improvement in the clinical practice change measure was seen for two practices (use of MAT waivers, and partnerships with local pharmacist related to OUD care). The pre- and post-ECHO series assessment of self-efficacy measures were evaluated. Respondents were asked about their confidence in their ability to employ SUD screening tools in the clinical setting, locate and utilize state and local resources for SUD treatment and recovery-oriented systems of care, devise strategies to counteract stigma in SUD treatment, and examine various harm reduction strategies and their role in disease treatment. The post-ECHO series evaluation results showed all four self-efficacy measurements were improved. At the end of the series, attendees were asked if they had made, or planned on making, changes based on what they learned in the series; 79% of them responded “yes.”

Key points from attendee feedback provided by 46 attendees are summarized below:

- 98% agreed or strongly agreed that they gained helpful knowledge from the ECHO series (n=45).
- 91% estimate their confidence level using this new information to better treat patients at 50% to 100% (n=42).
- 89% agreed or strongly agreed that they obtained helpful skills and techniques to improve professional practice (n=41).
- 80% estimated 50% to 100% of information was new (n=37).
- 74% agreed and strongly agreed that ECHO's interactive format was more effective than standard webinars (n=34).

The continuing education evaluation was also conducted at the end of each session. The results, summarized below, are based on the responses provided by the attendees who claimed CE credit:

- Across all five sessions, more than 76% of respondents reported their level of achievement to be good or outstanding regarding the employment of SUD screening tools in the clinical setting, locating and utilizing state and local resources for SUD treatment and recovery-oriented systems of care, devise strategies to counteract stigma in SUD treatment, and examining various harm reduction strategies and their role in disease treatment.
- Across all five sessions, 43.9% to 63.4% of respondents indicated they will use the information to improve their current patient safety practices; however, only 14.6% to 34.3% indicated they will use the information to validate their current patient safety practices. Only 6.7% to 17.1% indicated they will use the information to improve their current medical error prevention and analysis practices, and 0.0% to 11.4% indicated they will use the information to validate their current medical error prevention and analysis practices. With regard to current risk management practices, 19.5% to 34.9% indicated they will use the information to improve these practices, and 4.9% to 17.1% indicated they will use the information to validate these practices.
- Across all five sessions, more than 80% of respondents rated their level of agreement as “*somewhat agree*” or “*strongly agree*” when asked about the positive affect on their ability to be a part of team, and they learned information that they could share with their team to improve outcomes.

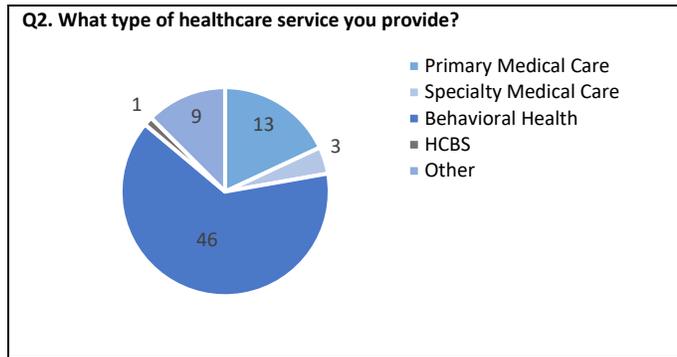
### Telehealth Provider Survey Results

The Telehealth Provider Survey was conducted from August 18, 2022, to September 12, 2022, with seventy-three providers responses from Urban and Non-Urban counties. Summary results are below.

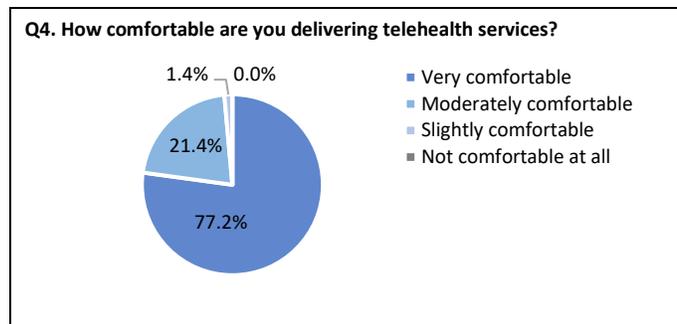
#### *Types of Healthcare Services Provided by the Survey Respondents:*

The majority of the survey respondents (46 providers) indicated they provide behavioral health care (31 mental health care providers and fifteen providers providing both mental health care and substance use disorder health care). Thirteen respondents noted providing primary health care, three noted specialty health care, and one noted HCBS. Nine respondents noted providing other types of healthcare services, including urgent care (3), speech language pathologist (1), physical therapy services to provide wheelchair evaluation (1), occupation therapy (1), outpatient pediatric occupation therapy (1), applied behavior analysis (1), and long term and skilled care (1). Figure 5.

Out of seventy-three respondents, seventy-one noted they provide telehealth services to KanCare members; one respondent noted providing telehealth services but was not sure if providing to KanCare members; and one respondent was not providing these services due to difficulty to connect or having audio and video issues.



**Figure 5. Type of Healthcare Services Provided – 2022**



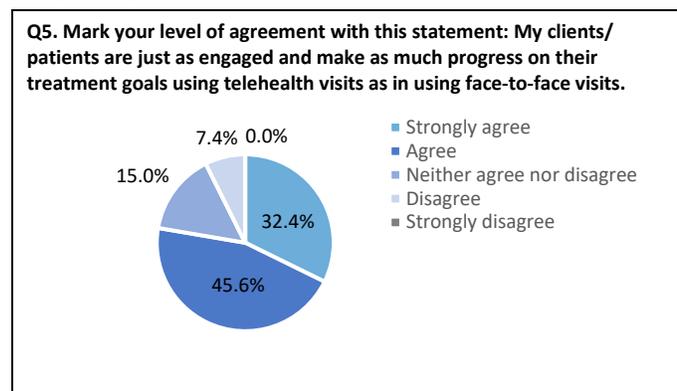
**Figure 6. Providers' Comfortability with Delivering Telehealth Services – 2022**

#### *Providers' Comfortability with Delivering Telehealth Services:*

Out of seventy survey respondents, the majority noted being “very comfortable” or “moderately comfortable” delivering telehealth services (77.2% and 21.4%, respectively). Figure 6.

#### *Engagement of Clients/Patients and Progress on Their Treatment Goals Using Telehealth Visits as in Using Face-to-Face Visits:*

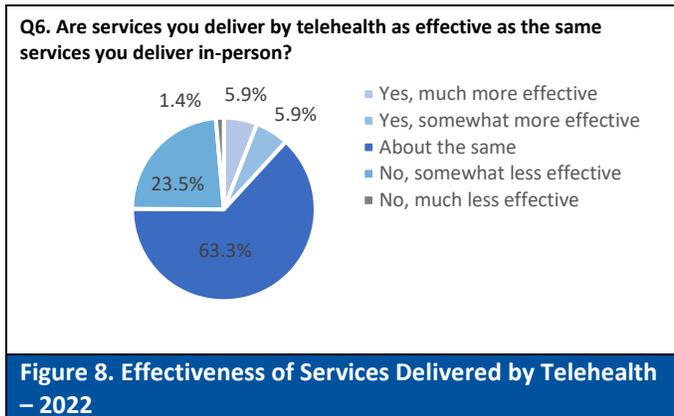
Survey respondents were asked to mark their agreement level with the statement: “My clients/patients are just as engaged and make as much progress on their treatment goals using telehealth visits as in using face-to-face visits.” (Q.5). Out of sixty-eight respondents, the majority “strongly agree” or “agree” with the statement (32.4% and 45.6%, respectively). Figure 7.



**Figure 7. Engagement of Clients/Patients and Progress on Their Treatment Goals Using Telehealth Visits – 2022**

**Effectiveness of Services Delivered by Telehealth:**

Survey respondents were asked whether the services delivered by telehealth were as effective as the same services they deliver in-person (Q6). Sixty-eight providers responded, with the majority of them noting effectiveness of the services delivered by telehealth was “*about the same*” as in-person (63.2%). Another 23.5% noted services delivered by telehealth were “*somewhat less effective*” than services delivered in-person. Figure 8.



**Telehealth Leading to an Improvement in the Overall Quality of Services Provided:**

Survey respondents were asked whether telehealth had improved the overall quality of the services provided (Q7). Sixty-eight providers responded to the question. Results were mixed. About 59% of the respondents answered “*yes, much improved*” or “*yes, somewhat improved*” (35.3% and 23.5%, respectively). However, another 33.8% noted it as “*about the same*”, and 7.4% marked “*no, somewhat worse.*”

**Opinions Regarding Telehealth Services:**

Survey respondents were asked to indicate their opinions regarding nine items related to telehealth services (Q8). For each item, respondents were asked to mark their opinion as “*strongly agree,*” “*agree,*” “*neither agree nor disagree,*” “*disagree,*” or “*strongly disagree.*” The results are summarized in Table 19.

Table 19. Opinions Regarding Telehealth Services – Telehealth Provider Survey, 2022						
Q8. Please indicate your opinions regarding telehealth services						
Item Related to Telehealth Services		Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree
	N	% (n)	% (n)	% (n)	% (n)	% (n)
Telehealth has improved access to care for KanCare members.	64	71.9% (46)	26.6% (17)	1.5% (1)	0.0% (0)	0.0% (0)
Telehealth expands my ability to see clients/patients over a greater geographic distance.	64	75.0% (48)	17.2% (11)	7.8% (5)	0.0% (0)	0.0% (0)
Telehealth increases my ability to see more clients/patients.	64	46.8% (30)	21.9% (14)	21.9% (14)	7.8% (5)	1.6% (1)
Telehealth fills an essential practitioner gap in my organization.	62	29.0% (18)	29.0% (18)	38.7% (24)	3.3% (2)	0.0% (0)
Telehealth improves workflow efficiencies in my practice.	63	33.3% (21)	33.3% (21)	23.9% (15)	7.9% (5)	1.6% (1)
Use of telehealth improves quality of care for clients/patients.	64	32.8% (21)	29.6% (19)	21.9% (14)	14.1% (9)	1.6% (1)
Telehealth decreases profitability/revenue.	64	1.6% (1)	6.1% (4)	42.3% (27)	32.8% (21)	17.2% (11)
Telehealth provides competitive advantage over other organizations in my region.	64	14.1% (9)	32.8% (21)	48.4% (31)	1.6% (1)	3.1% (2)
Telehealth is important to the success of my organization.	64	34.4% (22)	53.1% (34)	10.9% (7)	1.6% (1)	0.0% (0)

More than 86% of the respondents “strongly agree” or “agree” that telehealth has improved access to care for KanCare members, expands their ability to see clients/patients over a greater geographic distance, and is important to the success of their organization. About two-thirds of the respondents “strongly agree” or “agree” that telehealth increases their ability to see more clients/ patients, fills an essential practitioner gap in their organization, improves workflow efficiencies in their practice, and use of telehealth improves quality of care for clients/patients.

About half of the respondents indicated they “strongly agree” or “agree”, whereas other half of them indicated they “neither agree nor disagree” that telehealth provides competitive advantage over other organizations in my region. The half of the respondents “strongly disagree” or “disagree”, whereas slightly less than half of them indicated they “neither agree nor disagree” that telehealth decreases profitability/revenue.

**Barriers to Providing Telehealth Services:**

Survey respondents were asked about the barriers to providing telehealth services (Q9). Sixty-eight providers responded to the question. The results for this question are described in Table 20. Key points are summarized below.

- About 27% of the respondents noted no barriers to providing telehealth services.
- The following four barriers were selected by most of the providers:
  - “Clients lack the technology and resources for telehealth services (mobile phones, computers, internet access)” – selected by about 45% of the respondents.
  - “Lack of client familiarity or comfort with using telehealth services” – selected by about one-third (33.3%) of the respondents.
  - “Lack of reliable internet for providers” – selected by one in four (23.3%) respondents.
  - “Do not consider telehealth services as effective as in-person services” – selected by nearly one in five (21.7%) respondents.

<b>Table 20. Barriers to Providing Telehealth Services – Telehealth Provider Survey, 2022</b>		
<b>Q9. What are the barriers to providing telehealth services? (Mark all that apply)</b>		
<b>Barriers</b>	<b>Responses</b>	
	<b>n</b>	<b>%</b>
No barriers	16	26.7
Security/confidentiality of HIPAA compliance	6	10.0
Do not consider telehealth services as effective as in-person services	13	21.7
Lack of staff to implement telehealth services	4	6.7
Lack of training or education regarding telehealth services	7	11.7
Level of guidance available from payor of services	4	6.7
Clients lack the technology and resources for telehealth services (mobile phones, computers, internet access)	27	45.0
Lack of reliable internet for providers	14	23.3
Lack of staff familiarity or comfort with providing telehealth services	2	3.3
Lack of client familiarity or comfort with using telehealth services	20	33.3
Cost of starting telehealth services	0	0.0
Cost of maintaining telehealth services	3	5.0
Payor covers too few services	11	18.3
Other	6	10.0

### *Three Most Important Barriers:*

When asked to select up to three from the list of barriers they selected in response to Q9 of the survey, providers listed following three barriers as most important to them (Q10):

- *“Clients lack the technology and resources for telehealth services (mobile phones, computers, internet access)”* – listed by more than half of the respondents (55.8%). This barrier was also selected by most of the providers in response to Q9.
- *“Lack of client familiarity or comfort with using telehealth services”* – listed by about one-third (34.9%) of the respondents. This barrier was also selected by the second highest number of providers in response to Q9.
- *“Do not consider telehealth services as effective as in-person services”* – listed by about one-fifth (23.3%) of the respondents. This barrier was also selected by the fourth highest number of providers in response to Q9. It should be noted that this is consistent with the results seen for the question (Q6) asking whether the services delivered by telehealth as effective as the same services they deliver in-person (24.9% responded as *“somewhat less effective”* or *“much less effective”*).

### *Ideas to Improve Telehealth Services for KanCare Members*

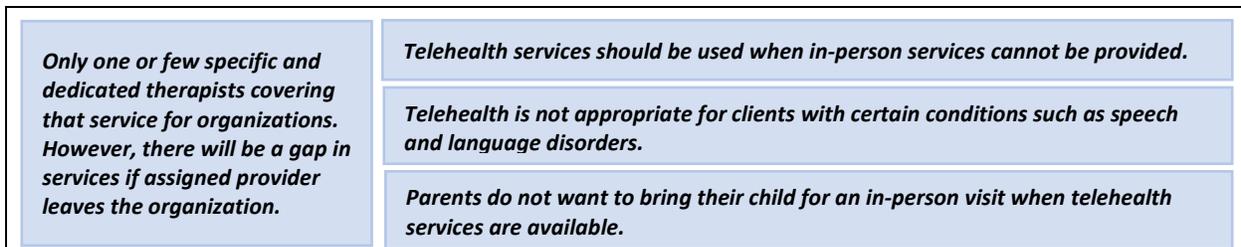
Providers were asked to provide recommendations for removing barriers to increase the use of these services and improve access to care among KanCare members (Q11). Thirty-four providers responded to this question. An overview of survey responses and key themes is described in Table C.14. The key similar and dissimilar themes are summarized below.

Several similar responses were provided by respondents that are summarized into eight key themes (Figure 9). However, three survey respondents provided specific comments related to use telehealth, that were dissimilar to those provided by rest of the respondents to this survey question. These comments are summarized into four key themes (Figure 10).

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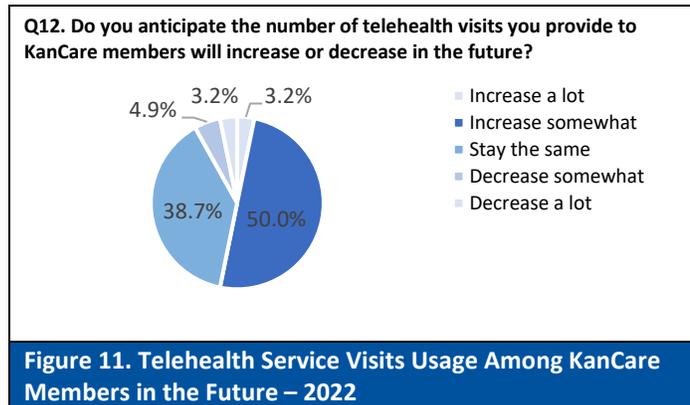
**Figure 9. Ideas to Improve Telehealth Services for KanCare Members – Key Themes Summarized from the Similar Responses Provided by the Survey Respondents**



**Figure 10. Ideas to Improve Telehealth Services for KanCare Members – Key Themes Summarized from the Dissimilar Responses Provided by the Survey Respondents**

**Telehealth Service Visits Usage Among KanCare Members in the Future:**

Providers were asked whether they anticipate the number of telehealth visits they provide to KanCare members will increase or decrease in future (Q12). Sixty-two providers responded to this question. Half of them (50%) noted number will “Increase somewhat”, and slightly more than one-third of the respondents noted it will “stay the same”. Figure 11.



**f. Hypothesis 4 – Removal of Payment Barriers for Services Provided in Institutions for Mental Diseases for KanCare Members with Substance Use Disorders**

As per a recommendation from, KanCare 2.0 Hypothesis 4 evaluation results are included as a part of a separate report prepared for the evaluation of KanCare 2.0 Section 1115 SUD Demonstration.

**g. Monitoring of the Overall KanCare 2.0 Performance Measures**

Quantitative Evaluation

Overall KanCare 2.0 performance measures were examined, and the results are summarized here.

HEDIS Measures

Prenatal and Postpartum Care (PPC):

- Timeliness of Prenatal Care – Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
- Postpartum Care – Percentage of deliveries that had a postpartum visit between 7 and 84 days after delivery.

This measure tracked PPC rates among the combined Medicaid and CHIP population. The KanCare PPC rates were weighted averages of MCO hybrid rates, weighted by administrative denominator. The goal for the PPC measure is to have higher rates and rankings. The rates from measurement years 2019 and 2020 were examined here. The results for this measure are described in Table 21.

Timeliness of Prenatal Care

The Timeliness of Prenatal Care rate declined 4.2 percentage points, from 84.3% for 2019 to 80.1% for 2020. The decline was statistically significant ( $p=.01$ ). The rates in both years were below the 33.33<sup>rd</sup> percentile.

Postpartum Care

The Postpartum Care rates increased 8.9 percentage points, from 67.0% for 2019 to 76.0% for 2020, which was statistically significant ( $p<.001$ ). The ranking increased from <25<sup>th</sup> to <50<sup>th</sup>.

Table 21. HEDIS Measure – Prenatal and Postpartum Care (PPC), MY 2019–2020					
Measure	MY 2019		MY 2020		Percentage Point Change
	Rate	Rank	Rate	Rank	
<b>Prenatal and Postpartum Care (PPC)</b>					
<b>Timeliness of Prenatal Care</b>	84.28%	<33.33 <sup>rd</sup>	80.06%↓	<33.33 <sup>rd</sup>	- 4.2 pp
<b>Postpartum Care</b>	67.04%	<25 <sup>th</sup>	75.96%↑	<50 <sup>th</sup>	+ 8.9 pp
Note: The KanCare rate is the average of the MCO adult population rates, weighted by administrative denominator. Testing for statistically significant differences between two consecutive years used a weighted Pearson chi-square test ( $p < .05$ was considered statistically significant); ↓ Indicates a statistically significant decrease in rate compared to the prior year; ↑ Indicates a statistically significant increase in rate compared to the prior year. Rank indicates Quality Compass ranking for the rate.					

**Comprehensive Diabetes Care:**

The comprehensive diabetes care measures were reorganized by NCQA since the KanCare 2.0 Evaluation Design was written. Three indicators were discontinued: Medical Attention for Nephropathy, HbA1C Testing, and HbA1c Control (<7.0%). The remaining four indicators were separated into three independent measures.

The following measures are percentages of members 18–75 years of age with diabetes (types 1 and 2).

- Hemoglobin A1c Control for Patients with Diabetes (HBD) – Percentage whose hemoglobin A1c (HbA1c) was at the following levels:
  - HbA1c Control (<8.0%)
  - Poor Control HbA1c (>9.0%)
- Eye Exam Performed for Patients with Diabetes (EED) – Percentage who had a retinal eye exam
- Blood Pressure Control for Patients with Diabetes (BPD) – Percentage whose blood pressure was adequately controlled (<140/90 mm Hg)

The goal for three comprehensive diabetes care indicators—HbA1c Control, Eye Exam Performed for Patients with Diabetes, and Blood Pressure Control for Patients with Diabetes—is to have higher rates and rankings. The goal for Poor Control HbA1c is to have a low rate and high ranking. The rates from measurement years 2018 to 2020 were examined for these four indicators of the CDC measure. There was a break in trending between 2019 and 2020 for the Blood Pressure Control for Patients with Diabetes indicator. Since only one data point was available, the indicator was not assessed for the interim evaluation. In addition to comparison of rates to the prior year’s rate for 2018 to 2020, a Mantel-Haenszel chi-square test was used to determine if the slope of the five-year trend line (MY 2016–2020) was statistically significantly different from horizontal. These results are described in Table 22.

For 2018 to 2020, changes in rates from prior years were not statistically significant except for one case: the Eye Exam Performed for Patients with Diabetes (EED) rate decreased significantly from 2018 (64.8%) to 2019 (62.9%). From 2016 to 2020, the EED rate decreased an average 0.5 percentage points per year, which was statistically significant.

The Quality Compass rankings increased to >75<sup>th</sup> for 2020 for all three comprehensive diabetes care measures, which indicates KanCare members fared relatively well in the first year of the pandemic compared to members in other health plans.

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Table 22. HEDIS Measures – Comprehensive Diabetes Care, MY 2018–2020							
Measure	MY 2018		MY 2019		MY 2020		Trend: 2016–2020
	Rate	Rank	Rate	Rank	Rate	Rank	p-value
<b>Hemoglobin A1c Control for Patients with Diabetes (HBD)</b>							
<b>HbA1c Control (&lt;8.0%)</b>	54.94%	>66.67 <sup>th</sup>	53.23%	≥50 <sup>th</sup>	53.91%	>75 <sup>th</sup>	p=.21
<b>Poor Control HbA1c (&gt;9.0%)</b>	36.79%	≥50 <sup>th</sup>	39.01%	<50 <sup>th</sup>	36.64%	>75 <sup>th</sup>	p=.12
<b>Eye Exam for Patients with Diabetes (EED)</b>	64.80%	>75 <sup>th</sup>	62.89%↓	>66.67 <sup>th</sup>	61.53%	>75 <sup>th</sup>	p<.01

Note: The KanCare rate is the average of the MCO adult population rates, weighted by administrative denominator. Testing for statistically significant differences between two consecutive years used a weighted Pearson chi-square test and testing whether the slopes of the 5-year trend lines were statistically significantly different from horizontal used a weighted Mantel-Haenszel chi-square test ( $p<.05$  was considered statistically significant); ↓ Indicates a statistically significant decrease in rate compared to the prior year. Rank indicates Quality Compass ranking for the rate.

**Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (<8.0%)**

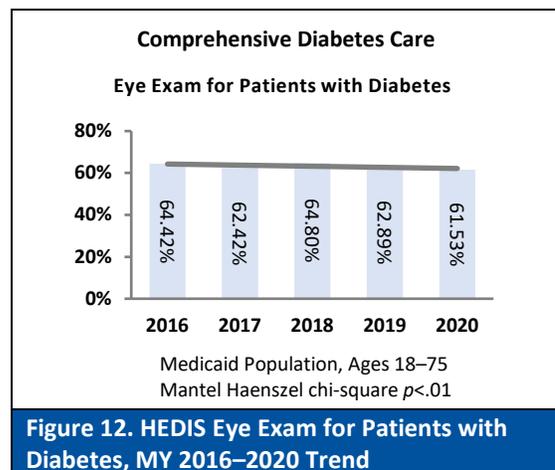
As mentioned above, the goal for this indicator was to see higher rates and ranks. No statistically significant change was seen in the rates for HbA1c Control (<8.0%) indicator from 2018 to 2019, and from 2019 to 2020 (MY 2018 rate: 54.94%, My 2019 rate: 53.23%, MY 2020 rate: 53.91%). A decline in rank was seen from 2018 to 2019 (>66.67<sup>th</sup> percentile vs. ≥50<sup>th</sup> percentile), however, an improvement was seen in MY 2020 to >75<sup>th</sup> percentile from >50<sup>th</sup> percentile in MY 2019. No statistically significant change was seen in the five-year trend from 2016 to 2020 for this indicator ( $p=.21$ ).

**Hemoglobin A1c Control for Patients with Diabetes: Poor Control HbA1c (>9.0%)**

As mentioned above, the goal for this indicator was to see lower rates and higher ranks. No statistically significant change was seen in the rates for the Poor Control HbA1c (>9.0%) indicator from 2018 to 2019, and from 2019 to 2020 (MY 2018 rate: 36.79%, MY 2019 rate: 39.01%, MY 2020 rate: 36.64%). A decline in rank was seen from 2018 to 2019 (≥50<sup>th</sup> percentile to <50<sup>th</sup> percentile), however, it increased in CY 2020 to >75<sup>th</sup> percentile, showing improvement in the indicator ranking status. No statistically significant change was seen in the five-year trend from 2016 to 2020 for this indicator ( $p=.12$ ).

**Eye Exam Performed for Patients with Diabetes**

As mentioned above, the goal for this indicator was to see higher rates and ranks. A statistically significant decline was seen in the rate for Eye Exam Performed for the Patients with Diabetes indicator of the CDC measure from 2018 to 2019 (MY 2018 rate: 64.80%, MY 2019 rate: 62.89%;  $p<.001$ ), whereas no significant difference was seen in 2019 and 2020 rates (MY 2020 rate: 61.53%). A decline in rank was seen from 2018 to 2019 (>75<sup>th</sup> percentile vs. 66.67<sup>th</sup> percentile), however, it increased in MY 2020 to >75<sup>th</sup> percentile. A statistically significant decreasing (worsening) trend from 2016 to 2020 was seen for this indicator ( $p<.01$ ), on average, the rate for the indicator worsened at 0.5 percentage points per year (Figure 12).



**Figure 12. HEDIS Eye Exam for Patients with Diabetes, MY 2016–2020 Trend**

CAHPS Survey Measures

Smoking and Tobacco Cessation:

HEDIS Measure – Medical Assistance with Smoking and Tobacco Use Cessation (MSC) measure included following indicators.

- Advising Smokers and Tobacco Users to Quit – Percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the prior six months
- Discussing Cessation Medications – Percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medication in the prior six months
- Discussing Cessation Strategies – Percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies in the prior six months.

The goal for Smoking and Tobacco Usage is to have lower rates and rankings. For the MSC indicators, higher rates and rankings are preferred. Slightly less than a third of KanCare adults were smokers or tobacco users in the three-year period. No statistically significant decline in rates was seen from 2019 to 2020 and from 2020 to 2021. From 2019 to 2020, KanCare rates were near the 50<sup>th</sup> percentile (ranking <50<sup>th</sup> or ≥50<sup>th</sup>) for each MSC indicator, but rankings for Advising Smokers and Tobacco Users to Quit and Discussing Cessation Strategies both dropped to <33.33<sup>rd</sup> for 2021. The rank for Discussing Cessation Medications remained <50<sup>th</sup>.

Advising Smokers and Tobacco Users to Quit

After being stable for two years, the statistically significant decrease in percentage advised to quit suggests a need for improvement. While the rate had been as high as 78.8% (in 2020), it is now 72% and ranked <33.33<sup>rd</sup>.

Discussing Cessation Medications

The KanCare adult rates for discussing cessation medications did not show any significant improvement from 2019 to 2020 and from 2020 to 2021. About 50% of the members reported their doctor or health provider discussed or recommended medication to assist them with quitting or using tobacco, and the rank remained in the <50<sup>th</sup> percentile in each of the three years (2019, 2020 and 2021).

Discussing Cessation Strategies

In 2021, about 44% (<33.33<sup>rd</sup>) of KanCare adults who smoked cigarettes or used tobacco reported a doctor or other health provider discussed or provided methods and strategies other than medication to assist them with quitting smoking or tobacco use—a 4.5 percentage point decrease from 2020.

Adult HEDIS Measure: Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	2019		2020		2021	
	Percent	Rank	Percent	Rank	Percent	Rank
Total % Current Smokers ( <i>lower is better</i> )	31.8%	≥50 <sup>th</sup>	30.0%	≥50 <sup>th</sup>	30.3%	≥50 <sup>th</sup>
Advising Smokers to Quit (“Always”, “Usually”, or “Sometimes”)	76.1%	<50 <sup>th</sup>	78.8%	≥50 <sup>th</sup>	72.0%↓	<33.33 <sup>rd</sup>
Discussing Cessation Medications (“Always”, “Usually”, or “Sometimes”)	53.4%	<50 <sup>th</sup>	54.1%	<50 <sup>th</sup>	52.5%	<50 <sup>th</sup>
Discussing Cessation Strategies (“Always”, “Usually”, or “Sometimes”)	46.1%	<50 <sup>th</sup>	48.6%	≥50 <sup>th</sup>	44.1%	<33.33 <sup>rd</sup>

Note: The KanCare rate represents the combined percentage of MCO adult populations, weighted by MCO. Rates are annual rates and not 2-year rolling averages. ↓ Indicates a statistically significant decrease compared to the prior year; p<.05. Rank indicates Quality Compass ranking for the rate.

NCI Survey Measures

*Social and Community Engagement Among Adult KanCare Members Receiving At Least One Intellectual/Developmental Disability (I/DD) Waiver Service:*

Six measures were examined to assess the aspect of social and community engagement among the Medicaid eligible members, 18 years and older, who received at least one Intellectual/Developmental Disability (I/DD) waiver service and participated in the Kansas NCI surveys.

<b>Table 24. Social and Community Engagement Among Adult KanCare Members Receiving At Least One Intellectual/Developmental Disability Waiver Service [Kansas NCI Survey Measures]</b>						
Measure	2016-2017		2017-2018		2018-2019	
	N	Percent	N	Percent	N	Percent
Can see and communicate with their family when they want (if not living with family)	196	82%	186	82%	195	82%
Has friends (may be staff or family) and can see them when wants	262	83%	236	78%	244	78%
Able to go out and do the things they like to do in the community as often as they want	253	81%	249	79%	245	85%
Services and Supports help person live a good life	265	90%	264	91%	262	92%
Decides or has input in deciding how to spend free time	384	91%	375	93%	393	89%
Decides or has input in deciding daily schedule	385	83%	374	85%	387	84%

Note: 2019-20 Survey: "The 2019-2020 in-person surveys ended early due to COVID19; all data collection was halted on April 15, 2020. Very few states had completed data collection by that date. For this reason, NCI decided not to publicly report these data." [2019-2020 National Core Indicators At-A-Glance Report \(ncilegacy.com\)](#) (Accessed 03/24/2022)

The percentages for four out of six measures were above 80% in all three years. The percentages of the measure assessing members’ ability to go out and do things they like to in the community as often as they want were above 80% for two years. The percentages for the measure assessing members’ ability to see friends when they want showed considerable decline in recent two years, from 83% in 2016–2017 to 78% in 2017–2018 and 2018–2019.

- Can see and communicate with their family when they want (if not living with family)
  - In each of the three years, 82% of members reported they can see and communicate with their family when they want (if not living with family).
- Has friends (may be staff or family) and can see them when wants
  - In the 2017-18 and 2018-19 surveys, 78% of members reported they have friends (may be staff or family) and can see them when they want, which was a decline of 5 percentage points from 2016-17.
- Able to go out and do the things they like to do in the community as often as they want
  - In 2017-18, 79% of members reported they were able to go out and do the things they like to do in the community as often as they want, showing a decline of 2 percentage points from 2016-17. However, compared to 2017-18, an increase by 6 percentage points was seen in 2018-19 with 85% of the members reporting they were able to go out and do the things they like to do in the community as often as they want.
- Services and Supports help person live a good life
  - The percentages of members reporting services and supports help them in living a good life were 90% or higher in all three survey years and showed increases of one percentage point from 2016-17 to 2017-18 and from 2017-18 to 2018-19.
- Decides or has input in deciding how to spend free time
  - The percentage of members reporting they decide or have input in deciding how to spend free time increased from 91% in 2016-17 to 93% in 2017-18 showing an increase of two percentage

points. However, in 2018-19, a decline of four percentage points was seen compared to 2017-18 with 89% reporting they decide or have input in deciding how to spend free time.

- Decides or has input in deciding daily schedule
  - The percentage of members reporting they decide or have input in deciding daily schedule increased from 83% in 2016-17 to 85% in 2017-18 showing an increase of two percentage points. However, in 2018-19, a slight decline of one percentage point was seen compared to 2017-18.

NCI-AD Survey Measures

*Social and Community Engagement Among Adults and Seniors Participating in the Frail Elderly (FE), Physical Disability (PD) and Brain Injury (BI) Waiver Programs to Receive LTSS*

Six measures were examined to assess the aspect of social and community engagement among adults and seniors, Medicaid eligible, participating in the FE, PD and BI waiver programs to receive LTSS.

The percentages for three out of six measures were above 90% in both years. The percentage of the measure assessing members’ ability to go out and do things they like to in the community as often as they want was above 90% in 2018-19, however it decreased to 87% in the recent year. The percentages for the measure assessing members’ ability to do things they enjoy outside of home as much as they want remained 73% in both years. The percentage of people who like how they spend their time during the day was low in 2018-19, and it further declined in 2019-20.

<b>Table 25. Social and Community Engagement Among Adults and Seniors Participating in the FE, PD, and BI Waiver Programs to Receive LTSS [Kansas NCI-AD Survey Measures]</b>				
Measure	2018-2019		2019-2020	
	N	Percent	N	Percent
Percentage of people who are always able to see or talk to friends and family when they want to (if have friends and family who do not live with person)	342	91%	238	87%
Percentage of people who are able to do things they enjoy outside of home as much as they want to	344	73%	247	73%
Percentage of people whose services help them live a better life	357	90%	226	97%
Percentage of people who like how they spend their time during the day	349	64%	249	53%
Proportion of people who get up and go to bed when they want to	353	96%	254	96%
Percentage of people who can eat their meals when they want to	356	94%	255	92%

Note: Percentages reported are "State Average" for all three populations included in the survey.

- Percentage of people who are always able to see or talk to friends and family when they want to (if have friends and family who do not live with person)
  - In 2019-20, 87% of members reported they were always able to see or talk to friends and family when they want to (if have friends and family who do not live with person), a decline of 4 percentage points compared to 2018-19.
- Percentage of people who are able to do things they enjoy outside of home as much as they want to
  - No change was seen in the two years with 73% of members reporting they were able to do things they enjoy outside of home as much as they want to.
- Percentage of people whose services help them live a better life
  - The percentages of members reporting their services help them live a better life were 90% or higher in both years and showed an increase of 7 percentage point from 2018-19 to 2019-20.
- Percentage of people who like how they spend their time during the day
  - The percentages of members reporting they like how they spend their time during the day were

below 75% in both years. A considerable decline of 11 percentage points was seen in 2019-20 from 2018-19.

- Percentage of people who get up and go to bed when they want to
  - In both years, 96% of members reported they get up and go to bed when they want to.
- Percentage of people who can eat their meals when they want to
  - In both years, more than 90% of members reported they can eat their meals when they want to, however a decline of 2 percentage points was seen in 2019-20.

## **Conclusions**

KFMC has prepared this interim evaluation report to reflect evaluation progress and present findings to date to examine the KanCare 2.0 Service Coordination Strategy, OneCare Kansas (OCK) program, KanCare 2.0 hypotheses presented above (Hypothesis 1-4), as well as the monitoring of KanCare 2.0 overall performance measures identified during the final evaluation of the previous KanCare Demonstration. Measurement data are provided, as available, for the time period of January 1, 2019, through December 31, 2021, while updates and qualitative data are provided for the time period through September 30, 2022.

It should be noted, the COVID-19 pandemic affected the utilization of health care services throughout the state and may have impacted the outcomes from this period. Thus, the results presented here should be interpreted with caution. Where feasible, adjustments were made to the analytic plans to account for the pandemic's impact on measurement outcomes. Data and analytic results for 2022 and 2023 may provide a better assessment of the impact of KanCare 2.0 efforts.

### **a. KanCare 2.0 Service Coordination Strategy**

The quantitative evaluation of the KanCare 2.0 Service Coordination Strategy examined whether the integration of physical and behavioral health services provided to KanCare members in the Intervention Group (received HRA and PCSP) improved quality of care, health outcomes, and cost outcomes.

- The results for the Outpatient or Professional Claims (for diabetic retinopathy, influenza, pneumonia or shingles) measure support the assertion that the KanCare 2.0 Service Coordination Strategy had a positive impact on its rates. It should be noted, instead of improving, this measure's rates increased for both the Intervention Group and Comparison Group 2. Since the Intervention Group's rates changed less, relative to Comparison Group 2, the Intervention Group's performance was deemed better under the circumstances.
- The 2019–2021 rates for ED Visits, Observation Stays, or Inpatient Admissions (for diabetic ketoacidosis/hyperglycemia, acute severe asthma, hypertensive crisis, fall injuries, SUD, or mental health issues), Annual Dental Visits, and Adolescent Well-Care Visits, worsened for both groups from 2016–2018, with the Intervention Group having poorer performance than Comparison Group 2.
- The relative improvements in both groups were about the same for the Access to Preventive/ Ambulatory Health Services and Emergency Department Visits (overall) measures.

### **Opportunities for Improvement**

- It was not clear from the MCOs' data whether all members eligible for participation in the Service Coordination Strategy received an HRA and Needs Assessment, along with a PCSP if applicable.

### **Recommendations**

- Ensure standardization of the MCOs' processes to collect and abstract HST, HRA, Needs Assessment and PCSP data from their case management data systems. Each MCO's data system should include all variable fields needed for evaluation of the KanCare 2.0 Service Coordination Strategy.
- As the State completes its public health emergency winding down period, review and improve the steps applied by the three MCOs to ensure all members eligible for participation in the Service Coordination Strategy receive an HRA and Needs Assessment, along with a PCSP and coordinated care, as appropriate during the remaining years of the KanCare 2.0 demonstration. Application of the Service Coordination Strategy to all eligible members will assist in achieving its impact on the performance outcomes.

### **b. OneCare Kansas**

The quantitative evaluation of the OCK program examined whether it improved the quality of care, health outcomes, and cost outcomes.

- The results support the assertion that the OCK program had a positive impact on the rates of three out of six measures (Adults' Access to Preventive/Ambulatory Health Services, Adolescent Well-Care Visits, and on Annual Dental Visits).
- There is potential for the other measures to improve during the remainder of the demonstration, as multiple measures showed relative improvements but were not statistically significant.

Information from OCK Learning Collaborative participants through routine meeting, a survey, and regional virtual meetings conducted from April 2020 through March 2022 was abstracted from OCK program summary reports for the qualitative evaluation.

- Identified key factors that facilitated OCK implementation include the availability of program information, resources, and trainings; staffing strategies and support; collaboration among OCK partners; collaboration with community and provider entities; and diagnostic code expansion.
- Key themes of identified barriers and challenges in OCK implementation included
  - Issues with program structure, including labor and time-intensive processes and unclear expectations
  - Access to member information, financial concerns, member enrollment, roster and engagement, opt-in/opt-out process, collaborations with partners/providers, staffing, and access to care in rural areas
- Key observations regarding OCK program successes included the following:
  - Improved care coordination
  - Improved support of members and increase in member trust and engagement
  - Increased partner collaboration
  - Sharing information about the program with community partners
- One learning need theme, identified by Learning Collaborative participants, that did not appear to be addressed pertained to trainings on OCK focused conditions, such as asthma, behavioral health, motivational interviewing and health literacy.
- OCK partners emphasized a need of continued peer learning and support for program implementation, sharing guidance and strategies to address barriers/challenges.
- OCK partners made the following key recommendations and suggestions for potential next steps.
  - Increase access to medical care among non-compliant patients by allowing initial in-person appointment and virtual appointments for follow-up visits.
  - OCKPs across the state could build their professional networks and provide mutual support

outside of the formal opportunities offered by the State.

- Development and use of the provider directory to assist in communication and collaboration across the network of OCK partners.
- Improve program processes and systems.
- Develop connections with local foster care contractors, child placing agencies, local hospitals, and emergency departments.
- Identification of the opportunities to obtain hospital data and provision of organizational data.

#### *Opportunities for Improvement*

- Review of the MCOs' databases indicated that the MCOs' processes to determine members' OCK eligibility, per the State's criteria, had some variability. Differences were also seen between KFMC's identification of eligible members from the Claims database, using the State's OCK program eligibility criteria, and the dataset provided by one of the MCOs, with KFMC identifying more eligible members.
- Potential unmet OCK partners' learning needs include topics specific to working with OCK members, such as asthma, behavioral health, motivational interviewing, and health literacy.

#### *Recommendations*

- Ensure standardization of the MCOs' process to determine members' eligibility for the OCK program, per the State's criteria.
- Determine OCK partners' continued learning needs specific to working with OCK members and their diagnoses, and provide related Learning Collaborative training or other resources.

### **c. Hypothesis 1 – MCOs' Value-Based Provider Incentive Programs**

Each of the MCOs designed a value-based provider incentive program (VBPs) to address KanCare 2.0

Hypothesis 1:

- Aetna VBP – CARE and CARE+ Programs with Community Mental Health Centers
- Sunflower Health Plan VBP – Behavioral Health Project
- UnitedHealthcare VBP – Pediatric Care Network Project

The MCOs are in the process of initiating their VBPs. Therefore, data are not currently available from these projects and an interim evaluation of Hypothesis 1 was not conducted. The evaluation of Hypothesis 1 will be conducted as a part of the summative evaluation of KanCare 2.0.

### **d. Hypothesis 2 – Employment and Independent Living Supports for KanCare 2.0 Members With Disabilities**

Data for Hypothesis 2 outcome measures were not available. Therefore, an interim evaluation of Hypothesis 2 was not conducted. The evaluation of Hypothesis 2 will be conducted as a part of the summative evaluation of KanCare 2.0.

### **e. Hypothesis 3 – Use of Telehealth Services**

The evaluation of Hypothesis 3, comprised of quantitative and qualitative components, examined whether the use of telehealth services (telemedicine, telemonitoring, and telementoring) enhanced access to care for KanCare members living in rural and semi-urban areas.

### *Quantitative Evaluation of Hypothesis 3:*

#### Telemedicine

The results suggested that the usage of telemedicine services increased among KanCare Non-Urban members. However, the ability of these results to show improvement was overshadowed by the impact of the COVID-19 pandemic. It should be noted, the increases in usage were also seen in Urban members. In addition, these increases were higher among Urban members compared to Non-Urban members in these years. These increases corresponded to the onset of the pandemic and may be due to changes related to the provision of services by providers and their usage by members made during the pandemic years. It should also be noted, though still above the pre-pandemic years, usage of telemedicine services among members started showing decline in 2021 compared to 2020. Additional key findings are described below.

- Telemedicine services for Non-Urban members were used most frequently for Mental, Behavioral and Neurodevelopmental Disorders throughout the time period, specifically Mood [affective] disorders ranked first.
- Analysis related to speech therapy supports the assertion that telehealth enhanced access to care for KanCare members.

#### Telemonitoring

The results for three measures assessed to examine the usage of telemonitoring services among Non-Urban members showed low utilization of telemonitoring services. However, all three measures showed an improvement in counts/percentages from 2019 to 2020 and 2021. These improvements corresponded to the onset of the pandemic and may be due to its impact. The main findings related to the outcome measures are described below.

- Similar patterns were seen for all three telemonitoring measures—the number and percentage of Non-Urban members who received telemonitoring services, the number of telemonitoring services provided to Non-Urban members, and the number of providers monitoring health indicator data transmitted to them by the members receiving telemonitoring services increased from 2019 to 2020 and 2021.

### *Qualitative Evaluation of Hypothesis 3:*

#### Telementoring

The data sources are not currently available to describe the status of the use of Telementoring; therefore, quantitative evaluation was not conducted. The focused on summarizing the telementoring efforts implemented by Sunflower Health Plan, the University of Kansas, and the University of Missouri, using the Project ECHO (Extension for Community Healthcare Outcomes) Model.

- From March 2019 through November 2021, there were twelve Project ECHO series comprised of fifty-one sessions, with an average of 42 participants per session. Following are the Project ECHO topics.
  - Behavioral health (3 of the 4 series focused on Substance Use Disorders)
  - Social Determinants of Health
  - Intellectual and Developmental Disabilities
  - Foster Care
  - Aging
  - Cancer
  - Care Coordination
  - Preventive Health

- The sessions were attended by providers from multiple disciplines, including medical and behavioral clinicians, nurses, pharmacists, and social workers. Participants were from non-urban and urban counties.
- Evaluation results (obtained after each session by the Project ECHO host) indicated participants' knowledge of the topic improved, and they obtained helpful skills and techniques to improve professional practice.

### *Recommendations*

- Continue to expand the use of telementoring, ensuring all MCOs develop and implement plans for this.

### Telehealth Provider Survey

Qualitative information was also collected, through a short online survey, from KanCare providers who offered telehealth services to KanCare members in 2020 or 2021. The survey was designed to gain an understanding of providers' telehealth experiences, perceptions regarding telehealth and access to care, and to identify providers' recommendations regarding telehealth. The survey was conducted in August and September 2022.

Seventy-three providers from urban and non-urban counties completed the survey, with the majority from behavioral health care providers. Other respondents were from primary care, specialty health care and home and community based services. The key points based on the survey results are summarized below:

- Most respondents “*strongly agree*” or “*agree*” that telehealth has improved access to care for KanCare members. It expands their ability to see clients/patients over a greater geographic distance, and it is important to the success of their organization. About two-thirds of the respondents “*strongly agree*” or “*agree*” that telehealth increases their ability to see more clients/patients, it fills an essential practitioner gap in their organization, improves workflow efficiencies in their practice, and it improves the quality of care for clients/patients.
- Most respondents noted being “*very comfortable*” or “*moderately comfortable*” delivering telehealth services.
- Most of the survey respondents “*strongly agree*” or “*agree*” clients are just as engaged and make as much progress on their treatment goals using telehealth visits as in using face-to-face visits.
- Three-fourths of respondents noted the effectiveness of services delivered by telehealth is “*about the same*” or “*better*” than services delivered in-person.
- Following are key barriers in providing telehealth services, identified by survey respondents, with the first two bullets being the most frequently noted.
  - Clients lack the technology and resources for telehealth services (mobile phones, computers, internet access).
  - Lack of client familiarity or comfort with using telehealth services.
  - Lack of reliable internet for providers; and
  - Do not consider telehealth services as effective as in-person services.
- Following are key recommendations (themes) by survey respondents.
  - Provide consistency in application of rules and systems.
  - Increase and improve technology and resources for the members and providers.
  - Continued coverage by insurance companies.

- Provide education, resources (such as searchable databases for identifying providers for needed services), and trainings to members to assist in the understanding benefits of telehealth and using it with ease.
- Increase reimbursement rate for telehealth services.
- Ensure opportunities for telehealth services are available for all members.
- Provide trainings for providers, including easy to understand training for everyone on how to bill that providers can access at any time and can reach an expert who can answer specific situational questions.
- Telehealth is a valuable source for members and providers.
- Only 6% of respondents indicated their usage of telehealth visits would decrease in the future, with 50% anticipating the number of telehealth visits for KanCare members will “*Increase somewhat.*”

### *Opportunities for Improvement*

- KanCare 2.0 Hypothesis 3’s focus is to enhance access to care for KanCare members living in rural and semi-urban areas. The results for the evaluation of telemonitoring service usage showed low utilization of the telemonitoring services. Although, some increases were seen in 2020 and 2021 among Non-Urban and Urban members, the increases seen were higher for Urban members than the Non-Urban members. Similarly, the increases seen in the telemedicine service usage were higher for the Urban members.
- Though still above pre-pandemic years, the results for the measures assessing the telemedicine and telemonitoring usage started showing a decline in 2021 compared to 2020, which may indicate the increases are due to COVID–19 pandemic.
- The focus of KanCare 2.0 Hypothesis 3, related to telementoring, is to pair rural and semi-urban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions. A data warehouse is not in place to collect detailed information on telementoring sessions offered to providers and to assess their impact in increasing the capacity rural and semi-urban healthcare providers have for the treatment of chronic, complex conditions among Non-Urban members.

### *Recommendations*

- Ensure application of the strategies to improve the usage of telemedicine and telemonitoring services among Non-Urban members to increase their access to appropriate care.
- Ensure increased provision and utilization of telementoring sessions to increase the capacity of rural and semi-urban healthcare providers for the treatment of chronic, complex conditions among Non-Urban members.
- Assist the University partners and Health Plans providing telementoring sessions in developing a standardized evaluation component to assess the impact of these sessions in improving the capacity of providers in rural and semi-urban areas.
- Develop a data warehouse to collect the information on the telementoring sessions offered to providers and to assess their impact in increasing the capacity rural and semi-urban healthcare providers have for the treatment of chronic, complex conditions among Non-Urban members.

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## **f. Hypothesis 4 – Removal of Payment Barriers for Services Provided in Institutions for Mental Diseases for KanCare Members with Substance Use Disorders**

As per a CMS recommendation, the conclusion for the KanCare 2.0 Hypothesis 4 evaluation is included as a part of a separate report prepared for the evaluation of KanCare 2.0 Section 1115 SUD Demonstration.

## **g. Monitoring of the Overall KanCare 2.0 Performance Measures**

The HEDIS, CAHPS Survey, NCI Survey and NCI-AD Survey measures related to the areas for improvement from the prior evaluation of the KanCare Demonstration (2013–2018) were assessed. The results for one HEDIS measure, two NCI Survey measures, and one NCI-AD Survey measure supported the assertion that an improvement was seen in the overall performance of KanCare 2.0. e.

### **HEDIS Measures**

- The Prenatal and Postpartum Care (PPC) measure includes Timeliness of Prenatal Care and Postpartum Care. An improvement in the Postpartum Care rate and its QC ranking was seen from Measurement year (MY) 2019 to MY 2020. The QC ranking for Postpartum Care rate also increased from <25<sup>th</sup> to <50<sup>th</sup> percentile.
- The rest of the HEDIS measures did not show improvement from 2019 to 2020.
- A statistically significant decline in the Timeliness of Prenatal Care rate was seen in MY 2020 from MY 2019, with rates for both years below 33.33<sup>rd</sup> percentile.
- The Eye Exam Performed for Patients with Diabetes (EED) rate had a statistically significant declining trend from My 2016 to MY 2020.
- However, the QC rankings increased to >75<sup>th</sup> for 2020 for all three comprehensive diabetes care measures, which indicates KanCare members fared relatively well in the first year of the pandemic compared to members in other health plans.

### **CAHPS Survey Measures**

- The three indicators of the Medical Assistance with Smoking and Tobacco Use Cessation (MSC) measure — Advising Smokers and Tobacco Users to Quit; Discussing Cessation Medications; and Discussing Cessation Strategies — did not show improvement (with some declines), and had QC rankings less than the 50<sup>th</sup> percentile, suggesting a need for improvement.

### **Kansas NCI Survey Measures for Social and Community Engagement (2016–2017, 2017–2018, and 2018–2019)**

- The percentage of members whose services and supports help them live a good life, was 90% or above in all three years.
- The percentages for three out of six measures—Can see and communicate with their family when they want (if not living with family); Decides or has input in deciding how to spend free time; and Decides or has input in deciding daily schedule—were above 80% in all three years.
- The percentage of members with the ability to go out and do things they like in the community increased from 79% to 85% in the most recent year.
- The percentage of members with the ability to see friends when they want declined from 83% in 2016-17 to 78% in 2017-18 and 2018-19.

### **Kansas NCI-AD Survey Measures for Social and Community Engagement (2018–2019, and 2019–2020):**

- The percentages for three out of six measures—Percentage of people whose services help them live

a better life; Proportion of people who get up and go to bed when they want to; and Percentage of people who can eat their meals when they want to— were above 90% in both years.

- The percentage of members with the ability to go out and do things they like to in the community as often as they want was above 90% in 2018-19, however it decreased to 87% in recent year.
- The percentages for the measure assessing members' ability to do things they enjoy outside of home as much as they want remained same in both years.
- The percentage of people who like how they spend their time during the day was low in 2018-19, and it further declined in 2019-20.

### *Recommendations*

- Review and ensure strategies are applied by the MCOs and health care providers to improve provision of timely prenatal care, comprehensive diabetes care, and medical assistance for smoking and tobacco use cessation to KanCare 2.0 members.
- Ensure MCOs and health care providers implement strategies to improve the social wellbeing of members receiving I/DD waiver services. Ensure the PCSPs of these members include the provision of assistance for them to engage socially, with friends and family, when they want.
- As the State completes the public health emergency winding down period, ensure MCOs and health care providers implement strategies to improve social and community engagement among adults and senior members obtain long term services and supports through the Frail Elderly, Physical Disability and Brain Injury waiver programs. Ensure the PCSPs of these members include provision of assistance for them to engage in activities of their interest outside their home when they want and to decide their daily activities.

## ***Interpretations, and Policy Implication and Interactions with Other State Initiatives***

KFMC will address the policy implications and interactions with other state initiatives in the summative KanCare 2.0 evaluation. For this interim evaluation, the following interpretations could be made.

- It is not yet known how much the COVID-19 pandemic will influence the impact of the KanCare 2.0 program overall. It will take more years to assess the impact of the program, overall, outside of the context of the pandemic.
- It is difficult to interpret the interactions with other Medicaid and State programs due to the pandemic, as well. KanCare 2.0 activities were drastically affected during the onset of the pandemic. The MCOs were instructed to pause many initiatives with members and providers in order to address the public health emergency. As a result, many of the projects that would have provided data for this evaluation were on hold for a considerable amount of time. Also, the Service Coordination Strategy could not be fully administered as designed, during much of the evaluation time period, due to limitations in face-to-face visits.

## ***Lessons Learned and Recommendations for States***

There were a few lessons learned as a result of this interim evaluation. These lessons learned are also recommendations to State Medicaid agencies for future demonstrations, as well as for the State of Kansas for the remainder of KanCare 2.0.

- There were additional delays in the implementation of KanCare 2.0 strategies that appeared unrelated to the delays due to the COVID-19 pandemic, such as the MCOs' Value Based Provider

Incentive Program delays. These delays will impact the ability to evaluate the efficacy of the KanCare 2.0 program, as a whole. KFMC recommends State Medicaid agencies evaluate MCO delays to determine whether any are unavoidable or whether stronger enforcement of timelines is warranted.

- Some of the programs that began (or were intended to begin) during the evaluation timeframe proved to be more time-intensive to implement than anticipated. KFMC recommends State Medicaid agencies and MCOs explore ways to accelerate the time to implementation of the programs. This will help to ensure adequate time is allowed for conducting the strategies as designed, collecting data and fully testing the hypotheses.
- Lessons learned and recommendations for other State Medicaid agencies will be further addressed in the summative KanCare 2.0 evaluation report.

### ***Summary of Opportunities for Improvement and Recommendations***

- **MCO care coordination assessment:** As the public health emergency completes its winding down period, all members eligible for participation in the Service Coordination Strategy should receive the appropriate assessments.
- **OneCare Kansas capacity and provider training:** The State should ensure the MCOs have a standardized process to determine member eligibility for OCK. The State and MCOs should continue to support the OCK Learning Collaborative, and address providers' training needs regarding working with OCK members (e.g., motivational interviewing, health literacy) and specific diagnoses.
- **Increase telemedicine and telemonitoring utilization:** The State and MCOs should review and implement, as feasible, the provider recommendations for how to improve telehealth services. The State and MCOs should also seek ways to increase the use of telemonitoring services.
- **Improve telementoring opportunities and capacity:** The State should ensure all MCOs develop and implement plans to increase telementoring opportunities targeted towards providers in rural and semi-urban areas of the state, as well as continue to support current telementoring efforts. Standardized methods should also be developed and implemented to collect information on telementoring opportunities across the state and to evaluate the impact for KanCare 2.0 providers, especially those in rural and semi-urban parts of Kansas.
- **Strategies to improve quality and timeliness of care:** The MCOs should evaluate their Quality Assurance and Performance Improvement Programs to ensure they and contracted providers are developing and applying strategies to improve identified KanCare 2.0 performance measures (prenatal, comprehensive diabetes care, medical assistance for smoking and tobacco use cessation).
- **Strategies to improve member social and community engagement:** As the public health emergency completes its winding down period, the State should ensure the MCOs are working through their own care management processes (specifically using the PCSP), as well as with contracted providers, to improve social and community engagement for members on waiver services (I/DD, FE, PD, and BI).

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End of written report

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# ***Appendix A***

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***KanCare 2.0 Interim Evaluation  
Report Evaluation of the State of Kansas  
Medicaid Section 1115(a) Demonstration  
Reporting Period – January 2019 – September 2022***

**OneCare Kansas Program Evaluation**

## **Interim Evaluation of the KanCare 2.0 Demonstration OneCare Kansas Program Evaluation**

### **Qualitative Evaluation of OCK Program**

The qualitative information was reviewed for key themes as summarized below.

#### **1. Learning Needs Identified and Discussed by the OneCare Kansas Learning Collaborative Participants**

##### **a) Learning Needs Identified (Table A.1.)**

The following learning needs were collected from information available from April 2020 through March 2022, including the virtual regional meetings and the survey.

<b>Table A1. Learning Needs Identified by OneCare Kansas Learning Collaborative Participants, April 2020–March 2022</b>	
<b>Learning Collaborative Participant Responses</b>	<b>Key Themes</b>
<ul style="list-style-type: none"> <li>• Health assessment tools (9)</li> <li>• Health assessment tools for children</li> <li>• Outcomes Health Assessment tools</li> <li>• Whole person assessment discussion would be helpful as well, more guidance on the whole person approach to care and how to do an assessment that captures a comprehensive picture of the person and how that would lead into goals more readily than asking a person what goals you are working on or want to work on.</li> <li>• How to provide a complete picture of care for a member when they are in several programs within our agency.</li> <li>• Health assessment portal use and training</li> <li>• Additional training on the different tools available for health assessment</li> <li>• SUD assessment tools</li> </ul>	<ul style="list-style-type: none"> <li>• Health assessment tools and trainings for use of different types of health assessment tools including those for the comprehensive care</li> </ul>
<ul style="list-style-type: none"> <li>• Goal mapping/setting with patients, goal setting ideas (3)</li> <li>• Goal writing</li> <li>• Further training or discussion re: goal writing, it was done once, and that topic is one that needs intermittent review</li> <li>• SMART goal specifics</li> <li>• Using Health Assessment Tools to help id smart goals, use of MI tech</li> </ul>	
<ul style="list-style-type: none"> <li>• Maybe ways to think about how we as an agency and state can show benefit and outcomes of OCK</li> <li>• Review of tracking and utilizing health assessment tools to tracking members outcomes and improvements on goals.</li> <li>• I was a bit lost on the discussion of how outcome measures are gathered, suggest that the focus of these type of conversations be clear in what our role is and if it is that we simply gather the info, and it is collected by OCK state staff then that would have helped.</li> <li>• Would be interested to know if any organizational or process measures may be planned to assess the system(s) providing OCK services and to evidence progress toward the OCK goals.</li> <li>• The focus of these type of conversations be clear in what our role is and if it is that we simply gather the info, and it is collected by OCK state staff then that would have helped.</li> </ul>	

Table A1. Learning Needs Identified by OneCare Kansas Learning Collaborative Participants, April 2020–March 2022 (Continued)	
OCK Partners’ Responses	Key Themes
<ul style="list-style-type: none"> <li>• How each partner responds to building the program during the pandemic</li> <li>• How others are developing creative ways during this Covid crisis to engage individuals</li> <li>• How others are dealing with limitations placed upon us all due to coronavirus. Are others maybe standing out in the yard while the client is on the porch or at the window. Maybe using phone X% of the time or mail X% of the time, etc.</li> <li>• COVID resources</li> <li>• How each partner responds to building the program during the pandemic</li> </ul>	<ul style="list-style-type: none"> <li>• Ways to build program and engage members during COVID-19 pandemic</li> </ul>
<ul style="list-style-type: none"> <li>• MCO resources and benefits (2)</li> <li>• MCO portals, MCO portal usage (2)</li> <li>• What the MCOs want on the surveys.</li> <li>• Member portals and tools</li> </ul>	<ul style="list-style-type: none"> <li>• MCO resources and benefits, tools, and portals</li> </ul>
<ul style="list-style-type: none"> <li>• Recruiting, staff retainment.</li> <li>• How to engage staff to do what is asked of them re: OCK.</li> </ul>	<ul style="list-style-type: none"> <li>• Staff recruitment, retention, and engagement</li> </ul>
<ul style="list-style-type: none"> <li>• Engaging providers in programs with members</li> <li>• How to coordinate with other providers to obtain records for continuity</li> <li>• Learning from each other</li> <li>• I will like a training on way that show us how to connect or what connecting with other provider look like / who does the connecting</li> <li>• Interesting to hear how others use their OCK information to further their agencies help clients in other ways (network with other agencies, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Provider engagement, networking, and peer learning</li> </ul>
<ul style="list-style-type: none"> <li>• Member engagement and recruitment strategies and information; helping clients to buy into the program (6)</li> <li>• Discussion of serving members who are not otherwise engaged in services at your agency. About half of our engaged members are not getting any other services from our agency (the OCK provider).</li> <li>• How to encourage patients to continue to actively participate in the program.</li> <li>• Outreach tips (2)</li> <li>• How to discuss benefits of OCK to members not interested in improving health outcomes.</li> <li>• How to provide a complete picture of care for a member when they are in several programs within our agency.</li> <li>• A "World Cafe" style of obtaining feedback to understand strengths/weaknesses/opportunities/threats that is participant driven.</li> <li>• Community events and supports of interest to OCK members</li> </ul>	<ul style="list-style-type: none"> <li>• Member engagement, recruitment, retention, and outreach tips</li> </ul>
<ul style="list-style-type: none"> <li>• Financial counseling/budgeting may be a good topic to address with members, so it would be awesome if there was a tool/assessment we could train with coordinators</li> <li>• Concrete examples of common activities done with members, per billable service category.</li> <li>• A final copy instead of a continuously changing draft. All billing information listed under the billing section instead of in the appendix.</li> <li>• Differences between CMHCs and FQHCs (billing).</li> <li>• Probably resources</li> <li>• Resources is always a plus how to afford to do OCK, right now this is a money loser.</li> </ul>	<ul style="list-style-type: none"> <li>• Finance and billing</li> </ul>

Table A1. Learning Needs Identified by OneCare Kansas Learning Collaborative Participants, April 2020–March 2022 (Continued)	
OCK Partners’ Responses	Key Themes
<ul style="list-style-type: none"> <li>• Staff to member ratios</li> <li>• Required staff spelled out, verbiage on HIPAA, more detailed services under the codes.</li> <li>• Ways to simplify inclusion process. All MCOs use same processes/protocols. Having different things for different situations.</li> <li>• How the State and MCOs might simplify opt-in and opt-out</li> <li>• Processes on accepting, transferring, or patient refusal of OCK services.</li> <li>• How to work collaboratively with MCO and Emergency Rooms for referrals.</li> <li>• OCK services and where to make referrals or what to look for in providers of other services for referrals of members.</li> <li>• Working with the foster care system.</li> <li>• Advanced directives</li> <li>• Information about how to demonstrate compliance with the manual.+</li> <li>• A blurb on we work on regulations [sic], the required staff laid out in the manual (MD, nurse, SW) - not referring to the application.</li> </ul>	<ul style="list-style-type: none"> <li>• Information and guidance on program processes and protocols:                             <ul style="list-style-type: none"> <li>○ Service codes</li> <li>○ Use of same protocols by MCOs</li> <li>○ Simplifying inclusion process</li> <li>○ Patient transfers and referrals</li> <li>○ Staff-to-member ratios</li> <li>○ Required staff</li> <li>○ HIPAA</li> <li>○ Foster care system</li> <li>○ Advanced directives</li> </ul> </li> <li>• Program manual, including demonstrating compliance</li> </ul>
<ul style="list-style-type: none"> <li>• Considering all the One Care Kansas patient have asthma, schizophrenia, or bipolar, I would think that education would be focused on these.</li> <li>• More asthma education; more information about asthma (2)</li> <li>• Using Peak Flow Meters to create action asthma plans in adults vs. kids; diagnosing the different levels of severity of asthma; interpreting in-office spirometry.</li> <li>• Discussion over Asthma and how it affects mental health/possible drug interactions with asthma meds and psychotropics.</li> <li>• Anything from KDADS on addiction including trainings on SBIRT. Also, various other topics on misuse of prescription meds (opioids, etc.) that we might incorporate into our assessments. Various tools that are out there to detect concerning use of mood-altering substances.</li> <li>• More in depth motivational interviewing, health literacy</li> <li>• Health Promotion resources and examples (12)</li> <li>• Health Promotion Resources for rural areas</li> <li>• Health promotion resources that can be given to members</li> <li>• Creating exercise programs and carving out time to participate in the exercise-group?</li> </ul>	<ul style="list-style-type: none"> <li>• Trainings on OCK focused conditions:                             <ul style="list-style-type: none"> <li>○ Asthma</li> <li>○ Asthma and mental health issues</li> <li>○ Addiction (SBIRT, etc.)</li> <li>○ Motivational interviewing</li> <li>○ Health literacy</li> </ul> </li> <li>• Health promotion resources for members</li> </ul>

b) [OCK Learning Collaborative Discussions and Sessions \(Table A.2\)](#)

Table A2. Topics Discussed in OneCare Kansas Learning Collaborative Meetings, April 2020–March 2022		
2020 Meetings		
Date	Session Topics	Approximate Number of Participants
April 21	<ul style="list-style-type: none"> <li>• Information about adjustments to OCK policy during the COVID-19 emergency (presented by KDHE Staff).</li> <li>• Information regarding recommended and mandatory learning opportunities that impact OCK providers (presented by Aetna and WSU CEI staff).</li> </ul>	50
May 19	<ul style="list-style-type: none"> <li>• Recruitment and engagement of potential OCK members:                             <ul style="list-style-type: none"> <li>○ KDHE shared the tools from the OCK website to assist in these efforts.</li> <li>○ Staff from a Behavioral Healthcare organization then shared tips and tools that they use to recruit members for their Integration Partnership initiative.</li> </ul> </li> </ul>	45

<b>Table A2. Topics Discussed in OneCare Kansas Learning Collaborative Meetings, April 2020–March 2022 (Continued)</b>		
<b>2020 Meetings</b>		
<b>Date</b>	<b>Session</b>	<b>Approximate Number of Participants</b>
June 16	<ul style="list-style-type: none"> <li>• Quality measures for the OneCare Kansas Program:               <ul style="list-style-type: none"> <li>○ KDHE staff reviewed the quality measures that will be collected as well as how and when the information will be gathered and reported.</li> <li>○ Group discussion on:                   <ul style="list-style-type: none"> <li>▪ Additional tools they are using to collect health related data</li> </ul> </li> </ul> </li> <li>• Strategies for using the information to tell the OCK story to potential partners and funders</li> </ul>	45
July 21	<ul style="list-style-type: none"> <li>• Information provided by KDHE on the difference between a Health Risk Assessment conducted by the MCOs and an OCK Health Assessment.</li> <li>• Partners from the Community Health Center of Southeast Kansas shared their model for providing services to OCK members (including the Health Assessment process); and strategies for engaging other providers in the process.</li> </ul>	50
August 18	<ul style="list-style-type: none"> <li>• KDHE shared information on a variety of programs available to support OCK partners for health promotion activities.</li> </ul>	50
September 15	<ul style="list-style-type: none"> <li>• Small group discussions related to challenges and opportunities that the partners have experienced in the first six months of the program’s implementation.</li> </ul>	60
October 20	<ul style="list-style-type: none"> <li>• Promoting staff resilience:               <ul style="list-style-type: none"> <li>○ Small groups discussion on:                   <ul style="list-style-type: none"> <li>▪ Efforts to improve staff competence around OneCare Kansas as one protective factor against stress.</li> </ul> </li> <li>○ Small and large group discussions on:                   <ul style="list-style-type: none"> <li>▪ Additional strategies that they employ to support their staff.</li> </ul> </li> </ul> </li> </ul>	60
November 17	<ul style="list-style-type: none"> <li>• Recruitment of potential OCK members:               <ul style="list-style-type: none"> <li>○ Updates provided by KDHE staff on upcoming adjustments in how potentially eligible individuals are identified.</li> <li>○ WSU CEI staff shared resources available via the OneCare Kansas website that can be used for talking with potentially eligible members and other community partners about the program.</li> <li>○ Staff from the HealthCore Clinic and High Plains Mental Health Center shared the strategies that they use for identifying and recruiting new members.</li> <li>○ Small group discussion on:                   <ul style="list-style-type: none"> <li>▪ Challenges they face related to member recruitment, those that are outside their control; and</li> <li>▪ Strategies to make progress on the challenges that can be controlled.</li> <li>▪ Participants shared their major takeaways from their small group discussion with the larger group.</li> </ul> </li> </ul> </li> </ul>	60
<b>2021 Meetings</b>		
January 19	<ul style="list-style-type: none"> <li>• Use of GIS map:               <ul style="list-style-type: none"> <li>○ KDHE staff presented how to use, and the benefits of a GIS map developed to make it easier to locate OCK partners across the state.</li> <li>○ Small group discussion to discuss following three questions:                   <ul style="list-style-type: none"> <li>▪ How can you use the map to set yourselves up to collaborate more intentionally?</li> <li>▪ What are the barriers you might face?</li> <li>▪ What are some strategies to overcome these?</li> </ul> </li> </ul> </li> <li>• Participants shared their small group discussion points with the larger group.</li> <li>• Participants asked to identify what else they need from the State team to successfully utilize the mapping tool.</li> </ul>	60

<b>Table A2. Topics Discussed in OneCare Kansas Learning Collaborative Meetings, April 2020–March 2022 (Continued)</b>		
<b>2021 Meetings</b>		
<b>Date</b>	<b>Session</b>	<b>Approximate Number of Participants</b>
March 16	<ul style="list-style-type: none"> <li>• A review of the first year done.</li> <li>• Introduction of a data dashboard that is compiled and posted by KDHE to the OCK website was done.</li> <li>• A review of aggregate results of the first OCK audit was done.</li> <li>• The story of one OCK Partner who achieved financial sustainability for their program during the first year was presented.</li> <li>• Expectations for the 2<sup>nd</sup> year of the program were discussed.</li> <li>• Described and held a large group discussion on the expanded eligibility criteria.</li> </ul>	70
May 18	<ul style="list-style-type: none"> <li>• Highlighted three OCK Partners, COMCARE of Sedgwick County, HealthCore Clinic, and Mental Health Association of South-Central Kansas.                             <ul style="list-style-type: none"> <li>○ Each partner presented the information to answer following questions:                                     <ul style="list-style-type: none"> <li>▪ What are you doing to get members engaged with your OCK program?</li> <li>▪ What is working well and what made this possible?</li> <li>▪ What’s been the biggest challenge along the way and how did you overcome it?</li> <li>▪ What are the elements of this activity that you are most proud of?</li> </ul> </li> <li>○ Small groups discussion to discuss three questions:                                     <ul style="list-style-type: none"> <li>▪ What themes did you hear as you listened to today’s presentations?</li> <li>▪ What additional questions do you have?</li> </ul> </li> <li>○ What would you like to hear more about in the future?</li> </ul> </li> </ul>	60
September 21	<ul style="list-style-type: none"> <li>• Program quality:                             <ul style="list-style-type: none"> <li>○ WSU staff reviewed the OCK quality goals and partner expectations related to monitoring program quality.</li> <li>○ KDHE staff then shared the results of a member survey that had been conducted earlier in the year.                                     <ul style="list-style-type: none"> <li>▪ Participants were then asked to discuss their own processes for gathering member feedback and what challenges they encounter in gathering this information.</li> </ul> </li> </ul> </li> </ul>	50
November 16	<ul style="list-style-type: none"> <li>• Collaborations with local healthcare partners in the community.                             <ul style="list-style-type: none"> <li>○ Groups were divided by regions of the state and asked to reflect on the following questions:                                     <ul style="list-style-type: none"> <li>▪ What is program’s plan or procedures for collaborating with other providers who work with the member?</li> <li>▪ What gets in the way?</li> <li>▪ What are the opportunities to improve these connections?</li> </ul> </li> <li>○ As a large group, participants were asked to share their learnings and discuss the following questions:                                     <ul style="list-style-type: none"> <li>▪ How do you document your interactions with partners?</li> <li>▪ How do you use your documentation to assure that staff get the credit they deserve for the good work that they do as they walk alongside the members they serve?</li> <li>▪ How are you using that documentation to not only talk to other providers, but also help communicate the value of the program to organizational leadership and funders such as the state legislature?</li> </ul> </li> </ul> </li> </ul>	60

Table A2. Topics Discussed in OneCare Kansas Learning Collaborative Meetings, April 2020–March 2022 (Continued)		
2022 Meetings		
Date	Session	Approximate Number of Participants
March 15	<ul style="list-style-type: none"> <li>• In response to provider concerns related to staffing their OCK programs, the virtual session focused on the challenges they face as well as potential opportunities to hire support level staff to complete certain tasks:                             <ul style="list-style-type: none"> <li>○ Using a virtual polling platform, participants were asked to share their biggest challenges when staffing their programs as well as strategies they have used to address those challenges.</li> <li>○ KDHE announced that OCKPs would now be able to hire CNA/CMA staff to complete tasks under the supervision of a nurse. Participants were then asked if they would consider this option and what, if any, additional information they would need to consider this option.</li> <li>○ KDHE is also currently considering an option of adding community health workers as a potential support role for the OCK program. GraceMed currently utilizes CHWs in a program that is similar in structure to OCK and was asked to share their experiences with this program. OCK partners were then asked for additional ideas for incorporating CHWs into the OCK program.</li> </ul> </li> <li>• Finally, OCK partners were asked to consider what organizational changes would need to happen to allow for hiring additional support staff such as CNA/CMAs in their programs.</li> </ul>	50

## 2. Factors that Facilitated the Implementation of the OneCare Kansas Program to Achieve Its Goals.

During discussions in the OCK Collaborative meetings, the participants identified the factors that facilitated their efforts for the implementation of the OCK program to achieve its goals. This information is reviewed, and key themes are summarized in Table A 3.

Table A3. Factors that Facilitated Implementation of OneCare Kansas to Achieve Its Goals, April 2020–March 2022	
OCK Partners' Responses	Key Themes
<ul style="list-style-type: none"> <li>• Learning about the OneCare program</li> <li>• This is my first OCK meeting, so it was all informational today, bulletins and required learning.</li> <li>• Educating staff about One Care Kansas Program</li> <li>• Newsletter will be useful.</li> <li>• Newsletters and campaigns</li> <li>• I appreciate the helpful information that was shared.</li> <li>• How we need to look at documentation and the benefit of the program to show to board of directors.</li> <li>• Training is great tool for me to understand the program as a whole. I would like to get a clear understanding of the OCK role and how much we as case Manager should be doing.</li> </ul>	<ul style="list-style-type: none"> <li>• Getting familiar with the program, its processes, and benefits.</li> </ul>

Table A3. Factors that Facilitated Implementation of OneCare Kansas to Achieve Its Goals, April 2020–March 2022 (Continued)	
OCK Partners’ Responses	Key Themes
<ul style="list-style-type: none"> <li>• The time frame for the completion of trainings</li> <li>• The information on additional training, I'm a new coordinator and this helps provide structure to how I move forward with staff</li> <li>• About the training series for care coordinators/social workers</li> <li>• The trainings that are being offered</li> <li>• Required ACEs (Adverse Childhood Experiences) training for all staff involved</li> <li>• Required training reminders</li> <li>• Continue getting training to improve services to members</li> <li>• Learned of an organization that has many resources re: training and/or training topics to help support the OCK staff and increase their knowledge base.</li> </ul>	<ul style="list-style-type: none"> <li>• Provision of trainings and re-trainings for the OCK providers for increasing their knowledge base to support their efforts, readily available information about the trainings and their time frames.</li> </ul>
<ul style="list-style-type: none"> <li>• Engaging members questions and tools</li> <li>• OCK Dashboard will be useful</li> <li>• Utilizing the resources from the MCOs</li> <li>• Population health portals with MCOs</li> <li>• MCO partners are there to help us if we need to reach out with questions.</li> <li>• Contact info for MCOs</li> <li>• Hearing about other tools used by other agencies.</li> <li>• Different tools that can be used to gather data</li> <li>• Learning about the different programs available to help our patients.</li> <li>• GIS maps will be helpful</li> <li>• Using the GIS map will be helpful to locate OCK partners across the state</li> <li>• Creating newsletter for health promotion hospital liaison opportunities</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of resources, variety of tools, OCK dashboard and GIS maps from State, MCOs and other agencies</li> </ul>
<ul style="list-style-type: none"> <li>• The expansion of the Diagnostic Codes</li> <li>• Diagnosis expansion will be helpful</li> <li>• Diagnostic codes updates (2)</li> </ul>	<ul style="list-style-type: none"> <li>• Diagnostic codes expansion and updates</li> </ul>
<ul style="list-style-type: none"> <li>• The core measure set review was helpful in knowing for sure what the state is looking at.</li> <li>• Quality Measures in use and considerations for data collection and reporting.</li> <li>• Focus more on success stories, and data collection that tells the story of the services we provide and the outcomes from those services.</li> <li>• Figuring out what internally we should be tracking outside of state reporting</li> <li>• I understand that there will be outcome measurements that we need to track</li> </ul>	<ul style="list-style-type: none"> <li>• Tracking and reporting of quality measures and focus on outcomes.</li> </ul>
<ul style="list-style-type: none"> <li>• Level of staff from FQHC</li> <li>• Continuing to look for medical background or knowledge in new hires for our OCK program</li> <li>• Up to date knowledge, having access to individuals who are knowledgeable in OCK domain.</li> <li>• KDHE announced that OCKPs would now be able to hire CNA/CMA staff to complete tasks under the supervision of a nurse.</li> <li>• KDHE is also currently considering an option of adding community health workers as a potential support role for the OCK program.</li> <li>• The option for CMA/CNA and Community Health Workers (5)</li> <li>• Staffing options</li> <li>• We can hire other staff to include CNA/CMAs to help with specific patient care.</li> <li>• Conversation about how we could utilize CNA's and CMA's in our work.</li> <li>• Investment of current staff's skills to promote services, which are provided by our agency.</li> <li>• How other agencies have their Integrated meetings set up- meaning what staff are involved.</li> <li>• Effective ways to show support to team</li> <li>• I liked the agency that got everyone to build moral within their own agency!</li> <li>• Staff connecting with each other regularly to boost each other's resilience.</li> </ul>	<ul style="list-style-type: none"> <li>• Staffing options and expertise; Staff support</li> </ul>

A3. Factors that Facilitated Implementation of OneCare Kansas to Achieve Its Goals, April 2020–March 2022 – (Continued)	
OCK Partners' Responses	Key Themes
<ul style="list-style-type: none"> <li>• Incorporating tobacco cessation options for full integration of care</li> <li>• Making an exercise program with patients and participating in that exercise.</li> <li>• Health Promotion topics resource I can share with participants</li> <li>• Just learning the latest about the KDHE Health Promotion Bureau is helpful to our agency and ultimately can be helpful to our clients.</li> <li>• Offering healthy living groups regularly</li> </ul>	<ul style="list-style-type: none"> <li>• Incorporation of the health promotion and risk factor prevention and control as the provision of care options; submission of separate claims for these options; and sharing of health promotion resources with clients.</li> </ul>
<ul style="list-style-type: none"> <li>• Doing home visits and recruiting peer support to help with enrollment.</li> <li>• Loved hearing from CHC/SEK. Loved the positive approach to members and potential members!</li> <li>• Increase engagement of clients to the program</li> <li>• Other ideas on how to help members opt-in despite COVID-19 issues</li> <li>• Sending our own invitation letters to attributed members</li> <li>• Sending letters might help get more people engaged</li> <li>• One thing I heard that will be helpful is how they connect with clients</li> <li>• Asking questions such as how we could help or how can this program benefit you. Instead of assuming a goal is right for the member. Let them be actively involved in goal setting.</li> <li>• Continuing to use a strengths-based approach</li> <li>• It was helpful to hear we are using same/similar strategies as others in engaging potential members for OCK.</li> <li>• Outreach methods</li> <li>• The way others are reaching out</li> <li>• Improving outreach</li> <li>• Do more specific outreach in the area to work with specific provider organizations.</li> <li>• Knowledge that we are not alone in the struggle to recruit new members to the program.</li> <li>• It was helpful to hear that we are not alone in experiencing difficulty in engaging clients, some of whom said they didn't know what we were talking when we talked to them about OCK.</li> </ul>	<ul style="list-style-type: none"> <li>• Discussing challenges encountered in member recruitment and engagement; and application of strategies, methods and processes for member recruitment, enrollment, engagement and outreach</li> </ul>
<ul style="list-style-type: none"> <li>• The referral process</li> <li>• That more referrals are coming in.</li> <li>• That Aetna is sending email confirmations for referrals. Will check with our Care Coordinator to see if she is getting them.</li> <li>• Hearing others have a little more advantage than CMHC in collaborating with getting physician referrals. Going to see how to make changes on this for us at CMHC.</li> </ul>	<ul style="list-style-type: none"> <li>• Referral processes and assistance from MCOs</li> </ul>
<ul style="list-style-type: none"> <li>• Ideas on Incorporating Psychosocial Groups</li> <li>• Working with hospitals and clinics in the area</li> <li>• Engaging the PCPs with this plan also and getting them on board</li> <li>• Utilizing the prescription program in a Community Mental Health setting to capture those current patients who may have Asthma through their comprehensive med lists. Also, having a question re: Asthma on our intake forms, this hasn't been the case until the idea came out of this collaborative.</li> <li>• Work with the pharmacies for recruiting... BRILLIANT!</li> </ul>	<ul style="list-style-type: none"> <li>• Collaboration with other entities such as psychosocial groups, hospitals, clinics, PCPs, and pharmacies to recruit clients                             <ul style="list-style-type: none"> <li>○ Use of prescription program to recruit clients</li> </ul> </li> </ul>

Table A3. Factors that Facilitated Implementation of OneCare Kansas to Achieve Its Goals, April 2020–March 2022 (Continued)	
OCK Program Partners’ Responses	Key Themes
<ul style="list-style-type: none"> <li>• Calling providers offices has been helpful</li> <li>• Utilizing KHIN to identify providers that can help connect providers and members together when there is no good contact information.</li> <li>• Utilizing more internal providers in OCK program within agency.</li> <li>• Care coordinators see providers with clinicians.</li> <li>• Go to lots of team meetings to talk to case managers, homeless outreach, children and family services to discuss OCK and services they can provide.</li> <li>• Partners working to connect with two hospitals in Topeka. Referrals, presentations, and helping other providers within their health care network.</li> <li>• External and internal marketing</li> <li>• Word of mouth</li> <li>• Reached out to some therapists of Central Kansas Medical Health (CKMH) for referrals (CKMH is one of the partners).</li> <li>• Working with the hospital with the behavioral health discharges.</li> <li>• Working in 5 county area - making calls to assist in coordinating care.</li> <li>• Ask for feedback from other providers/practitioners</li> <li>• Reaching out to individual providers, putting a face to the program and general education regarding the program.</li> <li>• Integrated team meetings to address holistic issues for members.</li> <li>• Email, snail mail, numerous meetings with internal staff.</li> <li>• Meetings with 1) Community based services (CBS), a service line within the Community Mental Health Services network; 2) Comprehensive Support and Stabilization (CSS), a service line within the Community Mental Health Services network; 3) medical staff (nurses/physicians who work with the FQHC and CMHCs; and 4) therapists.</li> <li>• Having an integrated providers meeting every month to stay connected. Staff certain cases that a provider might need help on.</li> </ul>	<ul style="list-style-type: none"> <li>• Applying strategies for building and improving collaboration with other local health partners/ providers who work with the members</li> </ul>
<ul style="list-style-type: none"> <li>• Hearing from other organizations</li> <li>• More ways to creatively grow your program</li> <li>• Reassurance that we were on the same track</li> <li>• The different struggles of other partners and ways to work around those difficulties.</li> <li>• Others are having similar problems.</li> <li>• Just knowing that other providers are experiencing similar challenges</li> <li>• Understanding we can only control so much and focusing time on those we can.</li> <li>• To not give up and keep doing what we are doing.</li> <li>• To continue what we are currently doing</li> <li>• Keep focusing on what we can do.</li> <li>• Thinking more outside of the box for on how to provide these services in a COVID world</li> </ul>	<ul style="list-style-type: none"> <li>• Collaboration, peer learning, and support among OCK partners to address similar challenges and implement OCK program</li> </ul>

Table A3. Factors that Facilitated Implementation of OneCare Kansas to Achieve Its Goals, April 2020–March 2022 (Continued)	
OCK Program Partners' Responses	Key Themes
<ul style="list-style-type: none"> <li>• OCK hours are added to my monthly billables.</li> <li>• Our staff do their notes using a certain few codes, so they get full credit for their work – if not documented it did not happen.</li> <li>• Document everything in ECW (eClinicalWorks) whether its billable or not.</li> <li>• EHR made a OCK template that allows us to capture most of what we do.</li> <li>• Looking for ways to include even if it is a zero dollar claim.</li> <li>• Make this part of the training. Discuss updates in team meetings, when there is a gap between what is being described and what is in the record, we discuss why there are gaps between the two.</li> <li>• Document every interaction in our EHR with the patients.</li> <li>• Document how clients are integrated into other areas of the organization, including family members becoming involved</li> <li>• Group supervision forms that we document our meetings and have a spot just for successes.</li> <li>• Executive Director asks for successes from each department as part of the report to the Board.</li> <li>• Document in both OneCare and Smart care to ensure that all documentation is accessible in both systems.</li> </ul>	<ul style="list-style-type: none"> <li>• Ensuring documentation fully reflects all activities and interactions for purposes of ongoing work with the client, billing, getting credit for work completed, and identification of successes.</li> </ul>
<ul style="list-style-type: none"> <li>• Recruiting (5)</li> <li>• Hire more staff (4)</li> <li>• Heavily recruiting (3)</li> <li>• Add an additional staff (3)</li> <li>• Just hired new nurse coordinator</li> <li>• Hired FTE who serves in both roles (2)</li> <li>• Moving positions around (3)</li> <li>• We have some part-time care coordinators who also function as BHC's. However, the 2 roles cannot overlap</li> <li>• Setting clear boundaries for staff who have multiple roles i.e., doing one care follow ups on certain days of the week (4)</li> <li>• Debriefing on regular basis to provide more support to staff</li> <li>• Contracting with other agencies to provide medical staff.</li> <li>• Cross training within the agency to bill OCK for people they are already working in other roles (10)</li> <li>• Staff bonuses (3)</li> <li>• Increasing pay (3)</li> <li>• Increased our wages (3)</li> <li>• Sign on bonus (2)</li> <li>• For us it's just a matter of internalizing a lower turnover rate</li> </ul>	

### 3. Barriers/Challenges Seen in the Implementation of the OneCare Kansas Program

During the discussions conducted in the OCK Collaborative meetings, the participants identified the barriers and challenges they encountered in the implementation of the OCK program. This information is reviewed, and key themes are summarized in table A 4.

Table A4. Barriers/Challenges Encountered by OneCare Kansas Partners in the Implementation of the Program, April 2020–March 2022		
OCK Program Partners' Responses	Key Themes	
<ul style="list-style-type: none"> <li>• Health Assessment Plans [HAP] are very labor intensive and take time to happen. Hope that with the use of technology that will improve over time.</li> <li>• Different levels of bureaucracy and each level wanting something different or having different requirements.</li> <li>• Requirement to continue to contact members for 6 months before issuing a refusal. I have had several people block our number due to trying to get them through the opt out process.</li> <li>• Individuals who qualify mental health Targeted Case Management (TCM) may not receive all the MH services they are eligible for if they choose another OCK provider outside the CMHC system.</li> <li>• The biggest issue we have had is with audits and we do not feel like the purpose of the audit and expectations of what is needed matches what we are originally told and what is in the program manual. Some parts of the audits are repetitive and more complex than they need to be. Not to seem simple minded but it would be easier if the Program manual would give a straightforward outline of what is needed, what needs to be in place, what policies you should have, etc. Our agency has some policies in place that would cover the OCK program, and we still get dinged for not having something else "created."</li> <li>• Agencies not given adequate time to develop and implement necessary changes to the program and processes after audit results are provided. Results of the first audit provided at the same time of submitting documents for the spring audit. This left us unable to show growth in our and appropriate use of the data to make necessary changes. Second audit results for member charts looked largely like the results of our first audit.</li> <li>• We feel some inconsistencies at times and do not feel like the program should have launched when it did last year. We have somehow managed to pull it together with one of the smallest OCK teams ever and are working on finding our own way.+</li> <li>• Diagnostic Code F20.9 not included</li> <li>• Expanding diagnosis criteria to have a more positive impact (state/national) decision</li> </ul>	<ul style="list-style-type: none"> <li>• Issues with program structure and processes:                             <ul style="list-style-type: none"> <li>○ Labor intensive and time-consuming HAP</li> <li>○ Multiple levels of bureaucracy and their requirements</li> <li>○ Unclear or inconsistent expectations</li> <li>○ Inadequate time to incorporate audit feedback.</li> <li>○ Limited diagnostic criteria</li> </ul> </li> </ul>	
<ul style="list-style-type: none"> <li>• I was a bit lost on the discussion of how outcome measures are gathered, suggest that the focus of these type of conversations be clear in what our role is and if it is that we simply gather the info, and it is collected by OCK state staff then that would have helped. Thanks for all you do to help us be successful! These forums are very helpful.</li> <li>• This was a difficult webinar to understand initially, I think the presenter on the quality measures was going through the information so fast, it was hard for me to understand.</li> <li>• Would be interested to know if any organizational or process measures may be planned to assess the system(s) providing OCK services and to evidence progress toward the OCK goals.</li> </ul>		
<ul style="list-style-type: none"> <li>• How to afford to do OneCare program, right now this is a money loser for us.</li> <li>• Reimbursement from MCOs Staffing.</li> <li>• Better delineation on when/how to bill the different codes.</li> <li>• Funding (lack of funding/resources) is one of the biggest barrier to providing OCK services.</li> <li>• The program is not money making at this time at our organization, is anyone making profit or at least breaking even and how are they doing so.</li> <li>• Paid more than 1 x a month.</li> </ul>		<ul style="list-style-type: none"> <li>• Unclear information on outcome and process measures gathering, and role OCK partners in collection of the measures</li> <li>• Financial concerns                             <ul style="list-style-type: none"> <li>○ Payment structure</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Correct telephone numbers and addresses</li> <li>• Sharing information with hospitals regarding members being inpatient and discharging.</li> <li>• Create a central information source (something similar to KHIN), that will work on increasing the provider portals with the MCOs.</li> </ul>		
<ul style="list-style-type: none"> <li>• OCK partners report ongoing difficulties reaching members due to inaccurate contact information or engaging those who have opted in. Some OCKPs are able to access their own agency records, internet searches and pharmacy contacts to attempt to locate updated information.</li> </ul>		

Table A4. Barriers/Challenges Encountered by OneCare Kansas Partners in the Implementation of the Program (Continued)	
OCK Program Partners' Responses	Key Themes
<ul style="list-style-type: none"> <li>• Members are not understanding the program.</li> <li>• Members not wanting to participate.</li> <li>• Challenges with the refusing non-participating members</li> <li>• Adding to roster</li> <li>• Rural areas and reaching patients (access)</li> <li>• Identify and anything to get them through the gate of the opt in process</li> <li>• Improve outreach; help with educating staff and clients with the availability</li> <li>• The provider organizations carry the burden of making OCK work. (Finding patients, finding contact info, getting patients to opt-in, etc.)</li> <li>• Foster parents are not told about OCK when the Foster Care Agency opts children into OCK, making it difficult to engage with them.</li> <li>• Being able to get ahold of clients, Zoom was a challenge but as of the beginning of this month we are seeing clients face to face which helps.</li> <li>• Explore more populations for OneCare eligibility.</li> <li>• People enrolled in the program engaged fully</li> </ul>	<ul style="list-style-type: none"> <li>• Member enrollment, roster and engagement issues</li> </ul>
<ul style="list-style-type: none"> <li>• Opt-in/ opt-out: discrepancy in numbers</li> <li>• The opting out and opting in of the clients in the program</li> <li>• Opt-in - better outcomes in long run, but the opt in process isn't working effectively</li> <li>• Timeline from opting in from appearing in the roster can be a long time - can be frustrating.</li> <li>• Clients opting themselves in and then not knowing what they've signed up for.</li> <li>• Requiring a referral to receive OneCare services is another level of administrative paperwork that has to be completed</li> <li>• Decrease the requirements for opting in; provide closer OCK partners for patients (&gt;100 miles away)</li> <li>• Reaching patients. They have opted in, but we don't have current addresses or phone numbers. By the time we reach patients that have been attributed to us, sometimes they don't remember opting in.</li> <li>• Clients opting in has been the biggest barrier at our agency. It has felt like the onus to recruit clients has been shifted to the providers, but when we submit opt ins or referrals they get denied for technicalities (i.e., didn't submit the most recent version of the form).</li> <li>• Individuals may indicate they don't want to engage with the system even after opting in but have not gone through the process of opting out. This is occasionally attributed to "accidental" opt-ins where members may not have understood what they were agreeing to and how the program can help. Others may be receiving services through Medicaid waiver programs and did not understand how OCK would impact those services.</li> </ul>	<ul style="list-style-type: none"> <li>• Issues related to opt-in/opt-out process</li> </ul>
<ul style="list-style-type: none"> <li>• Learning the process by employees.</li> <li>• Some programs are not engaging in efforts due to new staff or adjusting to the increased number of members due to the expansion.</li> <li>• Training (lack of/limited training) was also identified as one of the biggest barriers to providing OCK services.</li> <li>• Educate foster care and IDD population</li> <li>• Educate primary care providers</li> <li>• I think it is great to hear success stories, miss having some time to help problem solve barriers that occur.</li> <li>• Still have not received our email to access the HAP portal/Portal access</li> <li>• I am very frustrated with the required meetings for both me and my case manager regarding OCK. Considering all the OCK patient have asthma, schizophrenia, or bipolar, I would think that education would be focused on these. However, the education, including this one, and the CDC mandatory training on trauma-informed care, had NOTHING to do with the majority of our OCK patients. This program should not require more than 1 hour/month of for meetings but should have "office hours" available for providers having problems or questions that can be answered.</li> </ul>	<ul style="list-style-type: none"> <li>• Training, education, and support needed for employees, providers, and members</li> </ul>

Table A4. Barriers/Challenges Encountered by OneCare Kansas Partners in the Implementation of the Program (Continued)	
OCK Program Partners' Responses	Key Themes
<ul style="list-style-type: none"> <li>• At the point where we could use another care coordinator.</li> <li>• Time constraints due to other job duties.</li> <li>• Many different job titles</li> <li>• Not training enough staff currently.</li> <li>• Time is main factor.</li> <li>• Time consuming</li> <li>• COVID has slowed things down.</li> <li>• The not knowing due to COVID-19 mandates</li> <li>• Lack of providers.</li> <li>• Lack of correct information for outside contacts.</li> <li>• No buy in from outside providers</li> <li>• Getting phone calls back from providers.</li> <li>• Doctors attending to the things they prioritized vs. other things.</li> <li>• Reaching out PCPs to let them know about the OCK program, they do not always have time to speak, especially with COVID.</li> <li>• When hospitals are not letting you in, making sure care coordinators are referring the clients where they need to go.</li> <li>• Clients are not ready yet.</li> <li>• Spend lot of time just trying to connect with members.</li> <li>• Members not wanting their information shared with all of their providers.</li> <li>• Confidentiality.</li> </ul>	<ul style="list-style-type: none"> <li>• Barriers in collaborating with other health partners/providers who work with the members:                             <ul style="list-style-type: none"> <li>○ Time consuming</li> <li>○ COVID-19 pandemic</li> <li>○ Providers are not readily available or do not have buy in for the collaboration.</li> <li>○ Members not ready to join OCK</li> <li>○ Members not wanting to share their information with all of their providers</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• OCK program being short staffed.</li> <li>• Staffing challenges</li> <li>• We have agency wide staffing challenges</li> <li>• Getting a Nurse Care Coordinator on board</li> <li>• Finding Care Coordinators</li> <li>• We no longer have a peer support</li> <li>• Lack of professionals in the area</li> <li>• Multiple roles for same staff for sure (4)</li> <li>• Getting the case managers to actually do OCK work</li> <li>• Covering multiple counties</li> <li>• OCK Providers noted that staffing shortages that were present prior to the public health emergency have been exacerbated by the pandemic, making it difficult to meet the needs of current members and hampering efforts to promote and expand their programs.</li> <li>• Building our number of OneCare members to a high enough level that we can hire staff</li> <li>• Some reported they don't promote the program because they don't have the staff to serve additional members.</li> <li>• Medical Staff (4)</li> <li>• Retaining staff</li> <li>• Keeping a fulltime Care Coordinator</li> <li>• Competitive wages with other social work type jobs</li> <li>• Care Coordinators are required to have a degree. People who have a degree (social work, public health, psychology, etc.) want more than our organization can pay</li> <li>• Justifying the costs</li> <li>• Finding other duties for an FTE until the case load is built up</li> </ul>	

<b>Table A4. Barriers/Challenges Encountered by OneCare Kansas Partners in the Implementation of the Program (Continued)</b>	
<b>OCK Program Partners' Responses</b>	<b>Key Themes</b>
<ul style="list-style-type: none"> <li>In rural areas, some members are “dismissed” from a clinic—often for “non-compliance”—which then prevents them from accessing medical care anywhere in the area and distance travel is usually unrealistic. This is especially true for specialists. One suggestion for overcoming this challenge was to determine if patients are able to make an initial "meet" appointment with a specialist and then have virtual appointments after that.</li> <li>Rural areas compared to urban areas.</li> </ul>	<ul style="list-style-type: none"> <li>Issues related to access to care in rural areas</li> </ul>

#### 4. Observations Related to the OneCare Kansas Program Success in Achieving its Goals

In June of 2021, the Wichita State University Community Engagement Institute (WSU CEI) launched a brief online survey of OCK partners (OCKPs) on behalf of KDHE DHCF. This survey was intended to obtain a point-in-time impression of program success in achieving its goal from the perspective of contracted OCKPs. In addition, KDHE DHCF scheduled six regional virtual meetings with OCK partners in July 2021. The information collected through online survey and the virtual meetings is reviewed and key themes are summarized in Table A 5.

<b>Table A5. Impressions of the OCK Program Partners Regarding Major Successes of the Program, June and July 2021</b>	
<b>Individual Member Successes</b>	
<b>OCK Program Partners' Responses</b>	<b>Key Themes</b>
<ul style="list-style-type: none"> <li>Helped a member who was homeless find housing. He is very happy about that and managing his chronic illness very well now that he is stable.</li> <li>A hearing-impaired patient has benefitted from the coordination of her care. It's been difficult for her to reach other providers who do not provide a portal for communication.</li> <li>Received a call from a health provider regarding a client that has been inconsistently involved with the program. This patient often has medication discrepancies and has established creative ways to get her needs met that may not be to her benefit. By working with other internal staff, they were able to do a wellness check at the home to make sure the patient was safe. The team was also able to establish a single point of contact for the patient to assure the team has consistent information to reduce opportunities for treatment errors. This was an example of also showing the providers that the program was here to support their treatment efforts.</li> <li>A patient with significant wounds on her legs who was previously in a wheelchair is now able to get up and walk around her house (one of her goals). The OCK partner (OCKP) spoke with her the day of this meeting and was able to provide her more resources with other medical concerns. This also helped her family member present in the room today. She was very grateful for the assistance.</li> <li>Patient was able to complete pre-education required for bariatric surgery and had a successful surgery with support from the OCKP to manage her anxiety prior to surgery.</li> </ul>	<ul style="list-style-type: none"> <li>Coordination of care to assist members with their multiple health and social issues</li> <li>Provision of resources to the members for morbid conditions, and pre-surgical education and support</li> </ul>

Table A5. Impressions of the OCK Program Partners Regarding Major Successes of the Program, June and July 2021 (Continued)	
Individual Member Successes	
OCK Program Partners' Responses	Key Themes
<ul style="list-style-type: none"> <li>• Patient was referred to and successfully completed Tobacco Cessation program. Is still tobacco-free 13 months later.</li> <li>• A patient who had weight loss as a HAP goal has been making progress on that goal, but she didn't have a scale at home and wanted to monitor her weight between visits. The OCKP was able to secure a scale for her. She is now pursuing getting a free gym membership. She likes that the OCKP is supporting her.</li> <li>• Client that resisted engagement with any activities has multiple health issues but only wanted to focus on weight. Despite expressed interest, she was resistant. The OCKP was able to get her and her son (who also has significant weight issues) to accept enrollment in their Wellness Center's scholarship program. Both mother and son are now visiting the gym to walk together 1-3 times a week. They also have access to other types of fitness equipment as well as fitness measurements and goal setting to help monitor their progress. This has also led to them having conversations about eating differently. The OCKP is hoping this will lead to the two of them hold each other accountable and providing one another support on their weight loss journey.</li> <li>• Family (both parents in OCK program) with a newborn baby that had some feeding and growth concerns. PCP called the team to report these issues and concerns about parenting. During a home visit, the nurse care coordinator noticed they were putting rice in the baby's bottle which was counterproductive to the parent's goal to increase baby's weight. With some education, the baby is now gaining weight and doing very well. These efforts benefit the future health of the whole family.</li> </ul>	<ul style="list-style-type: none"> <li>• Provision of health promotion resources and support to the members to assist them with their disease prevention efforts</li> </ul>
Organization/System Successes	
<ul style="list-style-type: none"> <li>• Engagement with those members who participate is good and they appreciate having regular contact with someone who can act as a "wingman" or act as a sounding board.</li> <li>• Our agency serves children only, so the ability to support the family with tasks to benefit the family as a whole has been a great benefit to a few of the families that we serve.</li> <li>• For individuals who are seeing increased health issues as they age, it is helpful to have a "cheerleader" on your side to help identify alternative ways to exercise, etc.</li> <li>• Offering a monthly "meet and greet" for enrolled members to meet the OCK team and get a tour of the facility. Also discuss services and offer food from their food pantry program. Have only held this once so far but future events will have a theme like self-care, "Chopped" food demo, etc.</li> <li>• Success with just letting members know all the different benefits offered through their KanCare plans with the various MCO's. Several had not realized they could schedule transportation to health appointments!</li> <li>• Hiring additional or dedicated staff within the organization which allows the OCK team to focus more that program.</li> <li>• OCK program is growing in members and in staff – now at a point that the program is sustaining itself.</li> <li>• Members who are engaged seem to participate more fully because they have chosen to be in the program by opting in.</li> <li>• Seeing success with members identifying their own needs as they review assessments together and what they need to meet those needs.</li> <li>• OCKP is beginning to have more patients start reaching out to them for assistance, demonstrating that they are beginning to trust the partner and know they will be there to help.</li> </ul>	<ul style="list-style-type: none"> <li>• Engaging with the members and their families to support them with their health improvement efforts</li> <li>• Provision of information on program services available for the members</li> <li>• Growth and sustainability of the program due to increased number of members, member engagement and trust, and hiring of staff dedicated to OCK</li> </ul>

Table A5. Impressions of the OCK Program Partners Regarding Major Successes of the Program, June and July 2021 (Continued)	
Organization/System Successes	
OCK Program Partners' Responses	Key Themes
<ul style="list-style-type: none"> <li>• Collaboration with MCO providers on patient rosters and getting members that have moved to other areas of the state connected to a OCK partner in their community quickly.</li> <li>• Successes connecting members with resources in their community to meet needs beyond their physical health needs, like accessing food, managing insect infestations, improved living conditions.</li> <li>• Many members who had not seen a primary care provider in quite some time are going in to see their doctors and even having additional testing done as issues are being identified. Others getting into dental providers after not receiving ongoing care.</li> <li>• CMHC partnered with KU Cancer Center to hold an onsite cancer health screening for their patients/OCK members. Members received vouchers for more significant screenings (mammograms, etc.). MCOs provided incentives to give out at the event.</li> <li>• Engagement with medical providers has been good most of the time.</li> <li>• When visiting medical providers in the community, their staff are praising how the OCKP is helping their patients and asking how to enroll others.</li> <li>• Improved relationships with Primary Care Providers as their team attends appointments with members, etc.</li> <li>• Seen increased collaboration with internal staff as they are seeing how the OCK program can also benefit them as providers in addition to the patient.</li> <li>• Accessing internal providers to get information on community resources that can benefit OCK members.</li> </ul>	<ul style="list-style-type: none"> <li>• Collaboration between providers such as PCPs, dental providers, other medical providers, hospitals and MCOs that connect members to medical, dental, and community resources</li> </ul>
Program Successes in Connecting with Other Community Providers	
<ul style="list-style-type: none"> <li>• Has worked well to introduce ourselves to primary care providers as a care coordinator first as this is a role they understand, address the business at hand, and then talk to them more about OCK and what it can offer.</li> <li>• Sending flyers to different organizations and potential clients.</li> <li>• Branded flyers that briefly explain the program in a tangible way</li> <li>• helped to educate both providers and members.</li> <li>• Word of mouth when engaging with providers – offering what we do, who we serve, what is the focus of the program and what you plan to do. This sharing of information seems to also help with those who may be hesitant to engage.</li> <li>• Care coordinators are contacting local hospital social workers, etc. to inform about the program.</li> <li>• We educated foster care contractor staff about the program and its benefits as they often have never heard of it when children get opted in.</li> <li>• Staff did a “tour” of all of their own satellite locations across their service area to explain the program and establish an internal referral network.</li> <li>• Using medication reconciliation or Health Action Plan (HAP) process has led to an increase in communication with primary care physicians.</li> <li>• Have placed emphasis with physicians and medical providers on how the OCKP can enhance their work and act as an extension of their practice.</li> <li>• Participated in a case conference with staff from a local hospital emergency department to consult on a patient they have in common. This resulted in the hospital requesting that the OCKP do a presentation for new hospital social work staff to increase awareness of the program and reduce ER utilization. This resulted in the hospital contacting the OCKP more proactively about members.</li> <li>• OCKP (CMHC) has been in contact with another OCKP (FQHC) in town who is the primary provider for one of our patients. I was able to speak with his nurse to coordinate his care</li> <li>• For CMHCs, taking advantage of the hospital liaison staff to engage hospital providers for behavioral health needs. Others have “behaviorists” at local primary care clinics that have helped support connections.</li> <li>• CMHC sends patients to local FQHC (who is not an OCKP) for primary care. They have regular meetings with this organization, and this allows for opportunities to discuss the program.</li> </ul>	<ul style="list-style-type: none"> <li>• Utilizing collaborative strategies with community providers, such as PCPs, hospitals and FQHCs for member recruitment and referrals to OCK program.</li> </ul>

Table A5. Impressions of the OCK Program Partners Regarding Major Successes of the Program, June and July 2021 (Continued)	
Program Successes in Connecting with Other Community Providers	
OCK Program Partners' Responses	Key Themes
<ul style="list-style-type: none"> <li>• Have added a “global alert” in their internal electronic health record (EHR) to alert providers that a patient is enrolled in the program. This has led to their own internal providers making referrals for new patients as well.</li> <li>• FQHC reported having a Population Health Team that gets alerts for hospital and ER admissions and they have done a good job of checking the global alerts and getting that info to the OCK team.</li> </ul>	<ul style="list-style-type: none"> <li>• Using EHR global alert technology to assist providers in sending member enrollment information to the OCK program, and in making referrals to the program.</li> </ul>
Successes Related to the Marketing of the Program to the Community	
<ul style="list-style-type: none"> <li>• Several OCKPs reported being members of a variety of community coalitions such as local community needs assessment committees, monthly United Way meetings, LGBTQ Health Coalition, etc. They make an effort to discuss the OCK program during agency updates at these meetings</li> <li>• OCKPs report doing community presentations at agencies such as local homeless shelters and Area Agencies on Aging to promote awareness of the program for the clients they serve.</li> <li>• Having an OCK booth at a local Mental Health Awareness Day event in the courthouse square instead of holding it at the CMHC which meant they were exposed to a wider sector of the community than they have been in the past.</li> <li>• Small programs report that they are relying on “word of mouth.” Word about the program seems to be spreading this way among primary care providers.</li> <li>• Marketing the program to other providers within our own organization.</li> <li>• Assembled packets of information to distribute to providers in the area that includes tailored information about their specific program and role expectations for both the OCKP and the Primary Care Provider.</li> <li>• Presentations to partners emphasize the program’s ability to focus on physical and mental health needs at the same time and use written materials to supplement oral presentations.</li> <li>• Have designated staff for the OCK team that can talk with new clients to the CMHC who may be eligible for OCK.</li> <li>• Looking at using the organization’s mass text alert systems to reach out to members that they have been unable to engage and encourage them to come in for an appointment.</li> <li>• Others have attended COVID Vaccine clinics to identify potential members and provide education—even finding some individuals that are currently eligible and assisting them to opt-in.</li> </ul>	<ul style="list-style-type: none"> <li>• Use of a variety of marketing strategies for community and provider outreach                             <ul style="list-style-type: none"> <li>○ Program presentations and discussions at the Community Coalitions’ and community agencies’ meetings and at the community events conducted at the public venues.</li> <li>○ Communication of program information to the PCPs and other internal and external partners using word of mouth, packages with tailored information, and presentations</li> </ul> </li> <li>• Direct communication with the new clients attending various clinics and use of organization’s mass text alert system to provide information and encouraging them to join the OCK program and make appointments.</li> </ul>

## 5. Assistance Needed by the OCK Partners from OCK Partners’ Network and State/MCO Implementation Team to Assure Quality Services

During the July 2021 virtual meetings, participants were asked what their needs are that could be addressed by other partners within the OCK network, as well as by the State/MCO implementation team to assure quality services are provided to the members participating in the OCK program. This information is summarized in Tables A 6 and A 7.

Table A6. Needs to be Addressed Among OCK Partners, June and July 2021	
OCK Program Partners' Responses	Key Themes
<ul style="list-style-type: none"> <li>• Contact information for staff working within OCK partners from across the state and establishing a line of communication at regional or state level.</li> <li>• Establishing a line of communication to identify individuals receiving TCM services and the best way to serve them.</li> <li>• Opportunities for OCK partners to meet without members of the state/MCO team present. This could happen through provider associations (ACMHCK, CCNK, etc.) or organized independently at the local or regional level.</li> <li>• A “database” to share ideas.</li> <li>• Information from other providers regarding their programs operate. Allowing providers to learn from one another’s experiences.</li> <li>• New providers could benefit from a seasoned provider helping to navigate the system and be a contact for any questions.</li> <li>• Send out an email once a month asking to submit one success/thing that they helped a consumer with/new resource and then a list could be compiled and emailed out to everyone. One partner reported this would be helpful to have as something to save and review periodically that may spark ideas that could be used as agencies and with their consumers, that they may not have thought of.</li> <li>• Local meetings of OCKPs in the area to discuss what was learned in official OCK gatherings, mutual challenges, offer support, and share processes/ resources.</li> <li>• Ideas for how others are engaging members.</li> <li>• Willing to share contact information for their teams.</li> <li>• Willing to pair up with programs that may be new or small to offer them advice and support related to program operations and resource sharing.</li> <li>• Some partners have offered joint training to their communities and willing to continue to stay in contact that way.</li> </ul>	<ul style="list-style-type: none"> <li>• Peer learning and support                             <ul style="list-style-type: none"> <li>○ Peer mentoring</li> <li>○ Conducting joint trainings</li> <li>○ Sharing ideas and successes</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Strategies for marketing within Emergency Departments in some parts of the state. Especially when the doctors in those settings are somewhat transient. (Suggestion was to connect with hospital discharge planners and make them aware of the program.</li> <li>• One partner asked if anyone knew of or had an available nurse that the OCKP could purchase time or share – another partner offered someone they knew that would perhaps be interested in part-time work and exchanged contact information.</li> <li>• Additional dental resources (Johnson Co Community College has a dental hygiene school that offers cleanings and fillings as does Concorde Career College. Topeka Correctional Facility has a partnership with the Kansas Association for the Medically Underserved for dentures.)</li> <li>• Opportunities to identify and build bridges between CMHCs and FQHCs where there have been some historically strained relationships.</li> <li>• Knowledge of programs within CMHCs so that FQHCs can refer to additional specialty services for high need clients.</li> <li>• A way to identify when individuals who qualify for Mental Health TCM are assigned to a FQHC for OCK and ways to educate the patient about which organization would best meet the patients’ needs.</li> <li>• Ideas for connecting with community businesses to donate undesignated funds that could be used for items such as scales, pedometers, etc.</li> <li>• Community Care Network of Kansas was able to create a listserv for clinics to contact all the other FQHCs participating.</li> <li>• FQHC willing to get CMHC OCKPs patient records as quickly as possible and willing to advise staff on how the organization works when attending appointments with patients</li> <li>• Communication between partners when there are clients who may be shared.</li> </ul>	<ul style="list-style-type: none"> <li>• Making provider and community connections to identify resources.                             <ul style="list-style-type: none"> <li>○ Connections between CMHCs and FQHCs.</li> <li>○ Community business donations</li> <li>○ Hospital discharge planners</li> <li>○ Dental resources</li> <li>○ Listserv for clinics to contact all the other participating FQHCs</li> <li>○ Communication between partners sharing clients</li> </ul> </li> </ul>

Table A7. Assistance Needed from the State/MCO Implementation Team, July 2021	
OCK Program Partners' Responses	Key Themes
<ul style="list-style-type: none"> <li>• Demographics about each program (Who they serve, how many, etc.</li> <li>• A list of contacts within OCK partners – create a directory that includes the demographics of the programs.</li> <li>• Clarification about the impact of the new federal Certified Community Behavioral Health Clinics initiative on the OCK network.</li> <li>• More transparent diagnoses/qualifying information on clients. Even with portal access OCKPs may find it very difficult to find that information.</li> <li>• Additional organization level data from the HAP portal – trends in clinical outcomes and cost benefits, etc.</li> </ul>	<ul style="list-style-type: none"> <li>• Information needed:                             <ul style="list-style-type: none"> <li>○ Each program's demographics</li> <li>○ Contacts within OCK partners</li> <li>○ Clarification on new federal Certified Community Behavioral Health Clinics initiative</li> <li>○ Diagnosis/qualifying information on clients</li> <li>○ Organizational data on trends in clinical outcomes, cost benefits, etc. needed</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Improvements to adding the OCK flag and service start date to KMAP so that providers can verify eligibility more quickly.</li> <li>• Notification when any member one provider may have active claims on enrolls in OCK with another provider.</li> <li>• It would be helpful if the invitation letter could include that the member needs to actively participate in the program.</li> <li>• A universal electronic health record to make record access and transfers easier.</li> <li>• Improved process for getting members removed from monthly rosters whether it is an opt-out or the member doesn't ever engage.</li> <li>• Improved systems for educating members with developmental disabilities as well as the IDD TCM providers to understand what it means to opt-in.</li> <li>• Gaining access to Emergency Department and Hospital data to allow the OCKP to follow up and provide better transition planning. Often learn about the hospitalization after discharge.</li> <li>• Honoring organization capacity reports to allow OCKPs to balance staffing shortages with the number of individuals who opt-in.</li> </ul>	<ul style="list-style-type: none"> <li>• Improvement in program processes and systems for member recruitment, engagement, discharge, and transition:                             <ul style="list-style-type: none"> <li>○ Add OCK flag and service start date to KMAP</li> <li>○ Notification of member's OCK enrollment with another provider</li> <li>○ Electronic system in place for easier access and transfers of the records</li> <li>○ Improved process to remove from the roster the members who opt-out</li> <li>○ Improved education of members and providers regarding opt-in process, including need for active participation in client invitation letter.</li> <li>○ Access to ER and hospital data for better follow-up and transition planning for members</li> <li>○ Attention to organizational capacity of OCKPs</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• More overarching state level education to hospitals, foster care, etc. and then we can follow up with them, but they are already aware of the expectations to participate.</li> <li>• Additional assistance with locating children in the foster care system and educating foster parents about the program (suggestions for local efforts offered - OCKPs request to visit local foster parent support group meetings to provide education and also for the child placing agencies who support foster parents).</li> </ul>	<ul style="list-style-type: none"> <li>• State assistance needed to provide education about the program to hospitals, foster care agencies, and foster parents; and in locating children in the foster care system.</li> </ul>
<ul style="list-style-type: none"> <li>• More timely audit results so that the program can make changes and have time to implement the changes prior to the next audit.</li> <li>• Agreement on the audit results. Perhaps if we pass an audit, we earn the opportunity to bypass the next one.</li> </ul>	<ul style="list-style-type: none"> <li>• Timely provision of audit results to implement changes; agreement on audit results; bypassing the subsequent audit depending on audit results</li> </ul>
<ul style="list-style-type: none"> <li>• One OCKP reported that they appreciate the monthly meetings with the MCOs to just check in. Being able to review information on their provider portals is very helpful.</li> <li>• Consistent design between MCO portals and how they are populated and updated. Also access to SUD information.</li> <li>• MCO staff not responding to emails timely which adds to the administrative burden.</li> </ul>	<ul style="list-style-type: none"> <li>• MCO communications and systems                             <ul style="list-style-type: none"> <li>○ Regular meetings with MCOs and review of information on their provider portals</li> <li>○ Consistency in MCOs' systems and improvement in timely communication by MCO staff</li> </ul> </li> </ul>

## 6. Recommendations and Potential Next Steps for the OneCare Kansas Program

During the July 2021 virtual meetings, OCK program partners made recommendations and suggested potential next steps for the program. This information is summarized in Table A8.

Table A8. Recommendations and Potential Next Steps, July 2021
<ul style="list-style-type: none"> <li>● <b>Increase access to medical care among non-compliant patients by allowing initial in-person appointment and virtual appointments for follow-up visits.</b> <ul style="list-style-type: none"> <li>○ For overcoming the challenge of patients in rural areas who were dismissed from clinic for non-compliance and were unable to access medical care, determine if patients are able to make an initial "meet" appointment with a specialist and then have virtual appointments after that.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>● <b>OCKPs across the state could build their professional networks and provide mutual support outside of the formal opportunities offered by the State.</b> <ul style="list-style-type: none"> <li>○ Overall, OCKPs across the state indicated a desire to build their professional networks and provide mutual support outside of the formal opportunities offered by the KDHE DHCF and WSU CEI. All partners recognized that this would take intentional time and effort that they sometimes feel they do not have due to staffing shortages and high workload, but many regions reported that this investment would be beneficial to their programs.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>● <b>Development and use of the provider directory to assist in communication and collaboration across the network of OCK partners.</b> <ul style="list-style-type: none"> <li>○ Discussion between MCO representatives and WSU CEI staff to develop a provider directory to be distributed across the network (not publicly).</li> <li>○ OCK partners will utilize the directory to reach out to one another to establish local/ regional opportunities for connection and information sharing to enhance professional relationships across the network. This may be through email or regularly scheduled virtual/in-person meetings.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>● <b>Improve program processes and systems.</b> <ul style="list-style-type: none"> <li>○ OCKPs promote services within other programs to help boost their referrals as well.</li> <li>○ KDHE DHCF will continue to work with Gainwell Technologies to assure timely entry of information into KMAP.</li> <li>○ KDHE DHCF and the MCOs will review opportunities to improve processes related to member invitations, program audits, notice of enrollment when there are multiple potential providers and the Health Action Plan portal.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>● <b>Developing connections with local foster care contractors, child placing agencies, local hospitals, and emergency departments.</b> <ul style="list-style-type: none"> <li>○ OCKPs will reach out to local foster care contractors and child placing agencies to offer education about their local programs and the benefits to youth in foster care.</li> <li>○ OCKPs will continue to develop connections with local hospitals and emergency departments.</li> <li>○ KDHE DHCF will continue to research the relationship between CCBHCs and OCK.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>● <b>Identification of the opportunities to obtain hospital data and provision of organizational data.</b> <ul style="list-style-type: none"> <li>○ The State team will work to identify opportunities to obtain data from the hospital systems in Kansas.</li> <li>○ KDHE DHCF opportunities to provide organizational level data for quality improvement efforts.</li> </ul> </li> </ul>

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# ***Appendix B***

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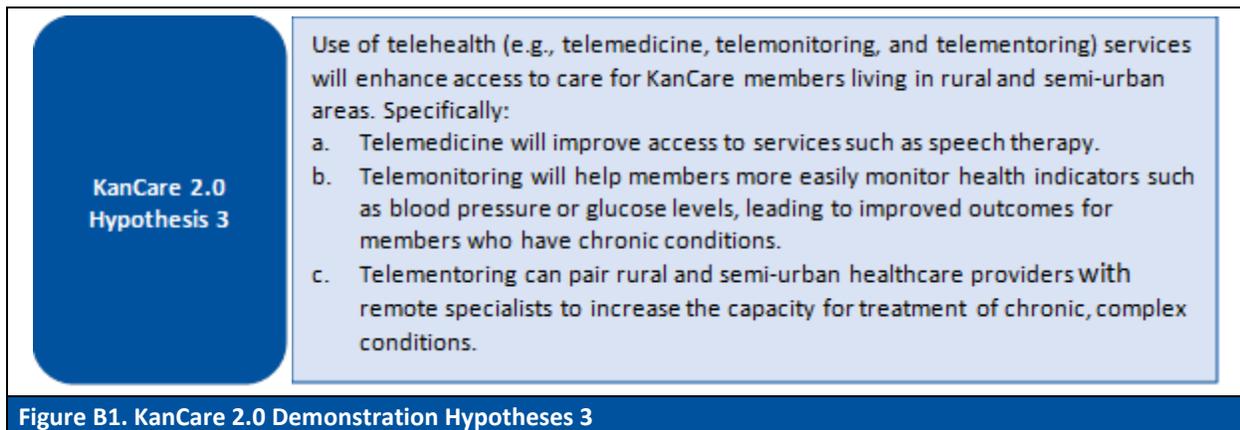
***KanCare 2.0 Interim Evaluation  
Report Evaluation of the State of Kansas  
Medicaid Section 1115(a) Demonstration  
Reporting Period – January 2019 – September 2022***

**Hypothesis 3: The Use of Telehealth Services**

## **Interim Evaluation of the KanCare 2.0 Demonstration**

### **Hypothesis 3: The Use of Telehealth Services**

Quantitative and qualitative analysis were used for the interim evaluation of KanCare 2.0 Hypothesis 3, stated in Figure B1. Measurement data for quantitative evaluation are provided, as available, for the time period of January 1, 2019, through December 31, 2021, while updates and qualitative data are provided for the time period through September 30, 2022. The results of the analyses assessing the quantitative and qualitative evaluation measures are described here.



### **Quantitative Evaluation**

#### Results of the Evaluation of Use of Telemedicine Services

The State has defined telemedicine as “*connecting participating providers with members at distant sites for purposes of evaluation, diagnosis, and treatment through two-way, real time interactive communication.*”

Two evaluation questions related to the use of telemedicine services were examined in the interim evaluation:

- Did use of telemedicine services increase over the five-year period for KanCare members living in rural or semiurban areas?
- Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?

Since the evaluation measures are focused on the use of telehealth services among KanCare members living in the rural or semi-urban areas, data were examined in two geographic areas, *Non-Urban* and *Urban*. KDHE’s grouping of counties into frontier, rural, densely rural, semi-urban and urban population density groups was used in defining the areas.<sup>12</sup> The Urban area is KDHE’s urban counties: Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte counties. The Non-Urban area contained the frontier, rural, densely rural, and semi-urban counties.

Five outcome measures were analyzed to evaluate the above-mentioned question:

1. Percentage of telemedicine services received by members living in the rural or semi-urban areas (Non-Urban). Subgroup analyses by age and primary diagnosis.
2. Number of receiving sites for telemedicine services in the rural and semi-urban areas (Non-Urban). Subgroup analyses by age.
3. Percentage of members living in the rural or semi-urban areas (Non-Urban) who received telemedicine services. Subgroup analyses by age.
4. Number of paid claims with selected procedure codes, stratified by area, mode of delivery, provider specialty, and selected diagnosis categories.
5. Number of members with selected diagnosis (e.g., speech-language pathology) per 1,000 members, stratified by area.

Based on outcomes of the first three measures, four sets of procedure and diagnosis codes were chosen to address the evaluation question, “Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?” The sets were related to speech therapy, individual psychotherapy, family and group psychotherapy, and community psychiatric supportive treatment. The strategy was to identify members (using diagnosis codes) for whom those services were likely to be beneficial (or *indicated*). Increases in the percent of members with indicating diagnosis who received the selected services would be evidence of an affirmative answer to the question. Toward this end, stratified results of Measures 4 and 5 were used to form eight additional metrics:

- Percentage of KanCare members receiving speech therapy who had a diagnosis in category F80
- Percentage of KanCare members with diagnosis in category F80 who received speech therapy
- Percentage of KanCare members receiving individual psychotherapy who had an indicating diagnosis (categories F34, F40, F43, F60, F91, and F93)
- Percentage of KanCare members with an indicating diagnosis who received individual psychotherapy
- Percentage of KanCare members receiving family or group psychotherapy who had an indicating diagnosis (categories F34, F91, F93, T74, and T76)
- Percentage of KanCare members with indicating diagnosis who received family or group psychotherapy
- Percentage of KanCare members receiving community psychiatric supportive treatment who had an indicating diagnosis (F20, F25, F34, F60, and F91)

The age strata used in analyzing the first three measures were 0–17 years, 18–45 years, and 46 years and older at the time of service received. These strata were selected to ensure adequate representation within each stratum. Also, the chronic diseases that can benefit from telemedicine services are more prevalent among 46 years and older adults.<sup>13</sup> In addition to age strata, counts by primary diagnosis were stratified by ICD-10-CM chapters and blocks, and strata with the highest counts are reported.

The encounter, demographics, eligibility, and enrollment records from the State’s Medicaid Management Information System (MMIS) reporting warehouse were used for the analyses of KanCare 2.0 data from January 2019 through December 2021, and pre-KanCare 2.0 data for 2018.

*Measure 1: Percentage of telemedicine services received by members living in rural or semi-urban areas*

Analytic results and findings of Measure 1 are presented in Table B1. The table includes stratifications by geographic area and age. Tables B1 and B2 provides result of stratification of primary diagnosis codes by

ICD-10-CM chapter and block (a *chapter* is a major division of the diagnosis codes based on body function or condition; a *block* is a subdivision of a chapter). Counts for 2018 and 2019 were combined and compared to counts for 2021 by ranking the strata by claim count. Chapters and blocks in the top five ranks of either period are included in the tables.

<b>Table B1. Telemedicine Services Received by KanCare Member Location and Age Group</b>						
<b>Measure 1: Percentage of KanCare telemedicine services that were received by members living in rural or semi-urban areas (Non-Urban) of Kansas</b>						
<b>Age on Day of Service</b>	<b>Pre-KanCare 2.0</b>	<b>KanCare 2.0</b>			<b>Statistical Analysis (For Percent Non-Urban)</b>	
<b>Area</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>Comparison Periods</b>	<b>p-value</b>
<b>All Ages</b>						
Non-Urban	24,034	26,844	355,386	251,844	2018 & 2019	p<.01
Urban	4,550	5,429	341,522	269,302	2019 & 2020	p<.001
Total	28,584	32,273	696,908	521,146	2020 & 2021	p<.001
<b>Percent Non-Urban</b>	84.08%	83.18%	50.99%	48.33%	Trend: 2019 to 2021	p<.001
<b>0–17 Years</b>						
Non-Urban	9,148	10,235	173,446	102,449	2018 & 2019	p<.001
Urban	2,512	3,310	166,369	111,851	2019 & 2020	p<.001
Total	11,660	13,545	339,815	214,300	2020 & 2021	p<.001
<b>Percent Non-Urban</b>	78.46%	75.56%	51.04%	47.81%	Trend: 2019 to 2021	p<.001
<b>18–45 Years</b>						
Non-Urban	5,912	6,308	94,188	83,409	2018 & 2019	p=.28
Urban	1,013	1,137	98,842	97,621	2019 & 2020	p<.001
Total	6,925	7,445	193,030	181,030	2020 & 2021	p<.001
<b>Percent Non-Urban</b>	85.37%	84.73%	48.79%	46.07%	Trend: 2019 to 2021	p<.001
<b>46 Years and Older</b>						
Non-Urban	8,974	10,301	87,752	65,986	2018 & 2019	p<.001
Urban	1,025	982	76,311	59,830	2019 & 2020	p<.001
Total	9,999	11,283	164,063	125,816	2020 & 2021	p<.001
<b>Percent Non-Urban</b>	89.75%	91.30%	53.49%	52.45%	Trend: 2019 to 2021	p<.001
<b>Interpretation/Comments:</b>						
<ul style="list-style-type: none"> <li>The number of telemedicine services increased from 2018 to 2019 for Non-Urban and Urban members. This pattern was also seen for each age stratum except for Urban members aged 46 years or older. The considerably large increases from 2019 to 2020 corresponded to the onset of the COVID-19 pandemic. Counts for Non-Urban and Urban members and each age stratum decreased from 2020 to 2021 but remained well above pre-pandemic levels.</li> <li>The increases were relatively greater in the Urban area than the Non-Urban area. Consequently, the percentage of the telemedicine services received by Non-Urban members decreased each year, except for the increase from 2018 to 2019 for members aged 46 years or older.</li> <li>The data and analytic results for 2022 and 2023 may provide a better assessment of the impact of State interventions on telemedicine services in Non-Urban areas of Kansas.</li> </ul>						
Counts of telemedicine services were stratified by age group and member’s county of residence; Urban counties were Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte. Testing for statistically significant differences in Non-Urban percentages between two years used a weighted Pearson chi-square test, and testing whether the slopes of the 3-year trend lines were statistically significantly different from horizontal used a weighted Mantel-Haenszel chi-square test (p<.05 was considered statistically significant).						

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<b>Table B2. Telemedicine Services Ranked by ICD-10 CM Diagnosis Chapter</b>					
<b>Area of Member Residence</b>	<b>Code Range</b>	<b>2018–2019 Count</b>	<b>2021 Count</b>	<b>2018–2019 Rank</b>	<b>2021 Rank</b>
ICD-10-CM Chapter of Primary Diagnosis Code					
<b>Statewide</b>					
Mental, Behavioral and Neurodevelopmental Disorders	F01–F99	55,781	421,511	1	1
Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified	R00–R99	893	29,382	3	2
Diseases of the Respiratory System	J00–J99	915	10,048	2	3
Diseases of the Nervous System	G00–G99	696	9,967	4	4
Endocrine, Nutritional and Metabolic Diseases	E00–E89	529	7,901	5	6
Factors Influencing Health Status and Contact with Health Services	Z00–Z99	325	8,092	6	5
<b>Non-Urban</b>					
Mental, Behavioral and Neurodevelopmental Disorders	F01–F99	47,403	202,712	1	1
Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified	R00–R99	645	12,127	2	2
Diseases of the Respiratory System	J00–J99	453	5,802	4	3
Diseases of the Nervous System	G00–G99	543	5,152	3	4
Factors Influencing Health Status and Contact with Health Services	Z00–Z99	208	4,218	6	5
Endocrine, Nutritional and Metabolic Diseases	E00–E89	349	3,988	5	6
<b>Urban</b>					
Mental, Behavioral and Neurodevelopmental Disorders	F01–F99	8,378	218,799	1	1
Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified	R00–R99	248	17,255	3	2
Diseases of the Nervous System	G00–G99	153	4,815	5	3
Diseases of the Respiratory System	J00–J99	462	4,246	2	4
Endocrine, Nutritional and Metabolic Diseases	E00–E89	180	3,913	4	5
Factors Influencing Health Status and Contact with Health Services	Z00–Z99	117	3,874	6	6
<b>Interpretation/Comments:</b>					
<ul style="list-style-type: none"> <li>The chapter Mental, Behavioral and Neurodevelopmental Disorders (Codes F01–F99) had the highest ranking for Non-Urban and Urban members in both time periods. For 2018–2019, number of claims for Non-Urban members with codes F01–F99 was over 60 times the number of claims in the second ranked chapter (Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified). In 2021, the number of claims for Non-Urban members was 17 times the number of claims in the second ranked chapter (Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified).</li> <li>The next five highest ranked chapters were the same in 2018–2019 as in 2021, but the rankings were slightly different.</li> </ul>					
Counts of telemedicine services were stratified by the ICD-10-CM chapter of the primary diagnosis code and by member’s county of residence; Urban counties were Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte. The six top ranked chapters for 2018–2019 and 2021 are shown in order of 2021 rank.					

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<b>Table B3. Telemedicine Services Ranked by ICD-10 CM Diagnosis Block</b>					
<b>Area of Member Residence</b>	<b>Code Range</b>	<b>2018–2019 Count</b>	<b>2021 Count</b>	<b>2018–2019 Rank</b>	<b>2021 Rank</b>
<b>Statewide</b>					
Mood [affective] disorders	F30–F39	23,501	153,875	1	1
Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	F40–F48	8,123	114,371	3	2
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	F90–F98	11,574	68,294	2	3
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	F20–F29	7,887	32,990	4	4
Mental and behavioral disorders due to psychoactive substance use	F10–F19	644	25,757	8	5
Mental disorders due to known physiological conditions	F01–F09	1,865	1,817	5	21
<b>Non-Urban</b>					
Mood [affective] disorders	F30–F39	19,934	77,127	1	1
Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	F40–F48	6,520	49,777	4	2
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	F90–F98	9,926	36,770	2	3
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	F20–F29	6,789	15,498	3	4
Mental and behavioral disorders due to psychoactive substance use	F10–F19	570	11,360	8	5
Mental disorders due to known physiological conditions	F01–F09	1,818	1,336	5	16
<b>Urban</b>					
Mood [affective] disorders	F30–F39	3567	76,748	1	1
Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	F40–F48	1603	64,594	3	2
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	F90–F98	1648	31,524	2	3
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	F20–F29	1098	17,492	4	4
Mental and behavioral disorders due to psychoactive substance use	F10–F19	74	14,397	13	5
Chronic lower respiratory diseases	J40–J47	299	1,945	5	10
<b>Interpretation/Comments:</b>					
<ul style="list-style-type: none"> <li>• In 2021, the top five ranked blocks of primary diagnosis codes on telemedicine claims had the same rank for Non-Urban and Urban areas. Each of the five blocks were from the Mental, Behavioral and Neurodevelopmental Disorders chapter. Mood [affective] disorders (codes F30–F39) ranked first in both years.</li> <li>• The top four blocks of primary codes were the same in 2018–2019 and in 2021 (statewide, Non-Urban and Urban areas), although the rankings had changed.</li> <li>• Mental and behavioral disorders due to psychoactive substance use (codes F10–F19), which ranked 8<sup>th</sup> in Non-Urban and 13<sup>th</sup> in Urban areas for 2018–2019, rose to 5<sup>th</sup> for 2021—displacing mental disorders due to known physiological conditions (F01–F09) in the Non-Urban area and chronic lower respiratory diseases (J40–J47) in the Urban area.</li> </ul>					
Counts of telemedicine services were stratified by the ICD-10-CM chapter block of the primary diagnosis code and by member’s county of residence; Urban counties are Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte. Blocks shown were in the top 5 ranked blocks for either 2018–2019 or 2021 and are shown in order of 2021 rank.					

**Measure 2: Number of receiving sites for telemedicine services in the rural and semi-urban areas**

Table B4 shows the number of *receiving sites*, that is, billing provider locations providing telehealth services to KanCare members. Stratification into Non-Urban and Urban areas is based on the member’s county of residence.

<b>Table B4. Receiving Sites for Telemedicine Services by KanCare Member Location and Age Group</b>				
<b>Measure 2: Number of receiving sites for telemedicine services in the rural and semi-urban areas (Non-Urban).</b>				
<b>Area of Member Residence</b>	<b>Pre-KanCare 2.0</b>	<b>KanCare 2.0</b>		
Age Group	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
<b>Non-Urban</b>				
0–17 Years	57	65	514	485
18–45 Years	70	71	547	521
46 Years and Older	73	65	458	440
All Ages	94	94	698	714
<b>Urban</b>				
0–17 Years	38	50	653	612
18–45 Years	32	56	727	727
46 Years and Older	23	36	505	475
All Ages	59	87	965	938
<b>Interpretation/Comments:</b>				
<ul style="list-style-type: none"> <li>• The number of receiving sites providing telemedicine services to Non-Urban KanCare members were relatively unchanged from 2018 to 2019, but increased considerably for 2020 and 2021, which were the initial years of the COVID-19 pandemic.</li> <li>• The number of receiving sites providing telemedicine services to Urban KanCare members increased slightly between 2018 and 2019 and then increased considerably for 2020 and 2021.</li> <li>• The data for 2022 and 2023 may indicate whether the increases observed during 2020 and 2021 are maintained as the pandemic resides.</li> <li>• Note, the data do not indicate the number of sites capable of offering telehealth services (many of the receiving sites counted for 2020 or 2021 may have been providing telehealth to non-KanCare persons in 2018 and 2019).</li> </ul>				
Telemedicine services provided to KanCare members were deduplicated to count the receiving site’s (i.e., provider location’s) billing provider National Provider IDs once per age group per area of the member’s residence. Counties defining the Urban area were Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte.				

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**Measure 3: Percentage of members living in the rural or semi-urban areas who received telemedicine services**

Table B5 shows the number and percentage of KanCare members who received telemedicine services, stratified by age and area. Stratification into Non-Urban and Urban areas is based on the member’s county of residence.

<b>Table B5. KanCare Members Receiving Telemedicine Services by Member Location and Age</b>					
<b>Measure 3: Percentage of members living in the rural or semi-urban areas (Non-Urban) who received telemedicine services.</b>					
<b>Area of Member Residence</b>		<b>Pre-KanCare 2.0</b>	<b>KanCare 2.0</b>		
<b>Age at Time of Service</b>	<b>Statistic</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
<b>Non-Urban</b> All Ages	Members (denominator)	179,043	176,020	188,599	206,837
	Members Receiving Telehealth	7,063	7,825	46,635	42,380
	<b>Percent</b>	<b>3.94%</b>	<b>4.45%</b>	<b>24.73%</b>	<b>20.49%</b>
<b>Non-Urban</b> 0–17 Years	Members (denominator)	100,879	100,879	106,498	111,518
	Members Receiving Telehealth	3,021	3,539	21,167	18,489
	<b>Percent</b>	<b>2.99%</b>	<b>3.51%</b>	<b>19.88%</b>	<b>16.58%</b>
<b>Non-Urban</b> 18–45 Years	Members (denominator)	40,576	38,040	42,695	53,775
	Members Receiving Telehealth	2,197	2,322	13,126	13,374
	<b>Percent</b>	<b>5.41%</b>	<b>6.10%</b>	<b>30.74%</b>	<b>24.87%</b>
<b>Non-Urban</b> 46 Years and Older	Members (denominator)	37,588	37,101	39,406	41,544
	Members Receiving Telehealth	1,845	1,964	12,342	10,517
	<b>Percent</b>	<b>4.91%</b>	<b>5.29%</b>	<b>31.32%</b>	<b>25.32%</b>
<b>Urban</b> All Ages	Members (denominator)	190,873	188,146	204,013	226,764
	Members Receiving Telehealth	1,610	1,937	44,150	38,966
	<b>Percent</b>	<b>0.84%</b>	<b>1.03%</b>	<b>21.64%</b>	<b>17.18%</b>
<b>Urban</b> 0–17 Years	Members (denominator)	111,069	110,907	118,526	125,173
	Members Receiving Telehealth	925	1,178	20,588	16,957
	<b>Percent</b>	<b>0.83%</b>	<b>1.06%</b>	<b>17.37%</b>	<b>13.55%</b>
<b>Urban</b> 18–45 Years	Members (denominator)	43,837	41,686	47,434	60,831
	Members Receiving Telehealth	410	520	13,021	13,279
	<b>Percent</b>	<b>0.94%</b>	<b>1.25%</b>	<b>27.45%</b>	<b>21.83%</b>
<b>Urban</b> 46 Years and Older	Members (denominator)	35,968	35,553	38,054	40,760
	Members Receiving Telehealth	275	239	10,541	8,730
	<b>Percent</b>	<b>0.76%</b>	<b>0.67%</b>	<b>27.70%</b>	<b>21.42%</b>
<b>Interpretation/Comments:</b>					
<ul style="list-style-type: none"> <li>• The percentages of Non-Urban and Urban KanCare members who received telemedicine services increased from 2018 to 2019, and from 2019 to 2020. However, percentages decreased from 2020 to 2021 but remained well above pre-pandemic levels. Similar patterns were seen for three age strata for Non-Urban members.</li> <li>• These patterns were also seen for each age stratum for Non-Urban members. Similar patterns were seen for each age stratum for Urban members, except for 2018–2019 comparison period for the members 46 years and older (no statistical difference seen in percentage from 2018 to 2019).</li> <li>• The overall increase in use of telemedicine services occurred in 2020 and 2021, the initial years of the COVID-19 pandemic. The data and analytic results for 2022 and 2023 may provide a better assessment of the impact of State interventions on telemedicine services in Non-Urban areas of Kansas.</li> </ul>					
Counts of KanCare members and KanCare members who received telemedicine services were stratified by age group and member’s county of residence; Urban counties were Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte. Testing for statistically significant differences between two consecutive years used a weighted Pearson chi-square test and testing whether the slopes of the 2019–2021 trend lines were statistically significantly different from horizontal used a weighted Mantel-Haenszel chi-square test ( $p < .05$ was considered statistically significant). Tests showed $p < .001$ except from 2018 to 2019 for members aged 45 or older in the Non-Urban ( $p = .02$ ) and Urban ( $p = .14$ ) areas.					

*Speech Therapy Analysis:*

- *Measure 4: Number of paid claims with selected procedure codes*
- *Measure 5: Number of members with selected diagnosis per 1,000 members*
- *Percentage of KanCare members receiving speech therapy who had a diagnosis in category F80*
- *Percentage of KanCare members with diagnosis in category F80 who received speech therapy*

The State approved a set of speech-language pathology or audiology codes for telemedicine delivery effective January 1, 2019.<sup>25</sup> The list of procedure allowed to be offered via telemedicine was expanded to include CPT codes 97129 and 94130, which became effective in January 2020. With the onset of the COVID-19 pandemic, telemedicine was approved for diagnostic evaluations related to speech and language and to procedures performed in homes.<sup>27,28</sup> Service delivery trends for these codes, and other codes approved for telemedicine during the demonstration, were studied, and Non-Urban (rural and semi-urban) and Urban trends were compared. During development of the evaluation design, it was hypothesized that an increase in access to evaluation services could lead to an increase in diagnosis of related conditions. Thus, the number of members diagnosed with speech-language and audiology pathological conditions were analyzed.

The first step of the analysis was to identify the procedure codes to be selected for the measures. Table B6 provides codes and descriptions of procedures commonly offered by speech-language pathologists (SLPs) and audiologists that had been provided via telemedicine at least once in 2019, 2020, or 2021. The table includes counts of paid services (strata of Measure 4) and the percentages of those which were by telemedicine. Paid claims on which a multiple-specialty billing provider (e.g., clinics) was listed as the performing provider instead of an individual SLP or Audiologist were excluded from the analysis for Table B6 because some procedure codes are not exclusive to speech and language. Table B7 provides codes and descriptions of procedures related to speech and language billed by HCBS providers.

Tables B6 and B7 show very few services related to speech and language were provided by SLPs, audiologists, or HCBS providers in 2019. Services with the most paid claims in 2020 and 2021 were as follows (with counts of paid claims via telemedicine in 2020 and 2021, respectively in parentheses):

- By speech-language pathologists and audiologists
  - 92507 – Treatment of speech, language, voice, communication, and/or hearing processing disorder (5,273 and 3,966)
  - 92526 – Treatment of swallowing dysfunction and/or oral function for feeding (658 and 446)
- By Home and Community Based Service providers
  - 97129 – Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes (4,296 and 3,309)
  - 97130 – Therapeutic interventions that focus on cognitive function; each additional 15 minutes (4,022 and 3,141)
  - G0153 – Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes (3,119 and 3,567)

KanCare 2.0 Interim Evaluation  
 Evaluation of the State of Kansas Medicaid Section 1115(a) Demonstration – KanCare 2.0  
 Reporting Period – January 2019 – September 2022  
 Appendix B – Hypothesis 3: The Use of Telehealth Services

<b>Table B6. Services by Speech-Language Pathologist and Audiologist Provided via Telemedicine</b>					
Procedure Code*	Procedure Description	Statistic	KanCare 2.0		
			2019	2020	2021
<b>92507</b>	Treatment of speech, language, voice, communication, and/or hearing processing disorder	Paid Services	45,766	51,523	67,346
		Via Telehealth	0	5,273	3,966
		% via Telehealth	0.0%	10.2%	5.9%
<b>92508</b>	Group treatment of speech, language, voice, communication, and/or hearing processing disorder	Paid Services	723	435	787
		Via Telehealth	0	1	0
		% via Telehealth	0.0%	0.2%	0.0%
<b>92522</b>	Evaluation of speech sound production	Paid Services	204	235	250
		Via Telehealth	0	10	3
		% via Telehealth	0.0%	4.3%	1.2%
<b>92523</b>	Evaluation of speech sound production with evaluation of language comprehension and expression	Paid Services	2,076	2,006	2,296
		Via Telehealth	0	86	76
		% via Telehealth	0.0%	4.3%	3.3%
<b>92524</b>	Behavioral and qualitative analysis of voice and resonance	Paid Services	178	119	185
		Via Telehealth	0	3	0
		% via Telehealth	0.0%	2.5%	0.0%
<b>92526</b>	Treatment of swallowing dysfunction and/or oral function for feeding	Paid Services	13,445	15,803	21,074
		Via Telehealth	0	658	446
		% via Telehealth	0.0%	4.2%	2.1%
<b>92610</b>	Evaluation of oral and pharyngeal swallowing function	Paid Services	1,327	1,308	1,503
		Via Telehealth	0	1	3
		% via Telehealth	0.0%	0.1%	0.2%
<b>96112</b>	Developmental test administration by qualified health care professional with interpretation and report; first 60 minutes	Paid Services	188	153	271
		Via Telehealth	0	22	53
		% via Telehealth	0.0%	14.4%	19.6%
<b>96113</b>	Developmental test administration by qualified health care professional with interpretation and report; additional 30 minutes	Paid Services	180	71	158
		Via Telehealth	0	11	30
		% via Telehealth	0.0%	15.5%	19.0%
<b>97112</b>	Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes	Paid Services	1	12	104
		Via Telehealth	0	10	20
		% via Telehealth	0%	83%	19.2%
<b>97129</b> (effective 1/1/2020)	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	Paid Services		1,135	1,338
		Via Telehealth		72	66
		% via Telehealth		6.3%	4.9%
<b>97130</b> (effective 1/1/2020)	Therapeutic interventions that focus on cognitive function; each additional 15 minutes	Paid Services		930	1,014
		Via Telehealth		73	63
		% via Telehealth		7.8%	6.2%
<b>97535</b>	Self-care or home management training, each 15 minutes	Paid Services	6	227	185
		Via Telehealth	0	9	14
		% via Telehealth	0%	4.0%	7.6%
<b>G0153</b>	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes	Paid Services	125	111	200
		Via Telehealth	0	28	0
		% via Telehealth	0.0%	25.2%	0.0%

\*Includes procedure codes with at least 100 paid claims and at least one paid telemedicine service identified from long-term care and outpatient claims with revenue codes 440–449 (speech-language pathology) and 470–479 (audiology) and professional claims for performing providers with specialty codes 173 (speech-language pathology) and 200 (audiology). Because some of the procedures (e.g., 96112 or 97129) are also provided other types of providers, counts excluded professional claims for which the performing provider was a clinic, practice, or home health agency listing multiple specialties.

<b>Table B7. HCBS Services Related to Speech and Language Provided via Telemedicine</b>					
Procedure Code*	Procedure Description	Statistic	KanCare 2.0		
			2019	2020	2021
<b>92507</b>	Treatment of speech, language, voice, communication, and/or hearing processing disorder	Paid Services	615	658	231
		Via Telehealth	0	283	25
		% via Telehealth	0.0%	43.0%	10.8%
<b>97129</b> (effective 1/1/2020)	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	Paid Services		10,355	12,472
		Via Telehealth		4,296	3,309
		% via Telehealth		41.5%	26.5%
<b>97130</b> (effective 1/1/2020)	Therapeutic interventions that focus on cognitive function; each additional 15 minutes	Paid Services		10,225	12,214
		Via Telehealth		4,022	3,141
		% via Telehealth		39.3%	25.7%
<b>G0153</b>	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes	Paid Services	4,445	7,528	8,592
		Via Telehealth	0	3,119	3,567
		% via Telehealth	0.0%	41.4%	41.5%

\*Includes procedure codes with at least 100 paid claims and at least one paid telemedicine service professional claims with billing provider type 55 (HCBS).

Based on tables B6 and B7, procedure codes 92507 and G0153 were chosen for the next steps of the analysis. Although codes 97129 and 97130 had sufficient volume for HCBS providers, the low counts from SLP and Audiologist indicated too many of the services may have been for therapeutic interventions focusing on cognitive functions not related to speech. The other procedures had too small of counts for inclusion in the analysis. Although technically inaccurate, for this analysis *speech therapy* will refer to services billed with codes 92507 and G0153.

Table B8 shows the ratio of members who received speech therapy to the number of KanCare members as a rate “per 1,000 members” for 2018 to 2021. Statewide, rates increased each year. The statewide rate increases from 2018 to 2019 (from 5.34 to 6.56) suggest causes unrelated to telehealth or the pandemic.

<b>Table B8. Speech Therapy Recipients Per 1,000 KanCare Members</b>					
Area of Member Residence		Pre-KanCare 2.0	KanCare 2.0		
Statistic		2018	2019	2020	2021
<b>Non-Urban</b>	KanCare Members	190,429	185,323	205,871	223,064
	With Speech Therapy	923	1,163	1,235	1,455
	Rate per 1,000 Members	4.85	6.28	6.00	6.52
<b>Urban</b>	KanCare Members	207,165	202,451	227,803	247,427
	With Speech Therapy	1,202	1,380	1,668	2,070
	Rate per 1,000 Members	5.80	6.82	7.32	8.37
<b>Statewide</b>	KanCare Members	397,594	387,774	433,674	470,491
	With Speech Therapy	2,125	2,543	2,903	3,525
	Rate per 1,000 Members	5.34	6.56	6.69	7.49

Procedure codes used to identify speech therapy were 92507 (Treatment of speech, language, voice, communication, and/or hearing processing disorder) and G0153 (Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes).

The number of paid claims with procedure codes 92507 and G0153 (Measure 4) was stratified by Non-Urban and Urban area and sub-stratified by mode of delivery, provider type, and primary diagnosis category (see Table B9).

<b>Table B9. Stratifications of Paid Claims Related to Speech Therapy</b>										
<b>Number of Paid Claims with Procedure Code 92507 or G0153</b>										
92507 – Treatment of speech, language, voice, communication, and/or hearing processing disorder										
G0153 – Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes										
Area of Member Residence		Pre-KanCare 2.0		KanCare 2.0						
		2018 N	%	2019 N	%	2020 N	%	2021 N	%	
Stratum										
<b>Statewide</b>	Statewide Total (Denominator)		41,837		51,496		59,503		77,200	
	Non-Urban		16,946 40.5%		21,184 41.1%		23,135 38.9%		27,896 36.1%	
	Urban		24,891 59.5%		30,312 58.9%		36,368 61.1%		49,304 63.9%	
<b>Non-Urban</b>	Non-Urban Total (Denominator)		16,946		21,184		23,135		27,896	
	Mode:		Telemedicine		1 0.0%		0 0%		2,286 9.9%	
			Non-Telemedicine		16,945 100%		21,184 100%		20,849 90.1%	
	Provider Type:		Hospital		8,117 47.9%		10,193 48.1%		9,346 40.4%	
			Therapist		3,120 18.4%		5,943 28.1%		7,253 31.4%	
			Custodial Care Facility		2,089 12.3%		2,951 13.9%		4,472 19.3%	
			HCBS		755 4.5%		922 4.4%		1,428 6.2%	
			Physician		2,499 14.7%		874 4.1%		501 2.2%	
			Other Provider Types		366 2.2%		301 1.4%		135 0.6%	
	Primary Diagnosis:*		F80		8,169 48.2%		10,165 48.0%		10,196 44.1%	
			R47–R49		1,495 8.8%		2,140 10.1%		1,818 7.9%	
			R68		654 3.9%		696 3.3%		1,254 5.4%	
			F84		630 3.7%		672 3.2%		1,099 4.8%	
			Other Diagnoses		5,998 35.4%		7,511 35.5%		8,768 37.9%	
<b>Urban</b>	Urban Total (Denominator)		24,891		30,312		36,368		49,304	
			Telemedicine		0 0%		6,253 17.2%		5,227 10.6%	
			Non-Telemedicine		24,891 100%		30,312 100%		30,115 82.8%	
			Therapist		7,559 30.4%		13,131 43.3%		17,045 46.9%	
			HCBS		4,188 16.8%		4,137 13.6%		6,798 18.7%	
			Hospital		4,599 18.5%		4,650 15.3%		3,891 10.7%	
			Physician		4,611 18.5%		5,474 18.1%		3,282 9.0%	
			Custodial Care Facility		1,650 6.6%		1,951 6.4%		4,278 11.8%	
			Other Provider Types		2,284 9.2%		969 3.2%		1,074 3.0%	
			F80		11,577 46.5%		15,070 49.7%		16,428 45.2%	
			R68		3,824 15.4%		4,068 13.4%		6,273 17.2%	
			F84		2,151 8.6%		3,199 10.6%		3,933 10.8%	
			R47–R49		1,636 6.6%		1,336 4.4%		1,167 3.2%	
			Other Diagnoses		5,703 22.9%		6,639 21.9%		8,567 23.6%	

\*F80 – Specific developmental disorders of speech and language  
 F84 – Pervasive developmental disorders (96% were F84.0, Autistic Disorder.)  
 R47–R49 – Symptoms and signs involving speech and voice  
 R68 – Other general symptoms and signs (R68.89 is often used claims for HCBS services.)

In 2018 and 2019, the total number of paid claims with the two codes was about 41% Non-Urban and 59% Urban. During the pandemic, the Non-Urban percentages declined, to 39% in 2020 and to 36% in 2021. In 2020, about 10% of the paid claims for the Non-Urban area were for services provided by telemedicine. The corresponding percentage for the Urban area was 17%. The Urban area’s greater ability, or need (mandates and COVID-10 incidence rates varied by county), was a contributing factor to the Non-Urban areas percentage of all paid claims declining to 39% for 2020. The percentages of services offered by telehealth was more equitable in 2021 (8% for Non-Urban, 11% for Urban), but the Non-Urban rates percentage of all paid claims decline even more from 2020 to 2021 (3 percentage points) than it had from 2019 to 2020 (2 percentage points). For a possible explanation, look at the counts in the statewide stratification by Non-Urban and Urban. Counts increased each year for both strata, with the greatest increase in the last year; the Urban area had a 36% relative increase, which is

disproportional to the increases in the KanCare membership for that year. Strata with the highest count increases from 2020 to 2021 were as follows (counts and relative increases are in parentheses):

- Non-Urban providers
  - Therapists (1,428; 20%)
  - Custodial Care Facilities (1,230; 28%)
  - Hospitals (1,055; 11%)
- Non-Urban primary diagnosis
  - Other Diagnoses (2,289; 26%)
  - Other general symptoms and signs (1,043; 83%)
- Urban providers
  - Therapists (9,390; 55%)
  - Custodial Care Facilities (1,473; 34%)
  - Hospitals (1,381; 35%)
- Urban primary diagnosis
  - Specific developmental disorders of speech and language (6,865; 42%)
  - Other Diagnoses (3,491; 41%)
  - Pervasive developmental disorders (1,936; 49%)

The ranking of the provider type strata shows fundamental differences between the two areas. For members in Non-Urban counties, the provider type with the greatest number of paid claims from 2018 through 2021 for speech therapy was hospitals. Therapists and custodial care facilities ranked second and third, respectively. In the Urban area, therapists ranked first, HCBS providers second, and hospitals third.

The most frequently used primary diagnosis on claims for speech therapy was F80, specific developmental disorders of speech and language. The percentage of paid claims for speech therapy that had an F80 category primary diagnosis was 40% for Non-Urban members and 47% for Urban members.

Based on review of Table B9, only F80 was selected for further analysis. The categories in the other strata were considered to have too little claims volume or would have a large proportion of claims not associated with speech therapy.

The prevalence rate for F80 diagnoses (the proportion of members diagnosed with an F80 category diagnosis per 1,000 KanCare members) is shown in Table B10. The statewide rate has a generally increasing trend—with a dip in 2020 that may be pandemic related.

The prevalence rates were greater for the Urban area than for the Non-Urban area, by about 4 diagnosed members per 1,000 KanCare members. The data do not indicate if the disparity is due to differences in members' health status, access to care for evaluation or treatment, or providers' coding of claims.

The statewide percentage of KanCare members receiving speech therapy who had a diagnosis in category F80 was relatively stable (61% in 2018, 2020, and 2021; 64% in 2019, corresponding to a bump in the Urban percentage). The choice of F80 as an indicating diagnosis for speech therapy is supported by these percentages; a about two-thirds of the members receiving speech therapy had an F80 diagnosis. As with the prevalence rates, the percentages for Urban members was greater than for Non-

Urban members, and the data do not indicate if the differences are due to differences in members' health status, access to care for evaluation or treatment, or providers' coding of claims.

<b>Table B10. Analytic Results Related to Developmental Disorders of Speech and Language</b>						
<b>Members with F80 Diagnosis per 1,000 KanCare Members</b>						
Area of Member Residence		Statistic	Pre-KanCare 2.0	KanCare 2.0		
			2018	2019	2020	2021
Non-Urban	KanCare Members		190,429	185,323	205,871	223,064
	With F80 Diagnosis		2,949	3,257	3,326	3,944
	Rate per 1,000 Members		15.5	17.6	16.2	17.7
Urban	KanCare Members		207,165	202,451	227,803	247,427
	With F80 Diagnosis		4,061	4,402	4,461	5,608
	Rate per 1,000 Members		19.6	21.7	19.6	22.7
Statewide	KanCare Members		397,594	387,774	433,674	470,491
	With F80 Diagnosis		7,010	7,659	7,787	9,552
	Rate per 1,000 Members		17.6	19.8	18.0	20.3
<b>Percentage of KanCare Members Receiving Speech Therapy Who Had a Diagnosis in Category F80</b>						
Area of Member Residence		Statistic	Pre-KanCare 2.0	KanCare 2.0		
			2018	2019	2020	2021
Non-Urban	Members in Speech Therapy		923	1,163	1,235	1,455
	With F80 Diagnosis		535	669	699	798
	Percent		57.96%	57.52%	56.60%	54.85%
Urban	Members in Speech Therapy		1,202	1,380	1,668	2,070
	With F80 Diagnosis		764	952	1,078	1,362
	Percent		63.56%	68.99%	64.63%	65.80%
Statewide	Members in Speech Therapy		2,125	2,543	2,903	3,525
	With F80 Diagnosis		1,299	1,621	1,777	2,160
	Percent		61.13%	63.74%	61.21%	61.28%
<b>Percentage of KanCare Members with Diagnosis in Category F80 Who Received Speech Therapy</b>						
Area of Member Residence		Statistic	Pre-KanCare 2.0	KanCare 2.0		
			2018	2019	2020	2021
Non-Urban	Members With F80 Diagnosis		3,132	3,514	3,432	4,054
	With Speech Therapy		535	669	699	798
	Percent		17.08%	19.04%	20.37%	19.68%
Urban	Members With F80 Diagnosis		4,310	4,682	4,541	5,692
	With Speech Therapy		764	952	1,078	1,362
	Percent		17.73%	20.33%	23.74%	23.93%
Statewide	Members With F80 Diagnosis		7,442	8,196	7,973	9,746
	With Speech Therapy		1,299	1,621	1,777	2,160
	Percent		17.45%	19.78%	22.29%	22.16%
Procedure codes used to identify speech therapy were 92507 (Treatment of speech, language, voice, communication, and/or hearing processing disorder) and G0153 (Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes). Diagnosis Category F80 codes specific developmental disorders of speech and language.						

Table B10 also the percentages of Non-Urban members with a diagnosis in category F80 who received speech therapy were greater for 2020 (20.4%) and 2021 (19.7%) than for 2018 (17.1%) and 2019 (19.0%), which supports the hypothesis that telemedicine will enhance access to services such as speech therapy for KanCare members living in rural or semi-urban counties. Access to speech therapy services also appears to have been enhanced for Urban members (percentages from 2018 to 2021 were 17.7%, 20.3%, 23.7%, and 23.9%, respectively).

**Telemedicine Services by Mental Health Providers – Background:**

Telemedicine services were provided to KanCare members prior to KanCare 2.0. A KDHE provider bulletin lists 59 procedure codes approved for telemedicine as of January 1, 2018 (some codes had earlier approval dates).<sup>26</sup> The list included codes for services offered by mental health providers, such as, psychotherapies, psychiatric diagnostic evaluations, adaptive behavior treatments, office visits for evaluation and management (E&M), and medical consultations. With the onset of the pandemic, additional services were approved for telemedicine.

Table B11 lists services commonly offered by mental health providers from 2019 to 2021. The table includes counts of paid claims by procedure code (Measure 4) and the number and percentage of those that were for telemedicine services. The following trends were observed in Table B11:

- Over 50% of services in 2020 were provided via telemedicine for 30-minute psychotherapy sessions and evaluation and management (E&M) office visits for established patients (15-, 25-, and 40-minute sessions).
- The number of family and group psychotherapy sessions in 2020 and 2021 were below 2019 levels; the decreases are offset by increases in 30-minute psychotherapy sessions.
- The percentages decreased for most services from 2020 to 2021, which may indicate members or providers preferred for face-to-face visits.
- Percentages increased from 2020 to 2021 for short E&M visits; psychiatric diagnostic evaluation with medical services; medical team conference with patient and/or family, and nonphysician health care professionals; and comprehensive management and care coordination for advanced illness. The increases could indicate members’ and providers’ experiences with telemedicine were positive.

After review of Table B11, three areas were chosen for continued analysis: individual psychotherapy, family and group psychotherapy, and community psychiatric supportive treatment.

<b>Table B11. Percentages of Services by Mental Health Providers Conducted via Telemedicine</b>				
<b>Telemedicine Services by Mental Health Providers*</b>				
Procedure Code Procedure Description	Statistic	KanCare 2.0		
		2019	2020	2021
<b>90832</b> Psychotherapy, 30 minutes	Paid Services	39,966	66,449	62,351
	Via Telehealth	736	38,038	24,647
	% via Telehealth	1.8%	57.2%	39.5%
<b>90834</b> Psychotherapy, 45 minutes	Paid Services	115,661	115,168	115,302
	Via Telehealth	434	52,209	38,468
	% via Telehealth	0.4%	45.3%	33.4%
<b>90837</b> Psychotherapy, 60 minutes	Paid Services	266,072	276,213	310,715
	Via Telehealth	565	91,189	79,898
	% via Telehealth	0.2%	33.0%	25.7%
<b>90847</b> Family psychotherapy including patient, 50 minutes	Paid Services	46,306	38,306	34,344
	Via Telehealth	80	14,183	8,438
	% via Telehealth	0.2%	37.0%	24.6%
<b>90853</b> Group psychotherapy (other than of a multiple-family group)	Paid Services	14,528	8,217	10,822
	Via Telehealth	0	1,909	3,387
	% via Telehealth	0.0%	23.2%	31.3%
<b>90785</b> Interactive complexity (list separately in addition to the code for primary procedure)	Paid Services	16,729	15,621	20,596
	Via Telehealth	1	3,525	2,790
	% via Telehealth	0.0%	22.6%	13.5%

\*Includes procedure codes with at least 5,000 paid claims and at least 200 paid telemedicine service from 2019 to 2021 identified from long-term care and outpatient claims with revenue codes 914–915 (behavioral health treatment therapies) and professional claims with billing provider type 11 (mental health).

KanCare 2.0 Interim Evaluation  
 Evaluation of the State of Kansas Medicaid Section 1115(a) Demonstration – KanCare 2.0  
 Reporting Period – January 2019 – September 2022  
 Appendix B – Hypothesis 3: The Use of Telehealth Services

<b>Table B11. Percentages of Services by Mental Health Providers Conducted via Telemedicine (Continued)</b>				
<b>Telemedicine Services by Mental Health Providers*</b>				
<b>Procedure Code</b> Procedure Description	Statistic	<b>KanCare 2.0</b>		
		<b>2019</b>	<b>2020</b>	<b>2021</b>
<b>90791</b> Psychiatric diagnostic evaluation	Paid Services	34,402	29,347	34,753
	Via Telehealth	317	8,142	7,789
	% via Telehealth	0.9%	27.7%	22.4%
<b>90792</b> Psychiatric diagnostic evaluation with medical services	Paid Services	7,238	6,872	7,165
	Via Telehealth	1,091	3,288	3,589
	% via Telehealth	15.1%	47.8%	50.1%
<b>97153</b> Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to one patient, each 15 minutes	Paid Services	7,739	17,299	38,367
	Via Telehealth	1	540	459
	% via Telehealth	0.0%	3.1%	1.2%
<b>97155</b> Adaptive behavior treatment with protocol modification administered by qualified health care professional to one patient, each 15 minutes	Paid Services	2,286	6,879	15,265
	Via Telehealth	1	1,261	1,227
	% via Telehealth	0.0%	18.3%	8.0%
<b>97156</b> Family adaptive behavior treatment guidance by qualified health care professional (with or without patient present), each 15 minutes	Paid Services	1,346	2,729	5,635
	Via Telehealth	0	1,103	990
	% via Telehealth	0.0%	40.4%	17.6%
<b>99211</b> Established patient office or other outpatient visit, typically 5 minutes	Paid Services	2,094	1,384	2,133
	Via Telehealth	15	252	546
	% via Telehealth	0.7%	18.2%	25.6%
<b>99213</b> Established patient office or other outpatient visit, typically 15 minutes	Paid Services	41,231	38,625	31,909
	Via Telehealth	5,569	25,564	22,429
	% via Telehealth	13.5%	66.2%	70.3%
<b>99214</b> Established patient office or other outpatient, visit typically 25 minutes	Paid Services	51,182	51,960	63,762
	Via Telehealth	7,662	29,323	36,764
	% via Telehealth	15.0%	56.4%	57.7%
<b>99215</b> Established patient office or other outpatient, visit typically 40 minutes	Paid Services	2,362	1,407	1,872
	Via Telehealth	367	710	698
	% via Telehealth	15.5%	50.5%	37.3%
<b>99366</b> Medical team conference with patient and/or family, and nonphysician health care professionals, 30 minutes or more	Paid Services	6,396	5,914	6,066
	Via Telehealth	47	2,641	2,860
	% via Telehealth	0.7%	44.7%	47.1%
<b>99368</b> Medical team conference with nonphysician health care professionals, 30 minutes or more or more	Paid Services	2,107	3,266	2,518
	Via Telehealth	5	1,410	800
	% via Telehealth	0.2%	43.2%	31.8%
<b>H0001</b> Alcohol and/or drug assessment	Paid Services	4,993	3,858	4,537
	Via Telehealth	59	1,614	1,961
	% via Telehealth	1.2%	41.8%	43.2%
<b>H0004</b> Behavioral health counseling and therapy, per 15 minutes	Paid Services	15,526	20,934	16,128
	Via Telehealth	21	9,030	6,003
	% via Telehealth	0.1%	43.1%	37.2%
<b>H0005</b> Alcohol and/or drug services; group counseling by a clinician	Paid Services	32,369	21,920	24,898
	Via Telehealth	0	7,365	8,849
	% via Telehealth	0.0%	33.6%	35.5%

\*Includes procedure codes with at least 5,000 paid claims and at least 200 paid telemedicine service from 2019 to 2021 identified from long-term care and outpatient claims with revenue codes 914–915 (behavioral health treatment therapies) and professional claims with billing provider type 11 (mental health).

<b>Table B11. Percentages of Services by Mental Health Providers Conducted via Telemedicine (Continued)</b>					
<b>Telemedicine Services by Mental Health Providers*</b>					
Procedure Code	Procedure Description	Statistic	KanCare 2.0		
			2019	2020	2021
<b>H0015</b>	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education	Paid Services	9,652	6,580	8,793
		Via Telehealth	0	1,627	2,547
		% via Telehealth	0.0%	24.7%	29.0%
<b>H0036</b>	Community psychiatric supportive treatment, face-to-face, per 15 minutes	Paid Services	390,369	421,587	410,869
		Via Telehealth	2	130,788	48,431
		% via Telehealth	0.0%	31.0%	11.8%
<b>H0038</b>	Self-help/peer services, per 15 minutes	Paid Services	41,795	47,510	45,589
		Via Telehealth	12	13,108	6,492
		% via Telehealth	0.0%	27.6%	14.2%
<b>H2011</b>	Crisis intervention service, per 15 minutes	Paid Services	37,478	36,028	37,942
		Via Telehealth	1,217	3,535	3,546
		% via Telehealth	3.2%	9.8%	9.3%
<b>H2017</b>	Psychosocial rehabilitation services, per 15 minutes	Paid Services	291,259	195,242	207,063
		Via Telehealth	1	17,254	5,207
		% via Telehealth	0.0%	8.8%	2.5%
<b>H2021</b>	Community-based wrap-around services, per 15 minutes	Paid Services	37,790	38,085	37,119
		Via Telehealth	21	8,826	8,709
		% via Telehealth	0.1%	23.2%	23.5%
<b>S0311</b>	Comprehensive management and care coordination for advanced illness, per calendar month	Paid Services		1,135	3,907
		Via Telehealth		112	509
		% via Telehealth		9.9%	13.0%
<b>S5110</b>	Parent support and training, per 15 minutes, HCBS-SED waiver.	Paid Services	22,501	28,367	25,803
		Via Telehealth	0	11,381	10,150
		% via Telehealth	0.0%	40.1%	39.3%
<b>T1017</b>	Targeted case management, each 15 minutes	Paid Services	172,414	199,322	167,440
		Via Telehealth	7	2,991	1,235
		% via Telehealth	0.0%	1.5%	0.7%
<b>T1019</b>	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)	Paid Services	96,848	94,838	104,752
		Via Telehealth	0	6,160	2,428
		% via Telehealth	0.0%	6.5%	2.3%
<b>T2038</b>	Community transition, waiver; per service	Paid Services	2,229	2,337	2,405
		Via Telehealth	0	488	127
		% via Telehealth	0.0%	20.9%	5.3%

\*Includes procedure codes with at least 5,000 paid claims and at least 200 paid telemedicine service from 2019 to 2021 identified from long-term care and outpatient claims with revenue codes 914–915 (behavioral health treatment therapies) and professional claims with billing provider type 11 (mental health).

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**Individual Psychotherapy Analysis:**

- Measure 4: Number of paid claims with selected procedure codes
- Measure 5: Number of members with selected diagnosis per 1,000 members
- Percentage of KanCare members receiving individual psychotherapy who had an indicating diagnosis
- Percentage of KanCare members with an indicating diagnosis who received individual psychotherapy

Table B12 shows the ratio of members who received individual psychotherapy to the number of KanCare members as a rate “per 1,000 members” for 2018 to 2021. The statewide rate increased from 2018 to 2019 (from 125.1 to 132.3), but statewide rates for 2020 (116.3) and (117.9) were lower than the 2018 level. The pattern was the same for Non-Urban and Urban rates. The pattern relates a decline in prevalence rates for indicating diagnosis and will be discussed further below.

Per 1,000 members, use of individual psychotherapy was greater in the Non-Urban area than the Urban area. From 2018 to 2021, the average difference was 36.6 psychotherapy recipients per 1,000 KanCare members. The difference was lowest in 2020 (35.4 recipients per 1,000 KanCare members).

<b>Table B12. Individual Psychotherapy Recipients Per 1,000 KanCare Members</b>						
Area of Member Residence		Statistic	Pre-KanCare 2.0		KanCare 2.0	
			2018	2019	2020	2021
<b>Non-Urban</b>	KanCare Members		190,429	185,323	205,871	223,064
	With Individual Therapy		27,493	28,146	27,776	30,589
	Rate per 1,000 Members		144.4	151.9	134.9	137.1
<b>Urban</b>	KanCare Members		207,165	202,451	227,803	247,427
	With Individual Therapy		22,241	23,167	22,671	24,886
	Rate per 1,000 Members		107.4	114.4	99.5	100.6
<b>Statewide</b>	KanCare Members		397,594	387,774	433,674	470,491
	With Individual Therapy		49,734	51,313	50,447	55,475
	Rate per 1,000 Members		125.1	132.3	116.3	117.9
Counts of KanCare members was as of December 31 of the measurement year. Individual psychotherapy was identified from paid claims with the following procedure codes: 90832 – Psychotherapy, 30 minutes      90833 – Psychotherapy with an evaluation and management service, 30 minutes 90834 – Psychotherapy, 45 minutes      90836 – Psychotherapy with an evaluation and management service, 45 minutes 90837 – Psychotherapy, 60 minutes      90838 – Psychotherapy with an evaluation and management service, 60 minutes						

Individual psychotherapy is billed using CPT procedure codes (90832 through 90838). Coding depends on the length of the session and whether or not evaluation and management was included. To compare utilization between strata, hours of service was use as the unit of analysis instead of the number of claims. The number of hours was stratified by Non-Urban and Urban areas and sub-stratified by mode of delivery, provider type, and primary diagnosis category (see Table B13). Key observations were made:

- There was a near 50-50 split between Non-Urban and Urban areas; Non-Urban’s share was slightly lower.
- In percentage of hours that were by telemedicine was slightly lower for Non-Urban members (37% for 2020 and 25% for 2021) than for the Urban area (38% for 2020 and 32% for 2021).
- The percentages stratified by provider type and primary diagnosis varied slightly between years but were stable enough for the analysis.
- Although fewer member received individual psychotherapy in 2020 than 2019 or 2021, the number of hours per person receiving psychotherapy was highest in 2021.

<b>Table B13. Hours of Service from Paid Claims for Individual Psychotherapy</b>									
<b>Hours of Individual Psychotherapy from Paid Claims with Procedure Codes 90832–90838</b>									
90832 – Psychotherapy, 30 minutes		90833 – Psychotherapy with an evaluation and management service, 30 minutes							
90834 – Psychotherapy, 45 minutes		90836 – Psychotherapy with an evaluation and management service, 45 minutes							
90837 – Psychotherapy, 60 minutes		90838 – Psychotherapy with an evaluation and management service, 60 minutes							
<b>Area of Member Residence</b>		<b>Pre-KanCare 2.0</b>		<b>KanCare 2.0</b>					
Stratum		<b>2018 N</b>	<b>%</b>	<b>2019 N</b>	<b>%</b>	<b>2020 N</b>	<b>%</b>	<b>2021 N</b>	<b>%</b>
<b>Statewide</b>	Statewide Total (Denominator)	378,550		403,576		426,338		462,297	
	Non-Urban	188,284	49.7%	198,703	49.2%	210,522	49.4%	227,758	49.3%
	Urban	190,266	50.3%	204,873	50.8%	215,816	50.6%	234,539	50.7%
<b>Non-Urban</b>	Non-Urban Total (Denominator)	188,284		198,703		210,522		227,758	
	Mode:								
	Telemedicine	1,360	0.7%	1,479	0.7%	77,352	36.7%	57,559	25.3%
	Non-Telemedicine	186,925	99.3%	197,224	99.3%	133,170	63.3%	170,199	74.7%
	Provider Type:								
	Mental Health	166,691	88.5%	183,419	92.3%	195,296	92.8%	210,102	92.2%
	Physician	13,311	7.1%	5,928	3.0%	4,851	2.3%	4,951	2.2%
	Clinic	4,956	2.6%	4,400	2.2%	7,570	3.6%	10,132	4.4%
	Other Provider Types	3,327	1.8%	4,956	2.5%	2,805	1.3%	2,573	1.1%
	Diagnosis categories:*								
	F40–F48	73,740	39.2%	79,468	40.0%	87,427	41.5%	96,364	42.3%
	F30–F39	59,390	31.5%	62,155	31.3%	67,242	31.9%	74,344	32.6%
	F90–F98	39,757	21.1%	40,386	20.3%	38,004	18.1%	39,139	17.2%
F20–F29	6,665	3.5%	7,679	3.9%	8,065	3.8%	7,983	3.5%	
Other F01–F99	7,677	4.1%	7,807	3.9%	8,506	4.0%	8,834	3.9%	
Other categories	1,055	0.6%	1,209	0.6%	1,277	0.6%	1,095	0.5%	
<b>Urban</b>	Urban Total (Denominator)	190,266		204,873		215,816		234,539	
	Telemedicine	150	0.1%	351	0.2%	82,400	38.2%	74,068	31.6%
	Non-Telemedicine	190,116	99.9%	204,522	99.8%	133,416	61.8%	160,471	68.4%
	Provider Type:								
	Mental Health	157,797	82.9%	190,483	93.0%	202,598	93.9%	218,768	93.3%
	Physician	27,367	14.4%	8,177	4.0%	9,972	4.6%	11,799	5.0%
	Clinic	2,601	1.4%	2,282	1.1%	2,119	1.0%	2,599	1.1%
	Other Provider Types	2,501	1.3%	3,930	1.9%	1,127	0.5%	1,373	0.6%
	Diagnosis categories:								
	F40–F48	89,041	46.8%	100,028	48.8%	110,893	51.4%	122,768	52.3%
	F30–F39	54,900	28.9%	56,497	27.6%	57,164	26.5%	64,009	27.3%
	F90–F98	31,444	16.5%	32,537	15.9%	30,038	13.9%	29,249	12.5%
	F20–F29	5,270	2.8%	5,481	2.7%	5,837	2.7%	6,557	2.8%
Other F01–F99	8,550	4.5%	9,374	4.6%	10,840	5.0%	10,960	4.7%	
Other categories	1,063	0.6%	955	0.5%	1,045	0.5%	997	0.4%	
<b>Hours of Individual Psychotherapy per Member Receiving Individual Psychotherapy</b>									
<b>Area of Member Residence</b>		<b>Pre-KanCare 2.0</b>		<b>KanCare 2.0</b>					
Stratum		<b>2018</b>		<b>2019</b>		<b>2020</b>		<b>2021</b>	
<b>Non-Urban</b>	Hours	188,284		198,703		210,521		227,758	
	Members	27,493		28,146		27,776		30,589	
	<b>Hours per Member</b>	<b>6.8</b>		<b>7.1</b>		<b>7.6</b>		<b>7.4</b>	
<b>Urban</b>	Hours	190,266		204,873		215,816		234,539	
	Members	22,241		23,167		22,671		24,886	
	<b>Hours per Member</b>	<b>8.6</b>		<b>8.8</b>		<b>9.5</b>		<b>9.4</b>	
*Stratified by category of primary diagnosis: F01–F99 – Mental, behavioral, and neurodevelopmental disorders F20–F29 – Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders F30–F39 – Mood [affective] disorders F40–F48 – Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders F90–F98 – Behavioral and emotional disorders with onset usually occurring in childhood and adolescence									

In the next stage of analysis, six diagnosis categories were chosen as the indicating diagnosis for the individual psychotherapy measures:

- F34 – Persistent mood [affective] disorders
- F40 – Phobic anxiety disorders
- F43 – Reaction to severe stress, and adjustment disorders
- F60 – Specific personality disorders
- F91 – Conduct disorders
- F93 – Emotional disorders with onset specific to childhood

These six were among the highest ranked categories when ranked by the measure “percentage of claims having a primary or secondary diagnosis in the given category that billed for an individual psychotherapy session.” About two-thirds of claims for individual psychotherapy contain one or more diagnosis in the six categories (see Table B14).

The prevalence rates, members with an indicating diagnosis per 1,000 KanCare members, were greater in the Non-Urban area than in the Urban area (e.g., 142.8 to 128.2 for 2020). These differences correspond to the Non-Urban area having higher rates of members receiving individual psychotherapy (see Table B12).

The trend in the rates of members with indicating diagnosis per 1,000 KanCare members from 2018 to 2021 follows a similar trend seen in the rates of members who received individual psychotherapy per 1,000 KanCare members—rates increased from 2018 to 2019, decreased in 2020, and increased again in 2021 but remained below the 2018 level. There are at least three likely factors.

- During the COVID-19 public health emergency, the State suspended disenrollment of members from KanCare under most circumstances. For example, KanCare members covered under the CHIP program were not disenrolled when they turned 18, and women with coverage due to pregnancy were not disenrolled 60 days after delivery.
- Reduced access to diagnostic evaluations and treatments while stay at home orders were in effect may have led to fewer members receiving the indicating diagnoses.
- Members mental health may have improved, thus decreasing the need for psychotherapy; however, this seems unlikely during the pandemic.

The percentage of KanCare members with an indicating diagnosis who received individual psychotherapy slightly increased from 2018 to 2019 but declined for 2020 and 2021. The declines were greater in the Non-Urban area than the Urban area. These results do not support an affirmative response to the study question, “Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?” This conclusion does mean telemedicine was not integral for member accessing care; telemedicine was just not able to override the barriers presented by the pandemic.

<b>Table B14. Prevalence Rates from Paid Claims – Individual Psychotherapy</b>						
<b>Members with Indicating Diagnosis per 1,000 KanCare Members*</b>						
<b>Area of Member Residence</b>		<b>Statistic</b>	<b>Pre-KanCare 2.0</b>	<b>KanCare 2.0</b>		
			<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
<b>Non-Urban</b>	KanCare Members		190,429	185,323	205,871	223,064
	With Indicating Diagnosis		25,673	26,467	25,933	28,803
	Rate per 1,000 Members		134.8	142.8	126.0	129.1
<b>Urban</b>	KanCare Members		207,165	202,451	227,803	247,427
	With Indicating Diagnosis		24,762	25,951	24,999	28,358
	Rate per 1,000 Members		119.5	128.2	109.7	114.6
<b>Statewide</b>	KanCare Members		397,594	387,774	433,674	470,491
	With Indicating Diagnosis		50,435	52,418	50,932	57,161
	Rate per 1,000 Members		126.9	135.2	117.4	121.5
<b>Percentage of KanCare Members Receiving Individual Psychotherapy Who Had an Indicating Diagnosis<sup>^</sup></b>						
<b>Area of Member Residence</b>		<b>Statistic</b>	<b>Pre-KanCare 2.0</b>	<b>KanCare 2.0</b>		
			<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
<b>Non-Urban</b>	Members in Psychotherapy		27,493	28,146	27,776	30,589
	With Indicating Diagnosis		17,196	17,880	17,338	18,872
	Percent		62.5%	63.5%	62.4%	61.7%
<b>Urban</b>	Members in Psychotherapy		22,241	23,167	22,671	24,886
	With Indicating Diagnosis		14,853	15,651	15,069	16,682
	Percent		66.8%	67.6%	66.5%	67.0%
<b>Statewide</b>	Members in Psychotherapy		49,734	51,313	50,447	55,475
	With Indicating Diagnosis		32,049	33,531	32,407	35,554
	Percent		64.4%	65.3%	64.2%	64.1%
<b>Percentage of KanCare Members with an Indicating Diagnosis Who Received Individual Psychotherapy</b>						
<b>Area of Member Residence</b>		<b>Statistic</b>	<b>Pre-KanCare 2.0</b>	<b>KanCare 2.0</b>		
			<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
<b>Non-Urban</b>	Members Indicated		25,673	26,467	25,933	28,803
	With Psychotherapy		17,196	17,880	17,338	18,872
	Percent		67.0%	67.6%	66.9%	65.5%
<b>Urban</b>	Members Indicated		24,762	25,951	24,999	28,358
	With Psychotherapy		14,853	15,651	15,069	16,682
	Percent		60.0%	60.3%	60.3%	58.8%
<b>Statewide</b>	Members Indicated		50,435	52,418	50,932	57,161
	With Psychotherapy		32,049	33,531	32,407	35,554
	Percent		63.5%	64.0%	63.6%	62.2%

\*Counts of KanCare members was as of December 31 of the measurement year.  
 Primary and secondary diagnosis in the following categories were designated as indicating individual psychotherapy:  
 F34 – Persistent mood [affective] disorders    F40 – Phobic anxiety disorders    F43 – Reaction to severe stress, and adjustment disorders  
 F60 – Specific personality disorders    F91 – Conduct disorders    F93 – Emotional disorders with onset specific to childhood  
<sup>^</sup>Individual psychotherapy was identified from paid claims with the following procedure codes:  
 90832 – Psychotherapy, 30 minutes    90833 – Psychotherapy with an evaluation and management service, 30 minutes  
 90834 – Psychotherapy, 45 minutes    90836 – Psychotherapy with an evaluation and management service, 45 minutes  
 90837 – Psychotherapy, 60 minutes    90838 – Psychotherapy with an evaluation and management service, 60 minutes

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**Family and Group Psychotherapy Analysis:**

- *Measure 4: Number of paid claims with selected procedure codes*
- *Measure 5: Number of members with selected diagnosis per 1,000 members*
- *Percentage of KanCare members receiving family or group psychotherapy who had an indicating diagnosis*
- *Percentage of KanCare members with an indicating diagnosis who received family or group psychotherapy*

Table B15 shows the ratio of members who received family or group psychotherapy to the number of KanCare members as a rate “per 1,000 members” for 2018 to 2021. The statewide rate decreased each year from 2018 to 2021 (from 36.0 to 34.3, to 25.3, to 22.0).

Per 1,000 members, use of group and family psychotherapy was greater in the Non-Urban area than the Urban area. From 2018 to 2021, the average difference was 4.2 recipients per 1,000 KanCare members. The difference was greatest in 2020 (4.5 recipients per 1,000 KanCare members).

<b>Table B15. Family and Group Psychotherapy Recipients Per 1,000 KanCare Members</b>						
<b>Area of Member Residence</b>		<b>Statistic</b>	<b>Pre-KanCare 2.0</b>		<b>KanCare 2.0</b>	
			<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
<b>Non-Urban</b>	KanCare Members		190,429	185,323	205,871	223,064
	With Individual Therapy		7,213	6,776	5,689	5,381
	Rate per 1,000 Members		37.9	36.6	27.6	24.1
<b>Urban</b>	KanCare Members		207,165	202,451	227,803	247,427
	With Individual Therapy		7,081	6,528	5,266	4,966
	Rate per 1,000 Members		34.2	32.2	23.1	20.1
<b>Statewide</b>	KanCare Members		397,594	387,774	433,674	470,491
	With Individual Therapy		14,294	13,304	10,955	10,347
	Rate per 1,000 Members		36.0	34.3	25.3	22.0

Counts of KanCare members was as of December 31 of the measurement year.  
 Individual psychotherapy was identified from paid claims with the following procedure codes:  
 90847 – Family psychotherapy including patient, 50 minutes  
 90853 – Group psychotherapy (other than of a multiple-family group), per day (50 minutes assumed for analysis)

For comparisons to individual psychotherapy, rates were also calculated using hours of service as the unit of analysis instead of the number of claims. The number of hours was stratified by Non-Urban and Urban area and sub-stratified by mode of delivery, provider type, and primary diagnosis category (see Table B16). Key observations were made:

- There was a near 50-50 split between Non-Urban and Urban areas Non-Urban’s share slightly lower.
- In percentage of hours that were by telemedicine was lower for Non-Urban members (28% for 2020 and 18% for 2021) than for the Urban area (36% for 2020 and 32% for 2021).
- The Non-Urban area’s use of telemedicine declined faster from 2020 to 2021 (10 percentage points) than the Urban area’s did (4 percentage points).
- About 80% of family and group psychotherapy was provided by mental health providers and about 15% by “other providers” in the Non-Urban area from 2019 to 2021. In contrast, the Urban area’s percentages were about 93% and 1%, respectively.
- Primary diagnoses varied between the two areas, but the difference was not a concern for the analysis.

<b>Table B16. Hours of Service from Paid Claims for Family and Group Psychotherapy</b>									
<b>Hours of Individual Psychotherapy from Paid Claims with Procedure Code 90847 or 90853</b>									
90847 – Family psychotherapy including patient, 50 minutes									
90853 – Group psychotherapy (other than of a multiple-family group), per day (50 minutes assumed for analysis)									
Area of Member Residence		Pre-KanCare 2.0		KanCare 2.0					
		2018 N	%	2019 N	%	2020 N	%	2021 N	%
<b>Statewide</b>	Statewide Total (Denominator)	62,259		55,916		43,011		41,819	
	Non-Urban	29,256	47.0%	27,809	49.7%	21,145	49.2%	20,571	49.2%
	Urban	33,003	53.0%	28,107	50.3%	21,866	50.8%	21,248	50.8%
<b>Non-Urban</b>	Non-Urban Total (Denominator)	29,256		27,809		21,145		20,571	
	Mode:								
	Telemedicine	67	0.2%	38	0.1%	5,935	28.1%	3,662	17.8%
	Non-Telemedicine	29,189	99.8%	27,771	99.9%	15,210	71.9%	16,909	82.2%
	Provider Type:								
	Mental Health	24,124	82.5%	22,981	82.6%	17,359	82.1%	16,341	79.4%
	Physician	3,079	10.5%	521	1.9%	354	1.7%	433	2.1%
	Clinic	242	0.8%	232	0.8%	413	2.0%	337	1.6%
	Other Provider Types	1,811	6.2%	4,075	14.7%	3,019	14.3%	3,460	16.8%
	Diagnosis categories:*								
	F40–F48	9,694	33.1%	8,794	31.6%	7,058	33.4%	6,886	33.5%
	F30–F39	7,582	25.9%	8,654	31.1%	6,393	30.2%	6,838	33.2%
	F90–F98	9,631	32.9%	8,167	29.4%	6,268	29.6%	5,395	26.2%
F20–F29	764	2.6%	953	3.4%	421	2.0%	221	1.1%	
Other F01–F99	1,404	4.8%	1,091	3.9%	854	4.0%	1,109	5.4%	
Other categories	183	0.6%	151	0.5%	151	0.7%	123	0.6%	
<b>Urban</b>	Urban Total (Denominator)	33,003		28,107		21,866		21,248	
	Telemedicine	12	0.0%	29	0.1%	7,883	36.1%	6,877	32.4%
	Non-Telemedicine	32,991	100%	28,078	99.9%	13,983	63.9%	14,371	67.6%
	Provider Type:								
	Mental Health	26,217	79.4%	26,289	93.5%	20,386	93.2%	19,365	91.1%
	Physician	5,350	16.2%	1,282	4.6%	1,272	5.8%	1,613	7.6%
	Clinic	154	0.5%	145	0.5%	42	0.2%	9	0.0%
	Other Provider Types	1,282	3.9%	391	1.4%	166	0.8%	261	1.2%
	Diagnosis categories:								
	F40–F48	12,832	38.9%	11,749	41.8%	8,866	40.5%	8,852	41.7%
	F90–F98	8,837	26.8%	6,952	24.7%	5,801	26.5%	4,968	23.4%
	F30–F39	7,943	24.1%	6,821	24.3%	4,985	22.8%	4,923	23.2%
	F20–F29	607	1.8%	350	1.2%	392	1.8%	587	2.8%
Other F01–F99	2,520	7.6%	1,983	7.1%	1,614	7.4%	1,776	8.4%	
Other categories	265	0.8%	252	0.9%	208	1.0%	141	0.7%	
<b>Hours of Group and Family Psychotherapy per Member Receiving Group or Family Psychotherapy</b>									
Area of Member Residence		Pre-KanCare 2.0		KanCare 2.0					
		2018	2019	2020	2021				
<b>Non-Urban</b>	Hours	29,257	27,809	21,145	20,571				
	Members	7,213	6,776	5,689	5,381				
	<b>Hours per Member</b>	<b>4.1</b>	<b>4.1</b>	<b>3.7</b>	<b>3.8</b>				
<b>Urban</b>	Hours	33,003	28,107	21,866	21,247				
	Members	7,081	6,528	5,266	4,966				
	<b>Hours per Member</b>	<b>4.7</b>	<b>4.3</b>	<b>4.2</b>	<b>4.3</b>				
*Stratified by category of primary diagnosis:									
F01–F99 – Mental, behavioral, and neurodevelopmental disorders									
F20–F29 – Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders									
F30–F39 – Mood [affective] disorders									
F40–F48 – Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders									
F90–F98 – Behavioral and emotional disorders with onset usually occurring in childhood and adolescence									

Five diagnosis categories were chosen as the indicating diagnosis for the family and group psychotherapy measures:

- F34 – Persistent mood [affective] disorders
- F91 – Conduct disorders
- F93 – Emotional disorders with onset specific to childhood
- T74 – Adult and child abuse, neglect, and other maltreatment, confirmed
- T76 – Adult and child abuse, neglect, and other maltreatment, suspected

The categories chosen were among the highest ranked categories when ranked by the measure “percentage of claims having a primary or secondary diagnosis in the given category that billed for a family or group session.” About two-fifths of claims for family and group psychotherapy contained one or more diagnosis in the five categories (see Table B17).

The prevalence rates, members with an indicating diagnosis per 1,000 KanCare members, were considerably greater in the Non-Urban area than in the Urban area (e.g., 55.7 to 39.5 for 2020). These differences correspond to the Non-Urban area having higher rates of members receiving individual psychotherapy (see Table B15), but the difference is much wider.

The general trend in the rates of members with indicating diagnosis per 1,000 KanCare members from 2018 to 2021 follows a similar trend seen in the rates of members who received family or group psychotherapy per 1,000 KanCare—rates were stable from 2018 to 2019, decreased in 2020, and decreased again in 2021. The same factors listed for individual psychotherapy may have contributed to the rate declines.

- During the COVID-19 public health emergency, the State suspended disenrollment under most circumstances. For example, KanCare members covered under the CHIP program were not disenrolled when they turned 18, and women with coverage due to pregnancy were not disenrolled 60 days after delivery.
- Reduced access to diagnostic evaluations and treatments while stay at home orders were in effect may have led to fewer members receiving the indicating diagnoses.
- Members mental health may have improved, thus decreasing the need for psychotherapy; however, this seems unlikely during the pandemic.

Percentages of KanCare members with an indicating diagnosis who received individual psychotherapy slightly decreased each year, from 27% in 2018 to 19% in 2021 for the Non-Urban area and from 29% for 2018 to 21% for 2021 for the Urban area. These results do not support an affirmative response to the study question, “Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?” This conclusion does mean telemedicine was not integral for member accessing care; telemedicine was just not able to override the barriers presented by the pandemic.

<b>Table B17. Prevalence Rates from Paid Claims for Family and Group Psychotherapy</b>						
<b>Members with Indicating Diagnosis per 1,000 KanCare Members*</b>						
<b>Area of Member Residence</b>		<b>Statistic</b>	<b>Pre-KanCare 2.0</b>	<b>KanCare 2.0</b>		
			<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
<b>Non-Urban</b>	KanCare Members		190,429	185,323	205,871	223,064
	With Indicating Diagnosis		12,504	12,449	11,477	11,977
	Rate per 1,000 Members		<b>65.7</b>	<b>67.2</b>	<b>55.7</b>	<b>53.7</b>
<b>Urban</b>	KanCare Members		207,165	202,451	227,803	247,427
	With Indicating Diagnosis		10,458	10,054	9,003	9,185
	Rate per 1,000 Members		<b>50.5</b>	<b>49.7</b>	<b>39.5</b>	<b>37.1</b>
<b>Statewide</b>	KanCare Members		397,594	387,774	433,674	470,491
	With Indicating Diagnosis		22,962	22,503	20,480	21,162
	Rate per 1,000 Members		<b>57.8</b>	<b>58.0</b>	<b>47.2</b>	<b>45.0</b>
<b>Percentage of KanCare Members Receiving Family or Group Psychotherapy Who Had an Indicating Diagnosis<sup>^</sup></b>						
<b>Area of Member Residence</b>		<b>Statistic</b>	<b>Pre-KanCare 2.0</b>	<b>KanCare 2.0</b>		
			<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
<b>Non-Urban</b>	Members in Psychotherapy		7,213	6,776	5,689	5,381
	With Indicating Diagnosis		3,373	3,164	2,457	2,272
	Percent		<b>46.8%</b>	<b>46.7%</b>	<b>43.2%</b>	<b>42.2%</b>
<b>Urban</b>	Members in Psychotherapy		7,081	6,528	5,266	4,966
	With Indicating Diagnosis		3,039	2,710	2,169	1,914
	Percent		<b>42.9%</b>	<b>41.5%</b>	<b>41.2%</b>	<b>38.5%</b>
<b>Statewide</b>	Members in Psychotherapy		14,294	13,304	10,955	10,347
	With Indicating Diagnosis		6,412	5,874	4,626	4,186
	Percent		<b>44.9%</b>	<b>44.2%</b>	<b>42.2%</b>	<b>40.5%</b>
<b>Percentage of KanCare Members with Indicating Diagnosis Who Received Family or Group Psychotherapy</b>						
<b>Area of Member Residence</b>		<b>Statistic</b>	<b>Pre-KanCare 2.0</b>	<b>KanCare 2.0</b>		
			<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
<b>Non-Urban</b>	Members Indicated		12,504	12,449	11,477	11,977
	With Psychotherapy		3,373	3,164	2,457	2,272
	Percent		<b>27.0%</b>	<b>25.4%</b>	<b>21.4%</b>	<b>19.0%</b>
<b>Urban</b>	Members Indicated		10,458	10,054	9,003	9,185
	With Psychotherapy		3,039	2,710	2,169	1,914
	Percent		<b>29.1%</b>	<b>27.0%</b>	<b>24.1%</b>	<b>20.8%</b>
<b>Statewide</b>	Members Indicated		22,962	22,503	20,480	21,162
	With Psychotherapy		6,412	5,874	4,626	4,186
	Percent		<b>27.9%</b>	<b>26.1%</b>	<b>22.6%</b>	<b>19.8%</b>

\*Counts of KanCare members was as of December 31 of the measurement year.  
 Primary and secondary diagnosis in the following categories were designated as indicating family or group psychotherapy:  
 F34 – Persistent mood [affective] disorders  
 F91 – Conduct disorders  
 F93 – Emotional disorders with onset specific to childhood  
 T74, T76 – Adult and child abuse, neglect, and other maltreatment; confirmed (T74) or suspected (T76)  
<sup>^</sup>Family and group psychotherapies were identified from paid claims with the following procedure codes:  
 90847 – Family psychotherapy including patient, 50 minutes  
 90853 – Group psychotherapy (other than of a multiple-family group), per day (50 minutes assumed for analysis)

**Community Psychiatric Supportive Treatment Analysis:**

- Measure 4: Number of paid claims with selected procedure codes
- Measure 5: Number of members with selected diagnosis per 1,000 members
- Percentage of KanCare members receiving community psychiatric supportive treatment who had an indicating diagnosis
- Percentage of KanCare members with an indicating diagnosis who received community psychiatric supportive treatment

Table B18 shows the ratio of members who received community psychiatric supportive treatment to the number of KanCare members as a rate “per 1,000 members” for 2018 to 2021. The statewide rate (47.8 in 2018) increased in 2019 (49.5) but decreased in both 2020 (42.3) and 2021 (40.9). Rates for the Non-Urban and Urban areas did likewise.

Per 1,000 member months, use of group and family psychotherapy was greater in the Non-Urban area than the Urban area. From 2018 to 2021 the difference increased each year (from 17.5 to 20.6 recipients per 1,000 KanCare members).

<b>Table B18. Community Psychiatric Supportive Treatment Recipients Per 1,000 KanCare Members</b>					
Area of Member Residence		Pre-KanCare 2.0	KanCare 2.0		
Statistic		2018	2019	2020	2021
<b>Non-Urban</b>	KanCare Members	190,429	185,323	205,871	223,064
	With Individual Therapy	10,844	11,010	10,835	11,542
	Rate per 1,000 Members	56.9	59.4	52.6	51.7
<b>Urban</b>	KanCare Members	207,165	202,451	227,803	247,427
	With Individual Therapy	8,164	8,169	7,522	7,694
	Rate per 1,000 Members	39.4	40.4	33.0	31.1
<b>Statewide</b>	KanCare Members	397,594	387,774	433,674	470,491
	With Individual Therapy	19,008	19,179	18,357	19,236
	Rate per 1,000 Members	47.8	49.5	42.3	40.9

Counts of KanCare members was as of December 31 of the measurement year.  
 Family and group psychotherapies were identified from paid claims with the following procedure codes:  
 H0036 – Community psychiatric supportive treatment, face-to-face, per 15 minutes

For comparisons to individual psychotherapy, rates were also calculated using hours of service as the unit of analysis instead of the number of claims. The number of hours was stratified by Non-Urban and Urban area and sub-stratified by mode of delivery, provider type, and primary diagnosis category (see Table B19). Key observations were made:

- There was roughly a 60 to 40 ratio of total hours of treatment between Non-Urban and Urban areas. The difference widened each year. The difference in hours of treatment per recipient also widened.
- The service was not approved for telehealth by KDHE until the public health emergency. In the Non-Urban area, the percent by telemedicine was 18.5% in 2020 but only 5.0% in 2021; the percentages for the Urban area were greater and had a smaller relative decrease (25.1% in 2020 and 12.1% in 2021).
- At least 99% of the hours of treatment were provided by mental health providers.
- Primary diagnoses varied between the two areas, but the difference was not a concern for the analysis.

<b>Table B19. Hours of Service from Paid Claims for Community Psychiatric Supportive Treatment</b>									
<b>Hours of Community Psychiatric Supportive Treatment from Paid Claims with Procedure Code H0036</b>									
H0036 – Community psychiatric supportive treatment, face-to-face, per 15 minutes									
Area of Member Residence		Pre-KanCare 2.0		KanCare 2.0					
		2018	%	2019	%	2020	%	2021	%
<b>Statewide</b>	Statewide Total (Denominator)	478,809		479,154		432,214		469,358	
	Non-Urban	280,224	58.5%	285,832	59.7%	270,562	62.6%	299,001	63.7%
	Urban	198,585	41.5%	193,322	40.3%	161,652	37.4%	170,357	36.3%
<b>Non-Urban</b>	Non-Urban Total (Denominator)	280,224		285,832		270,562		299,001	
	Mode:								
	Telemedicine	0	0.0%	3	0.0%	50,178	18.5%	15,061	5.0%
	Non-Telemedicine	280,224	100%	285,829	100%	220,384	81.5%	283,940	95.0%
	Provider Type:								
	Mental Health	279,034	99.6%	285,171	99.8%	270,556	100%	298,997	100%
	Other Provider Types	1,190	0.4%	661	0.2%	6	0.0%	4	0.0%
	Diagnosis categories:*								
	F90–F98	104,652	37.3%	106,127	37.1%	94,759	35.0%	104,493	34.9%
	F30–F39	88,873	31.7%	90,775	31.8%	85,554	31.6%	93,617	31.3%
F40–F48	46,633	16.6%	49,354	17.3%	52,380	19.4%	61,738	20.6%	
F20–F29	31,607	11.3%	31,565	11.0%	29,711	11.0%	31,115	10.4%	
Other F01–F99	7,996	2.9%	7,616	2.7%	7,372	2.7%	7,599	2.5%	
Other categories	466	0.2%	396	0.1%	787	0.3%	440	0.1%	
<b>Urban</b>	Urban Total (Denominator)	198,585		193,322		161,652		170,357	
	Telemedicine	0	0.0%	0	0.0%	40,506	25.1%	20,586	12.1%
	Non-Telemedicine	198,585	100%	193,322	100%	121,146	74.9%	149,771	87.9%
	Provider Type:								
	Mental Health	195,692	98.5%	193,287	100%	161,634	100%	170,357	100%
	Other Provider Types	2,893	1.0%	35	0.0%	17	0.0%	0	0%
	F30–F39	71,299	35.9%	66,813	34.6%	59,093	36.6%	63,919	37.5%
	F90–F98	48,158	24.3%	48,473	25.1%	38,501	23.8%	38,381	22.5%
	F20–F29	44,693	22.5%	40,513	21.0%	33,242	20.6%	34,354	20.2%
	F40–F48	30,107	15.2%	33,675	17.4%	27,517	17.0%	29,472	17.3%
Other F01–F99	3,995	2.0%	3,620	1.9%	3,166	2.0%	4,143	2.4%	
Other categories	333	0.2%	228	0.1%	132	0.1%	88	0.1%	
<b>Hours of Treatment per Member Receiving Community Psychiatric Supportive Treatment</b>									
Area of Member Residence		Pre-KanCare 2.0		KanCare 2.0					
		2018	2019	2020	2021				
<b>Non-Urban</b>	Hours	280,224	285,832	270,562	299,001				
	Members	10,844	11,010	10,835	11,542				
	<b>Hours per Member</b>	<b>25.8</b>	<b>26.0</b>	<b>25.0</b>	<b>25.9</b>				
<b>Urban</b>	Hours	198,585	193,322	161,651	170,357				
	Members	8,164	8,169	7,522	7,694				
	<b>Hours per Member</b>	<b>24.3</b>	<b>23.7</b>	<b>21.5</b>	<b>22.1</b>				
*Stratified by category of primary diagnosis: F01–F99 – Mental, behavioral, and neurodevelopmental disorders F20–F29 – Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders F30–F39 – Mood [affective] disorders F40–F48 – Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders F90–F98 – Behavioral and emotional disorders with onset usually occurring in childhood and adolescence									

Five diagnosis categories were chosen as the indicating diagnosis for the community psychiatric supportive treatment measures:

- F20 – Schizophrenia
- F25 – Schizoaffective disorders
- F34 – Persistent mood [affective] disorders
- F60 – Specific personality disorders
- F91 – Conduct disorders

The categories chosen were among the highest ranked categories when ranked by the measure “percentage of claims for community psychiatric supportive treatment having a primary or secondary diagnosis in a given category.” About three-fifths of claims for community psychiatric supportive treatment contained one or more diagnosis in the five categories (see Table B20).

<b>Table B20. Prevalence Rates from Paid Claims for Community Psychiatric Supportive Treatment</b>					
<b>Members with Indicating Diagnosis per 1,000 KanCare Members*</b>					
<b>Area of Member Residence</b>		<b>Pre-KanCare 2.0</b>	<b>KanCare 2.0</b>		
Statistic		<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
<b>Non-Urban</b>	KanCare Members	190,429	185,323	205,871	223,064
	With Indicating Diagnosis	15,847	15,853	14,961	15,570
	Rate per 1,000 Members	<b>83.2</b>	<b>85.5</b>	<b>72.7</b>	<b>69.8</b>
<b>Urban</b>	KanCare Members	207,165	202,451	227,803	247,427
	With Indicating Diagnosis	14,503	14,382	13,422	13,920
	Rate per 1,000 Members	<b>70.0</b>	<b>71.0</b>	<b>58.9</b>	<b>56.3</b>
<b>Statewide</b>	KanCare Members	397,594	387,774	433,674	470,491
	With Indicating Diagnosis	30,350	30,235	28,383	29,490
	Rate per 1,000 Members	<b>76.3</b>	<b>78.0</b>	<b>65.4</b>	<b>62.7</b>
<b>Percentage of KanCare Members Receiving H0036 Treatment Who Had an Indicating Diagnosis<sup>^</sup></b>					
<b>Area of Member Residence</b>		<b>Pre-KanCare 2.0</b>	<b>KanCare 2.0</b>		
Statistic		<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
<b>Non-Urban</b>	Members in Psychotherapy	10,844	11,010	10,835	11,542
	With Indicating Diagnosis	6,205	6,249	5,767	5,848
	Percent	<b>57.2%</b>	<b>56.8%</b>	<b>53.2%</b>	<b>50.7%</b>
<b>Urban</b>	Members in Psychotherapy	8,164	8,169	7,522	7,694
	With Indicating Diagnosis	4,906	4,842	4,482	4,495
	Percent	<b>60.1%</b>	<b>59.3%</b>	<b>59.6%</b>	<b>58.4%</b>
<b>Statewide</b>	Members in Psychotherapy	19,008	19,179	18,357	19,236
	With Indicating Diagnosis	11,111	11,091	10,249	10,343
	Percent	<b>58.5%</b>	<b>57.8%</b>	<b>55.8%</b>	<b>53.8%</b>
<b>Percentage of KanCare Members with Indicating Diagnosis Who Received H0036 Treatment</b>					
<b>Area of Member Residence</b>		<b>Pre-KanCare 2.0</b>	<b>KanCare 2.0</b>		
Statistic		<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
<b>Non-Urban</b>	Members Indicated	15,847	15,853	14,961	15,570
	With Psychotherapy	6,205	6,249	5,767	5,848
	Percent	<b>39.2%</b>	<b>39.4%</b>	<b>38.5%</b>	<b>37.6%</b>
<b>Urban</b>	Members Indicated	14,503	14,382	13,422	13,920
	With Psychotherapy	4,906	4,842	4,482	4,495
	Percent	<b>33.8%</b>	<b>33.7%</b>	<b>33.4%</b>	<b>32.3%</b>
<b>Statewide</b>	Members Indicated	30,350	30,235	28,383	29,490
	With Psychotherapy	11,111	11,091	10,249	10,343
	Percent	<b>36.6%</b>	<b>36.7%</b>	<b>36.1%</b>	<b>35.1%</b>

\*Counts of KanCare members was as of December 31 of the measurement year.  
 Primary and secondary diagnosis in the following categories were designated as indicating community psychiatric supportive treatment:  
 F20 – Schizophrenia                      F25 – Schizoaffective disorders                      F34 – Persistent mood [affective] disorders  
 F60 – Specific personality disorders                      F91 – Conduct disorders

<sup>^</sup>Family and group psychotherapies were identified from paid claims with the following procedure codes:  
 H0036 – Community psychiatric supportive treatment, face-to-face, per 15 minutes

The prevalence rates, members with an indicating diagnosis per 1,000 KanCare members, were greater in the Non-Urban area than in the Urban area (e.g., 72.7 and to 58.9 in 2020). The prevalence rates were also greater in the Non-Urban area than the Urban are for individual psychotherapy and family and group psychotherapy (see Tables B14 and B17).

The general trend in the rates of members with indicating diagnosis per 1,000 KanCare members from 2018 to 2021 follows a similar trend seen in the rates for two types of psychotherapy—rates were stable from 2018 to 2019, decreased in 2020, and decreased again in 2021. The same factors listed for individual psychotherapy may have contributed to the rate declines.

- During the COVID-19 public health emergency, the State suspended disenrollment under most circumstances. For example, KanCare members covered under the CHIP program were not disenrolled when they turned 18, and women with coverage due to pregnancy were not disenrolled 60 days after delivery.
- Reduced access to diagnostic evaluations and treatments while stay at home orders were in effect may have led to fewer members receiving the indicating diagnoses.
- Members mental health may have improved, thus decreasing the need for treatment; however, this seems unlikely during the pandemic.

The percentages of KanCare members with an indicating diagnosis who received individual psychotherapy were about the same in 2018 and 2019 (36.6% and 36.7%, respectively), but in the last two years, to 36.1% in 2020 and 35.1% in 2021. The pattern was the same for both areas. These results do not support an affirmative response to the study question, “Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?” This conclusion does mean telemedicine was not integral for member accessing care; telemedicine was just not able to override the barriers presented by the pandemic.

### Results for the Evaluation of Use of Telemonitoring Services

The State has defined telemonitoring as “Technologies that target specific disease type (i.e., congestive heart failure) or high utilizers of health services, particularly ER services and medication regimen management. Technologies are available that measure health indicators of patients in their homes and transmit the data to an overseeing Provider. The provider, who might be a physician, nurse, social worker, or even a non-clinical staff member, can filter patient questions and report to a clinical team as necessary. The goal would be to reduce admission, ER utilization and improve overall health of the member.”

The following evaluation question related to the use of telemonitoring services was examined in the interim evaluation:

- Did use of telemonitoring services increase over the five-year period for KanCare members with chronic conditions living in rural or semi-urban areas?

Three outcome measures were assessed to evaluate the above-mentioned question:

1. Percentage of members living in the rural and semi-urban areas who received telemonitoring services.
2. Number of telemonitoring services provided to members living in the rural and semi-urban areas.
3. Number of providers monitoring health indicator data transmitted to them by members receiving telemonitoring services.

The evaluation measures focused on the use of telehealth services among KanCare members living in rural or semi-urban areas, therefore, data were examined in two geographic areas, Urban and Non-Urban, based on county population density. Non-Urban area included all counties except Urban counties. Urban area is defined Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte counties.

The encounter, demographics, eligibility, and enrollment records from the State’s Medicaid Management Information System (MMIS) reporting warehouse were used for the analyses of KanCare 2.0 data from January 2019 through December 2021, and pre-KanCare 2.0 data for 2018. Table B21 displays results for the three telemonitoring measures.

<b>Table B21. Use of Telemonitoring Services</b>					
<b>Measure 1: Percentage of members living in rural or semi-urban areas (Non-Urban) who received telemonitoring services.</b>					
Area of Member Residence		Statistic	KanCare 2.0		
			2019	2020	2021
Non-Urban	Members (denominator)		176,020	188,599	206,837
	Members Receiving Telemonitoring		*	15	42
	Percent			0.01%	0.02%
Urban	Members (denominator)		188,146	204,013	226,764
	Members Receiving Telemonitoring		*	29	98
	Percent			0.01%	0.04%
<b>Measure 2: Number of telemonitoring services provided to members living in rural and semi-urban (Non-Urban) areas.</b>					
Area of Member Residence		Statistic	KanCare 2.0		
			2019	2020	2021
Non-Urban	Telemonitoring Services		*	84	132
Urban	Telemonitoring Services		*	90	738
Statewide	Telemonitoring Services		*	174	870
<b>Measure 3: Number of providers monitoring health indicator data transmitted to them by members receiving telemonitoring services.</b>					
Area of Provider Location		Statistic	KanCare 2.0		
			2019	2020	2021
Non-Urban	Billing Providers			3	6
	Performing Providers			5	9
Urban	Billing Providers			6	15
	Performing Providers			13	31
Statewide	Billing Providers			9	21
	Performing Providers			18	40
<b>Interpretation/Comments:</b>					
<ul style="list-style-type: none"> <li>• Telemonitoring of KanCare members’ health indicator data kicked off with the onset of the COVID-19 pandemic in 2020.</li> <li>• The percentages of Non-Urban and Urban members who received telemonitoring services increased from 2019 to 2020 and 2021. A statistically significant increase for Non-Urban and Urban members was seen in 2021 from 2020.</li> <li>• In 2020 and 2021, the number of telemonitoring services provided to Non-Urban and Urban members increased from 2019.</li> <li>• Compared to 2020, the number of telemonitoring services provided in 2021 was 1.6 times higher for Non-Urban members and 8.2 times higher for Urban members. The increase was seen in 2021 for both Non-Urban and Urban members, however, higher increase was seen for Urban members.</li> <li>• The statewide number of performing providers increased from 18 in 2020 and to 40 in 2021. In both Non-Urban and Urban areas of the state, the number of performing and billing providers roughly doubled from 2020 to 2021.</li> <li>• It should be noted that these increases were seen in the initial years of the COVID-19 pandemic (2020 and 2021). The data and analytical results for 2022 and 2023 may provide a better assessment of the impact of State interventions on telemonitoring services in Non-Urban areas of Kansas.</li> </ul>					
<p><b>Note:</b> Counts of KanCare members and telemonitoring services received by members were stratified into Non-Urban and Urban areas by member’s county of residence; counts of telemonitoring providers were stratified into Non-Urban and Urban areas by provider address; the Non-Urban area was defined as all counties except Urban counties; Urban area was defined as Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte counties. The increase in the percent of members receiving telemonitoring services from 2020 to 2021 was statistically significant for Non-Urban (p&lt;.01) and Urban (p&lt;.001) areas (weighted Pearson chi-square).</p>					
<p>*The number of members receiving telemonitoring services in 2019 was insufficient for analysis (percent of members was less than 0.001%).</p>					

## Qualitative Evaluation

### Results for the Evaluation of Use of Telementoring Services

Hypothesis 3 stated, *“Telementoring can pair rural and semi-urban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions.”*<sup>6</sup>

The data sources describing the use of telementoring that pairs rural and semi-urban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions are currently not known. Therefore, the related evaluation is focused on summarizing the telementoring efforts implemented by Sunflower Health Plan, the University of Kansas, and the University of Missouri.

The Project ECHO® (Extension for Community Healthcare Outcomes) Model was used by Sunflower Health Plan and the University of Kansas to provide telementoring services to providers. These efforts are summarized below.

#### *Project ECHO® Sunflower Health Plan:*

In response to the telementoring component of the KanCare 2.0 Hypothesis 3, Sunflower Health Plan served as a Project ECHO® hub. A Project ECHO hub refers to *“a regional center where a team of subject matter experts is located, replicates the ECHO Model™ and runs their own ECHO program.”*<sup>14</sup> To conduct this program, Sunflower Health Plan collaborated initially with the University of Kansas and later with the University of Missouri’s Office of Continuing Education, School of Medicine, and Sinclair School of Nursing.

The information summarized below is abstracted from the report provided by Sunflower Health Plan titled *“Project ECHO®. Sunflower Health Plan Kansas. 2019–Present.”*<sup>15</sup>

From March 2019 through November 2021, eleven series comprised of forty-six sessions were conducted by the project. The sessions were attended by Centene staff (parent managed care company for Sunflower Health Plan) and providers from multiple disciplines, including medical and behavioral clinicians, nurses, pharmacists, and social workers. The participants were from non-urban and urban counties. Further information regarding the sessions is summarized in Tables B22-B24.

Table B22. Sunflower Health Plan Project ECHO® Series Goals	
ECHO Series	ECHO Series Goals
<b>2019 Sunflower Project ECHO®</b>	
<b>Fundamentals of Addiction Treatment</b>	<ul style="list-style-type: none"> <li>• Broadening understanding of addiction therapies</li> <li>• Increasing the number of rural and frontier providers and addiction treatments</li> <li>• Maximizing access to medication assisted treatment</li> </ul>
<b>Supporting and Integrated Life for Members with Intellectual and Developmental Disabilities</b>	<ul style="list-style-type: none"> <li>• Broadening understanding of needs of individuals with I/DD</li> <li>• Increasing collaboration with community, rural, and frontier providers</li> <li>• Maximizing access to coordinated supports for individuals with I/DD</li> </ul>
<b>Social Determinants of Health</b>	<ul style="list-style-type: none"> <li>• Broadening understanding of social determinants of health</li> <li>• Broadening understanding of how where we live, work, and play impacts our health</li> <li>• Understanding how to access supports within the state</li> </ul>
<b>Foster Care</b>	<ul style="list-style-type: none"> <li>• Broadening understanding of trauma informed interventions</li> <li>• Understanding how unique needs of members in foster care affect their health</li> <li>• Understanding how to access supports within Kansas</li> </ul>

Table B22. Sunflower Health Plan Project ECHO® Series Goals (Continued)	
ECHO Series	ECHO Series Goals
<b>2020 Sunflower Project ECHO®</b>	
<b>Cancer</b>	<ul style="list-style-type: none"> <li>• Broadening understanding of the long-lasting effects of a cancer diagnosis and treatment</li> <li>• Broadening understanding of the unique needs of members who have cancer</li> <li>• Understanding how to access supports for members across Kansas</li> </ul>
<b>Behavioral Health</b>	<ul style="list-style-type: none"> <li>• Understanding evidence-based practices for people with behavioral health needs</li> <li>• Understanding the unique needs of members who have behavioral health needs</li> <li>• Understanding how to access supports for members across Kansas</li> </ul>
<b>Aging</b>	<ul style="list-style-type: none"> <li>• Supports available to members in the aging population</li> <li>• Unique medication needs and approaches for the aging population</li> <li>• Accessing supports for the aging population across Kansas</li> </ul>
<b>Preventative Health</b>	<ul style="list-style-type: none"> <li>• Broadening the understanding of expectations of Early Periodic Screening Diagnosis and Treatment (EPSDT)</li> <li>• Understanding the schedule for preventative care and immunizations for youth</li> <li>• Understanding how to access supports related to immunizations and preventative care in Kansas</li> </ul>
<b>2021 Sunflower Project ECHO®</b>	
<b>Behavioral Health and Addiction</b>	<ul style="list-style-type: none"> <li>• Broadening understanding of trauma informed interventions</li> <li>• Understanding how unique needs of members in foster care affect their health</li> <li>• Understanding how to access supports within Kansas</li> </ul>
<b>Preventative Care</b>	<ul style="list-style-type: none"> <li>• Broadening the understanding of preventive care across the lifespan</li> <li>• Understanding the impact of preventive health across the lifespan</li> <li>• Understanding how to navigate supports related to preventive care in Kansas</li> </ul>
<b>Care Coordination</b>	<ul style="list-style-type: none"> <li>• Understanding the expectations of care coordination</li> <li>• The unique needs of members who may benefit from care coordination</li> <li>• Understanding how to access supports related to care coordination</li> </ul>

Table B23. Project ECHO® Sunflower Health Plan Sessions			
ECHO Series	Session	Date	Participants
<b>2019 Sunflower Project ECHO®</b>			
<b>Fundamentals of Addiction Treatment</b>	Week 1: Overview of the Fundamentals of Addiction Treatment	3/07/2019	61
	Week 2: Pain Management and Addiction Interaction	3/14/2019	47
	Week 3: Opioid Dependence Addiction and Naloxone Education	3/21/2019	55
	Week 4: Medication Assisted Treatment, Kansas State Policy	3/28/2019	44
<b>Supporting and Integrated Life for Members with Intellectual and Developmental Disabilities</b>	Week 1: The Quality of Life Assessment: An Integrated Approach to Identifying Solutions	6/06/2019	47
	Week 2: Dementia and I/DD	6/13/2019	39
	Week 3: Crisis Planning for Dual Diagnosis	6/20/2019	41
	Week 4: Creating a Path to Employment	6/27/2019	35
<b>Social Determinants of Health</b>	Week 1: Social Determinants of Health	9/05/2019	31
	Week 2: Housing Supports	9/12/2019	26
	Week 3: Employment	9/19/2019	29
	Week 4: Food Insecurity	9/16/2019	28
<b>Foster Care</b>	Week 1: Trauma Informed Interventions	11/07/2019	52
	Week 2: Physical Health and Impact on Behavioral Health	11/14/2019	38
	Week 3: Culturally Competent Care for the LGBT Community	11/21/2019	44
	Week 4: Psychotropic Medication Use in the Foster Care Population in Kansas	12/05/2019	38

<b>Table B23. Project ECHO® Sunflower Health Plan Sessions (Continued)</b>			
<b>ECHO Series</b>	<b>Session</b>	<b>Date</b>	<b>Participants</b>
<b>2020 Sunflower Project ECHO®</b>			
<b>Cancer</b>	Week 1: How to Help Childhood Cancer Survivors Thrive	3/19/2020	22
	Week 2: Cancer Prevention and Immunization	3/26/2020	27
	Week 3: Supports, Prevention and Barriers to Care for Members with Intellectual and Developmental Disabilities	4/02/2020	22
	Week 4: Nutrition and Cancer	4/09/2020	16
<b>Behavioral Health</b>	Week 1: Parent Management Training Oregon Model	5/07/2020	81
	Week 2: Anxiety	5/14/2020	72
	Week 3: Peer Support	5/21/2020	59
	Week 4: Hope and Healing	5/28/2020	55
<b>Aging</b>	Week 1: Social Isolation and Aging	8/06/2020	38
	Week 2: Aging in COVID	8/13/2020	39
	Week 3: Nursing Home Planning in COVID	8/20/2020	31
	Week 4: Atypical Antipsychotics in the Elderly & Nursing Home Population	8/27/2020	35
<b>Preventative Health</b>	Week 1: EPSDT Overview	10/15/2020	39
	Week 2: KAN Be Healthy	10/22/2020	39
	Week 3: Childhood Immunizations	10/29/2020	38
	Week 4: Treatment and Therapies	11/05/2020	34
<b>2021 Sunflower Project ECHO®</b>			
<b>Behavioral Health and Addiction</b>	Week 1: Medication Assisted Treatment	3/10/2021	65
	Week 2: Peer Mentoring and Addiction	3/17/2021	58
	Week 3: Methadone Clinic	3/24/2021	40
	Week 4: Therapeutic Supports	3/31/2021	45
<b>Preventative Care</b>	Week 1: Navigating Barriers to Preventative Care, Sunflower Approach	6/03/2021	20
	Week 2: COVID-19 Vaccine Equity	6/10/2021	19
	Week 3: Nutrition	6/17/2021	20
	Week 4: Dental Care	6/24/2021	13
<b>Care Coordination</b>	Week 1: Case Management Overview	10/07/2021	38
	Week 2: OneCare Kansas	10/14/2021	29
	Week 3: Behavioral Health	10/21/2021	21
	Week 4: Physical Health	10/28/2021	23
	Week 5: HCBS and Care Coordination	11/04/2021	23
	Week 6: Transitions to Employment	11/11/2021	18

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Some of the participants attending the sessions in the October-November 2021 Series titled “Care Coordination” provided further insights by responding to survey questions asked regarding these sessions. This information is summarized below in Table B24.

Table B24. Project ECHO® Sunflower Health Plan October-November 2021 Series Survey	
Project ECHO® Sunflower October-November 2021 Series: Care Coordination	
Survey Item	Survey Results/Key Themes
<b>Week 1: Case Management Overview (17 survey participants)</b>	
<ul style="list-style-type: none"> <li>Understanding of care coordination</li> </ul>	<ul style="list-style-type: none"> <li>Out of 17 participants, 10 (59%) indicated attending the session improved their understanding of care coordination.</li> </ul>
<ul style="list-style-type: none"> <li>Knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients</li> </ul>	<ul style="list-style-type: none"> <li>Out of 17 participants, 11 (65%) indicated attending the session improved their knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients.</li> </ul>
<ul style="list-style-type: none"> <li>What did you learn in this continuing education activity that you will apply to your practice?</li> </ul>	Key themes based on participants responses: <ul style="list-style-type: none"> <li>Coordination of care and services for members</li> <li>Benefits of case management and care coordination in managing member care and getting resources</li> <li>Resources/ways to access more coordination</li> <li>Networking and communication</li> </ul>
<b>Week 2: OneCare Kansas (12 survey participants)</b>	
<ul style="list-style-type: none"> <li>Understanding of care coordination</li> </ul>	<ul style="list-style-type: none"> <li>Out of 12 participants, 8 (67%) indicated attending the session improved their understanding of care coordination.</li> </ul>
<ul style="list-style-type: none"> <li>Knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients</li> </ul>	<ul style="list-style-type: none"> <li>Out of 12 participant, 10 (83%) indicated attending the session improved their knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients.</li> </ul>
<ul style="list-style-type: none"> <li>What did you learn in this continuing education activity that you will apply to your practice?</li> </ul>	Key themes based on participants responses: <ul style="list-style-type: none"> <li>Information on benefits of OneCare Kansas program</li> <li>Access to increased resources to assist members with services</li> <li>Utilization of CMHCs for in-person help, and in coordination of medical services for members with dual diagnoses</li> </ul>
<b>Week 3: Behavioral Health (15 survey participants)</b>	
<ul style="list-style-type: none"> <li>Understanding of care coordination</li> </ul>	<ul style="list-style-type: none"> <li>Out of 15 participants, 2 (13%) indicated attending the session improved their understanding of care coordination.</li> </ul>
<ul style="list-style-type: none"> <li>Knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients</li> </ul>	<ul style="list-style-type: none"> <li>Out of 15 participants, 12 (80%) indicated attending the session improved their knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients.</li> </ul>
<ul style="list-style-type: none"> <li>What did you learn in this continuing education activity that you will apply to your practice?</li> </ul>	Key themes based on participants responses: <ul style="list-style-type: none"> <li>Information on benefits of and resources available through Smart Start for Babies program for pregnant women</li> <li>Referring pregnant women to Smart Start for Babies program for better outcomes</li> <li>Several resources available for members</li> </ul>
<b>Week 4: Physical Health (5 survey participants)</b>	
<ul style="list-style-type: none"> <li>Understanding of care coordination</li> </ul>	<ul style="list-style-type: none"> <li>All 5 participants (100%) indicated attending the session improved their understanding of care coordination.</li> </ul>
<ul style="list-style-type: none"> <li>Knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients</li> </ul>	<ul style="list-style-type: none"> <li>All 5 participants (100%) indicated attending the session improved their knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients.</li> </ul>
<ul style="list-style-type: none"> <li>What did you learn in this continuing education activity that you will apply to your practice?</li> </ul>	Key themes based on participants responses: <ul style="list-style-type: none"> <li>Information on benefits of coordinating behavioral health and medical care</li> <li>Resources and services available for members</li> </ul>

<b>Table B24. Project ECHO® Sunflower Health Plan October-November 2021 Series Survey (Continued)</b>	
<b>Project ECHO® Sunflower October-November 2021 Series: Care Coordination</b>	
<b>Survey Item</b>	<b>Survey Results/Key Themes</b>
<b>Week 5: HCBS and Care Coordination (6 survey participants)</b>	
<ul style="list-style-type: none"> <li>Understanding of care coordination</li> </ul>	<ul style="list-style-type: none"> <li>Out of 6 participants, 3 (50%) indicated attending the session improved their understanding of care coordination.</li> </ul>
<ul style="list-style-type: none"> <li>Knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients</li> </ul>	<ul style="list-style-type: none"> <li>Out of 6 participants, 4 (66.7) indicated attending the session improved their knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients.</li> </ul>
<ul style="list-style-type: none"> <li>What did you learn in this continuing education activity that you will apply to your practice?</li> </ul>	Key themes based on participants responses: <ul style="list-style-type: none"> <li>Importance of coordination with other agencies</li> <li>Better understanding of final rule and KDADS expectations</li> <li>Importance of communication</li> </ul>
<b>Week 6: Transitions to Employment (6 survey participants)</b>	
<ul style="list-style-type: none"> <li>Understanding of care coordination</li> </ul>	<ul style="list-style-type: none"> <li>Out of 6 participants, 4 (67%) indicated attending the session improved their understanding of care coordination.</li> </ul>
<ul style="list-style-type: none"> <li>Knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients</li> </ul>	<ul style="list-style-type: none"> <li>Out of 6 participants, 4 (67%) indicated attending the session improved their knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients.</li> </ul>
<ul style="list-style-type: none"> <li>What did you learn in this continuing education activity that you will apply to your practice?</li> </ul>	Key themes based on participants responses: <ul style="list-style-type: none"> <li>Continue member-centered work</li> <li>Communications and giving choices</li> <li>The dynamics that can occur with I/DD waiver and how to get other resources/departments involved</li> </ul>

**KUMC Project ECHO® Series:**

In 2021, Kansas University Medical Center (KUMC) conducted the KUMC Project ECHO® Series titled “Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders” for providers including physicians, advanced practice clinicians, nurses, behavioral health providers, and other providers.<sup>16</sup> The purpose of the series was to improve healthcare provider capacity to implement evidence-based practices related to substance use disorder (SUD) prevention, screening, early intervention, referral to treatment, and risk reduction.

The information summarized below regarding the five sessions included in this ECHO series, conducted during April 2021, is abstracted from the report titled “Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders. KUMC Project ECHO® Series Summary Report” provided by the KUMC Project ECHO®.<sup>16</sup>

A total of 383 attendees participated in five series sessions, with an average of 77 attendees per session. Through this ECHO series, 240 hours of the Continuing Education (CE) Credit were awarded, with nearly 50 hours of CE credit claimed during each session, on average. Out of 383 attendees, 240 attendees (63%) claimed CE credit. There were 212 unique registrants for the series. Out of these 212 unique registrants, 158 (75%) were target learners, including 33 physicians (21%), 49 advanced practice clinicians (31%), 42 nurses (27%), and 34 behavioral health providers (21%). Out of the 212 unique registrants, 172 (81%) were Kansas providers, whereas 40 registrants (19%) were from other states. The Kansas registrants were from both non-urban and urban areas. Out of 172 unique Kansas registrants, 77 (45%) were from non-urban areas, whereas 95 registrants (55%) were from urban areas.

Table B25. KUMC Project ECHO® Series Sessions			
ECHO Series	Session	Date	Participants
<b>2021 KUMC Project ECHO®</b>			
<b>Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders</b>	Session 1: Opioid Use Disorder: The Natural History of a Wicked Problem	4/01/2021	93
	Session 2: SBIRT: Starting the Conversation about Substance Use	4/08/2021	87
	Session 3: Implementing SUD Treatment in Primary Care: A Rural Health Example	4/15/2021	70
	Session 4: The Kansas Perspective on the Opioid Crisis	4/22/2021	65
	Session 5: Strategies for Harm Reduction and Maximizing Pharmacy Partners	4/29/2021	68

Attendee knowledge was assessed through pre-test and post-test evaluations, and forty-six attendees completed the evaluations. The post-test percentages for the correct response rates for three of the four evaluation items were improved. The evaluation information is summarized in Table B26.

Table B26. KUMC Project ECHO® Series Evaluation		
Series: Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders		
Evaluation Item	Percent Correct	
	Pre-test	Post-test
Which of the following is NOT a tool available to all primary care providers attempting to reduce the risk of overdose and other harms related to substance use?	43%	60%
SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention for individuals with risky alcohol and drug use, as well as the timely referral to more intensive substance abuse treatment for those who have substance use disorders.	91%	96%
What are the benefits to providing MAT to patients in a primary care setting?	89%	93%
Drug overdose events and controlled substance prescriptions were substantially impacted by the COVID-19 pandemic in Kansas.	98%	93%

About 89% of the attendees agreed that “Complex care circumstances were mastered through case-based learning”. The evaluation of three clinical practices for screening and treating SUDs was conducted at registration and again post-series to determine practice change regarding screening for SUD, use of medication assisted treatment (MAT) waivers, and partnerships with local pharmacist related to opioid use disorder (OUD) care. This evaluation was conducted by using a 5-point measure, with 1 = no practice planned to 5 = established practice. The post-series improvement in the clinical practice change was seen for two practices (use of MAT waivers, and partnerships with local pharmacist related to OUD care). The pre- and post-ECHO series assessment of self-efficacy measures aligned with series’ overarching learning objectives and were evaluated with a 5-point ranking scale (1= strongly disagree, and 5 = strongly agree). Respondents were asked about their confidence in their ability to employ SUD screening tools in the clinical setting, locate and utilize state and local resources for SUD treatment and recovery-oriented systems of care, devise strategies to counteract stigma in SUD treatment, and examine various harm reduction strategies and their role in disease treatment. The post-ECHO series evaluation results showed an improvement in all four self-efficacy measures indicating improved self-efficacy of the attendees. At the end of the series, when attendees were asked if they had made, or planned on making changes based on what they learned in the series, 79% of them responded “yes.”

Key points from attendee feedback are summarized in Table B27.

<b>Table B27. KUMC Project ECHO® Series Attendees’ Feedback</b>	
<b>Series: Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders</b>	
<b>Feedback provided by 46 attendees (N=46)</b>	
<ul style="list-style-type: none"> <li>• 98% agreed or strongly agreed that they gained helpful knowledge from this ECHO series (n=45)</li> <li>• 91% estimated their confidence level using this new information to better treat patients at 50% to 100% (n=42)</li> <li>• 89% agreed or strongly agreed that they obtained helpful skills and techniques to improve professional practice (n=41)</li> <li>• 80% estimated 50% to 100% of information was new (n=37)</li> <li>• 74% agreed and strongly agreed that ECHO’s interactive format is more effective than standard webinars (n=34)</li> </ul>	

The continuing education evaluation was also conducted at the end of each session. Three evaluation items were included in this assessment. These results, summarized in Table B28, are based on the responses provided by the attendees who claimed CE credit.

<b>Table 28. KUMC Project ECHO® Series Continuing Education Evaluation</b>					
<b>Series: Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders</b>					
<b>Continuing Education Evaluation Item</b>	<b>Session</b>				
	<b>#1</b>	<b>#2</b>	<b>#3</b>	<b>#4</b>	<b>#5</b>
Number of Attendees Responding					
<b>Please rate your level of achievement (% reporting good or outstanding)</b>					
• Employ SUD screening tools in the clinical setting	87%	89%	89%	83%	95%
• Locate and utilize state and local resources for SUD treatment and recovery-oriented systems of care	89%	80%	89%	89%	95%
• Devise strategies to counteract stigma in SUD treatment	92%	86%	89%	86%	98%
• Examine various harm reduction strategies and their role in disease treatment	89%	78%	93%	77%	100%
<b>I will use this information to (% responding “yes”)</b>					
• Improve my current patient safety practices	59%	48%	53%	43%	63%
• Validate my current patient safety practices	21%	25%	18%	34%	15%
• Improve my current medical error prevention and analysis practices	14%	2%	7%	17%	12%
• Validate my current medical error prevention and analysis practices	5%	5%	4%	11%	0%
• Improve my current risk management practices	35%	20%	31%	20%	20%
• Validate my current risk management practices	11%	14%	13%	17%	5%
<b>Please rate your level of agreement (% responding “somewhat agree” or “strongly agree”)</b>					
• This activity has positively affected my ability to function as part of a team	87%	82%	89%	86%	90%
• I learned something today that I can take back to my team to improve outcomes	92%	86%	93%	89%	93%

These results for the three continuing education evaluation items described in Table B28 are further summarized below.

- Across all five sessions, more than 76% of respondents reported their level of achievement to be good or outstanding regarding the employment of SUD screening tools in the clinical setting, locating and utilizing state and local resources for SUD treatment and recovery-oriented systems of care, device strategies to counteract stigma in SUD treatment, and examining various harm reduction strategies and their role in disease treatment.
- Across all five sessions, 43% to 63% of respondents indicated they will use the information to improve their current patient safety practices, however, only 15% to 34% indicated they will use the information to validate their current patient safety practices. Only 2% to 17% indicated they will use the information to improve their current medical error prevention and analysis practices, whereas 0% to 11% indicated they will use the information to validate their current medical error prevention and analysis practices. With regard to current risk management practices, 20% to 35% indicated

they will use the information to improve these practices, and 5% to 17% indicated they will use the information to validate these practices.

- Across all five sessions, more than 80% of respondents rated their level of agreement as “somewhat agree” or “strongly agree” when asked about the positive affect on their ability to be a part of team, and they learned the information that they can share with their team to improve outcomes.

### Results for the Telehealth Provider Survey

The Telehealth Provider Survey was conducted in September 2022. The survey was designed to gain an understanding of providers’ experiences regarding telehealth services they offer to KanCare members, including facilitators and barriers to the use of telehealth services, and whether use of the services improved access to care among KanCare members.

In addition, providers were asked to provide recommendations for removing barriers to increase the use of these services and improve access to care among KanCare members. An overview of survey responses and key themes are summarized in Table B29.

Table B29. Telehealth Provider Survey: Ideas to Improve Telehealth Services for KanCare Members	
Survey Participants’ Responses	Key Themes
<ul style="list-style-type: none"> <li>• I think it would be helpful to have some consistency in terms of rules/forms, etc. It seems like everyone requires something different (Commercial/VA, etc.).</li> <li>• Specify required in-person visits, i.e. q6 month or yearly.</li> <li>• To keep telehealth open for all providers (no silos) and not having specific platforms we have to use per each MCO. As long as it is HIPAA certified, providers should be able to utilize their selected HIPAA compliant platform for telehealth.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide consistency in application of rules and systems.                             <ul style="list-style-type: none"> <li>○ Use of the same forms by all entities involved.</li> <li>○ Specify required in-person visits.</li> <li>○ Providers should not have to use specific platforms for each MCO.</li> <li>○ Providers should be able to utilize their selected HIPAA compliant platform for telehealth.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Ensure reliable Wi-Fi connection for members with capable technology.</li> <li>• Increase internet access.</li> <li>• Ensure that all members can access telehealth services.</li> <li>• Improved access to higher speed internet access for patients in medically underserved regions.</li> <li>• Clients don't always have reliable internet/cell service as we are in rural area.</li> <li>• For therapy evaluations such as mine, I can perform up to 12 evaluations a day with outstanding effectivity and results. I have a better setup with a dual screen monitor to assess patient charts while documenting and using the audiovisual platform of their choice.</li> <li>• Bigger screens, better audio, connectivity issues.</li> <li>• Helping clients obtain reliable and adequate Internet services and devices to improve telehealth sessions, e.g., more than just phone.</li> <li>• I would like clients to have access to apps for monitoring of mood symptoms or electronic journals that they could electronically send to providers. It could provide insights into what may be triggering panic attacks, dreams about unresolved issues, and/or medication adherence monitoring. Government phones with limited minutes or access to applications inhibits progress with care.</li> <li>• Communicating to KanCare members that telehealth is available, free, and useful. Helping clients know what to do if they don't have access to internet (how to apply for waivers/grants if they don't have access to internet or for free/reduced cost cell phone plans).</li> </ul>	<ul style="list-style-type: none"> <li>• Increase and improve technology and resources for the members and providers.                             <ul style="list-style-type: none"> <li>○ Ensure availability of reliable high speed internet technology for all members, especially in medically underserved and rural areas.</li> <li>○ Provide better technical resources and system capabilities for members and providers, such as devices, bigger screens, better audio, capability for providers to use audiovisual platforms of patients' choice.</li> <li>○ Members’ access to mobile apps for monitoring of mood symptoms or electronic journals that they could electronically send to providers.</li> <li>○ Government phones with limited minutes or access to applications inhibits progress with care. Better devices should be provided to members.</li> <li>○ Giving information to members on how to apply for waivers/grants if they don't have access to internet or for free/reduced cost cell phone plans.</li> </ul> </li> </ul>

Table B29. Telehealth Provider Survey: Ideas to Improve Telehealth Services for KanCare Members (Continued)	
Survey Participants' Responses	Key Themes
<ul style="list-style-type: none"> <li>• Continued coverage.</li> <li>• Maintain coverage by insurance companies.</li> </ul>	<ul style="list-style-type: none"> <li>• Continued coverage by insurance companies.</li> </ul>
<ul style="list-style-type: none"> <li>• Provide education to member on the ease and benefit of telehealth.</li> <li>• Educate patients on the benefits of being seen from a telehealth platform.</li> <li>• Offer webinars to and members on telehealth, how it works, tips for effectiveness via Telehealth services</li> <li>• Most clients stumble upon me through Psychologytoday.com because they don't know how to find a qualified therapist who specializes in their needs when the therapist lives in a different area of the state. Any kind of database that's easily searchable for potential clients seeking services to be able to sort through all qualified providers in order for them to make an informed decision would go over well, I think. If that already exists, then getting the word out to KanCare members is the key that seems to be missing.</li> <li>• Assisting clients with lack of resources into getting those resources to receive services.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide education, resources (such as searchable databases for identifying providers for needed services), and trainings to members to assist in the understanding benefits of telehealth and using it with ease.</li> </ul>
<ul style="list-style-type: none"> <li>• Provide telehealth services to your customers at the same rate as in person services.</li> <li>• Increase reimbursement.</li> <li>• Reimbursement rates prevent providers from taking new KanCare members. It is not cost effective to provide services with such poor rates and no pay for no-shows.</li> <li>• Increased rate for telehealth services as this opens doors for increased services.</li> <li>• Offer greater reimbursement to companies who participate in telehealth due to convenience of telehealth capabilities.</li> </ul>	<ul style="list-style-type: none"> <li>• Increase reimbursement rate for telehealth services.                             <ul style="list-style-type: none"> <li>○ Offer same reimbursement rate for telehealth services as in person services.</li> <li>○ Increase in reimbursement rates to make telehealth use cost-effective and for its increased use.</li> <li>○ Offer greater reimbursement to companies who participate in telehealth due to convenience of telehealth capabilities.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• I believe all KanCare members should have access to telehealth as a part of their comprehensive health services. It should be up to the clinical judgment of the provider and client to determine who would benefit from telehealth services delivery.</li> <li>• More opportunities for KanCare members to participate in telehealth services from school.</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure opportunities for telehealth services are available for all members.                             <ul style="list-style-type: none"> <li>○ Access to telehealth as part of comprehensive health services for the member with the decision to use telehealth services being based on the provider's clinical judgment and the member.</li> <li>○ Provide more opportunities for telehealth services from school.</li> </ul> </li> </ul>

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Table B29. Telehealth Provider Survey: Ideas to Improve Telehealth Services for KanCare Members (Continued)	
Survey Participants' Responses	Key Themes
<ul style="list-style-type: none"> <li>• Offer webinars to providers on telehealth, how it works, tips for effectiveness via Telehealth services</li> <li>• More training</li> <li>• We need training for billing staff, leadership staff, and all providers that is on easy-to-understand terms and language. Everything I have seen so far leaves more questions than it provides answers for. It is vague. It does not address my specific situation.</li> </ul> <p>I also want to see leadership buy in. I am always being pushed to see patients so always register for webinars I hope I get to see and then end up having to miss them because I have appointments. I would like to see the training easily accessible and easy to find on self-paced courses that I can watch, start, and stop on my own time. I want to be able to ask credible subject matter experts my question about my exact situation to see if I am applying the correct billing codes.</p> <p>My organization says telehealth is not profitable. Other organizations say it is. I think we are not billing it correctly. We also need easy to understand training for everyone on how to bill for it that we can access at any time. We also need an expert who can answer specific situational questions.</p> <ul style="list-style-type: none"> <li>• Right manners, attitude and rules when attend telehealth appointment.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide trainings for providers.                             <ul style="list-style-type: none"> <li>○ Trainings with easy to understand terms and language for billing staff, leadership staff, and all providers.</li> <li>○ Provide trainings in user-friendly format that is easily accessible and easy to find on self-paced courses.</li> <li>○ Leadership buy-in to accommodate time for providers' trainings.</li> <li>○ Availability of trainings on a variety of specific situations providers deal with.</li> <li>○ Availability of credible subject matter experts to respond to the provider's exact situation to see if correct billing codes are applied.</li> <li>○ Provide easy to understand training for everyone on how to bill that providers can access at any time and can reach an expert who can answer specific situational question</li> <li>○ Training on appropriate attitude and rules for telehealth appointments.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Telehealth is an amazing resource to KanCare members. I believe it has lessened the stress of members in attending appointments. It has improved show rates.</li> <li>• None. It is working well, and I have found a growing confidence in telehealth services.</li> <li>• None (3)</li> <li>• None at this time.</li> <li>• Telehealth is not the issue.</li> <li>• Our patients need this service because without it many will simply go untreated. At the beginning of the pandemic, I had one man on telehealth tell me "Thank God you offer Zoom sessions now. I tried to come see you for months about my anxiety but always turned around and went home because I was too anxious. I even got into the waiting room once and left. Now on Zoom I can finally feel comfortable enough to get the medication I need." I had several patients tell me they were homeless or jobless and had no food. They lived in another city or county or too many miles to walk in the heat of summer. They needed to maintain their mental health medications but did not have a car or could not afford the gas and did not have access to other transportation sources. Some of them do have jobs and can only take limited time off so cannot afford to take time off for every doctor appointment to keep up with seeing me to get their medications. Seeing me on a lunch break while in their car on Zoom is the only way they can stay on top of their mental health. Some patients were caring for kids with COVID, had COVID, had Strep throat, or recovering from a broken leg, or had cellulitis so bad they could not get in the car and drive. For them telehealth is the only way they can see a behavioral health provider to get their medication refilled and check in. Otherwise, they would miss an appointment and go without their meds. This would be detrimental to their health. WE NEED THIS SERVICE FOR BEHAVIORAL HEALTH.</li> </ul>	<ul style="list-style-type: none"> <li>• Telehealth is a valuable source for members and providers.                             <ul style="list-style-type: none"> <li>○ Great resource for members.</li> <li>○ No recommendations for improving it.</li> <li>○ Telehealth services are needed for provision of behavioral health care services.</li> </ul> </li> </ul>

<b>Table B29. Telehealth Provider Survey: Ideas to Improve Telehealth Services for KanCare Members (Continued)</b>	
<b>Survey Participants' Responses</b>	<b>Key Themes</b>
<ul style="list-style-type: none"> <li>• Having a one or a few specific and dedicated therapist covering that service for organizations instead of spreading it among all providers. The benefit would be a person more familiar and specifically competent in this area. The barrier is that should the organization lose the faculty member covering this service, it may be difficult to cover those services until they have a replacement.</li> <li>• Use them as a fall back when usual in person visits are impeded.</li> <li>• I don't. I do not like telehealth for my profession. I cannot accurately see the child or hear the child. I work with speech and language disorders, often requiring intense evaluation of the articulators and if I can't easily see the child's mouth or be able to look into their mouth or be able to complete certain techniques to help teach the articulators how to make sounds it is not a functional session.</li> </ul> <p>I also do not like that our telehealth services have become a crutch for parents. All but one of my telehealth kids all attend school in person as well as attend other functions in person, yet do not come to in person therapy. It demonstrates lack of investment for many of the parents.</p>	<p>Note: Three survey respondents provided specific comments related to use telehealth that were dissimilar to those provided by rest of the respondents to this survey question. These comments are summarized into following dissimilar themes:</p> <ul style="list-style-type: none"> <li>• Only one or few specific and dedicated therapists covering that service for organizations. However, there will be a gap in services if assigned provider leaves the organization.</li> <li>• Telehealth services should be used when in-person services cannot be provided.</li> <li>• Telehealth is not appropriate for clients with certain conditions such as speech and language disorders.</li> <li>• Parents do not want to bring their child for an in-person visit when telehealth services are available.</li> </ul>

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# ***Appendix C***

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***KanCare 2.0 Interim Evaluation  
Report Evaluation of the State of Kansas  
Medicaid Section 1115(a) Demonstration  
Reporting Period – January 2019 – September 2022***

**List of Abbreviations and Acronyms**

<b>List of Abbreviations and Acronyms</b>	
Abbreviation/Acronym	Description
AAP	Adults’ Access to Preventive/Ambulatory Health Services
ADV	Annual Dental Visit
Aetna or ABH	Aetna Better Health of Kansas
AOD	Alcohol or Other Drug
AWC	Adolescent Well-Care Visit
BI	Brain Injury
BPD	Blood Pressure Control for Patients with Diabetes
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBMH	Community-Based Mental Health
CDC	Comprehensive Diabetes Care
CE	Continuing Education
CHIP	Children’s Health Insurance Program
CITS	Comparative Interrupted Time Series
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
E&M	Evaluation and Management
ECHO (Project ECHO)	Extension for Community Healthcare Outcomes
ECHO (Survey)	Experience of Health Outcomes
ED	Emergency Department
EED	Eye Exam Performed for Patients with Diabetes
EHR	Electronic Health Record
EQRO	External Quality Review Organization
FE	Frail Elderly
FQHC	Federally Qualified Health Center
FUH	Follow-Up After Hospitalization for Mental Illness
HbA1c	Hemoglobin A1c
HBD	Hemoglobin A1c Control for Patients with Diabetes
HCBS	Home and Community Based Services
HCBS CAHPS	Consumer Assessment of Healthcare Providers and Systems Home and Community-Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HRA	Health Risk Assessment
HST	Health Screening Tool
I/DD	Intellectual/Developmental Disability

<b>List of Abbreviations and Acronyms</b>	
<b>Abbreviation/Acronym</b>	<b>Description</b>
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
IMDs	Institutions for Mental Diseases
KDADS	Kansas Department of Aging and Disability Services
KDHE-DHCF	Kansas Department of Health and Environment, Division of Health Care Finance
KFMC	KFMC Health Improvement Partners (the EQRO)
KMAP	Kansas Medical Assistance Program
KUMC	University of Kansas Medical Center
LTSS	Long Term Services and Supports
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
MSC	Medical Assistance with Smoking and Tobacco Use Cessation
MY	Measurement Year
NCI	National Core Indicators
NCI-AD	National Core Indicators Adults with Disabilities
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
NPI	National Provider Identifier
OCK	OneCare Kansas
OCKPs	OCK Partners
OCD	Obsessive Compulsive Disorder
OUD	Opioid Use Disorder
P4P	Pay-for-Performance
PCP	Primary Care Provider
PCSP	Person-Centered Service Plan
PD	Physical Disability
PPC	Prenatal and Postpartum Care
QC	Quality Compass
RFR	Reduction in the Failure Rate
SLP	Speech-Language Pathologist
SMI	Severe Mental Illness
SUD	Substance Use Disorder
Sunflower or SHP	Sunflower Health Plan
UnitedHealthcare or UHC	UnitedHealthcare Community Plan of Kansas

<b>List of Abbreviations and Acronyms</b>	
<b>Abbreviation/Acronym</b>	<b>Description</b>
<b>VBP</b>	Value-Based Purchasing
<b>WSU CEI</b>	Wichita State University Community Engagement Institute

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# ***Attachment***

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***KanCare 2.0 Interim Evaluation Report  
Evaluation of the State of Kansas Medicaid  
Section 1115(a) Demonstration  
Reporting Period – January 2019 – September 2022***

# KanCare 2.0 Evaluation Design

Revised per CMS feedback

January 17, 2020

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## KanCare 2.0 Evaluation Design

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## A. General Background Information

KanCare, the Kansas statewide mandatory Medicaid managed care program, was implemented January 1, 2013, under authority of a waiver through Section 1115 of the Social Security Act. The initial demonstration was approved for five years, and the Centers for Medicare and Medicaid Services (CMS) approved a one-year extension on October 13, 2017. The State submitted the Section 1115 demonstration renewal application for the KanCare program, titled “KanCare 2.0,” in December 2018.<sup>1</sup> CMS approved the renewal of the KanCare 2.0 demonstration for the period of January 1, 2019 through December 31, 2023.<sup>2</sup> The KanCare Evaluation Design was submitted within 180 days of the CMS approval, as required. The CMS review of the evaluation design was received November 18, 2019. This updated evaluation design submission incorporates modifications recommended by CMS.<sup>3</sup>

KanCare 2.0 is an integrated managed care Medicaid program that serves the State of Kansas through a coordinated approach. KanCare is operating concurrently with the State’s Section 1915(c) HCBS waivers, and together they provide the authority necessary for the State to require enrollment of almost all Medicaid members (including the aged, people with disabilities, and some individuals who are dually eligible). The KanCare managed care delivery system provides state plan and HCBS waiver services to Medicaid recipients statewide.<sup>4</sup>

The original goals of the KanCare demonstration focused on providing integrated and whole-person care, creating health homes, preserving or creating a path to independence, and establishing alternative access models with an emphasis on home and community-based services (HCBS). Building on the success of the current KanCare demonstration, the goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid and Children’s Health Insurance Program (CHIP) benefits.<sup>1</sup> KanCare 2.0 aims to improve integration and coordination of care across the healthcare spectrum. Services related to social determinants of *health* include addressing safe housing; food sources; educational, economic, and job opportunities; access to health care services; transportation options; community-based resources in support of community living; and opportunities for recreational and leisure-time activities. Services that address social determinants of *independence* are tailored to an individual’s vision for their life, including areas such as career, community participation and contribution, and social/emotional connections. Strategies to achieve the enhanced goals of KanCare 2.0 include service coordination, the OneCare Kansas (OCK) program, value-based models and purchasing strategies, increasing employment and independent living supports, and telehealth (e.g., telemedicine, telemonitoring, and telementoring) services.

KanCare 2.0 will expand upon care coordination to provide service coordination, which is a comprehensive, holistic, integrated approach to person centered care.<sup>1</sup> It allows for maximum access to supports by coordinating and monitoring all of an individual’s care (acute, behavioral health, and LTSS) through direct interventions, provider referrals, and linkages to community resources. Case management, disease management, discharge planning, and transition planning are also elements of service coordination.

OCK is a care management service model, based on the health home model, where all professionals involved in a member’s care communicate with one another so that the member’s medical and behavioral health and social service needs are addressed in a comprehensive manner. The coordination of a member’s care is done through a dedicated care manager who oversees and coordinates access to all of the services a member requires in order to optimize member health.

Value-based models and purchasing strategies will include provider payment and/or innovative delivery system design methods between MCOs and their contracted providers, as well as the pay-for-performance (P4P) program between the State and contracted MCOs. Also, in 2021, the Delivery System Reform Incentive Payment (DSRIP) program will transition to an Alternative Payment Model (APM) approach, shifting from DSRIP project-based metrics to APM

provider-based quality and outcome metrics. Similar to the DSRIP program, the APM approach will require that providers meet or exceed predetermined quality and outcome improvements to receive incentive payments.<sup>1</sup> Increasing employment-related services in KanCare 2.0 includes the Employment Support Pilot. The pilot will provide access to pre-employment services for individuals that are ineligible for, or less likely to seek, existing post-employment services and benefits. The two disability groups served by the pilot are individuals with a behavioral health condition who are eligible for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) and individuals eligible for a Home and Community Based Services (HCBS) wait list or waiver and who are SSI eligible only. Services will include supported employment, personal assistant services, assistive technology, pre-vocational services (if not able to access Vocational Rehabilitation [VR] service), transportation, and independent living skill building.

## B. Evaluation Questions and Hypotheses

### KanCare 2.0 Demonstration Goal

The goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid benefits.<sup>4</sup>

### KanCare 2.0 Demonstration Hypotheses

1. Value-based models and purchasing strategies will further integrate services and eliminate the current silos between physical health services and behavioral health services, leading to improvements in quality, outcomes, and cost-effectiveness.
2. Increasing employment and independent living supports for members who have disabilities or behavioral health conditions, and who are living and working in the community, will increase independence and improve health outcomes.
3. Use of telehealth (e.g., telemedicine, telemonitoring, and telementoring) services will enhance access to care for KanCare members living in rural and semi-urban areas. Specifically:
  - a. Telemedicine will improve access to services such as speech therapy.
  - b. Telemonitoring will help members more easily monitor health indicators such as blood pressure or glucose levels, leading to improved outcomes for members who have chronic conditions.
  - c. Telementoring can pair rural and semi-urban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions.
4. Removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members will result in improved beneficiary access to substance use disorder (SUD) treatment services. The evaluation question and methodology are described in the SUD-specific evaluation design, *KanCare 2.0 Section 1115 Substance Use Disorder (SUD) Demonstration Evaluation Design* (submitted separately), in accordance with the first research question noted in Table B.1 of Appendix B of CMS's *Evaluation Design Guidance for Section 1115 Demonstrations for Beneficiaries with Serious Mental Illness/Serious Emotional Disturbance and Substance Abuse Disorders*.<sup>5</sup>

### KanCare 2.0 Demonstration Evaluation Questions

As the focus of the evaluation is to examine whether the KanCare 2.0 Demonstration achieved its objectives, the proposed evaluation questions are developed in alignment with the demonstration's goal and hypotheses (Tables B1 and B2).

**Table B1** describes two evaluation questions. The **first evaluation question** will examine the effectiveness of the overall **Service Coordination Strategy** of the KanCare 2.0 demonstration that is designed to enhance the quality of care and health outcomes and to reduce cost of care. A **quasi-experimental evaluation design** will be used to assess this question. The evaluation design for the overall **Service Coordination Strategy** of KanCare 2.0 demonstration will include an intervention group and appropriate comparison groups. The Intervention Group will include members who met a health risk assessment (HRA) threshold and received service coordination (excluding those members who opted for the OneCare Kansas program). These members in the pre-intervention period will serve as the Comparison Group 1, whereas KanCare 2.0 members who scored 3 to 5 points below the HRA threshold and received traditional care instead of service coordination will serve as the Comparison Group 2. The Comparison Group 2 will also include KanCare 2.0 members who met the HRA threshold but opted not to receive service coordination and received traditional care. The further details of the evaluation design are described in the Methodology section.

The **second evaluation question** will evaluate the effectiveness of the **OneCare Kansas** program of KanCare 2.0 demonstration, a new Medicaid option based on the health home model. This program will be offered to KanCare 2.0 members with chronic conditions and is designed to apply a comprehensive and intense method of care coordination that will integrate and coordinate all services and supports to treat the “whole person” across the life span. A **quasi-experimental evaluation design** will be used to assess this question. The evaluation of the **OneCare Kansas** program of KanCare 2.0 demonstration will include an intervention group and appropriate comparison groups. The Intervention Group will include eligible members for the OneCare Kansas program who opted to participate in the program and received core services of the program. These members in the pre-intervention period will serve as the Comparison Group 1. The KanCare 2.0 members eligible for the OneCare Kansas program who did not opt to participate in the program and received traditional care will constitute the Comparison Group 2. Further details of the evaluation design are described in the Methodology section.

Table B1. Evaluation Questions for Examination of Overall Service Coordination Among KanCare 2.0 Demonstration Members	
1) Did the <b>Service Coordination Strategy</b> of integrating physical and behavioral health services provided to KanCare members <b>improve quality of care, health and cost outcomes</b> ?	
2) Did the <b>OneCare Kansas</b> program that implements comprehensive and intense method of care coordination <b>improve the quality of care, health and cost outcomes</b> ?	

**Table B2** describes evaluation questions related to **four hypotheses of the KanCare 2.0 demonstration**. Depending upon the availability of appropriate comparison groups for the evaluation of these hypotheses, the **quasi-evaluation designs (with comparison groups) and non-experimental designs (without comparison groups)** will be applied for the evaluation of these hypotheses. The further details of the evaluation designs are described in the Methodology section.

Table B2. Evaluation Questions for Examination of the KanCare 2.0 Hypotheses	
KanCare 2.0 Hypotheses	Evaluation Questions
<b>Hypothesis 1:</b> Value-based models and purchasing strategies will further integrate services and eliminate the current silos between physical health services and behavioral health services, leading to improvements in quality, outcomes, and cost-effectiveness.	1) Did the <b>Value-Based Provider Incentive Program</b> increase integration and reduce silos between physical and behavioral health services provided to KanCare members?
	2) Did the <b>Value-Based Provider Incentive Program</b> for integration between physical and behavioral health services <b>improve quality of care, health, and cost outcomes</b> ?

Table B2. Evaluation Questions for Examination of the KanCare 2.0 Hypotheses (Continued)	
KanCare 2.0 Hypotheses	Evaluation Questions
<p><b>Hypothesis 2:</b> Increasing employment and independent living supports for members who have disabilities or behavioral health conditions, and who are living and working in the community, will increase independence and improve health outcomes.</p>	<p>1) Did <b>provision of supports for employment and independent living</b> to the KanCare 2.0 members with disabilities and behavioral health conditions who are living in the community <b>improve their independence and health outcomes</b>?</p>
<p><b>Hypothesis 3:</b> The use of telehealth (e.g., telemedicine, telemonitoring, and telementoring) services will enhance access to care for KanCare members living in rural and semi-urban areas. Specifically:</p> <ul style="list-style-type: none"> <li>a. Telemedicine will improve access to services such as speech therapy.</li> <li>b. Telemonitoring will help members more easily monitor health indicators such as blood pressure or glucose levels, leading to improved outcomes for members who have chronic conditions.</li> <li>c. Telementoring can pair rural and semi-urban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions.</li> </ul>	<p>1) Did <b>use of telemedicine services increase over the five-year period</b> for KanCare members living in <b>rural or semi-urban areas</b>?</p>
	<p>2) Did <b>use of the tele-monitoring services increase over the five-year period</b> for KanCare members with chronic conditions living in <b>rural or semi-urban areas</b>?</p>
	<p>3) <b>Evaluation question related to telementoring:</b> Data sources for describing the baseline and five-year status of the use of telementoring to pair rural and semi-urban healthcare providers with remote specialists are currently not known; therefore, <b>the related evaluation question and design will be developed later.</b></p>
	<p>4) Did <b>use of telemedicine increase access to services over the five-year period</b> for KanCare members living in <b>rural or semi-urban areas</b>?</p>
<p><b>Hypothesis 4:</b> Removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members will result in improved beneficiary access to substance use disorder (SUD) treatment services.</p>	<p>1) Did <b>removing payment barriers for services provided in IMDs</b> for KanCare members <b>improve members' access to substance use disorder (SUD) treatment services.</b> (See SUD-specific Evaluation Design)<sup>6</sup></p>

[Logic Model for KanCare 2.0 Demonstration](#)

See Appendix 1.

## C. Evaluation Design Methodology

The detailed proposed methodologies for the evaluation of the Service Coordination Strategy, the OneCare Kansas program, and three KanCare 2.0 hypotheses are described in this section and summarized in Table C1. The proposed evaluation methodology for the KanCare 2.0 Hypothesis 4 is also summarized in Table C1, though a more detailed proposed methodology for this hypothesis is described in a separate evaluation design for the *KanCare 2.0 Section 1115 SUD Demonstration*.<sup>6</sup>

The present evaluation methodology is designed to meet the standards of scientific rigor that will assist in obtaining statistically valid and reliable evaluation results. The focus of the evaluation is to examine the effectiveness of demonstration strategies and policies on achievement of the goal of helping Medicaid members to live healthier, more independent lives by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid benefits. Where possible, measures are developed according to recognized measures from sources such as: *Adult Core Set*<sup>7</sup> measures, including *Healthcare Effectiveness Data and Information Set*<sup>®</sup> (HEDIS) measures,<sup>8</sup> stewarded by the National Committee for Quality Assurance (NCQA) and endorsed by the National Quality Forum (NQF).

The two final appendices to this evaluation design incorporate enhanced discussion on the performance measures and data sources that will be used for the evaluation of the KanCare 2.0 program. **Appendix 2** offers tables providing more detailed summaries of the performance measures in Table C1, including measure name, steward, numerator, denominator, unit of measure, and data source. **Appendix 3** offers tables providing further details on the data sources of the evaluation, including data source name, type of data provided by data source, description of data source, efforts for cleaning/validation of data, and quality/limitation of data source.

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Table C1. Design for the Evaluation of the KanCare 2.0 Demonstration				
Evaluation Question	Outcome Measures	Sample or Population Subgroups to be Compared	Data Sources	Analytic Methods
<b>Overall Service Coordination</b>				
<p><b>1. Did the <i>Service Coordination Strategy</i> of integrating physical and behavioral health services provided to KanCare members improve quality of care, health, and cost outcomes?</b></p>	<ul style="list-style-type: none"> <li>• Annual Dental Visit (HEDIS)</li> <li>• Adults’ Access to Preventive/ Ambulatory Health Services (HEDIS)</li> <li>• Adolescent Well-Care Visits (HEDIS)</li> <li>• Follow-Up After Hospitalization for Mental Illness (HEDIS)</li> <li>• Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (HEDIS)</li> <li>• Antidepressant Medication Management (HEDIS)</li> <li>• ED visits, observation stays, or inpatient admissions for following conditions (Administrative):               <ul style="list-style-type: none"> <li>○ Diabetic Ketoacidosis/ Hyperglycemia, or</li> <li>○ Acute severe asthma, or</li> <li>○ Hypertensive crisis, or</li> <li>○ Fall injuries, or</li> <li>○ SUD, or</li> <li>○ Mental health issues</li> </ul> </li> <li>• Outpatient or professional claims for following conditions (Administrative):               <ul style="list-style-type: none"> <li>○ Diabetic retinopathy, or</li> <li>○ Influenza, or</li> <li>○ Pneumonia, or</li> <li>○ Shingles</li> </ul> </li> <li>• Emergency department visits overall (Administrative)</li> <li>• Inpatient Utilization (IPU)— General Hospitalization/Acute Care, excluding maternity admissions.</li> </ul>	<p><b>Intervention Group:</b> All members who met an HRA threshold based on health screening scores and received service coordination (excluding those who opted for the OneCare Kansas program).</p> <p><b>Comparison Group 1:</b> Above mentioned members in pre-intervention period.</p> <p><b>Comparison Group 2:</b> All members who received health screening score 3 to 5 points below the HRA threshold and received traditional care instead of service coordination, as well as the members who met an HRA threshold but opted not to receive service coordination.</p> <p><b>Potential Subgroups:</b> Members with specific chronic conditions, members with specific behavioral conditions, &amp; members receiving HCBS services.</p>	<ul style="list-style-type: none"> <li>• Medicaid Management Information System (MMIS) Encounter database;</li> <li>• MMIS Eligibility and Enrollment database.</li> <li>• MCOs’ Member-level case management data systems.</li> </ul>	<p>Comparative Interrupted Time Series Evaluation Design</p>

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Table C1. Design for the Evaluation of the KanCare 2.0 Demonstration (Continued)				
Evaluation Question	Outcome Measures	Sample or Population Subgroups to be Compared	Data Sources	Analytic Methods
<b>Overall Service Coordination (Continued)</b>				
2. Did the <i>OneCare Kansas</i> program, by implementing comprehensive and intense method of care coordination, improve the quality of care, health, and cost outcomes?	<p>Quantitative Measures:</p> <ul style="list-style-type: none"> <li>• Same as above.</li> </ul> <p>Qualitative Measures:</p> <ul style="list-style-type: none"> <li>• Learning needs identified by the OneCare Kansas Learning Collaborative.</li> <li>• Processes to address the learning needs identified by the OneCare Kansas Learning Collaborative.</li> <li>• Factors that facilitated the implementation of the OneCare Kansas program to achieve its goal.</li> <li>• Barriers encountered in implementation of the OneCare Kansas program.</li> <li>• Processes to further improve the quality of OneCare Kansas program.</li> <li>• Observations about why this program was able to succeed or why it did not meet its goals.</li> </ul>	<p><b>Intervention Group:</b> All members eligible for OneCare Kansas program who opted to participate in the program and received its core services.</p> <p><b>Comparison Group 1:</b> Above mentioned members in pre-intervention period.</p> <p><b>Comparison Group 2:</b> All members eligible for OneCare Kansas program who opted not to participate in the program and received traditional care.</p> <p><b>Potential Subgroups:</b> Members with severe bipolar disorder; members with paranoid schizophrenia; &amp; members with asthma.</p>	<ul style="list-style-type: none"> <li>• MMIS Encounter database.</li> <li>• MMIS Eligibility and Enrollment database.</li> <li>• OneCare Kansas members' eligibility &amp; participation database.</li> <li>• MCOs' Member-level case management data systems.</li> <li>• OneCare Kansas Learning Collaborative reports.</li> </ul>	Comparative Interrupted Time Series Evaluation Design
<b>Hypothesis 1</b>				
<p>1. Did the <i>Value-Based Provider Incentive Program</i> increase integration and reduce silos between physical and behavioral health services provided to KanCare members?</p> <p>2. Did the <i>Value-Based Provider Incentive Program</i> for integration between physical and behavioral health services improve quality of care, health, and cost outcomes provided to the KanCare members?</p>	<p><b>Potential list (to be finalized according to the specific programs):</b></p> <p><b>Quantitative Measures:</b></p> <ul style="list-style-type: none"> <li>• Same as above.</li> <li>• Identification of Alcohol and Other Drug Services (HEDIS)</li> <li>• Follow-Up Care for Children Prescribed ADHD Medication (HEDIS)</li> <li>• Use of Opioids at High Dosage (HEDIS)</li> <li>• Use of Opioids from Multiple Providers (HEDIS)</li> <li>• Mental Health Utilization (HEDIS)</li> <li>• MCO-specified measures on effectiveness of their value-based provider incentive programs (to be determined)</li> </ul>	<p><b>Intervention Group:</b> All members seen by the providers who participated in the <i>Value-Based Provider Incentive Program</i> will serve as the Intervention Group.</p> <p><b>Comparison Group 1:</b> Above-mentioned members in the pre-intervention period.</p> <p><b>Comparison Group 2:</b> All members seen by the providers who did not participate in the <i>Value-Based Provider Incentive Program</i>.</p> <p><b>Potential Subgroups:</b> Rural-urban groups, other identified subgroups.</p>	<ul style="list-style-type: none"> <li>• MCOs' administrative databases on Value-Based Provider Incentive Programs.</li> <li>• Medicaid Management Information System (MMIS) Encounter database.</li> <li>• MMIS Eligibility and Enrollment database.</li> <li>• MCOs' Member-level case management data systems.</li> </ul>	Comparative Interrupted Time Series Evaluation Design

Table C1. Design for the Evaluation of the KanCare 2.0 Demonstration (Continued)				
Evaluation Question	Outcome Measures	Sample or Population Subgroups to be Compared	Data Sources	Analytic Methods
<b>Hypothesis 1 (Continued)</b>				
	<p><b>Qualitative Measures:</b></p> <ul style="list-style-type: none"> <li>• Factors that facilitated the implementation of the Value-Based Provider Incentive Program.</li> <li>• Barriers encountered in implementing the Value-Based Provider Incentive Program.</li> <li>• Recommendations to further improve Value-Based Provider Incentive Program.</li> <li>• Recommendations to remove barriers encountered in the implementation of the Value-Based Provider Incentive Program.</li> </ul> <p>Observations about why this program was able to succeed or why it did not meet its goals.</p>		<ul style="list-style-type: none"> <li>• MCO databases/tables for Value-based Provider Incentive Programs performance measures.</li> <li>• Online provider survey.</li> <li>• Key informant interviews of the providers.</li> </ul>	
<b>Hypothesis 2</b>				
1. Did provision of supports for employment and independent living to the KanCare 2.0 members with disabilities and behavioral health conditions who are living in the community improve their independence and health outcomes?	<p>Final list of outcomes will be determined based on data availability:</p> <ul style="list-style-type: none"> <li>• Current employment status</li> <li>• # of members who felt they were employed based on their skills and knowledge (if employed)</li> <li>• Increased stable housing – # of addresses member lived in the past year (and assess type of housing).</li> <li>• Decreased current legal problem (e.g., probation, parole, arrests)</li> <li>• # of days living in the community</li> <li>• # of members worried about paying bills</li> <li>• Decreased ED visits</li> <li>• Decreased inpatient hospitalizations</li> </ul>	<p><b>Study population:</b> Members living in the community and receiving behavioral health services or HCBS services in the Physical Disability, Intellectual or Developmental Disability, and Brain Injury waiver programs who opted to receive service coordination and were identified as potentially needing employment or independent living supports. <b>Target Intervention Group:</b> Study population members who received employment or independent living supports through KanCare 2.0 service coordination.</p>	<ul style="list-style-type: none"> <li>• MMIS Encounter database;</li> <li>• MMIS Eligibility and Enrollment database;</li> <li>• MCOs Member-level case management data systems (including HRA questionnaire).</li> </ul>	Pretest-Posttest Design with Nonequivalent Groups

Table C1. Design for the Evaluation of the KanCare 2.0 Demonstration (Continued)				
Evaluation Question	Outcome Measures	Sample or Population Subgroups to be Compared	Data Sources	Analytic Methods
<b>Hypothesis 2 (Continued)</b>				
		<p><b>Comparison Group:</b> Study population members who did not receive supports through KanCare 2.0 service coordination.</p> <p><b>Potential subgroups:</b> Members receiving behavioral health services; members receiving HCBS services in the PD, I/DD, &amp; BI waiver programs.</p>		
<b>Hypothesis 3</b>				
<p>1. Did use of telemedicine services increase over the five-year period for KanCare members living in rural or semi-urban areas?</p> <p>2. Did use of the telemonitoring services increase over the five-year period for KanCare members with chronic conditions living in rural or semi-urban areas?</p> <p>3. Evaluation question related to the telemonitoring: Evaluation question and design will be developed later</p>	<p><b>Quantitative Measures:</b></p> <p><b>Telemedicine:</b></p> <ul style="list-style-type: none"> <li>• % of telemedicine services received by the members living in rural or semi-urban areas.</li> <li>• # of receiving sites for telemedicine services in rural or semi-urban areas</li> </ul> <p>• % of members living in rural or semi-urban areas who received telemedicine services</p> <p><b>Telemonitoring:</b></p> <ul style="list-style-type: none"> <li>• % of members living in rural or semi-urban areas who received telemonitoring services</li> <li>• # of telemonitoring services provided to members living in rural or semi-urban areas (total number and by types of service or claims)</li> <li>• # of providers monitoring health indicator data transmitted to them by the members living in rural or semi-urban counties receiving telemonitoring services</li> <li>• Other measures (TBA)</li> </ul>	<p><b>Intervention Group:</b> All members living in the rural or semi-urban areas and the providers who participated in the telehealth strategies.</p> <p><b>No Comparison Group.</b></p> <p><b>Potential Subgroups:</b> Telemedicine and/or telemonitoring service type; provider specialty type; specific chronic conditions; &amp; geographic regions of the state</p>	<ul style="list-style-type: none"> <li>• MMIS Encounter database.</li> <li>• MMIS Eligibility and Enrollment database.</li> <li>• Other data sources for measures (will be identified later).</li> </ul>	<p>Non-experimental method (One-Group Pretest–Posttest Design)</p>

Table C1. Design for the Evaluation of the KanCare 2.0 Demonstration (Continued)				
Evaluation Question	Outcome Measures	Sample or Population Subgroups to be Compared	Data Sources	Analytic Methods
<b>Hypothesis 3 (Continued)</b>				
4. Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?	<ul style="list-style-type: none"> <li>• # of paid claims with selected procedure codes, stratified by area, mode of delivery, and service type.</li> <li>• # of members with selected diagnosis (e.g., speech-language pathology) per 1,000 members.</li> </ul> <p><b>Qualitative Measures:</b></p> <ul style="list-style-type: none"> <li>• Factors that facilitated the use of telemedicine and/or telemonitoring services for the Medicaid members.</li> <li>• Barriers encountered in using telemedicine and/or telemonitoring services for the Medicaid members.</li> <li>• Recommendations about how to further improve the use of telemedicine and/or telemonitoring services.</li> <li>• Recommendations about how to remove barriers encountered in using telemedicine and/or telemonitoring services.</li> <li>• Observations about why the use of telemedicine and/or telemonitoring services succeeded or did not succeed in increasing the access to care for the Medicaid members in rural and semi-rural areas.</li> </ul>	<p><b>Area Strata:</b> rural, semi-urban, urban counties.  <b>Mode Strata:</b> telehealth, in-person.  <b>Service Type Strata:</b> e.g., speech-language pathology, audiology, primary care, behavioral health.</p>	<ul style="list-style-type: none"> <li>• MMIS Encounter database.</li> <li>• Online provider survey and/or key-informant interviews with the providers who submitted claims for telemedicine and/or telemonitoring services.</li> </ul>	<p>Trending analysis; Independence of variables (Pearson’s chi-square); Homogeneity of odd ratios (Breslow-Day)</p>
<b>Hypothesis 4</b>				
1. Did removing payment barriers for services provided in IMDs for KanCare members improve member access to SUD treatment services.	<ul style="list-style-type: none"> <li>• Number of IMDs providing SUD services.</li> <li>• Number of geographic locations (by region/ county) for SUD treatment in IMDs.</li> <li>• Number of admissions with SUD treatment services in IMDs.</li> <li>• Average length of stay for SUD treatment services within IMDs.</li> </ul>	<p>The evaluation will focus on examining increased availability of IMD facilities providing SUD treatment services over the five-year period. <b>No Intervention or Comparison groups will be examined.</b></p>	<ul style="list-style-type: none"> <li>• Provider Network Report</li> <li>• MMIS encounter data</li> <li>• Provider licensing data</li> <li>• MCO utilization reports</li> </ul>	<p>Non-experimental method (descriptive data)</p>

## a. Methodology for the Evaluation of the Service Coordination Strategy

### Evaluation Question

Did the ***Service Coordination Strategy*** of integrating physical and behavioral health services provided to KanCare members **improve quality of care, health, and cost outcomes?**

### Demonstration Strategy

The ***Service Coordination Strategy*** implements health risk assessments (HRA), needs assessments, and development and implementation of plans of service (POS) or person-centered service plans (PCSP) among KanCare 2.0 members who meet HRA thresholds based on health screening scores.

### Evaluation Design

***Comparative Interrupted Time Series Evaluation Design*** will be used to examine the evaluation question.

To conduct *Comparative Interrupted Time Series* analysis, KanCare 2.0 members who met the HRA threshold based on health screening scores and received service coordination (excluding those who opted for the OneCare Kansas program) will serve as the **Intervention Group**. The program members in the pre-intervention period will serve as the **Comparison Group 1**. The design will also include **Comparison Group 2** that will be comprised of KanCare 2.0 members who received a health screening score 3 to 5 points below the threshold and received traditional care, as well as members who met the HRA threshold but opted not to receive service coordination and received traditional care. Outcome data for pre- and post-intervention periods will be compared to examine whether pre-post intervention change differed between these groups or not. This comparison will assist in examining whether the intervention changed the level of outcome or if it also impacted the long-term trend.

### Target and Comparison Population

**Study Population:** KanCare 2.0 members who met the HRA threshold or had scores 3-5 points below the HRA threshold based on health screening scores.

**Intervention Group:** KanCare 2.0 members who met the HRA threshold based on health screening scores and received service coordination (e.g., HRA, needs assessments, and development and implementation of the POS or PCSP) will constitute the Intervention Group (excluding those who opted for the OneCare Kansas program). Their post-intervention outcome data for the period of five years will be examined (2019 through 2023).

**Comparison Group 1:** Above-mentioned members in the pre-intervention period will serve as the Comparison Group 1. The pre-intervention outcome data for the period of three years will be examined (2016 through 2018).

**Comparison Group 2:** This group will include: 1) KanCare 2.0 members whose health screening scores were 3-5 points below the HRA threshold and who received traditional care instead of service coordination; and 2) KanCare 2.0 members who met the HRA threshold but opted not to receive service coordination and received traditional care. The outcome data for the pre- and post-intervention periods for this group will be compared (pre-intervention period: 2016–2018; post-intervention period: 2019–2023).

### Potential Subgroups:

In addition to assessing evaluation measures in overall Intervention and Comparison Groups described above, subgroup analyses will also be conducted within these groups to identify the benefit of the *Service Coordination Strategy* on any specific subpopulation group.

Subgroup analyses will be conducted among the following subpopulation groups depending upon the availability of sufficient sample size (members among Intervention and Comparison groups with the following conditions):

- Members with specific chronic conditions;
- Members with specific behavioral health conditions; and
- Members receiving HCBS services.

### Evaluation Period

The total evaluation period will be 2016 through 2023.

Pre-Intervention Period: 2016–2018; and Post-Intervention Period: 2019–2023.

### Evaluation Measures

The following outcomes will be assessed among Intervention and Comparison Groups to examine the evaluation question:

- Annual Dental Visit (ADV) (HEDIS measure – Quality of Care outcome)
- Adults’ Access to Preventive/Ambulatory Health Services (AAP) (HEDIS measure – Quality of Care outcome)
- Adolescent Well-Care Visits (AWC) (HEDIS measure – Quality of Care outcome)
- Follow-Up After Hospitalization for Mental Illness (FUH) (HEDIS measure – Quality of Care outcome)
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) (HEDIS measure – Quality of Care outcome)
- Antidepressant Medication Management (AMM) (HEDIS measure – Quality of Care/Adherence outcome)
- ED visits, observation stays, or inpatient admissions for following conditions (Administrative measure – Health outcome)
  - Diabetic Ketoacidosis/Hyperglycemia, or
  - Acute severe asthma, or
  - Hypertensive crisis, or
  - Fall injuries, or
  - SUD, or
  - Mental health issues
- Outpatient or professional claims for following conditions (Administrative measure – Health outcome):
  - Diabetic retinopathy, or
  - Influenza, or
  - Pneumonia, or
  - Shingles
- Emergency department visits (Administrative measure – Cost outcome)
- Inpatient Utilization (IPU), excluding maternity admissions (HEDIS measure – Cost outcome)

See **Table A2.1** within **Attachment 2** for enhanced discussion of these measures.

### Data Sources

The following data sources will be used to collect data to determine outcomes of the Service Coordination Strategy:

- MMIS Encounter database;
- MMIS Eligibility and Enrollment database; and
- MCOs’ Member-level case management data systems.

See **Table A3.1** within **Appendix 3** for enhanced discussion of these data sources.

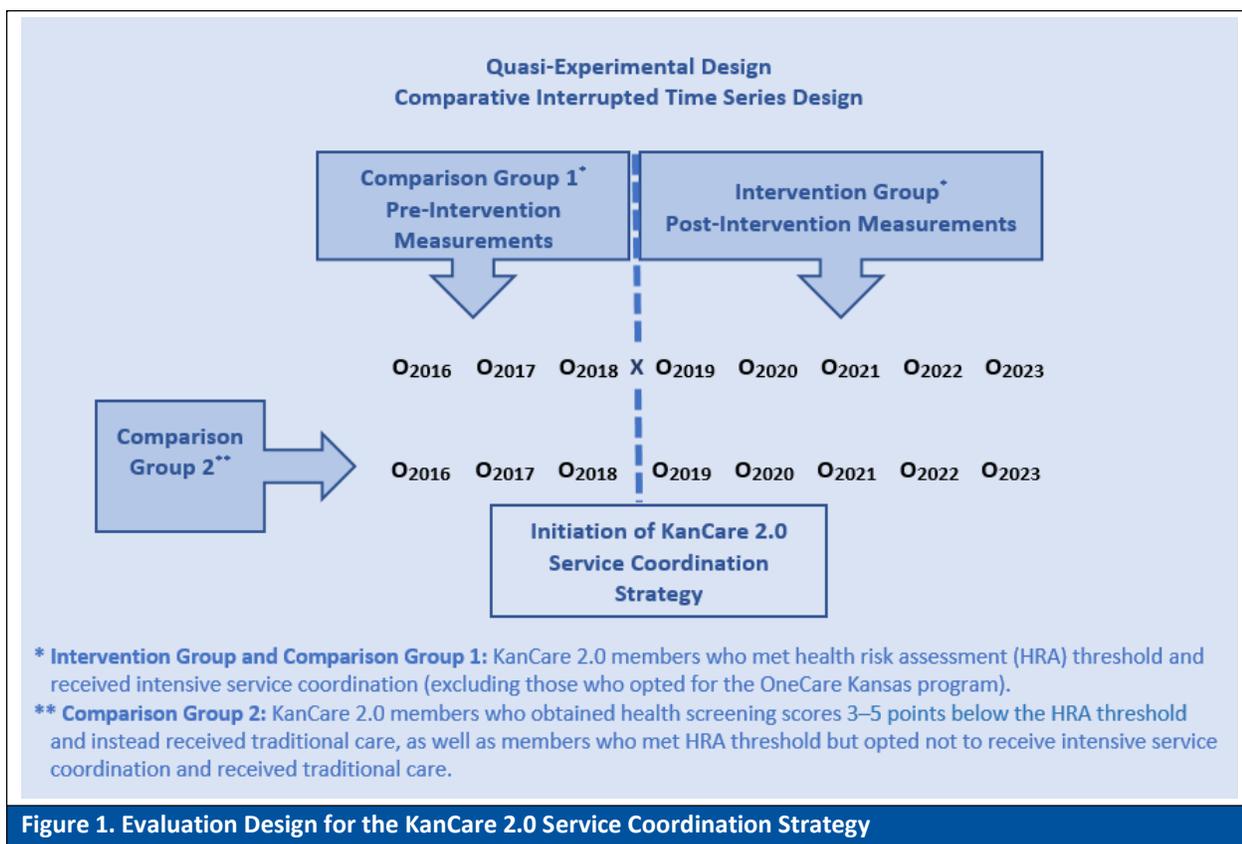
### Analytic Methods

The entire eligible populations for the Intervention and Comparison Groups will be included in the study, and any pre- and post-intervention changes will be examined. If samples are needed, then power calculations will be completed to ensure validity of the findings.

The following analytical methods will be used to examine the evaluation question:

- Data obtained from various sources will be reviewed for missing values, inconsistent patterns, and outliers to ensure quality and appropriateness of data for analyses required by the evaluation design.
- For statistical procedures, a final dataset with all required variables will be created by merging data from various sources.
- Descriptive statistics will examine homogeneity of the demographic characteristics of the members in Intervention and Comparison Group 2.
- Trend analysis will be conducted using statistical tests such as a Mantel-Haenszel chi-square test with  $p < .05$  indicating statistical significance.
- Comparative interrupted time series analysis will be conducted using aggregate data collected for equally-spaced intervals before and after the intervention. A time series of selected outcomes of interest will be used to establish underlying trends and examined to see if these trends are “interrupted” by the intervention at known points in time (longitudinal effects of intervention), through regression modelling. The covariates such as age, gender, and multimorbidity will also be included in the regression models to adjust for the confounding factors. If needed, adjustment will also be done for other appropriate confounding factors. The methodological issues related to the analytical method such as autocorrelation will be assessed by examining the plot of residuals and the partial autocorrelation function. Sensitivity analyses will be done to test the impact of a varying range of model assumptions, such as different lags and types of impact models.
- Subgroup analyses using above-mentioned statistical procedures will be conducted for subpopulation groups (members with specific chronic conditions, members with specific behavioral conditions, and members receiving HCBS services). These subgroup analyses will depend on availability of sufficient sample sizes.

Design for the evaluation of the Service Coordination Strategy is summarized in Figure 1.



## b. Methodology for the Evaluation of OneCare Kansas

### Evaluation Question

Did the **OneCare Kansas** program, by implementing comprehensive and intense method of care coordination, **improve the quality of care, health, and cost outcomes?**

### Demonstration Strategy

The **OneCare Kansas** program will provide coordination of physical and behavioral care with long term services and supports for KanCare members with chronic conditions, like diabetes, asthma, or mental illness. The program will be an opt-in program for adults and children. The program expands upon medical home models to include links to community and social supports. OneCare Kansas will use a “team of health professionals” approach of the health home model. In this model, the three KanCare managed care organizations (MCOs) will serve as the Lead Entities (LEs) for OCK and will contract with community providers to be OneCare Kansas Partners (OCKPs). The OCKPs will provide all OCK services, and the MCO will not provide any direct services in this model.<sup>9</sup> All the caregivers involved in a OneCare Kansas member’s health will communicate with one another for addressing all needs of the patient in a comprehensive manner.<sup>10</sup> OneCare Kansas will provide six core services<sup>10</sup> that include comprehensive care management, care coordination, health promotion, comprehensive transitional care (including appropriate follow-up) from inpatient to other settings, members and family support, and referral to community and social support services.<sup>11</sup>

### Evaluation Design

**Comparative Interrupted Time Series Evaluation Design** will be used to examine the evaluation question.

To conduct *Comparative Interrupted Time Series* analysis, KanCare 2.0 members eligible for OneCare Kansas and opted to participate in the program and received core services of the program will serve as the **Intervention Group**. The program members in the pre-intervention period will serve as the **Comparison Group 1**. KanCare 2.0 members eligible for OneCare Kansas who did not opt to participate in the program and received traditional care instead of the OneCare Kansas services will constitute the **Comparison Group 2**. Outcome data for the pre- and post-intervention periods will be compared to examine whether pre-post intervention change differed between these groups or not. This comparison will assist in examining whether the intervention changed the level of outcome or if it also impacted the three-year trend.

### Target and Comparison Population

**Study Population:** KanCare 2.0 members eligible for the OneCare Kansas program.

**Intervention Group:** KanCare 2.0 members eligible for the OneCare Kansas program who opted to participate in the program and received its core services will constitute the Intervention Group. The post-intervention outcome data for the period of four years will be examined (2020 through 2023). Please note, the length of post-intervention period will depend on the start date of the program. Currently, the program start date is planned as January 1, 2020.

**Comparison Group 1:** Program members in the pre-intervention period will serve as the Comparison Group 1. The pre-intervention outcome data for the period of three years will be examined (2016 through 2019). The pre-intervention period will depend on the start date of the program.

**Comparison Group 2:** KanCare 2.0 members eligible for the OneCare Kansas program who did not opt to participate in the program and received traditional care will serve as the Comparison Group 2. The outcome data for the pre- and post-intervention periods for this group will be compared with the Intervention Group data (pre-intervention period: 2016–2019; post-intervention period: 2020–2023). The pre- and post-intervention period will depend on the start date of the OneCare Kansas program.

*Potential Subgroups:*

In addition to assessing evaluation measures in overall Intervention and Comparison Groups described above, subgroup analyses will also be conducted within these groups to identify the benefit of the OneCare Kansas program on any specific subpopulation group.

Subgroup analyses will be conducted among the following subpopulation groups depending upon the availability of sufficient sample size (members among the Intervention and Comparison groups with the following conditions):

- Members with severe bipolar disorder,
- Members with Paranoid Schizophrenia, and
- Members with asthma that are also at risk for developing:
  - Diabetes
  - Hypertension
  - Kidney Disease (not including Chronic Kidney Disease Stage 4 and ESRD)
  - Cardiovascular Disease
  - COPD
  - Metabolic Syndrome
  - Mental Illness (not including Paranoid Schizophrenia and Severe Bipolar Disorder)
  - Substance Use Disorder
  - Morbid Obesity (body weight 100lbs over normal body weight, BMI greater than 40, or BMI over 31 with obesity-related health problems)
  - Tobacco Use or exposure to second hand smoke

Evaluation Period

The tentative evaluation period will be 2016 through 2023.

Pre-Intervention Period: 2016–2019; and Post-Intervention Period: 2020–2023.

Please note, the pre- and post-intervention period will depend on the start date of the OneCare Kansas program.

Evaluation Measures

The following quantitative outcomes will be examined among Intervention and Comparison Groups to examine the evaluation question (tentative list, as it will depend on the final selection of chronic conditions to constitute eligibility criteria for the program):

- Annual Dental Visit (ADV) (HEDIS measure – Quality of Care outcome)
- Adults’ Access to Preventive/Ambulatory Health Services (AAP) (HEDIS measure – Quality of Care outcome)
- Adolescent Well-Care Visits (AWC) (HEDIS measure – Quality of Care outcome)
- Follow-Up After Hospitalization for Mental Illness (FUH) (HEDIS measure – Quality of Care outcome)
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) (HEDIS measure – Quality of Care outcome)
- Antidepressant Medication Management (AMM) (HEDIS measure – Quality of Care outcome)
- ED visits, observation stays, or inpatient admissions for the following conditions (Administrative measure – Health outcome)
  - Diabetic Ketoacidosis/Hyperglycemia, or
  - Acute severe asthma, or
  - Hypertensive crisis, or
  - Fall injuries, or
  - SUD, or
  - Mental health issues
- Outpatient or professional claims for following conditions (Administrative measure – Health outcome):
  - Diabetic retinopathy, or
  - Influenza, or
  - Pneumonia, or
  - Shingles

- Emergency department visits (Administrative measure – Cost outcome)
- Inpatient admissions (IPU), excluding maternity admissions (HEDIS measure – Cost outcome)

In addition to the quantitative measures, qualitative information will be collected twice during the evaluation period (mid-year and the last year of the evaluation period) from the OneCare Kansas Learning Collaborative that will include KDHE, MCOs, OCK partners (OCKPs), and Association partners. The Learning Collaborative process will identify evolving learning needs, as well as ways to address those needs, allowing for continual quality improvement of the OCK system. This information will be categorized to examine similar and dissimilar themes to further understand the program.

Following is the potential list of qualitative measures:

- Learning needs identified by the OneCare Kansas Learning Collaborative.
- Processes to address the learning needs identified by the OneCare Kansas Learning Collaborative.
- Factors that facilitated the implementation of the OneCare Kansas program to achieve its goal.
- Barriers encountered in implementation of the OneCare Kansas program.
- Recommendations regarding how the quality of the OneCare Kansas program can be further improved.
- Observations why this program was able to succeed or why it did not meet its goals.

Additional qualitative measures will be examined based on the themes identified from the information obtained from the OneCare Kansas Learning Collaborative members.

See **Table A2.2** and **Table A2.3** within **Appendix 2** for enhanced discussion of these measures.

### Data Sources

The following data sources will be used to collect data to determine outcomes of the Service Coordination Strategy:

- MMIS Encounter database
- MMIS Eligibility and Enrollment database
- OneCare Kansas members' eligibility and participation database
- MCOs' Member-level case management data systems.
- OneCare Kansas Learning Collaborative reports

See **Table A3.1** within **Appendix 3** for enhanced discussion of these data sources.

### Analytic Methods

The entire eligible populations for the intervention and comparison groups will be included in the study, and any pre- and post-intervention changes will be examined. If samples are needed, then power calculations will be done to ensure validity of the findings.

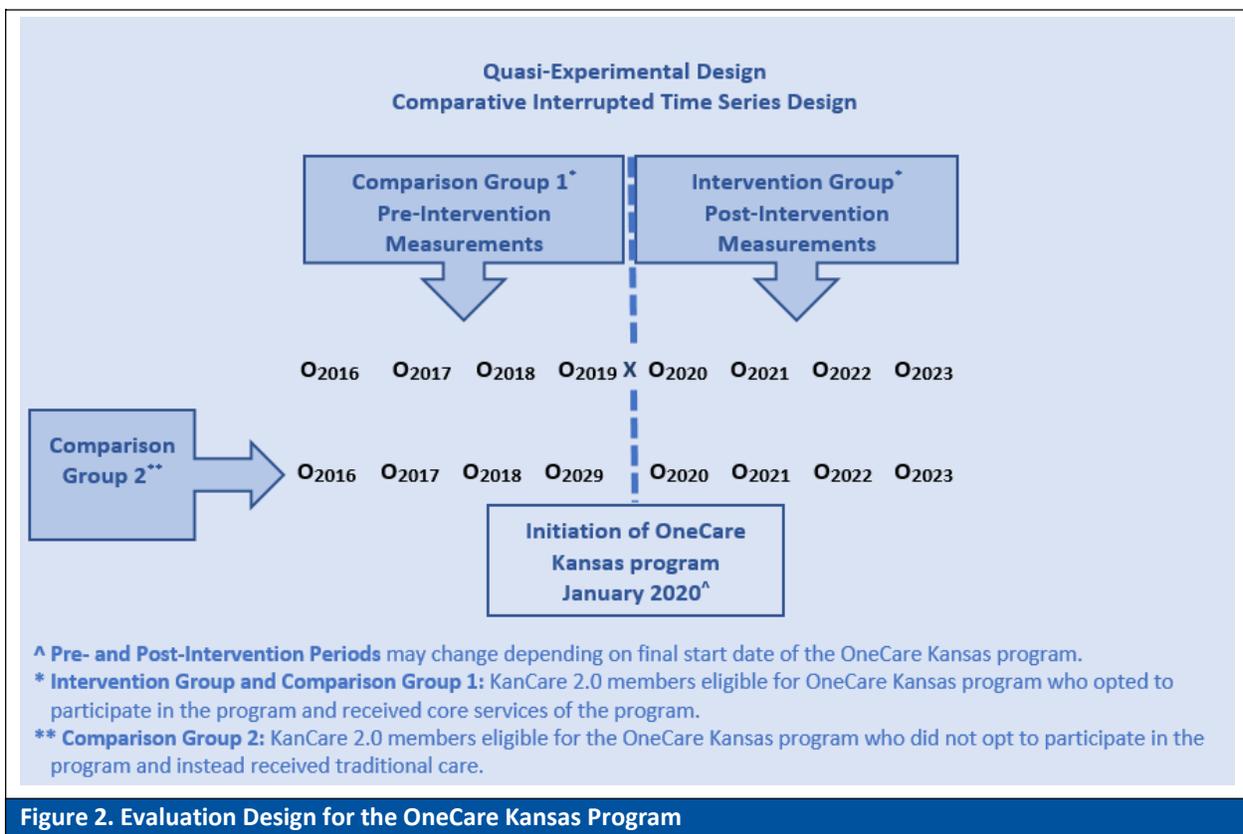
The following analytical methods will be used to examine the evaluation question:

- Data obtained from various sources will be reviewed for missing values, inconsistent patterns, and outliers to ensure quality and appropriateness of the data for analyses required by the evaluation design.
- For statistical procedures, a final dataset with all required variables will be created by merging data from various sources.
- Descriptive statistics will examine homogeneity of the demographic characteristics of the members in the Intervention and Comparison Group 2.
- Trend analysis will be conducted using statistical tests such as a Mantel-Haenszel chi-square test with  $p < .05$  indicating statistical significance.
- Comparative interrupted time series analysis will be conducted using aggregate data collected for equally spaced intervals before and after the intervention. A time series of selected outcomes of interest will be used to establish underlying trends and examined to see if these trends are "interrupted" by the intervention at known points in

time (longitudinal effects of intervention), through regression modelling. The covariates such as age, gender, and multimorbidity will be included in the regression models to adjust for the confounding factors. If needed, adjustment will also be done for other appropriate confounding factors. The methodological issues related to the analytical method such as autocorrelation will be assessed by examining the plot of residuals and the partial autocorrelation function. Sensitivity analyses will be done to test the impact of varying range of model assumptions, such as different lags, and types of impact models.

- Subgroup analyses using above-mentioned statistical procedures will be conducted for subpopulation groups (members with severe bipolar disorder, members with paranoid schizophrenia, and members with asthma and at risk for at least one other chronic condition). These subgroup analyses will depend on availability of sufficient sample sizes.
- Qualitative data analysis techniques will be used to analyze qualitative data collected through OneCare Kansas Learning Collaborative sessions/reports. The steps for qualitative data analysis will include: **getting familiar with the data** by looking for basic observations or patterns; **revisiting research objectives** to identify the questions that can be answered through the collected data; **developing a framework** (coding and indexing) to identify broad ideas, concepts, behaviors, or phrases, and assign codes for structuring and labeling data; **identifying themes, patterns, and connections** to answer research questions, and finding areas that can be explored further (Content and Narrative analyses); and **summarization of the qualitative information** to add to the overall evaluation results.

The design for the evaluation of the OneCare Kansas program is summarized in Figure 2.



## c. Methodology for the Evaluation of Hypothesis 1

### Evaluation Questions

- Did the **Value-Based Provider Incentive Program** increase integration and reduce silos between physical and behavioral health services provided to KanCare members?
- Did the **Value-Based Provider Incentive Program** for integration between physical and behavioral health services **improve quality of care, health, and cost outcomes?**

### Demonstration Strategy

A **Value-Based Provider Incentive Program** for integration between physical health and behavioral health services designed by the MCOs will be used to engage providers to implement physical and behavioral health service coordination (value-based purchasing strategy).

### Evaluation Design

**Comparative Interrupted Time Series Evaluation Design** will be used to examine the evaluation questions for Hypothesis 1.

To evaluate the effect of the *Value-Based Provider Incentive Program* on the quality of care, health, and cost outcomes, *Comparative Interrupted Time Series* analysis will be conducted, in which KanCare 2.0 members seen by the providers who participated in the program will serve as the **Intervention Group**.

The program members in the pre-intervention period will serve as the **Comparison Group 1**. KanCare 2.0 members seen by the providers who did not participate in the *Value-Based Provider Incentive Program* will serve as the **Comparison Group 2**. The pre- and post-intervention outcome data will be examined to assess whether changes differed between Intervention and Comparison Groups. This comparison will assist in examining whether the intervention changed the level of outcome or if it also changed the long-term trend.

### Target and Comparison Population

**Intervention Group:** KanCare 2.0 members seen by the providers who participated in the *Value-Based Provider Incentive Program* promoting physical and behavioral health service coordination will constitute the Intervention Group. Their post-intervention outcome data for the period of five years will be examined (2019 through 2023).

**Comparison Group 1:** Program members in the pre-intervention period will serve as the Comparison Group 1. The pre-intervention outcome data for the period of three years will be examined (2016 through 2018).

**Comparison Group 2:** KanCare 2.0 members seen by the providers who did not participate in the *Value-Based Provider Incentive Program* will serve as the Comparison Group 2. The outcome data for the pre- and post-intervention periods for this group will be compared with the Intervention Group data. The pre-intervention period will be comprised of 2016 through 2018 (as data allows). The post-intervention period will be comprised of 2019 through 2023.

### Potential Subgroups:

The Intervention and Comparison Groups will be examined to identify potential subpopulation groups, such as rural-urban subgroups. In addition to assessing evaluation measures in overall Intervention and Comparison Groups, subgroup analyses will also be conducted to identify the benefit of the *Value-Based Provider Incentive Program* among identified subpopulation groups (depending on availability of sufficient sample size).

### Evaluation Period

The total evaluation period will be 2016 through 2023.

Pre-Intervention Period: 2016–2018; and Post-Intervention Period: 2019–2023.

## Evaluation Measures

Following is the potential list of quantitative outcomes to examine the evaluation questions (**final list will be based on specific value-based provider incentive programs implemented by the MCOs**):

- Annual Dental Visit (ADV) (HEDIS measure – Quality of Care outcome)
- Adults’ Access to Preventive/Ambulatory Health Services (AAP) (HEDIS measure – Quality of Care outcome)
- Adolescent Well-Care Visits (AWC) (HEDIS measure – Quality of Care outcome)
- Follow-Up After Hospitalization for Mental Illness (FUH) (HEDIS measure – Quality of Care outcome)
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) (HEDIS measure – Quality of Care outcome)
- Antidepressant Medication Management (AMM) (HEDIS measure – Quality of Care/Adherence outcome)
- Identification of Alcohol and Other Drug Services (IAD) (HEDIS measure – Quality of Care outcome)
- Follow-Up Care for Children Prescribed ADHD Medication (ADD) (HEDIS measure – Quality of Care outcome)
- Use of Opioids at High Dosage (UOD) (HEDIS measure – Quality of Care outcome)
- Use of Opioids from multiple providers (UOP) (HEDIS measure – Quality of Care outcome)
- Mental Health Utilization (MPT) (HEDIS measure – Quality of Care and Health outcome)
- ED visits, observation stays, or inpatient admissions for following conditions (Administrative measure – Health outcome):
  - Diabetic Ketoacidosis/Hyperglycemia, or
  - Acute severe asthma, or
  - Hypertensive crisis, or
  - Fall injuries, or
  - SUD, or
  - Mental health issues
- Outpatient or professional claims for following conditions (Administrative measure – Health outcome):
  - Diabetic retinopathy, or
  - Influenza, or
  - Pneumonia, or
  - Shingles
- Emergency department visits (Administrative measure – Cost outcome)
- Inpatient admission (IPU), excluding maternity admissions (HEDIS measure – Cost outcome)
- MCO-specified measure on effectiveness of their value-based purchasing program on increasing physical and behavioral health service integration (to be determined)

In addition to the above-mentioned quantitative outcome measures, the qualitative information will also be collected twice during the evaluation period (mid-year and the last year of the evaluation period) to further assess whether the *Value-Based Provider Incentive Program* increased the integration between physical and behavioral services. The qualitative information will be collected by designing and conducting an online provider survey and/or key-informant interviews with the providers participating in the *Value-Based Provider Incentive Program*. The online survey will be designed using Survey Monkey software and will include open-ended questions. The survey questions will collect information from the providers on the facilitators and barriers related to the implementation of the *Value-Based Provider Incentive Program*. In addition, providers will be asked to provide recommendations for removing barriers and to further strengthen the program to make it successful in achieving its goals. The survey responses will be categorized to examine similar and dissimilar themes and finding areas that can be further explored through key informant interviews of the providers. Key informant interviews will be conducted from a random sample of the providers participating in the *Value-Based Provider Incentive Program* to collect in-depth information to assess the reasons why this program succeeded or why it did not meet its goals.

Following is the potential list of qualitative measures:

- Factors that facilitated the implementation of the Value-Based Provider Incentive Program.
- Barriers encountered in implementing the Value-Based Provider Incentive Program.

- Recommendation about how to further improve the Value-Based Provider Incentive Program.
- Recommendations about how to remove barriers encountered in the implementation of the Value-Based Provider Incentive Program.
- Observations regarding why this program was able to succeed or why it did not meet its goals.

Additional qualitative measures will be examined based on the themes identified from the survey and Key informant interviews.

See **Table A2.4** and **Table A2.5** within **Appendix 2** for enhanced discussion of these measures.

### Data Sources

The following data sources will be used for the evaluation of Hypothesis 1:

- MCOs' administrative databases on *Value-Based Provider Incentive Programs*,
- MMIS Encounter database,
- MMIS Eligibility and Enrollment database,
- MCOs' member-level case management data systems,
- MCO databases/tables for *Value-based Provider Incentive Program* performance measures,
- Online provider survey to collect qualitative information from the providers participating in the *Value-Based Provider Incentive Program*, and
- Key informant interviews from a sample of the providers participating in the *Value-Based Provider Incentive Program*.

See **Table A3.1** within **Appendix 3** for enhanced discussion of these data sources.

### Analytic Methods

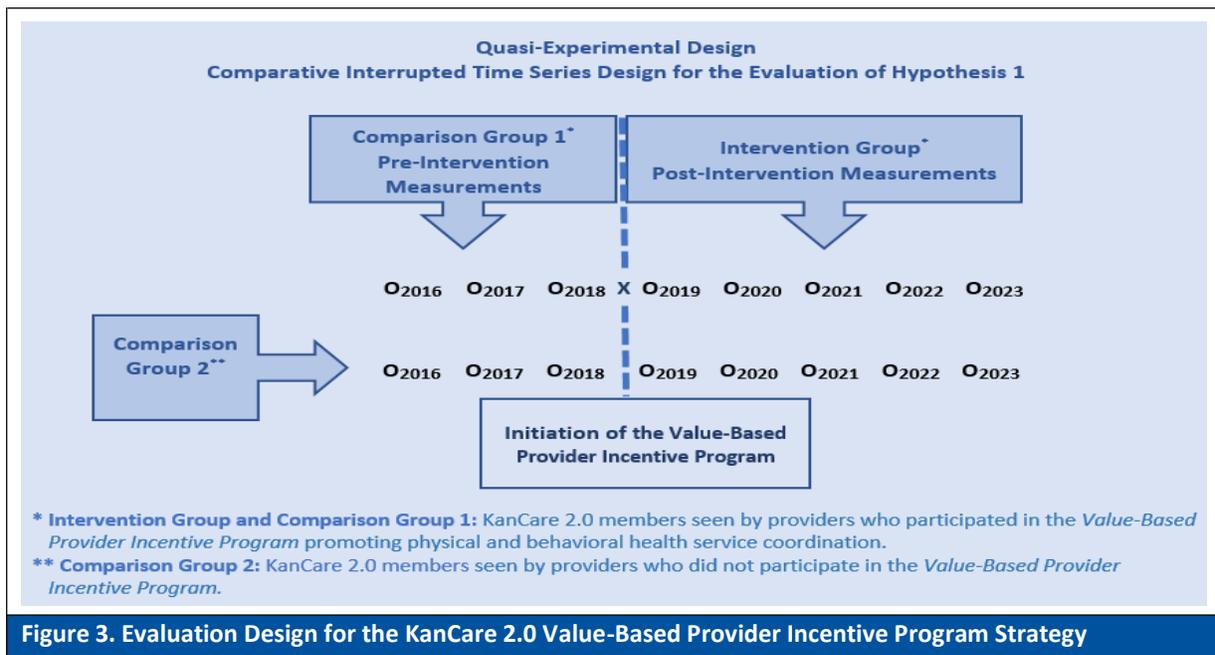
The entire eligible population for the intervention and comparison groups will be included in the study and any pre- and post-intervention changes will be examined. If samples are needed, then power calculations will be done to ensure validity of the findings.

The following analytical methods will be used to examine the evaluation questions:

- Data obtained from various sources will be reviewed for missing values, inconsistent patterns, and outliers to ensure quality and appropriateness of the data for analyses required by the evaluation design.
- For statistical procedures, a final dataset with all required variables will be created by merging data from various sources.
- Descriptive statistics will examine homogeneity of the demographic characteristics of the members in the Intervention Group and Comparison Group 2.
- Trend analysis will be conducted using statistical tests such as a Mantel-Haenszel chi-square test with  $p < .05$  indicating statistical significance.
- Comparative interrupted time series analysis will be conducted using aggregate data collected for equally spaced intervals before and after the intervention. A time series of selected outcomes of interest will be used to establish underlying trends and examined to see if these trends are "interrupted" by the intervention at known points in time (longitudinal effects of intervention), through regression modelling. The covariates such as age, gender, and multimorbidity will be included in the regression models to adjust for the confounding factors. If needed, adjustment will also be done for other appropriate confounding factors. The methodological issues related to this analytical method such as autocorrelation will be assessed by examining the plot of residuals and the partial autocorrelation function. Sensitivity analyses will be done to test the impact of varying range of model assumptions, such as different lags and types of impact models.

- Subgroup analyses using above-mentioned statistical procedures will be conducted for identified subpopulation groups (such as rural-urban groups). These subgroup analyses will depend on availability of sufficient sample sizes.
- Qualitative data analysis techniques will be used to analyze qualitative data collected through online survey and key informant interviews of the providers participating in the *Value-Based Provider Incentive Program*. The steps for qualitative data analysis will include: **getting familiar with the data** by looking for basic observations or patterns; **revisiting research objectives** to identify the questions that can be answered through the collected data; **developing a framework** (coding and indexing) to identify broad ideas, concepts, behaviors, or phrases, and assign codes for structuring and labeling data; **identifying themes, patterns, and connections** to answer research questions, and finding areas that can be explored further (Content and Narrative analyses); and **summarization of the qualitative information** to add to the overall evaluation results.

The design for the evaluation of the Hypothesis 1 is summarized in Figure 3.



#### d. Methodology for the Evaluation of Hypothesis 2

##### Evaluation Question

Did provision of supports for employment and independent living to the KanCare 2.0 members with disabilities and the behavioral health conditions who are living in the community improve their independence and health outcomes?

##### Demonstration Strategy

Employment or independent living supports will be provided through KanCare 2.0 service coordination to the members who are living in the community and receiving behavioral health services or HCBS services in the Physical Disability (PD), Intellectual or Developmental Disability (I/DD), and Brain Injury (BI) waiver programs.

##### Evaluation Design

**Pretest–Posttest Design with Nonequivalent Groups** will be used to examine the evaluation question.

The Intervention and Comparison Groups will be derived from the study population. The study population will include members living in the community and receiving behavioral health services or HCBS services in the PD, I/DD, and BI waiver programs who opted to receive service coordination and were potentially needing employment or independent living supports, as indicated through a set of KanCare 2.0 health screening and HRA questions. The members from this

study population who received employment or independent living supports will constitute the **Intervention Group**. The members from the study population who did not receive employment or independent living supports will constitute the **Comparison Group**.

The outcome data for both groups obtained from the health screening and HRA conducted in 2019, as well as the 2019 encounter database will constitute the pre-test data. The 2020–2023 outcome data for both groups will constitute the post-test data. Pre- and post-test data for two groups will be compared.

### Target and Comparison Population

**Study Population:** KanCare 2.0 members living in the community and receiving behavioral health services or HCBS services in the PD, I/DD, and BI waiver programs who opted for service coordination and were identified through a set of KanCare 2.0 health screening and HRA questions as potentially needing employment or independent living supports.

**Intervention Group:** Members in the study population receiving employment or independent living supports (as identified by billing procedure codes) through KanCare 2.0 service coordination will serve as the Intervention Group.

**Comparison Group:** Members in the study population not receiving employment or independent living supports through KanCare 2.0 service coordination will serve as the Comparison Group.

### *Potential Subgroups:*

In addition to assessing evaluation measures in overall Intervention and Comparison Groups described above, subgroup analyses will be conducted within these groups to identify the benefit of the provision of employment or independent living supports among any specific subpopulation group.

Subgroup analyses will be conducted among the following subpopulation groups depending upon the availability of sufficient sample size (members among Intervention and Comparison groups in following subgroups):

- Members receiving behavioral health services,
- Members on HCBS wait lists, and
- Members receiving HCBS services in the PD, I/DD, and BI waiver programs.

### Evaluation Period

The total evaluation period will be 2019 through 2023.

Pre-Intervention Period: 2019; and Post-Intervention Period: 2020–2023.

### Evaluation Measures

The following outcomes will be assessed among Intervention and Comparison Groups to examine the evaluation question (Final list of outcomes will be determined based on data availability):

- Current employment status
- Number of members who felt they were employed based on their skills and knowledge (if employed)
- Number of members with stable housing – number of addresses member lived in the past year;
- Current legal problems (e.g., probation, parole, arrests)
- Number of days in the community
- Number of members who worried about paying bills
- ED visits
- Inpatient hospitalizations

See **Table A2.6** within **Appendix 2** for enhanced discussion of these measures.

### Data Sources

The following data sources will be used for the evaluation of Hypothesis 2:

- MMIS Encounter database
- MMIS Eligibility and Enrollment database
- MCOs' member-level case management data systems.

See **Table A3.1** within **Appendix 3** for enhanced discussion of these data sources.

### Analytic Methods

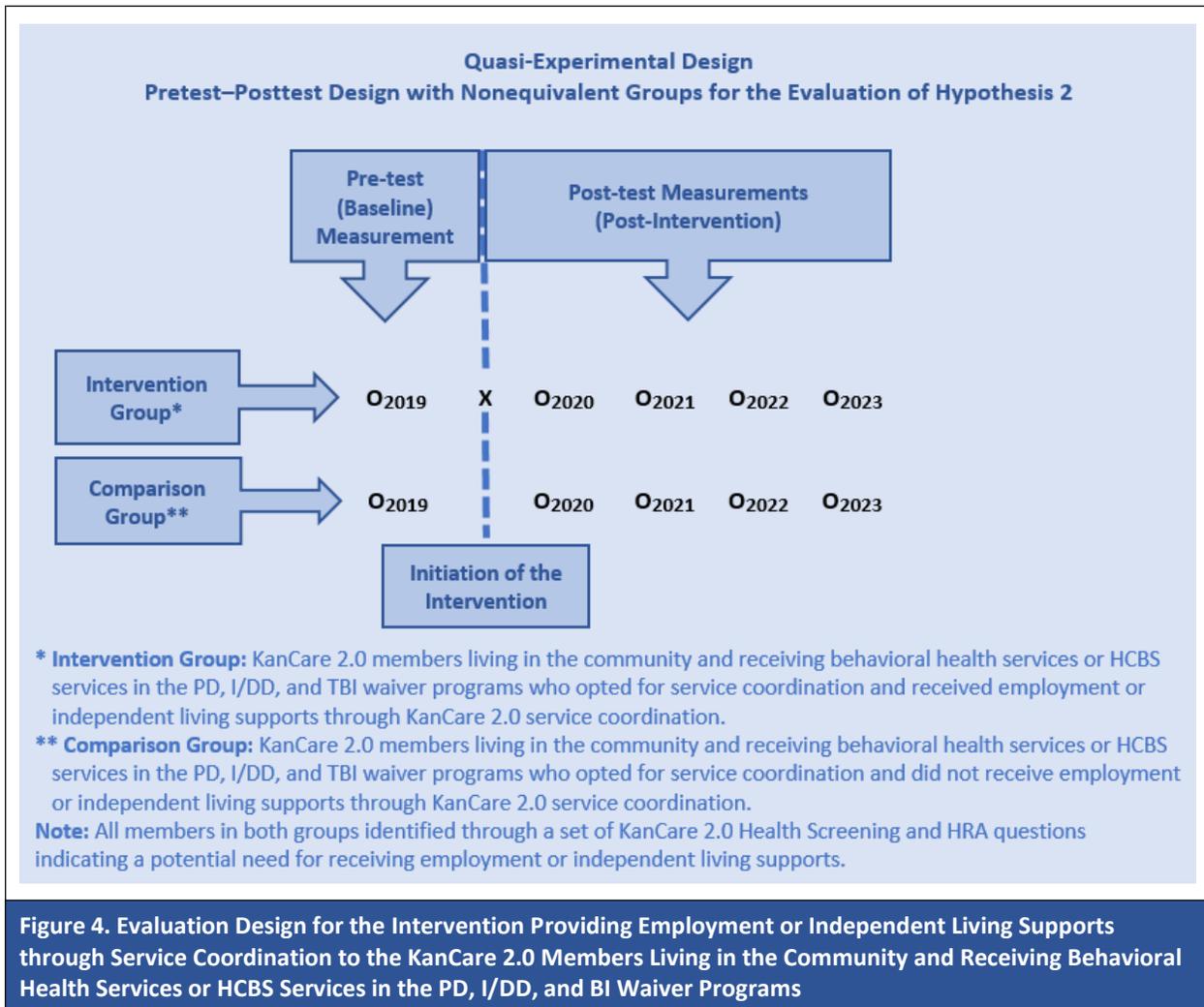
The entire eligible population for the Intervention and Comparison Groups will be included in the study, and any baseline and post-intervention changes will be examined. If samples are needed, then power calculations will be done to ensure validity of the findings.

The following analytical methods will be used to examine the evaluation questions:

- Data obtained from various sources will be reviewed for missing values, inconsistent patterns, and outliers to ensure quality and appropriateness of the data for analyses required by the evaluation design.
- For statistical procedures, a final dataset with all required variables will be created by merging data from various sources.
- Descriptive statistics will examine homogeneity of the demographic characteristics of the members in the Intervention Group and Comparison Group.
- Five-year trends for the outcomes will be examined using statistical tests such as a Mantel-Haenszel chi-square test with  $p < .05$  indicating statistical significance.
- Difference-in-differences (DID) statistical techniques will be used to analyze pre- and post-test data. By applying DID techniques, the impact of providing employment and independent living supports to the members will be measured as the pre-post difference in an outcome for the Intervention Group minus the pre-post difference for the Comparison Group. Assuming *parallel trends*, the amount by which outcomes changed in the Comparison Group over time is the amount by which outcomes in the Intervention Group would have changed over time in the absence of intervention. Given the differences in observed outcomes at the baseline, a similar pre-post difference in the post-intervention period would be considered normal. The additional difference between the Intervention and Comparison Groups (treatment effect) will be attributable to the intervention.
- Subgroup analyses using above-mentioned statistical procedures will be conducted for subpopulation groups (members receiving behavioral health services; members on HCBS wait lists; members receiving HCBS services in the PD, I/DD, and BI waiver programs). These subgroup analyses will depend on availability of sufficient sample sizes.

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The design for the evaluation of the Hypothesis 2 is summarized in Figure 4.



### e. Methodology for the Evaluation of Hypothesis 3

#### Evaluation Questions

- Did use of telemedicine services increase over the five-year period for KanCare members living in rural or semi-urban areas?
- Did *use of telemonitoring services increase over the five-year period* for KanCare members with chronic conditions living in rural or semi-urban areas?
- Evaluation question related to the *telementoring*: Data sources are currently not known to describe the baseline and 5-year status for the use of telementoring pairing rural and semi-urban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions, therefore the related evaluation question and design will be developed later.
- Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?

#### Demonstration Strategies

The State has asked KanCare 2.0 managed care organizations to utilize telehealth solutions in designing, establishing, and maintaining provider networks and to develop models to expand use and effectiveness of telehealth strategies, including telemedicine, telemonitoring, and telementoring, with a focus on enhancing access to services in rural or

semi-urban areas, access to behavioral health services, and support chronic pain management interventions.<sup>1</sup> The State document for MCOs titled “Kansas Medicaid Managed Care Request for Proposal for KanCare 2.0” has described telemedicine, telemonitoring, and telementoring as follows (pp. 106–107):<sup>12</sup>

- a) **“Telemedicine:** *The State is interested in positively impacting member access by exploring telemedicine strategies that expand the full scope of practice by connecting network providers with members at distant sites for purposes of evaluation, diagnosis, and treatment through two-way, real time interactive communication. such projects can greatly enhance access, save time, money and improve outcomes in communities with limited access to health care.”* The state has defined telemedicine as “connecting participating providers with members at distant sites for purposes of evaluation, diagnosis, and treatment through two-way, real time interactive communication.”
- b) **“Telemonitoring:** *Technologies that target specific disease type (i.e. congestive heart failure) or high utilizers of health services, particularly ER services and medication regimen management. Technologies are available that measure health indicators of patients in their homes and transmit the data to an overseeing Provider. The provider, who might be a physician, nurse, social worker, or even a non-clinical staff member, can filter patient questions and report to a clinical team as necessary. The goal would be to reduce admission, ER utilization and improve overall health of the member.”*
- c) **“Telementoring:** *Technologies such as the Project ECHO model to connect community PCPs with specialists remotely located to provide consultations, grand rounds, education, and to fully extend the range of care available within a community practice. The State is also interested in ways that the use of telementoring can attract and retain providers in rural health shortage areas. This could include creating learning and joint consultation strategies that may make working in more isolated environments or practices more attractive.”*

### Evaluation Design

The demonstration strategies related to the three components of Hypothesis 3 will be developed during the five-year period by the MCOs as per State’s guidelines and approval; currently no appropriate comparison group is available. Therefore, the **Non-experimental method (One-Group Pretest–Posttest Design)** will be used to examine the evaluation questions 1, 2, and 3 for Hypothesis 3. The evaluation design will include baseline and cross-year comparisons of the selected evaluation measures among the members living in rural or semi-urban areas who received telehealth strategies (**Intervention Group**). Assessment of trends over time will also be conducted.

The fourth evaluation question is designed to determine if the number of services received is increased by telehealth or if in-person visits are converted to telehealth visits with no overall increase in frequency or level of care received. The State approved a set of speech-language pathology or audiology codes for telehealth delivery effective January 1, 2019. Service delivery trends for these codes, and other codes approved for telehealth during the demonstration, will be monitored and comparisons between rural, semi-urban and urban rates studied. Trends for other services available by telehealth prior to 2018 will also be analyzed, but the impact of telehealth on access to services may already be established. Increase in access to evaluation services may lead to an increase in diagnosis of related conditions. Thus, number of members diagnosed with speech-language and audiology pathological conditions will be analyzed.

### Target and Comparison Population

**Target Population:** KanCare 2.0 members living in the rural or semi-urban areas will constitute the target population.

**Intervention Group:** The members who received telehealth strategies (telemedicine and telemonitoring strategies) will constitute the intervention group.

**Comparison Group:** As described above, the **evaluation design will not include comparison group**. If it is possible to apply the *Pretest–Posttest Design with Non-Equivalent Comparison Groups* for any of the telehealth strategies implemented by the MCOs, then an appropriate comparison group with pre- and post-intervention data will be selected.

*Potential Subgroups:*

Subgroup analyses will also be conducted to identify the benefit of the use of telemedicine and/or telemonitoring services in any specific subgroup. The subgroups, depending upon the availability of sufficient sample size, will be based on:

- Telemedicine and/or telemonitoring service type,
- Provider specialty type,
- Specific chronic conditions, and
- Geographic regions of the state (Western, Central, Eastern regions).

Evaluation Period

The baseline year will depend on the start dates of the implementation of telemedicine and telemonitoring strategies. The evaluation period will be comprised of the intervention start year through 2023.

Evaluation Measures

The following quantitative performance measures for the members living in the rural and semi-urban areas will be assessed to examine the evaluation questions:

**Telemedicine:**

- Percentage of telemedicine services received by the members living in the rural or semi-urban areas. Potential stratification by service, specialty type, or diagnosis.
- Number and percentage of receiving sites for telemedicine services in the rural and semi-urban areas. Potential stratification by service, specialty type, or diagnosis.
- Number and percentage of members living in the rural or semi-urban areas who received telemedicine services. Potential stratification by service, specialty type, or diagnosis.
- Number of paid claims with selected procedure codes, stratified by area, mode of delivery, and provider specialty.
- Number of members with selected diagnosis (e.g., speech-language pathology) per 1,000 members.

**Telemonitoring:**

- Number and percentage of members living in the rural and semi-urban areas who received telemonitoring services. Potential stratification by service, specialty type, or diagnosis.
- Number of telemonitoring services provided to members living in the rural and semi-urban areas.
- Number of providers monitoring health indicator data transmitted to them by the members receiving telemonitoring services.
- Other appropriate measures related to specific telemonitoring strategies implemented for the members living in the rural and semi-urban areas (to be determined).

In addition to the above-mentioned quantitative outcome measures, qualitative information will be collected twice during the evaluation period (mid-year and the last year of the evaluation period) through an online provider survey and/or key-informant interviews with the providers who submitted claims for telemedicine and/or telemonitoring services. The online survey will be designed using Survey Monkey software and will include open-ended questions. The survey questions will collect information from the providers on the facilitators and barriers related to the use telemedicine and telemonitoring services, and whether the use of these services improved access to care among Medicaid members living in rural and semi-urban areas. In addition, providers will be asked to provide recommendations for removing barriers to increasing the use of these services and improving the access to care among Medicaid members. The survey responses will be categorized to examine similar and dissimilar themes and to find areas that can be further explored through key informant interviews of the providers. Key informant interviews will be conducted from a random sample of these providers to collect in-depth information regarding why the use of these services succeeded or did not succeed in increasing the access to care among Medicaid members in rural and semi-rural areas.

Following is the potential list of qualitative measures that will be examined:

- Factors facilitating the use of telemedicine and/or telemonitoring services for the Medicaid members.
- Barriers encountered in using telemedicine and/or telemonitoring services for the Medicaid members.

- Opinions about how to further improve the use of telemedicine and/or telemonitoring services.
- Opinion about how to remove barriers encountered in using telemedicine and/or telemonitoring services.
- Reasons why the use of telemedicine and/or telemonitoring services succeeded or did not succeed in increasing the access to care for the Medicaid members in rural and semi-rural areas.

Additional qualitative measures will be examined based on the themes identified from the survey and key informant interviews.

See **Table A2.7** and **Table A2.8** within **Appendix 2** for enhanced discussion of these measures.

### Data Sources

The following data sources will be used for the evaluation of Hypothesis 3:

- MMIS Encounter database,
- MMIS Eligibility and Enrollment database,
- Other appropriate data sources for measures identified later in accordance with specific telehealth strategies,
- Online provider survey to collect qualitative information from the providers using telemedicine and telemonitoring services (identified through claims submitted for telemedicine and telemonitoring services), and
- Key informant interviews from a sample of the providers using telemedicine and telemonitoring services (identified through claims submitted for telemedicine and telemonitoring services).

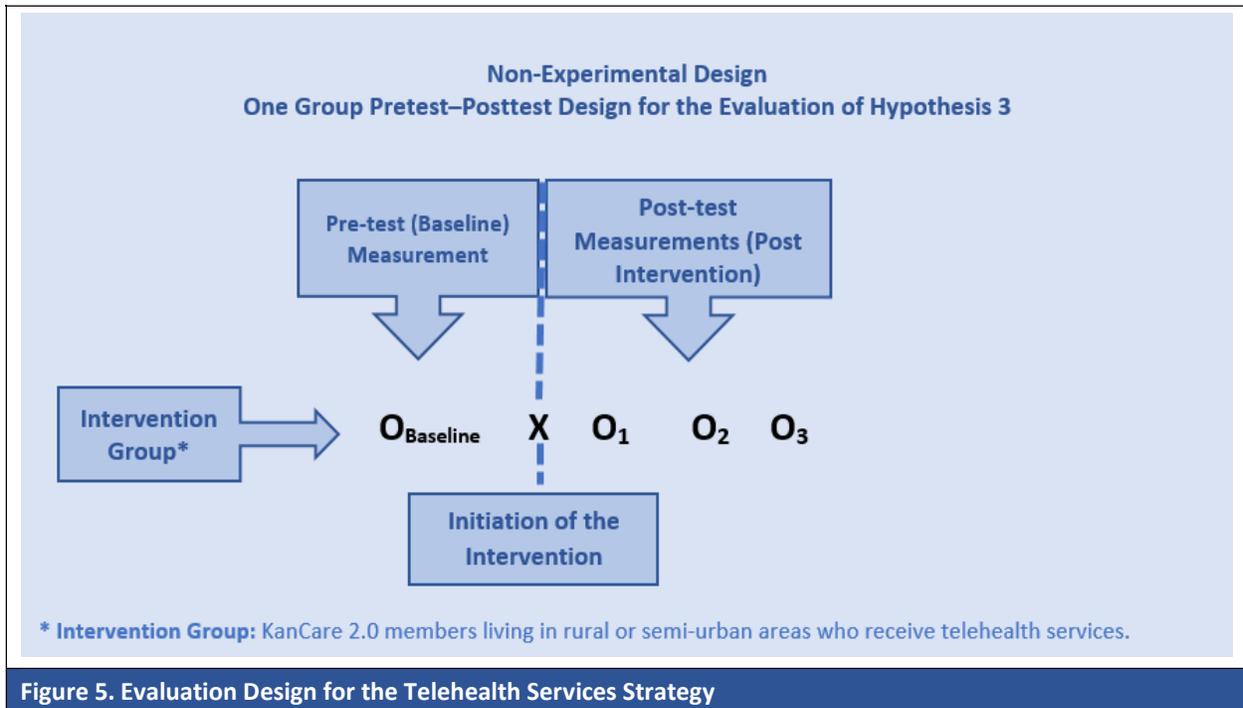
See **Table A3.1** within **Appendix 3** for enhanced discussion of these data sources.

### Analytic Methods

The following analytical methods will be used to assess the evaluation questions:

- Data obtained from various sources will be reviewed for missing values, inconsistent patterns, and outliers to ensure quality and appropriateness of the data for analyses required by the evaluation design.
- For statistical procedures, a final dataset with all required variables will be created by merging data from various sources.
- Descriptive statistics will examine demographic characteristics of the members.
- The descriptive statistics (e.g., numbers and percentages or rates) of the selected evaluation measures will be calculated for baseline and subsequent years of the evaluation period.
- Appropriate statistical tests such as Fisher’s Exact and Pearson chi-square tests with  $p < .05$  will be used to compare percentages or rates for the baseline and subsequent years.
- Absolute improvement will be examined by comparing percentages or rates for the baseline year and most recent year (as per availability of data).
- Trend analysis will be conducted using statistical tests such as a Mantel-Haenszel chi-square test with  $p < .05$  indicating significance.
- Difference of differences between subgroups will be tested using Breslow-Day tests for homogeneity of the odds ratio.
- Subgroup analyses using appropriate statistical procedures will also be conducted for subpopulation groups (telemedicine and/or telemonitoring service type; provider specialty type; specific chronic conditions; and geographic regions of the state). These subgroup analyses will depend on availability of sufficient sample sizes.
- Qualitative data analysis techniques will be used to analyze qualitative data collected through online survey and key informant interviews of the providers using telemedicine and/or telemonitoring services. The steps for qualitative data analysis will include: **getting familiar with the data** by looking for basic observations or patterns; **revisiting research objectives** to identify the questions that can be answered through the collected data; **developing a framework** (coding and indexing) to identify broad ideas, concepts, behaviors, or phrases, and assign codes for structuring and labeling data; **identifying themes, patterns, and connections** to answer research questions, and finding areas that can be explored further (Content and Narrative analyses); and **summarization of the qualitative information** to add to the overall evaluation results.

The design for the evaluation of the Hypothesis 3 is summarized in Figure 5.



#### f. Methodology for the Evaluation of Hypothesis 4

##### Evaluation Questions

Did removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members improve beneficiary access to substance use disorder (SUD) treatment services.

##### Demonstration Strategy

The Kansas Medicaid IMD Exclusion has been removed allowing IMDs to bill for SUD treatment services with the expectation that access to SUD services will increase for members with behavioral health conditions.

##### Evaluation Design

As per CMS recommendation, evaluation of Hypothesis 4 will be conducted as part of the SUD Evaluation Design.<sup>6</sup>

#### g. SUD Evaluation

A separate evaluation design for the *KanCare 2.0 Section 1115 SUD Demonstration* is being developed to evaluate the approved Implementation Plan.<sup>6,13</sup> This evaluation is in accordance with the CMS document, “SUD, Section 1115 Demonstration Evaluation Design, Technical Assistance,” provided March 6, 2019.<sup>14</sup>

#### h. Monitoring of the Overall KanCare 2.0 Performance Measures

The final Evaluation of the KanCare Demonstration conducted for the first six years of the program (2013–2018) identified areas for improvement. The following potential performance measures related to a few of these areas will be monitored during the period of 2019 through 2023:

- Prenatal and Postpartum Care (HEDIS measure)
- Comprehensive Diabetes Care (HEDIS Measure)
- Smoking and Tobacco Cessation (CAHPS Measure)

- Improved ability to handle daily life and deal with crisis (MH Survey)
- Social and Community Engagement (HCBS CAHPS)

See **Table A2.9** within **Appendix 2** for enhanced discussion of these measures.

### Data Sources

- HEDIS data from MCOs
- Consumer Assessment of the Healthcare Providers and Systems (CAHPS) Survey
- Mental Health Survey
- HCBS CAHPS Survey (potential data source)

See **Table A3.2** within **Appendix 3** for enhanced discussion of these data sources.

### Analytical Methods

- The descriptive statistics (e.g., percentages or rates) of the selected evaluation measures will be calculated for baseline and subsequent years of the evaluation period.
- Comparison of the percentages or rates for the baseline year with the subsequent years will be done by applying appropriate statistical tests such as Fisher's Exact and Pearson chi-square tests with  $p < .05$  indicating statistical significance.
- Absolute improvement will be examined by comparing percentages or rates for the baseline years with the most recent year (as per availability of data).
- Trend analysis will be conducted using statistical tests such as a Mantel-Haenszel chi-square test with  $p < .05$  indicating significance.

#### i. DSRIP Evaluation

The Delivery System Reform Incentive Payment (DSRIP) program was implemented in 2015 and extends through 2020. In January 2021, an Alternate Payment Model (APM) program will replace DSRIP. The DSRIP evaluation plan, submitted to CMS separately, reflects an additional two years of DSRIP assessment and a final overall evaluation summary. Also, the evaluation report for 2020 will summarize the activities KDHE has completed throughout the state meeting with a wide range of stakeholders to define the APM goals and metrics to be implemented in 2021 through 2023. The APM evaluation plan, including specific metrics, will be developed and submitted to CMS by the end of 2020.

## D. Methodological Limitations

Due to state-wide implementation of the KanCare 2.0 Demonstration, the evaluation of overall strategies (Service Coordination Strategy and OneCare Kansas program) and four hypotheses is limited by the lack of true comparison groups. All Medicaid clients in the state are subject to participation in the Demonstration. As a result, the evaluation design included comparisons among members in the Intervention and Comparison Groups (without true external comparison groups); therefore, the pre- and post-test evaluation design or comparisons to baselines may suggest overall improvements in outcomes due to the demonstration and observed associations may not imply causality due to a specific intervention. To address this limitation, the **Comparative Interrupted Time Series Evaluation Design** will be used for the evaluation of Overall Strategies (Service Coordination Strategy and OneCare Kansas program) and Hypothesis 1. This will provide a possibility to assess causal inference between interventions and outcomes for these evaluations. The **Pretest–Posttest Design with Nonequivalent Groups Design** will be used for the evaluation of Hypothesis 2. This will also provide a possibility to assess causal inference.

As the demonstration strategies related to the three components of the Hypothesis 3 will be developed during the five-year period by the MCOs (subject to State guidelines and approval) and appropriate comparison group is currently not available, **Non-experimental method (One-Group Pretest–Posttest Design)** will be used to examine the evaluation questions. This will limit the ability to assess any causal relationship between the use of telehealth services and access or health outcomes among members living in rural or semi-urban areas.

Due to changes in the data system, pre-demonstration data on the participating members' characteristics and outcomes will not be used. Therefore, **Non-experimental methods (descriptive data)** will be used for conducting the evaluation of Hypothesis 4. Only descriptive data will be examined for assessing the evaluation question; therefore, association between the intervention and improved beneficiary access to SUD treatment services within IMDs cannot be assessed.

The use of administrative claims and encounters data sources can be a limitation. These data sources are designed and collected for billing purposes but will be used in the evaluation to determine changes in access to services, quality of care, and health outcomes. However, most of the measures selected for assessment of the evaluation questions are validated and widely used for this purpose. While administrative data might be able to identify key cases and statistical trends, these are usually limited in providing detailed health and health behavior information, thus making it difficult to obtain information on possible covariates. Also, due to the use of population-level data, the effect size of measured differences represents true differences; however, this may or may not correspond to meaningful changes at the intervention or program levels.

Data lag also causes a challenge in measuring and reporting change in a timely manner. This can affect the availability of data for conducting the evaluation for the entire five-year period of the demonstration.

As evaluation is based on five-year period, the definitions and specifications of the evaluation measures, policies for data collection, and infrastructure of the data sources may change during the evaluation period, thus leading to unavailability of appropriate data for the analysis of multiple pre- and post- intervention evaluation points needed for comparative interrupted time series and one group pretest-posttest designs.

Comparison group options using members who are the members of the intervention's target population will be applied, therefore, there is a possibility of encountering methodological issues (such as selection bias due to differences in the characteristics of members opting-in for the participation in the intervention and those not opting-in, spillover effects, multiple treatment threats due to other interventions, effect of confounding variables, inadequate statistical power, and multiple comparisons issue) that will require application of appropriate techniques.<sup>15,16</sup> Appropriate techniques will be applied to address these issues as much as possible.

To have an adequate number of members in the Intervention and comparison groups for the evaluation of overall service coordination strategies (Service Coordination Strategy and OneCare Kansas program) and Hypothesis 1, the entire eligible population for the intervention and comparison groups will be included in the study, and pre- and post-intervention changes will be examined. However, if the eligible population is very large, then samples of eligible members with power calculations may be used to ensure validity of the findings.

Over the five-year period, eligibility for receiving Medicaid services may change for some members and they may not be the part of Intervention or Comparison Groups. Also, during subsequent years, some members may opt in or opt out of the interventions. This issue will be monitored and addressed accordingly by applying appropriate techniques (Intent-to-treat analysis; exclusion from analysis, etc.).

## E. Special Methodological Considerations

MCOs are in the process of developing strategies for the implementation of the value-based provider incentive program. Therefore, final evaluation design and measures may need modifications based on specific aspects of the program.

MCOs have not yet developed specific strategies for the use of telehealth services and an appropriate comparison group cannot be currently be identified, therefore, a rigorous scientific design with additional comparison group (such as a comparative interrupted time series design) could not be used for the evaluation of Hypothesis 3. As mentioned above, a less rigorous non-experimental method (One-Group Pretest–Posttest Design) will be used. This will limit the ability to examine any causal relationship between use of telehealth services and access or health outcomes among members.

As mentioned above, due to data system changes, pre-demonstration data will not be used limiting the ability to compare pre- and post-intervention outcomes, a scientifically rigorous design could not be used for the evaluation of Hypothesis 4. For this evaluation, only descriptive data will be examined over the demonstration period.

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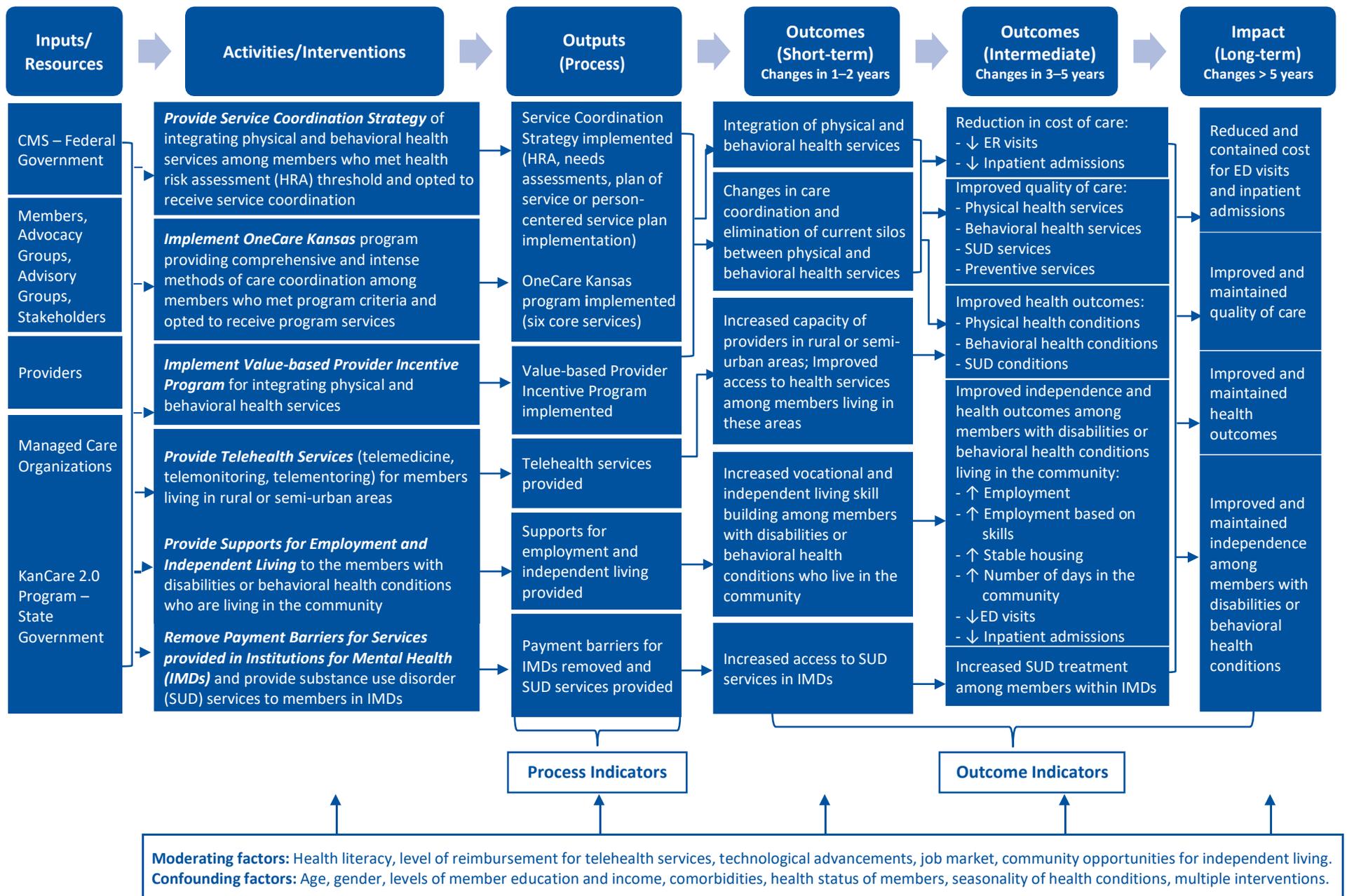
# Appendices

**Appendix 1: Logic Model for KanCare 2.0 Demonstration**

**Appendix 2: Detailed Summary of Performance Measures**

**Appendix 3: Detailed Discussion of Data Sources**

## Appendix 1: Logic Model for KanCare 2.0 Demonstration



## Appendix 2: Detailed Summary of Performance Measures

Table A2.1. Detailed Summary of Performance Measures for Service Coordination Strategy					
Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
<p><b>Annual Dental Visit (ADV)</b> Percentage of members, 2–20 years, who had one or more dental visit with a dental practitioner during the measurement year.</p>	NCQA	Medicaid members 2–20 years of age.	Members 2–20 years of age who had one or more dental visit with a dental practitioner during the measurement year.	Percentage	Medicaid Management Information System (MMIS) Encounter database; MMIS Eligibility and Enrollment database; MCOs' member-level case management data systems.
<p><b>Adults' Access to Preventive/ Ambulatory Health Services (AAP)</b> Percentage of Medicaid members 20 years &amp; older who had an ambulatory or preventive care visit during the measurement year.</p>	NCQA	Medicaid members 20 years & older.	Members 20 years & older who had one or more ambulatory or preventive care visits during the measurement year.	Percentage	Same as above.
<p><b>Adolescent Well-Care Visits (AWC)</b> Percentage of Medicaid members, 12–21 years, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.</p>	NCQA	Medicaid members 12–21 years of age.	Members, 12–21 years, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Percentage	Same as above.
<p><b>Follow-Up After Hospitalization for Mental Illness (FUH)</b> Percentage of discharges for members, 6 years &amp; older, who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses &amp; who had a follow-up visit with a mental health practitioner within 7 days after discharge.</p>	NCQA	Medicaid members, 6 years & older, who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses.	A follow-up visit with a mental health practitioner within 7 days of discharge.	Percentage	Same as above.
<p><b>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)</b> Percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received:</p> <ul style="list-style-type: none"> <li>• <b>Initiation of AOD treatment:</b> % of members who initiate a treatment through inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.</li> <li>• <b>Engagement of AOD treatment:</b> % of members who initiated treatment and who are engaged in ongoing AOD treatment within 34 days of the initiation visit.</li> </ul>	NCQA	<p><b>Initiation:</b> Members who were diagnosed with a new episode of AOD abuse or dependence during the first 10½ months of the measurement year.</p> <p><b>Engagement:</b> Members who were diagnosed with a new episode of AOD during the first 10½ months of the measurement year.</p>	<p><b>Initiation:</b> Members who began initiation of AOD treatment within 14 days of the index episode start date (IESD).</p> <p><b>Engagement:</b> Members who began initiation of AOD treatment within 14 days of IESD &amp; had two or more engagement visits within 34 days after the date of the initiation visit. [Engagement visits will be defined as per HEDIS administrative specifications].</p>	<p><b>Initiation:</b> Percentage</p> <p><b>Engagement:</b> Percentage</p>	Same as above.
<p>Denominators and numerators will be defined and calculated as per <i>Healthcare Effectiveness Data and Information Set®</i> (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. Performance Measures: Measures will be calculated for Intervention &amp; Comparison Groups designed for the evaluation of <i>Service Coordination</i> strategy.</p>					

## Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.1. Detailed Summary of Performance Measures for Service Coordination Strategy (Continued)					
Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
<p><b>Antidepressant Medication Management (AMM)</b> Percentage of members, 18 years and older, who were treated with antidepressant medication, had a diagnosis of major depression &amp; who remained on an antidepressant medication treatment:</p> <ul style="list-style-type: none"> <li>• <b>Effective Acute Phase Treatment:</b> Percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).</li> <li>• <b>Effective Continuation Phase Treatment:</b> Percentage of members who remained on an antidepressant medication for at least 180 days (6 months).</li> </ul>	NCQA	<p><b>Effective Acute Phase Treatment:</b> Medicaid members, 18 years and older, who were treated with antidepressant medication, had a diagnosis of major depression. [Eligible population for denominator will be defined as per HEDIS administrative specifications].</p> <p><b>Effective Continuation Phase Treatment:</b> Same as above.</p>	<p><b>Effective Acute Phase Treatment:</b> Medicaid members, 18 years and older, who were treated with antidepressant medication for at least 84 days (12 weeks), beginning on the Index prescription Start Date (IPSD) through 114 days after IPSD.</p> <p><b>Effective Continuation Phase Treatment:</b> Medicaid members, 18 years and older, who were treated with antidepressant medication for at least 180 days (6 months), beginning on IPSD through 231 days after IPSD.</p>	Percentage	MMIS Encounter database; MMIS Eligibility and Enrollment database; MCOs Member-level case management data systems.
<p><b>ED visits, observation stays, or inpatient admissions per 1,000 member-months for following conditions</b></p> <ul style="list-style-type: none"> <li>• Diabetic Ketoacidosis/ Hyperglycemia, or</li> <li>• Acute severe asthma, or</li> <li>• Hypertensive crisis, or</li> <li>• Fall injuries, or</li> <li>• SUD, or</li> <li>• Mental health issues</li> </ul>	N/A	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	Number (#) of ED visits, observation stays, or inpatient admissions for diabetic ketoacidosis /hyperglycemia, or acute severe asthma, or hypertensive crisis, or fall injuries, or substance use disorder, or mental health issues.	1,000 member-months	Same as above.
<p><b>Outpatient or professional claims for following conditions:</b></p> <ul style="list-style-type: none"> <li>• Diabetic retinopathy, or</li> <li>• Influenza, or</li> <li>• Pneumonia, or</li> <li>• Shingles</li> </ul>	N/A	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	# of Outpatient or professional claims for diabetic retinopathy, or influenza, or pneumonia, or shingles.	1,000 member-months	Same as above.
<p><b>Emergency department visits per 1,000 member-months</b></p>	N/A	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	# of ED visits during the measurement period.	1,000 member-months	Same as above.
<p><b>Inpatient Utilization—General Hospitalization/Acute Care (IPU), excluding maternity admissions</b></p>	NCQA	Members, 18 years & older enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	# of acute inpatient discharges (excluding discharges for maternity admissions) during the measurement period.	Days per 1,000 member-months	Same as above.
<p>Denominators and numerators will be defined and calculated as per <i>Healthcare Effectiveness Data and Information Set®</i> (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. Performance Measures: Measures will be calculated for the Intervention and Comparison Groups designed for the evaluation of <i>Service Coordination Strategy</i>.</p>					

## Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.2. Detailed Summary of Quantitative Performance Measures for OneCare Kansas Program					
Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
<b>Annual Dental Visit (ADV)</b> Percentage of Medicaid members, 2–20 years, who had one or more dental visit with a dental practitioner during the measurement year.	NCQA	Medicaid members 2–20 years of age.	Members 2–20 years of age who had one or more dental visit with a dental practitioner during the measurement year.	Percentage	MMIS Encounter database; MMIS Eligibility and Enrollment database; OneCare Kansas members’ eligibility & participation database; MCOs Member-level case management data systems.
<b>Adults’ Access to Preventive/Ambulatory Health Services (AAP)</b> Percentage of Medicaid members 20 years & older who had an ambulatory or preventive care visit during the measurement year.	NCQA	Medicaid members 20 years & older.	Members 20 years & older who had one or more ambulatory or preventive care visits during the measurement year.	Percentage	Same as above.
<b>Adolescent Well-Care Visits (AWC)</b> Percentage of Medicaid members, 12–21 years, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	NCQA	Medicaid members 12–21 years of age.	Members, 12–21 years, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Percentage	Same as above.
<b>Follow-Up After Hospitalization for Mental Illness (FUH)</b> Percentage of discharges for members, 6 years & older, who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses & who had a follow-up visit with a mental health practitioner within 7 days after discharge.	NCQA	Medicaid members, 6 years & older, who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses.	A follow-up visit with a mental health practitioner within 7 days of discharge.	Percentage	Same as above.
<b>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)</b> Percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received: <ul style="list-style-type: none"> <li>• <b>Initiation of AOD treatment:</b> Percentage of members who initiate a treatment through inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.</li> <li>• <b>Engagement of AOD treatment:</b> Percentage of members who initiated treatment and who are engaged in ongoing AOD treatment within 34 days of the initiation visit.</li> </ul>	NCQA	<b>Initiation:</b> Members who were diagnosed with a new episode of AOD abuse from January 1 – November 13 of the measurement year. <b>Engagement:</b> Members who were diagnosed with a new episode of AOD from January 1 – November 13 of the measurement year.	<b>Initiation:</b> Members who began initiation of AOD treatment within 14 days of the index episode start date (IESD). <b>Engagement:</b> Members who began initiation of AOD treatment within 14 days of IESD & had two or more engagement visits within 34 days after the date of the initiation visit. [Engagement visits will be defined as per HEDIS administrative specifications].	<b>Initiation:</b> Percentage <b>Engagement:</b> Percentage	Same as above.
Denominators and numerators will be defined and calculated as per <i>Healthcare Effectiveness Data and Information Set®</i> (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. Performance Measures: Measures will be calculated for the Intervention and Comparison Groups designed for the evaluation of <i>OneCare Kansas</i> program.					

## Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.2. Detailed Summary of Quantitative Performance Measures for OneCare Kansas Program (Continued)					
Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
<p><b>Antidepressant Medication Management (AMM)</b>                      Percentage of members, 18 years and older, who were treated with antidepressant medication, had a diagnosis of major depression &amp; who remained on an antidepressant medication treatment:</p> <ul style="list-style-type: none"> <li>• <b>Effective Acute Phase Treatment:</b> Percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).</li> <li>• <b>Effective Continuation Phase Treatment:</b> Percentage of members who remained on an antidepressant medication for at least 180 days (6 months).</li> </ul>	NCQA	<p><b>Effective Acute Phase Treatment:</b> Medicaid members, 18 years and older, who were treated with antidepressant medication, had a diagnosis of major depression. [Eligible population for denominator will be defined as per HEDIS administrative specifications.]</p> <p><b>Effective Continuation Phase Treatment:</b> Same as above.</p>	<p><b>Effective Acute Phase Treatment:</b> Medicaid members, 18 years and older, who were treated with antidepressant medication for at least 84 days (12 weeks), beginning on the Index prescription Start Date (IPSD) through 114 days after IPSD. <b>Effective Continuation Phase Treatment:</b> Medicaid members, 18 years and older, who were treated with antidepressant medication for at least 180 days (6 months), beginning on IPSD through 231 days after IPSD.</p>	Percentage	(MMIS Encounter database; MMIS Eligibility and Enrollment database; OneCare Kansas members' eligibility & participation database; MCOs' member-level case management data systems.
<p><b>ED visits, observation stays, or inpatient admissions per 1,000 member-months for following conditions (Administrative):</b></p> <ul style="list-style-type: none"> <li>• Diabetic Ketoacidosis/ Hyperglycemia, or</li> <li>• Acute severe asthma, or</li> <li>• Hypertensive crisis, or</li> <li>• Fall injuries, or</li> <li>• SUD, or</li> <li>• Mental health issues</li> </ul>	N/A	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	Number (#) of ED visits, observation stays, or inpatient admissions for diabetic ketoacidosis /hyperglycemia, or acute severe asthma, or hypertensive crisis, or fall injuries, or substance use disorder, or mental health issues.	1,000 member-months	Same as above.
<p><b>Outpatient or professional claims for following conditions:</b></p> <ul style="list-style-type: none"> <li>• Diabetic retinopathy, or</li> <li>• Influenza, or</li> <li>• Pneumonia, or</li> <li>• Shingles</li> </ul>	N/A	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	# of Outpatient or professional claims for diabetic retinopathy, or influenza, or pneumonia, or shingles.	1,000 member-months	Same as above.
<p><b>Emergency department visits per 1,000 member-months</b></p>	N/A	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	# of ED visits during the measurement period.	1,000 member-months	Same as above.
<p><b>Inpatient Utilization—General Hospitalization/Acute Care (IPU), excluding maternity admissions.</b></p>	NCQA	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	# of acute inpatient discharges (excluding discharges for maternity admissions) during the measurement period.	Days per 1,000 member-months	Same as above.

Denominators and numerators will be defined and calculated as per *Healthcare Effectiveness Data and Information Set®* (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. Performance Measures: Measures will be calculated for the Intervention and Comparison Groups designed for the evaluation of OneCare Kansas program.

## Appendix 2: Detailed Summary of Performance Measures (Continued)

<b>Table A2.3. Detailed Summary of Qualitative Performance Measures for OneCare Kansas Program</b>			
<b>Performance Measure</b>	<b>Steward</b>	<b>Unit of Measure</b>	<b>Data Source</b>
Learning needs identified by the OneCare Kansas Learning Collaborative.	N/A	Similar and dissimilar themes based on content and narrative analyses	OneCare Kansas Learning Collaborative reports.
Processes to address the learning needs identified by the OneCare Kansas Learning Collaborative.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Factors that facilitated the implementation of the OneCare Kansas program to achieve its goal.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Barriers encountered in implementation of the OneCare Kansas program.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Recommendations about how the quality of OneCare Kansas program can be further improved.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Observations why this program was able to succeed or why it did not meet its goals.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Additional qualitative measures will be examined based on the themes identified from the information obtained from the OneCare Kansas Learning Collaborative members.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Qualitative data will be collected through OneCare Kansas Learning Collaborative reports. Qualitative data analysis procedures will be applied.			

## Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.4. Detailed Summary of Quantitative Performance Measures for KanCare 2.0 Hypothesis 1 – Value-Based Provider Incentive Program					
Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
<p><b>Annual Dental Visit (ADV)</b> Percentage of Medicaid members, 2–20 years, who had one or more dental visit with a dental practitioner during the measurement year.</p>	NCQA	Medicaid members 2–20 years of age.	Members 2–20 years of age who had one or more dental visit with a dental practitioner during measurement year.	Percentage	MCOs’ administrative databases on Value-Based Provider Incentive Programs; MMIS Encounter database; MMIS Eligibility and Enrollment database; MCOs’ member-level case management data systems; MCO databases/ tables for Value-based Provider Incentive Programs performance measures.
<p><b>Adults’ Access to Preventive/Ambulatory Health Services (AAP)</b> Percentage of Medicaid members 20 years &amp; older who had an ambulatory or preventive care visit during the measurement year.</p>	NCQA	Medicaid members 20 years & older.	Members 20 years & older who had one or more ambulatory or preventive care visits during the measurement year.	Percentage	Same as above.
<p><b>Adolescent Well-Care Visits (AWC)</b> Percentage of Medicaid members, 12–21 years, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.</p>	NCQA	Medicaid members 12–21 years of age.	Members, 12–21 years, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Percentage	Same as above.
<p><b>Follow-Up After Hospitalization for Mental Illness (FUH)</b> Percentage of discharges for members, 6 years &amp; older, who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses &amp; who had a follow-up visit with a mental health practitioner within 7 days after discharge.</p>	NCQA	Medicaid members, 6 years & older, who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses.	A follow-up visit with a mental health practitioner within 7 days of discharge.	Percentage	Same as above.
<p><b>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)</b> Percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received:</p> <ul style="list-style-type: none"> <li><b>Initiation of AOD treatment:</b> Percentage of members who initiate a treatment through inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.</li> <li><b>Engagement of AOD treatment:</b> Percentage of members who initiated treatment and who are engaged in ongoing AOD treatment within 34 days of the initiation visit.</li> </ul>	NCQA	<p><b>Initiation:</b> Members who were diagnosed with a new episode of AOD abuse or dependence during the first 10% months of the measurement year.</p> <p><b>Engagement:</b> Members who were diagnosed with a new episode of AOD during the first 10% months of the measurement year.</p>	<p><b>Initiation:</b> Members who began initiation of AOD treatment within 14 days of the index episode start date (IESD). <b>Engagement:</b> Members who began initiation of AOD treatment within 14 days of IESD &amp; had two or more engagement visits within 34 days after the date of the initiation visit. [Engagement visits defined as per HEDIS administrative specifications].</p>	<p><b>Initiation:</b> Percentage</p> <p><b>Engagement:</b> Percentage</p>	Same as above.
Denominators and numerators will be defined and calculated as per <i>Healthcare Effectiveness Data and Information Set®</i> (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. Performance Measures: Measures will be calculated for the Intervention and Comparison Groups designed for the evaluation of Hypothesis 1.					

## Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.4. Detailed Summary of Quantitative Performance Measures for KanCare 2.0 Hypothesis 1 – Value-Based Provider Incentive Program (Continued)					
Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
<p><b>Antidepressant Medication Management (AMM)</b>                      Percentage of members, 18 years and older, who were treated with antidepressant medication, had a diagnosis of major depression &amp; who remained on an antidepressant medication treatment:</p> <ul style="list-style-type: none"> <li>• <b>Effective Acute Phase Treatment:</b>                              Percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).</li> <li>• <b>Effective Continuation Phase Treatment:</b>                              Percentage of members who remained on an antidepressant medication for at least 180 days (6 months).</li> </ul>	NCQA	<p><b>Effective Acute Phase Treatment:</b> Medicaid members, 18 years and older, who were treated with antidepressant medication, had a diagnosis of major depression. [Eligible population for denominator will be defined as per HEDIS administrative specifications].</p> <p><b>Effective Continuation Phase Treatment:</b> Same as above.</p>	<p><b>Effective Acute Phase Treatment:</b> Medicaid members, 18 years and older, who were treated with antidepressant medication for at least 84 days (12 weeks), beginning on the Index prescription Start Date (IPSD) through 114 days after IPSD.</p> <p><b>Effective Continuation Phase Treatment:</b> Medicaid members, 18 years and older, who were treated with antidepressant medication for at least 180 days (6 months), beginning on IPSD through 231 days after IPSD.</p>	Percentage	MCOs' administrative databases on Value-Based Provider Incentive Programs; MMIS Encounter database; MMIS Eligibility and Enrollment database; MCOs Member-level case management data systems; MCO databases/tables for Value-based Provider Incentive Programs performance measures.
<p><b>ED visits, observation stays, or inpatient admissions per 1,000 member-months for following conditions:</b></p> <ul style="list-style-type: none"> <li>o Diabetic Ketoacidosis/ Hyperglycemia, or</li> <li>o Acute severe asthma, or</li> <li>o Hypertensive crisis, or</li> <li>o Fall injuries, or</li> <li>o SUD, or</li> <li>o Mental health issues</li> </ul>	N/A	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	Number (#) of ED visits, observation stays, or inpatient admissions for diabetic ketoacidosis /hyperglycemia, or acute severe asthma, or hypertensive crisis, or fall injuries, or substance use disorder, or mental health issues.	1,000 member-months	Same as above.
<p><b>Outpatient or professional claims for following conditions:</b></p> <ul style="list-style-type: none"> <li>o Diabetic retinopathy, or</li> <li>o Influenza, or</li> <li>o Pneumonia, or</li> <li>o Shingles</li> </ul>	N/A	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	# of Outpatient or professional claims for diabetic retinopathy, or influenza, or pneumonia, or shingles.	1,000 member-months	Same as above.
<p><b>Emergency department visits per 1,000 member-months</b></p>	N/A	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	# of ED visits during the measurement period.	1,000 member-months	Same as above.
<p><b>Inpatient Utilization—General Hospitalization/Acute Care (IPU), excluding maternity admissions.</b></p>	NCQA	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	# of acute inpatient discharges (excluding discharges for maternity admissions) during the measurement period.	Days per 1,000 member-months	Same as above.
Denominators and numerators will be defined and calculated as per Healthcare Effectiveness Data and Information Set® (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. Performance Measures: Measures will be calculated for the Intervention and Comparison Groups designed for the evaluation of Hypothesis 1.					

## Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.4. Detailed Summary of Quantitative Performance Measures for KanCare 2.0 Hypothesis 1 – Value-Based Provider Incentive Program (Continued)					
Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
<p><b>Identification of Alcohol and Other Drug Services (IAD)</b> Percentage of members with an alcohol and other drug (AOD) claim who received chemical dependency services during the measurement year.</p>	NCQA	Medicaid members with an AOD diagnosis during the measurement year.	Medicaid members with an AOD diagnosis who received a specific AOD-related service including inpatient, intensive outpatient or partial hospitalization, outpatient or medication treatment, ED visit, telehealth, or any service during the measurement year.	Percentage	MCOs’ administrative databases on Value-Based Provider Incentive Programs; MMIS Encounter database; MMIS Eligibility and Enrollment database; MCOs’ member-level case management data systems; MCO databases/tables for Value-based Provider Incentive Programs performance measures.
<p><b>Follow-Up Care for Children Prescribed ADHD Medication (ADD)</b> Percentage of children newly prescribed ADHD medication who had at least 3 follow-up care visits within 10-month period:</p> <ul style="list-style-type: none"> <li>• <b>Initiation Phase:</b> Percentage of members 6–12 years as of IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during 30-day Initiation Phase.</li> <li>• <b>Continuation &amp; Maintenance (C&amp;M) Phase:</b> Percentage of members 6–12 years as of IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on medication for at least 210 days and in addition to a visit in Initiation Phase, had at least two follow-up visits with practitioner within 270 days (9 months) after Initiation Phase ended.</li> </ul>	NCQA	<p><b>Initiation Phase:</b> Children 6–12 years as of IPSD, with an ambulatory prescription dispensed for ADHD medication, and continually enrolled in Medicaid (120 days before IPSD through 30 days after IPSD). <b>C&amp;M Phase:</b> Children 6–12 years as of IPSD, continually enrolled in Medicaid (120 days before IPSD through 300 days after IPSD) with an ambulatory prescription dispensed for ADHD medication, &amp; who remained on medication for at least 210 days.</p>	<p><b>Initiation Phase:</b> Eligible members with an outpatient, intensive outpatient or partial hospitalization follow-up visit with practitioner with prescribing authority within 30 days after the IPSD. <b>C&amp;M Phase:</b> Eligible members with an outpatient, intensive outpatient or partial hospitalization follow-up visit with practitioner with prescribing authority within 30 days after the IPSD <b>and</b> at least two follow-up visits on different dates of service with any practitioner, from 31-300 days (9 months) after IPSD.</p>	Percentage	Same as above.
<p><b>Use of Opioids at High Dosage (HDO)</b> Proportion of members, 18 years and older, who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 total days during measurement period.</p>	NCQA	<p>Medicaid members, 18 years and older, who met following criteria:</p> <ul style="list-style-type: none"> <li>• Two or more opioid dispensing events on different dates of service; and</li> <li>• ≥15 total days covered by opioids.</li> </ul>	Number of members whose average MME was ≥90 during treatment period.	Percentage	Same as above.
<p>Denominators and numerators will be defined and calculated as per Healthcare Effectiveness Data and Information Set® (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. Performance Measures: Measures will be calculated for the Intervention and Comparison Groups designed for the evaluation of Hypothesis 1.</p>					

## Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.4. Detailed Summary of Quantitative Performance Measures for KanCare 2.0 Hypothesis 1 – Value-Based Provider Incentive Program (Continued)					
Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
<b>Use of Opioids from multiple providers (UOP)</b> Proportion of members, 18 years and older, receiving prescription opioids for ≥15 days during measurement period who received opioids from multiple providers. • <b>Multiple Prescribers:</b> Proportion of members receiving prescriptions for opioids from four or more different providers during the measurement year.	NCQA	Medicaid members, 18 years and older, who met following criteria: <ul style="list-style-type: none"> <li>• Two or more opioid dispensing events on different dates of service; and</li> <li>• ≥15 total days covered by opioids.</li> </ul>	Members who received prescriptions for opioids from four or more different providers during the measurement year	Percentage	MCOs’ administrative databases on Value-Based Provider Incentive Programs; MMIS Encounter database; MMIS Eligibility and Enrollment database; MCOs’ member-level case management data systems; MCO databases/ tables for Value-based Provider Incentive Program performance measures.
<b>Mental Health Utilization (MPT)</b> Percentage of members receiving mental health services (inpatient, intensive outpatient or partial hospitalization, outpatient, ED, telehealth, or any service) during the measurement year.	NCQA	Medicaid members with a diagnosis of mental illness during the measurement year.	Members who received mental health services) during the measurement year.	Percentage	Same as above
<b>MCO-specified measures on effectiveness of their value-based purchasing program on increasing physical and behavioral health service integration.</b> To be Determined (TBD)	TBD	TBD	TBD	TBD	MCO measured data.
Denominators and numerators will be defined and calculated as per Healthcare Effectiveness Data and Information Set® (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. Performance Measures: Measures will be calculated for the Intervention and Comparison Groups designed for the evaluation of Hypothesis 1.					

Table A2.5. Detailed Summary of Qualitative Performance Measures for KanCare 2.0 Hypothesis 1 – Value-Based Provider Incentive Program			
Performance Measure	Steward	Unit of Measure	Data Source
Factors that facilitated the implementation of the Value-Based Provider Incentive Program.	N/A	Similar and dissimilar themes based on content and narrative analyses	Online provider survey and key informant interviews of the providers participating in the <i>Value-Based Provider Incentive Program</i> .
Barriers encountered in implementing the Value-Based Provider Incentive Program.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Recommendations about ways to further improve the Value-Based Provider Incentive Program.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Recommendations about ways to remove barriers encountered in the implementation of the Value-Based Provider Incentive Program.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Observations why this program was able to succeed or why it did not meet its goals.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Additional qualitative measures based on the themes identified from the survey and Key informant interviews.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Qualitative data will be collected through online provider survey and/or key-informant interviews with the providers participating in the Value-Based Provider Incentive Program. Qualitative data analysis procedures will be applied.			

## Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.6. Detailed Summary of Performance Measures for KanCare 2.0 Hypothesis 2 – Provision of Supports for Employment & Independent Living to the Members with Disabilities and the Behavioral Health Conditions who are Living in the Community					
Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
Current employment status.	N/A	Study Population (members living in the community & receiving behavioral health services or HCBS services in the PD, I/DD, and BI waiver programs who opted for service coordination & potentially needing employment or independent living supports).	Members in study population who are currently employed.	Percentage	MMIS Encounter database; MMIS Eligibility and Enrollment database; MCOs’ member-level case management data systems.
Percentage of members who felt they were employed based on their skills and knowledge (if employed).	N/A	Members in study population who are currently employed.	Members who are currently employed & felt they were employed based on their skills and knowledge.	Percentage	Same as above.
Percentage of members with stable housing – number of addresses member lived in the past year.	N/A	Members in study population.	Members with one or two addresses in the past year.	Percentage.	Same as above.
Current legal problems (e.g., probation, parole, arrests).	N/A	Members in study population.	Members with no current legal problems.	Percentage	Same as above.
Number of days in the community.	N/A	N/A	Average # of days members live in the community.	Days in the community	Same as above.
Percentage of members who worried about paying bills.	N/A	Members in study population.	Members who worried about paying bills.	Percentage	Same as above.
ED visits per 1,000 member-months.	N/A	Members in study population (enrolled in Medicaid for at least 30 consecutive days during the measurement period).	# of ED visits during the measurement period.	1,000 member-months	Same as above.
Inpatient hospitalizations (excluding discharges for maternity admissions) per 1,000 member-months.	N/A	Members in study population (enrolled in Medicaid for at least 30 consecutive days during the measurement period).	# of acute inpatient discharges during the measurement period.	1,000 member-months	Same as above.
Study Population includes members living in the community & receiving behavioral health services or HCBS services in the PD, I/DD, and BI waiver programs who opted for service coordination & potentially needing employment or independent living supports.					

## Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.7. Detailed Summary of Quantitative Performance Measures for KanCare 2.0 Hypothesis 3 – Use of Telehealth Services (Telemedicine; Telemonitoring)					
Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
<b>Telemedicine</b>					
Percentage of telemedicine services received by the members living in the rural or semi-urban areas (potential stratification by service, specialty type, or diagnosis).	N/A	Medicaid members living in the rural or semi-urban areas.	Number (#) of telemedicine services received by the members living in the rural or semi-urban areas.	Percentage	MMIS Encounter database; MMIS Eligibility and Enrollment database.
Number of receiving sites for telemedicine services in the rural and semi-urban areas. (potential stratification by service, specialty type, or diagnosis).	N/A	N/A	# of receiving sites for telemedicine services in the rural and semi-urban areas.	Sites	Same as above.
Percentage of members living in the rural or semi-urban areas who received telemedicine services (potential stratification by service, specialty type, or diagnosis).	N/A	Medicaid members living in the rural or semi-urban areas.	Medicaid members living in the rural or semi-urban areas who received telemedicine services.	Percentage	Same as above.
Number of paid claims with selected procedure codes (stratified by area, mode of delivery, and provider specialty).	N/A	N/A	Number of paid claims with selected procedure codes.	Paid claims	Same as above.
Number of members with selected diagnosis (e.g., speech-language pathology) per 1,000 members.	N/A	Medicaid members living in the rural or semi-urban areas.	Number of members with selected diagnosis (e.g., speech-language pathology).	1,000 members	Same as above.
<b>Telemonitoring</b>					
Percentage of members living in the rural and semi-urban areas who received telemonitoring services (stratification by service, specialty type, or diagnosis).	N/A	Medicaid members living in the rural or semi-urban areas.	Medicaid members living in the rural or semi-urban areas who received telemonitoring services.	Percentage	Same as above.
Number of telemonitoring services provided to members living in the rural and semi-urban areas.	N/A	N/A	# of telemonitoring services received by the members living in the rural or semi-urban areas.	Telemonitoring services	Same as above.
Number of providers monitoring health indicator data transmitted to them by the members receiving telemonitoring services.	N/A	N/A	# of providers monitoring health indicator data transmitted to them by the members receiving telemonitoring services.	Providers	Same as above.
Other appropriate measures related to specific telemonitoring strategies implemented for the members living in the rural and semi-urban areas.	To be determined (TBD)	TBD	TBD	TBD	TBD
Other appropriate data sources for measures will be identified later in accordance with specific telehealth strategies.					

## Appendix 2: Detailed Summary of Performance Measures (Continued)

<b>Table A2.8. Detailed Summary of Qualitative Performance Measures for KanCare 2.0 Hypothesis 3 – Use of Telehealth Services (Telemedicine; Telemonitoring)</b>			
<b>Performance Measure</b>	<b>Steward</b>	<b>Unit of Measure</b>	<b>Data Source</b>
Factors that facilitated the use of telemedicine and/or telemonitoring services for the Medicaid members.	N/A	Similar and dissimilar themes based on content and narrative analyses.	Online provider survey and/or key-informant interviews with the providers who submitted claims for telemedicine and/or telemonitoring services.
Barriers encountered in using telemedicine and/or telemonitoring services for the Medicaid members.	N/A	Similar and dissimilar themes based on content and narrative analyses.	Online provider survey and/or key-informant interviews with the providers who submitted claims for telemedicine and/or telemonitoring services.
Recommendations about how to further improve the use of telemedicine and/or telemonitoring services.	N/A	Similar and dissimilar themes based on content and narrative analyses.	Online provider survey and/or key-informant interviews with the providers who submitted claims for telemedicine and/or telemonitoring services.
Recommendations about how to remove barriers encountered in using telemedicine and/or telemonitoring services.	N/A	Similar and dissimilar themes based on content and narrative analyses.	Online provider survey and/or key-informant interviews with the providers who submitted claims for telemedicine and/or telemonitoring services.
Observations why the use of telemedicine and/or telemonitoring services succeeded or did not succeed in increasing the access to care for the Medicaid members in rural and semi-rural areas.	N/A	Similar and dissimilar themes based on content and narrative analyses.	Online provider survey and/or key-informant interviews with the providers who submitted claims for telemedicine and/or telemonitoring services.
Additional qualitative measures based on the themes identified from the survey and key informant interviews.	N/A	Similar and dissimilar themes based on content and narrative analyses.	Online provider survey and/or key-informant interviews with the providers who submitted claims for telemedicine and/or telemonitoring services.
Qualitative data will be collected through online provider survey and/or key-informant interviews with the providers who submitted claims for telemedicine and/or telemonitoring services. Qualitative data analysis procedures will be applied.			

## Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.9. Detailed Summary of Performance Measures for Monitoring of Overall KanCare 2.0 Program					
Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
<p><b>Prenatal and Postpartum Care (PPC)</b>                      Percentage of deliveries of live births on or between October 8 of the year prior to measurement year and October 7 of the measurement year:</p> <ul style="list-style-type: none"> <li>• Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.</li> <li>• Postpartum Care: Percentage of deliveries that had a postpartum visit on or between 7 &amp; 84 days after delivery.</li> </ul>	NCQA	Number (#) of deliveries of live births on or between October 8 of the year prior to measurement year and October 7 of the measurement year among women continually enrolled in Medicaid.	<ul style="list-style-type: none"> <li>• A prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment.</li> <li>• A postpartum care visit on or between 7 and 84 days after delivery.</li> </ul>	Percentage	MCO HEDIS data.
<p><b>Comprehensive Diabetes Care (CDC)</b>                      Percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following:</p> <ul style="list-style-type: none"> <li>• Hemoglobin A1c (HbA1c) testing;</li> <li>• HbA1c poor control (&gt;9.0%);</li> <li>• HbA1c control (&lt;8.0%);</li> <li>• Eye exam (retinal) performed;</li> <li>• Medical attention for Nephropathy;</li> <li>• BP control (&lt;140/90 mm Hg).</li> </ul>	NCQA	Members 18-75 years of age with diabetes (type 1 and type 2) enrolled in Medicaid during the measurement year.	<p><b>HbA1c testing:</b> A HbA1c test performed during the measurement year.</p> <p><b>HbA1c poor control (&gt;9.0%):</b> Most recent HbA1c level is &gt;9.0% or is missing a result, or if test was not done during the measurement year.</p> <p><b>HbA1c control (&lt;8.0%):</b> Most recent HbA1c level is &lt;8.0%.</p> <p><b>Eye exam (retinal) performed:</b> A retinal or dilated eye exam by eye care professional in the measurement year or a negative retinal or dilated eye exam in the year prior to measurement year or bilateral eye enucleation any time during the member’s history through December 31 of the measurement year.</p> <p><b>Medical attention for Nephropathy:</b> a nephropathy screening or monitoring test or evidence of nephropathy documented.</p> <p><b>BP control (&lt;140/90 mm Hg):</b> a member with most recent reading of BP &lt;140/90 mm Hg taken during outpatient visit or a nonacute inpatient encounter during the measurement year.</p>	Percentage	Same as above.
Denominators and numerators will be defined and calculated as per Healthcare Effectiveness Data and Information Set® (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. HEDIS Measures: Measures will be calculated for the eligible KanCare 2.0 population and associated strata. CAHPS, MH and HCBS-CAHPS Survey measures will be calculated for eligible KanCare 2.0 population.					

## Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.9. Detailed Summary of Performance Measures for Monitoring of Overall KanCare 2.0 Program (Continued)					
Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
<p><b>Smoking and Tobacco Cessation</b>                      Measure is based on the following Consumer Assessment of the Healthcare Providers and Systems (CAHPS) Survey questions:</p> <ul style="list-style-type: none"> <li>Do you now smoke cigarettes or use tobacco: every day, some days, or not at all?</li> </ul> <p>If response is “every day” or “some days”:</p> <ul style="list-style-type: none"> <li>In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?</li> <li>In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco?</li> <li>In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco?</li> </ul>	N/A	Number of survey respondents who currently smoke cigarettes or use tobacco every day or some days.	<p><b>Advice to quit smoking or using tobacco by a doctor or other health provider:</b> Current smokers who always/usually receive the advice.</p> <p><b>Medication recommended or discussed by a doctor or health provider to assist with quitting smoking or using tobacco:</b> Current smokers to whom a doctor or health provider always/usually/sometimes recommended or discussed medication.</p> <p><b>Doctor or health provider discussed or provided methods and strategies other than medication to assist with quitting smoking or using tobacco:</b> Current smokers with whom a doctor or health provider always/usually/sometimes discussed or provided methods and strategies other than medication.</p>	Percentage	CAHPS Survey.
<p><b>Improved ability to handle daily life and deal with crisis</b>                      Measure is based on the following Mental Health (MH) Survey questions:</p> <p><b>Youth:</b> As a direct result of the services my child and/or family received:</p> <ul style="list-style-type: none"> <li>My child is better at handling daily life.</li> <li>My child is better to cope when things go wrong.</li> </ul> <p><b>Adults:</b> As a direct result of the services I received:</p> <ul style="list-style-type: none"> <li>I deal effectively with daily problems.</li> <li>I am better able to deal with crisis.</li> </ul>	N/A	Number of survey respondents with responses “Strongly Agree,” “Agree,” “Disagree,” or “Strongly Disagree.”	<p><b>My child is better at handling daily life:</b> Number of responses marked “Strongly Agree” or “Agree.”</p> <p><b>My child is better to cope when things go wrong:</b> Number of responses marked “Strongly Agree” or “Agree.”</p> <p><b>I deal effectively with daily problems:</b> Number of responses marked “Strongly Agree” or “Agree.”</p> <p><b>I am better able to deal with crisis:</b> Number of responses marked “Strongly Agree” or “Agree.”</p>	Percentage	MH Survey.
<p><b>Social and Community Engagement</b>                      Measure is based on the following HCBS – CAHPS Survey questions:</p> <ul style="list-style-type: none"> <li>Ability to get together with family who live nearby;</li> <li>Ability to get together with friends who live nearby;</li> <li>Ability to do things in the community;</li> <li>Have enough help from staff to do things in the community;</li> <li>Decided what to do with your time each day;</li> <li>Decided when to do things each day.</li> </ul>	N/A	Number of eligible survey respondents.	<ul style="list-style-type: none"> <li><b>Ability to get together with family who live nearby:</b> Number of responses marked “Always”</li> <li><b>Ability to get together with friends who live nearby:</b> Number of responses marked “Always”</li> <li><b>Ability to do things in the community:</b> Number of responses marked “Always”</li> <li><b>Have enough help from staff to do things in the community:</b> Number of responses marked “Yes”</li> <li><b>Decided what to do with your time each day:</b> Number of responses marked “Yes”</li> <li><b>Decided when to do things each day:</b> Number of responses marked “Yes”</li> </ul>	Percentage	HCBS – CAHPS Survey.
Denominators and numerators will be defined and calculated as per Healthcare Effectiveness Data and Information Set® (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. HEDIS Measures will be calculated for the KanCare 2.0 population and associated strata. CAHPS, MH and HCBS-CAHPS Survey measures will be calculated for eligible KanCare 2.0 population.					

### Appendix 3: Detailed Discussion of Data Sources

Table A3.1. Detailed Discussion of Data Sources for KanCare 2.0 Evaluation Design (Service Coordination Strategy; OneCare Kansas program; Hypothesis 1, Hypothesis 2 and Hypothesis 3)				
Data Source	Type of Data Provided by the Data Source	Description of Data Source	Efforts for Cleaning/Validation of Data	Quality/Limitations of Data Source
Medicaid Management Information System (MMIS) Encounter database.	Claims and Encounters.	Encounter/claims data submitted to the State by MCOs used to support HEDIS® and HEDIS®-like performance, Medication Assisted Treatment, service utilization, and cost metrics for all enrollees.	<ul style="list-style-type: none"> <li>MMIS member demographics, enrollment, &amp; encounter data obtained from the database will be reviewed for missing values, duplicate values, inconsistent patterns, &amp; outliers to ensure quality &amp; appropriateness of data for analyses of performance measures required by the evaluation design.</li> <li>Encounter data related pay-for-performance metrics are validated annually by KFMC as a part of their validation of all pay-for-performance metrics.</li> <li>For applying statistical procedures for analysis of performance measures, a final dataset with all required variables will be created by merging data variables obtained from the MMIS database with data from other data sources.</li> </ul>	<ul style="list-style-type: none"> <li>Encounters submitted to the State by MCOs are records of the billed claims MCOs receive from providers for service payment. Administrative claims and encounter data are routinely used in HEDIS and other performance measurement. These data sources will be used in the evaluation to determine changes in access to services, quality of care, and health outcomes. Most of the measures selected for assessment of the evaluation questions are validated and widely used for this purpose.</li> <li>Data are generally considered complete if one quarter is allowed for claims processing and encounter submission.</li> <li>There are known gaps in MCO submission of pharmacy encounters.</li> <li>There is known inconsistency in the population of the MCO claim status field for zero-dollar paid claims.</li> </ul>
MMIS Eligibility and Enrollment database.	Medicaid Eligibility & Enrollment data.	Eligibility & enrollment detail for Medicaid members used to determine enrollee aid category and stratify data into subgroups.	<ul style="list-style-type: none"> <li>Data variables obtained from MMIS Eligibility and Enrollment database will be merged with data from other data sources to create a final database for applying statistical procedures for analysis of performance measures.</li> </ul>	<ul style="list-style-type: none"> <li>Enrollment records include beginning and end dates for eligibility periods.</li> <li>MCOs receive updated MMIS Eligibility and Enrollment data daily.</li> </ul>
MCOs' member-level case management data systems.	Administrative data on health screening scores & service coordination.	Member-level data maintained by MCOs within their specific case management data systems.	<ul style="list-style-type: none"> <li>Data on health screening scores &amp; service coordination obtained from the MCOs will be reviewed for missing values, duplicate values, inconsistent patterns, and outliers to ensure quality and appropriateness of data. The data will be used for creation of intervention and comparison groups, as well as for analyses of performance measures required by the evaluation design.</li> <li>Data variables obtained from MCOs' member-level case management data systems will be merged with data from other data sources to create a final database for applying statistical procedures for analysis of performance measures.</li> </ul>	<ul style="list-style-type: none"> <li>In the first year, MCOs are establishing the health screening and service coordination strategies; the database may not capture information on all members.</li> <li>MCOs have different case management systems, which may be a barrier to aggregating data.</li> </ul>
Data Sources will provide data for creation of intervention and comparison groups, stratification into subgroups, and calculation of denominators & numerators of the performance measures for implementation of one or multiple components of KanCare Evaluation Design.				

### Appendix 3: Detailed Discussion of Data Sources (Continued)

Table A3.1. Detailed Discussion of Data Sources for KanCare 2.0 Evaluation Design (Service Coordination Strategy; OneCare Kansas program; Hypothesis 1, Hypothesis 2 and Hypothesis 3) – Continued				
Data Source	Type of Data Provided by the Data Source	Description of Data Source	Efforts for Cleaning/Validation of Data	Quality/Limitations of Data Source
OneCare Kansas eligibility & participation database.	Administrative data on OneCare Kansas eligibility and participation.	Eligibility and participation details for KanCare 2.0 members for the OneCare Kansas program used for determining groups.	<ul style="list-style-type: none"> <li>Record counts will be trended to assess data completeness.</li> <li>Data variables obtained from database will be merged with data from other data sources to create a final database for applying statistical procedures for analysis of performance measures.</li> </ul>	<ul style="list-style-type: none"> <li>In the first year, the OneCare Kansas program will be establishing the data collection system and the database may not capture all information for members.</li> </ul>
OneCare Kansas Learning Collaborative reports	Qualitative data will be collected from the OneCare Kansas Learning Collaborative.	The Learning Collaborative reports will provide information on evolving learning needs for continual quality improvement of OneCare Kansas system. Learning Collaborative will include multiple program components to support provider implementation of OneCare Kansas program.	<ul style="list-style-type: none"> <li>Information from the OneCare Kansas Learning Collaborative reports will be reviewed for completeness and clarity.</li> <li>Themes will be identified to understand learning needs of the partners and ways to improve the quality of program.</li> </ul>	<ul style="list-style-type: none"> <li>Over the five-year period, changes may occur in the collection process for the report information.</li> </ul>
MCOs' administrative databases on Intervention and comparison Provider Incentive Programs.	Data on providers participating and not participating in the Intervention and comparison Provider Incentive Program	MCOs' administrative databases providing detailed provider data for identification of providers participating and not participating in the Intervention and comparison Provider Incentive Program for creation of the intervention & comparison groups & for subgroup stratification.	<ul style="list-style-type: none"> <li>Record counts will be trended to assess data completeness.</li> <li>Data variables obtained from database will be merged with data from other data sources to create a final database for applying statistical procedures for analysis of performance measures.</li> </ul>	<ul style="list-style-type: none"> <li>In the first year, MCOs are establishing the Intervention and comparison Provider Incentive Program and the database may not capture information on all members.</li> <li>MCOs have different case management systems, which may be a barrier to aggregating data.</li> </ul>
MCO databases/tables for the intervention and comparison Provider Incentive Program performance measures.	MCO measured effectiveness measures for intervention and comparison Provider Incentive Programs.	MCO databases/tables providing data for performance measures assessing effectiveness of the intervention and comparison Provider Incentive Programs.	<ul style="list-style-type: none"> <li>Data validation will be a responsibility of the MCOs.</li> <li>Data variables obtained from MCO databases/tables for intervention and comparison Provider Incentive Program performance measures will be merged with data from other data sources to create a final database for applying statistical procedures for analysis of performance measures.</li> </ul>	<ul style="list-style-type: none"> <li>Each MCO may have different provider incentives, metrics, and reporting periods. This may prevent aggregation of results across MCOs.</li> </ul>
Online provider survey of the providers participating in intervention and comparison Provider Incentive Programs.	Qualitative data to understand the facilitating factors & barriers and recommendations from providers to make the program successful in achieving its goal.	Online provider survey will be conducted to collect qualitative information from the providers participating in the intervention and comparison Provider Incentive Programs.	<ul style="list-style-type: none"> <li>Information from the online provider survey will be reviewed for completeness &amp; clarity.</li> <li>Themes will be identified to understand facilitating factors &amp; barriers and ways make the program successful in achieving its goal.</li> </ul>	<ul style="list-style-type: none"> <li>Low response rate of the survey is a potential barrier to evaluation.</li> <li>Three MCOs may not start the program at the same time, therefore all providers may not have same amount of time and experience with the program. This may cause complexity in identifying similar and dissimilar themes from the survey data.</li> </ul>
Data Sources will provide data for creation of intervention and comparison groups, stratification into subgroups, and calculation of denominators & numerators of the performance measures for implementation of one or multiple components of KanCare Evaluation Design.				

### Appendix 3: Detailed Discussion of Data Sources (Continued)

Table A3.1. Detailed Discussion of Data Sources for KanCare 2.0 Evaluation Design (Service Coordination Strategy; OneCare Kansas program; Hypothesis 1, Hypothesis 2 and Hypothesis 3) – Continued				
Data Source	Type of Data Provided by the Data Source	Description of Data Source	Efforts for Cleaning/Validation of Data	Quality/Limitations of Data Source
Key informant interviews from a sample of the providers participating in the intervention and comparison Provider Incentive Programs.	Qualitative data to explore reasons why this program succeeded or why it did not meet its goals.	Key informant interviews will explore further in-depth the themes identified through the provider survey to assess the reasons why this program succeeded or why it did not meet its goals.	<ul style="list-style-type: none"> <li>Information from the key informant interviews will be reviewed for completeness &amp; clarity.</li> <li>The in-depth information on the themes identified through provider interviews will be summarized.</li> </ul>	<ul style="list-style-type: none"> <li>Few providers may participate in the interviews.</li> <li>Three MCOs may not start the program at the same time, therefore all providers may not have same amount of time and experience with the program. This may cause complexity in identifying similar and dissimilar themes from the survey data.</li> </ul>
Appropriate data sources for measures identified later in accordance with specific telehealth strategies	TBD	TBD	TBD	TBD
Online Provider Survey to collect qualitative information from the providers using telemedicine &/or telemonitoring services	Qualitative data on facilitators & barriers in using telemedicine &/or telemonitoring services & how the use of these services increases access to care in rural or semi-urban areas.	Online Provider Survey will be conducted to collect qualitative information on facilitators & barriers encountered by the providers in using telemedicine &/or telemonitoring services among members living in rural or semi-urban areas; & how the use of these services increases the access to care in rural or semi-urban areas.	<ul style="list-style-type: none"> <li>Information from the Online Provider Survey will be reviewed for completeness &amp; clarity.</li> <li>Themes will be identified to understand facilitating factors &amp; barriers and ways make the program successful in achieving its goal.</li> </ul>	<ul style="list-style-type: none"> <li>Few providers may participate in the survey.</li> <li>Time consuming process.</li> <li>As providers may not start using telemedicine &amp;/or telemonitoring services at the same time, therefore may not have same amount of time and experience in using these services. This may cause complexity in identifying similar and dissimilar themes from the survey data.</li> </ul>
Key informant interviews from a sample of the providers using telemedicine &/or telemonitoring services	Qualitative data to explore reasons why use of telemedicine &/or telemonitoring was succeeded or not succeeded in increasing the access to care.	Key Informant interviews will explore further in-depth the themes identified through provider survey to assess the reasons why telemedicine &/or telemonitoring was succeeded or not succeeded in increasing the access to care.	<ul style="list-style-type: none"> <li>Information from the key informant interviews will be reviewed for completeness &amp; clarity.</li> <li>The in-depth information on the themes identified through provider interviews will be summarized.</li> </ul>	<ul style="list-style-type: none"> <li>Inadequate number of providers participating in the survey.</li> <li>Time-consuming process.</li> <li>As all three MCOs may not start the program at the same time, therefore all providers may not have same amount of time and experience with the program. This may cause complexity in exploring in-depth information of the program.</li> </ul>
Data Sources will provide data for creation of intervention and comparison groups, stratification into subgroups, and calculation of denominators & numerators of the performance measures for implementation of one or multiple components of KanCare Evaluation Design.				

### Appendix 3: Detailed Discussion of Data Sources (Continued)

Table A3.2. Detailed Discussion of Data Sources for Monitoring of the Overall KanCare 2.0 Performance Measures				
Data Source	Type of Data Provided by the Data Source	Description of Data Source	Efforts for Cleaning/Validation of Data	Quality/Limitations of Data Source
HEDIS data from MCOs.	Data for HEDIS performance measures.	Member-level detail tables for HEDIS measures submitted by the MCOs.	<ul style="list-style-type: none"> <li>• Comparison of numerator and denominator counts to NCQA-certified compliance audit results.</li> <li>• Files provide numerator and denominator values for stratified HEDIS results.</li> <li>• The MCOs subcontract with HEDIS Certified Auditors to validate their HEDIS data for NCQA submission.</li> <li>• KFMC subcontracts with a different HEDIS Certified Auditor to conduct validation of MCO HEDIS data; CMS validation protocols are followed.</li> </ul>	<ul style="list-style-type: none"> <li>• Data Quality is closely monitored by the MCOs and EQRO.</li> <li>• MCOs use NCQA Certified HEDIS software to calculate HEDIS measures and submit data to NCQA as part of their NCQA accreditation requirement.</li> <li>• Data become available seven months after the measurement year. This can affect the availability of data for conducting the evaluation for the entire five-year period of the demonstration.</li> </ul>
Consumer Assessment of the Healthcare Providers and Systems (CAHPS) Survey	Member survey data	Survey results on consumer reported experiences with healthcare. Member-level data are not available.	<ul style="list-style-type: none"> <li>• Validated by KFMC following CMS protocols.</li> <li>• Trend analysis will be performed.</li> </ul>	<ul style="list-style-type: none"> <li>• MCOs use NCQA Certified CAHPS vendors to conduct the survey and submit data to NCQA as part of their NCQA accreditation requirement.</li> <li>• Member-level results are not available.</li> </ul>
Mental Health Survey	Member survey data	Member-level data are available.	<ul style="list-style-type: none"> <li>• Trend analysis will be performed.</li> </ul>	<ul style="list-style-type: none"> <li>• Member-level data are available. However, sample sizes restrict subgroup analysis.</li> </ul>
HCBS– CAHPS Survey	Member survey data	Member-level data are available.	<ul style="list-style-type: none"> <li>• Trend analysis will be performed.</li> </ul>	<ul style="list-style-type: none"> <li>• Member-level data are available. However, sample sizes restrict subgroup analysis.</li> </ul>
HEDIS Measures will be calculated for the KanCare 2.0 population and associated strata. CAHPS, MH and HCBS-CAHPS Survey measures will be calculated for eligible KanCare 2.0 population.				

# Attachments

**Attachment 1: Independent Evaluator**

**Attachment 2: Evaluation Budget**

**Attachment 3: Timeline and Major Milestones**

## Attachment 1: Independent Evaluator

KDHE has arranged to contract with the Kansas External Quality Review Organization (EQRO), Kansas Foundation for Medical Care (KFMC), to conduct the evaluation of KanCare 2.0 at the level of detail needed to research the approved hypotheses. They have agreed to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved draft Evaluation Design. KFMC has over 45 years of demonstrated success in carrying out both Federal and State healthcare quality related contracts. They have provided healthcare quality improvement, program evaluation, review, and other related services including the following:

- Kansas Medicaid Managed Care EQRO since 1995 (over 24 years).
- CMS quality improvement organization (QIO) or QIO-Like entity since 1982 (38 years).
- Utilization Review/Independent Review Organization for the Kansas Insurance Department since 2000 (19 years) and for five other states.

KFMC is accredited as an Independent Review Organization (IRO) through URAC (formerly known as the Utilization Review Accreditation Commission). The URAC Accreditation process is a rigorous, independent evaluation, ensuring that organizations performing IRO services are free from conflicts of interest and have established qualifications for reviewers. Furthermore, through their sub-contract with the Great Plains Quality Innovation Network (a prime CMS contractor), KFMC submits an annual Organizational Conflict of Interest (OCI) certificate to CMS. KFMC considers ethics and compliance an integral part of all their business decisions and the services they provide. The KFMC Corporate Compliance Program supports the commitment of KFMC to conduct its business with integrity and to comply with all applicable Federal and State regulations, including those related to organizational and personal conflicts of interest. The KFMC compliance program ensures potential, apparent, and actual organizational and personal conflicts of interest (PCI) will be identified, resolved, avoided, neutralized, and/or mitigated.

Prior to entering into any contract, KFMC evaluates whether the identified entity or the work presents an actual, potential, or apparent OCI with existing KFMC contracts. KFMC will not enter into contracts that are an OCI. If it is undetermined whether the new work could be a conflict of interest with their EQRO and independent evaluation responsibilities, KFMC will discuss the opportunity with KDHE, to determine whether a conflict would exist. In some cases, an approved mitigation strategy may be appropriate.

All Board members, managers, employees, consultants and subcontractors receive education regarding conflicts of interest and complete a CMS developed PCI Disclosure Form. Disclosures include the following:

- Relationships with Insurance Organizations or Subcontractor of Insurance Organizations
- Relationships with Providers or Suppliers Furnishing Health Services Under Medicare
- Financial Interests in Health Care Related Entities
- Investments in Medical Companies, Healthcare or Medical Sector Funds
- Governing Body Positions

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## Attachment 2: Evaluation Budget

Job Description	Description of Services	FTE	Cost
<b>Researchers:</b> <ul style="list-style-type: none"> <li>• Epidemiologist Consultant (MBBS, PhD, MPH)</li> <li>• Senior Health Data Analyst (PhD, MA)</li> </ul>	<ul style="list-style-type: none"> <li>• Work with State and MCOs defining and developing measures (&gt;65 measures with multiple indicators each).</li> <li>• Work with State and MCOs on data collection tools, databases, and reports.</li> <li>• Obtain data; review for missing values, inconsistent patterns, and outliers to ensure quality and appropriateness of data.</li> <li>• Create final dataset for each measure merging data from various sources.</li> <li>• Examine homogeneity of the demographic characteristics of the members in Intervention and Comparison Group 2 for applicable study.</li> <li>• Conduct analysis according to the design, including trend, comparison, and regression analysis as appropriate.</li> <li>• Interpret analysis at least annually and create interim and summative reports.</li> </ul>	.93	\$120,000
<b>Analyst and Programmers</b> <ul style="list-style-type: none"> <li>• Quality Review Analyst (RN)</li> <li>• Programmer</li> </ul>	<ul style="list-style-type: none"> <li>• Assists Researchers with steps noted above.</li> <li>• Assist with case record review as needed, ensuring inter-rater-reliability.</li> <li>• DSRIP evaluation.</li> </ul>	.29	\$35,680
<b>Contract and Project Managers:</b> <ul style="list-style-type: none"> <li>• EQRO Director (RN, BSN, MSW, CCEP)</li> <li>• Project Manager (LMSW)</li> </ul>	<ul style="list-style-type: none"> <li>• Work with State and MCOs defining and developing measures.</li> <li>• Work with State and MCOs on data collection tools, databases, and reports.</li> <li>• Oversee evaluation operations and timelines to ensure deliverables are met.</li> <li>• Provider routine monthly or quarterly updates to KDHE regarding evaluation progress.</li> <li>• Assist with interpretation of data findings.</li> <li>• Assist with interim and summation report writing,</li> <li>• Facilitate communications with the Researchers, State, and MCOs as needed.</li> <li>• Assist with case record review as needed, ensuring inter-rater-reliability.</li> <li>• DSRIP evaluation.</li> </ul>	.13	\$22,681
<b>Project Specialist</b> <ul style="list-style-type: none"> <li>• Administrative support</li> <li>• Data entry</li> </ul>	<ul style="list-style-type: none"> <li>• Provide administrative support for report development and submission.</li> <li>• Assist with data abstraction or data entry as needed/appropriate.</li> </ul>	.13	\$11,495
<b>Total Annual Cost:</b>  *Evaluation time period; July 2019 through June 2025 (6 years); June 2025 is the due date of Draft Summative Evaluation Report, 18 months after the end of the demonstration date of December 2023.		1.5	\$189,856

### Attachment 3: Timeline and Major Milestones

Deliverable/Activity	Due Date(s)
Initiate meetings with EQRO/State/MCOs to finalize study measures, determining data sources.	July 31, 2019
Conduct meetings at least quarterly (more frequently in first year) with EQRO/State/MCOs to review and discuss data sources, reports, and findings.	To be determined
Quarterly update of KanCare 2.0 Evaluation progress.	August 31; November 30; February 28; May 31
Annual progress report of KanCare 2.0 Evaluation and key findings.	By April 1
Draft Interim Evaluation Report, in accordance with Attachment N (Preparing the Evaluation Report) of the STCs, will discuss evaluation progress and findings to date.	One year prior to the end of the demonstration ( <b>December 2022</b> ), or with renewal application (to be determined)
Final Interim Evaluation Report.	60 days after receipt of CMS comments
Draft Summative Evaluation Report in accordance with Attachment N of the STCs.	18 months from the end of the demonstration ( <b>June 2025</b> )
Final Summative Evaluation Report.	60 calendar days after receipt of CMS comments

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## **Attachment B. Substance Use Disorder Interim Evaluation**

[See following page.]



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October 17, 2022

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SUD Programs/Womens Treatment Services Coordinator  
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Kansas Department for Aging and Disability Services (KDADS)  
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RE: KanCare 2.0 Substance Use Disorder Demonstration Interim Evaluation Report

Dear Ms. Corliss:

Enclosed is KFMC's KanCare 2.0 Substance Use Disorder Demonstration Interim Evaluation Report. Please contact me, [bnech@kfmc.org](mailto:bnech@kfmc.org), if you have any questions or concerns.

Sincerely,

Beth Nech, MA  
EQRO Manager

Electronic Version: Andrew Brown, Commissioner of Behavioral Health Services, KDADS  
Brad Ridley, Director of Operations, KDADS  
Shirley Norris, Director of Managed Care, KDHE  
Ryan Gonzales, EQR Audit Manager/Supervisor, KDHE

Enclosure(s)



# ***KanCare 2.0 Interim Evaluation Report***

## ***Evaluation of the State of Kansas Medicaid***

### ***Section 1115(a) Demonstration***

#### ***Substance Use Disorder***

***Reporting Period – January 2019 – October 2021***

**Contract Number: 46100**

**Submission Date: October 17, 2022**

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**Substance Use Disorder**  
**Reporting Period – January 2019 – October 2021**

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***KanCare 2.0 Interim Evaluation Report  
Evaluation of the State of Kansas Medicaid Section 1115(a)  
Demonstration – Substance Use Disorder  
January 2019 – December 2021  
Submission Date: October 17, 2022***

***Executive Summary***

**Substance Use Disorder Demonstration Overview**

KanCare, the Kansas statewide mandatory Medicaid managed care program, was implemented January 1, 2013, under authority of a waiver through Section 1115 of the Social Security Act. The initial demonstration was approved for five years, with a subsequent one year extension. CMS approved the KanCare 2.0 Section 1115 Substance Use Disorder (SUD) Demonstration Implementation Plan for the period of January 1, 2019, through December 31, 2023.

The Implementation Plan outlines the State’s strategy to provide a full continuum of services for SUD treatment to KanCare members. It is in alignment with the overall KanCare 2.0 goals that were designed to provide efficient and effective health care services and to ensure coordination of care and integration of physical health (PH), behavioral health (BH), and Home and Community Based Services (HCBS). KanCare 2.0 provides access to all critical levels of care for SUD and opioid use disorder (OUD). The three KanCare managed care organizations (MCOs) provide access to a range of services across much of the American Society of Addiction Medicine (ASAM) levels of care. The spectrum of care—which includes outpatient treatment, peer recovery support, intensive outpatient services, medication-assisted treatment (MAT), intensive inpatient services, withdrawal management, and residential treatment—is provided to eligible Medicaid and CHIP recipients who need SUD or OUD treatment. In addition, all members aged 19 through 64 have access to additional covered services, including SUD treatment services provided to individuals with SUD who are short-term residents in residential treatment facilities that meet the definition of an IMD. Since 2020, KanCare covers methadone for MAT as required by the SUPPORT Act. Through the Implementation Plan, Kansas requires all inpatient residential treatment centers, including all those previously excluded as Institutions for Mental Disease (IMDs), to provide access to MAT through direct provision or by coordinated referral and treatment initiation to a MAT provider. This requirement was implemented through State policy instead of the initially planned licensing requirement.

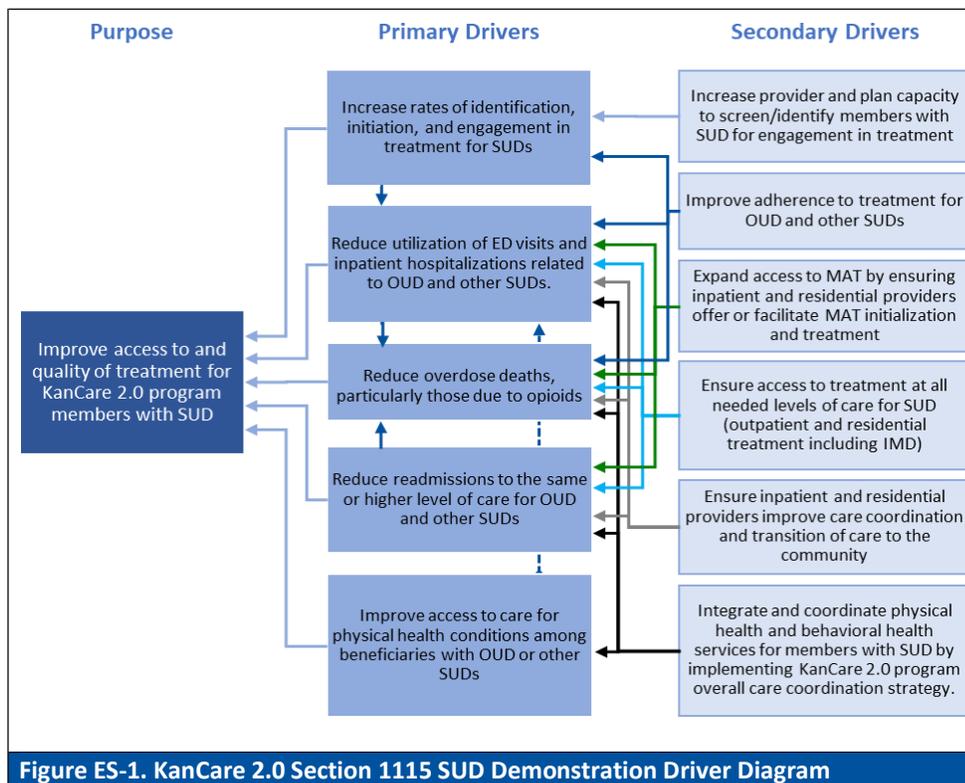
KanCare 2.0 requires the provision of person-centered case management, as a one-on-one goal-directed service for individuals with a SUD, to assist in obtaining access to needed family, legal, medical, employment, educational, psychiatric, and other services. This service must be a part of the treatment plan developed and determined medically necessary by the MCO.

### KanCare 2.0 Section 1115 SUD Demonstration Goals

Kansas uses the 1115 demonstration authority to pursue the following goals to improve access to and quality of treatment for KanCare 2.0 program members with SUD:

1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.
2. Reduced utilization of emergency departments (EDs) and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.
3. Reduction in overdose deaths, particularly those due to opioids.
4. Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.
5. Improved access to care for physical health conditions among members with OUD or other SUDs.

The following driver diagram for the overall SUD demonstration (Figure ES-1) shows the relationship between the demonstration’s purpose, the primary drivers that contribute directly to achieve the purpose, and the secondary drivers necessary to achieve the primary drivers.



### SUD Demonstration Goals, Evaluation Questions, and Hypotheses

As the focus of the SUD Demonstration evaluation is to examine whether the demonstration achieved its goals, the following evaluation questions were designed in alignment with the five goals and related hypotheses (Table ES-1). This evaluation is in accordance with the CMS-approved “SUD, Section 1115 Demonstration Evaluation Design.” (Attachment A)

<b>Table ES-1. SUD Demonstration Goals, Evaluation Questions, and Hypotheses</b>			
	<b>Goals</b>	<b>Evaluation Questions</b>	<b>Hypotheses</b>
1.	Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.	Does the demonstration increase access to and utilization of SUD treatment services?	The demonstration will increase the percentage of members who are referred and engaged in treatment for SUDs.
2.	Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.	Does the demonstration decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population?	The demonstration will decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population.
3.	Reductions in overdose deaths, particularly those due to opioids.	Are rates of opioid-related overdose deaths impacted by the demonstration?	The demonstration will decrease the rate of overdose deaths due to opioids.
4.	Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.	Do enrollees receiving SUD services experience reduction in readmissions to the same or higher level of care for OUD and other SUDs?	Among members receiving care for SUD, the demonstration will reduce readmissions to SUD treatment.
5.	Improved access to care for physical health conditions among members with OUD or other SUDs.	Do enrollees receiving SUD services experience improved access to care for physical health conditions?	The demonstration will increase the percentage of members with SUD who access care for physical health conditions.

### **KanCare 2.0 Demonstration Hypothesis 4**

#### ***(Associated with SUD Demonstration Evaluation Design Question 1)***

Removing payment barriers for services provided in IMDs for KanCare members is a strategy in both the KanCare 2.0 Demonstration (Hypothesis 4) and SUD Demonstrations (Goal 1). To avoid duplicating evaluation activities, KanCare 2.0 Hypothesis 4 is addressed within the SUD Demonstration evaluation per CMS recommendation. (Table ES-2.)

<b>Table ES-2. KanCare 2.0 Demonstration Hypothesis 4 and Evaluation Question</b>	
<b>Hypothesis</b>	<b>Evaluation Question</b>
Removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members will result in improved member access to substance use disorder (SUD) treatment services.	Did removing payment barriers for services provided in IMDs for KanCare members improve member access to SUD treatment services?

### **Interim Evaluation of Substance Use Disorder Demonstration**

In accordance with CMS guidelines, the KanCare 2.0 SUD Demonstration evaluation design was submitted for CMS approval. The CMS review of the evaluation design was received April 2, 2020. An updated evaluation design as per CMS guidance and feedback was submitted, and it was approved by CMS on June 30, 2020.

KFMC Health Improvement Partners (KFMC), under contract with the Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF), serves as the External Quality Review Organization (EQRO) for KanCare. As the EQRO, KFMC is conducting the required SUD Demonstration evaluation and has prepared this interim evaluation report to reflect evaluation progress and presently available findings for January 2019 through December 31, 2021.

## Substance Use Disorder Demonstration Interim Evaluation Results

The interim evaluation included the assessment of performance measures for the five goals of the SUD Demonstration (*outcome evaluation*). It should be noted, the demonstration goals are also referred as *primary drivers*. The analytical results and interpretation of the outcome measures assessing the goals will follow discussion of the assessment of six secondary drivers (*process evaluation*). All results should be interpreted with caution as the evaluation period corresponded with the onset and continuation of the COVID-19 pandemic. The data and analytical results for 2022 and 2023 will better assess progress towards the demonstration goals.

### Outcome Evaluation

#### Goal 1 (Primary Driver 1)

The performance measures assessed to evaluate Goal 1 are described in Table ES-3.

Table ES-3. Performance Measures for SUD Demonstration Goal 1
<b>Outcome Measures for Goal 1 (Primary Driver 1)</b>
<ul style="list-style-type: none"> <li>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation. (2017–2020)</li> <li>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement. (2017–2020)</li> </ul>
<b>Process Measures for Secondary Drivers</b>
<i>Increase provider and plan capacity to screen/identify members with SUD for engagement in treatment (Relates to Goal 1)</i>
<ul style="list-style-type: none"> <li>Percentage of physical health and behavioral health service providers that billed <i>Screening, Brief Intervention, and Referral to Treatment</i> (SBIRT) services. (Not included in interim evaluation)</li> <li>Receipt of care for SUD and/or OUD after SBIRT service. (2017–2021)</li> </ul>
<i>Improve adherence to treatment for OUD and other SUDs (Related to Goals 1–3)</i>
<ul style="list-style-type: none"> <li>Continuity of Pharmacotherapy for OUD (POD). (CMS Metric #22). (2019–2020)</li> <li>Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2020)</li> <li>Percentage of beneficiaries with SUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2021)*</li> <li>Percentage of beneficiaries with OUD who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2021)*</li> <li>Percentage of beneficiaries with SUD diagnosis who used SUD peer support services. (2017–2021)</li> </ul>
<small>*Service Type Strata: <i>early intervention</i>, e.g., SBIRT (CMS Metric #7); <i>outpatient services</i> (CMS Metric #8); <i>intensive outpatient and partial hospitalization</i> (CMS Metric #9); <i>residential and inpatient services</i> (CMS Metric #10); <i>withdrawal management</i> (CMS Metric #11); <i>medication-assisted treatment (MAT)</i> (CMS Metric #12)</small>

### Key Results and Conclusions

The findings indicated improvement towards this goal. However, low rates for both outcome measures indicated further improvement is needed. The main findings related to the outcome measures are summarized below.

- The Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) rates for initiation of treatment within 14 days of SUD diagnosis had an increasing trend from 2017 to 2020, with an average increase of 3 percentage points per year. The Quality Compass rankings (a

comparison to national percentiles) for the measure also improved.

- The 2019 and 2020 rates for continued engagement within 34 days of the initial treatment were greater than the 2017 and 2018 rates; the average increase was 0.5 percentage points per year. The rates for engagement within 34 days provided weaker supporting evidence.
- The Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) measures (Initiation within 14 days, Engagement within 34 days) were low. Rates improved in 2020; however, further improvement is needed.

### Goal 2 (Primary Driver 2)

The performance measures assessed to evaluate Goal 2 are described in Table ES-4.

Table ES-4. Performance Measures for SUD Demonstration Goal 2
<b>Outcome Measures for Goal 2 (Primary Driver 2)</b>
<ul style="list-style-type: none"> <li>• ED utilization for SUD per 1,000 Medicaid beneficiaries. (CMS Metric #23; 2017–2021)</li> <li>• ED utilization for OUD per 1,000 Medicaid beneficiaries. (CMS Metric #23, OUD stratum; 2017–2021)</li> <li>• Inpatient stays for SUD per 1,000 Medicaid beneficiaries. (CMS Metric #24; 2017–2021)</li> <li>• Inpatient stays for OUD per 1,000 Medicaid beneficiaries. (CMS Metric #24, OUD stratum; 2017–2021)</li> </ul>
<b>Process Measures for Secondary Drivers</b>
<i>Improve adherence to treatment for OUD and other SUDs (Related to Goals 1–3)</i>
<ul style="list-style-type: none"> <li>• Continuity of Pharmacotherapy for OUD (POD). (CMS Metric#22; 2019–2020)</li> <li>• Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2020)</li> <li>• Percentage of beneficiaries with SUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2021)*</li> <li>• Percentage of beneficiaries with OUD who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2021)*</li> <li>• Percentage of beneficiaries with SUD diagnosis who used SUD peer support services during the monthly measurement period. (2017–2021)</li> </ul>
<i>Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment. (Related to Goals 2–4)</i>
<ul style="list-style-type: none"> <li>• Residential OUD discharges with MAT claim. (2017–2021)</li> <li>• Inpatient OUD discharges with MAT claim. (2017–2021)</li> <li>• Percentage of members with OUD diagnosis who have a MAT claim for OUD during the measurement period. (2017–2021)</li> </ul>
<i>Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD). (Related to Goals 2–4)</i>
<ul style="list-style-type: none"> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who were treated in an IMD for SUD during the measurement year. (2019–2021)</li> <li>• Average length of stay for SUD treatment services within IMDs. (CMS Metric #36; 2019–2021)</li> <li>• Number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members with SUD diagnosis. (2017–2021)</li> <li>• Number of outpatient, intensive outpatient, and partial hospitalization days of SUD treatment per 1,000 members with SUD diagnosis. (2017–2021) <b>Note:</b> <i>Partial hospitalization in KS has same service code as inpatient.</i></li> </ul>
<p>*Service Type Strata: early intervention, e.g., SBIRT (CMS Metric #7); outpatient services (CMS Metric #8); intensive outpatient and partial hospitalization (CMS Metric #9); residential and inpatient services (CMS Metric #10); withdrawal management (CMS Metric #11); medication-assisted treatment (MAT) (CMS Metric #12).</p>

Table ES-4. Performance Measures for SUD Demonstration Goal 2 (Continued)
<b>Process Measures for Secondary Drivers (Continued)</b>
<i>Ensure inpatient &amp; residential providers improve care coordination &amp; transition of care to the community. (Related to Goals 2–4)</i>
<ul style="list-style-type: none"> <li>• 30-Day Readmission for SUD treatment. (2017–2021)</li> <li>• ED utilization for SUD per 1,000 beneficiaries. (CMS Metric #23; 2019–2021 (first three quarters))</li> <li>• ED utilization for OUD per 1,000 beneficiaries. (CMS Metric #23, OUD stratum; 2019–2021 (first three quarters))</li> <li>• Inpatient stays for SUD per 1,000 beneficiaries. (CMS Metric #24; 2017–2021 (first three quarters))</li> <li>• Inpatient stays for OUD per 1,000 beneficiaries. (CMS Metric #24, OUD stratum; 2017–2021 (first three quarters))</li> <li>• Follow-Up After ED Visit for Alcohol and Other Drug Abuse/ Dependence (FUA). (2017–2020)</li> <li>• Initiation &amp; Engagement of Alcohol &amp; Other Drug Dependence Treatment (IET). (2017–2020)</li> <li>• Follow-Up After High-Intensity Care for SUD (FUI). (2019–2020)</li> </ul>
<i>Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy. (Related to Goals 2–5)</i>
<ul style="list-style-type: none"> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager (2019–2021)</li> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and have a service/treatment plan or person-centered service plan (PCSP). (2019–2021)</li> </ul>
<i>*Service Type Strata: early intervention, e.g., SBIRT (CMS Metric #7); outpatient services (CMS Metric #8); intensive outpatient and partial hospitalization (CMS Metric #9); residential and inpatient services (CMS Metric #10); withdrawal management (CMS Metric #11); medication-assisted treatment (MAT) (CMS Metric #12).</i>

### Key Results and Conclusions

The four outcome measures (service utilization measures) indicated some improvement towards reducing preventable utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment. Additional improvements efforts may be needed to realize this goal. The main findings related to the outcome measures are summarized below:

- All four measures showed a decline from 2019 to 2020 and in the first three quarters of 2021.

### Goal 3 (Primary Driver 3)

The performance measures assessed to evaluate Goal 3 are described in Table ES-5.

Table ES-5. Performance Measures for SUD Demonstration Goal 3
<b>Outcome Measures for Goal 3 (Primary Driver 3)</b>
<ul style="list-style-type: none"> <li>• Opioid Drug Overdose Deaths. (CMS Metric #27, OUD Stratum; 2019–2021)</li> <li>• Use of Opioids at High Dosage in Persons without Cancer per 1,000 beneficiaries. (CMS Metric #18; 2019–2020)</li> <li>• Concurrent Use of Opioids and Benzodiazepines, per 1,000 beneficiaries. (CMS Metric #21; 2019–2020)</li> </ul>
<b>Process Measures for Secondary Drivers</b>
<i>Improve adherence to treatment for OUD and other SUDs (Related to Goals 1–3)</i>
<ul style="list-style-type: none"> <li>• Continuity of Pharmacotherapy for OUD (POD). (CMS Metric #22; 2019–2020)</li> <li>• Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). 2017–2020)</li> <li>• Percentage of beneficiaries with SUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2021)*</li> <li>• Percentage of beneficiaries with OUD who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2021)*</li> <li>• Percentage of beneficiaries with SUD diagnosis who used SUD peer support services during the monthly measurement period. (2017–2021)</li> </ul>
<i>*Service Type Strata: early intervention, e.g., SBIRT (CMS Metric #7); outpatient services (CMS Metric #8); intensive outpatient and partial hospitalization (CMS Metric #9); residential and inpatient services (CMS Metric #10); withdrawal management (CMS Metric #11); medication-assisted treatment (MAT) (CMS Metric #12).</i>

Table ES-5. Performance Measures for SUD Demonstration Goal 3 (Continued)
<b>Process Measures for Secondary Drivers (Continued)</b>
<i>Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment. (Related to Goals 2–4)</i>
<ul style="list-style-type: none"> <li>• Residential OUD discharges with MAT claim. (2017–2021)</li> <li>• Inpatient OUD discharges with MAT claim. (2017–2021)</li> <li>• Percentage of members with OUD diagnosis who have a MAT claim for OUD during the measurement period. (2017–2021)</li> </ul>
<i>Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD). (Related to Goals 2–4)</i>
<ul style="list-style-type: none"> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who were treated in an IMD for SUD during the measurement year. (2019–2021)</li> <li>• Average length of stay for SUD treatment services within IMDs. (CMS Metric #36; 2019–2021)</li> <li>• Number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members with SUD diagnosis. (2017–2021)</li> <li>• Number of outpatient, intensive outpatient, &amp; partial hospitalization days of SUD treatment per 1,000 members with SUD diagnosis. (2017–2021) <b>Note:</b> <i>Partial hospitalization in KS has same service code as inpatient.</i></li> </ul>
<i>Ensure inpatient &amp; residential providers improve care coordination &amp; transition of care to the community. (Related to Goals 2–4)</i>
<ul style="list-style-type: none"> <li>• 30-Day Readmission for SUD treatment. (2017–2021)</li> <li>• ED utilization for SUD per 1,000 beneficiaries. (CMS Metric #23; 2019–2021 (first three quarters))</li> <li>• ED utilization for OUD per 1,000 beneficiaries. (CMS Metric #23, OUD stratum; 2019–2021 (first three quarters))</li> <li>• Inpatient stays for SUD per 1,000 beneficiaries. (CMS Metric #24; 2017–2021 (first three quarters))</li> <li>• Inpatient stays for OUD per 1,000 beneficiaries. (CMS Metric #24, OUD stratum; 2017–2021 (first three quarters))</li> <li>• Follow-Up After ED Visit for Alcohol and Other Drug Abuse/ Dependence (FUA). (2017–2020)</li> <li>• Initiation &amp; Engagement of Alcohol &amp; Other Drug Dependence Treatment (IET). (2017–2020)</li> <li>• Follow-Up After High-Intensity Care for SUD (FUI). (2019–2020)</li> </ul>
<i>Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy. (Related to Goals 2–5)</i>
<ul style="list-style-type: none"> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager (2019–2021)</li> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and have a service/treatment plan or person-centered service plan (PCSP). (2019–2021)</li> </ul>
<p><i>*Service Type Strata: early intervention, e.g., SBIRT (CMS Metric #7); outpatient services (CMS Metric #8); intensive outpatient and partial hospitalization (CMS Metric #9); residential and inpatient services (CMS Metric #10); withdrawal management (CMS Metric #11); medication-assisted treatment (MAT) (CMS Metric #12).</i></p>

### Key Results and Conclusions

The findings for three outcome measures indicated mixed results. The findings of one outcome measure indicated some improvement being made towards reduced use of opioid drugs—which in turn should reduce overdose deaths, particularly those due to opioids. However, the measure directly assessing the opioid drug overdose death rates did not indicate any improvement. The third measure’s results are too preliminary to evaluate. The main findings related to the outcome measures are summarized below.

- Rates for Use of Opioids at High Dosage in Persons without Cancer per 1,000 Medicaid Beneficiaries decreased from 2019 to 2020, indicating some improvement is being made towards Goal 3.
- The Opioid Drug Overdose death rates increased slightly from 2019 to 2021, which does not indicate improvement.
- Coverage for Medication Assisted Treatment (MAT) drugs and biological products used for opioid use disorder (OUD) became effective October 1, 2020. Consequently, insufficient information was available on the concurrent use of opioids and benzodiazepines to draw conclusion.

**Goal 4 (Primary Driver 4)**

The performance measures assessed to evaluate Goal 4 are described in Table ES-6.

Table ES-6. Performance Measures for SUD Demonstration Goal 4
<b>Outcome Measures for Goal 4 (Primary Driver 4)</b>
<ul style="list-style-type: none"> <li>• 30-Day Readmission for SUD treatment. (2017–2021)</li> <li>• 30-Day Readmission for SUD treatment (among discharges from a residential or inpatient facility for OUD treatment). (2017–2021)</li> </ul>
<b>Process Measures for Secondary Drivers</b>
<i>Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment. (Related to Goals 2–4)</i>
<ul style="list-style-type: none"> <li>• Residential OUD discharges with MAT claim. (2017–2021)</li> <li>• Inpatient OUD discharges with MAT claim. (2017–2021)</li> <li>• Percentage of members with OUD diagnosis who have a MAT claim for OUD during the measurement period. (2017–2021)</li> </ul>
<i>Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD). (Related to Goals 2–4)</i>
<ul style="list-style-type: none"> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who were treated in an IMD for SUD during the measurement year. (2019–2021)</li> <li>• Average length of stay for SUD treatment services within IMDs. (CMS Metric #36; 2019–2021)</li> <li>• Number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members with SUD diagnosis. (2017–2021)</li> <li>• Number of outpatient, intensive outpatient, &amp; partial hospitalization days of SUD treatment per 1,000 members with SUD diagnosis. (2017–2021) <b>Note:</b> <i>Partial hospitalization in KS has same service code as inpatient.</i></li> </ul>
<i>Ensure inpatient &amp; residential providers improve care coordination &amp; transition of care to the community. (Related to Goals 2–4)</i>
<ul style="list-style-type: none"> <li>• 30-Day Readmission for SUD treatment. (2017–2021)</li> <li>• ED utilization for SUD per 1,000 beneficiaries. (CMS Metric #23; 2019–2021 (first three quarters))</li> <li>• ED utilization for OUD per 1,000 beneficiaries. (CMS Metric #23, OUD stratum; 2019–2021 (first three quarters))</li> <li>• Inpatient stays for SUD per 1,000 beneficiaries. (CMS Metric #24; 2017–2021 (first three quarters))</li> <li>• Inpatient stays for OUD per 1,000 beneficiaries. (CMS Metric #24, OUD stratum; 2017–2021 (first three quarters))</li> <li>• Follow-Up After ED Visit for Alcohol and Other Drug Abuse/ Dependence (FUA). (2017–2020)</li> <li>• Initiation &amp; Engagement of Alcohol &amp; Other Drug Dependence Treatment (IET). (2017–2020)</li> <li>• Follow-Up After High-Intensity Care for SUD (FUI). (2019–2020)</li> </ul>
<i>Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy. (Related to Goals 2–5)</i>
<ul style="list-style-type: none"> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager (2019–2021)</li> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and have a service/treatment plan or person-centered service plan (PCSP). (2019–2021)</li> </ul>

**Key Results and Conclusions**

Both measures indicated progress towards reducing preventable readmissions. The main findings related to the outcome measures are summarized below.

- 30-Day Readmission for SUD Treatment rates declined (improved) from 2017 to 2021, decreasing 1.7 percentage points per year, on average.
- Similarly, the rate of readmission for SUD treatment within 30 days of an OUD discharges had a declining trend, averaging 2.0 percentage points decreases from 2017 to 2021.

**Goal 5 (Primary Driver 5)**

The performance measures assessed to evaluate Goal 5 are described in Table ES-7.

Table ES-7. Performance Measures for SUD Demonstration Goal 5
<b>Outcome Measures for Goal 5 (Primary Driver 5)</b>
<ul style="list-style-type: none"> <li>• Annual Dental Visits (ADV). (SUD stratum; 2016–2021)</li> <li>• Adults’ Access to Preventive/Ambulatory Health Services (AAP). (Not included in interim evaluation)</li> <li>• Adolescent Well-Care Visits (AWC). (SUD stratum; 2016–2021)</li> <li>• Prenatal and Postpartum Care (PPC)–Timeliness of Prenatal Care. (SUD stratum; 2016–2021)</li> <li>• Prenatal and Postpartum Care (PPC)–Postpartum Care. (SUD stratum; 2017–2022)</li> </ul>
<b>Process Measures for Secondary Drivers</b>
<i>Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy. (Related to Goals 2–5)</i>
<ul style="list-style-type: none"> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager (2019–2021)</li> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and have a service/treatment plan or person-centered service plan (PCSP). (2019–2021)</li> </ul>

**Key Results and Conclusions**

For evaluation of the primary driver for Goal 5, improvements in rates for 2016 to 2018 and 2019 to 2021 were compared between an intervention group (KanCare members, aged 16–75, who had a SUD diagnosis during the measurement year) and a comparison group (members, aged 16–75, who did not have a SUD diagnosis). The groups’ 2016–2018 rates were not equal, so differences in 2019–2021 rates were expected. If the SUD demonstration had positive impact on the outcome measures, then the Intervention Group should show relatively more improvement between periods than the Comparison Group, or at least not decline as badly.

Comparisons of relative improvements for the four outcome measures did not yield supporting evidence that the SUD demonstration specifically is improving Goal 5. However, timeliness of prenatal care improved for both the SUD intervention group and non-SUD comparison group. The main findings related to the outcome measures are summarized below:

- The relative improvements in the percentage of members 16 to 20 years old who had a dental visit in the measurement year were not statistically significantly different between the intervention and comparison groups.
- The percentage of members 16 to 20 years old who had a well-care visit in the measurement year decreased for both the intervention and comparison group, but the decreases were less than 1 percentage point. The difference between the negative relative improvements of the two groups was not statistically significant.
- Timeliness of Prenatal Care rates improved for both the intervention group and comparison group. However, the relative improvements were not statistically significantly different. The rate increases between measurement periods is interpreted to be caused by a factor outside the SUD Demonstration, such as MCOs’ performance improvement projects.

**Outcome Evaluation – Opportunities for Improvement**

- The rates for the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) measures (Initiation within 14 days, Engagement within 34 days) were low. Rates improved in 2020; however, further improvement is needed.
- Further improvement is needed to reduce use of opioids at high doses among patients without cancer for their pain management treatments.
- Improvement in care coordination to assist members with SUD in receiving appropriate services for prevention and treatment of physical health conditions is needed.

## Recommendations

- Strategies should be identified and implemented to help ensure members are aware of primary prevention and availability of treatment.
- Strategies should be identified and implemented to help ensure providers are aware of the SUD demonstration strategies and to identify and address associated provider training and skill building opportunities.
- Strategies should be identified and implemented to improve the use of early intervention services (SBIRT) and outpatient services among members with SUD. The improvement in the appropriate use of these levels of care will assist in reducing the burden on providers and facilities providing higher levels of care.
- Address barriers and challenges to engaging in the needed SUD treatment encountered by the members with SUD. Enhance action steps to improve availability of supportive services, such as peer support services, coordination of care for ensuring regular follow-up visits with SUD care providers, and provider trainings to assist members with SUD to engage in receiving needed SUD treatment.
- Review and improve the steps applied by the three MCOs to ensure all members with an SUD diagnosis receive an HRA and Needs Assessment, along with a PCSP and coordinated care, as appropriate. Application of the Service Coordination Strategy for members with an SUD diagnosis will help ensure coordination of care for co-occurring physical and mental health conditions.

## **Process Evaluation – Secondary Drivers**

### Secondary Driver 1 (Related to Goal 1)

*Increase provider and plan capacity to screen/identify members with SUD for engagement in treatment*

The performance measure assessed to evaluate Secondary Driver 1 are described in Table ES-3.

#### *Key Results and Conclusions*

- Secondary Driver 1 was related to Goal 1. Since there were no significant changes in the percentage of members who received SBIRT services with a SUD service within 60 days, Secondary Driver 1 did not provide evidence supporting Goal 1's hypothesis that the demonstration will increase the percentage of members who are referred and engaged in treatment for SUDs. Further improvements are needed.
- One of the performance measures for Secondary Driver 1 was assessed for the interim evaluation, the percentage of beneficiaries who received SBIRT services with evidence of SUD service within 60 days after SBIRT service. Changes were not seen between years and across five years.

### Secondary Driver 2 (Related to Goals 1, 2, and 3)

*Improve adherence to treatment for OUD and other SUDs*

The performance measures for evaluating Secondary Driver 2 are listed in Tables ES-3, ES-4, and ES-5.

#### *Key Results and Conclusions*

- Secondary Driver 2 is related to Goals 1, 2 and 3. The evaluation found Secondary Driver 2 has contributed towards the progress towards achieving Goals 1, 2 and 3. Further improvements in this driver are needed to strengthen its contribution towards these goals.
- Secondary Driver 2 was examined by assessing five performance measures, including rates stratified by service type for two measures. The results for two out of five measures, and several service type strata, indicate that adherence to treatment for OUD and other SUDs is increasing.

- The rates of members with an OUD or other SUD receiving SUD treatment increased significantly in 2021. While almost all service type strata within these measures had some increase in 2021, most notable were increases in outpatient services and MAT. Members with an OUD diagnosis had higher rate increases for SUD treatment, overall and for several service type strata.
- Over the five-year period, the percentages of members with a SUD diagnosis who received peer support services remained low, between 5% and 6%. These results do not indicate adherence to treatment for OUD and other SUDs is improving.

### Secondary Driver 3 (Related to Goals 2, 3, and 4)

#### *Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment*

The performance measures assessed to evaluate Secondary Driver 3 are described in Tables ES-3, ES-5, and ES-6.

#### *Key Results and Conclusions*

- Secondary Driver 3 is related to Goals 2, 3 and 4. Evaluation indicates this driver has contributed to progress towards achieving Goals 2, 3 and 4. Further improvements in this driver are needed to strengthen its contribution towards these goals.
- The three performance measures used to assess Secondary Driver 3 indicated progress toward expanding access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment.
- The percentages of inpatient OUD discharges with a MAT claim were low from 2017 to 2020; however, the 2021 rate doubled compared to preceding years and showed a statistically significant change from 2020, indicating improvement in Secondary Driver 3.
- The percentages of members with OUD diagnosis who have a MAT claim for OUD increased statistically significantly from the previous year in 2020 and 2021 and increased over five years, averaging 1.67 percentage points per year, which indicates improvement in Secondary Driver 3.

### Secondary Driver 4 (Related to Goals 2, 3, and 4)

#### *Ensure access to treatment at all needed levels of care for SUD*

The performance measures assessed to evaluate Secondary Driver 4 are described in Tables ES-4, ES-5, and ES-6. Since the severity of condition for which the member was treated and extenuating circumstances are unknown, interpreting rate increases or decreases as improvements must be done with caution.

#### *Key Results and Conclusions*

- Secondary Driver 4 is related to Goals 2, 3 and 4. Evaluation of this driver did not find enough evidence to conclude this driver is contributing to progress towards achieving Goals 2, 3 and 4. Further improvements in this driver are needed to establish its contribution towards these goals.
- The results of the four process measures did not provide strong enough evidence to indicate that an improvement is being made in ensuring access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD).
- The percentages of KanCare members with SUD diagnosis who were treated in an IMD for SUD during the measurement year changed little from 2019 to 2021. The decline in the percentage for 2020 corresponded with the onset of pandemic.

- The average length of stay for SUD treatment services within IMDs fluctuated between 2019 and 2021.
- The number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members was higher than average in 2021.
- The number of beneficiaries in outpatient, intensive outpatient, and partial hospitalization SUD treatment per 1,000 members with SUD diagnosis showed declines in 2019 and 2020. In 2021, the rate increased back to those seen in 2017 and 2018.

#### Secondary Driver 5 (Related to Goals 2, 3, and 4)

##### *Ensure inpatient & residential providers improve care coordination & transition of care to the community*

The performance measures assessed to evaluate Secondary Driver 5 are described in Tables ES-4, ES-5, and ES-6.

#### *Key Results and Conclusions*

- Secondary Driver 5 is related to Goals 2, 3 and 4. Based on results for the evaluation of this driver, it can be concluded that this driver has contributed towards the progress of achieving Goals 2, 3, and 4. Further improvements in this driver are needed to strengthen its contribution towards these goals.
- Secondary Driver 5 was assessed with nine performance measures, including four HEDIS measures. Of these nine measures, the results for seven indicated that progress is being made towards ensuring inpatient and residential providers improve care coordination and the transition of care to the community. However, some results showed that further improvement may be needed.
- As mentioned in the description of Goal 1, the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) rates for initiation of treatment within 14 days of SUD diagnosis had an increasing trend from 2017 to 2020, with an average increase of 3 percentage points per year. The Quality Compass ranking for the measure also improved. The 2019 and 2020 rates for continued engagement within 34 days of the initial treatment were greater than the 2017 and 2018 rates; the average increase was 0.5 percentage points per year. The rates for initiation within 14 days indicated improvement of Secondary Driver 5. The rates for engagement within 34 days provided weaker supporting evidence.
- A decreasing trend (improving 1.7 percentage points per year on average) was seen from 2017 to 2021 for the 30-day readmission for SUD treatment measure. These results are evidence that inpatient and residential providers are improving care coordination and transition of care to the community.
- As mentioned in the description of Goal 2, four service utilization measures were also examined for the evaluation of this driver. All four service utilization measures indicated an improvement is being seen in Secondary Driver 5.

#### Secondary Driver 6 (Related to Goals 2, 3, 4, and 5)

##### *Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy*

The performance measures assessed to evaluate Secondary Driver 6 are described in Tables ES-4, ES-5, ES-6, and ES-7.

### Key Results and Conclusions

- Secondary Driver 6 is related to Goals 2, 3, 4, and 5. Evidence that this driver contributes to the progress towards achieving Goals 2, 3, 4, and 5 was found by the two process measures reviewed. Further improvements in in this driver are needed to establish its contribution towards these goals.
- From 2019 to 2021, the percentages of Medicaid members with a SUD diagnosis who had an assigned MCO care manager were quite low. For physical and behavioral health services to be properly integrated and coordinated, MCOs care management teams should work with all members who have a SUD diagnosis and do not decline an offer for care management. The rate of increase from 2019 to 2021 (1.5 percentage points per year) indicates improvement in Secondary Driver 6 may be insufficient to obtain the Demonstration Goals.
- The percentages of Medicaid members with a SUD diagnosis who had an assigned MCO care manager and a patient centered service plan (PCSP) were also very low (about 2% in 2021). Percentages declined each year. These findings did not indicate that Secondary Driver 6 improved.

### Outcome Evaluation – Opportunities for Improvement

- Improvements in the provision of early intervention (SBIRT) and care for SUD after provision of SBIRT services are needed.
- The rates for the Continuity of Pharmacotherapy for OUD (POD) measure were low and without change between years.
- Rates for both indicators of the Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA) were low (Within 7 days and Within 30 days).
- MAT rates remain low (16% and less), and continued improvement, building on 2021, is needed.
- Peer Support services were not provided to most of the members to assist them in continuing their SUD treatment.
- Improvements are needed for follow-up after ED visits for SUD treatment and after high-intensity care for SUD.
- The Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) measures (Initiation within 14 days, Engagement within 34 days) were low. Rates improved in in 2020; however, further improvement is needed.
- A lack of standardization of the Health Screening Tool, Health Risk Assessment (HRA), Needs Assessment, and PCSP variable fields (in the datasets provided by the MCOs) created limitations in identifying members with SUD who received care coordination in line with the KanCare 2.0 program service coordination strategy.
- Low percentage of members with SUD who were assigned MCO care managers and who had a PCSP hindered progress towards multiple demonstration goals.

### Recommendations

- Review and improve the efforts for providing support to the expansion SBIRT among physical health and behavioral health service providers to identify members at different risk levels for OUD or other SUDs and provide the appropriate level of referral to SUD providers.
- Improve availability and utilization of peer support services to assist members with SUD in adhering to their SUD treatment.
- Improve efforts, including care coordination, to assist members with SUD in scheduling and receiving follow-up visits at an appropriate level of care after ED visits for SUD treatment and after receipt of high-intensity care for SUD.

- Review and improve the steps applied by the three MCOs to ensure all members with SUD eligible to receive KanCare 2.0 Service Coordination Strategy (such as use of the Health Screening Tool) are identified and receive an HRA Needs Assessment, PCSP, and coordinated care through an assigned care manager, as appropriate, during the remaining years of the SUD demonstration. Application of the Service Coordination Strategy to members with SUD will assist in achieving performance goals.

#### **Evaluation KanCare 2.0 Hypothesis 4**

It was not clear how many IMDs are currently providing SUD treatment services to the KanCare members. The number of admissions with SUD treatment services in IMDs and average length of stay for SUD treatment services within IMDs did not show improvements from 2019 to 2021.

#### Opportunities for Improvement

- The information regarding the total number of IMDs in the State providing SUD services to KanCare members is not readily available.

#### Recommendations

- Insert and maintain an IMD designation flag in the provider tables of the Kansas Modular Medicaid System.
- Review and address the barriers encountered by the IMDs and the members in provision and utilization of SUD treatment services through IMDs.

#### **Evaluation of Cost Measures**

Based on paid claims, the SUD demonstration has maintained budget neutrality in the first three years. KFMC is working with KDADS to further identify the administrative costs that could be included in the evaluation of the cost measures. The findings of the evaluation will be included in the summative evaluation of the SUD demonstration.

#### ***Interpretations, Policy Implications, and Interactions with Other State Initiatives***

KFMC will address the policy implications and interactions with other State initiatives in the summative SUD Demonstration evaluation. For this interim evaluation, the following interpretations could be made.

- It is not yet known how much the COVID-19 pandemic will influence the impact of the SUD Demonstration. It will take more years of data to assess the impact of the program, overall, outside of the context of the pandemic.
- It is difficult to interpret the interactions with other Medicaid and State programs due to the pandemic, as well. SUD Demonstration activities were drastically affected during the onset of the pandemic. The MCOs were instructed to pause many initiatives with members and providers in order to address the public health emergency.

#### ***Lessons Learned and Recommendations for State***

Lessons learned and recommendations for other State Medicaid agencies will be further addressed in the summative SUD Demonstration evaluation report.

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***KanCare 2.0 Interim Evaluation Report  
Evaluation of the State of Kansas Medicaid Section 1115(a)  
Demonstration – Substance Use Disorder  
January 2019 – September 2021  
Submission Date: October 17, 2022***

***General Background Information***

On August 20, 2019, the Centers for Medicare & Medicaid Services (CMS) approved the KanCare 2.0 Section 1115 Substance Use Disorder (SUD) Demonstration Implementation Plan for the period of January 1, 2019, through December 31, 2023.<sup>1</sup> In accordance with CMS guidelines, the KanCare 2.0 SUD Demonstration evaluation design was submitted for CMS approval. The CMS review of the evaluation design was received April 2, 2020. An updated evaluation design as per CMS guidance and feedback was submitted, and it was approved by CMS on June 30, 2020.<sup>2</sup>

KFMC Health Improvement Partners (KFMC), under contract with the Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF), serves as the External Quality Review Organization (EQRO) for KanCare. As the EQRO, KFMC is conducting the required SUD Demonstration evaluation and has prepared this interim evaluation report to reflect evaluation progress and presently available findings for January 2019 through December 31, 2021.

The Implementation Plan outlines the State’s strategy to provide a full continuum of services for SUD treatment to KanCare members. It is in alignment with the overall KanCare 2.0 goals that were designed to provide efficient and effective health care services and to ensure coordination of care and integration of physical health (PH), behavioral health (BH), and Home and Community Based Services (HCBS). KanCare 2.0 provides access to all critical levels of care for SUD and opioid use disorder (OUD).<sup>1,3</sup> The three KanCare managed care organizations (MCOs) provide access to a range of services across much of the American Society of Addiction Medicine (ASAM) levels of care. The spectrum of care— which includes outpatient treatment, peer recovery support, intensive outpatient services, medication-assisted treatment (MAT), intensive inpatient services, withdrawal management, and residential treatment— is provided to eligible Medicaid and CHIP recipients who need SUD or OUD treatment.<sup>1</sup> In addition, all members ages 19 through 64 have access to additional covered services, including SUD treatment services provided to individuals with SUD who are short-term residents in residential treatment facilities that meet the definition of an IMD.<sup>3,4</sup> Since 2020, KanCare covers methadone for MAT as required by the SUPPORT Act. Through the Implementation Plan, Kansas requires all inpatient residential treatment centers, including all those currently excluded as Institutions for Mental Disease (IMDs), to provide access to MAT through direct provision or by coordinated referral and treatment initiation to a MAT provider. This requirement was implemented through State policy instead of the initially planned licensing requirement.

KanCare 2.0 requires the provision of person-centered case management, as a one-on-one goal-directed service for individuals with a SUD, to assist in obtaining access to needed family, legal, medical, employment, educational, psychiatric, and other services. This service must be a part of the treatment plan developed and determined medically necessary by the MCO.<sup>3</sup>

### KanCare 2.0 Section 1115 SUD Demonstration Goals

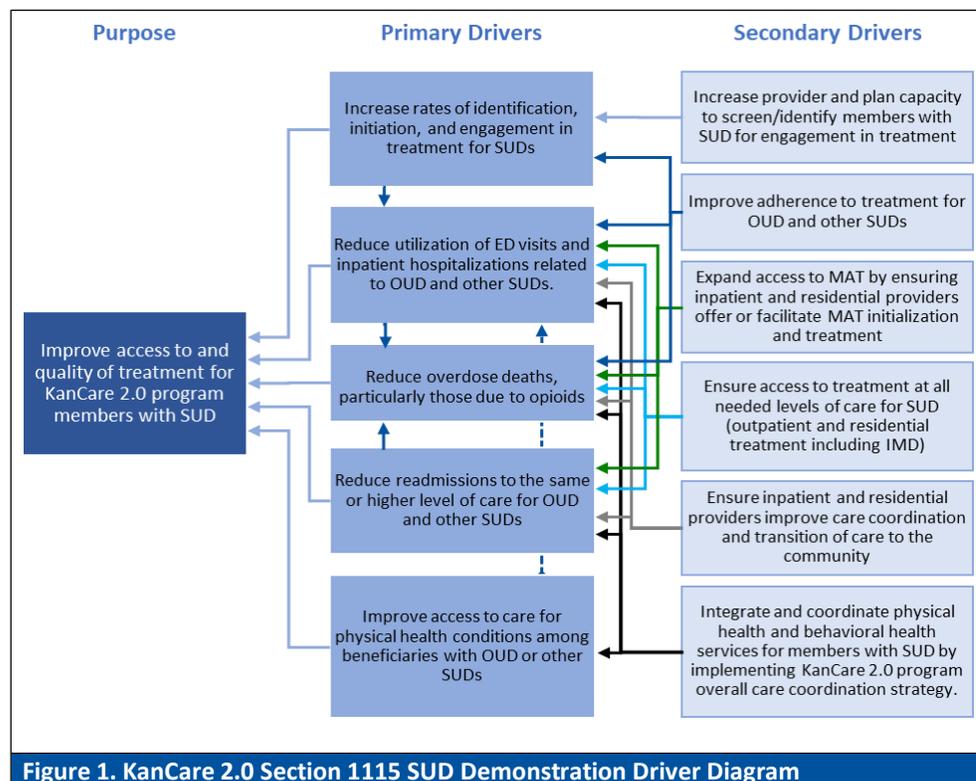
Kansas uses the 1115 demonstration authority to pursue the following goals to improve access to and quality of treatment for KanCare 2.0 program members with SUD:

1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.
2. Reduced utilization of emergency departments (EDs) and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.
3. Reduction in overdose deaths, particularly those due to opioids.
4. Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.
5. Improved access to care for physical health conditions among members with OUD or other SUDs.

### Evaluation Question and Hypotheses

#### SUD Demonstration Driver Diagram

The following driver diagram for the overall SUD demonstration (Figure 1) shows the relationship between the demonstration’s purpose, the primary drivers that contribute directly to achieve the purpose, and the secondary drivers necessary to achieve the primary drivers.



## SUD Demonstration Goals, Evaluation Questions, and Hypotheses

As the focus of the SUD Demonstration evaluation is to examine whether the demonstration achieved its goals, the following evaluation questions are designed in alignment with the five goals and related hypotheses (Table 1). This evaluation is in accordance with the CMS-approved “SUD, Section 1115 Demonstration Evaluation Design.” (Attachment A)

Table 1. SUD Demonstration Goals, Evaluation Questions, and Hypotheses			
	Goals	Evaluation Questions	Hypotheses
1.	Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.	Does the demonstration increase access to and utilization of SUD treatment services?	The demonstration will increase the percentage of members who are referred and engaged in treatment for SUDs.
2.	Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.	Does the demonstration decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population?	The demonstration will decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population.
3.	Reductions in overdose deaths, particularly those due to opioids.	Are rates of opioid-related overdose deaths impacted by the demonstration?	The demonstration will decrease the rate of overdose deaths due to opioids.
4.	Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.	Do enrollees receiving SUD services experience reduction in readmissions to the same or higher level of care for OUD and other SUDs?	Among members receiving care for SUD, the demonstration will reduce readmissions to SUD treatment.
5.	Improved access to care for physical health conditions among members with OUD or other SUDs.	Do enrollees receiving SUD services experience improved access to care for physical health conditions?	The demonstration will increase the percentage of members with SUD who access care for physical health conditions.

## KanCare 2.0 Demonstration Hypothesis 4

### (Associated with SUD Demonstration Evaluation Design Question 1)

Within the CMS November 18, 2019, review of the KanCare 2.0 Section 1115 Demonstration Evaluation Design, CMS noted that removing payment barriers for services provided in IMDs for KanCare members was a strategy in both the KanCare 2.0 and SUD Demonstration.<sup>5</sup> To avoid duplicating evaluation activity, the KanCare 2.0 Hypothesis 4 and related question are addressed in the SUD Demonstration evaluation per CMS recommendation. (Table 2.)

Table 2. KanCare 2.0 Demonstration Hypothesis 4 and Evaluation Question	
Hypothesis	Evaluation Question
Removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members will result in improved member access to substance use disorder (SUD) treatment services.	Did removing payment barriers for services provided in IMDs for KanCare members improve member access to SUD treatment services?

This evaluation question corresponds to the SUD Demonstration Evaluation Question 1, “Does the demonstration increase access to and utilization of SUD treatment services?”

## **Methodology**

The evaluation methodology presented in the SUD Demonstration evaluation design document (Attachment 1) was designed to meet the standards of scientific rigor that will assist in obtaining statistically valid and reliable evaluation results. The focus of the interim evaluation is to examine progress towards the overall goal of helping Medicaid members with SUD to have improved access to and quality of treatment.

The following sections present an overview of methods and rationale for the demonstration evaluation, followed by sections detailing evaluation questions, evaluation hypotheses, and strategies for each goal of the Demonstration as well as KanCare 2.0 Program Hypothesis 4 and the overall cost evaluation.

Evaluation of the demonstration is primarily focused on KanCare 2.0 members with a SUD diagnosis (“study population”). In certain cases, members without a SUD diagnosis may access services (e.g., screenings or assessments) and will be included within the target population for certain measures or hypotheses. Due to state-wide implementation of the SUD Demonstration, the evaluation of overall strategies and hypotheses is hindered by the lack of true comparison groups, as all KanCare 2.0 members will be eligible for the same benefits. Target and comparison populations for each goal are described within that goal’s evaluation methodology, discussed in the sections below. Several potential comparison populations have been identified for the final evaluation report that may provide additional perspective for certain measures or drivers, such as comparisons between rural and urban regions of the state (see Attachment 1).

The interrupted time series (ITS) evaluation design proposed in the SUD Demonstration Evaluation Design was not performed for the interim evaluation because the number of data points available for the analysis was insufficient. The ITS analysis will be performed for the summative evaluation to compare the selected performance outcomes in intervention and comparison groups from 2017 through 2023 (Pre-Intervention Period: 2017–2018; and Post-Intervention Period: 2019–2023).

Where possible, measures were developed according to recognized measures from sources such as the CMS Metrics,<sup>6</sup> Adult Core Set,<sup>7</sup> and the Healthcare Effectiveness Data and Information Set® (HEDIS),<sup>8</sup> which are stewarded by the National Committee for Quality Assurance (NCQA) and endorsed by the National Quality Forum (NQF). It should be noted, some of the measures proposed in the evaluation design are not assessed in the interim evaluation. The assessment results for these measures will be included in the summative evaluation.

Following are the evaluation methods by goal.

### **a. Methodology for the Evaluation of Goal 1 – Identification, Initiation, and Engagement in Treatment**

The SUD Demonstration Implementation Plan identifies the following strategies for reaching this goal:

- Support the expansion of *Screening, Brief Intervention, and Referral to Treatment* (SBIRT) among

physical health and behavioral health service providers to identify members at different risk levels for OUD or other SUDs and provide the appropriate level of referral to SUD providers.

- Run a statewide media campaign to increase member and general population awareness of primary prevention and availability of treatment (utilizing funding from the federal State Opioid Response [SOR] grant).

**Hypothesis**

The demonstration will increase the percentage of members who are referred and engaged in treatment for SUDs.

**Evaluation Design**

In place of ITS analysis, the selected performance measures of the target population were examined across years (2017 to 2021, if available). Analysis of year-over-year changes and three- to five-year trend analysis were conducted.

**Target Population**

KanCare 2.0 members diagnosed with SUD or OUD.

**Evaluation Period**

January 1, 2019 – December 31, 2021.

**Evaluation Measures**

The outcome and process measures for evaluation progress toward Goal 1 stated in the Evaluation Design are shown in Table 3. One measure (the percentage of physical health and behavioral health service providers that billed SBIRT services) was not included in the interim evaluation; identifying individual providers within the provider types being licensed for SBIRT, as specified in state policy, was not possible with data made available.

<b>Table 3. Performance Measures for SUD Demonstration Goal 1</b>
<b>Outcome Measure for Goal 1(Primary Driver 1)</b>
<ul style="list-style-type: none"> <li>• Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation. (2017–2022)</li> <li>• Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement. (2017–2022)</li> </ul>
<b>Process Measures for Secondary Drivers</b>
<i>Increase provider and plan capacity to screen/identify members with SUD for engagement in treatment (Relates to Goal 1)</i>
<ul style="list-style-type: none"> <li>• Percentage of physical health and behavioral health service providers that billed <i>Screening, Brief Intervention, and Referral to Treatment</i> (SBIRT) services. (2017–2023)</li> <li>• Receipt of care for SUD and/or OUD after SBIRT service. (2017–2023)</li> </ul>
<i>Improve adherence to treatment for OUD and other SUDs (Related to Goals 1–3)</i>
<ul style="list-style-type: none"> <li>• Continuity of Pharmacotherapy for OUD (POD). (CMS Metric #22). (2017–2023)</li> <li>• Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2022)</li> <li>• Percentage of beneficiaries with SUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023)*</li> <li>• Percentage of beneficiaries with OUD who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023).*</li> <li>• Percentage of beneficiaries with SUD diagnosis who used SUD peer support services during the monthly measurement period.</li> </ul>
<small>*Service Type Strata: <i>early intervention</i>, e.g., SBIRT (CMS Metric #7); <i>outpatient services</i> (CMS Metric #8); <i>intensive outpatient and partial hospitalization</i> (CMS Metric #9); <i>residential and inpatient services</i> (CMS Metric #10); <i>withdrawal management</i> (CMS Metric #11); <i>medication-assisted treatment (MAT)</i> (CMS Metric #12)</small>

### Data Sources

HEDIS data for the interim evaluation of the SUD Demonstration Goal 1 were obtained from the MCO. Encounter data and membership data were queried from the MMIS reporting warehouse.

### Analytic Methods

Descriptive statistics are displayed in tables. Testing significance of changes between years used Fisher’s exact or Pearson’s chi-square tests with  $p$  less than 0.05 considered significant. A Mantel-Haenszel chi-square test was used to determine if the slopes of three- to five-year linear trend lines were statistically significantly different from horizontal.

## **b. Methodology for the Evaluation of Goal 2 – Emergency Department Visits and Inpatient Hospitalizations**

The SUD Demonstration Implementation Plan identifies the following strategies for reaching this goal.

- Community Crisis Centers (CCCs) across the state to provide support and stabilization services for Kansans in crisis and engage with them in community-based services.
- Expand medication-assisted treatment (MAT).
- Expand the use of peer-supported rehabilitation and recovery services (“peer support services”).
- Improve transitions between levels of care related to SUD treatment.

### Hypothesis

The demonstration will decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population.

### Evaluation Design

In place of ITS analysis, the selected performance measures of the target population were examined across years (2017 to 2021, if available). Analysis of year-over-year changes and three- to five-year trend analysis were conducted.

### Target Population

KanCare 2.0 members diagnosed with SUD or OUD.

### Evaluation Period

January 1, 2019 – December 31, 2021.

### Evaluation Measures

The outcome and process measures for evaluation progress toward Goal 2 stated in the Evaluation Design are shown in Table 4. Each measure was analyzed for they measurement years in which data were available.

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Table 4. Performance Measures for SUD Demonstration Goal 2
<b>Outcome Measures (Primary Drivers)</b>
<ul style="list-style-type: none"> <li>• ED utilization for SUD per 1,000 Medicaid beneficiaries. (CMS Metric #23; 2017–2023)</li> <li>• ED utilization for OUD per 1,000 Medicaid beneficiaries. (CMS Metric #23, OUD stratum; 2017–2023)</li> <li>• Inpatient stays for SUD per 1,000 Medicaid beneficiaries. (CMS Metric #24; 2017–2023)</li> <li>• Inpatient stays for OUD per 1,000 Medicaid beneficiaries. (CMS Metric #24, OUD stratum; 2017–2023)</li> </ul>
<b>Process Measures (Secondary Drivers)</b>
<i>Improve adherence to treatment for OUD and other SUDs (Related to Goals 1–3)</i>
<ul style="list-style-type: none"> <li>• Continuity of Pharmacotherapy for OUD (POD). (CMS Metric #22; 2017–2023)</li> <li>• Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2022)</li> <li>• Percentage of beneficiaries with SUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023)*</li> <li>• Percentage of beneficiaries with OUD who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023)*</li> <li>• Percentage of beneficiaries with SUD diagnosis who used SUD peer support services during the monthly measurement period. (2017–2023)</li> </ul>
<i>Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment. (Related to Goals 2–4)</i>
<ul style="list-style-type: none"> <li>• Residential OUD discharges with MAT claim. (2017–2023)</li> <li>• Inpatient OUD discharges with MAT claim. (2017–2023)</li> <li>• Percentage of members with OUD diagnosis who have a MAT claim for OUD during the measurement period. (2017–2023)</li> </ul>
<i>Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD). (Related to Goals 2–4)</i>
<ul style="list-style-type: none"> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who were treated in an IMD for SUD during the measurement year. (2017–2023)</li> <li>• Average length of stay for SUD treatment services within IMDs. (CMS Metric #36; 2017–2023)</li> <li>• Number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members with SUD diagnosis. (2017–2023)</li> <li>• Number of outpatient, intensive outpatient, &amp; partial hospitalization days of SUD treatment per 1,000 members with SUD diagnosis. (2017–2023) <b>Note:</b> <i>Partial hospitalization in KS has same service code as inpatient.</i></li> </ul>
<i>Ensure inpatient &amp; residential providers improve care coordination &amp; transition of care to the community. (Related to Goals 2–4)</i>
<ul style="list-style-type: none"> <li>• 30-Day Readmission for SUD treatment. (2017–2023)</li> <li>• ED utilization for SUD per 1,000 beneficiaries. (CMS Metric #23; 2017–2023)</li> <li>• ED utilization for OUD per 1,000 beneficiaries. (CMS Metric #23, OUD stratum; 2017–2023)</li> <li>• Inpatient stays for SUD per 1,000 beneficiaries. (CMS Metric #24; 2017–2023)</li> <li>• Inpatient stays for OUD per 1,000 beneficiaries. (CMS Metric #24, OUD stratum; 2017–2023)</li> <li>• Follow-Up After ED Visit for Alcohol and Other Drug Abuse/ Dependence (FUA). (2017–2022)</li> <li>• Initiation &amp; Engagement of Alcohol &amp; Other Drug Dependence Treatment (IET). (2017–2022)</li> <li>• Follow-Up After High-Intensity Care for SUD (FUI). (2019–2022)</li> </ul>
<i>Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy. (Related to Goals 2–5)</i>
<ul style="list-style-type: none"> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager (2019–2023)</li> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and have a service/treatment plan or person-centered service plan (PCSP). (2019–2023)</li> </ul>
<p><small>*Service Type Strata: <i>early intervention</i>, e.g., SBIRT (CMS Metric #7); <i>outpatient services</i> (CMS Metric #8); <i>intensive outpatient and partial hospitalization</i> (CMS Metric #9); <i>residential and inpatient services</i> (CMS Metric #10); <i>withdrawal management</i> (CMS Metric #11); <i>medication-assisted treatment (MAT)</i> (CMS Metric #12).</small></p>

### Data Source

HEDIS data and care manager assignments for the interim evaluation of the SUD Demonstration Goal 2 were obtained from the MCO. Encounter data and membership data were queried from the MMIS reporting warehouse.

### Analytic Methods

Descriptive statistics are displayed in tables. Testing significance of changes between years used Fisher's exact or Pearson's chi-square tests with  $p$  less than 0.05 considered significant. A Mantel-Haenszel chi-square test was used to determine if the slopes of three- to five-year linear trend lines were statistically significantly different from horizontal.

### **c. Methodology for the Evaluation of Goal 3 – Overdose Deaths Due to Opioids**

The SUD Demonstration Implementation Plan identifies the following strategies to contribute towards reaching this goal.

- Expansion of medication-assisted treatment (MAT).
- Care coordination requirements by the MCOs to improve transitions to the community and participation in community-based recovery services.

In addition to the above-mentioned secondary drivers and strategies, the following secondary drivers and their related strategies (described for Goal 2) will also contribute toward achieving Goal 3.

- Ensure access to services at all needed levels of care for SUD, including outpatient treatment (group, individual, and/or family counseling, community psychiatric support, crisis intervention), residential treatment (including coverage of SUD treatment in IMDs), and peer support services (Secondary Driver 3).
- Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy (Secondary Driver 5).

### Evaluation Design

In place of ITS analysis, the selected performance measures of the target population were examined across years (2017 to 2021, if available). Analysis of year-over-year changes and three- to five-year trend analysis were conducted.

### Target Population

KanCare 2.0 members diagnosed with SUD, particularly those due to opioids.

### Evaluation Period

January 1, 2019 – December 31, 2021.

### Evaluation Measures

The outcome and process measures for evaluation progress toward Goal 3 stated in the Evaluation Design are shown in Table 5. Each measure was analyzed for the measurement years in which data were available.

Table 5. Performance Measures for SUD Demonstration Goal 3
<b>Outcome Measures (Primary Drivers)</b>
<ul style="list-style-type: none"> <li>• Opioid Drug Overdose Deaths. (CMS Metric #27, OUD Stratum; 2019–2022)</li> <li>• Use of Opioids at High Dosage in Persons without Cancer per 1,000 beneficiaries. (CMS Metric #18; 2017–2023)</li> <li>• Concurrent Use of Opioids and Benzodiazepines, per 1,000 beneficiaries. (CMS Metric #21; 2018–2023)</li> </ul>
<b>Process Measures (Secondary Drivers)</b>
<i>Improve adherence to treatment for OUD and other SUDs (Related to Goals 1–3)</i>
<ul style="list-style-type: none"> <li>• Continuity of Pharmacotherapy for OUD (POD). (CMS Metric#22; 2017–2023)</li> <li>• Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2022)</li> <li>• Percentage of beneficiaries with SUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023)*</li> <li>• Percentage of beneficiaries with OUD who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023)*</li> <li>• Percentage of beneficiaries with SUD diagnosis who used SUD peer support services during the monthly measurement period. (2017–2023)</li> </ul>
<i>Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment. (Related to Goals 2–4)</i>
<ul style="list-style-type: none"> <li>• Residential OUD discharges with MAT claim. (2017–2023)</li> <li>• Inpatient OUD discharges with MAT claim. (2017–2023)</li> <li>• Percentage of members with OUD diagnosis who have a MAT claim for OUD during the measurement period. (2017–2023)</li> </ul>
<i>Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD). (Related to Goals 2–4)</i>
<ul style="list-style-type: none"> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who were treated in an IMD for SUD during the measurement year. (2017–2023)</li> <li>• Average length of stay for SUD treatment services within IMDs. (CMS Metric #36; 2017–2023)</li> <li>• Number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members with SUD diagnosis. (2017–2023)</li> <li>• Number of outpatient, intensive outpatient, &amp; partial hospitalization days of SUD treatment per 1,000 members with SUD diagnosis. (2017–2023) <b>Note:</b> <i>Partial hospitalization in KS has same service code as inpatient.</i></li> </ul>
<i>Ensure inpatient &amp; residential providers improve care coordination &amp; transition of care to the community. (Related to Goals 2–4)</i>
<ul style="list-style-type: none"> <li>• 30-Day Readmission for SUD treatment. (2017–2023)</li> <li>• ED utilization for SUD per 1,000 beneficiaries. (CMS Metric #23; 2017–2023)</li> <li>• ED utilization for OUD per 1,000 beneficiaries. (CMS Metric #23, OUD stratum; 2017–2023)</li> <li>• Inpatient stays for SUD per 1,000 beneficiaries. (CMS Metric #24; 2017–2023)</li> <li>• Inpatient stays for OUD per 1,000 beneficiaries. (CMS Metric #24, OUD stratum; 2017–2023)</li> <li>• Follow-Up After ED Visit for Alcohol and Other Drug Abuse/ Dependence (FUA). (2017–2022)</li> <li>• Initiation &amp; Engagement of Alcohol &amp; Other Drug Dependence Treatment (IET). (2017–2022)</li> <li>• Follow-Up After High-Intensity Care for SUD (FUI). (2019–2022)</li> </ul>
<i>Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy. (Related to Goals 2–5)</i>
<ul style="list-style-type: none"> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager (2019–2023)</li> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and have a service/treatment plan or person-centered service plan (PCSP). (2019–2023)</li> </ul>
<p><i>*Service Type Strata: early intervention, e.g., SBIRT (CMS Metric #7); outpatient services (CMS Metric #8); intensive outpatient and partial hospitalization (CMS Metric #9); residential and inpatient services (CMS Metric #10); withdrawal management (CMS Metric #11); medication-assisted treatment (MAT) (CMS Metric #12).</i></p>

### Data Sources

HEDIS data and care manager assignments for the interim evaluation of the SUD Demonstration Goal 2 were obtained from the MCO. Claims data and membership data were queried from the MMIS reporting

warehouse. Data for the three measures for evaluating the primary driver were provided by the Kansas Department on Aging and Disability Services (KDADS).

### Analytic Methods

Descriptive statistics are displayed in tables. Testing significance of changes between years used Fisher's exact or Pearson's chi-square tests with  $p$  less than 0.05 considered significant. A Mantel-Haenszel chi-square test was used to determine if the slopes of three- to five-year linear trend lines were statistically significantly different from horizontal.

### **d. Methodology for the Evaluation of Goal 4 – Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs**

**Two strategies** contributing to the primary and secondary drivers for Goal 4 will be implemented over the demonstration period. The strategies include:

- To ensure admission of members with SUD to the appropriate level of care, documentation of an assessment which follows ASAM criteria will be required.
  - Licensing standards for all providers across the network will be aligned with the ASAM criteria.
- Care coordination requirements will aim to decrease readmission to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.

The two strategies described here will contribute to the following two secondary drivers, which in turn will lead to the reduced readmissions to the same or higher level of care for OUD and other SUDs (primary driver for Goal 4):

- Ensure access to services at all needed levels of care for SUD, including outpatient treatment (group, individual, and/or family counseling, community psychiatric support, crisis intervention), residential treatment (including coverage of SUD treatment in IMDs), and peer support services.
- Ensure inpatient and residential providers improve care coordination and transition of care to the community.

In addition to the above-mentioned secondary drivers and strategies, the following secondary drivers and their related strategies (described for Goal 2) will also contribute in achieving Goal 4.

- Expand access to MAT by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment for those who meet the need criteria and choose treatment.
- Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy.

### Evaluation Design

In place of ITS analysis, the selected performance measures of the target population were examined across years (2017 to 2021, if available). Analysis of year-over-year changes and three- to five-year trend analysis were conducted.

### Target Population

KanCare 2.0 members diagnosed with SUD or OUD.

### Evaluation Period

January 1, 2019 – December 31, 2021.

## Evaluation Measures

The outcome and process measures for evaluation progress toward Goal 4 stated in the Evaluation Design are shown in Table 6. Each measure was analyzed for they measurement years in which data were available.

Table 6. Performance Measures for SUD Demonstration Goal 4
<b>Outcome Measures (Primary Drivers)</b>
<ul style="list-style-type: none"> <li>• 30-Day Readmission for SUD treatment. (2017–2023)</li> <li>• 30-Day Readmission for SUD treatment (among discharges from a residential or inpatient facility for OUD treatment). (2017–2023)</li> </ul>
<b>Process Measures (Secondary Drivers)</b>
<i>Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment. (Related to Goals 2–4)</i>
<ul style="list-style-type: none"> <li>• Residential OUD discharges with MAT claim. (2017–2023)</li> <li>• Inpatient OUD discharges with MAT claim. (2017–2023)</li> <li>• Percentage of members with OUD diagnosis who have a MAT claim for OUD during the measurement period. (2017–2023)</li> </ul>
<i>Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD). (Related to Goals 2–4)</i>
<ul style="list-style-type: none"> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who were treated in an IMD for SUD during the measurement year. (2017–2023)</li> <li>• Average length of stay for SUD treatment services within IMDs. (CMS Metric #36; 2017–2023)</li> <li>• Number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members with SUD diagnosis. (2017–2023)</li> <li>• Number of outpatient, intensive outpatient, &amp; partial hospitalization days of SUD treatment per 1,000 members with SUD diagnosis. (2017–2023) <b>Note:</b> Partial hospitalization in KS has same service code as inpatient.</li> </ul>
<i>Ensure inpatient &amp; residential providers improve care coordination &amp; transition of care to the community. (Related to Goals 2–4)</i>
<ul style="list-style-type: none"> <li>• 30-Day Readmission for SUD treatment. (2017–2023)</li> <li>• ED utilization for SUD per 1,000 beneficiaries. (CMS Metric #23; 2017–2023)</li> <li>• ED utilization for OUD per 1,000 beneficiaries. (CMS Metric #23, OUD stratum; 2017–2023)</li> <li>• Inpatient stays for SUD per 1,000 beneficiaries. (CMS Metric #24; 2017–2023)</li> <li>• Inpatient stays for OUD per 1,000 beneficiaries. (CMS Metric #24, OUD stratum; 2017–2023)</li> <li>• Follow-Up After ED Visit for Alcohol and Other Drug Abuse/ Dependence (FUA). (2017–2022)</li> <li>• Initiation &amp; Engagement of Alcohol &amp; Other Drug Dependence Treatment (IET). (2017–2022)</li> <li>• Follow-Up After High-Intensity Care for SUD (FUI). (2019–2022)</li> </ul>
<i>Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy. (Related to Goals 2–5)</i>
<ul style="list-style-type: none"> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager (2019–2023)</li> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and have a service/treatment plan or person-centered service plan (PCSP). (2019–2023)</li> </ul>

## Data Sources

HEDIS data and care manager assignments for the interim evaluation of the SUD Demonstration Goal 2 were obtained from the MCO. Claims data and membership data were queried from the MMIS reporting warehouse.

## Analytic Methods

Descriptive statistics are displayed in tables. Testing significance of changes between years used Fisher’s exact or Pearson’s chi-square tests with *p* less than 0.05 considered significant. A Mantel-Haenszel chi-square test was used to determine if the slopes of three- to five-year linear trend lines were statistically significantly different from horizontal.

## **e. Methodology for the Evaluation of Goal 5 – Access Care for Physical Health Conditions**

The **strategy** contributing to the primary and secondary drivers for Goal 5 will be implemented over the demonstration period. The strategy includes:

- KanCare 2.0 contracts with MCOs will focus on the integration of behavioral health and physical health among members with SUDs.
  - Care coordination includes health screening, health risk assessment, needs assessment, and development and implementation of service/treatment plan or person-centered service plan (PCSP).

The strategy described here will contribute to the following secondary driver, which in turn will lead to improved access to care for physical health conditions among members with OUD or other SUDs (primary driver for Goal 5):

- Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy.

### Evaluation Design

In place of ITS analysis, the selected performance measures of the target population were examined across years (2017 to 2021, if available). Analysis of year-over-year changes and five-year trend analysis were conducted.

Since the access to services was impacted by the pandemic, an alternate approach was added to the interim evaluation of the KanCare 2.0 SUD Demonstration. Relative improvements in measurement rates from a pre-KanCare 2.0 baseline period (2016–2018) to a KanCare 2.0 remeasurement period (2019–2021) were compared. Under the assumption that the pandemic and other external influences would equally impact rates for intervention and comparison groups, greater relative improvements for the intervention group than for the comparison group would support the assertion that the SUD Demonstration was effective.

### Target Population

KanCare 2.0 members diagnosed with SUD or OUD.

For evaluation of the primary driver for Goal 5, comparisons were made between two groups:

- **Intervention Group:** KanCare members, aged 16–75, who had a SUD diagnosis during the measurement year.
- **Comparison Group:** KanCare members, aged 16–75, who did not have a SUD diagnosis during the measurement year

### Evaluation Period

January 1, 2019 – December 31, 2021.

### Evaluation Measures

The outcome and process measures for evaluation progress toward Goal 5 stated in the Evaluation Design are shown in Table 7. One measure (Adults' Access to Preventive/Ambulatory Health Services) was excluded from analysis when the Intervention Group and Comparison Groups were found to be too different for the proposed analysis.

Table 7. Performance Measures for SUD Demonstration Goal 5
<b>Outcome Measures for Goal 1(Primary Driver 1)</b>
<ul style="list-style-type: none"> <li>• Annual Dental Visits (ADV). (SUD stratum; 2017–2022)</li> <li>• Adults’ Access to Preventive/Ambulatory Health Services (AAP). (SUD stratum; 2017–2022)</li> <li>• Adolescent Well-Care Visits (AWC). (SUD stratum; 2017– 2022)</li> <li>• Prenatal and Postpartum Care (PPC)–Timeliness of Prenatal Care. (SUD stratum; 2017–2022)</li> <li>• Prenatal and Postpartum Care (PPC)–Postpartum Care. (SUD stratum; 2017–2022)</li> </ul>
<b>Process Measures for Secondary Drivers</b>
<i>Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy. (Related to Goals 2–5)</i>
<ul style="list-style-type: none"> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager (2019–2023)</li> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and have a service/treatment plan or person-centered service plan (PCSP). (2019–2023)</li> </ul>

Data Sources

HEDIS data for 2019 and 2020 and care manager assignments for the interim evaluation of the SUD Demonstration Goal 5 were obtained from the MCO. HEDIS rates measuring the primary driver were calculated from encounter and membership data queried from the State’s MMIS reporting warehouse.

Analytic Methods

For measuring the performance of the secondary drivers, statistics are displayed in tables. Testing significance of changes between years used Fisher’s exact or Pearson’s chi-square tests with *p* less than 0.05 considered significant. A Mantel-Haenszel chi-square test was used to determine if the slopes of three-year linear trend lines were statistically significantly different from horizontal.

The following outcome measures were assessed to examine the primary driver for Goal 5:

- Annual Dental Visit (HEDIS)
- Adolescent Well-Care Visits (HEDIS)
- Prenatal and Postpartum Care (PPC)

Evaluation Measures

The following outcome measures were assessed to examine the evaluation question:

- Annual Dental Visit (HEDIS)
- Adolescent Well-Care Visits (HEDIS)
- Prenatal and Postpartum Care (PPC)

The following analytical steps are applied to examine the outcome measures for the evaluation of the KanCare 2.0 SUD Demonstration:

- 1) KanCare 2.0 members constituting the target and comparison populations (intervention and comparison groups) were identified from MMIS data files. SUD members were identified using ICD-10-CM diagnosis codes listed in HEDIS value sets Alcohol Abuse and Dependence, Opioid Abuse and Dependence, and Other Abuse and Dependence. Age was calculated as of December 31 of the measurement year.
- 2) Demographic characteristics of the members in the intervention and comparison groups were examined for homogeneity. Ages were restricted to 16–75 to improve homogeneity.
- 3) MMIS encounter records related to the outcome measures for the intervention and comparison groups was reviewed for missing values, inconsistent patterns, and outliers.

- 4) Outcome measures rates were calculated from encounter data for measurement years (MY) 2016–2021 and MCO HEDIS datafiles for MY 2019–2020.
- 5) For HEDIS measures, MY 2019–2020 rates calculated by KFMC were compared to rates calculate from member-level data submitted by the MCOs. To check the adequacy of the encounter- based rates to measure improvement, the differences between the groups’ rates calculated from encounters were compared to the differences in groups’ rates calculated from the MCOs’ data.
- 6) Statistical testing for statistically significant differences in rates between baseline (2016 to 2018) and remeasurement (2019 to 2021) periods was conducted for Intervention Group and Comparison Group.
- 7) Relative improvement from baseline to remeasurement was calculated for the Intervention Group and Comparison Group. A chi-square test for equality of relative improvements of the was conducted with  $p$  less than 0.05 indicating statistical significance.

Because member-level HEDIS data from the MCOs were available only for measurement years 2019 and 2020, HEDIS rates were calculated from encounter data. If technical specifications changed between measurement years that required a break in trending, then the more current version of the specifications were applied to the earlier measurement years to allow trending. Rates calculated from encounter records are not to be considered HEDIS Health Plan rates; calculation of HEDIS rates by the MCOs incorporates supplemental data not available through encounters, such as data extracted from medical records and claims from their other lines of business. The HEDIS rates calculated from the encounter data are Uncertified, Unaudited HEDIS rates. In addition to the three HEDIS rates listed above, 2016–2021 rates were calculated for Adults’ Access to Preventive/Ambulatory Health Services (AAP); however, the difference in rates between the Intervention Group and Comparison Group was deemed too large for the analysis (since the SUD population is identified though claims, their AAP rate was very high; members abusing substances and not receiving health services were in the comparison group). Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) and Follow-Up After ED Visit for Alcohol and Other Drug Abuse/ Dependence (FUA) were excluded from the analysis because they were not applicable to Comparison Group—only members with a SUD diagnosis are included in the measures’ denominators.

*Reduction in the failure rate (RFR)* was used for relative improvement. RFR is the amount of improvement relative to the amount of potential improvement. The formula is:

$$RFR = (Remeasurement\ Rate\ minus\ Initial\ Rate)/(Goal\ minus\ Initial\ Rate).$$

For HEDIS rates for which a rate increase is an improvement, the goal was set to 100%.

The tests for equality of relative improvement between the Intervention Group and Comparison Group followed these steps:

1. Comparison Group’s RFR was calculated.
2. The rate the Intervention Group would have had for 2019–2020 if the RFR from the group’s 2016–2018 to the projected rate equaled Comparison Group’s RFR (a.k.a., the *projected rate*) was calculated. The denominator of the projected rate was set equal to the denominator of 2016–2018 rate for the Intervention Group.
3. The statistical significance of the difference between the projected rate and the 2019–2021 rate for the Intervention Group was tested using a Pearson’s chi-square test.

**f. Methodology for the Evaluation of KanCare 2.0 Hypothesis 4**

As a strategy, the Kansas Medicaid IMD Exclusion was removed, allowing IMDs to bill KanCare for SUD treatment services, with the expectation that access to SUD services will increase for members with behavioral health conditions.

**KanCare 2.0 Hypothesis 4**

Removing payment barriers for services provided in IMDs for KanCare members will result in improved member access to SUD treatment services.

**Evaluation Question**

Did removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members improve member access to substance use disorder (SUD) treatment services?

This question corresponds to the SUD Demonstration Evaluation Question 1, “Does the demonstration increase access to and utilization of SUD treatment services?”

Evaluation Design

Non-experimental methods (descriptive data) were used for assessing the evaluation question. Pre-demonstration encounter data were not available due to KanCare payments to IMDs for SUD treatment services began with this SUD demonstration

Target Population

The evaluation for this hypothesis will focus on increasing the availability of IMD facilities providing SUD treatment services over the five-year period.

Evaluation Period

January 1, 2019 – December 31, 2021.

Evaluation Measures

The outcome and process measures for addressing the evaluation question are stated in Table 8. Each measure was analyzed for they measurement years in which data were available.

<b>Table 8. Performance Measures for KanCare 2.0 Hypothesis 4</b>	
<b>Measure Description</b>	
•	Number of IMDs providing SUD services
•	Number of geographic locations of IMDs providing SUD services (by region/county)
•	Number of admissions with SUD treatment services in IMDs
•	Average length of stay for SUD treatment services within IMDs

**g. Methodology for the Evaluation of Cross-Cutting Cost Measures**

The investigation of costs for the KanCare 2.0 SUD Demonstration is a separate but cross-cutting element of the demonstration evaluation. Cost studies investigate both granular (i.e., specific treatment costs) and macro aspects of the KanCare program unique to the SUD demonstration. The SUD demonstration is designed to maintain budget neutrality while improving the effectiveness of services delivered to the Medicaid population. The intent of cost studies is not to identify statistically

significant increases or decreases in program costs but to understand how spending within different categories may contribute to enhanced program effectiveness. This is, in large part, due to how Medicaid managed care capitation payments obscure true administrative spending versus a fee-for-service paradigm.

### Demonstration Goal for Costs of SUD

Improved impact of the KanCare 2.0 program via provision of a full continuum of services for SUD treatment to members.

### Evaluation Question

Does the SUD demonstration maintain or decrease total KanCare 2.0 SUD expenditures?

### Evaluation Hypothesis

The SUD demonstration will maintain or decrease total KanCare 2.0 SUD expenditures.

### Demonstration Strategy

Each of the strategies within the Evaluation Design Methodology, which support the primary and secondary drivers, are also utilized in the investigation of program costs. The outcomes of these strategies are anticipated to contribute to enhanced program efficiency and effectiveness.

Enhancements to efficiency may include reductions to admissions (or readmissions) and other burdens related to treatment of preventable or medically inappropriate encounters as well as any other outcomes that reduce unnecessary utilization or duplication of efforts. This may also shift costs associated with the transition from formal treatment to community recovery services.

### Evaluation Measures

The SUD demonstration cost measures, listed in Table 9, are stratified into three interrelated cost categories, each expressed in terms of dollars per member per month (\$MPM):

- **Type of Care Cost Drivers:** treatment costs for members with SUD diagnosis, stratified by types of care using claims data
- **SUD Cost Drivers:** treatment costs for members, stratified by services rendered within IMDs and other SUD-related costs for members with and without SUD diagnosis
- **Total KanCare 2.0 SUD Demonstration Costs:** treatment costs from the cost drivers listed above as well as administrative costs associated with the demonstration

The evaluation measures for the type of care and SUD cost drivers were derived from encounters for paid claims. Administrative data for the Total KanCare 2.0 SUD Demonstration Costs measures were not available. Administrative costs relate to regular business operations, including office buildings, utilities, equipment, supplies, salaries, and benefits. These types of costs for the State are not generally allocated by specific program, such as the SUD Demonstration program. KFMC continues discussions with KDADS to determine a potential method to identify administrative costs for the cost measures.

Table 9. SUD Demonstration Cost Measures
<b>Type of Care Cost Drivers</b>
<ul style="list-style-type: none"> <li>• ED Outpatient SUD spending during the measurement period. Expressed in dollars per member per month (\$PMPM).</li> <li>• Non-ED Outpatient SUD spending during the measurement period. (\$PMPM)</li> <li>• Inpatient and residential SUD spending during the measurement period. (\$PMPM)</li> <li>• Pharmacy SUD spending during the measurement period. (\$PMPM)</li> <li>• Total KanCare 2.0 SUD treatment spending on beneficiaries with SUD diagnosis during the measurement period. (\$PMPM)</li> </ul>
<b>SUD Cost Drivers</b>
<ul style="list-style-type: none"> <li>• SUD spending on inpatient/residential services and pharmaceuticals within IMDs during the measurement period. Expressed in dollars per member per month (\$PMPM). [CMS Metric #31]</li> <li>• SUD spending on services other than within IMDs during the measurement period. (\$PMPM) [CMS Metric #30]</li> <li>• SUD spending on SBIRT services for beneficiaries without SUD diagnosis during the measurement period. (\$PMPM)</li> <li>• SUD spending on assessment services for beneficiaries without SUD diagnosis during the measurement period. (\$PMPM)</li> <li>• Total KanCare 2.0 SUD treatment spending during the measurement period. (\$PMPM)</li> </ul>
<b>Total KanCare 2.0 SUD Demonstration Costs</b>
<ul style="list-style-type: none"> <li>• Total administrative costs related to the KanCare 2.0 SUD demonstration. Expressed in dollars per member per month (\$PMPM).</li> <li>• Total administrative and SUD service costs related to the KanCare 2.0 SUD demonstration. (\$PMPM)</li> <li>• Total Federal costs related to the KanCare 2.0 SUD demonstration. (\$PMPM)</li> </ul>

### Data Sources

MCO payment totals and membership counts were queried from databases from the State’s MMIS reporting warehouse. Amounts paid by primary payors and Medicare were not reported in the cost analysis because those amounts are known to be incompletely populated in the encounter data.

### **Methodological Limitations**

The interim evaluation has a strong reliance upon year-over-year comparisons or comparisons to baselines that may not imply causality due to a specific intervention. Further, the reliance upon non-experimental methods for KanCare 2.0 Hypothesis 4 will inhibit interpretations and conclusions from investigation in changes to Kansas’ IMDs. Lastly, the Kansas Medicaid managed care model hinders the ability to investigate costs with the same precision that would be possible in fee-for-service models due to capitation arrangements. Every attempt to ensure quality data and analysis were made for observed limitations to evaluation design.

As noted previously, the lack of true comparison groups due to state-wide implementation was a major limitation in evaluating the SUD Demonstration.

Methodological issues encountered include:

- Spillover effects – The percentage of beneficiaries with SUD diagnosis who used SUD treatment services, for example, is subject to spill-over effects. Ensuring access to the appropriate levels of treatment may lead to increase in inpatient and residential treatment. Interventions promoting preventive medicine and early intervention aim to reduce usage of higher levels of care.
- Multiple treatment threats due to other interventions – The target population is the same, KanCare members with SUD or OUD, for Goals 1–5. These members are also included in the target populations for the KanCare 2.0 Demonstration strategies and MCO performance improvement projects.
- Effect of confounding variables – The COVID-19 public health emergency was a very strong confounding variable that impacted almost all aspects of the evaluation.
  - Stay-at-home orders and the increasing care needs of those infected reduced access to care.

- Social isolation, loss of jobs, and deaths of family or friends can lead to increased alcohol or drug use.
- As an emergency measure, disenrollment from KanCare was suspended for many members who would otherwise have become ineligible for benefits (e.g., CHIP members turning 19 years old and 60 days after delivery for women receiving benefits due to pregnancy). Consequently, the number of KanCare members increased in 2020 and 2021 (impacting utilization rates) and the homogeneity of the population changed (impacting statewide outcome measures).
- Inadequate statistical power – Receipt of care for SUD after SBIRT Service had a denominator less than 75.
- Statistical testing results on measures with large denominators frequently produced  $p$ -values less than 0.001. If confounding variables were known, test results may not have been meaningful for evaluation of the hypotheses.
- Data unavailability – Data for identifying IMDs is not contained within MMIS; a current list of IMDs was provided by the State, but the list did not contain changes from prior years. Data for cost analysis was incomplete or not available.

The use of administrative claims and encounters data for performance measures can be a limitation when used to determine changes in access to services, quality of care, and health outcomes. However, many of the performance measures are validated and stewarded by nationally recognized bodies such as NCQA and widely used for these purposes. While administrative data may identify key cases and statistical trends in performance, these are usually limited in providing detailed health and health behavior information, thus making it difficult to obtain information on possible covariates influencing performance. The use of administrative accounting data for evaluation of costs may also present a challenge in reconciling costs unique to the demonstration across different accounting platforms and practices.

Claim payments by primary payors and Medicare were incompletely populated on the encounter records. This limited cost analysis from encounter data to amounts paid by the MCOs. Claims paid completely by other payors, or counted toward member spend down amounts, are referred to as *zero dollar paid claims*. Depending on the claim type and MCO, the MCO-payment status may be paid or denied, which makes identification of services or diagnoses from paid claims inconsistent.

Data lag also causes a challenge in measuring and reporting change in a timely manner. Analysis from encounter data were limited to dates of service occurring in 2017 through 2021 and further limited to encounters received into the State's system within 3 months of the measurement year. The latest HEDIS data from the MCOs available for analysis was measurement year 2020. Additional challenges specific to cost data are lags related to both the resolution and reconciliation of claims but also in availability of administrative data due to fiscal timeframes and policies.

A lack of standardization of the Health Screening Tool, Health Risk Assessment (HRA), needs assessment, and PCSP variable fields, in the datasets provided by the MCOs, created limitations in identifying members with SUD who receive the KanCare 2.0 program service coordination strategy.

## Results

The secondary drivers, which are process measures, frequently apply to more than one of the demonstration’s goals. The first part of this section provides the analytical results of the secondary drivers and an interpretation applicable to the drivers’ goals. Each of the primary drivers are basically the demonstration goals. The analytical results and interpretation of the outcome measures assessing the primary drivers will follow discussion of the secondary drivers.

All results should be interpreted with caution as the evaluation period corresponded with the onset and continuation of the COVID-19 pandemic. The data and analytical results for 2022 and 2023 will better assess progress towards the demonstration goals.

### Process Evaluation – Secondary Drivers

#### Secondary Driver 1 (Related to Goal 1)

##### *Increase provider and plan capacity to screen/identify members with SUD for engagement in treatment*

One of the performance measures for Secondary Driver 1 was assessed for the interim evaluation, the percentage of beneficiaries who received SBIRT services with evidence of SUD service within 60 days after SBIRT service. Changes between years and across five years were not statistically significant (Table 10). These results did not indicate that provider and plan capacity to screen and identify members with SUD for engagement in treatment is being increased, and further improvements are needed.

<b>Table 10. Measurements of Secondary Driver 1</b>						
<b>Secondary Driver 1 (Related to Goal 1): Increase provider and plan capacity to screen/identify members with SUD for engagement in treatment</b>						
Measure	Year	Numerator	Denominator	Rate	p-value	Trend
<b>Receipt of care for SUD after SBIRT Service</b> Percentage of beneficiaries who received SBIRT services with evidence of SUD service within 60 days after SBIRT service	2017	20	46	43%	p=.73	p=.12
	2018	29	72	40%		
	2019	22	47	47%		
	2020	22	74	30%		
	2021	22	65	34%		

The p-value reports a Pearson chi-square test for statistically significant differences between the year’s rate and the prior year’s rate. Trend reports the p-value for Mantel-Haenszel chi-square test to see if the slope of the 5-year trend line is statistically significantly different from horizontal.

#### *Conclusions Related to Goals*

##### Goal 1 – Identification, Initiation, and Engagement in Treatment for OUD and other SUDs

Since there were no significant changes in the percentage of members who received SBIRT services with a SUD service within 60 days, Secondary Driver 1 did not provide evidence supporting Goal 1’s hypothesis that the demonstration will increase the percentage of members who are referred and engaged in treatment for SUDs.

#### Secondary Driver 2 (Related to Goals 1, 2, and 3)

##### *Improve adherence to treatment for OUD and other SUDs*

The Secondary Driver 2 was examined by assessing five performance measures, including stratified rates for service types for two measures (Tables 11–14). The results for two out of five measures, and several service type strata, indicate that adherence to treatment for OUD and other SUDs is increasing. Results are summarized below. Based on these results, it can be concluded that some evidence is being seen towards improvement of Secondary Goal 2, however, further improvement is needed.

Table 11. Measurements of Secondary Driver 2 – HEDIS								
Secondary Driver 2 (Related to Goals 1, 2, and 3): Improve adherence to treatment for OUD and other SUDs								
Measure	Year	Numerator	Denominator	Rate	Rank	p-value	Trend	
Continuity of Pharmacotherapy for OUD (POD)	2019	55	183	30.05				
	2020	68	218	31.19	≥50 <sup>th</sup>	p>.99		
Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	– Within 7 Days	2017	160	1,039	15.40	>66.67 <sup>th</sup>		p=.88
		2018	234	1,499	15.61	>66.67 <sup>th</sup>	p=.89	
		2019	211	1,462	14.43	≥50 <sup>th</sup>	p=.37	
		2020	217	1,393	15.58	≥50 <sup>th</sup>	p=.39	
	– Within 30 Days	2017	233	1,039	22.43	>66.67 <sup>th</sup>		p=.31
		2018	344	1,499	22.95	>66.67 <sup>th</sup>	p=.76	
		2019	312	1,462	21.34	≥50 <sup>th</sup>	p=.29	
		2020	297	1,393	21.32	≥50 <sup>th</sup>	p>.99	

Rankings are based on Quality Compass national percentile rankings.  
 The p-value reports a Pearson chi-square test for statistically significant differences between the year's rate and the prior year's rate.  
 Trend reports the p-value for Mantel-Haenszel chi-square test to see if the slope of the 4-year trend line is statistically significantly different from horizontal, and if significant, the slope measured in percentage points per year (pp/y).

The 2019 and 2020 rates for the HEDIS measure Continuity of Pharmacotherapy for OUD (POD) were low, about 31%, with no statistically significant change. Therefore, almost 70% of members with an OUD prescription had more than a seven-day gap in a 180-day period. Also, the rates follow up within 7 days and follow up within 30 days indicators of the HEDIS measure Follow-Up After ED Visit for Alcohol and Other Drug Abuse/Dependence (FUA) were low from 2017 to 2020, and no statistically significant changes were seen. Less than one-fourth of members who had an Emergency Department visit for alcohol or other drug use were seen by any practitioner within 30 days, and even fewer within 7 days. These results do not indicate adherence to treatment for OUD and other SUDs is increasing.

Similar results were seen for the two measures examining SUD treatment among members with a SUD diagnosis and among beneficiaries with an OUD diagnosis. The increases for the overall rates and many of the service type strata indicate adherence to treatment for OUD and other SUDs is being increased.

- The percentages of members with a SUD diagnosis who received SUD treatment (overall measure) was generally flat until 2021, when the rate increased 6.39 percentage points (pp) to 50%. This increase was primarily due to increases in outpatient services (4.37 pp) and residential/inpatient services (2.5 pp). The remaining service types all had small improvements in 2021. Of note, MAT services for members with a SUD diagnosis have had statistically significant increases each year.
- Increases in SUD treatment for members with an OUD diagnosis were higher than the increases seen in the population diagnosed with any SUD. In 2021, there was a 6.92 pp increase, to 63%, of members with an OUD diagnosis who received SUD treatment, including a 5.55 pp increase in outpatient services, a 3.2 pp increase in residential/inpatient services, and a 3.86 pp increase in MAT services.
- In absence of the information on the root causes for the changes seen, a definitive conclusion could not be made whether a positive or negative result is seen for the receipt of the following two service types.
  - The percentages of beneficiaries with a SUD diagnosis who received intensive outpatient/partial hospitalization for 2019 to 2021 have been below pre-demonstration levels. It should be noted, these decreases could be considered good if these are due to effective use of lower levels of care. However, if the decreasing rates are due to fewer members receiving this level of care who need it, then they could be considered moving in wrong direction.

- The increases in members with an OUD or other SUD diagnosis who received residential/inpatient services could be considered good if it is due to more members needing this level of care and receiving it. However, if increases are due to ineffective use of lower levels of care, this could be considered moving in wrong direction.

Table 12. Measurements of Secondary Driver 2 – Receipt of Treatment for SUD						
Secondary Driver 2 (Related to Goal 1, Goal 2, and Goal 3): Improve adherence to treatment for OUD and other SUDs						
Type of SUD treatment used	Year	Numerator	Denominator	Rate	p-value	Trend
<b>Overall percentage of beneficiaries with a SUD diagnosis who received SUD Treatment</b>	2017	9,774	22,119	44.19%		1.18
	2018	10,236	23,378	43.78%	p=.39	
	2019	10,369	23,751	43.66%	p=.78	
	2020	9,927	22,703	43.73%	p=.88	
	2021	11,414	22,774	50.12%	p<.001	
<b>Stratification by Service Type</b> (members may be counted for each service type)						
<b>Percentage of beneficiaries with a SUD diagnosis who received early intervention (e.g., SBIRT)</b>	2017	18	22,119	0.08%		-0.01
	2018	15	23,378	0.06%	p=.58	
	2019	16	23,751	0.07%	p=.07	
	2020	8	22,703	0.04%	p=.19	
	2021	16	22,774	0.07%	p=.26	
<b>Percentage of beneficiaries with a SUD diagnosis who received outpatient services</b>	2017	6,471	22,119	29.26%		0.71
	2018	6,744	23,378	28.85%	p=.34	
	2019	6,846	23,751	28.82%	p=.95	
	2020	6,485	22,703	28.56%	p=.54	
	2021	7,500	22,774	32.93%	p<.001	
<b>Percentage of beneficiaries with a SUD diagnosis who received intensive outpatient/partial hospitalization</b>	2017	886	22,119	4.01%		-0.37
	2018	937	23,378	4.01%	p=.99	
	2019	704	23,751	2.96%	p<.001	
	2020	557	22,703	2.45%	p<.01	
	2021	670	22,774	2.94%	p<.01	
<b>Percentage of beneficiaries with a SUD diagnosis who received residential/inpatient services</b>	2017	4,451	22,119	20.12%		0.62
	2018	4,526	23,378	19.36%	p=.04	
	2019	4,654	23,751	19.59%	p=.52	
	2020	4,605	22,703	20.28%	p=.06	
	2021	5,188	22,774	22.78%	p<.001	
<b>Percentage of beneficiaries with a SUD diagnosis who received withdrawal management services</b>	2017	29	22,119	0.13%		0.04
	2018	45	23,378	0.19%	p=.10	
	2019	33	23,751	0.14%	p=.15	
	2020	46	22,703	0.20%	p=.10	
	2021	85	22,774	0.37%	p<.001	
<b>Percentage of beneficiaries with a SUD diagnosis who received medication-assisted treatment (MAT)</b>	2017	757	22,119	3.42%		0.81
	2018	936	23,378	4.00%	p<.01	
	2019	1,035	23,751	4.36%	p=.05	
	2020	1,152	22,703	5.07%	p<.001	
	2021	1,579	22,774	6.93%	p<.001	
Percentages are annual rates (members may be counted once per year). The p-value reports a Pearson chi-square test for statistically significant differences between the year's rate and the prior year's rate. A Mantel-Haenszel chi-square test showed slope of the 5-year trend lines were statistically significantly different from horizontal (p<.001). Trend reports the slope (i.e., the average change per year) measured in percentage points per year (pp/y).						

<b>Table 13. Measurements of Secondary Driver 2 – Receipt of Treatment for OUD</b>						
<b>Secondary Driver 2 (Related to Goal 1, Goal 2, and Goal 3): Improve adherence to treatment for OUD and other SUDs</b>						
Type of SUD treatment used	Year	Numerator	Denominator	Rate	p-value	Trend
<b>Overall percentage of beneficiaries with an OUD diagnosis who received SUD Treatment</b>	2017	1,982	3,582	55.33%		<i>p</i> <.001 1.18
	2018	2,223	3,863	57.55%	<i>p</i> =.06	
	2019	2,184	3,833	56.98%	<i>p</i> =.90	
	2020	1,979	3,522	56.19%	<i>p</i> <.001	
	2021	2,238	3,546	63.11%	<i>p</i> <.001	
<b>Stratification by Service Type</b> (members may be counted for each service type)						
<b>Percentage of beneficiaries with an OUD diagnosis who received early intervention (e.g., SBIRT)</b>	2017	7	3,582	0.20%		<i>p</i> =.03 -0.04
	2018	11	3,863	0.28%	<i>p</i> =.43	
	2019	3	3,833	0.08%	<i>p</i> =.03	
	2020	3	3,522	0.09%	<i>p</i> >.99	
	2021	3	3,546	0.08%	<i>p</i> >.99	
<b>Percentage of beneficiaries with an OUD diagnosis who received outpatient services</b>	2017	1,462	3,582	40.82%		<i>p</i> <.001 1.37
	2018	1,689	3,863	43.72%	<i>p</i> <.01	
	2019	1,680	3,833	43.83%	<i>p</i> =.92	
	2020	1,502	3,522	42.65%	<i>p</i> =.31	
	2021	1,709	3,546	48.20%	<i>p</i> <.001	
<b>Percentage of beneficiaries with an OUD diagnosis who received intensive outpatient/partial hospitalization</b>	2017	152	3,582	4.24%		<i>p</i> <.001 -0.34
	2018	157	3,863	4.06%	<i>p</i> =.70	
	2019	120	3,833	3.13%	<i>p</i> =.03	
	2020	97	3,522	2.75%	<i>p</i> =.34	
	2021	113	3,546	3.19%	<i>p</i> =.28	
<b>Percentage of beneficiaries with an OUD diagnosis who received residential/inpatient services</b>	2017	869	3,582	24.26%		<i>p</i> =.14
	2018	902	3,863	23.35%	<i>p</i> =.36	
	2019	838	3,833	21.86%	<i>p</i> =.12	
	2020	808	3,522	22.94%	<i>p</i> =.27	
	2021	927	3,546	26.14%	<i>p</i> <.01	
<b>Percentage of beneficiaries with an OUD diagnosis who received withdrawal management services</b>	2017	8	3,582	0.22%		<i>p</i> =.02 0.07
	2018	10	3,863	0.26%	<i>p</i> =.76	
	2019	8	3,833	0.21%	<i>p</i> =.65	
	2020	11	3,522	0.31%	<i>p</i> =.38	
	2021	19	3,546	0.54%	<i>p</i> =.15	
<b>Percentage of beneficiaries with an OUD diagnosis who received medication-assisted treatment (MAT)</b>	2017	316	3,582	8.82%		<i>p</i> <.001 1.67
	2018	388	3,863	10.04%	<i>p</i> =.07	
	2019	382	3,833	9.97%	<i>p</i> =.91	
	2020	430	3,522	12.21%	<i>p</i> <.01	
	2021	570	3,546	16.07%	<i>p</i> <.001	

Percentages are annual rates (members may be counted once per year).  
 The *p*-value reports a Pearson chi-square test for statistically significant differences between the year's rate and the prior year's rate.  
 Trend reports the *p*-value for Mantel-Haenszel chi-square test to see if the slope of the 5-year trend line is statistically significantly different from horizontal, and if significant, the slope measured in percentage points per year (pp/y).

<b>Table 14. Measurements of Secondary Driver 2 – Peer Support Services</b>						
<b>Secondary Driver 2 (Related to Goals 1, 2, and 3): Improve adherence to treatment for OUD and other SUDs</b>						
Measure	Year	Numerator	Denominator	Rate	p-value	Trend
<b>Percentage of beneficiaries with a SUD diagnosis who received peer support services</b>	2017	1,283	22,119	5.80%		<i>p</i> =.01 -0.12
	2018	1,377	23,378	5.89%	<i>p</i> =.68	
	2019	1,305	23,751	5.49%	<i>p</i> =.06	
	2020	1,153	22,703	5.08%	<i>p</i> =.05	
	2021	1,280	22,774	5.62%	<i>p</i> <.01	

Percentages are annual rates (members may be counted once per year).  
 The *p*-value reports a Pearson chi-square test for statistically significant differences between the year's rate and the prior year's rate.  
 Trend reports the *p*-value for Mantel-Haenszel chi-square test to see if the slope of the 5-year trend line is statistically significantly different from horizontal, and if significant, the slope measured in percentage points per year (pp/y).

Over the five-year period, the percentages of members with a SUD diagnosis who received peer support services remained low, between 5% and 6%. These results do not indicate adherence to treatment for OUD and other SUDs is improving.

### *Conclusions Related to Goals 1, 2, and 3*

#### Goal 1 – Identification, Initiation, and Engagement in Treatment for OUD and other SUDs

The findings related to Secondary Driver 2 provided some support to the Goal 1 evaluation hypothesis (the demonstration will increase the percentage of members who are referred and engaged in treatment for SUDs). The rates of members with an OUD or other SUD receiving SUD treatment increased significantly in 2021, with between 6 and 7 percentage point increases; 50% of members with a SUD diagnosis, and 63% of members with an OUD diagnosis were receiving SUD services in 2021. While almost all service type strata within these measures had some increases, the overall increase in SUD treatment rates was primarily due to increases in outpatient services, inpatient/residential, and MAT. It should be noted, MAT rates remain low (16% and less) and continued improvement, building on 2021, is needed.

The following measures had low rates and remained generally flat over the 5-year period. Less than one-third of members with an OUD that were prescribed medication had continuity in pharmacotherapy with no more than a 7-day gap. Follow-up with members after ED visits with a principal diagnosis of alcohol or other drug use or dependence, is infrequently occurring (20% or less). Also, the rate of members with a SUD diagnosis receiving peer support services is very low, between 5% and 6%. Further improvement in this driver is needed to make progress towards this goal.

#### Goal 2 – Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment through improved access to other continuum of care services

The findings related to Secondary Driver 2 indicated there has been an increase in several continuum of care services; however, as noted above, continued improvement is needed. The number of ED visits for alcohol and other drug use or dependence decreased in 2019 and 2020. There were increases in members with an OUD or other SUD diagnosis who received residential/inpatient services, while members receiving outpatient services also increased. In absence of the information on the root causes for the changes, a definitive conclusion could not be made whether a positive or negative result is seen.

#### Goal 3 – Reductions in overdose deaths, particularly those due to opioids.

The assessment of Secondary Driver 2 supported the evaluation hypothesis for Goal 3 (the demonstration will decrease the rate of overdose deaths due to opioids). Members with an OUD diagnosis had higher increases in rates of SUD treatment and several service type strata. However, to have a strong impact on Goal 3, further improvement in this driver is needed.

### Secondary Driver 3 (Related to Goals 2, 3, and 4)

#### *Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment*

The Secondary Driver 3 was assessed with three performance measures (Table 15). The indicate progress toward expanding access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment.

<b>Table 15. Measurements of Secondary Driver 3</b>						
<b>Secondary Driver 3 (Related to Goals 2, 3, and 4): Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment</b>						
Measure	Year	Numerator	Denominator	Rate	p-value	Trend
<b>Percentage of Inpatient OUD discharges with MAT claim</b>	2017	13	369	3.52%		<i>p</i> <.01 1.37
	2018	31	453	6.84%	<i>p</i> =.04	
	2019	17	396	4.29%	<i>p</i> =.11	
	2020	23	394	5.84%	<i>p</i> =.32	
	2021	44	405	10.86%	<i>p</i> =.01	
<b>Percentage of members with OUD diagnosis who have a MAT claim for OUD</b>	2017	312	3,577	8.72%		<i>p</i> <.01 1.67
	2018	385	3,856	9.98%	<i>p</i> =.06	
	2019	379	3,828	9.90%	<i>p</i> =.90	
	2020	428	3,517	12.17%	<i>p</i> <.01	
	2021	565	3,540	15.96%	<i>p</i> <.001	
<b>Residential and Inpatient OUD discharges with MAT claim</b>	2017	25	587	4.3%		<i>p</i> .20
	2018	49	648	7.6%	<i>p</i> =.01	
	2019	19	596	3.2%	<i>p</i> <.001	
	2020	25	567	4.4%	<i>p</i> =.28	
	2021	49	637	7.7%	<i>p</i> =.02	

Percentages are annual rates (members may be counted once per year).  
 The *p*-value reports a Pearson chi-square test for statistically significant differences between the year's rate and the prior year's rate.  
 Trend reports the *p*-value for Mantel-Haenszel chi-square test to see if the slope of the 5-year trend line is statistically significantly different from horizontal, and if significant, the slope measured in percentage points per year (pp/y).

The Secondary Driver 3 is focused on the expansion of access to MAT by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment. The percentages of inpatient OUD discharges with a MAT claim were low from 2017 to 2020, however, the 2021 rate doubled compared to preceding years and showed a statistically significant change from 2020. The results for the measure indicate that an improvement is being seen in Secondary Driver 3.

The percentages of members with OUD diagnosis who have a MAT claim for OUD increased statistically significantly from the previous year in 2020 and 2021 and increased over five years, averaging 1.67 percentage points change per year, which indicates improvement in Secondary Driver 3.

**Conclusions Related to Goals 2, 3, and 4**

**Goal 2 – Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment through improved access to other continuum of care services.**

The increases in MAT for members with an OUD diagnosis indicate improved access to other continuum of care services. This supports Goal 2. However, to have a strong impact on Goal 2, further improvement in this driver is needed.

**Goal 3 – Reductions in overdose deaths, particularly those due to opioids.**

The increases in MAT for members with an OUD diagnosis indicates improved access to services that support efforts towards reaching Goal 3. However, to have a strong impact on Goal 3, further improvement is needed.

**Goal 4 – Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.**

The increases in inpatient and residential OUD discharges with a MAT claim indicates improved access to services to support the reduction in readmissions.

**Secondary Driver 4 (Related to Goals 2, 3, and 4)**

*Ensure access to treatment at all needed levels of care for SUD*

The Secondary Driver 4 was examined by assessing four performance measures (Table 16). The results for these four measures did not provide enough evidence to indicate that an improvement is being made in ensuring access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD).

<b>Table 16. Measurements of Secondary Driver 4</b>						
<b>Secondary Driver 4 (Related to Goals 2, 3, and 4): Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD)</b>						
Measure	Year	Numerator	Denominator	Rate	p-value	Trend
Percentage of Medicaid beneficiaries with SUD diagnosis who were treated in an IMD for SUD during the measurement year.	2019	582	23751	2.45%		p<.01
	2020	502	22703	2.21%	p=.09	0.06
	2021	582	22774	2.56%	p<.001	pp/y
Measure	Year	Numerator	Denominator	Days		
Average length of stay for SUD treatment services within IMDs	2019	12,747	747	17.1		
	2020	10,151	489	20.8		
	2021	11,115	601	18.5		
Measure	Year	Numerator	Denominator	per 1000	p-value	Trend
Number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members SUD diagnosis	2017	4,451	22,119	201		
	2018	4,526	23,378	194	p=.04	p<.001
	2019	4,654	23,751	196	p=.52	6.3
	2020	4,605	22,703	203	p=.06	m/Km/y
	2021	5,188	22,774	228	p<.001	
Number of beneficiaries in outpatient, intensive outpatient, & partial hospitalization SUD treatment per 1,000 members SUD diagnosis	2017	10,119	22,119	457		
	2018	10,668	23,378	456	p=.80	p<.001
	2019	10,365	23,751	436	p<.001	-4.9
	2020	9,247	22,703	407	p<.001	m/Km/y
	2021	10,405	22,774	457	p<.001	

Percentages are annual rates (members may be counted once per year).  
 The p-value reports a Pearson chi-square test for statistically significant differences between the year's rate and the prior year's rate.  
 Trend reports the p-value for Mantel-Haenszel chi-square test to see if the slope of the 3- or 5-year trend line is statistically significantly different from zero, and if significant, the slope in percentage points per year (pp/y) or members per 1,000 members per year (m/Km/y).

The percentages of Medicaid beneficiaries with SUD diagnosis who were treated in an IMD for SUD during the measurement year did not show any significant changes from 2019 to 2021. The 2021 rate showed a significant increase compared to 2020, however, it was only slightly higher than the 2019 rate. The decline seen in 2020 rate corresponded with the onset of pandemic.

The rates for an average length of stay for SUD treatment services within IMDs did not show statistically significant changes from 2019 to 2021.

The number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members with a SUD diagnosis did not show any statistically significant changes from 2017 to 2020. However, a statistically significant increase was seen from 2020 to 2021, with a twelve percent relative increase. Though, the increase was seen in 2021, these results provided limited insight to draw any definite conclusion about the measure's performance.

The number of beneficiaries in outpatient, intensive outpatient, and partial hospitalization SUD treatment per 1,000 members SUD diagnosis showed statistically significant declines in 2019 and 2020. In 2021, the rate increased back to those seen in 2017 and 2018.

**Conclusions Related to Goals 2, 3, and 4:**

**Goal 2 – Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment through improved access to other continuum of care services.**

The findings did not provide enough evidence to indicate support of Goal 2.

**Goal 3 – Reductions in overdose deaths, particularly those due to opioids.**

The findings did not provide enough evidence to indicate support of Goal 3.

**Goal 4 – Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.**

The findings did not provide enough evidence to indicate support of Goal 4.

**Secondary Driver 5 (Related to Goals 2, 3, and 4)**

***Ensure inpatient & residential providers improve care coordination & transition of care to the community:***

The Secondary Driver 5 was examined by assessing nine performance measures including four HEDIS measures (Tables 17–19). Of these nine measures, the results for seven indicated that progress is being made towards ensuring inpatient and residential providers improve care coordination and the transition of care to the community. However, the results showed that further improvement is also needed in a few aspects of this driver.

<b>Table 17. Measurements of Secondary Driver 5 – HEDIS Rates</b>									
<b>Secondary Driver 5 (Related to Goals 2, 3, and 4): Ensure inpatient and residential providers improve care coordination and transition of care to the community</b>									
Measure		Year	Numerator	Denominator	Rate	Rank	p-value	Trend	
<b>Follow-Up After ED Visit for Alcohol and Other Drug Abuse/Dependence (FUA)</b>	<b>– Within 7 days</b>	2017	160	1,039	15.40	>66.67 <sup>th</sup>		<b>p=.88</b>	
		2018	234	1,499	15.61	>66.67 <sup>th</sup>	p=.89		
		2019	211	1,462	14.43	≥50 <sup>th</sup>	p=.37		
		2020	217	1,393	15.58	≥50 <sup>th</sup>	p=.39		
	<b>– Within 30 days</b>	2017	233	1,039	22.43	>66.67 <sup>th</sup>			<b>p=.31</b>
		2018	344	1,499	22.95	>66.67 <sup>th</sup>	0.76		
		2019	312	1,462	21.34	≥50 <sup>th</sup>	0.29		
		2020	297	1,393	21.32	≥50 <sup>th</sup>	0.99		
<b>Follow-Up After High-Intensity Care for SUD (FUI)</b>	<b>– Within 7 days</b>	2019	89	406	21.92				
		2020	98	472	20.76	<25 <sup>th</sup>	p=.68		
	<b>– Within 30 days</b>	2019	171	406	42.12				
		2020	187	472	39.62	<33.33 <sup>rd</sup>	p=.45		
<b>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation within 14 days (Total)</b>		2017	3,158	8,829	35.77	<25 <sup>th</sup>		<b>p&lt;.01</b> 3.05	
		2018	3,239	8,945	36.21	<25 <sup>th</sup>	p=.46		
		2019	3,363	8,162	41.20	<50 <sup>th</sup>	p<.001		
		2020	3,692	8,338	44.28	<50 <sup>th</sup>	p=.16		
<b>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement within 34 days (Total)</b>		2017	1,057	8,829	11.97	<50 <sup>th</sup>		<b>p&lt;.001</b> 0.48	
		2018	1,039	8,945	11.62	<50 <sup>th</sup>	p=.54		
		2019	1,113	8,162	13.64	<50 <sup>th</sup>	p<.001		
		2020	1,075	8,338	12.89	<50 <sup>th</sup>	p<.001		

Rankings are based on Quality Compass national percentile rankings.  
 The p-value reports a Pearson chi-square test for statistically significant differences between the year's rate and the prior year's rate.  
 Trend reports the p-value for Mantel-Haenszel chi-square test to see if the slope of the 4-year trend line is statistically significantly different from horizontal, and if significant, the slope measured in percentage points per year (pp/y).

For the Follow-Up After ED Visit for Alcohol and Other Drug Abuse/Dependence (FUA) measure, rates for follow-up within 7 days and follow-up within 30 days were low for measurement years 2017 to 2020

(14.43% to 15.61% follow-up within 7 days and 21.32% to 22.95% for follow-up within 30 days). Changes were not statistically significant. These results did not indicate that an improvement is being seen in ensuring inpatient and residential providers improve care coordination and transition of care to the community.

Similarly, For Follow-Up After High-Intensity Care for SUD (FUI), 2019 and 2020 rates for follow-up within 7 days (21.92% and 20.76%, respectively) and follow-up within 30 days (42.12% and 39.62%) were low, based on comparison to Quality Compass national percentiles. Changes between years were not statistically significant. These results do not indicate improvement in the performance of Secondary Driver 5, and the results also showed poor performance relative to the nation.

The Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) rates for initiation of treatment within 14 days of SUD diagnosis had an increasing trend from 2017 to 2020, with an average increase of 3.05 percentage points per year. The Quality Compass ranking for the measure also improved. The 2019 and 2020 rates for continued engagement within 34 days of the initial treatment were greater than the 2017 and 2018 rates; the average increase was 0.48 percentage points per year. The rates for initiation within 14 days indicated improvement of Secondary Driver 5. The rates for engagement within 34 days provided weaker supporting evidence.

<b>Table 18. Measurements of Secondary Driver 5 – Readmission Rates</b>						
<b>Secondary Driver 5 (Related to Goals 2, 3, and 4): Ensure inpatient and residential providers improve care coordination and transition of care to the community</b>						
Measure	Year	Numerator	Denominator	Rate	p-value	Trend
<b>30-Day Readmission for SUD treatment</b>	2017	595	4,986	11.9%	p>.99	1.7 decrease
	2018	617	5,171	11.9%		
	2019	463	5,295	8.7%	p<.001	
	2020	349	5,327	6.6%	p<.001	
	2021	345	5,857	5.9%	p=.15	

The p-value reports a Pearson chi-square test for statistically significant differences between the year's rate and the prior year's rate. Trend reports the slope of the 5-year trend line in percentage points per year (pp/y). The slopes are statistically significantly different from horizontal (Mantel-Haenszel chi-square test, p<.001).

<b>Table 19. Measurements of Secondary Driver 5 – Service Utilization Rates</b>						
<b>Secondary Driver 5 (Related to Goals 2, 3, and 4): Ensure inpatient and residential providers improve care coordination and transition of care to the community</b>						
Measure	Year	Months	Numerator	Denominator	Per 1,000	Change per Year
<b>ED utilization for SUD per 1,000 Medicaid beneficiaries (CMS Metric #23)</b>	2019	Jan–Dec	10,993	394,150	27.9	1.6 decrease
	2020	Jan–Dec	9,927	414,819	23.9	
	2021	Jan–Sep	8,397	341,153	24.6	
<b>ED utilization for OUD per 1,000 Medicaid beneficiaries (CMS Metric #23, OUD stratum)</b>	2019	Jan–Dec	855	394,150	2.2	0.3 decrease
	2020	Jan–Dec	596	414,819	1.4	
	2021	Jan–Sep	536	341,153	1.6	
<b>Inpatient stays for SUD per 1,000 Medicaid beneficiaries (CMS Metric #24)</b>	2019	Jan–Dec	5,451	394,150	13.8	0.2 decrease
	2020	Jan–Dec	5,907	414,819	14.2	
	2021	Jan–Sep	4,548	341,153	13.3	
<b>Inpatient stays for OUD per 1,000 Medicaid beneficiaries (CMS Metric #24, OUD stratum)</b>	2019	Jan–Dec	681	394,150	1.7	0.1 decrease
	2020	Jan–Dec	633	414,819	1.5	
	2021	Jan–Sep	504	341,153	1.5	

Source: KDADS  
 Numerator is the count of visits or stays in the measurement period. Denominator is the average monthly KanCare membership count.

A statistically significant decreasing trend (improving 1.7 percentage points per year on average) was seen for a five-period from 2017 to 2021 for the 30-day readmission for SUD treatment measure. The decreases from 2018 to 2019 and 2019 to 2020 were statistically significant. These results are evidence that inpatient and residential providers are improving care coordination and transition of care to the community.

Four service utilization measures were examined for 2019, 2020, and the first three quarters of 2021. All four measures showed a decline from 2019 to 2020 and in the first three quarters of 2021. All four service utilization measures indicated an improvement is being seen in Secondary Driver 5.

#### *Conclusions Related to Goals 2, 3, and 4*

Goal 2 – Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.

The Secondary Driver 5's assessment supported the hypothesis for Goal 2, which stated the demonstration will decrease the rate of ED visits and inpatient hospitalizations related to SUD within the member population. However, some deficiencies were noted, indicating improvement efforts may be needed to realize Goal 2.

Goal 3 – Reductions in overdose deaths, particularly those due to opioids.

Assessment of the Secondary Driver 5 supported Goal 3's evaluation hypothesis (the demonstration will decrease the rate of overdose deaths due to opioids).

Goal 4 – Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.

The findings related to the assessment of the Secondary Driver 5 provided evidence supporting the evaluation hypothesis (among members receiving care for SUD, the demonstration will reduce readmissions to SUD treatment) of Goal 4.

#### Secondary Driver 6 (Related to Goals 2, 3, 4 and 5)

*Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy*

For the interim evaluation, two performance measures were assessed for Secondary Driver 6 (Table 20). The findings for both measures did not indicate improvement for this secondary driver.

From 2019 to 2021, the percentages of Medicaid members with a SUD diagnosis who had an assigned MCO care manager were quite low. For physical and behavioral health services to be properly integrated and coordinated, MCOs care management teams should work with all members who have a SUD diagnosis and do not decline an offer for care management. The rate of increase from 2019 to 2021 (1.5 percentage points per year) indicates improvement in Secondary Driver 6 may be insufficient to obtain the Demonstration Goals.

The percentages of Medicaid members with a SUD diagnosis who had an assigned MCO care manager and a patient centered service plan (PCSP) were also very low (about 2% in 2021). Percentages declined each year. These findings did not indicate that Secondary Driver 6 improved.

<b>Table 20. Measurements of Secondary Driver 6</b>						
<b>Secondary Driver 6 (Related to Goals 2, 3, 4, and 5): Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy</b>						
Measure	Year	Numerator	Denominator	Rate	p-value	Trend
Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager	2019	3,544	16,321	21.71%		1.49
	2020	4,055	15,164	26.74%	p<.001	
	2021	4,253	17,233	24.68%	p<.001	
Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and have service/treatment plan or person-centered service plan (PCSP)	2019	821	16,321	5.03%		-1.46
	2020	440	15,164	2.90%	p<.001	
	2021	364	17,233	2.11%	p<.001	

Percentages are annual rates (members may be counted once per year).  
 The p-value reports a Pearson chi-square test for statistically significant differences between the year's rate and the prior year's rate.  
 Trend reports the slope of the 3-year trend line in percentage points per year (pp/y). The slopes are statistically significantly different from horizontal (Mantel-Haenszel chi-square test, p<.001).

### Conclusions Related to Goals 2, 3, 4, and 5

The findings related to the assessment of the Secondary Driver 6 did not provide evidence to support the hypotheses for Goal 2 (decrease in ED visits and inpatient hospitalizations related to SUD), Goal 3 (decrease in rate of overdose deaths due to opioids), Goal 4 (reduce readmissions to SUD treatment), or Goal 6 (increase members with SUD who access care for physical health conditions). As a crucial step of the KanCare 2.0 Service Coordination Strategy is to make progress towards this goal, it should be implemented adequately.

### Outcome Evaluation – Primary Drivers (Goals)

It should be noted, the primary drivers are also referred as demonstration goals.

#### Primary Driver 1 (Goal 1)

##### *Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.*

The Primary Driver 1 (Goal1) was examined by assessing two HEDIS measures (Table 21). These two are also measures of Secondary Driver 5. The findings for one measure indicated progress toward increasing the rates of identification, initiation, and engagement in treatment for OUD and other SUDs. However, the findings for the second measure provided much weaker evidence to indicate that progress is being made. The results of both performance measures indicated further improvement is needed to make progress toward Goal 1.

<b>Table 21. Performance Measures for SUD Demonstration Goal 1 (Outcome Evaluation)</b>							
<b>Goal 1: Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs</b>							
Measure Description	Year	Numerator	Denominator	Rate	Rank	p-value	Trend
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation within 14 days (Total)	2017	3,158	8,829	35.77%	<25 <sup>th</sup>		3.05
	2018	3,239	8,945	36.21%	<25 <sup>th</sup>	p=.46	
	2019	3,363	8,162	41.20%	<50 <sup>th</sup>	p<.001	
	2020	3,692	8,338	44.28%	<50 <sup>th</sup>	p=.16	
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement within 34 days (Total)	2017	1,057	8,829	11.97%	<50 <sup>th</sup>		0.48
	2018	1,039	8,945	11.62%	<50 <sup>th</sup>	p=.54	
	2019	1,113	8,162	13.64%	<50 <sup>th</sup>	p<.001	
	2020	1,075	8,338	12.89%	<50 <sup>th</sup>	p<.001	

Rankings are based on Quality Compass national percentile rankings.  
 The p-value reports a Pearson chi-square test for statistically significant differences between the year's rate and the prior year's rate.  
 Trend reports the p-value for Mantel-Haenszel chi-square test to see if the slope of the 5-year trend line is statistically significantly different from horizontal, and if significant, the slope measured in percentage points per year (pp/y).

The Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) rates for initiation of treatment within 14 days of SUD diagnosis had an increasing trend from 2017 to 2020, with an average increase of 3.05 percentage points per year. The Quality Compass ranking for the measure also improved. The 2019 and 2020 rates for continued engagement within 34 days of the initial treatment were greater than the 2017 and 2018 rates; the average increase was 0.48 percentage points per year. The rates for initiation within 14 days indicated improvement of Secondary Driver 5. The rates for engagement within 34 days provided weaker supporting evidence.

**Primary Driver 2 (Goal 2)**

*Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services*

The Primary Driver 2 (Goal 2) was assessed using four performance measures (Table 22). It should be noted, these four measures were also assessed to evaluate Secondary Driver 5. All four measures indicated that some improvement was being made towards reducing the utilization of ED and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services (Goal 2).

Four service utilization measures were examined for 2019, 2020, and the first three quarters of 2021. All four measures showed a decline from 2019 to 2020 and in the first three quarters of 2021. All four service utilization measures indicated an improvement is being seen in Secondary Driver 5.

<b>Table 22. Performance Measures for SUD Demonstration Goal 2 (Outcome Evaluation)</b>						
<b>Goal 2: Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services</b>						
Measure	Year	Months	Numerator	Denominator	Per 1,000	Change per Year
<b>ED utilization for SUD per 1,000 Medicaid beneficiaries (CMS Metric #23)</b>	2019	Jan–Dec	10,993	394,150	27.9	1.6 decrease
	2020	Jan–Dec	9,927	414,819	23.9	
	2021	Jan–Sep	8,397	341,153	24.6	
<b>ED utilization for OUD per 1,000 Medicaid beneficiaries (CMS Metric #23, OUD stratum)</b>	2019	Jan–Dec	855	394,150	2.2	0.3 decrease
	2020	Jan–Dec	596	414,819	1.4	
	2021	Jan–Sep	536	341,153	1.6	
<b>Inpatient stays for SUD per 1,000 Medicaid beneficiaries (CMS Metric #24)</b>	2019	Jan–Dec	5,451	394,150	13.8	0.2 decrease
	2020	Jan–Dec	5,907	414,819	14.2	
	2021	Jan–Sep	4,548	341,153	13.3	
<b>Inpatient stays for OUD per 1,000 Medicaid beneficiaries (CMS Metric #24, OUD stratum)</b>	2019	Jan–Dec	681	394,150	1.7	0.1 decrease
	2020	Jan–Dec	633	414,819	1.5	
	2021	Jan–Sep	504	341,153	1.5	

Source: KDADS  
 Numerator is the count of visits or stays in the measurement period. Denominator is the average monthly KanCare membership count.

**Primary Driver 3 (Goal 3)**

*Reductions in overdose deaths, particularly those due to opioids.*

The Primary Driver 3 had three performance measures (Table 23). The findings of one indicated that some improvement is being made towards reduced use of opioid drugs; however, the measure directly assessing the opioid drug overdose death rates did not indicate any improvement. The findings of third measure are too preliminary to provide any conclusion regarding its contribution towards making progress to achieve Goal 3.

<b>Table 23. Performance Measures for SUD Demonstration Goal 3 (Outcome Evaluation)</b>				
<b>Goal 3: Reductions in overdose deaths, particularly those due to opioids</b>				
<b>Measure</b>	<b>Year</b>	<b>Numerator</b>	<b>Denominator</b>	<b>Per 1,000</b>
<b>Opioid Drug Overdose Deaths.</b> (CMS Metric #27, OUD Stratum)	2019	34	412,812	0.08
	2020	47	404,701	0.12
	2021	104	511,960	0.20
<b>Use of Opioids at High Dosage in Persons without Cancer per 1,000 Medicaid beneficiaries.</b> (CMS Metric #18)	2019	390	3,802	103
	2020	262	2,731	95.9
<b>Concurrent use of opioids and benzodiazepines per 1,000 Medicaid beneficiaries.</b> (CMS Metric #21)	2019	0	2,758	0
	2020	275	2,856	9.6

Source: KDADS  
 Numerator is the count of visits or stays in the measurement period. Denominator is the average monthly KanCare membership count.

Small but steady increases in the Opioid Drug Overdose death rates were seen from 2019 to 2021. These findings indicate no improvement was being made toward Goal 3.

Rates for Use of Opioids at High Dosage in Persons without Cancer per 1,000 Medicaid Beneficiaries decreased from 2019 to 2020. These finding did indicate that some improvement is being made towards Goal 3.

The State informed providers in KMAP GENERAL BULLETIN 20191, “Effective October 1, 2020 through September 30, 2025, all Medication Assisted Treatment (MAT) drugs and biological products, used for Opioid Use Disorder (OUD) will be covered. All MAT drugs and biologicals billed through the medical benefit require a diagnosis code to be considered for payment.”<sup>9</sup> As per this notification, information available on concurrent use of opioids and benzodiazepines is very preliminary. Thus, no conclusions were made about this measure or its contribution towards the Goal 3.

#### Primary Driver 4 (Goal 4)

*Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs*

The Primary Driver 4 (Goal 4) was examined by assessing two performance measures (Table 24). The findings for both measures indicate that a progress is made towards achieving Goal 4.

<b>Table 24. Performance Measures for SUD Demonstration Goal 4 (Outcome Evaluation)</b>						
<b>Goal 4: Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs</b>						
<b>Measure</b>	<b>Year</b>	<b>Numerator</b>	<b>Denominator</b>	<b>Rate</b>	<b>p-value</b>	<b>Trend</b>
<b>30-Day Readmission for SUD treatment</b>	2017	595	4,986	11.9%		1.7 decrease
	2018	617	5,171	11.9%	p>.99	
	2019	463	5,295	8.7%	p<.001	
	2020	349	5,327	6.6%	p<.001	
	2021	345	5,857	5.9%	p=.15	
<b>30-Day Readmission for SUD treatment – OUD discharges</b>	2017	79	628	12.6%		1.9 decrease
	2018	85	675	12.6%	p>.99	
	2019	42	596	7.0%	p<.01	
	2020	30	527	5.7%	p=.36	
	2021	47	717	6.6%	p=.53	

Percentages are annual rates (members may be counted once per year).  
 The p-value reports a Pearson chi-square test for statistically significant differences between the year’s rate and the prior year’s rate.  
 Trend reports the slope of the 5-year trend line in percentage points per year (pp/y). The slopes are statistically significantly different from horizontal (Mantel-Haenszel chi-square test, p<.001).

A steady decline is seen in the 30-Day Readmission for SUD treatment rates, along with a statistically significant decreasing trend over a five-year period, with an average -1.7 percentage points change per year from 2017 to 2021. These findings indicate that a progress is made towards achieving Goal 4.

Similarly, a steady decline is seen in the rates for the measure—30-Day Readmission for SUD treatment – OUD discharges, along with a statistically significant decreasing trend over a five-year period, with about an average -2.0 percentage points change per year from 2017 to 2021. These findings indicate that a progress is made towards achieving Goal 4.

**Primary Driver 5 (Goal 5)**

*Improved access to care for physical health conditions among members with OUD or other SUDs*

The Primary Driver 5 (Goal 5) was examined by assessing four performance measures (Table 25). The findings for the four measures did not indicate that the SUD demonstration specifically is improving access to care for physical health conditions among members with OUD or other SUDs. However, timeliness of prenatal care improved for both the SUD intervention group and non-SUD comparison group.

<b>Table 25. Performance Measures for SUD Demonstration Goal 5 (Outcome Evaluation)</b>						
<b>Goal 5: Improved access to care for physical health conditions among members with OUD or other SUDs</b>						
	<b>SUD Intervention Group</b>		<b>SUD Comparison Group</b>		<b>Statistics</b>	
	<b>Rate</b>	<b>Denominator</b>	<b>Rate</b>	<b>Denominator</b>	<b>Difference</b>	<b>Significance</b>
<b>Annual Dental Visit (ADV)</b>						
2016–2018	55.4%	1,211	52.3%	97,641	3.1 pp	p=.03
2019–2021	49.6%	1,553	47.9%	134,049	1.7 pp	p=.19
Difference, p-value	-5.8 pp	p<.01	-4.4 pp	p<.001		
RFR Improvement	-13.1%		-9.1%			p=.35
<b>Adolescent Well-Care Visit (AWC)</b>						
2016–2018	35.2%	1,211	33.1%	97,641	2.1 pp	p=.12
2019–2021	34.6%	1,553	32.6%	134,049	2.0 pp	p=.09
Difference, p-value	-0.6 pp	p=.74	-0.5 pp	p=.01		
RFR Improvement	-0.9%		-0.7%			p=.95
<b>Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care</b>						
2016–2018	27.3%	802	27.6%	32,223	-.3 pp	p=.87
2019–2021	38.6%	766	35.4%	31,463	3.3 pp	p=.06
Difference, p-value	11.3 pp	p<.001	7.8 pp	p<.001		
RFR Improvement	15.6%		10.8%			p=.15
<b>Prenatal and Postpartum Care (PPC) – Postpartum Care</b>						
2016–2018	19.8%	802	26.5%	32,223	-6.7 pp	p<.001
2019–2021	18.1%	766	24.5%	31,463	-6.4 pp	p<.001
Difference, p-value	-1.7 pp	p<.001	-2.0 pp	p<.001		
RFR Improvement	-2.1%		-2.7%			p=.77
Measures were calculated from MMIS encounter data based on specifications for HEDIS Health Plan measures. Since specification changes for PPC between measurement years 2018 and 2019 caused a break in trending, HEDIS MY 2021 specifications were used for PPC. Rates differ from Certified, Audited HEDIS Health Plan rates calculated by MCOs due to differences in available source data. The Intervention Group is members aged 16–75 who had a SUD diagnosis in the measurement year. Comparison Group are members aged 16–75 without a SUD diagnosis. Differences between rates, shown as percentage points (pp), were tested for statistical significance using Person’s chi-square. Reduction in failure rate (RFR) measures improvement relative to the amount of possible improvement. The formula is: $RFR = \frac{\text{Final Rate} - \text{Initial Rate}}{\text{Goal} - \text{Initial Rate}}$ where Goal = 100% or 0%, depending on the measure. The goal for ADV, AWC, and PPC was 100%. A chi-square test was used to test for equality of RFR improvements.						

**Measure 1: Annual Dental Visit (ADV)**

Results do not establish that the KanCare 2.0 SUD Demonstration had a positive impact on Annual Dental Visit rates. The Intervention Group's RFR improvement was not statistically different from that of Comparison Group. The RFR, which measures improvement relative to the amount of possible improvement, should be higher for the intervention group to show effectiveness. Following results were seen for ADV measure:

- The 2016–2018 ADV rates were for Intervention Group (55.4%) and Comparison Group (52.3%) were very similar, within 3.1 percentage points.
- The groups had similar rate decreases for the 2019–2021 remeasurement period. The Intervention Group's ADV rate decreased 5.9 percentage points (to 49.6%), and Comparison Group's ADV rate decreased 4.4 percentage points (to 47.9%). Negative values are displayed in Table # to indicate the rate changes were not improvements.
- The RFR improvements were also about the same. The RFR for the Intervention group was –13.1%; the formula is  $RFR = (49.6\% - 55.4\%)/(100\% - 55.4\%)$ . The RFR for Comparison Group was –9.1%.
- The difference in RFRs was not statistically significant ( $p=.35$ ).
- The rate decreases between 2016–2018 and 2019–2021 were statistically significant, but this was expected; it was assumed the COVID-19 pandemic would impact ADV rates. Also, the denominators are large, so small changes in rates would yield significant findings.
- The differences between Intervention Group and Comparison Group rates are indications of comparability of the two groups. The significance of the differences for 2019–2018 was not surprising given the denominator sizes. The ADV rates for ages 19-20 are generally lower than rates for younger members, and the distribution of members of a given age differ between the groups; adjusting for age may improve comparability. Differences in rates between groups are accounted for by comparing RFRs instead of percentage point differences between years.

**Measure 2. Adolescent Well-Care Visit (AWC)**

Results do not establish that the SUD Demonstration had a positive impact on Adolescent Well-Care Visit rates. AWC rates decreased both the Intervention Group and Comparison Group, but the decreases were less than 1 percentage point. The difference between the RFRs was not statistically significant. The following results were seen for AWC measure:

- The 2016–2018 AWC rates for the Intervention Group and the Comparison Group were 35.2% and 33.1%, respectively, which was not statistically significant.
- The Intervention Group's rate decreased 0.6 percentage points. The rate for Comparison Group decreased 0.5 percentage points.
- The RFR for the Intervention Group was –0.9%. The RFR for Comparison Group was –0.7%. The difference in RFRs was not statistically significant ( $p=.95$ ).

**Measure 3. Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care**

Results do not establish that the SUD Demonstration had a positive impact on Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care rates. Timeliness of Prenatal Care rates improved for both the Intervention Group and Comparison Group. Although the rate increase was greater for the Intervention Group, the difference between the RFRs was not statistically significant. The following results were seen for Timeliness of Prenatal Care measure:

- The 2016–2018 Timeliness of Prenatal Care rates for the Intervention Group and the Comparison Group were 27.3% and 27.6%, respectively, which was not statistically significant.

- Both groups had statistically significant rate increases. The Intervention Group’s rate increased 11.3 percentage points. The rate for Comparison Group increased 7.8 percentage points.
- The RFR for the Intervention Group was 15.6%, which was better than the RFR for Comparison Group (10.87%). However, the difference in RFRs was not statistically significant ( $p=.15$ ).

**Measure 4. Prenatal and Postpartum Care (PPC) – Postpartum Care**

Results do not establish that the SUD Demonstration had a positive impact on Prenatal and Postpartum Care (PPC) – Postpartum Care rates. The rates decreased similarly for both the Intervention Group and Comparison Group, and difference between the RFRs was not statistically significant. The following results were seen for the Postpartum Care measure:

- The 2016–2018 Postpartum Care rates for Comparison Group (26.5%) was better than the Intervention Group’s rate (19.8%).
- The Intervention Group’s rate decreased 1.7 percentage points. The rate for Comparison Group decreased 2.0 percentage points.
- The RFR for the Intervention Group (–2.1%) and the RFR for Comparison Group (–2.7%) were not statistically significant.

**Evaluation Measures for KanCare 2.0 Hypothesis 4**

Four evaluation measures were examined to evaluate KanCare 2.0 Hypothesis 4 (Table 26). The findings for the four measures did not indicate improvement in the services provided in IMDs for KanCare members to increasing access to SUD treatment services.

<b>Table 26. Measurements for KanCare 2.0 Hypothesis 4</b>				
<b>Hypothesis 4: Removing payment barriers for services provided in IMDs for KanCare members will result in improved member access to SUD treatment services</b>				
<b>Measure</b>	<b>Status</b>			
<b>Number of IMDs providing SUD services</b>	14 submitted claims in 2019, 16 in 2020, and 14 in 2021			
<b>Number of geographic locations of IMDs providing SUD services</b>	19 IMD located in 15 counties are network providers			
	<b>Year</b>	<b>Admissions</b>	<b>Members</b>	
<b>Number of admissions with SUD treatment services in IMDs</b>	2019	733	497	
	2020	461	384	
	2021	580	478	
	<b>Year</b>	<b>Total Days</b>	<b>Stays</b>	<b>Avg Days</b>
<b>Average length of stay for SUD treatment services within IMDs</b>	2019	12,747	747	17.1
	2020	10,151	489	20.8
	2021	11,115	601	18.5

Admissions do not equal Stays because year of admission may differ from date of discharge (used to count stays).

There are nineteen IMDs located in fifteen counties credentialed to provide services for Medicaid. The number of IMDs providing SUD services who submitted claims in 2019 and 2021 was same, with two more IMDs submitting claims in 2019. The number of admissions with SUD treatment in IMDs were lower in 2020 and 2021 compared to 2019. The average length of stay for SUD treatment services within IMDs did not show much variation.

**Evaluation of Cross-Cutting Cost Measures**

Based on paid claims, the SUD demonstration has maintained budget neutrality in the first three years. KFMC is working with KDADS to further identify the administrative costs that could be included in the evaluation of the cost measures. The findings of the evaluation will be included in the summative evaluation of the SUD demonstration.

Amounts paid to providers for SUD services by the MCO were tabulated from encounters for 2017 to 2021. Total amounts paid and a capitated rate (amount paid per member with SUD diagnosis) are displayed in Table 27, stratified by type of care. Across the five years, costs per member slightly declined. The costs per member were decreased an average of \$33 per year for the total KanCare 2.0 SUD treatment spending amount. An alternate division of spending amounts for 2019 to 2021 is displayed in Table 28, which breaks out spending for treatment in IMDs and includes spending for assessments and SBIRT that do not result in a SUD diagnosis. Within the five years, spending tended to be lower in 2019 and 2020 than in 2017, 2018, or 2021. Consequently, the increasing three-year trend shown in Table 28 is a return to the earlier spending levels.

<b>Table 27. Type of Care Cost Drivers</b>					
<b>Treatment costs for members with SUD diagnosis, stratified by types of care using claims data</b>					
<b>Measure</b>	<b>Year</b>	<b>Total Paid</b>	<b>Members</b>	<b>\$/Member</b>	<b>Trend</b>
<b>ED Outpatient SUD Spending</b>	2017	\$970,225	22,119	\$44	(\$0.70) per year decrease
	2018	\$1,133,938	23,378	\$49	
	2019	\$1,025,114	23,751	\$43	
	2020	\$958,765	22,703	\$42	
	2021	\$997,211	22,774	\$44	
<b>Non-ED Outpatient SUD Spending</b>	2017	\$12,272,872	22,119	\$555	(\$27) per year decrease
	2018	\$11,863,727	23,378	\$507	
	2019	\$11,185,994	23,751	\$471	
	2020	\$9,644,711	22,703	\$425	
	2021	\$10,482,530	22,774	\$460	
<b>Inpatient and Residential SUD Spending</b>	2017	\$39,413,465	22,119	\$1,782	(\$9) per year decrease
	2018	\$49,238,017	23,378	\$2,106	
	2019	\$39,083,659	23,751	\$1,646	
	2020	\$39,309,490	22,703	\$1,731	
	2021	\$43,798,079	22,774	\$1,923	
<b>Pharmacy SUD Spending</b>	2017	\$864,607	22,119	\$39	\$4 per year
	2018	\$1,170,824	23,378	\$50	
	2019	\$1,103,346	23,751	\$46	
	2020	\$1,123,968	22,703	\$50	
	2021	\$1,348,016	22,774	\$59	
<b>Total KanCare 2.0 SUD Treatment Spending</b>	2017	\$53,521,169	22,119	\$2,437	(\$33) per year decrease
	2018	\$63,406,506	23,378	\$2,731	
	2019	\$52,398,113	23,751	\$2,217	
	2020	\$51,036,934	22,703	\$2,261	
	2021	\$56,625,836	22,774	\$2,493	

Denominator is the number of KanCare 2.0 members with a SUD diagnosis and a SUD treatment during the measurement period and/or in the 12 months before the measurement period (based on paid claims).  
 Trend is the average change in spending per member over five years calculated as the slope of the linear trend line.

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<b>Table 28. SUD Cost Drivers</b>					
<b>Treatment costs for members, stratified by services rendered within IMDs and other SUD-related costs for members with and without SUD diagnosis</b>					
<b>Measure</b>	<b>Year</b>	<b>Total Paid</b>	<b>Members</b>	<b>\$/Member</b>	<b>Trend</b>
<b>SUD Spending on Inpatient/ Residential Services and Pharmaceuticals Within IMDs</b>	2019	\$2,285,660	605	\$3,778	(\$79) per year decrease
	2020	\$1,867,069	515	\$3,625	
	2021	\$2,132,881	589	\$3,621	
<b>SUD Spending on Services Other Than Within IMDs</b>	2019	\$50,112,453	23,751	\$2,110	\$141 per year
	2020	\$49,169,865	22,703	\$2,166	
	2021	\$54,492,955	22,774	\$2,393	
<b>SUD Spending on SBIRT Services for Beneficiaries Without SUD Diagnosis</b>	2019	\$0	0	\$0	
	2020	\$0	0	\$0	
	2021	\$0	0	\$0	
<b>SUD Spending on Assessment Services for Beneficiaries Without SUD Diagnosis (excludes SBIRT)</b>	2019	\$13,390	103	\$130	(\$0.50) per year decrease
	2020	\$10,099	78	\$129	
	2021	\$13,000	101	\$129	
<b>Total KanCare 2.0 SUD Treatment Spending per Member with SUD Assessment or Diagnosis</b>	2019	\$52,411,503	23,854	\$2,197	\$140 per year
	2020	\$51,047,033	22,781	\$2,241	
	2021	\$56,638,836	22,875	\$2,476	
Denominator is the number of KanCare 2.0 members with a SUD diagnosis and a SUD treatment during the measurement period and/or in the 12 months before the measurement period (based on paid claims).					
Trend is the average change in spending per member over three years calculated as the slope of the linear trend line.					

## Conclusions

KFMC prepared this interim SUD Demonstration evaluation report to reflect evaluation progress and to present findings for January 2019 through December 2021. The SUD evaluation has two components: process evaluation and the outcome evaluation. The process evaluation is focused on examining the demonstration’s six secondary drivers. The outcome evaluation is focused on whether the demonstration made progress towards achieving its five goals (also referred as *primary drivers*).

It should be noted, the COVID-19 pandemic affected the utilization of health care services throughout the state and may have impacted the outcomes from this period. Thus, the results presented here should be interpreted with caution. Where feasible, adjustments were made to the analytic plans to account for the pandemic’s impact on measurement outcomes. Data and analytical results for 2022 and 2023 may provide a better assessment of the impact of the SUD Demonstration’s efforts.

### Process Evaluation – Secondary Drivers

The conclusions based on the assessment of performance measures to evaluate the demonstration’s six secondary drivers are summarized in Table 29.

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Table 29. Summary of Conclusions for Process Evaluation (Secondary Drivers)		
Secondary Driver	Goals	Process Evaluation Conclusions
1. Increase provider and plan capacity to screen/identify members with SUD for engagement in treatment	1	<ul style="list-style-type: none"> <li>One performance measure was assessed for Secondary Driver 1.</li> <li>Evaluation results did not indicate that an improvement is being seen in this driver.</li> <li>Further improvements are needed in this driver.</li> </ul>
2. Improve adherence to treatment for OUD and other SUDs	1, 2, 3	<ul style="list-style-type: none"> <li>Five performance measures were assessed for Secondary Driver 2.</li> <li>Two out of five measures and some of their service type strata indicated improvement in this driver.</li> <li>The other three performance measures indicated further improvements are needed.</li> </ul>
3. Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment	2, 3, 4	<ul style="list-style-type: none"> <li>Two performance measures were assessed for Secondary Driver 3.</li> <li>Results indicated improvement in this driver.</li> <li>Additional improvements will assist progress for this driver.</li> </ul>
4. Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD)	2, 3, 4	<ul style="list-style-type: none"> <li>Four performance measures were assessed for Secondary Driver 4.</li> <li>Results did not provide enough evidence to indicate improvement.</li> <li>Improvements are needed in this driver.</li> </ul>
5. Ensure inpatient and residential providers improve care coordination and transition of care to the community	2, 3, 4	<ul style="list-style-type: none"> <li>Nine performance measures were assessed for Secondary Driver 5.</li> <li>Seven out of nine measures indicated improvement in this driver.</li> <li>However, further improvements are needed.</li> </ul>
6. Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy	2, 3, 4, 5	<ul style="list-style-type: none"> <li>Two performance measures were assessed for Secondary Driver 6.</li> <li>Results did not indicate improvement in this driver, specifically by the SUD demonstration.</li> <li>Further improvements are needed in this driver.</li> </ul>

### Process Evaluation Findings Showing Progress Towards SUD Demonstration Goals

Progress is noted in several areas, although continued improvement is needed for all areas.

- The rates of members with an OUD or other SUD receiving SUD treatment increased significantly in 2021. While almost all service type strata within these measures had some increase in 2021, most notable were increases in outpatient services and MAT. Members with an OUD diagnosis had higher rate increases for SUD treatment, overall and for several service type strata.
- There were increases the percentages of inpatient and residential OUD discharges with a MAT claim.
- There was a decrease in the rate for use of opioids at high dosage (excluding persons with cancer).
- The rates for the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) measures (Initiation within 14 days and Engagement within 34 days) improved.
- ED and inpatient stays per 1,000 members decreased for members with an OUD and members with any SUD. There was a steady decline in 30-day readmissions for OUD and all SUD discharges.

### Opportunities for Improvement

- Improvements in the provision of early intervention (SBIRT) and care for SUD after provision of SBIRT services are needed.
- The rates for the Continuity of Pharmacotherapy for OUD (POD) measure were low and without change between years.

- Rates for both indicators of the Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA) were low (Within 7 days and Within 30 days).
- MAT rates remain low (16% and less), and continued improvement, building on 2021, is needed.
- Peer Support services were not provided to most of the members to assist them in continuing their SUD treatment.
- Improvements are needed for follow-up after ED visits for SUD treatment and after high-intensity care for SUD.
- The Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) measures (Initiation within 14 days, Engagement within 34 days) were low. Rates improved in 2020; however, further improvement is needed.
- A lack of standardization of the Health Screening Tool, Health Risk Assessment (HRA), Needs Assessment, and PCSP variable fields (in the datasets provided by the MCOs) created limitations in identifying members with SUD who received care coordination in line with the KanCare 2.0 program service coordination strategy.
- Low percentage of members with SUD who were assigned MCO care managers and who had a PCSP hindered progress towards multiple demonstration goals.

### Recommendations

- Review and improve the efforts for providing support to the expansion SBIRT among physical health and behavioral health service providers to identify members at different risk levels for OUD or other SUDs and provide the appropriate level of referral to SUD providers.
- Improve availability and utilization of peer support services to assist members with SUD in adhering to their SUD treatment.
- Improve efforts, including care coordination, to assist members with SUD in scheduling and receiving follow-up visits at an appropriate level of care after ED visits for SUD treatment and after receipt of high-intensity care for SUD.
- Review and improve the steps applied by the three MCOs to ensure all members with SUD eligible to receive KanCare 2.0 Service Coordination Strategy (such as use of the Health Screening Tool) are identified and receive an HRA Needs Assessment, PCSP, and coordinated care through an assigned care manager, as appropriate, during the remaining years of the SUD demonstration. Application of the Service Coordination Strategy to members with SUD will assist in achieving performance goals.

### **Outcome Evaluation – Primary Drivers (Goals)**

The conclusions based on the assessment of performance measures to evaluate demonstration’s five primary drivers are summarized in Table 30.

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<b>Table 30. Summary of Conclusions for Outcome Evaluation (Primary Drivers)</b>		
<b>Primary Driver (Demonstration Goal)</b>	<b>Secondary Drivers</b>	<b>Outcome Evaluation Conclusions</b>
1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.	1, 2	<ul style="list-style-type: none"> <li>• Two outcome measures were assessed for Primary Driver 1.</li> <li>• One of the two measures indicated improvement in this driver.</li> <li>• Further improvements are needed in this driver.</li> </ul>
2. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services	2, 3, 4, 5, 6	<ul style="list-style-type: none"> <li>• Four outcome measures were assessed for Primary Driver 2.</li> <li>• Results indicated improvement in this driver.</li> <li>• Additional improvements will assist in further progress in this driver.</li> </ul>
3. Reductions in overdose deaths, particularly those due to opioids	2, 3, 4, 5, 6	<ul style="list-style-type: none"> <li>• Three outcome measures were assessed for Primary Driver 3.</li> <li>• One measure indicated improvement in this driver.</li> <li>• The opioid drug overdose death rates did not indicate improvement.</li> <li>• The findings of the third measure are preliminary and a conclusion could not be drawn.</li> <li>• Further improvements are needed in this driver.</li> </ul>
4. Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs	3, 4, 5, 6	<ul style="list-style-type: none"> <li>• Two outcome measures were assessed for Primary Driver 4.</li> <li>• Results indicated improvement in this driver.</li> <li>• Additional improvements will assist in further progress in this driver.</li> </ul>
5. Improved access to care for physical health conditions among members with OUD or other SUDs	6	<ul style="list-style-type: none"> <li>• Four outcome measures were assessed for Primary Driver 5.</li> <li>• Three measures did not indicate improvement in this driver.</li> <li>• One measure showed improvement that could not be attributed to the demonstration strategies.</li> <li>• Further improvements are needed in this driver.</li> </ul>

### Outcome Evaluation Findings Showing Progress Towards SUD Demonstration Goals

- The rates for the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) measures (Initiation within 14 days, Engagement within 34 days) improved. However, further improvement is needed since rates remained low.
- ED and inpatient stays per 1,000 members decreased for members with an OUD and members with any SUD.
- Rates of the use of opioids at high dosage for persons without cancer declined.
- 30-day readmission rates for SUD and OUD treatments declined.
- Timeliness of Prenatal Care rates improved for the SUD intervention population and for the comparison group.

### Opportunities for Improvement

- Further improvement is needed to reduce use of opioids at high doses among patients without cancer for their pain management treatments.
- The Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) measures (Initiation within 14 days; and Engagement within 34 days) were low, indicating improvements are needed.

- Improvement in care coordination to assist members with SUD in receiving appropriate services for prevention and treatment of physical health conditions is needed.

### Recommendations

- Strategies should be identified and implemented to help ensure members are aware of primary prevention and availability of treatment.
- Strategies should be identified and implemented to help ensure providers are aware of the SUD demonstration strategies and to identify and address associated provider training and skill building opportunities.
- Strategies should be identified and implemented to improve the use of early intervention services (SBIRT) and outpatient services among members with SUD. The improvement in the appropriate use of these levels of care will assist in reducing the burden on providers and facilities providing higher levels of care.
- Address barriers and challenges encountered by the members with SUD for engaging in the needed SUD treatment. Enhance action steps to improve availability of supportive services, such as peer support services, coordination of care for ensuring regular follow-up visits with SUD care providers, and provider trainings to assist members with SUD to engage in receiving needed SUD treatment.
- Review and improve the steps applied by the three MCOs to ensure all members with an SUD diagnosis receive an HRA and Needs Assessment, along with a PCSP and coordinated care, as appropriate. Application of the Service Coordination Strategy for members with an SUD diagnosis will help ensure coordination of care for co-occurring physical and mental health conditions.

### **Evaluation KanCare 2.0 Hypothesis 4**

It was not clear how many IMDs are currently providing SUD treatment services to the KanCare members. The number of admissions with SUD treatment services in IMDs and average length of stay for SUD treatment services within IMDs did not show improvements from 2019 to 2021.

### Opportunities for Improvement

- The information regarding the total number of IMDs in State providing SUD services to KanCare members is not readily available.

### Recommendations

- Insert and maintain an IMD designation flag in the provider tables of the Kansas Modular Medicaid System.
- Review and address the barriers encountered by the IMDs and the members in provision and utilization of SUD treatment services through IMDs.

### **Evaluation of Cost Measures**

Based on paid claims, the SUD demonstration has maintained budget neutrality in the first three years. KFMC is working with KDADS to further identify the administrative costs that could be included in the evaluation of the cost measures. The findings of the evaluation will be included in the summative evaluation of the SUD demonstration.

## ***Interpretations, Policy Implications, and Interactions with Other State Initiatives***

KFMC will address the policy implications and interactions with other state initiatives in the summative SUD Demonstration evaluation. For this interim evaluation, the following interpretations could be made.

- It is not yet known how much the COVID-19 pandemic will influence the impact of the SUD Demonstration 2.0 program. It will take more years of data to assess the impact of the program, overall, outside of the context of the pandemic.
- It is difficult to interpret the interactions with other Medicaid and State programs due to the pandemic, as well. SUD Demonstration activities were drastically affected during the onset of the pandemic. The MCOs were instructed to pause many initiatives with members and providers in order to address the public health emergency.

## ***Lessons Learned and Recommendations for State***

Lessons learned and recommendations for other State Medicaid agencies will be further addressed in the summative SUD Demonstration evaluation report.

End of written report

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# ***Appendix A***

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***KanCare 2.0 Interim Evaluation Report  
Evaluation of the State of Kansas Medicaid  
Section 1115(a) Demonstration  
Substance Use Disorder  
Reporting Period – January 2019 – October 2021***

**List of Abbreviations and Acronyms**

<b>List of Abbreviations and Acronyms</b>	
Abbreviation/Acronym	Description
<b>AAP</b>	Adults’ Access to Preventive/Ambulatory Health Services
<b>ADV</b>	Annual Dental Visit
<b>ASAM</b>	American Society of Addiction Medicine
<b>AWC</b>	Adolescent Well-Care Visit
<b>BH</b>	Behavioral Health
<b>CHIP</b>	Children’s Health Insurance Program
<b>CMS</b>	Centers for Medicare & Medicaid Services
<b>CY</b>	Calendar Year
<b>ED</b>	Emergency Department
<b>EQRO</b>	External Quality Review Organization
<b>FUA</b>	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence
<b>FUH</b>	Follow-Up After Hospitalization for Mental Illness
<b>FUI</b>	Follow-Up After High-Intensity Care for SUD
<b>HCBS</b>	Home and Community Based Services
<b>HEDIS</b>	Healthcare Effectiveness Data and Information Set
<b>ICD-10-CM</b>	International Classification of Diseases, Tenth Revision, Clinical Modification
<b>IET</b>	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
<b>IMDs</b>	Institutions for Mental Diseases
<b>ITS</b>	Interrupted Time Series
<b>KDADS</b>	Kansas Department of Aging and Disability Services
<b>KDHE-DHCF</b>	Kansas Department of Health and Environment, Division of Health Care Finance
<b>KFMC</b>	KFMC Health Improvement Partners (the EQRO)
<b>KMAP</b>	Kansas Medical Assistance Program
<b>MAT</b>	Medication Assisted Treatment
<b>MCO</b>	Managed Care Organization
<b>MMIS</b>	Medicaid Management Information System
<b>MY</b>	Measurement Year
<b>NCQA</b>	National Committee for Quality Assurance
<b>NQF</b>	National Quality Forum
<b>OUD</b>	Opioid Use Disorder
<b>PCSP</b>	Person-Centered Service Plan
<b>PH</b>	Physical Health
<b>POD</b>	Continuity of Pharmacotherapy for OUD
<b>PPC</b>	Prenatal and Postpartum Care
<b>QC</b>	Quality Compass

<b>List of Abbreviations and Acronyms</b>	
<b>Abbreviation/Acronym</b>	<b>Description</b>
<b>RFR</b>	Reduction in the Failure Rate
<b>SBIRT</b>	Screening, Brief Intervention, and Referral to Treatment
<b>SUD</b>	Substance Use Disorder
<b>SUPPORT Act</b>	Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities
<b>\$MPM</b>	Dollars per Member per Month

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# ***Attachment***

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***KanCare 2.0 Interim Evaluation Report  
Evaluation of the State of Kansas Medicaid  
Section 1115(a) Demonstration  
Substance Use Disorder  
Reporting Period – January 2019 – October 2021***

**SUD Evaluation Design**

**KanCare 2.0  
Section 1115  
Substance Use  
Disorder  
Demonstration  
Evaluation Design**

Revised per CMS Feedback

May 22, 2020

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## A. General Background Information

The State of Kansas submitted the KanCare 2.0 Section 1115 Substance Use Disorder (SUD) Demonstration Implementation Plan (“Implementation Plan”) to the Centers for Medicare & Medicaid Services (CMS) on June 14, 2019.<sup>1</sup> CMS approved the Implementation Plan on August 20, 2019, for the period of January 1, 2019 through December 31, 2023.<sup>2</sup>

The Implementation Plan is in alignment with the goals and objectives of the state’s mandatory Medicaid managed care program: *KanCare*. The Implementation Plan outlines the State’s strategy to provide a full continuum of services for SUD treatment to KanCare members. The KanCare program was implemented January 1, 2013, under authority of a waiver through Section 1115 of the Social Security Act. The initial demonstration was approved for five years and CMS approved a one-year extension on October 13, 2017. The State submitted the Section 1115 demonstration renewal application for the KanCare program, titled “KanCare 2.0,” in December 2018.<sup>1</sup> CMS approved the renewal of the KanCare 2.0 demonstration for the period of January 1, 2019 through December 31, 2023.<sup>3</sup> KanCare 2.0, an integrated managed care program, serves populations covered by the Kansas Medicaid and Children’s Health Insurance Programs (CHIP) through a coordinated approach. KanCare 2.0 is designed to provide efficient and effective health care services and to ensure coordination of care and integration of physical health (PH) and behavioral health (BH) services and Home and Community Based Services (HCBS). KanCare operates concurrently with the State’s section 1915(c) HCBS waivers and together provides the authority necessary for the State to require enrollment of almost all Medicaid members (including the aged, people with disabilities, and those with dual Medicare-Medicaid eligibility) across Kansas into a managed care delivery system to receive state plan and waiver services.<sup>3</sup>

KanCare 2.0 provides access to all critical levels of care for SUD and opioid use disorder (OUD).<sup>1,3</sup> The State of Kansas contracts with three statewide managed care organizations (MCOs) to provide access to a range of services across much of the American Society of Addiction Medicine (ASAM) levels of care. The KanCare criteria for treatment are a fidelity-based adaptation of the ASAM Patient Placement Criteria. The Kansas Department for Aging and Disability Services (KDADS) provides required licenses to KanCare-enrolled SUD treatment providers. KanCare 2.0 delivers the outpatient benefits pursuant to the service requirements in the Kansas Medicaid State Plan.<sup>1</sup> The State Plan requires the provision of inpatient and detoxification (withdrawal management) services in State-certified facilities. The spectrum of care – which includes outpatient treatment, peer recovery support, intensive outpatient services, medication-assisted treatment (MAT), intensive inpatient services, withdrawal management, and residential treatment – is provided to eligible Medicaid and CHIP recipients who need SUD or OUD treatment.<sup>1</sup> MCO network providers include specialty providers such as designated women’s treatment programs, which offer prenatal services for women and children. KanCare 2.0 requires the provision of person-centered case management, as a one-on-one goal-directed service for individuals with a SUD, to assist individuals in obtaining access to needed family, legal, medical, employment, educational, psychiatric, and other services. For individuals served by an MCO, this service must be a part of the treatment plan developed and determined medically necessary by the MCO.<sup>3</sup> Additionally, KanCare will cover methadone for MAT as required by the SUPPORT Act during the 2020, though coverage was explored in 2019. Through the Implementation Plan, Kansas will amend state licensing standards to include the requirement that all inpatient residential treatment centers, including all those currently excluded as Institutions for Mental Disease (IMDs), provide access to MAT through direct provision or by coordinated referral and treatment initiation to a MAT provider.<sup>1</sup>

CMS's July 2016 regulation (Federal Rule 42 C.F.R. 438.6(e) as amended) prohibits the State from claiming federal financial participation for a monthly payment made by the State to a member's MCO responsible for all care of the member when the member's stay in an IMD is longer than 15 days during any given month. This exclusion causes a loss of Medicaid coverage for members requiring inpatient psychiatric care and limits provider innovation.<sup>3</sup> In its renewal application for KanCare 2.0, the State requested and received approval from CMS for a waiver of the authority to provide coverage under KanCare 2.0 for otherwise-covered services provided to Medicaid-eligible individuals aged 21 through 64 who are enrolled in a Medicaid MCO and who are receiving services in a publicly-owned or non-public IMD.<sup>3,4</sup> This approval will enable the State of Kansas to better address OUD and other SUDs and will assist the SUD program to improve access to high-quality addiction services that are critical to addressing SUD in the state. Under this program, all Medicaid members will continue to have access to all current mental health and SUD benefits. In addition, all members ages 19 through 64 will have access to additional covered services, authorized under section 1115(a)(2) of the Social Security Act, including SUD treatment services provided to individuals with SUD who are short-term residents in residential treatment facilities that meet the definition of an IMD. These services would otherwise be excluded from federal reimbursement due to the statutory restrictions on coverage of services provided in an IMD setting.<sup>3,4</sup>

### KanCare 2.0 Section 1115 SUD Demonstration Goals

Kansas will use the 1115 demonstration authority to pursue the following goals to improve access to and quality of treatment for KanCare 2.0 program members with SUD:

1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.
2. Reduced utilization of emergency departments (EDs) and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.
3. Reduction in overdose deaths, particularly those due to opioids.
4. Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.
5. Improved access to care for physical health conditions among members with OUD or other SUDs.

## B. Evaluation Questions and Hypotheses

### KanCare 2.0 Section 1115 SUD Demonstration Driver Diagram

The following driver diagram for the overall SUD demonstration (Figure B-1) shows the relationship between the demonstration's purpose, the primary drivers that contribute directly to achieve the purpose, and the secondary drivers necessary to achieve the primary drivers.

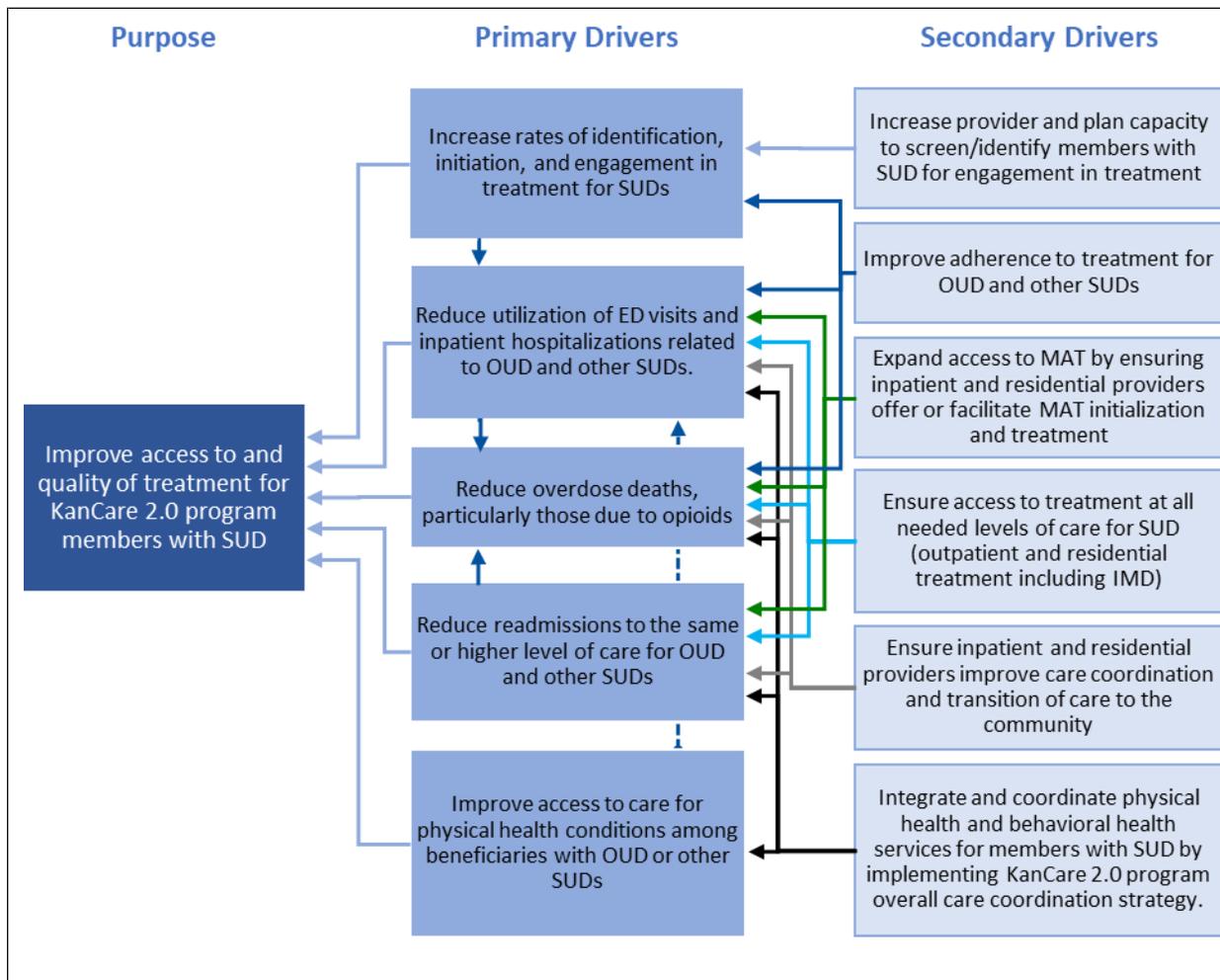


Figure B-1. KanCare 2.0 Section 1115 SUD Demonstration Driver Diagram

### KanCare 2.0 Section 1115 SUD Demonstration Goals, Evaluation Questions and Hypotheses

As the focus of the KanCare 2.0 Section 1115 SUD Demonstration evaluation is to examine whether the demonstration achieved its goals, the following proposed evaluation questions are designed in alignment with the five goals and related hypotheses (Table B-1). This evaluation is in accordance with the CMS document, “SUD, Section 1115 Demonstration Evaluation Design, Technical Assistance,” provided on March 6, 2019.<sup>5</sup>

## KanCare 2.0 Section 1115 Substance Use Disorder Demonstration Evaluation Design

Table B-1. KanCare 2.0 Section 1115 SUD Demonstration Goals, Evaluation Questions, and Hypotheses		
Goals	Evaluation Questions	Hypotheses
1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.	1. Does the demonstration increase access to and utilization of SUD treatment services?	1. The demonstration will increase the percentage of members who are referred and engaged in treatment for SUDs.
2. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.	2. Does the demonstration decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population?	2. The demonstration will decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population.
3. Reductions in overdose deaths, particularly those due to opioids.	3. Are rates of opioid-related overdose deaths impacted by the demonstration?	3. The demonstration will decrease the rate of overdose deaths due to opioids.
4. Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.	4. Do enrollees receiving SUD services experience reduction in readmissions to the same or higher level of care for OUD and other SUDs?	4. Among members receiving care for SUD, the demonstration will reduce readmissions to SUD treatment.
5. Improved access to care for physical health conditions among members with OUD or other SUDs.	5. Do enrollees receiving SUD services experience improved access to care for physical health conditions?	5. The demonstration will increase the percentage of members with SUD who access care for physical health conditions.

### [KanCare 2.0 Demonstration Hypothesis 4 \(associated with SUD Demonstration Evaluation Design Question 1\)](#)

Within the CMS' November 18, 2019 review of the Kansas KanCare 2.0 Section 1115 Demonstration Evaluation Design, CMS noted that removing payment barriers for services provided in IMDs for KanCare members was a strategy in both the KanCare 2.0 Demonstration and SUD Demonstration.<sup>6</sup> To avoid duplicating evaluation for the activity, CMS recommended that the State remove evaluation of Hypothesis 4 and related questions from that evaluation design and address those components within the evaluation of the SUD Demonstration. Thus, the KanCare 2.0 Demonstration Hypothesis 4 has been reproduced within this document (see Table B-2 and Table B-15 and Subsection C.f).

Table B-2. KanCare 2.0 Section 1115 Demonstration Hypothesis 4 and Evaluation Question	
KanCare 2.0 Demonstration Hypothesis 4	Evaluation Question for KanCare 2.0 Demonstration Hypothesis 4
Removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members will result in improved member access to substance use disorder (SUD) treatment services.	Did removing payment barriers for services provided in IMDs for KanCare members improve member access to SUD treatment services?

This evaluation question corresponds to the SUD Demonstration Evaluation Question 1, “Does the demonstration increase access to and utilization of SUD treatment services?”

### KanCare 2.0 Section 1115 SUD Demonstration Process and Outcome Summary

As shown in the driver diagram for the overall SUD Demonstration (Figure B-1, above), the five *primary drivers* and six *secondary drivers* support the hypotheses for the five evaluation questions to the performance of the SUD Demonstration. An additional question related to KanCare 2.0 Demonstration Hypothesis 4, as a part of the first evaluation question, will also be examined within the SUD Demonstration evaluation. The hypotheses for the five SUD Demonstration evaluation questions, as well as the evaluation question for KanCare 2.0 Demonstration Hypothesis 4, will be assessed according to both processes and outcomes of the SUD Demonstration. Measures which may be investigated for inclusion of comparison groups are noted as ‘candidate measures’ within Analytic Approach. The SUD Demonstration evaluation questions and hypotheses are matched to their respective drivers and measure details within the following tables:

- Tables B-3 to B-7 provide information on the *outcome evaluation component* of the SUD Demonstration Evaluation Design according to the five primary drivers;
- Tables B-8 to B-14 provide information on the *process evaluation component* of the SUD Demonstration Evaluation Design according to the six secondary drivers; and
- Table B-15 provides information specific to *KanCare 2.0 Demonstration Hypothesis 4*.

#### Outcome Evaluation – Primary Drivers

<b>Table B-3. Summary of Measures and Analytic Approach for Primary Driver 1 (Outcome Evaluation)</b>					
<b>Demonstration Goal 1: Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.</b>					
<b>Evaluation Question 1: Does the demonstration increase access to and utilization of SUD treatment services?</b>					
<b>Evaluation Hypothesis 1: The demonstration will increase the percentage of members who are referred and engaged in treatment for SUDs.</b>					
<b>Measure Description</b>	<b>Steward</b>	<b>Denominator</b>	<b>Numerator</b>	<b>Data Source</b>	<b>Analytic Approach</b>
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NQF #0004 NCQA	<b>Initiation:</b> Members who were diagnosed with a new episode of alcohol or drug dependency during the first 10½ months of the measurement year	<b>Initiation:</b> Number of members who began initiation of treatment through an inpatient admission, residential, outpatient visits, intensive outpatient encounter, or partial hospitalization within 14 days of the index episode start date	HEDIS data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel $\chi^2$ )
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NQF #0004 NCQA	<b>Engagement:</b> Members who were diagnosed with a new episode of alcohol or drug dependency during the first 10½ months of the measurement year	<b>Engagement:</b> Initiation of treatment and two or more engagement events (inpatient admissions, residential, outpatient visits, intensive outpatient encounters or partial hospitalizations) with any alcohol or drug diagnosis within 34 days after the initiation event	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis

Table B-4. Summary of Measures and Analytic Approach for Primary Driver 2 ( <i>Outcome Evaluation</i> )					
<p><b>Demonstration Goal 2:</b> <i>Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.</i></p> <p><b>Evaluation Question 2:</b> <i>Does the demonstration decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population?</i></p> <p><b>Evaluation Hypothesis 2:</b> <i>The demonstration will decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population.</i></p>					
Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
ED utilization for SUD per 1,000 Medicaid beneficiaries (CMS Metric #23)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of ED visits for SUD during the measurement period	MMIS Encounter data from MCOs; State Medicaid Eligibility and Enrollment data	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel $\chi^2$ )
ED utilization for OUD per 1,000 Medicaid beneficiaries (CMS Metric #23, OUD stratum)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of ED visits for OUD during the measurement period.	Encounter, eligibility, and enrollment data	Descriptive statistics; ITS design; Trend analysis
Inpatient stays for SUD per 1,000 Medicaid beneficiaries (CMS Metric #24)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of inpatient discharges related to a SUD stay during the measurement period.	Encounter, eligibility, and enrollment data	Descriptive statistics; ITS design; Trend analysis; <i>candidate for block grant comparison</i>
Inpatient stays for OUD per 1,000 Medicaid beneficiaries (CMS Metric #24, OUD stratum)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of inpatient discharges related to an OUD stay during the measurement period.	Encounter, eligibility, and enrollment data	Descriptive statistics; ITS design; Trend analysis; <i>candidate for block grant comparison</i>

## KanCare 2.0 Section 1115 Substance Use Disorder Demonstration Evaluation Design

Table B-5. Summary of Measures and Analytic Approach for Primary Driver 3 ( <i>Outcome Evaluation</i> )					
<b>Demonstration Goal 3:</b> <i>Reduction in overdose deaths, particularly those due to opioids.</i>					
<b>Evaluation Question 3:</b> <i>Are rates of opioid-related overdose deaths impacted by the demonstration?</i>					
<b>Evaluation Hypothesis 3:</b> <i>The demonstration will decrease the rate of overdose deaths due to opioids.</i>					
Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Opioid Drug Overdose Deaths. (CMS Metric #27, OUD Stratum)	None	Number of adult beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	Number of overdose deaths due to Opioids among eligible beneficiaries	Mortality data (Vital Statistics); State Medicaid Eligibility and Enrollment data	Descriptive statistics; Trend analysis via Mantel-Haenszel (MH) chi-square test or Fisher’s Exact test for comparison of percentages for final year (2022) and baseline year (2019).
Use of Opioids at High Dosage in Persons without Cancer per 1,000 Medicaid beneficiaries. (CMS Metric #18)	NQF #2940 (Adult Core Set) PQA NCQA	Number of adult beneficiaries without cancer divided by 1,000. <b>Note:</b> Hospice patients will be excluded.	Number of beneficiaries with opioid prescription claims with daily dosage greater than 120 morphine milligram equivalents for 90 consecutive days or longer.	MMIS Encounter data from MCOs; HEDIS data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel $\chi^2$ )
Concurrent use of opioids and benzodiazepines per 1,000 Medicaid beneficiaries. (CMS Metric #21)	PQA (Adult Core Set)	Number of adult beneficiaries without cancer divided by 1,000. <b>Note:</b> Excludes patients in hospice care and those with cancer.	Number of beneficiaries with concurrent use of prescription opioids and benzodiazepines for at least 30 days	MMIS Encounter data from MCOs	Descriptive statistics; Trend analysis via Mantel-Haenszel (MH) chi-square test or Fisher’s Exact test for comparison of percentages for final year (2023) and baseline year (2018).

<b>Table B-6. Summary of Measures and Analytic Approach for Primary Driver 4 (Outcome Evaluation)</b>					
<b>Demonstration Goal 4:</b> <i>Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.</i>					
<b>Evaluation Question 4:</b> <i>Do enrollees receiving SUD services experience reduction in readmissions to the same or higher level of care for OUD and other SUDs?</i>					
<b>Evaluation Hypothesis 4:</b> <i>Among members receiving care for SUD, the demonstration will reduce readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.</i>					
<b>Measure Description</b>	<b>Steward</b>	<b>Denominator</b>	<b>Numerator</b>	<b>Data Source</b>	<b>Analytic Approach</b>
30-Day Readmission for SUD treatment	None	Number of discharges from a residential or inpatient facility for SUD treatment.	Number of discharges with a subsequent admission to a residential or inpatient facility for SUD treatment at the same or higher level of care within 30 days (i.e., inpatient-to-inpatient, inpatient-to-residential, and residential-to-residential)	MMIS Encounter data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel $\chi^2$ ); <i>candidate for block grant comparison</i>
30-Day Readmission for SUD treatment (among discharges from a residential or inpatient facility for OUD treatment)	None	Number of discharges from a residential or inpatient facility for OUD treatment.	Number of discharges with a subsequent admission to a residential or inpatient facility for SUD treatment at the same or higher level of care within 30 days (i.e., inpatient-to-inpatient, inpatient-to-residential, and residential-to-residential)	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis; <i>candidate for block grant comparison</i>

## KanCare 2.0 Section 1115 Substance Use Disorder Demonstration Evaluation Design

<b>Table B-7. Summary of Measures and Analytic Approach for Primary Driver 5 (Outcome Evaluation)</b>					
<b>Demonstration Goal 5: Improved access to care for physical health conditions among members with OUD or other SUDs.</b>					
<b>Evaluation Hypothesis 5: The demonstration will increase the percentage of members with SUD who access care for physical health conditions.</b>					
<b>Evaluation Question: Do enrollees receiving SUD services experience improved access to care for physical health conditions?</b>					
Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Annual Dental Visits (ADV) (SUD stratum).	NCQA	Eligible beneficiaries 2–20 years of age with SUD diagnosis enrolled in Medicaid	Number of members 2–20 years of age who had one or more dental visits with a dental practitioner during the measurement year.	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis
Adults’ Access to Preventive/ Ambulatory Health Services (AAP) (SUD stratum).	NCQA	Eligible beneficiaries 20 years and older with SUD diagnosis enrolled in Medicaid	Number of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis
Adolescent Well-Care Visits (AWC) (SUD stratum).	NCQA	Eligible beneficiaries 12–21 years of age with SUD diagnosis enrolled in Medicaid	Number of members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care (SUD stratum).	NCQA	Number of deliveries with live births for eligible members with SUD diagnosis	Number of deliveries that received a prenatal care visit in first trimester, on or before enrollment start date, or within 42 days of enrollment in the organization.	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis
Prenatal and Postpartum Care (PPC) – Postpartum Care (SUD stratum).	NCQA	Number of deliveries with live births for eligible members with SUD diagnosis	Number of deliveries that had a postpartum visit on or b/w 7 & 84 days after delivery.	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis

Process Evaluation – Secondary Drivers

Table B-8. Summary of Measures and Analytic Approach for Secondary Driver 1 (Process Evaluation)					
Secondary Driver 1 (Related to Goal 1): Increase provider and plan capacity to screen/ identify members with SUD for engagement in treatment					
Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Percentage of physical health and behavioral health service providers that billed SBIRT services.	None	The number of distinct performing provider NPIs on claims. Measured on dental, outpatient and professional claims; see policy for provider types.	The number of distinct performing provider NPIs on claims for <i>Screening, Brief Intervention, and Referral to Treatment</i> (SBIRT) services	MMIS Encounter data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel $\chi^2$ )
Receipt of care for SUD after SBIRT service.	None	Number of beneficiaries who received SBIRT services. (CMS Metric #1)	Number of beneficiaries who received SBIRT services with evidence of SUD service within 60 days after SBIRT service.	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis

Table B-9. Summary of Measures and Analytic Approach for Secondary Driver 2 (Process Evaluation)					
Secondary Driver 2 (Related to Goal 1, Goal 2 and Goal 3): Improve adherence to treatment for OUD and other SUDs					
Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Continuity of Pharmacotherapy for OUD (POD) – (CMS Metric #22).	NCQA	Number of beneficiaries age 18 to 64 with an OUD diagnosis (excluding adults initiating pharmacotherapy after 6/30/20 and those deliberately phased out of MAT prior to the 180 days).	Number of beneficiaries with at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days.	MMIS Encounter data from MCOs; HEDIS data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel $\chi^2$ )
Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA).	NCQA	ED visits for members <del>years of</del> age 13 or older with a principal diagnosis of alcohol or other drug abuse (AOD) or dependence in the measurement year.	A follow-up visit with any practitioner after a principal diagnosis of AOD within 7/30 days of the ED visit.	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis; <i>candidate for block grant comparison</i>
* Service Type Strata: <i>early intervention</i> , e.g., SBIRT (CMS Metric #7); <i>outpatient services</i> (CMS Metric #8); <i>intensive outpatient and partial hospitalization</i> (CMS Metric #9); <i>residential and inpatient services</i> (CMS Metric #10); <i>withdrawal management</i> (CMS Metric #11); <i>medication-assisted treatment (MAT)</i> (CMS Metric #12)					

<b>Table B-9. Summary of Measures and Analytic Approach for Secondary Driver 2 (Process Evaluation) (cont.)</b>					
<b>Secondary Driver 2 (Related to Goal 1, Goal 2 and Goal 3): Improve adherence to treatment for OUD and other SUDs</b>					
<b>Measure Description</b>	<b>Steward</b>	<b>Denominator</b>	<b>Numerator</b>	<b>Data Source</b>	<b>Analytic Approach</b>
Percentage of beneficiaries with SUD who used SUD treatment services during the monthly measurement period, stratified by service type.	None	Number of enrollees with a SUD diagnosis (CMS Metric #3).	Number of beneficiaries with a SUD diagnosis who receive any SUD treatment service (CMS Metric #6). Stratified by service type*	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis
Percentage of beneficiaries with OUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type.	None	Number of enrollees with an OUD diagnosis (CMS Metric #3, OUD stratum).	Number of beneficiaries with an OUD diagnosis who receive any SUD treatment service (CMS Metric #6; OUD stratum). Stratified by service type*	MMIS Encounter data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel $\chi^2$ )
Percentage of beneficiaries with SUD diagnosis who received peer support services during the monthly measurement period	None	Number of enrollees with a SUD diagnosis (CMS Metric #3).	Number of beneficiaries with a SUD diagnosis who receive peer support service (HCPCTS Codes: H0038, H0038 HQ)	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis
* Service Type Strata: <i>early intervention</i> , e.g., SBIRT (CMS Metric #7); <i>outpatient services</i> (CMS Metric #8); <i>intensive outpatient and partial hospitalization</i> (CMS Metric #9); <i>residential and inpatient services</i> (CMS Metric #10); <i>withdrawal management</i> (CMS Metric #11); <i>medication-assisted treatment (MAT)</i> (CMS Metric #12)					

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<b>Table B-10. Summary of Measures and Analytic Approach for Secondary Driver 3 (Process Evaluation)</b>					
<b>Secondary Driver 3 (Related to Goal 2, Goal 3, and Goal 4): Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment.</b>					
<b>Measure Description</b>	<b>Steward</b>	<b>Denominator</b>	<b>Numerator</b>	<b>Data Source</b>	<b>Analytic Approach</b>
Residential OUD discharges with MAT claim	None	Number of residential discharges for SUD treatment with OUD diagnosis.	Number of denominator discharges with MAT claim during the stay or within 15 days of discharge.	MCO Encounter data from MCOs	Descriptive statistics; Trend analysis via Mantel-Haenszel (MH) chi-square test or Fisher’s Exact test for comparison of percentages for final year (2023) and baseline year (2019) ; <i>candidate for block grant or rural/urban comparison</i>
Inpatient OUD discharges with MAT claim	None	Number of inpatient discharges for SUD treatment with OUD diagnosis.	Number of denominator discharges with MAT claim during the stay or within 15 days of discharge.	MCO Encounter data from MCOs	Descriptive statistics; Trend analysis via Mantel-Haenszel (MH) chi-square test or Fisher’s Exact test for comparison of percentages for final year (2023) and baseline year (2019) ; <i>candidate for block grant or rural/urban comparison</i>
Percentage of members with OUD diagnosis who have a MAT claim for OUD during the measurement period	None	Number of members with OUD diagnosis (CMS Metric #3, OUD stratum).	Number of members with a claim for MAT for OUD (CMS Metric #12, OUD stratum).	MMIS Encounter data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis via Mantel-Haenszel (MH) chi-square test; <i>candidate for block grant or rural/urban comparison</i>

Table B-11. Summary of Measures and Analytic Approach for Secondary Driver 4 (Process Evaluation)					
Secondary Driver 4 (Related to Goal 2, Goal 3, and Goal 4): Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD).					
Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Percentage of Medicaid beneficiaries with SUD diagnosis who were treated in an IMD for SUD during the measurement year.	None	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period and/or in the 12 months before the measurement period (CMS Metric #4).	Number of beneficiaries with a claim for residential treatment in an IMD (CMS Metric #5).	MMIS Encounter data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel $\chi^2$ )
Average length of stay for SUD treatment services within IMDs (CMS Metric #36).	None	Total number of discharges from an IMD for beneficiaries with a residential treatment stay for SUD.	Total number of days in an IMD for all beneficiaries with an identified SUD.	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis
Number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members with SUD diagnosis	None	Number of beneficiaries with SUD diagnosis divided by 1,000. (CMS Metric #3)	Total number of beneficiaries in residential and inpatient treatment (refer to CMS Metric #10).	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis; <i>candidate for block grant comparison</i>
Number of beneficiaries in outpatient, intensive outpatient, & partial hospitalization SUD treatment per 1,000 members with SUD diagnosis.	None	Number of beneficiaries with SUD diagnosis divided by 1,000. (CMS Metric #3)	Total number of members in outpatient, intensive outpatient or partial hospitalization treatment (refer to CMS Metrics #8 & #9). <b>Note:</b> Partial hospitalization in KS has same service code as inpatient.	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis; <i>candidate for block grant comparison</i>

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Table B-12. Summary of Measures and Analytic Approach for Secondary Driver 5 (Process Evaluation)					
Secondary Driver 5 (Related to Goal 2, Goal 3, and Goal 4): Ensure inpatient & residential providers improve care coordination & transition of care to the community.					
Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
30-Day Readmission for SUD treatment	None	Number of discharges from a residential or inpatient facility for SUD treatment.	Number of discharges with a subsequent admission to a residential or inpatient facility for SUD treatment at the same or higher level of care within 30 days.	MMIS Encounter data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel $\chi^2$ ); <i>candidate for block grant comparison</i>
ED utilization for SUD per 1,000 beneficiaries (CMS Metric #23)	None	Beneficiaries enrolled for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of ED visits for SUD during the measurement period	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis
ED utilization for OUD per 1,000 beneficiaries (CMS Metric #23, OUD stratum)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of ED visits for OUD during the measurement period.	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis
Inpatient stays for SUD per 1,000 beneficiaries (CMS Metric #24)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of inpatient discharges related to a SUD stay during the measurement period.	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis; <i>candidate for block grant comparison</i>
Inpatient stays for OUD per 1,000 beneficiaries (CMS Metric #24, OUD stratum)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of inpatient discharges related to an OUD stay during the measurement period.	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis; <i>candidate for block grant comparison</i>
Follow-Up After ED Visit for Alcohol and Other Drug Abuse/Dependence (FUA).	NCQA	ED visits for members 13 years or older with a principal diagnosis of alcohol or other drug abuse (AOD) or dependence in the measurement year.	A follow-up visit with any practitioner after a principal diagnosis of AOD within 7/30 days of the ED visit.	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis; <i>candidate for block grant comparison</i>

<b>Table B-13. Summary of Measures and Analytic Approach for Secondary Driver 5 (Process Evaluation)</b>					
<b>Secondary Driver 5 (Related to Goal 2, Goal 3, and Goal 4): Ensure inpatient &amp; residential providers improve care coordination &amp; transition of care to the community</b>					
Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Follow-Up After High-Intensity Care for SUD (FUI)	NCQA	# of inpatient hospitalizations, residential treatment or detoxification visits for a SUD diagnosis among members age 13 or older	# of visits or discharges that result in a follow-up visit or service for SUD within 7/30 days.	HEDIS data from MCOs	Descriptive statistics; Trend analysis; Differences between final and baseline years (Fisher’s Exact or $X^2$ )
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET)	NQF #0004 NCQA	<b>Initiation:</b> See above Table B-3 – Primary Driver, Goal 1. <b>Engagement:</b> See Table B-3 – Primary Driver, Goal 1	<b>Initiation:</b> See Table B-3– Primary Driver 1. <b>Engagement:</b> See Table B-3 – Primary Driver 1.	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis

<b>Table B-14. Summary of Measures and Analytic Approach for Secondary Driver 6 (Process Evaluation)</b>					
<b>Secondary Driver 6 (Related to Goal 2, Goal 3, Goal 4, and Goal 5): Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy.</b>					
Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager.	None	Number of Medicaid beneficiaries with SUD diagnosis	Number of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager.	MCO case management data (available for 2019 onwards)	Descriptive statistics; Trend analysis (Mantel-Haenszel $X^2$ ); Differences between final and baseline years (Fisher’s Exact or $X^2$ )
Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and have service/treatment plan or person-centered service plan (PCSP).	None	Number of Medicaid beneficiaries with SUD diagnosis.	Number of Medicaid Beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and service/treatment plan or PCSP.	MCO case management data (available for 2019 onwards)	Descriptive statistics; Trend analysis

KanCare 2.0 Section 1115 Demonstration Hypothesis 4 Evaluation

Table B-15. Summary of Measures and Analytic Approach for KanCare 2.0 Section 1115 Demonstration Hypothesis 4					
<p><b>KanCare 2.0 Section 1115 Demonstration Hypothesis 4:</b> <i>Removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members will result in improved member access to substance use disorder (SUD) treatment services.</i></p> <p><b>KanCare 2.0 Hypothesis 4 Evaluation Question:</b> <i>Did removing payment barriers for services provided in IMDs for KanCare members improve member access to SUD treatment services?</i></p>					
Performance Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Number of IMDs providing SUD services.	None	NA	Number of IMDs providing SUD services.	Provider Network reports; MMIS Encounter data; Provider licensing data; MCO utilization reports.	Descriptive statistic (count).
Number of geographic locations by region for SUD treatment in IMDs.	None	NA	Number of geographic locations by Kansas Department for Children and Families (DCF) region for SUD treatment in IMDs.	Network reports, encounter data, licensing data, utilization reports	Descriptive statistic (count).
Number of admissions with SUD treatment services in IMDs.	None	NA	Number of admissions with SUD treatment services in IMDs.	Network reports, encounter data, licensing data, utilization reports	Descriptive statistic (count).
Average length of stay for SUD treatment services within IMDs.	None	NA	Average length of stay for SUD treatment services within IMDs.	Network reports, encounter data, licensing data, utilization reports	Descriptive statistic (average).

Where applicable, measures were developed according to recognized measures from sources such as:

- *1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics (“CMS Metrics”)*<sup>7</sup>;
- *Adult Core Set* measures including those endorsed by the National Quality Forum (NQF) and stewarded by the National Committee for Quality Assurance (NCQA), and the Pharmacy Quality Alliance (PQA)<sup>8</sup>; and
- *Healthcare Effectiveness Data and Information Set*<sup>®</sup> (HEDIS) measures.<sup>9</sup>

### C. Evaluation Design Methodologies

The evaluation design methodologies are designed to meet the standards of scientific rigor that will assist in obtaining statistically valid and reliable evaluation results. The focus of the evaluation is to examine the effectiveness of demonstration strategies and policies on achievement of the overall goal of helping Medicaid members with SUD to have improved access to and quality of treatment.

The following sections present an overview of methods and rationale for the Demonstration evaluation, followed by sections detailing evaluation questions, evaluation hypotheses, and strategies for each goal of the Demonstration as well as the KanCare 2.0 Program Hypothesis 4 and the overall cost evaluation. See **Attachment 1- Detailed Design Methodology and Limitations** for additional methods discussions.

#### Evaluation Design Overview

Evaluation of the Demonstration is primarily focused on the subset of KanCare 2.0 members with a SUD diagnosis will be the primary participants (“study population”). In certain cases, members without an

SUD diagnosis may access services (e.g., SBIRT or assessment) and will be included within the target population for certain measures or hypotheses. Due to state-wide implementation of the SUD Demonstration, the evaluation of overall strategies and hypotheses is hindered by the lack of true comparison groups as all KanCare 2.0 members will be eligible for the same benefits. Several potential comparison populations have been identified that may provide additional perspective for certain measures or drivers, such as the Beacon program block grant recipients (external comparison) and an internal comparison of access between rural and urban regions of the state (see Attachment 1). Target and comparison populations for each goal are described within that goal’s evaluation methodology, discussed in the sections below.

The difference-in-differences evaluation design was considered for use with identified internal or external comparison populations but was ultimately determined to be infeasible due to lack of comparability of populations (see Attachment 1). To address those limitations, the **Interrupted Time Series (ITS)** and **One-Group Pretest-Posttest (OGPP)** evaluation designs will be used throughout the majority of the evaluation. The evaluation of KanCare 2.0 Hypothesis 4 focuses on increasing availability of IMD facilities providing SUD services following the removal of the Kansas Medicaid IMD Exclusion. Though, due to changes in data systems, pre-demonstration data will not be available. Therefore, non-experimental methods (descriptive statistics) will be used for conducting the evaluation of KanCare 2.0 Hypothesis 4. Specific to cost analyses, the Kansas Medicaid managed care model hinders the ability to investigate costs with the same precision that would be possible in fee-for-service models due to capitation arrangements. Further discussions on how to best evaluate SUD Demonstration costs will be held to determine alternative approaches such as a “shadow pricing” retrospective cost analysis.

*Interrupted Time Series (ITS) Evaluation Design*

The ITS is performed as a continuous series of measurements on a population based on the variable of interest within a treatment or intervention to determine trends ‘interrupted’ by application of the treatment or intervention at those times. The quasi-experimental ITS evaluation design was selected for Evaluation Hypothesis 1 and the Demonstration Cost Hypothesis, in their entirety, and for subsets of Evaluation Hypotheses 2 through 5. As shown in Figure C-1, below, the two-year baseline measurements will be for years 2017–2018 and the five-year intervention period will span 2019–2023.

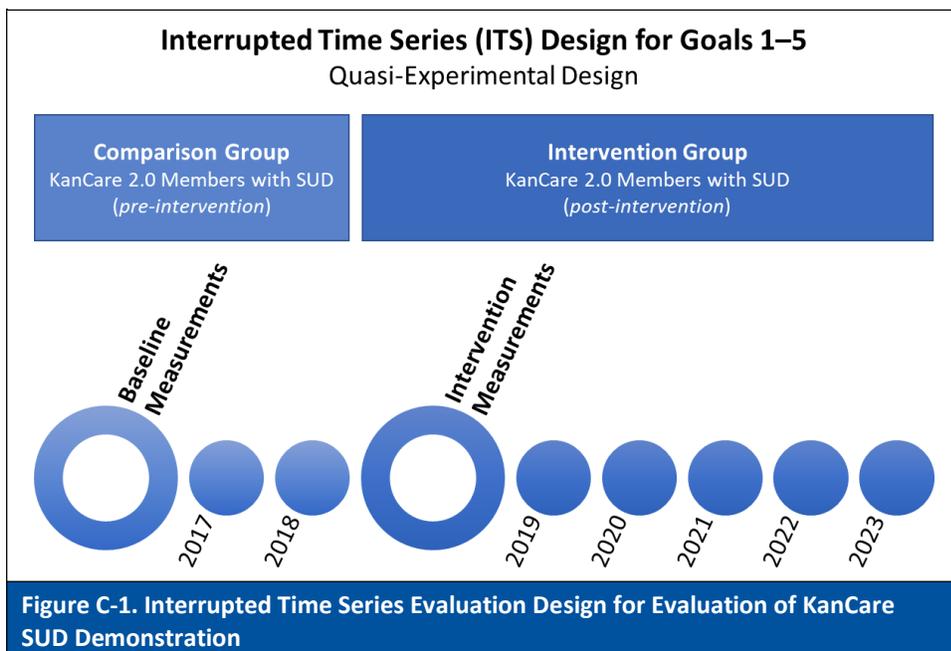


Figure C-1. Interrupted Time Series Evaluation Design for Evaluation of KanCare SUD Demonstration

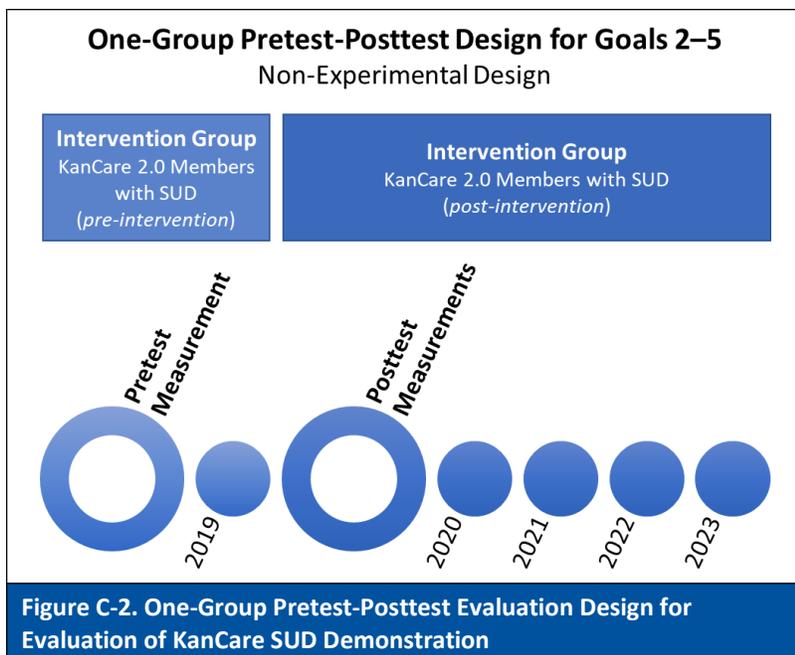
We will estimate ITS models using the following segmented linear regression equation:

$$Y_t = \beta_0 + \beta_1 T + \beta_2 X_t + \beta_3 T X_t$$

Where  $Y_t$  is the outcome at time  $t$ ,  $T$  represents the time elapsed since the start of the program,  $\beta_0$  represents the baseline (where  $T=0$ ),  $X_t$  is a dummy variable indicating the pre-intervention period,  $\beta_1$  represents the increment change per time unit before intervention (i.e., baseline trend),  $\beta_2$  is the level change following the intervention, and  $\beta_3$  indicates the slope change following the program.

*One Group Pretest-Posttest (OGPP) Evaluation Design*

As some demonstration strategies are currently in development (subject to State guidelines and approval) and appropriate comparison groups may not be available, the OGPP non-experimental evaluation design will be used. The OGPP is performed for a single population based on the variable of interest within a treatment or intervention with initial (pre-) and subsequent (post-) measurements. Where possible, the quasi-experimental OGPP with non-equivalent comparison groups will be applied with an appropriate comparison group and pre- and post-intervention data. The OGPP evaluation design was selected to examine the evaluation questions for subsets of Hypotheses 2 through 5. As shown in Figure C-2, below, the one-year baseline pretest measurement will be taken from 2019 and the four-year posttest period will span 2020–2023.



**a. Evaluation Methodology for SUD Demonstration Goal 1**

Demonstration Goal 1

Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.

Evaluation Question for Goal 1

Does the demonstration increase access to and utilization of SUD treatment services?

Evaluation Hypothesis for Goal 1

The demonstration will increase the percentage of members who are referred and engaged in treatment for SUDs.

Demonstration Strategies for Goal 1

**Two strategies** contributing to the primary and secondary drivers for Goal 1 will be implemented over the demonstration period. The strategies include:

- Support the expansion of *Screening, Brief Intervention, and Referral to Treatment* (SBIRT) among physical health and behavioral health service providers to identify members at different risk levels for OUD or other SUDs and provide the appropriate level of referral to SUD providers. This support will be provided by:
  - Increasing training opportunities for the physical health and behavioral health service providers to become credentialed to bill for SBIRT services;
  - Working with the MCOs to expand their network of SBIRT-credentialed providers; and
  - Working with the MCOs to increase the utilization of SBIRT.
- Run a statewide media campaign to increase member and general population awareness of primary prevention and availability of treatment (utilizing funding from the federal State Opioid Response (SOR) grant).

The two strategies described here will contribute to the following two secondary drivers, which in turn will increase the rates of identification, initiation, and engagement in treatment for OUD and other SUDs (Primary Driver 1 for Goal 1):

- Increase provider and plan capacity to screen/ identify members with SUD for engagement in treatment (Secondary Driver 1);
- Improve adherence to treatment for OUD and other SUDs (Secondary Driver 1).

Drivers and Performance Measures for Goal 1

The primary and secondary drivers for Goal 1 and their associated performance measures are shown in Table C-1.

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Table C-1. Drivers and Associated Performance Measures for SUD Demonstration Goal 1	
Primary Driver	Performance Measure
Increase rates of identification, initiation, and engagement in treatment for SUDs	<ul style="list-style-type: none"> <li>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET). (2017–2022)*</li> </ul>
Secondary Drivers	Performance Measures
Increase provider and plan capacity to screen/ identify members with SUD for engagement in treatment.	<ul style="list-style-type: none"> <li>Percentage of physical health and behavioral health service providers that billed <i>Screening, Brief Intervention, and Referral to Treatment</i> (SBIRT) services. (2017–2023)*</li> <li>Receipt of care for SUD and/or OUD after SBIRT service. (2017–2023)*</li> </ul>
Improve adherence to treatment for OUD and other SUDs.	<ul style="list-style-type: none"> <li>Continuity of Pharmacotherapy for OUD (POD). (CMS Metric #22). (2017–2023)*</li> <li>Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2022)*<sup>†</sup></li> <li>Percentage of beneficiaries with OUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023)*<sup>^</sup></li> <li>Percentage of beneficiaries with SUD who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023).*<sup>^</sup></li> <li>Percentage of beneficiaries with SUD diagnosis who used SUD peer support services during the monthly measurement period.*</li> </ul>
<p>* Interrupted Time Series Design will be used for the assessment of the performance measure.</p> <p><sup>^</sup> Service Type Strata: <i>early intervention</i>, e.g., SBIRT (CMS Metric #7); <i>outpatient services</i> (CMS Metric #8); <i>intensive outpatient and partial hospitalization</i> (CMS Metric #9); <i>residential and inpatient services</i> (CMS Metric #10); <i>withdrawal management</i> (CMS Metric #11); <i>medication-assisted treatment (MAT)</i> (CMS Metric #12)</p> <p><sup>†</sup> Candidate measure to investigate feasibility of comparison group (Beacon block grant recipients).</p>	

All eight performance measures will be examined using the interrupted time series design. The post-intervention observation period for six performance measures will be 2019 through 2023. The remaining two performance measures are based on HEDIS data (IET and FUA). HEDIS data for 2022 will be available in the final year of the demonstration period (2023); therefore, the post-intervention observation period for the performance measures based on HEDIS data (IET and FUA) will be 2019 through 2022. The FUA measure may be investigated for feasibility of comparison group analysis (Beacon block grant recipients).

## b. Evaluation Methodology for SUD Demonstration Goal 2:

### Demonstration Goal 2

Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.

### Evaluation Question for Goal 2

Does the demonstration decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population?

### Evaluation Hypothesis for Goal 2

The demonstration will decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population.

### Demonstration Strategies for Goal 2

**Four strategies** contributing to the Primary and Secondary Drivers for Goal 2 will be implemented over the demonstration period. The strategies include:

- The five Community Crisis Centers (CCCs) across the state became operational in 2019 and provide support and stabilization services for Kansans in crisis and engage with them in community-based services. Early indicators show the Crisis Centers to be effective in diverting members from admission to hospitals and emergency rooms. Groundbreaking on a sixth CCC occurred in late 2019 and it is expected that more CCCs will become operational.
- Expansion of medication-assisted treatment (MAT). This includes:
  - Changing licensing requirements for all residential providers
  - Coverage of methadone maintenance by Medicaid.
- Expand of the use of peer-supported rehabilitation and recovery services (“peer support services”). This includes:
  - Increasing the number of peer mentors credentialed
  - Increasing utilization of peer support services.
- Improve transitions between levels of care related to SUD treatment.

The four strategies described here will contribute to the following five secondary drivers, which in turn will reduce the utilization of preventable or medically inappropriate emergency department visits and inpatient hospital admissions related OUD and other SUD (Primary Driver 2 for Goal 2):

- Improve adherence to treatment for OUD and other SUDs (Secondary Driver 2);
- Expand access to MAT by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment for those who meet the need criteria and choose treatment (Secondary Driver 3);
- Ensure access to services at all needed levels of care for SUD, including outpatient treatment (group, individual, and/or family counseling, community psychiatric support, crisis intervention), residential treatment (including coverage of SUD treatment in IMDs), and peer support services (Secondary Driver 4);
- Ensure inpatient and residential providers improve care coordination and transition of care to the community (Secondary Driver 5); and
- Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy (Secondary Driver 6).

### Drivers and Performance Measures for Goal 2

The evaluation of this goal involves assessment of twenty-five performance measures for its primary and secondary drivers. Interrupted time series evaluation design will be used to evaluate twenty-two outcome and process measures related to the primary and secondary drivers, whereas one-group pretest–posttest design will be used to examine three process measures related to its secondary drivers. The primary and secondary drivers for Goal 2 and their associated performance measures are shown in Table C-2.

Table C-2. Drivers and Associated Performance Measures for SUD Demonstration Goal 2	
Primary Driver	Performance Measures
Reduce utilization of ED visits and inpatient hospitalizations related to OUD and other SUDs.	<ul style="list-style-type: none"> <li>• ED utilization for SUD per 1,000 Medicaid beneficiaries. (CMS Metric #23; 2017–2023)*</li> <li>• ED utilization for OUD per 1,000 Medicaid beneficiaries. (CMS Metric #23, OUD stratum; 2017–2013)*</li> <li>• Inpatient stays for SUD per 1,000 Medicaid beneficiaries. (CMS Metric #24; 2017–2023)*^</li> <li>• Inpatient stays for OUD per 1,000 Medicaid beneficiaries. (CMS Metric #24, OUD stratum; 2017–2023)*^</li> </ul>
Secondary Drivers	Performance Measures
Improve adherence to treatment for OUD and other SUDs.	<ul style="list-style-type: none"> <li>• Continuity of Pharmacotherapy for OUD (POD). (CMS Metric#22; 2017–2023)*</li> <li>• Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2022)*^</li> <li>• Percentage of beneficiaries with OUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023).*<sup>†</sup></li> <li>• Percentage of beneficiaries with SUD who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023)*<sup>†</sup></li> <li>• Percentage of beneficiaries with SUD diagnosis who used SUD peer support services during the monthly measurement period. (2017–2023)*</li> </ul>
Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment.	<ul style="list-style-type: none"> <li>• Residential OUD discharges with MAT claim. (2017–2023)^‡</li> <li>• Inpatient OUD discharges with MAT claim. (2017–2023)^‡</li> <li>• Percentage of members with OUD diagnosis who have a MAT claim for OUD during the measurement period. (2017–2023)*^</li> </ul>
Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD).	<ul style="list-style-type: none"> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who were treated in an IMD for SUD during the measurement year. (2017–2023)*</li> <li>• Average length of stay for SUD treatment services within IMDs. (CMS Metric #36; 2017–2023)*</li> <li>• Number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members with SUD diagnosis. (2017–2023)*</li> <li>• Number of outpatient, intensive outpatient, &amp; partial hospitalization days of SUD treatment per 1,000 members with SUD diagnosis.(2017–2023)* <b>Note: Partial hospitalization in KS has same service code as inpatient.</b></li> </ul>
<p>* Interrupted Time Series Design will be used for the assessment of the performance measure.                      ^ Candidate measure to investigate feasibility of comparison group (Beacon block grant recipients, rural/urban comparison).                      † Service Type Strata: <i>early intervention</i>, e.g., SBIRT (CMS Metric #7); <i>outpatient services</i> (CMS Metric #8); <i>intensive outpatient and partial hospitalization</i> (CMS Metric #9); <i>residential and inpatient services</i> (CMS Metric #10); <i>withdrawal management</i> (CMS Metric #11); <i>medication-assisted treatment (MAT)</i> (CMS Metric #12).                      ‡ One-group Pretest–Posttest Design will be used for the assessment of the performance measure.</p>	

Table C-2. Drivers and Associated Performance Measures for SUD Demonstration Goal 2 (cont.)	
Secondary Driver	Performance Measures
Ensure inpatient and residential providers improve care coordination and transition of care to the community.	<ul style="list-style-type: none"> <li>• 30-Day Readmission for SUD treatment. (2017–2023)*^</li> <li>• ED utilization for SUD per 1,000 beneficiaries. (CMS Metric #23; 2017–2023)*</li> <li>• ED utilization for OUD per 1,000 beneficiaries. (CMS Metric #23, OUD stratum; 2017–2023)*</li> <li>• Inpatient stays for SUD per 1,000 beneficiaries. (CMS Metric #24; 2017–2023)*^</li> <li>• Inpatient stays for OUD per 1,000 beneficiaries. (CMS Metric #24, OUD stratum; 2017–2023)*^</li> <li>• Follow-Up After ED Visit for Alcohol and Other Drug Abuse/ Dependence (FUA). (2017–2022)*^</li> <li>• Initiation &amp; Engagement of Alcohol &amp; Other Drug Dependence Treatment (IET). (2017–2022)*</li> <li>• Follow-Up After High-Intensity Care for SUD (FUI). (2019–2022)‡</li> </ul>
Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy	<ul style="list-style-type: none"> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager (2019–2023)‡</li> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and have a service/treatment plan or person-centered service plan (PCSP). (2019–2023)‡</li> </ul>
<p>* Interrupted Time Series Design will be used for the assessment of the performance measure.                      ^ Candidate measure to investigate feasibility of comparison group (Beacon block grant recipients, rural/urban comparison).                      † Service Type Strata: <i>early intervention</i>, e.g., SBIRT (CMS Metric #7); <i>outpatient services</i> (CMS Metric #8); <i>intensive outpatient and partial hospitalization</i> (CMS Metric #9); <i>residential and inpatient services</i> (CMS Metric #10); <i>withdrawal management</i> (CMS Metric #11); <i>medication-assisted treatment (MAT)</i> (CMS Metric #12).                      ‡ One-group Pretest–Posttest Design will be used for the assessment of the performance measure.</p>	

Twenty-two performance measures will be examined using the interrupted time series design. The post-intervention observation period for nineteen performance measures will be 2019 through 2023. The remaining three performance measures are based on HEDIS data (FUA and IET). HEDIS data for 2022 will be available in the final year of the demonstration period (2023); therefore, the post-intervention observation period for the performance measures based on HEDIS data (FUA and IET) will be 2019 through 2022.

Three process measures will be examined using the one group pretest–posttest design. The post-intervention observation period for two performance measures will be 2019 through 2023. The remaining one performance measure is based on HEDIS data (FUI). HEDIS data for 2022 will be available in the final year of the demonstration period (2023); therefore, the post-intervention observation period for this performance measure (FUI) will be 2019 through 2022.

Several measures may be investigated for feasibility of comparison group analysis such as readmission and inpatient stays (Beacon block grant recipients) and MAT claim measures (Beacon recipients and rural/urban comparisons).

### c. Evaluation Methodology for SUD Demonstration Goal 3:

#### Demonstration Goal 3

Reduction in overdose deaths, particularly those due to opioids.

### Evaluation Question for Goal 3

Are rates of opioid-related overdose deaths impacted by the demonstration?

### Evaluation Hypothesis for Goal 3

The demonstration will decrease the rate of overdose deaths due to opioids.

### Demonstration Strategies for Goal 3

**Two strategies** contributing to the primary and secondary drivers for Goal 3 will be implemented over the demonstration. The strategies include:

- Expansion of medication-assisted treatment (MAT). This includes:
  - Changing licensing requirements for all residential providers; and
  - Coverage of methadone maintenance by Medicaid.
- Care coordination requirements by the MCOs to improve transitions to the community and participation in community-based recovery services.

These two strategies will contribute to the following three secondary drivers, which in turn will lead to the reduction in overdose deaths, particularly those due to opioids (Primary Driver 3 for Goal 3):

- Improve adherence to treatment for OUD and other SUDs (Secondary Driver 2);
- Expand access to MAT by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment for those who meet the need criteria and choose treatment (Secondary Driver 3);
- Ensure inpatient and residential providers improve care coordination and transition of care to the community (Secondary Driver 5).

In addition to the above-mentioned secondary drivers and strategies, the following secondary drivers and their related strategies (described for Goal 2) will also contribute in achieving the Goal 3.

- Ensure access to services at all needed levels of care for SUD, including outpatient treatment (group, individual, and/or family counseling, community psychiatric support, crisis intervention), residential treatment (including coverage of SUD treatment in IMDs), and peer support services (Secondary Driver 3);
- Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy (Secondary Driver 5).

### Drivers and Performance Measures for Goal 3

The evaluation of this goal involves assessment of eighteen performance measures for its primary and secondary drivers. Interrupted time series evaluation design will be used to evaluate fifteen outcome and process measures related to the primary and secondary drivers, whereas the one-group pretest–posttest design will be used to examine three outcome and process measures related to Goal 3’s primary and secondary drivers. The primary and secondary drivers for Goal 3 and their associated performance measures are shown in Table C-3.

Table C-3. Drivers and Associated Performance Measures for SUD Demonstration Goal 3	
Primary Driver	Performance Measures
Reduce overdose deaths, especially those due to opioids.	<ul style="list-style-type: none"> <li>➔ Opioid Drug Overdose Deaths. (CMS Metric #27, OUD Stratum; 2019–2022)*</li> <li>• Use of Opioids at High Dosage in Persons without Cancer. (CMS Metric #18; 2017–2023)^</li> <li>• Concurrent Use of Opioids and Benzodiazepines. (CMS Metric #21; 2018–2023)*</li> </ul>
Secondary Drivers	Performance Measures
Improve adherence to treatment for OUD and other SUDs.	<ul style="list-style-type: none"> <li>• Continuity of Pharmacotherapy for OUD (POD). (CMS Metric #22; 2017–2023)^</li> <li>• Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2022)^†</li> <li>• Percentage of beneficiaries with OUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023)^‡</li> <li>• Percentage of beneficiaries with SUD who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023)^‡</li> <li>• Percentage of beneficiaries with SUD diagnosis who used SUD peer support services during the monthly measurement period. (2017–2023)^</li> </ul>
Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment.	<ul style="list-style-type: none"> <li>• Residential OUD discharges with MAT claim. (2017–2023)^†</li> <li>• Inpatient OUD discharges with MAT claim. (2017–2023)^†</li> <li>• Percentage of members with OUD diagnosis who have a MAT claim for OUD during the measurement period. (2017–2023)^†</li> </ul>
Ensure inpatient and residential providers improve care coordination and transition of care to the community.	<ul style="list-style-type: none"> <li>• 30-Day Readmission for SUD treatment. (2017–2023)^†</li> <li>• ED utilization for SUD per 1,000 beneficiaries (CMS Metric #23). (2017–2023)^</li> <li>• ED utilization for OUD per 1,000 beneficiaries (CMS Metric #23, OUD stratum; 2017–2023)^</li> <li>• Inpatient stays for SUD per 1,000 beneficiaries (CMS Metric #24; 2017–2023)^†</li> <li>• Inpatient stays for OUD per 1,000 beneficiaries (CMS Metric #24, OUD stratum; 2017–2023)^†</li> <li>• Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2022)^†</li> <li>• Initiation &amp; Engagement of Alcohol &amp; Other Drug Dependence Treatment (IET). (2017–2022)^</li> <li>• Follow-Up After High-Intensity Care for SUD (FUI). (2019–2022)*</li> </ul>
<p>* One-group pretest–posttest design will be used for the assessment of the performance measure.                      ^ Interrupted time series design will be used for the assessment of the performance measure.                      † Candidate measure to investigate feasibility of comparison group (Beacon block grant recipients, rural/urban comparison).                      ‡ Service Type Strata: <i>early intervention</i>, e.g., SBIRT (CMS Metric #7); <i>outpatient services</i> (CMS Metric #8); <i>intensive outpatient and partial hospitalization</i> (CMS Metric #9); <i>residential and inpatient services</i> (CMS Metric #10); <i>withdrawal management</i> (CMS Metric #11); <i>medication-assisted treatment (MAT)</i> (CMS Metric #12).</p>	

Fifteen performance measures will be examined using the interrupted time series design. The post-intervention observation period for twelve performance measures will be 2019 through 2023. The post-intervention period for three performance measures are based on HEDIS data. Since HEDIS data for 2023 is not expected to be available for analysis, the post-intervention observation period for the

performance measures based on HEDIS data will be 2019 through 2022.

Three outcome measures will be examined using the one-group pretest–posttest design. The evaluation periods will vary by measure, as discussed below.

The baseline observation period for the Concurrent Use of Opioids and Benzodiazepines measure will be 2018; the post-intervention data points will be 2019 through 2023.

The Opioid Drug Overdose Deaths measure of overdose deaths due to any opioid is related to the primary driver of this goal. Currently, KDHE is in the process of developing a warehouse, “HealthIntent Data Warehouse,” to link birth and death data to Medicaid members. The development of this warehouse will assist in death-Medicaid data linking. This system will be used to provide data for calculating the rates of overdose deaths due to any opioid. It is anticipated that these data will be available for 2019 through 2022 for analysis; therefore, the one-group pretest–posttest evaluation design will be used. If this system can provide opioid overdose death data for the years 2017 and 2018, then the interrupted time series design will be applied to examine this measure.

Follow-Up After High-Intensity Care for SUD (FUI) became a HEDIS measure starting with measurement year 2019. Since HEDIS data for 2023 may not be available for analysis, the pre-intervention year for FUI will be 2019, and the post-intervention period will be 2020 through 2022.

Several measures may be investigated for feasibility of comparison group analysis such as readmission and inpatient stays (Beacon block grant recipients) and MAT claim measures (Beacon recipients and rural/urban comparisons).

### **d. Evaluation Methodology for SUD Demonstration Goal 4**

#### Demonstration Goal 4

Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.

#### Evaluation Question for Goal 4

Do enrollees receiving SUD services experience reduction in readmissions to the same or higher level of care for OUD and other SUDs?

#### Evaluation Hypothesis for Goal 4

Among members receiving care for SUD, the demonstration will reduce readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.

#### Demonstration Strategy for Goal 4

**Two strategies** contributing to the primary and secondary drivers for Goal 4 will be implemented over the demonstration period. The strategies include:

- To ensure admission of members with SUD to the appropriate level of care, documentation of an assessment which follows ASAM criteria will be required.
  - Licensing standards for all providers across the network will be aligned with the ASAM criteria.
- Care coordination requirements will aim to decrease readmission to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.

The two strategies described here will contribute to the following two secondary drivers, which in turn will lead to the reduced readmissions to the same or higher level of care for OUD and other SUDs (primary driver for Goal 4):

- Ensure access to services at all needed levels of care for SUD, including outpatient treatment (group, individual, and/or family counseling, community psychiatric support, crisis intervention), residential treatment (including coverage of SUD treatment in IMDs), and peer support services;
- Ensure inpatient and residential providers improve care coordination and transition of care to the community;

In addition to the above-mentioned secondary drivers and strategies, the following secondary drivers and their related strategies (described for Goal 2) will also contribute in achieving Goal 4.

- Expand access to MAT by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment for those who meet the need criteria and choose treatment.
- Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy.

*Drivers and Performance Measures for Goal 4*

The evaluation of this goal involves assessment of fourteen performance measures for its primary and secondary drivers. Interrupted time series evaluation design will be used to evaluate thirteen performance measures related to the primary and secondary drivers, whereas the one-group pretest–posttest design will be used to examine one performance measure related to one of its secondary drivers. The primary and secondary drivers for Goal 4 and their associated performance measures are shown in Table C-4.

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Table C-4. Drivers and Associated Performance Measures for SUD Demonstration Goal 4	
Primary Driver	Performance Measure
Reduce readmissions to the same or higher level of care for OUD and other SUDs.	<ul style="list-style-type: none"> <li>• 30-Day Readmission for SUD treatment. (2017–2013)*^</li> <li>• 30-Day Readmission for SUD treatment (among discharges from a residential or inpatient facility for OUD treatment). (2017–2023)*^</li> </ul>
Secondary Drivers	Performance Measures
Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD).	<ul style="list-style-type: none"> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who were treated in an IMD for SUD during the measurement year. (2017–2023)*</li> <li>• Average length of stay for SUD treatment services within IMDs (CMS Metric #36; 2017–2023)*</li> <li>• Number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members with SUD diagnosis. (2017–2023)*</li> <li>• Number of outpatient, intensive outpatient, &amp; partial hospitalization days of SUD treatment per 1,000 members with SUD diagnosis. (2017–2023)* <b>Note:</b> <i>Partial hospitalization in KS has same service code as inpatient.</i></li> </ul>
Ensure inpatient and residential providers improve care coordination and transition of care to the community.	<ul style="list-style-type: none"> <li>• 30-Day Readmission for SUD treatment. (2017–2023)*^</li> <li>• ED utilization for SUD per 1,000 beneficiaries. (CMS Metric #23; 2017–2023)*</li> <li>• ED utilization for OUD per 1,000 beneficiaries (CMS Metric #23, OUD stratum; 2017–2023)*</li> <li>• Inpatient stays for SUD per 1,000 beneficiaries (CMS Metric #24; 2017–2023)*^</li> <li>• Inpatient stays for OUD per 1,000 beneficiaries (CMS Metric #24, OUD stratum; 2017–2023)*^</li> <li>• Follow-Up After ED Visit for Alcohol and Other Drug Abuse/ Dependence (FUA). (2017–2022)*^</li> <li>• Initiation &amp; Engagement of Alcohol &amp; Other Drug Dependence Treatment (IET). (2017–2022)*</li> <li>• Follow-Up After High-Intensity Care for SUD (FUI). (2019–2022)^†</li> </ul>
<p>* Interrupted Time Series Design will be used for the assessment of the performance measure.                      ^ Candidate measure to investigate feasibility of comparison group (Beacon block grant recipients, rural/urban comparison).                      † One-group Pretest–Posttest Design will be used for the assessment of the performance measure.</p>	

Thirteen performance measures will be examined using the interrupted time series design. The post-intervention observation period for eleven performance measures will be 2019 through 2023. The remaining two performance measures are based on HEDIS data (FUA and IET). As 2022 HEDIS data will be available in the final year of the demonstration period (2023), therefore, the post-intervention observation period for the performance measures based on HEDIS data (FUA and IET) will be 2019 through 2022.

One performance measure will be examined using the one-group pretest–posttest design. The post-intervention observation period for this performance measure will be 2019 through 2022. The performance measure with data availability for 2019 through 2022 is based on HEDIS data (FUI). HEDIS data for 2022 will be available in the final year of the demonstration period (2023); therefore, the post-intervention observation period for this performance measure (FUI) will be 2019 through 2022.

Several measures may be investigated for feasibility of comparison group analysis such as readmission and inpatient stays (Beacon block grant recipients).

### e. Evaluation Methodology for SUD Demonstration Goal 5

#### Demonstration Goal 5

Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

#### Evaluation Question for Goal 5

Do enrollees receiving SUD services experience improved access to care for physical health conditions?

#### Evaluation Hypothesis for Goal 5

The demonstration will increase the percentage of beneficiaries with SUD who access care for physical health conditions.

#### Demonstration Strategy for Goal 5

The **strategy** contributing to the primary and secondary drivers for Goal 5 will be implemented over the demonstration period. The strategy includes:

- KanCare 2.0 contracts with MCOs will focus on the integration of behavioral health and physical health among members with SUDs.
  - Care coordination includes health screening, health risk assessment, needs assessment, and development and implementation of service/treatment plan or person-centered service plan (PCSP).

The strategy described here will contribute to the following secondary driver, which in turn will lead to improved access to care for physical health conditions among members with OUD or other SUDs (primary driver for Goal 5):

- Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy.

#### *Drivers and Performance Measures for Goal 5*

The evaluation of this goal involves assessment of six performance measures for its primary and secondary drivers. Interrupted time series evaluation design will be used to evaluate five performance measures related to the primary and secondary drivers, whereas the one-group pretest–posttest design will be used to examine two performance measure related to its secondary driver. The primary and secondary drivers for Goal 3 and their associated performance measures are shown in Table C-5.

Table C-5. Primary Driver and Associated Performance Measures for SUD Demonstration Goal 5	
Primary Driver	Performance Measures
Improve access to care for physical health conditions among members with OUD or other SUDs.	<ul style="list-style-type: none"> <li>• Annual Dental Visits (ADV). (SUD stratum; 2017–2022)*</li> <li>• Adults’ Access to Preventive/Ambulatory Health Services (AAP). (SUD stratum; 2017–2022)*</li> <li>• Adolescent Well-Care Visits (AWC). (SUD stratum; 2017–2022)*</li> <li>• Prenatal and Postpartum Care (PPC). (SUD stratum; 2017–2022)*</li> </ul>
Secondary Driver	Performance Measure
Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy.	<ul style="list-style-type: none"> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager (2019–2023)^</li> <li>• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and have Service/Treatment plan or PCSP. (2019–2023)^</li> </ul>
<p>* Interrupted Time Series Design will be used for the assessment of the performance measure.                      ^ One-group Pretest–Posttest Design will be used for the assessment of the performance measure.                      † Care Coordination Includes: <i>health screening, health risk assessment, needs assessment and development and implementation of service/treatment plan or person-centered service plan (PCSP)</i></p>	

Four performance measures will be examined using the interrupted time series design. Each of the four performance measures are based on HEDIS data (ADV, AAP, AWC, and PPC). HEDIS data for 2022 will be available in the final year of the demonstration period (2023); therefore, the post-intervention observation period for the performance measures based on HEDIS data (ADV, AAP, AWC, and PPC) will be 2019 through 2022.

Two performance measure will be examined using the one-group pretest–posttest design. The post-intervention observation period for this performance measure will be 2019 through 2023.

#### f. Methodology for the Evaluation of KanCare 2.0 Hypothesis 4

##### KanCare 2.0 Hypothesis 4 Evaluation Question

Did removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members improve member access to substance use disorder (SUD) treatment services.?

This question corresponds to the SUD Demonstration Evaluation Question 1, “Does the demonstration increase access to and utilization of SUD treatment services?”

##### KanCare 2.0 Hypothesis 4

Removing payment barriers for services provided in IMDs for KanCare members will result in improved member access to SUD treatment services.

##### Demonstration Strategy for KanCare 2.0 Hypothesis 4

The Kansas Medicaid IMD Exclusion has been removed allowing IMDs to bill for SUD treatment services with the expectation that access to SUD services will increase for members with behavioral health conditions.

##### Evaluation Design for KanCare 2.0 Hypothesis 4

Non-experimental methods (descriptive data) will be used for assessing the evaluation question. Due to changes in data systems, pre-demonstration data will not be used.

### *Target and Comparison Population*

The evaluation for this hypothesis will focus on increasing the availability of IMD facilities providing SUD treatment services over the five-year period. **No intervention and comparison groups will be examined.**

### *Evaluation Period*

2019–2023 will be the evaluation period.

### Evaluation Measures for KanCare 2.0 Hypothesis 4

- Number of IMDs providing SUD services
- Number of geographic locations of IMDs providing SUD services (by region/county)
- Number of admissions with SUD treatment services in IMDs
- Average length of stay for SUD treatment services within IMDs

### **g. Methodology for the Evaluation of Cross-Cutting Cost Measures**

The investigation of costs for the KanCare 2.0 SUD Demonstration is a separate but cross-cutting element of the demonstration evaluation. Cost studies investigate both granular (i.e., specific treatment costs) and macro aspects of the KanCare program unique to the SUD demonstration. The SUD demonstration is designed to maintain budget neutrality while improving the effectiveness of services delivered to the Medicaid population. The intent of cost studies is not to identify statistically significant increases or decreases in program costs but to understand how spending within different categories may contribute to enhanced program effectiveness. This is, in large part, due to how Medicaid managed care capitation payments obscure true administrative spending versus a fee-for-service paradigm.

### Goal for Costs of SUD Demonstration

Improved impact of the KanCare 2.0 program via provision of a full continuum of services for SUD treatment to members.

### Evaluation Question for Demonstration Cost

Does the SUD demonstration maintain or decrease total KanCare 2.0 SUD expenditures?

### Evaluation Hypothesis for Demonstration Cost

The SUD demonstration will maintain or decrease total KanCare 2.0 SUD expenditures.

### Demonstration Strategy for Demonstration Cost

Each of the strategies within the Evaluation Design Methodology, that support the primary and secondary drivers, are also utilized in the investigation of program costs. The outcomes of these strategies are anticipated to contribute to enhanced program efficiency and effectiveness. Enhancements to efficiency may include reductions to admissions (or readmissions) and other burdens related to treatment of preventable or medically inappropriate encounters as well as any other outcomes which reduce unnecessary utilization or duplication of efforts. This may also shift costs associated with the transition from formal treatment to community recovery services. See subsections C.a through C.e for detailed discussion on evaluation strategies.

### Evaluation Measures for Demonstration Cost

The SUD demonstration cost measures are stratified into three interrelated cost categories, each expressed in terms of dollars per member per month (\$MPM):

- **Type of Care Cost Drivers (Table C-6):** treatment costs for members with SUD diagnosis, stratified by types of care using claims data;

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- **SUD Cost Drivers (Table C-7):** treatment costs for members, stratified by services rendered within IMDs and other SUD-related costs for members with and without SUD diagnosis; and
- **Total KanCare 2.0 SUD Demonstration Costs (Table C-8):** treatment costs from the cost drivers listed above as well as administrative costs associated with the demonstration.

Table C-6. Type of Care Cost Drivers	
Measure Description	Numerator and Denominator Specification
ED Outpatient SUD spending during the measurement period. Expressed in dollars per member per month (\$PMPM).	<b>Numerator:</b> Spending on SUD treatment services in emergency department (ED) outpatient settings during the measurement period (CMS Metric #28, outpatient ED stratum)
	<b>Denominator:</b> Number of beneficiaries with a SUD diagnosis and a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4, outpatient non-ED stratum)
Non-ED Outpatient SUD spending during the measurement period. (\$PMPM)	<b>Numerator:</b> Spending on SUD treatment services and peer support in non-ED outpatient settings during the measurement period. (CMS Metric #28, outpatient stratum)
	<b>Denominator:</b> Number of beneficiaries with a SUD diagnosis and a SUD treatment or peer support service during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4, outpatient stratum)
Inpatient and residential SUD spending during the measurement period. (\$PMPM)	<b>Numerator:</b> Spending on SUD treatment services in inpatient and residential settings during the measurement period. (CMS Metric #28, inpatient stratum)
	<b>Denominator:</b> Number of beneficiaries with a SUD diagnosis and a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4, inpatient stratum)
Pharmacy SUD spending during the measurement period. (\$PMPM)	<b>Numerator:</b> Spending on SUD pharmaceuticals during the measurement period. (CMS Metric #28, pharmaceutical stratum)
	<b>Denominator:</b> Number of beneficiaries with a SUD diagnosis and a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4, pharmaceutical stratum)
Total KanCare 2.0 SUD treatment spending on beneficiaries with SUD diagnosis during the measurement period. (\$PMPM)	<b>Numerator:</b> The sum of all Medicaid spending on SUD treatment and peer support services during the measurement period. (CMS Metric #28)
	<b>Denominator:</b> Number of beneficiaries with a SUD diagnosis and a SUD treatment or peer support service during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4)

**Note:** Long-term care services are included within institutional claims and may be stratified from the Total.

Table C-7. SUD Cost Drivers	
Measure Description	Numerator and Denominator Specification
SUD spending on inpatient/residential services and pharmaceuticals within IMDs during the measurement period. Expressed in dollars per member per month (\$PMPM). [CMS Metric #31]	<b>Numerator:</b> Spending on treatment or peer support for SUD within IMDs during the measurement period. (exclude room & board; CMS Metric #29)
	<b>Denominator:</b> Number of beneficiaries with a claim for treatment or peer support for SUD in an IMD during the reporting year. (paid service or pharmacy claims, only; CMS Metric #5)
SUD spending on services other than within IMDs during the measurement period. (\$PMPM) [CMS Metric #30]	<b>Numerator:</b> Spending on SUD treatment or peer support services <i>not within IMDs</i> during the measurement period. (CMS Metric #28, non-IMD stratum)
	<b>Denominator:</b> Number of beneficiaries with a SUD diagnosis and a SUD treatment or peer support during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4, non-IMD stratum)
SUD spending on SBIRT services for beneficiaries without SUD diagnosis during the measurement period. (\$PMPM)	<b>Numerator:</b> Spending on SUD <i>Screening, Brief Intervention, and Referral to Treatment</i> (SBIRT) for beneficiaries <i>without a SUD diagnosis and not within IMDs</i> during the measurement period. (CMS Metric #28, non-IMD and non-SUD diagnosis strata)
	<b>Denominator:</b> Number of beneficiaries without SUD diagnosis but with a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4, non-IMD stratum)
SUD spending on assessment services for beneficiaries without SUD diagnosis during the measurement period. (\$PMPM)	<b>Numerator:</b> Spending on SUD assessment for beneficiaries <i>without a SUD diagnosis and not within IMDs</i> during the measurement period. (CMS Metric #28, non-IMD and non-SUD diagnosis strata)
	<b>Denominator:</b> Number of beneficiaries without SUD diagnosis but with a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4, non-IMD stratum)
Total KanCare 2.0 SUD treatment spending during the measurement period. (\$PMPM)	<b>Numerator:</b> The sum of all Medicaid spending on SUD treatment, SBIRT, assessment, and peer support services during the measurement period. (CMS Metric #28, includes non-SUD diagnosis stratum)
	<b>Denominator:</b> Number of beneficiaries who received SUD treatment, SBIRT, assessment, or peer support services during the measurement period and/or in the 12 months before the measurement period. ( <i>paid claims, only</i> ; CMS Metric #4, includes non-SUD diagnosis stratum)

Table C-8. Total KanCare 2.0 SUD Demonstration Costs	
Measure Description	Numerator and Denominator Specification
Total administrative costs related to the KanCare 2.0 SUD demonstration. Expressed in dollars per member per month (\$PMPM).	<b>Numerator:</b> Sum of all administrative costs related to the SUD demonstration.
	<b>Denominator:</b> Number of beneficiaries who received SUD treatment, SBIRT, assessment, or peer support services during the measurement period and/or in the 12 months before the measurement period. ( <i>paid claims, only</i> ; CMS Metric #4, includes non-SUD diagnosis stratum)
Total administrative and SUD service costs related to the KanCare 2.0 SUD demonstration. (\$PMPM)	<b>Numerator:</b> The sum of 1) all administrative costs related to the SUD demonstration and 2) all Medicaid spending on SUD treatment, SBIRT, assessment, and peer support services during the measurement period. (includes non-SUD diagnosis stratum).
	<b>Denominator:</b> Number of beneficiaries who received SUD treatment, SBIRT, assessment, or peer support services during the measurement period and/or in the 12 months before the measurement period. ( <i>paid claims, only</i> ; CMS Metric #4, includes non-SUD diagnosis stratum)
Total Federal costs related to the KanCare 2.0 SUD demonstration. (\$PMPM)	<b>Numerator:</b> The Federal Medical Assistance Percentage (FMAP) multiplied by the sum of 1) all administrative costs related to the SUD demonstration and 2) all Medicaid spending on SUD treatment, SBIRT, assessment, and peer support services during the measurement period. (includes non-SUD diagnosis stratum).
	<b>Denominator:</b> Number of beneficiaries who received SUD treatment, SBIRT, assessment, or peer support services during the measurement period and/or in the 12 months before the measurement period. ( <i>paid claims, only</i> ; CMS Metric #4, includes non-SUD diagnosis stratum)

**Evaluation Design for Demonstration Cost**

Interrupted time series evaluation design will be used to examine the evaluation question for all measures. This approach will not include a comparison group but will demonstrate trends unique to the SUD demonstration as costs per member per month (\$PMPM).

To conduct interrupted time series analysis, the design will compare nine cost measures during pre- and post-intervention periods; these cost measures are also aggregated into four total measures across the three cost categories. The pre- and post-intervention comparisons will examine whether the pre-post intervention change shows a statistically significant shift in level or trend of demonstration costs. Though interrupted time series models without a comparison group cannot adequately determine whether any observed changes are associated with the demonstration, the cost measures will be used to track overall expenditures. If deemed appropriate, “shadow pricing” methods may be used to determine fee-for-service costs as a retrospective comparison.

**Target and Comparison Population**

**Study Population:** The study population for the cost measures will include those that support understanding both total health care spending and costs of individual member services:

- KanCare 2.0 members (*primarily those with SUD diagnosis*);
- State of Kansas administrative agencies overseeing KanCare 2.0 program (*KDHE, KDADS*);
- KanCare 2.0 MCOs (*Aetna Better Health, Amerigroup Kansas\*, Sunflower State Health Plan, UnitedHealthcare*); and
- KanCare 2.0 in-network providers.

\*Amerigroup Kansas, Inc. data may be used for calculations related to pre-intervention costs.

**Comparison Population:** Financial information for the Beacon program block grant recipients may be

available at sufficient detail to perform Demonstration cost comparisons for measures eligible for comparison group analysis.

*Evaluation Period*

The total evaluation period will be 2017 through 2023. The pre- and post-intervention periods for the Interrupted Time Series analysis will be as follows:

**Pre-Intervention Period:** 2017–2018;

**Post-Intervention Period:** 2019–2023.

*Analytic Plan for Demonstration Cost*

A general regression model will be developed for this analysis. Demonstration costs will be transformed to log costs to account for wide variation in spending across months. The final regression model will include covariates to control for confounding factors such as member demographics (including Medicare-Medicaid dual eligibility), geographic location of treatment, comorbid diagnoses, etc.

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## D. Attachments

### 1. Detailed Design Methodology and Limitations

#### Study, Target and Comparison Populations

Due to state-wide implementation of the SUD Demonstration, the evaluation of overall strategies and hypotheses is hindered by the lack of true comparison groups as all KanCare 2.0 members will be eligible for the same benefits. The subset of KanCare 2.0 members with a SUD diagnosis will be the primary participants (“study population”) in the Demonstration. It is also expected that for certain measures members without such diagnosis may receive SBIRT or assessment and will be included in the denominator of performance measures and costs within cost measures. Target populations for each intervention, hypothesis, and measure are specified when they differ from the study population (e.g., metric technical specifications). Target and any comparison populations for each goal are described within that goal’s evaluation methodology, discussed in Section C.

Because of the lack of comparability, evaluation designs generally included comparisons among members in both intervention and comparison groups and a lack of true external comparison groups limits options for evaluation design. Based on CMS feedback, the design team considered multiple internal and external comparison groups, including utilizing an out-of-state comparison group.<sup>10</sup> The next subsections discuss selected internal and external comparison populations that may provide additional perspective for certain measures or drivers.

#### *External Comparison Population – Administrative Services Organization (ASO) Individuals*

A potential external comparison population for the Demonstration are block grant recipients within the Beacon program. The ASO program covers SUD treatment for recipients and providers used by recipients would provide the same services or treatments as they would Medicaid beneficiaries. Aggregate data made available in “Provider Report Cards” from the State Quality Committee of the Behavioral Health Services Planning Council may be compared to the KanCare 2.0 study population for certain measures such as seven-day and thirty-day readmissions, length of stay in treatment, follow-up to services, and MAT access (assumed to have reduced access for ASO individuals). A critical limitation in comparison to target and study populations is that the block grant recipient demographics differ greatly: recipients are uninsured, mostly male, and would not have similar access to services or care coordination. In the event Kansas moves forward with Medicaid expansion, these individuals would likely be included in the expansion gap and may no longer be a valid comparison group but may become an intervention subgroup. The block grant population will be investigated for their potential to serve as comparison groups for select readmission, length of stay, follow-up to services, and MAT measures.

#### *Internal Comparison Population – Geographic Locations of Members and Services*

Potential internal comparison populations for the Demonstration may fall along the Kansas population density spectrum (frontier-to-urban) or location of services as availability and access will likely differ by location in Kansas. For example, methadone treatment requires daily (or near daily) clinic visits but methadone clinics may not be accessible in regions of lower population density. Kansas counties are designated to different population density peer groups according to their population relative to their size in persons per square mile (ppsm): Frontier (less than 6.0 ppsm), Rural (6.0 - 19.9 ppsm), Densely-settled Rural (20.0 - 39.9 ppsm), Semi-Urban (40.0 - 149.9 ppsm), and Urban (150.0 ppsm or more).<sup>11</sup> Another potential comparison could be comparing services or providers in different geographic locations, such as comparison between different urban areas offering methadone clinics and likelihood of accepting Medicaid. Non-urban regions will be investigated for their potential to serve as comparison groups to urban regions for select MAT measures.

Data Sources

The following data sources will be utilized for the Demonstration (see Table D-1, below). The majority of data will be provided by the KanCare 2.0 MCOs with additional member and administrative data from the State of Kansas. Specific datasets and elements for evaluating are discussed with each metric within Section B, above, and in the demonstration goal sections to follow.

Primary data collection is expected for the qualitative elements of the demonstration evaluation, with particular interest in understanding referrals for MAT from residential treatment facilities. Member survey questions related to SUD have historically been fielded by MCOs. Those surveys will be reviewed for validity and reliability and questions will be reviewed for precision to the qualitative objective with potential for modification (objectives to be determined). Key informant interviews and focus group sessions may also be a source of primary data collection, though the topics, objectives, and participants/settings have not yet been determined.

<b>Table D-1. Data Sources for Evaluation of the SUD Demonstration</b>		
<b>Data Source</b>	<b>Owner/Steward</b>	<b>Brief Description</b>
Healthcare Effectiveness Data and Information Set (HEDIS)	KanCare 2.0 MCOs	Member-level detail tables for HEDIS measures submitted by the MCOs.
Managed care administrative data	KanCare 2.0 MCOs	Administrative overhead, contractual, and other costs unique to the SUD Demonstration.
Managed care case management data	KanCare 2.0 MCOs	Member-level data maintained by MCOs within their specific case management data systems.
Medicaid Management Information System (MMIS) encounter data	KanCare 2.0 MCOs	Encounter/claims data submitted to the State by MCOs used to support HEDIS® and HEDIS®-like performance, Medication-Assisted Treatment, service utilization, and cost metrics for all enrollees.
Member survey data	KanCare 2.0 MCOs	Member responses to questions within MCO-fielded SUD surveys. Survey objectives and questions to be determined.
Medicaid eligibility and enrollment files (“834 files”)	State of Kansas	Eligibility and enrollment detail for KanCare members used to determine enrollee aid category and stratify data into subgroups.
Mortality data	State of Kansas	Public health birth, death and other vital records used to track overdose deaths attributed to Kansas residents.
State administrative data	State of Kansas	Administrative overhead, contractual, and other costs unique to the SUD Demonstration.
Key informant / focus group responses	TBD	Feedback resulting from key informant interviews and/or focus group sessions. Qualitative topics, objectives, and participants/settings to be determined.

Analytic Methods

Standard data analysis methods will be used to examine each evaluation question and will be applied to the measures discussed in Section B, above. Where possible, the entire eligible population for the intervention and comparison groups will be included in the evaluation of Demonstration goals, and any pre- and post-intervention changes will be examined. If samples are needed, then power calculations will be completed to ensure validity of the findings.

Source data will be cleaned as appropriate with steps to include reviewing data for missing values, inconsistent patterns, and identification of outliers to ensure quality and appropriateness of data for

analyses required by the evaluation design. For statistical procedures, a final dataset with all required variables will be created by merging data from various sources.

Descriptive statistics will be used to describe demographic characteristics of the study population, intervention groups, comparison groups, and any subgroups. Stratified analysis will be performed to evaluate the impact of the Demonstration on subpopulations if evidence suggests significant differences may exist. Analysis may include chi square testing for independence, logistic regression, and Breslow-Day testing for homogeneity of odds ratios. Trend analysis will be conducted using statistical tests such as a Mantel-Haenszel chi-square test with  $p < .05$  indicating statistical significance.

### *Interrupted Time Series (ITS) Analysis*

The ITS analysis will be conducted using aggregate data collected for equally-spaced intervals before and after the intervention. A time series of selected outcomes of interest will be used to establish underlying trends and examined to see if these trends are “interrupted” by the intervention at known points in time (longitudinal effects of intervention), through segmented regression modeling. Segmented regression modeling refers to a model with different intercept and slope coefficients for the pre- and post-intervention time periods.<sup>12</sup> This analysis will measure immediate (level) changes in the rate of the performance measures, as well as changes in the trend (slope) from pre-intervention to post-intervention associated with time. The general form of the ITS model will be used for segmented regression.<sup>5,12</sup> CMS suggestion to consider controls adjustments for confounding variables such as age, gender, race, dual Medicare-Medicaid enrollment, and an error term will be considered for the final model. The methodological issues related to the analytical method such as autocorrelation will be assessed by examining the plot of residuals and the partial autocorrelation function.

### *One Group Pretest-Posttest (OGPP) Analysis*

The OGPP analysis will include statistical tests such as Fisher’s Exact and Pearson chi-square tests with  $p < .05$  to compare percentages or rates for the baseline and subsequent years. Net improvement will be examined by comparing percentages or rates for the baseline year and final year of the demonstration (as per availability of data). The general form of the intent to treat model will be used for regression.<sup>5</sup> Similar to discussed for ITS, the final model will follow CMS’ suggestion where appropriate.

### *Qualitative Analyses*

Qualitative analyses will be performed against the objectives of each qualitative study. For surveys and other qualitative approaches needing a representative sample of the population, a sampling strategy will be devised to include sampling method (random sampling, stratified sampling, convenience sampling, etc.), sample frame, sample size, desired response rate, and quality control and bias reduction elements. For key informant interviews or focus groups a participation strategy will be devised to include participant selection (purposive sample, quota sample, etc.), recruitment, discussion protocols, and communications procedures. Data will be analyzed through theming and descriptive statistics, where appropriate. Research and professional ethics (informed consent, risk minimization, confidentiality, etc.) will be adhered to for all qualitative research.

### Evaluation Design Limitations

The Demonstration evaluation has a strong reliance upon quasi-experimental ITS and non-experimental OGPP designs. Therefore, the resultant pre- and post-test evaluation design or comparisons to baselines may not imply causality due to a specific intervention. Further, the reliance upon non-experimental methods for KanCare 2.0 Hypothesis 4 will inhibit interpretations and conclusions from investigation in changes to Kansas’ IMDs. Lastly, the Kansas Medicaid managed care model hinders the ability to investigate costs with the same precision that would be possible in fee-for-service models due to capitation arrangements. Every attempt to ensure quality data and analysis will be made for observed

limitations to evaluation design.

### *Study Population Limitations*

As noted previously, the lack of true comparison groups due to state-wide implementation is a major limitation in evaluating the SUD Demonstration. Potential internal and external comparison groups are also limited in their ability to generalize to the study population. The design team ultimately decided against utilizing comparison states due to factors such as T-MSIS Analytic File data lag and challenges in selecting comparison states that would have outcomes identical to Kansas pre-Demonstration state not influenced by state or national trends (e.g., SUPPORT Act and other opioid disaster response, Medicaid waivers or expansions, etc.). Similarly, difference-in-differences analysis was considered for the SUD evaluation but core assumptions were unable to be made due to either lack of true comparison populations ('group invariance'), limited phasing of the statewide demonstration to establish cohorts ('time invariance'), or dynamic changes in comparison population service needs and access ('strict exogeneity').<sup>13</sup>

When available, subgrouping of members within a strategy's target population will be performed. Therefore, there is a possibility of encountering methodological issues that will require application of appropriate techniques. Methodological issues may include: selection bias (e.g., differences between those who may opt-in versus those who may not); spillover effects; multiple treatment threats due to other interventions; effect of confounding variables; inadequate statistical power; and other issues inherent within experimental comparisons and inferences. Appropriate techniques will be applied to address these issues as much as possible.

Over the five-year period, eligibility for receiving Medicaid services may change for some members and they may not be part of intervention or comparison groups. Additionally, the SUD diagnosis status of members may change over time, and certain members may receive SBIRT or assessments even without diagnosis. These issues will be monitored and addressed accordingly by applying appropriate techniques (intent-to-treat analysis; exclusion from analysis, etc.).

### *Data Source Limitations*

The use of administrative claims and encounters data sources for performance measures can be a limitation when used to determine changes in access to services, quality of care, and health outcomes. However, many of the performance measures are validated and stewarded by nationally recognized bodies such as NCQA and widely used for these purposes. While administrative data may identify key cases and statistical trends in performance, these are usually limited in providing detailed health and health behavior information, thus making it difficult to obtain information on possible covariates influencing performance. The use of administrative accounting data for evaluation of costs may also present a challenge in reconciling costs unique to the demonstration across different accounting platforms and practices.

Data lag also causes a challenge in measuring and reporting change in a timely manner. This can affect the availability of data for conducting the evaluation for the entire five-year period of the demonstration. As the evaluation is based on a five-year period, the definitions and specifications of the evaluation measures, policies for data collection, and infrastructure of the data sources may change during the evaluation period following administrative rule or other policy changes, thus leading to unavailability of appropriate data for the analysis of multiple pre- and post- intervention evaluation points needed for comparative interrupted time series and one-group pretest-posttest designs. Additional challenges specific to cost data are lags related to both the resolution and reconciliation of claims but also in availability of administrative data due to fiscal timeframes and policies.

## KanCare 2.0 Section 1115 Substance Use Disorder Demonstration Evaluation Design

From a qualitative perspective, limitations may exist in the collection and coding of open-ended questions and comments. This includes limitations to the accuracy and precision of data obtained through primary data collection as well as the extent to which interpretations and conclusions may be made. As the SUD surveys are administered independently by each MCO, analysis across the KanCare 2.0 program may not be feasible if survey designs or fielding differs significantly between one or more of the MCOs.

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## 2. Independent Evaluator

KDHE has arranged to contract with the Kansas External Quality Review Organization (EQRO), Kansas Foundation for Medical Care (KFMC), to conduct the evaluation of SUD Demonstration at the level of detail needed to research the approved hypotheses. They have agreed to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved, draft Evaluation Design. KFMC has over 45 years of demonstrated success in carrying out both Federal and State healthcare quality related contracts. They have provided healthcare quality improvement, program evaluation, review and other related services including the following:

- Kansas Medicaid Managed Care EQRO since 1995 (24 years).
- CMS quality improvement organization (QIO) or QIO-Like entity since 1982 (37 years).
- Utilization Review/Independent Review Organization for the Kansas Insurance Department since 2000 (19 years) and for five other states.

KFMC is accredited as an Independent Review Organization (IRO) through URAC (formerly known as the Utilization Review Accreditation Commission). The URAC Accreditation process is a rigorous, independent evaluation, ensuring that organizations performing IRO services are free from conflicts of interest and have established qualifications for reviewers. Furthermore, through their sub-contract with the Great Plains Quality Innovation Network (a prime CMS contractor), KFMC submits an annual Organizational Conflict of Interest (OCI) certificate to CMS. KFMC considers ethics and compliance an integral part of all their business decisions and the services they provide. The KFMC Corporate Compliance Program supports the commitment of KFMC to conduct its business with integrity and to comply with all applicable Federal and State regulations, including those related to organizational and personal conflicts of interest. The KFMC compliance program ensures potential, apparent and actual organizational and personal conflicts of interest (PCI) will be identified, resolved, avoided, neutralized, and/or mitigated.

Prior to entering into any contract, KFMC evaluates whether the identified entity or the work presents an actual, potential, or apparent OCI with existing KFMC contracts. KFMC will not enter into contracts that are an OCI. If it is undetermined whether the new work could be a conflict of interest with their EQRO and independent evaluation responsibilities, KFMC will discuss the opportunity with KDHE to determine whether a conflict would exist. In some cases, an approved mitigation strategy may be appropriate.

All Board members, managers, employees, consultants and subcontractors receive education regarding conflicts of interest and complete a CMS-developed PCI Disclosure Form. Disclosures include the following:

- Relationships with Insurance Organizations or Subcontractor of Insurance Organizations
- Relationships with Providers or Suppliers Furnishing Health Services Under Medicare
- Financial Interests in Health Care Related Entities
- Investments in Medical Companies, Healthcare or Medical Sector Funds
- Governing Body Positions

### 3. EQRO Evaluation Budget

This information is available upon request.

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#### 4. Timeline and Major Milestones

<b>Table D-3. Evaluation Budget for the KanCare 2.0 Section 1115 SUD Demonstration</b>	
<b>Deliverable/Activity</b>	<b>Due Date(s)</b>
Finalize technical specifications for non-required (state-developed) metrics.	To be determined (following CMS evaluation feedback)
Discuss SUD Demonstration implementation and evaluation progress during existing quarterly EQRO/State/MCO meetings.	Quarterly (already in progress)
Quarterly EQRO/State meetings for preparation of SUD Demonstration progress reports.	Two weeks prior to State deliverable requirements
Draft Interim Evaluation Report in accordance with Attachment N (Preparing the Evaluation Report) of the STCs; will discuss evaluation progress and findings to date.	December 2022 (one year prior to the end of the demonstration)
Final Interim Evaluation Report.	60 days after receipt of CMS comments
Draft Summative Evaluation Report in accordance with Attachment N of the STCs.	June 2025 (18 months from the end of the demonstration)
Final Summative Evaluation Report.	60 calendar days after receipt of CMS comments

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## Attachment C. Tribal Notice

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## **Attachment D. Public Notice (Abbreviated)**

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## Attachment E. Full Public Notice

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## Attachment F. Responses to Public Comments

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