The Centers for Medicare and Medicaid Services requires Managed Care Organizations (MCOs) to conduct performance improvement projects (PIPs) that focus on both clinical and non-clinical areas each year (42 CFR 438330 and 4571240(b). A PIP is a pilot project designed to improve member health and quality of life. KanCare 2.0 requires each MCO to conduct at least three clinical and two non-clinical State-approved PIPs. The MCOs must conduct one of these PIP collaboratively, and one of the two non-clinical PIPS must be in the area of long-term-care. In addition, the MCOs must conduct a PIP on Early Periodic Screening Diagnostic and Testing (EPSDT) when the MCOs' overall rates drop below 85%.

The following table represents the current KanCare 2.0 PIPs and the interventions the MCOs are using to improve the goals. Each PIP is assessed annually for successes, and changes are made to enhance effectiveness and improve impact.

*Some interventions are being adjusted due to face-to face interaction restrictions during Covid-19

KanCare 2.0 Individual Performance Improvement Projects		
Aetna Better Health (ABH)	Sunflower Health Plan (SHP)	UnitedHealthcare (UHC)
Topic: Reducing food insecurity Current Interventions: • Annual calls to members to identify those with food needs • Quarterly webinars for members with diabetes given by RN/Diabetic Educator. Focus will be on topics such as how to make and access healthy food choices, reading food labels and managing a chronic condition • Identify members who could benefit from pharmacy consultation. Partner with pharmacists who complete an assessment and send results to ABH. Care Managers then reach out to members to address food needs • Education and outreach to providers in food desert areas to increase provider use of billing codes that identify members with food needs. This intervention will first be piloted with 1 urban, 1 rural and 1 frontier provider. • Donations to food banks located in food deserts	**Topic: Improving access to mental health services for children in foster care** Current Interventions: • Access to myStrength, a digital behavioral health application used for behavioral health self-management that can be used on a phone, tablet or computer • Evaluation of SED waiver eligibility to enhance services for children in foster care and waiting for placement in a Psychiatric Residential Treatment Facility • Expand Parent Management Training-Oregon Model, an Evidence-Based Practice, to the two new State Foster Care Contractors. Track the number of families who complete most of the modules • Pilot an expedited intake and treatment appointment process with 2 urban and 2 rural/frontier FQHCs • Open the behavioral health portion of the provider portal to allow mental health providers to upload behavioral health documents. This access will allow the provider to guide their sessions and pick up in treatment where a previous provider left off	**Topic: Provide housing resources for members who are homeless or at-risk of homelessness** Current Interventions: • Provide temporary financial help for eligible members to get and/or keep housing • 10 units of transitional housing to serve medically complex members who are homeless and have high utilization in medical claims • Work with homeless shelters to identify members to connect them with services as needed • Provide financial support to add Community Health Workers at 2 urban and 1 rural health clinics to increase the use of billing codes to identify those who may have housing needs • Train UHC Care Management staff on identifying and assisting members with housing needs • Member services will ask housing status questions to any member who calls Member Services for assistance with transportation issues. Members who

		report housing needs will be referred to a Housing Specialist
Topic: Increasing prenatal care visits and MCO notice of pregnancy Current Interventions: • $20 gift card to member for notifying ABH of pregnancy through interactive text message • $20 gift card to member for notifying ABH of pregnancy through interactive phone message • Direct phone calls to new members who are pregnant to offer enrollment in Promise Pregnancy Program. Calls are made within 3 days of ABH being notified of enrollment • $100 reward to behavioral health and FQHC providers for notifying ABH of member's pregnancy • $25 reward to urgent care providers for notifying ABH of member's pregnancy	**Topic: Increasing cervical cancer screening rates** Current Interventions: • Phone call reminders from case manager to women who are overdue for a screening • Bi-directional and Interactive text message reminders to women who are overdue for a screening • Co-branded letters with providers who have not transitioned to electronic record keeping. SHP will identify the members who are overdue for screenings and mail the reminder. • Reports to providers, who are not participating in SHP's performance incentive, listing assigned/attributed women who are overdue for a screening • Provider webinar focused on overcoming screening concerns of members with an Intellectual or Developmental Disability (I/DD)	**Topic: Increasing medication compliance for members with newly prescribed antidepressant medications** Current Interventions: • Wellness-call within 21 calendar days of prescription being filled to provide medication coaching and discuss use of mental health app, outpatient therapy and enrollment into OneCare Kansas program • Follow-up call within 14 calendar days of the initial call to discuss progress and questions since the initial call • Ensure members reached during the initial call complete an annual Health Screening Assessment
Topic: Reducing non-emergent use of emergency room (ER) by members in the Home and Community-Based Services (HCBS) program Current Interventions: • Refrigerator magnet with individualized phone numbers for non-ER care resources • Individual meeting with member and caregiver following non-urgent use of ER to discuss non-ER options	**Topic: Increasing employment for members in the I/DD, Physical Disability and Brain Injury waiver programs** Current Interventions: • Mailers to members with employment-related information and assistance options in the member's community. Mailers will include the Employment Specialist's contact information as well. • Transportation to job interviews and job fairs	**Topic: Increasing number of HCBS members who have Advance Directives** Current Interventions: • Develop an easily understood Advance Directives form and a process to inform, document, store and track the sharing of the form with the member's primary care physician, care providers, family, and interested parties per the member's choice • Mail information about Advance Directives to members on the Frail

• Text message reminders with non-ER options including use of Nurse Help Line • Quicker notification to ABH of member's use of the ER through the CareUnify notification system. Case Managers will then contact the member within 3 days to discuss non-ER options when appropriate. • Study trends of non-emergent ER use by members on the HCBS waivers	• Partnering with employers to increase job opportunities for young adults in Project SEARCH • Rewards to day support providers to help members find and maintain competitive employment for members receiving services • Annual training for case managers on regional employment resources and employment incentive programs. Attendees will complete a pre and post survey to assure the training materials met the case manager's needs.	Elderly waiver in Sedgwick County 3 weeks prior to annual visit. This will allow members an opportunity to prepare for the conversation. • Assist members with completion of Advance Directives for members on the Frail Elderly waiver in Sedgwick County during their annual visit • Train UHC Community Health Workers and Care Coordinators on the sensitivity of discussing Advance Directives • Collect and store completed Advance Directives in the UHC care management record (Community Care). Assist members with sharing their completed Advance Directives with at least one other person • Inform providers of the Advance Directives project
Topic: Increasing flu vaccination rates for children ages 6 months to 17 years Current Interventions: • $15 gift card to parent/guardian when child gets flu vaccination • Nurse will be available to give flu shots at four community health events • Up to four interactive reminder texts to parents or guardians until reply text is received that child has been vaccinated • Reminders on CVS prescription packages during flu season • Reports to providers of children who have not received a flu vaccination. Providers will then receive a survey to assess if reports were helpful in increasing flu vaccinations.	**Topic: Diabetes monitoring for people with diabetes and schizophrenia** Current Interventions: • Phone call reminders from case managers to members who are overdue for a HbA1c and LDL-C test • Reminder letters to members who are overdue for their HbA1c and LDL-C tests, using both SHP and the physician's letterhead with 5 pilot providers • Send reports biannually to providers with names of members who are due for their annual HbA1c and LDL-C test	**Topic: Diabetes monitoring for people with diabetes and schizophrenia** Current Interventions: • Phone call reminders from Care Manager to members identified with complex medical needs and are overdue for a HbA1c and LDL-C test • Phone call reminders from Care Coordinators to members who are receiving waiver services and are overdue for a HbA1c and LDL-C test • Send reports biannually to providers with names of members who are due for their annual HbA1c and LDL-C test

KanCare 2.0 Early Periodic Screening Diagnostic Treatment (EPSDT) KAN Be Healthy PIP

Topic: Increasing EPSDT rates to 85%
Current Interventions:

- $25 each year for completing annual well visit - Members ages 13 to 20 years
- $10 card and gift pack (including an activity book from Ted E. Bear, M.D.) each year for completing annual well visit - Members birth to 12 years
- Interactive text message, in the member's language preference, to parents/guardians of children who are overdue for a visit. System will ask for a response and transfer to member services all those who respond that they do not plan to go/make an appointment
- Automated phone message to parents/guardians of children who are overdue for a visit. System will allow the member to warm transfer to customer service for assistance
- A reminder message attached to prescriptions at all CVS pharmacies in Kansas. Reminder will be included on the first prescription filled during the quarter prior to the member's birthdate
- Two provider education webinars. Strategies for adherence and difference between younger and older children will be covered

Topic: Increasing EPSDT rates to 85%
Current Interventions:

- Interactive text message reminder to parent/guardian or members who are overdue for a visit. System allows members to respond to and ask questions.
- Two community outreach events where KAN Be Healthy visits can be completed onsite
- Case Manager phone call reminder of annual visit for members on the SED waiver
- Improve and coordinate tracking of EPSDT visits with contracted foster care agencies
- In-person provider education visits to 5 large practices to discuss individual goals and barriers for their membership

Topic: Increasing EPSDT rates to 85%
Current Interventions:

- Phone call reminders to members who are 18-20 years old and overdue for a visit, with the option to warm transfer to schedule an appointment
- Mailing reminders to members without a known phone number. Mailer will include information detailing how members can obtain a phone through the health plan using UHCCP KS's value-added benefits (VAB)
- Monetary incentive for providers who have over 50 members needing an EPSDT visit
- Notification to contracted foster care agencies of those members who need an EPSDT visit
- Reports of members who are due for a visit to providers who are not part of any other UHC EPSDT incentive program

COVID-19 Collaborative Vaccination PIP

Topic: Increasing COVID-19 Vaccination Rates to 70%
Current Interventions:

- Host two vaccine events in partnership with Health Departments and/or Federally Qualified Health Centers where members can get vaccinated
- Provide incentives for members who are vaccinated at either of the two vaccination events
- Outreach to members who have not received the COVID-19 vaccine in a variety of ways (texting, IVR calls and emails)

- Survey OneCare Kansas providers to better understand what type of COVID-19 related communication/education would be most helpful
- Based on survey results, distribute quarterly communication to OneCare Kansas providers focusing on COVID-19 topics such as mental-health related needs and notification of vaccine-related events throughout Kansas

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