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URAC ACCREDITED Independent Review Organization: External Expires 06/01/2021

April 26, 2019

Becky Ross
Medicaid Initiatives Coordinator
Kansas Department of Health & Environment
Division of Health Care Finance
900 SW Jackson St.
Topeka, KS 66612

RE: **KanCare Final Evaluation: 2013–2018**

Dear Ms. Ross:

Enclosed, to review is the 2013-2018 Final KanCare Evaluation report for January 2013–December 2018. If you have questions regarding this information, please contact me, lvaldivia@kfmc.org.

Sincerely,

Lynne Valdivia

Lynne Valdivia, MSW, BSN, RN, CCEP
Vice President, Director of Quality Review, and Compliance Officer

Electronic Version: Shirley Norris, Senior Manager, MCO Operations, KDHE
Amy Swanson, Quality Manager, KDHE

Enclosures

Kansas Foundation for Medical Care, Inc

URAC ACCREDITED Independent Review Organization: External Expires 06/01/2021

KanCare Final Evaluation Report: 2013–2018

January 2013–December 2018

KFMC Contract Number: 11231

Program(s) Reviewed: KanCare Demonstration

Submission Date: April 26, 2019

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Prepared for:

KanCare

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January 2013 – December 2018

KanCare Final Evaluation Report
Evaluation of the State of Kansas Medicaid Section 1115(a) Demonstration Waiver – KanCare
January 2013–December 2018
Executive Summary
April 26, 2019

In December 2012, the State of Kansas received approval from the Centers for Medicare and Medicaid Services (CMS) for the Medicaid Section 1115(a) demonstration waiver authority, entitled KanCare, to reform Medicaid in Kansas with a focus to improve health outcomes and establish financial responsibility.[1,2] In the beginning of 2014, Kansas also received approval from CMS for the KanCare demonstration amendment which included providing Long-Term Services and Supports (LTSS) for individuals with intellectual or developmental disabilities (I/DD) through KanCare Managed Care Organizations (MCOs); and changing in the timeline for the Delivery System Reform Incentive Payment (DSRIP) Pool.[4] In addition, Kansas also received approval for a one-year extension of the current KanCare demonstration, including the Uncompensated Care Cost (UCC) Pool and the DSRIP Pool for the period of January – December 2018.[4]

This is the final report on the evaluation results of the KanCare Demonstration implemented over a six-year period (January 2013 through December 2018).

KanCare Section 1115(A) Demonstration Waiver Program Overview:

KanCare, an integrated managed care program, serves populations covered by the Kansas Medicaid and Children's Health Insurance Programs (CHIP) through a coordinated approach. KanCare 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 with each other and with 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 beneficiaries (including the aged, people with disabilities, and some dually eligible individuals) across Kansas into a managed care delivery system to receive state plan and waiver services. KanCare also includes a safety net care pool (UCC Pool) to support certain hospitals that incur uncompensated care costs for Medicaid beneficiaries and the uninsured. [1,2] KanCare also includes a DSRIP Pool, which aims to advance the goals of access to services and healthy living by specifically focusing on incentivizing projects that increase access to integrated delivery systems and projects that expand successful models for prevention and management of chronic and complex diseases. Participating hospitals work with community partners statewide to implement projects with measurable milestones for improvements in infrastructure, processes, and healthcare quality. The State contracted with three MCOs, Amerigroup Kansas, Inc. (Amerigroup), Sunflower Health Plan of Kansas (Sunflower), and UnitedHealthcare Community Plan of Kansas (UnitedHealthcare), to serve the KanCare program during the six-year demonstration period. [2,5]

Evaluation of KanCare Program – Progress Over Six-Year Period

The final evaluation of the KanCare program was conducted to measure the effectiveness and usefulness of the demonstration as a model to help shape health care delivery and policy at the state and national level. The Kansas Foundation for Medical Care, Inc. (KFMC) has completed this final evaluation in accordance with the approved Evaluation Design.[6]

KanCare Program Goals, Performance Objectives and Evaluation Questions/Hypotheses

The State formulated the following four hypotheses to address the goals and objectives for the KanCare Program (Figure ES-1).

GOALS	Performance Objectives	Evaluation Hypotheses
• Provide integration and coordination of care across the whole spectrum of health to include PH, BH, and LTSS/HCBS; • Improve the quality of care Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes); • Control Medicaid costs by emphasizing health, wellness, prevention and early detection as well as integration and coordination of care; and • Establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms.	• Measurably improve health care outcomes for members in the areas including: diabetes, coronary artery disease, prenatal care, and BH; • Improve coordination and integration of PH care with BH care; • Support members' desires to live successfully in their communities; • Promote wellness and healthy lifestyles; and • Lower the overall cost of health care.	• By holding MCOs to outcomes and PMs, and tying measures to meaningful financial incentives, the State will improve health care quality and reduce costs; • The KanCare model will reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired; • The State will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between PH, BH, and LTSS; and • KanCare will provide integrated care coordination to individuals with developmental disabilities, which will improve access to health services and improve the health of those individuals.

Figure ES-1. Alignment of KanCare Goals and Performance Objectives with Evaluation Questions/Hypotheses

KanCare Program Evaluation Design

The evaluation design was structured into eight categories in alignment with the KanCare program goals, objectives, and evaluation hypotheses, as well as Special Terms and Conditions (STC) evaluation domains of focus (Figure ES-2).

The eight evaluation design categories were organized into subcategories and appropriate PMs were assigned for each subcategory to examine the related evaluation hypotheses (Figure ES-3).

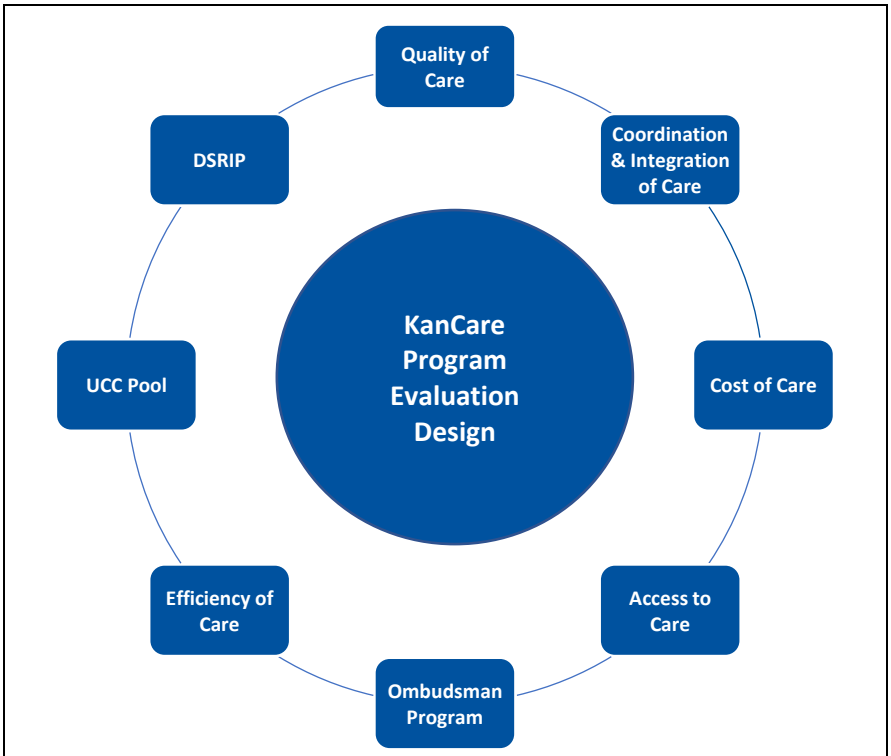

Figure ES-2. KanCare Program Evaluation Design Categories

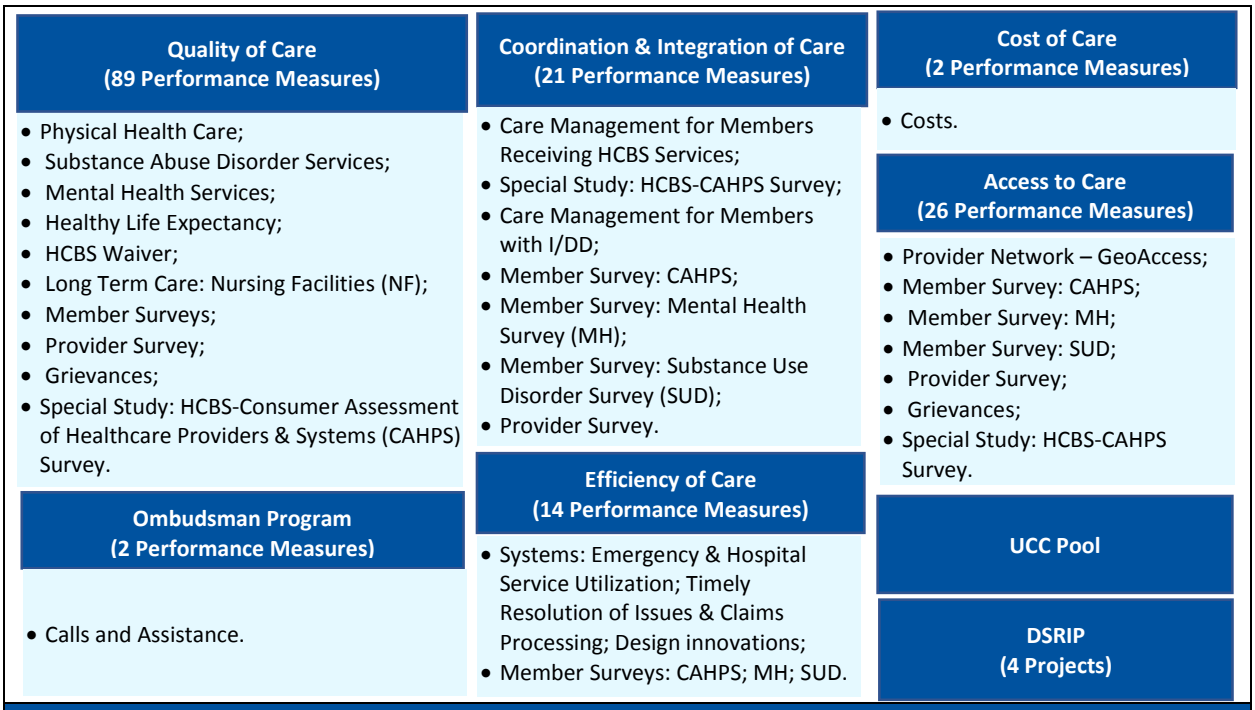

Figure ES-3. Subcategories and Number of Performance Measures for KanCare Program Evaluation Categories

Evaluation Methodology

The evaluation methodology included baseline and cross-year comparisons, as well as assessment of trends over time. For these comparisons, the first year of the KanCare demonstration, calendar year (CY) 2013, served as a baseline year. In some instances, 2013/2014 data were used as baselines. Also, for some of the PMs, pre-KanCare data (multi-year data) were used as the baseline. Use of pre-KanCare data as baselines was not considered appropriate where pre-KanCare and KanCare populations were too different. In addition, analysis of PMs was also conducted by one or more of the stratified populations.

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The final evaluation timeline is described in Figure ES-4.

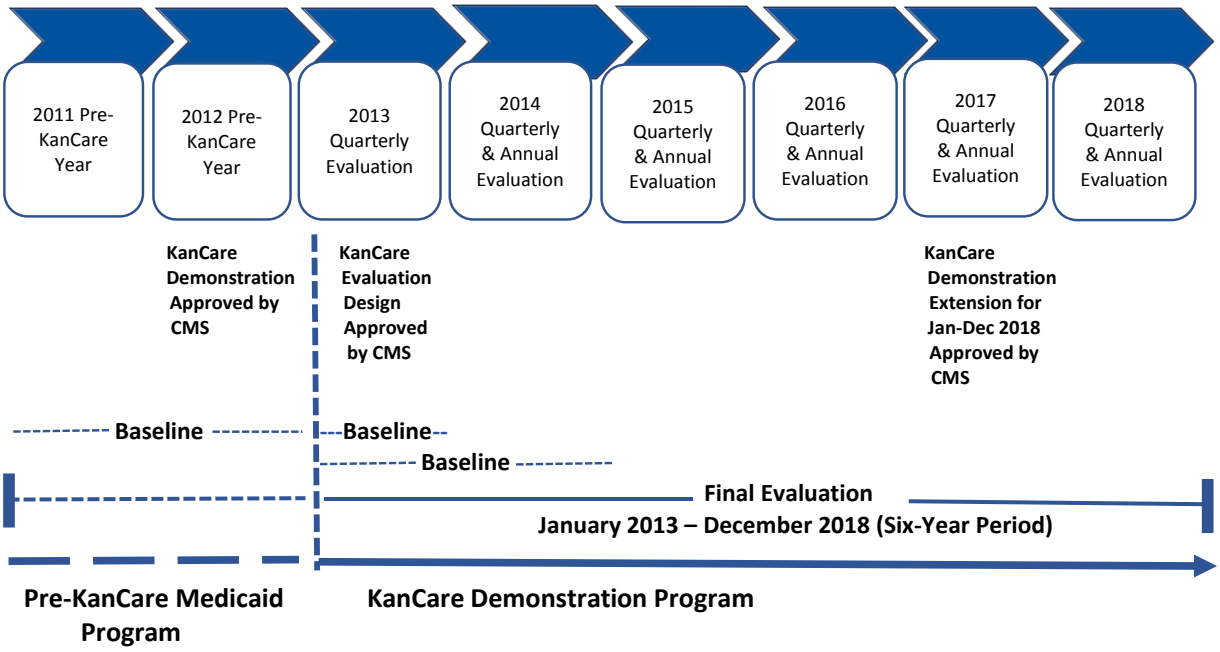

Figure ES-4. KanCare Program Evaluation Timeline

In addition to the overall KanCare population, the evaluation was structured to identify any variability among demographic groups (age groups, county type), the General Child (GC) population including Title XIX (TXIX)/Medicaid and Title XXI (TXXI)/CHIP program members and Children with Chronic Conditions (CCC) including TXIX/Medicaid and TXXI/CHIP program members, waiver services, providers, members receiving MH services, SUD treatment and receiving NF services (wherever appropriate, and where data were available). The evaluation process included assessment of quantitative and qualitative data and outcome PMs; therefore, a variety of data sources were used to obtain data. The Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF), and the Kansas Department for Aging and Disability Services (KDADS) provided data from the State tracking systems and databases. In addition, the KanCare MCOs provided data for the evaluation (MCO reports) and the hospitals in the DSRIP program provided project reports for review. Given the comprehensiveness of the State Quality Strategy and required reporting and monitoring, most of the data were drawn from existing reports.

Statistical tests were applied to assess improvement in trends over time and comparison of percentages/rates for the most recent and baseline years. For examining the pattern in the PMs (time series data) over the six-year program period, trend analyses were conducted using Mantel Haenszel Chi-Square test with $p<.05$ used for assessing statistical significance of the results. For comparisons with the baseline, appropriate statistical tests such as Fisher's Exact and Pearson Chi-Square tests were applied with $p<.05$ used to determine the statistical significance of the comparison results. When appropriate, absolute improvement in percentage points was examined by comparing percentages/rates for the most recent year as per availability of data with the baseline. Several PMs were based on standardized Healthcare Effectiveness Data and Information Set (HEDIS) data; therefore, these measures were also compared to the National Committee for Quality Assurance (NCQA) Quality Compass (QC) percentiles. Similarly, several measures based on the CAHPS Surveys were also compared

to the NCQA QC percentiles. For some PMs, where inferential statistical testing could not be done, comparisons were based on descriptive data and assessment of absolute differences was conducted without applying statistical testing. In the report, if the rates for measures remained consistently high or low in the appropriate direction throughout the evaluation period, then they were identified and labelled as "*maintained."*

A Special Study, 2019 Kansas HCBS–CAHPS Survey, examines the quality and care coordination/access aspects among beneficiaries receiving home and community based long-term services and supports through the KanCare Program. In the fall of 2018, KFMC contracted with Vital Research (VR) to conduct this survey study using the standard HCBS CAHPS Survey instrument developed by CMS for state Medicaid programs. In addition to the standard sections of the survey, KFMC and KDADS opted to include the Supplemental Employment Module about the participant's employment status, whether he/she has a job coach, their experience with this job coach, etc. At the time of preparation of this report, the data collection for the survey was still in progress with completion of in-person interviews with 194 respondents (target sample 400). For this report, the preliminary data were reviewed and summarized.

Final KanCare Program Evaluation Key Findings

The key findings obtained from the review of the evaluation design categories and subcategories are presented here.

Highlights of the Overall Findings for Eight Evaluation Categories

For the final evaluation, a total of 154 PMs addressing six subcategories, and information related to the remaining two subcategories (UCC Pool and DSRIP), were monitored to assess improvement in the KanCare program. The evaluation results showed that out of these 154 PMs, 113 PMs were either improved or maintained in appropriate direction over the evaluation period contributing to the impact of different aspects of the program in achieving its goals and objectives. In addition, two categories, the UCC Pool Program and DSRIP through its four projects also strengthened the KanCare program. The assessment of some of the PMs also indicated that certain aspects of the program need improvement. Efforts are needed to improve these areas to enable the KanCare program model to achieve its goals of providing efficient and effective health care services to all beneficiaries to its highest extent.

The highlights of the positive results and areas of opportunity for each subcategory are summarized below. Recommendations based on these results of the final evaluation are also included to assist the State and MCOs to further strengthen the positive aspects of the program as well as to develop and implement strategies to address areas of opportunities.

The evaluation results have also provided insights related to the policy implications and provided an opportunity to suggest recommendations for other states that are interested in a similar approach for their demonstration program.

The number of PMs in each evaluation category that showed improvement or were maintained during the evaluation period contributing to the impact of different aspects of the program are presented in Figure ES-5.

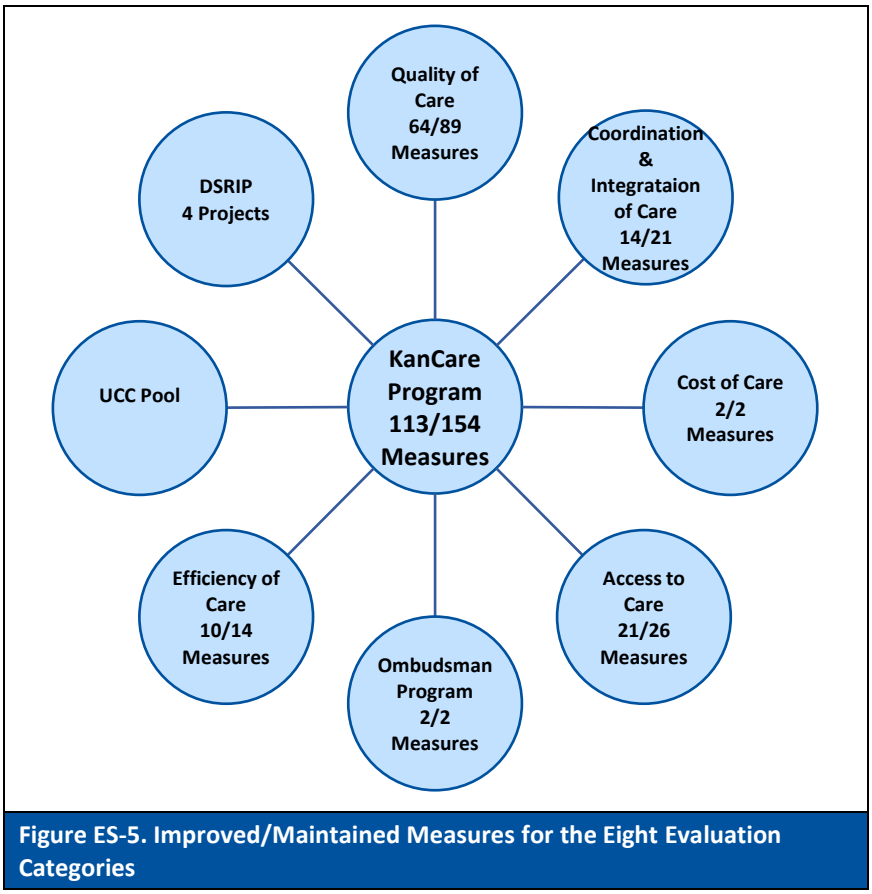

Figure ES-5. Improved/Maintained Measures for the Eight Evaluation Categories

Highlights of the Findings for the Subcategories of the Eight Evaluation Categories

Results showing positive improvement over time, as well as areas of opportunities based on the assessment of the PMs for the subcategories of each evaluation category are summarized below.

Highlights of the Positive Results Based on the Final KanCare Evaluation

Quality of Care

The following two hypotheses were evaluated to assess the improvement in the quality of care provided to KanCare beneficiaries and its contribution to the related goal and performance objectives (Goal 2; Objectives 1, 2, 3 and 4):

- By holding MCOs to outcomes and PMs, and tying measures to meaningful financial incentives, the State will improve health care quality and reduce costs; and
- The State will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between PH, BH, and LTSS.

The eighty-nine PMs addressing eight subcategories and information related to the ninth subcategory (Grievances) were monitored to assess the improvement in the quality of care received by KanCare program beneficiaries (Figure ES6). Information for the Grievance subcategory showed improvements made in data collection and in addressing grievances. The preliminary results for the tenth subcategory (Special Study: HCBS-CAHPS Survey) are included in the Results section of the report. **Out of the eighty-nine PMs assessed for the eight subcategories, sixty-four PMs were improved or maintained during the evaluation period**.

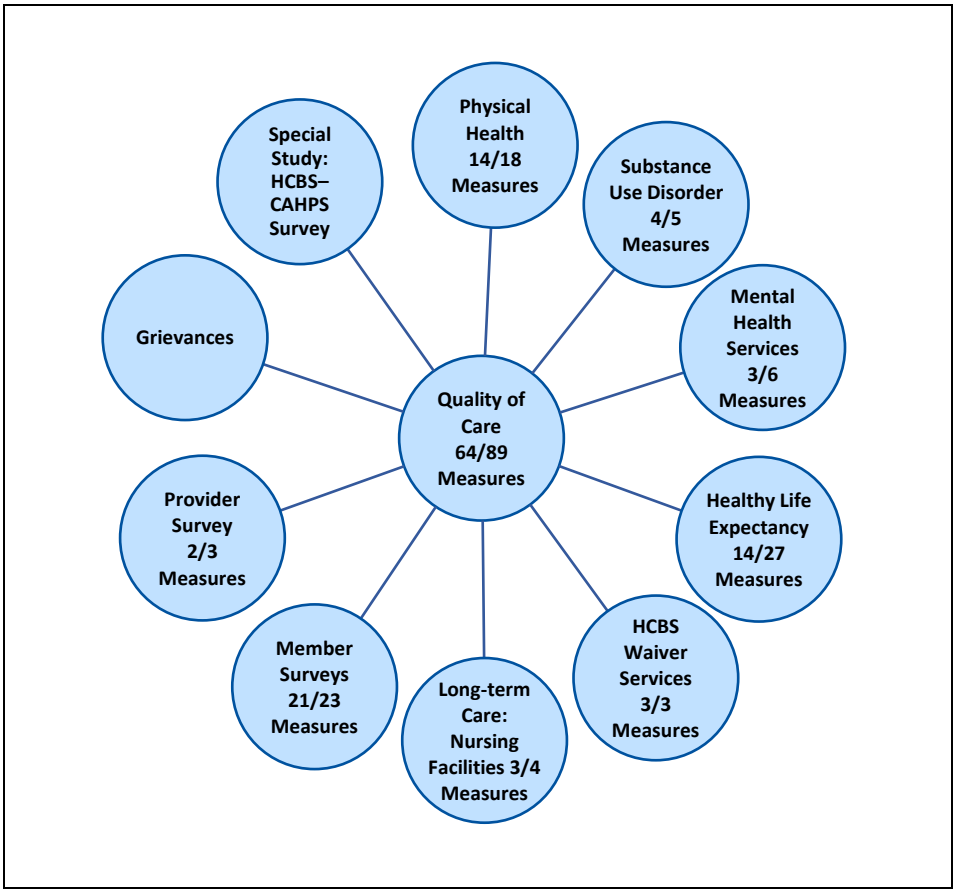

Figure ES-6. Improved/Maintained Measures for the Quality of Care Subcategories

Physical Health: The data for the eighteen HEDIS measures related to PH care were available for the five-year period. Several PMs showed statistically significant improvements in the trends over time and in the rates for the most recent year compared to the baseline. The results are summarized below.

- Statistically significant **improvements were seen in the *trends over time* for thirteen out of the eighteen PMs**. These include:
  - Annual dental visits among members ages 2–20 years (ADV);
  - Adult BMI assessment among members ages 18 years and older (ABA);
  - Weight assessment and counseling for nutrition and physical activity including weight assessment/BMI, counseling for nutrition and counseling for physical activity for children/ adolescents ages 3–17 years (WCC). This PM has three components. All three components showed increasing trends and higher rates in the recent year compared to the baseline;
  - Follow-up after hospitalization for mental illness, within seven days of discharge (FUH);
  - Adolescent well care visits (ages 12–21 years) (AWC);
  - Well-child visits in third, fourth, fifth and sixth year of life (ages 3–6 years) (W34);
  - Well-child visits in the first 15 months of life (3 visits, 4 visits, 5 visits, 6 or more visits) (W15);
  - Controlling high blood pressure (CBP);
  - Comprehensive diabetes care (CDC). This PM is based on six metrics. The trend analysis and comparison of rates in the most recent year with the baseline showed improvement in appropriate directions for all six metrics;
  - Appropriate testing for children with pharyngitis (CWP);
  - Medication management for people with asthma (MMA);

  - Annual monitoring for patient on persistent medications (MPM); and
  - Appropriate treatment for children with upper respiratory infection (URI).
- Statistically significant **improvements were also *seen in the trends* for most of the age groups.**
- Statistically significant **higher rates in the *most recent year compared to the baseline* were seen for fourteen out of the eighteen PMs.** These include all thirteen PMs described above. In addition, a statistically significant high rate in the most recent year compared to the baseline was also seen for follow-up care for children prescribed Attention Deficit Hyperactivity Disorder (ADHD) medication (initiation phase and continuation and maintenance phase). Similar results were also seen in most of the age groups for these PMs.
- The **rates above 80% were seen in the most recent year for four PMs**:
  - Adults' access to preventive/ambulatory health services (AAP);
  - Adult BMI assessment among members ages 18 years and older (ABA);
  - Annual monitoring for patient on persistent medications (MPM); and
  - Appropriate treatment for children with upper respiratory infection (URI).

Substance Use Disorder (SUD) Services: The National Outcome Measurement System (NOMS) data for the five PMs related to SUD Services were available from 2012–2018. Although only one PM related to SUD services showed improvement in the trend over time, **several PMs remained high throughout the evaluation period** reflecting the quality of care provided to the members receiving SUD services. The results are summarized below:

- Statistically significant **improvement was seen in the trend over time,** as well as a **higher rate in the most recent year compared to the baseline for one out of the five PMs**. This includes:
  - The number/percent of members receiving SUD services whose employment status was improved or maintained.
- Though, no statistically significant improvement in the trends was seen, the **rates were consistently high and maintained for the following three PMs** throughout the six-year period:
  - The number and percent of members receiving SUD services whose living arrangements improved;
  - The number and percent of members receiving SUD services whose criminal justice involvement improved; and
  - The number and percent of members receiving SUD services whose drug and/or alcohol use decreased.

Mental Health (MH) Services: The NOMS data for the six PMs related to MH Services among adults with SPMI and among youth with Serious Emotional Disturbance (SED) were available from 2012–2018. In addition, two proxy measures related to the identification of adults with SPMI and youth with SED receiving MH services were assessed in place of two PMs for increased access to MH services as data for these initial PMs were not available. The results for the six measures are summarized below:

- Statistically significant **improvements were seen in the trend over the six-year period for two out of six PMs.** These include:
  - The number and percent of youth with SED with improvement in their residential status;
  - The number and percent of KanCare members utilizing inpatient MH services.
- **Consistently maintained rates in appropriate directions for three measures** throughout the evaluation period were seen;
  - The number and percent of youth with SED with improvement in their residential status (>80%);
  - The number and percent of youth with SED who maintained their residential status (>98%);
  - The number and percent of KanCare members utilizing inpatient MH services (≤0.3%).

Healthy Life Expectancy: This subcategory was assessed by examining 27 PMs related to health literacy, and prevention and treatment/recovery aspects among the child (GC and CCC) and adult populations (21 CAHPS Survey PMs). The prevention and treatment/recovery aspects were assessed among the members with schizophrenia (one HEDIS PM), and among members with Serious Mental Illness (SMI), I/DD, and Physically Disabled (PD) (five HEDIS-like PMs). **Several of the CAHPS PMs for the child and adult populations were consistently high throughout the five-year period** showing high quality of care received by KanCare beneficiaries during this period. The **higher rates were also seen in the most recent year compared to the baseline for three PMs among members with SMI, I/DD, and PD**. The results are summarized below:

- Significantly improved trends over the five-year period for **four health literacy PMs among the child populations** were seen. These include:
  - Did you and a doctor or other health provider talk about specific things you could do to prevent illness (in your child)?
  - How often did your child's personal doctor explain things about your child's health in a way that was easy to understand?
  - How often did your child's personal doctor listen carefully to you?
  - When you talked about (your child) starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you (your child)? (CCC population only, 2015–2018)
- Significantly improved rates for **two health literacy PMs** in 2018 compared to the baseline **among the child populations** were seen:
  - How often did your child's personal doctor explain things in a way that was easy for your child to understand?
  - How often did your child's personal doctor listen carefully to you? (CCC only)
- Significantly improved trends over the five-year period in **four health literacy and prevention/treatment PMs among the adult population** were seen:
  - How often did your personal doctor listen carefully to you?
  - Do you now smoke cigarettes or use tobacco: every day, some days, or not at all?
  - If you smoke every day/some days, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco?
  - If you smoke every day/some days, 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?
- Significantly improved rates for **three health literacy and prevention/treatment PMs in 2018 compared to the baseline among the adult population**:
  - How often did your personal doctor listen carefully to you? (Higher rate compared to baseline)
  - If you smoke every day/some days, 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? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program. (Higher rate compared to baseline)
  - Do you now smoke cigarettes or use tobacco: every day, some days, or not at all? (Lower/improved rate compared to baseline)
- Though no statistically significant improved trends were seen, **the consistently high rates for some health literacy and prevention/treatment PMs among child and adult populations** throughout this period reflected high quality of care received by KanCare beneficiaries. These PMs include:
  - When you talked about your child starting or stopping a prescription medicine, did you and a doctor or other health provider talk about the reasons you might want to take a medicine? (Child; > 93%, 2015–2018)

  - How often did your child's personal doctor explain things in a way that was easy for your child to understand? (Child; > 91%)
  - How often did you have your questions answered by your child's doctors or other health providers? (Child; >89%)
  - When you talked about (your child) starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you? (GC; > 80%, 2015–2018)
  - In the last six months, how often did your personal doctor explain things in a way that was easy to understand? (Adult; >91%)
  - When you talked about starting or stopping a prescription medicine, did you and a doctor or other health provider talk about the reasons you might want to take a medicine? (Adult; >91%)
- **Consistently high rates were seen for one prevention PM and remained throughout the five-year period among the PD, I/DD, and SMI populations**:
  - Adults' access to preventive ambulatory health services (>94%).
- **The two metrics for the Comprehensive Diabetes Care PM (treatment/recovery PM based on five metrics) remained consistently high** during the evaluation period **in the members among PD, I/DD, and SMI populations**:
  - HbA1c testing (>84% throughout the five years);
  - Medical attention for nephropathy (>87% in most recent years).
- **Higher rates in the most recent year compared to the baseline were seen for three prevention and treatment/recovery PMs in the members among PD, I/DD, and SMI** populations:
  - Breast Cancer Screening (2016 compared to 2014);
  - Cervical Cancer Screening (2017 compared to 2014);
  - Comprehensive Diabetes Care (for 3 metrics: 2017 compared to 2013; for two metrics: 2015 compared to 2013).

HCBS Waiver Services: Three PMs were assessed to examine the quality of the HCBS waiver services provided to the I/DD, PD, Frail Elderly (FE), Traumatic Brain Injury (TBI), Technical Assistance (TA), SED and Autism waiver populations. The results are summarized below:

- Higher percentages for **three PMs in the most recent year compared to the baseline** were seen:
  - Number of KanCare members receiving **PD, TBI, or I/DD waiver** services who are participating in the WORK program (2017–2018);
  - Percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment – **six out of seven waiver types** (I/DD, PD, FE, TBI, TA and Autism) (2016–2017); and
  - Percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan – **six out of seven waiver types** (I/DD, PD, FE, TBI, TA and SED) (2016–2017).
- High percentages were seen in the **most recent year for two PMs**:
  - Waiver participants (I/DD, PD, FE, TA and SED) who received services in the type, scope, amount, duration, and frequency specified in the service plan – **above 80% for five out of the seven waiver types.**
  - Waiver participants (PD, FE, TA and SED) whose service plans address their assessed needs and capabilities as indicated in the assessment – **above 80% for four out of the seven waiver types.**

Long Term Care – Nursing Facilities (NFs): Four PMs assessed the quality of care for NFs.

- A **statistically significant reduction in the trend** over the six-year period (2012–2017), as well as a **lower percentage in the most recent year compared to the baseline (2012) for one PM** was seen:
  - The percentage of Medicaid NF claims denied by the MCO.

- An improved number in the **most recent year compared to the baseline was seen for one PM**:
  - Person-Centered Care Homes as recognized by the Promoting Excellent Alternatives in Kansas (PEAK) program in the MCO network.
- Consistently lower percentages for **one PM** throughout the six-year period were seen:
  - Percentage of NF members who had a fall with a major injury.

Member Surveys: Seventeen PMs related to member perception of provider treatment of the child and adult populations (CAHPS Survey), member perception of MH provider treatment (MH Survey), and member perception of SUD services (SUD Survey) were assessed.

CAHPS Survey: The 2014–2018 data for six Child and six Adult CAHPS Survey PMs were assessed. The results are summarized below:

- Improved **trends occurred over the five-year period for the rates of five out of six PMs** for the member perception of provider treatment measures among **the GC population; four out of the six PMs for the CCC population;** and **one out of the six PMs among the adult population.** The results are described below:
  - High rating (rating of 8, 9, or 10) for all health care received by the child in last six months. (GC/CCC)
  - How often did your child's personal doctor show respect for what you had to say? (GC/ CCC)
  - How often did your child's personal doctor spend enough time with your child? (GC/CCC)
  - High rating (rating of 8, 9, or 10) for the child's personal doctor. (GC)
  - High rating (rating of 8, 9, or 10) for the specialist most often seen for the child. (GC)
  - High rating (rating of 8, 9, or 10) for the child's health plan. (CCC)
  - Among the adult population – high rating (rating of 8, 9, or 10) for the health plan.
- Improved **rates for one PM in the most recent year compared to the baseline among the child population**:
  - How often did your child's personal doctor spend enough time with you (your child)? (CCC)
- The rates for all **six PMs were consistently high (>80%) throughout the five years for both the GC and CCC populations** indicating member satisfaction. For **two of these PMs, the rates were above 90%.**
- The rates for **four of the six PMs were consistently high (>80%) throughout the five years for the adult population** indicating member satisfaction. For **two of these PMs, the rates were above 90%**.
  - A high rating (rating of 8, 9, or 10) for the personal doctor. (around 80%)
  - A high rating (rating of 8, 9, or 10) for the specialist most often seen. (above 83%)
  - How often did your personal doctor show respect for what you had to say? (> 91%)How often did your personal doctor spend enough time with you? (>88%)

MH Survey: The 2011–2018 data for eight MH survey PMs among the Adult, Youth, and SED Waiver youth and young adult populations were assessed. The results are summarized below:

- The rates for **three PMs showed statistically significant improved trends or improved rates compared to the baseline**:
  - My mental health provider spoke with me in a way that I understood. (SED Waiver Youth, ages 12-17, youth responding)
  - I, not my mental health provider, chose my treatment goals. (SED Waiver and General Youth, ages 12–17, youth responding)
  - As a direct result of the services I received, I am better able to do things I want to do. (Improved 2018 compared to baseline– Adults)

- The following measures showed **consistently high rates (>90%)** over the evaluation period, although there was no statistically significant improvement:
  - I helped to choose my child's treatment goals/I, not my mental health providers, decided my treatment goals. (≥93.1% – SED Waiver Youth and Young Adults, family/member responding)
  - My mental health provider spoke with me in a way that I understood. (90.0% to 96.3% – Adults and General Youth, ages 12–17)
  - I have people I am comfortable talking with about my child's problems. (≥90.4% – Youth (ages 0–17), family responding)
- The following PMs **showed consistently maintained rates** throughout the evaluation period without statistically significant improvement over time:
  - If I had other choices, I would get services from my mental health providers. (≥85.0% – Adults)
  - R I, not my mental health providers, decided my treatment goals. (>78.0% – Adults)
  - As a result of the services I received, I am better at handling daily life/As a result of the services my child and /or family member received, my child is better at handling daily life:
    - Rates were ≥85.3% – General Youth (ages 12–17), youth responding
    - Rates were ≥79.6% – SED Waiver Youth (ages 12–17), youth responding
    - Rates were ≥77.8% – Youth (ages 0–17), family responding
  - As a direct result of the services my child and/or family received, my child is better able to do things he or she wants to do. (≥80.0% during the evaluation period; however, the most current rate was lower than the baseline (2011 and 2012) – Youth (ages 0–17), family responding)
  - I felt comfortable asking questions about my treatment and medication. (≥85.9% and greater than 90% in four of six years – Adults)
  - I have people I am comfortable talking with about my child's problems. (≥87.7% – SED Waiver Youth and Young Adults, family/member responding)
  - My mental health providers helped me obtain information I needed so that I could take charge of managing my illness. (≥82.7% – Adults)
  - As a direct result of the services I received, I am better able to control my life. (≥74.8% – Adults)
  - I helped to choose my child's treatment goals. (≥ 90.5% - Youth, family responding)

SUD Survey: Member perceptions of SUD services were assessed by three PMs based on the SUD Survey questions. The SUD surveys were conducted by the MCOs on an annual basis from 2014 through 2017. The results are summarized below:

- The rates for **all three measures were above 80% throughout the four-year evaluation period**:
  - Members rated the quality of services received from their counselor consistently high (>88%) from 2014 through 2017.
  - Members highly rated (>87%) their counselors involving them in decisions about their care as very good/good throughout the four-year period.
  - Throughout the four years, a high rate of members responded they were feeling much better or better since beginning treatment (>84%).

Provider Survey: The Quality of Care aspect of the Provider Survey subcategory was assessed by examining one PM. The data were for varying time periods from the MCOs. Results summarized below:

- **Two of the three MCOs had statistically significant higher rates of providers' perception of their commitment to high quality care**.
  - Amerigroup had a significantly higher rate of providers (general and BH) being very or somewhat satisfied with the MCO's commitment to high quality of care for their members, in 2018 compared to 2014.

- Sunflower had a statistically significant improvement in general provider satisfaction with the MCO's commitment to high quality care, in 2017 compared to 2014 (unable to compare 2018).

Grievances: The MCOs report grievances by category through quarterly Grievance and Appeal reports (GAR), as well as in the quarterly STC report through 2016. Due to MCO inconsistencies and grievance mis-categorizations, as well as the State's report improvements and definition clarifications, baseline to current comparisons are not possible. Available results are summarized below:

- Generally, around 8% to 15% of grievances appear to be related to quality of care.
- KDHE has focused efforts on improvements in reporting templates, grievance category details, clarifications and training to MCO staff, addressing internal and External Quality Review Organization (EQRO) reviews/recommendations to improve reporting consistency.

Special Study – 2019 Kansas HCBS–CAHPS Survey – Quality Aspect: Survey: At the time of preparation of this evaluation report, the data collection for the survey was still in progress. The Quality of Care aspect of the beneficiaries' experience receiving their home and community based long-term services and supports was based on three PMs. The preliminary findings are included in the Results section of the report.

Coordination and Integration of Care

The following hypothesis was evaluated to assess the improvement in the coordination and integration of care provided to KanCare beneficiaries and its contribution to the related goal and performance objectives (Goal 1; Objectives 2 and 3):

- The KanCare model will reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired.

The twenty-one PMs addressing five subcategories and information related to the sixth subcategory (care management for members with I/DD) were monitored to assess the improvement in the coordination and integration of care received by KanCare program beneficiaries. The preliminary results for the seventh subcategory (special study: HCBS-CAHPS Survey) are reported in the Results section of the report. **Out of the twenty-one PMs assessed for the five subcategories, the fourteen PMs were improved or maintained during the evaluation period.** The results are summarized in Figure ES-7. **The information related to the care management for members with I/DD subcategory also showed positive results.**

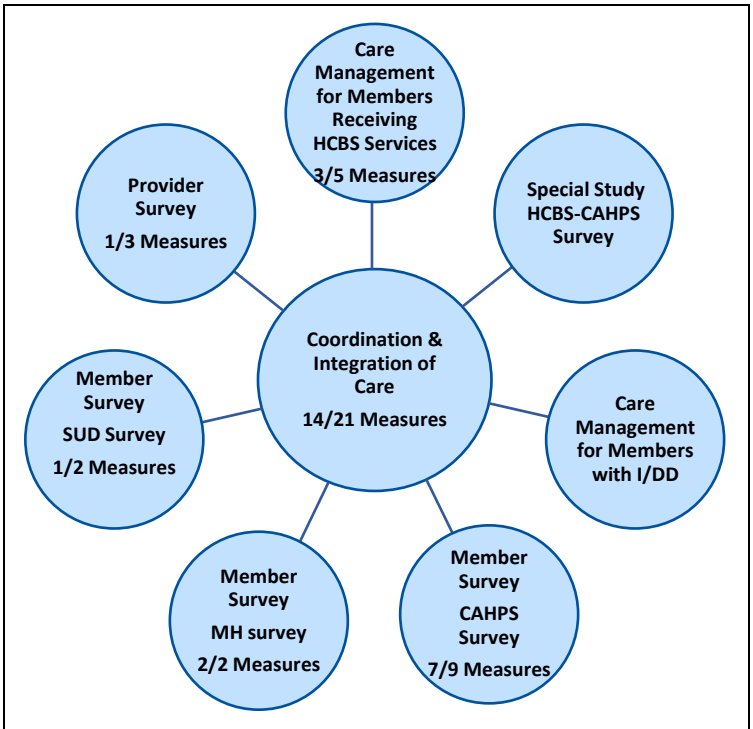

Figure ES-7. Improved/Maintained Measures for the Coordination and Integration of Care Subcategories

Care Management for Members Receiving HCBS Services: The descriptive data for the five PMs were assessed for the final evaluation. **Three PMs remained maintained over time and had higher rates for the most recent year compared to the baseline**. The results are summarized below:

- The percentages were **maintained for the three PMs throughout the evaluation period and the percentages for the most recent year were higher compared to the baseline**:
  - Percent of the HCBS Waiver participants who had assessments completed that included physical, behavioral, and functional components to determine their needs – six out of seven waiver types (I/DD, PD, FE, TBI, TA, and Autism) (2016–2017);
  - Percent of the HCBS Waiver participants with documented change in needs whose service plans were revised, as needed, to address the change – four out of seven waiver types (I/DD, FE, TA, and Autism) (2016–2017);
  - Percent of the HCBS Waiver participants, ages 20 and older, with adults' access to preventive/ambulatory health services (2013–2016);
  - Percent of HCBS Waiver participants, ages 2–20, with an annual dental visit (2013–2016); and
  - Percent of the HCBS Waiver participants, ages 18 and older, with ED visits (2013–2016).
- High percentages were seen in the most recent year for the **three PMs**:
  - Percent of HCBS Waiver participants who had assessments completed that included physical, behavioral, and functional components to determine their needs – five out of the seven waiver types (I/DD, PD, FE, TBI, and TA) (>88%);
  - Percent of HCBS Waiver participants with documented change in needs whose service plans were revised, as needed, to address the change – two out of the seven waiver types (TA and SED) (>82%); and
  - Percent of the HCBS Waiver participants, ages 20 and older, with adults' access to preventive/ ambulatory health services (>91%).

Special Study – 2019 Kansas HCBS–CAHPS Survey – Coordination and Integration of Care Aspect: The Coordination and Integration of Care aspect of the beneficiaries' experience was based on five PMs. The preliminary findings are included in the Results section of the report.

Care Management for Members with Intellectual/Developmental Disability (I/DD): While people using I/DD services came into the KanCare program on January 1, 2013 for all non-HCBS services, their long-term services and supports were initially carved out. The State was able to offer a voluntary pilot project for I/DD members and preparation began in July 2012 with KDADS' assembly of the I/DD Advisory Committee. KDADS launched the KanCare Pilot Project for persons with I/DD during the spring of 2013. Over 500 individuals receiving services through the HCBS Waiver and approximately 25 service providers volunteered to be enrolled in the KanCare I/DD Pilot Project. The Project's primary objective was to prepare the I/DD population being served by the HCBS I/DD Waiver for full inclusion in KanCare by January 1, 2014. Successes of the I/DD pilot project are as follows:

- Infrastructure and Processes included:
  - The I/DD Pilot Advisory Committee.
  - Increased shared understanding through frequent and varied methods of communication and education among Consumers, MCOs, I/DD providers, and State Agencies.
  - Collaborative determinations of services, the service delivery model and workflows.
  - Development and testing of billing processes.
- Lessons Learned and Improvements included:
  - Lesson learned during Pilot testing of the billing/claims systems resulted in improvements.

  - Continued use of the Kansas Medical Assistance Program (KMAP) system for front-end billing as well as allowing billing through the MCO web portals.
  - Extended existing plans of care to allow sufficient time for MCOs to load authorizations and develop integrated service plans.
  - Each MCO developed and posted billing guides.
- Quality:
  - There were no major service delivery interruptions for members receiving I/DD services while participating in the Pilot Project.
  - Access to complex case staffing and MCO Value-Added services.
  - Integration of PH, BH, and LTSS services.
  - Continued Targeted Case Management/Manager (TCM) services.
  - Service delivery and related assessment/tiering remained a responsibility of the Community Developmental Disability Organizations (CDDOs), Community Service Providers (CSPs), and TCMs.

Member Survey – CAHPS Survey: Nine PMs related to the members perception of the providers treatment for the child and adult populations (CAHPS Survey), were assessed. The 2014–2018 data for fifteen child and adult CAHPS Survey questions were examined to assess these nine PMs. The child PMs were assessed in both the GC and CCC populations. **The rates for seven out of nine PMs were improved or remained high during the evaluation period.** The results are summarized below:

- Improved trends over the five-year period in the **rates of the three PMs were seen (two in the GC and one in the CCC populations)**:
  - In the last six months, how often did you get an appointment (for your child) to see a specialist as soon as you needed? (GC)
  - How often was it easy to get the care, tests, or treatment you (your child) needed? (GC)
  - Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines? (CCC)
- Improved rates for the **three PMs in the most recent year compared to the baseline among the child populations** were seen (one in both and two in the CCC population):
  - Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines? (GC/CCC)
  - Did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare? (CCC)
  - Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life? (CCC)
- Though, no statistically significant improvement was seen in the trends over the five-year period for most of the measures among child and adult populations, the **rates for these measures were consistently high throughout this period**. High rates were maintained throughout showing high satisfaction of the members with these aspects:
  - How often did your (child's) personal doctor seem informed and up-to-date about the care you (your child) got from these doctors or other health providers? (GC/CCC; >80%)
  - Did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare? (GC/CCC; > 91%)
  - Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life? (GC/CCC; > 91%)
  - Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your family's day-to-day life? (GC/CCC; > 88%)

- How often was it easy to get prescription medicines for your child through his or her health plan? (GC; >93%)
- In the last six months, how often did you get an appointment (for your child) to see a specialist as soon as you needed? (CCC; > 83%)
- How often was it easy to get the care, tests, or treatment you (your child) needed? (CCC; >91%)
- How often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers? (Adults; >82%)
- In the last six months, how often did you get an appointment to see a specialist as soon as you needed? (Adults; >81%)
- How often was it easy to get the care, tests, or treatment you (your child) needed? (Adults; > 87%)

Member Survey – MH Survey: The two PMs related to the perception of Care Coordination for members receiving mental health services among the Adult, Youth, and SED Waiver Youth and Young Adult populations were assessed. These PMs were based on the questions from the MH surveys conducted from 2011 to 2018. The subgroups, General Youth and SED Waiver Youth (ages 12–17 youth responding) and SED Waiver Youth and Young Adults (family/member responding) were assessed 2011 through 2017; and the Youth (ages 0–17, family responding), and Adult subgroups were assessed 2011 through 2018. The **rates of both PMs were improved or maintained over time**. The results are summarized below:

- Statistically significant improvement in the trends over time (2011 to 2017) and (2013 to 2017) for **one out of two measures in the SED Waiver Youth (ages 12–17), youth responding, survey subgroup population** – I was able to get all the services I thought I needed.
- The following measure showed a **statistically significant decrease and subsequent increase when comparing the most recent year to the baseline (2011 and 2012 respectively)**:
  - Adults – I was able to get all the services I thought I needed.
- In 2018, rates for one out of two measures were improved compared to the baseline rate among the SED Waiver Youth (ages 12–17, youth responding), and SED Waiver Youth and Young Adults (family/member responding), survey subgroup populations:
  - My family got as much help as we needed for my child. (≤79.3% during the evaluation period – SED Waiver Youth and Young Adults, family/member responding)

Member Survey – SUD Survey: The two PMs related to member perceptions of SUD treatment were assessed to examine the improvement in Coordination of Care among members using SUD services. These PMs were based on the SUD Survey questions related to counselors requesting releases of information. The survey was a convenience survey administered in May through August in 2017 through face-to-face interviews, mail, telephone, and provider-initiated at time of visit/treatment. **One of the two PMs showed improvement.** The results are summarized below:

- One PM improved to greater than 80% in 2015 and was maintained through the most recent evaluation period:
  - Has your current counselor asked you to sign "release of information" forms to allow the counselor to share information with other SUD counselors seen by the member.

Provider Survey: The Coordination of Care aspect of the Provider Survey subcategory was assessed by examining three PMs. The data were available for varying time periods from the MCOs. The results are summarized below:

- **Amerigroup had a statistically significant improvement in the rate of providers** (general and BH providers in one survey) being very or somewhat satisfied with the MCO's pre-certifications and/or authorizations in 2018 compared to 2014.

Cost of Care

The following hypothesis was evaluated to assess the cost of care aspect of the KanCare program and its contribution to the related goal and performance objectives (Goal 3; Objective 4 and 5):

- By holding MCOs to outcomes and PMs, and tying measures to meaningful financial incentives, the State will improve health care quality and reduce costs.

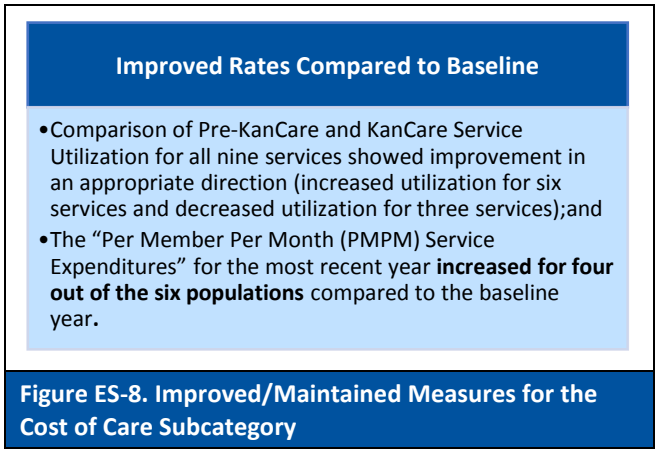

Figure ES-8. Improved/Maintained Measures for the Cost of Care Subcategory

The two PMs addressing one subcategory were monitored to assess the cost of care aspect of the KanCare program. **Both PMs assessed for the subcategory were improved during the evaluation period.** The results are summarized in Figure ES-8.

Costs: Results for the two PMs are summarized below:

- Comparison of Pre-KanCare and KanCare Service Utilization for **all nine services showed improvement in an appropriate direction**.
  - **Increased utilization for six services (positive result):** Non-Emergency Transportation; Home and Community Based Services; Vision; Dental; Primary Care Physician; and Pharmacy.
  - **Decreased utilization for three services (positive result):** Inpatient Hospitalization; Non-Emergency Outpatient visits; and Emergency Room Outpatient visits.
- The "Per Member Per Month (PMPM) Service Expenditures" for the most recent year (2017) **increased for four out of the six populations** compared to the baseline year (2013): Children and Families; Waiver Services; Long Term Care; and Aged, Blind, Disabled – Supplemental Security Income (SSI) and Medically Needy populations.

Access to Care

The following hypothesis was evaluated to assess the improvement in the access to care provided to the KanCare beneficiaries and its contribution to the related goal and performance objectives (Goal 4; Objectives 1, 2, 3, 4 and 5):

- The State will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between PH, BH, and LTSS.

The twenty-six PMs addressing six subcategories were monitored to assess the improvement in the access to care received by KanCare program beneficiaries. **Out of the twenty-six PMs assessed for the six subcategories, the twenty-one PMs were improved or maintained during the evaluation period.** The results are summarized in Figure ES-9. The preliminary results for the Special study: HCBS–CAHPS Survey are reported in the Results section of the report.

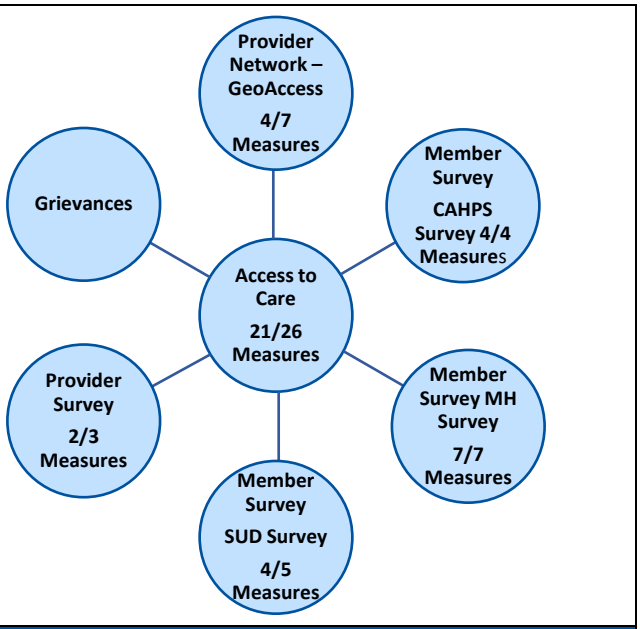

Figure ES-9. Improved/Maintained Measures for the Access to Care Subcategories

Provider Network – GeoAccess: The data for the seven PMs related to this subcategory were available for varying time periods (2013–2018, 2013–2017, and 2014–2018). **The four PMs and their components had shown improvement over time and in the most recent year compared to the baseline.** Due to the changes the State required the MCOs to make in provider network reporting and caveats related to the MCO and vendor descriptions of the survey sampling, methodology, survey conclusions, and comparisons to prior year survey results, results summarized here should be interpreted cautiously. The results are summarized below:

- **Five out of seven PMs** had components of the measure that improved/maintained throughout the evaluation period.
- **One out of seven** PMs showed 100% compliance each year of the evaluation period.
- **Positive results seen over time included**:
  - The BH provider type had 100% access during the evaluation period and 2012 (pre-KanCare) for all the 105 counties in Kansas.
  - There was a 28% average increase in the number of BH providers in 2013 to 2018.
  - Incorrectly included records, duplicate entries, or apparent/presumed duplicate entries in Network Provider reporting, have decreased to 0.25%.
  - The largest increase in both number of providers and provider locations since 2013 were for the provider types Physical Therapy, Obstetrician/Gynecologist, Podiatry, and Gastroenterology, and Podiatry had one of the largest increases in number of providers.
  - Since 2012, access to provider specialties has improved for members who were residents of any of the Frontier, Rural, and Densely-Settled Rural (Non-Urban) counties.
  - Fifteen of 29 provider types in Urban and Semi-Urban counties and 16 of 29 Non-Urban counties had a decrease in the percent not within access standards.
  - All members who were residents of any of the 16 Urban/Semi-Urban counties had access to at least one provider in all provider types in 2012 (pre-KanCare) and since 2013 by at least one MCO.

- When comparing 2013 to 2017, two MCOs had at least two providers in all 105 Kansas counties for most of the HCBS services.
- Of the 14 I/DD provider services, in 2017, most of them had 2 or more providers in ≥100 Kansas counties from all three MCOs.
- For provider after-hours access surveys completed 2013 through 2018, the average rate of compliance was 84.6%.
- Overall, from 2016 to 2018, for the appointment availability access standards reported by all three MCOs, most rates ranged from 74.9%–100%.

Member Survey – CAHPS Survey: Four PMs assessed the member experience with appointment availability among the child (GC and CCC) and adult populations. The 2014–2018 data for eight Child and Adult CAHPS Survey questions were examined to assess these four PMs. The **rates for all four PMs were improved or remained high during the evaluation period.** The results are summarized below:

- Statistically significant **improvements in the trends over time for two out of four PMs in the GC population, and for one out of four PMs in the CCC population were seen.** These include:
  - In the last 6 months, when you (your child) needed care right away, how often did you (your child) get care as soon as you (he or she) needed? (GC)
  - How often was it easy to get the care, tests, or treatment you (your child) needed? (GC)
  - How often did you get an appointment (for your child) to see a specialist as soon as you needed? (CCC)
- High rates for **four PMs were seen during 2014–2018 among the child populations**. These include:
  - In the last 6 months, how often did you get (when you made) an appointment for a check-up or routine care for your child at a doctor's office or clinic (how often did you get an appointment) as soon as your child needed? (GC/CCC; >90%)
  - A In the last 6 months, when your child needed care right away, how often did you (your child) get care as soon as he or she needed? (GC; >93%)
  - How often was it easy to get the care, tests, or treatment you (your child) needed? (CCC; >91%)
  - How often did you get an appointment (for your child) to see a specialist as soon as you needed? (CCC; >83%)
- High rates for **four PMs were seen during 2014–2018 among the adult population**. These include:
  - In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? (>86%)
  - In the last 6 months, how often did you get (when you made) an appointment for a check-up or routine care at a doctor's office or clinic (how often did you get an appointment) as soon as you needed? (>82%)
  - How often was it easy to get the care, tests, or treatment you needed? (>87%)
  - How often did you get an appointment to see a specialist as soon as you needed? (>81%)

Member Survey – MH Survey: The seven PMs related to the perception of access to MH services among the Adult, Youth, and SED Waiver youth and young adult populations were assessed. These PMs were based on MH surveys conducted from 2011 to 2018. The **rates for all seven PMs were improved or maintained over time**. The results are summarized below:

- **Three PMs showed a statistically significant improvement in the trends** over the six-year and seven-year period and **improved rates in 2018, compared to the baseline** (2012 and 2013):
  - Adults – I was able to see a psychiatrist when I wanted to.
  - Adults and SED Waiver Youth (ages 12–17), youth responding – I was able to get all the services I thought I needed.

  - Youth (ages 0–17), family responding, and SED Waiver Youth and Young Adults, family/member responding – Medication available timely.
- **Two PMs showed high rates (>90%)** during the evaluation period – Medication available timely:
  - Rates above 90.3% – Adults
  - Rates above 90.9% – SED Waiver Youth and Young Adults, family/member responding
- The **rates for five PMs were maintained** during the evaluation period:
  - Services were available at times that were good for me (convenient for us/me). (Adults; General Youth (ages 12–17), youth responding; Youth (ages 0–17), family responding; SED Waiver Youth (ages 12–17), youth responding; and SED Waiver Youth and Young Adults, family/member responding)
  - My mental health providers returned my calls in 24 hours. (Adults)
  - My mental health providers were able to see me as often I as felt it was necessary. (Adults)
  - I was able to get all the services I thought I needed/My family got as much help as we needed for my child. (Youth (ages 0–17), family responding; General Youth (ages 12–17), youth responding; and SED Waiver Youth and Young Adults, family/member responding.)
  - During a crisis, I (my family) was able to get the services I (we) needed. (Adults; Youth, family responding; and SED Waiver Youth and Young Adults, family/member responding)

Member Survey – SUD Survey: The five PMs related to member perceptions of SUD treatment were assessed for the improvement in access to care among members using SUD services. These PMs were based on the seven SUD Survey questions. The **rates for four out of the five PMs were improved or maintained in recent years.** The results are summarized below:

- High **rates (90%) were seen for one PM for most of the years** during the evaluation period:
  - How satisfied are you with the time it took you to see someone? ("Very satisfied" and "Satisfied" responses)
- Maintained **rates in appropriate directions for four PMs were seen for most of the years during the evaluation period (>83% for three PMs and <20% for one PM)**:
  - Thinking back to your first appointment for your current treatment, did you get an appointment as soon as you wanted? (Yes responses)
  - How satisfied are you with the time it took you to see someone? ("Very satisfied" and "Satisfied" responses)
  - Is the distance you travel to your counselor a problem or not a problem? ("Not a Problem" responses)
  - Were you seen within 24 hours, 24 to 48 hours, or did you have to wait longer than 48 hours? (“longer than 48 hours” responses)

Provider Survey: The access to care aspect of the Provider Survey subcategory was assessed by examining one PM based on a survey question asking providers to rate their “satisfaction with availability of specialists.” The data were available for varying time periods from the MCOs. **Statistically significant higher rates in most recent years compared to the baseline were seen for two MCOs. The** results are summarized below:

- The statistically significant **higher rates in most recent years compared to the baseline** were seen for **two MCOs**.
  - In 2018, Amerigroup providers had a significantly higher rate of satisfaction with the availability of specialists compared to 2014 ($p<.05$).
  - Sunflower BH provider survey respondents had a significantly higher rate of satisfaction in 2017 compared to 2015 ($p<.05$).

Grievances: Available results are summarized below:

- Generally, around 3% to 10% of grievances appear to be related to access to care.
- KDHE has focused efforts on improvements in reporting templates, grievance category details, clarifications and training to MCO staff, addressing internal and EQRO reviews/ recommendations to improve reporting consistency.

Special Study – 2019 Kansas HCBS–CAHPS Survey – Access to Care Aspect: Survey: The *access to care* aspect of the beneficiaries' experience receiving their home and community based long-term services and supports was based on two PMs. The preliminary findings are included in the Results section of the report.

Ombudsman Program

The following hypothesis was evaluated to assess the improvement in the access to care provided to the KanCare beneficiaries and its contribution to the related goal and performance objectives (Goal 4; Objectives 1, 2, 3, 4 and 5):

- The State will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between PH, BH, and LTSS.

The two PMs addressing one subcategory, "Calls and Assistance" were monitored. These PMs showed improvement over time. The infrastructure and capacity of the office was also improved.

Calls and Assistance: The following progress over time was seen**:**

- Improved Infrastructure and Capacity:
  - Increased number of staff and trained volunteers to fulfill the responsibilities of the Ombudsman's Office; Training of the volunteers;
  - Improved data tracking system to collect information on PMs;
  - Improved reporting on number and types of contacts, inquiries by waiver type, and tracking of time to response to the inquiry by the Ombudsman Office and other entities.
- Number of initial contacts tracked in most recent year were higher than initial years.
- The most frequent type of issues/inquiries received in five years (2014–2018) were related to the "Medicaid Eligibility Issues" including Medicaid General Issues/Questions, Medicaid Eligibility Questions, Medicaid Application Assistance, and Medicaid Information/Status Update. For the types of issues for which data were available for each of the five years, a decline in frequency was seen over time for "Billing Issues," "Medical Services," and "Pharmacy."
- In 2018, the Ombudsman Office responded to 86% of the 4,484 contacts within the two business days, whereas it responded to 72% of the 3,672 contacts within two business days in 2017 (an improvement by 13.7 percentage points in 2018 compare to 2017).

Efficiency of Care

The following hypothesis was evaluated to assess the improvement in the efficiency of care provided to the KanCare beneficiaries and its contribution to the related goal and performance objectives (Goal 4; Objectives 1, 2, 3, 4 and 5):

- The State will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between PH, BH, and LTSS.

The 14 PMs addressing the subcategories were monitored to assess the improvement in the efficiency of care received by KanCare program beneficiaries. **Out of the 14 PMs assessed for the subcategories, the 10 PMs were improved or maintained during the evaluation period.** The results are summarized in Figure ES-10.

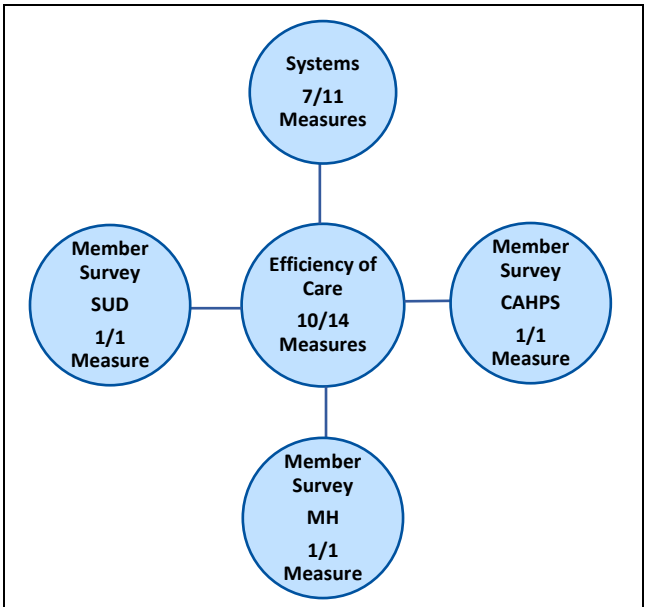

Figure ES-10. Improved/Maintained Measures for the Efficiency of Care Subcategories

Systems: The subcategory included focus areas: Utilization - the assessment of the service utilization through Emergency Department (ED) visits, inpatient admissions and inpatient readmissions within 30 days of discharge; Process Timeliness - assessment of the timely resolution of grievances, customer service inquiries and claims processing; and System Design Innovations. The 11 measures were monitored for the first two focus areas. The data for the 11 PMs related to Systems were available for varying time periods. Several performance measures had improvement overtime in the most recent year compared to the baseline and trending across years. The results are summarized below:

- Service utilization through ED visits, inpatient admissions and inpatient readmissions within 30 days of discharge:
  - The following measure showed considerable improvement in the most recent year (2017) compared to the baseline (2014):
    - HCBS and MH ED Visits (including dual eligible members) – TBI and MH
  - The following measures maintained over the four-year period (2014 through 2017):
    - HCBS and MH ED Visits (including dual-eligible members) – All KanCare Members, Total Waiver Populations (TBI, FE, I/DD, and PD), and FE and I/DD Waiver members;
    - HCBS Inpatient Admissions – All KanCare Members, Total Waiver Populations (TBI, FE, I/DD, and PD), and the four individual waivers (TBI, FE, I/DD, and PD); and
    - HCBS Readmissions within 30 days of Discharge – All KanCare Members, Total Waiver Populations (TBI, FE, I/DD, and PD), FE, I/DD, and PD Waiver members
- **Timely resolution of grievances, customer service inquiries and claims processing:** Member and provider inquiries were consistently resolved within the timeliness standards of 95% within two business days and 98% within 5 business days. Grievance resolutions were routinely resolved at rates above the required 98% within 30 days. Processing of non-clean claims consistently met the standard of 99% within 60 days.
- **System Design Innovations:** The programs included Health Homes, DSRIP – Expansion of Patient Centered Medical Homes (PCMH) and Neighborhoods, Patient Centered Medical Homes, the Comprehensive Primary Care Plus project, Practice Redesign Initiatives, Health Information Exchange (HIE) and Telehealth and Telemedicine. The information for these programs is described in the Results section of the report.

Member Surveys – CAHPS: One PM related to the member experience with the health plan's customer service among the child (GC and CCC) and adult populations was assessed. The 2014–2018 data for two questions from the child and adult CAHPs Surveys were examined to assess this PM. The **rates for the**

PM (positive responses) were consistently high throughout the evaluation period. The high rates throughout this period indicated high satisfaction of the members. The results are summarized below:

- The rates among both the child (GC and CCC) and the adult populations remained high and maintained throughout the five-year period (Percent of "Always/Usually" Responses):
  - Among the GC population, rates were above 83% – In the last 6 months, how often did your (child's) health plan's customer service give you the information or help you needed? Among the CCC population, rates were ≥ 82% – In the last 6 months, how often did your (child's) health plan's customer service give you the information or help you needed?
  - The rates were ≥ 80% – In the last 6 months, how often did your (child's) health plan's customer service give you the information or help you needed?

Member Survey – MH Survey: One PM related to the adult members' perception of the mental health provider returning their calls in 24-hours was assessed. This PM was based on MH surveys conducted from 2011 to 2018 among KanCare members who received one or more MH services in the prior six-month period of each survey year. The rates for this PM were consistently maintained and were high throughout the six-year evaluation period (2013–2018) and pre-KanCare (2011 and 2012). The results are summarized below:

- For Adult members, the rates were consistently maintained over the six-year period (2013–2018), ranging from 79.6% in 2016 to 86.4% in 2018 (most recent year).

Member Survey – SUD Survey: One PM related to the members' experience with clear communication from the counselor (rating of the counselor on communicating clearly with the member) was assessed. The PM was based on one SUD Survey question. The **rates for this PM were consistently high throughout the four-year period** indicating high satisfaction with SUD services provided to them through the KanCare program. The results are summarized below:

- High rates for the members' positive experiences with counselors' communication were maintained throughout the four-year evaluation period (≥87%).
  - How well does your counselor communicate with you? (Percent of "Very well" or "Well" responses).

Uncompensated Care Cost Pool (UCC Pool)

The UCC Pool permits payments from the State to hospitals based on the uncompensated cost of furnishing services to Medicaid and uninsured individuals. The UCC Pool funding is based on historical costs. UCC Pool payments increased from $20,568,567 in CY2012 to $41,026,795 in CY2013. This increase was partially due to a change in Kansas Statute 65-6208 to increase Health Care Access Improvement Program (HCAIP) funding implemented at the start of the FY2013. UCC Pool payments ranged from $40,698,530 to $40,983,780 in subsequent years.

Delivery System Reform Incentive Program (DSRIP)

The Goal of DSRIP is as follows:
To advance the goals of access to services and healthy living by specifically focusing on incentivizing projects that increase access to integrated delivery systems and projects that expand successful models for prevention and management of chronic and complex diseases.

The Kansas DSRIP program, launched in 2015, includes two major hospital systems, Children's Mercy Hospital and Clinics (CMH) and the University of Kansas Health Systems (UKHS). UKHS implemented two projects within the "prevention and management of chronic and complex diseases" focus area, while CMH implemented one project from each focus area. CMH projects include *the Beacon Program* and

Expansion of Patient Centered Medical Homes and Neighborhoods (PCMH). UKHS projects include STOP Sepsis (*Standard Techniques, and Procedures for Sepsis*) and SPARCC (*Supporting personal Accountability and Resiliency for Clinic Conditions*). Each project contains Infrastructure Milestones (Category 1), Process Milestones (Category 2), Quality and Outcome Milestones (Category 3), and Population Focused Metrics (Category 4). **Several improvements and accomplishments were noted in all Category Metrics** and are summarized in Figure ES-11.

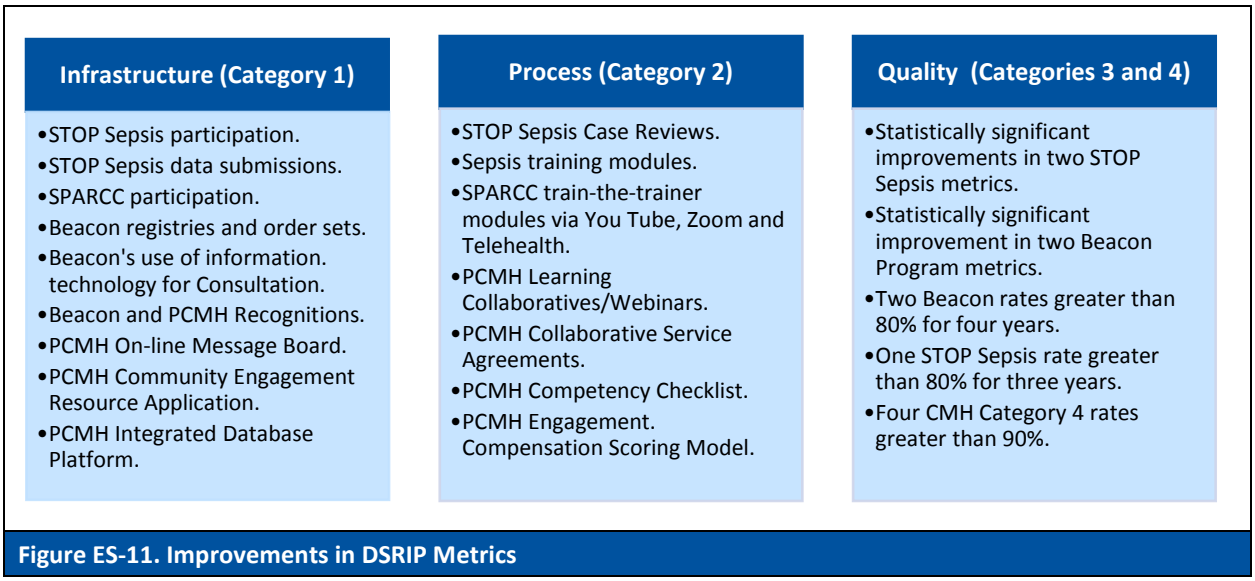

Figure ES-11. Improvements in DSRIP Metrics

Highlights of the Opportunities for Improvement Based on the Final KanCare Evaluation

Quality of Care

Physical Health: Declining trends over time were seen for a couple of the HEDIS PMs along with consistent low rates for one of these and three other PMs, indicating areas of improvement.

- Decreasing trends for two out of eighteen PMs were seen. These included:
  - Adults' access to preventive/ambulatory health services (AAP); and
  - Initiation and engagement in alcohol or other drug dependence treatment (IET).
- The consistently low rates for Initiation and engagement in the treatment for alcohol or other drug dependence (IET) were seen throughout the evaluation period (Initiation in treatment <40%; Engagement in treatment <16%).
- No change in trends over time, as well as the low rate in the most recent year compared to the baseline was seen for Prenatal and Postpartum Care (<70%); Chlamydia screening in women ages 16–24 years (<47%); and Follow-up care for children prescribed ADHD medication, both initiation phase and continuation and maintenance phase (<57%).

Substance Use Disorder (SUD) Services: Opportunity for improvement was seen for a couple of the SUD services PMs as no improvement in the trend along with consistently low rates throughout the evaluation period were seen for one PM and consistently low rates for another PM. These include:

- No improvement in the trend over time, as well as consistently low rates over time were seen – Percentage of the members receiving SUD services attending self-help meetings.
- Rates remained <50% overtime – Percentage of members receiving SUD services whose employment status was improved or maintained (rates remained <50% overtime).

Mental Health (MH) Services: Opportunity for improvement was seen for the following three PMs:

- A statistically significant decline in trend over time – Percent of youth with SED who maintained their residential status."
- Consistently lower rates without showing any significant change in the trends over time – Percent of adults with SPMI who were competitively employed (<17%).
- Statistically significant declining trends over time and significantly lower rates in the most recent year compared to the baseline – Percent of adults with SPMI who were homeless at the beginning of the reporting period that were housed by the end of reporting period.

Healthy Life Expectancy: Opportunity for improvement was seen for two PMs in the child populations, six measures in the adult population, one measure among members with schizophrenia, and three PMs among members with SMI, I/DD, and PD. These include:

- Health literacy measures showing average/low rates during 2015–2018 among the child population:
  - Rates were below 34% in the GC population and below 54% in the CCC population – Did you and your child's doctor or other health provider talk about starting or stopping a prescription medicine for your child?
  - Rates were below 78% in the GC population and below 82% in the CCC population – When you talked about your child starting or stopping a prescription medicine, did you and a doctor or other health provider talk about the reasons you might not want your child to take a medicine?
- Health literacy measures showing average/low rates during 2014–2018 among the adult population:
  - Rates were below 72% – Did you and a doctor or other health provider talk about specific things you could do to prevent illness?
  - Rates were below 55% (2015–2018) – Did you and a doctor or other health provider talk about starting or stopping a prescription medicine?
  - Rates were below 82% (2015–2018) – When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?
- The prevention/treatment measures among adults showed consistently lower rates:
  - The rates for receiving influenza vaccine not only remained low throughout this period, but also did not show any improvement over time.
  - A declining trend in the percentage of members who were current smokers (smoked every day/some days) was seen; however, as shown by these percentages, about one-third of the Medicaid adult population were current smokers.
  - In addition, the rates for two measures related to the health providers efforts for assisting these current smokers with the cessation treatment remained low throughout the five-year period. Thus, efforts needed to be focused on the improvement of the rates for these measures.
- No statistically significant change in trends over time and consistently low rates – Diabetes monitoring for people, ages 18–64 years, with diabetes and schizophrenia (SMD).
- Consistently average/low rates throughout the evaluation period for three prevention PMs and three metrics of the treatment PM assessed among members among PD, I/DD, and SMI populations:
  - Breast Cancer Screening (<52%);
  - Cervical Cancer Screening (<53%);
  - Immunization rate for Combination 2 Vaccine (25.3%).
  - Comprehensive Diabetes care metrics – Eye Exam – Retinal (below 68%); HbA1c Control <8.0% (below 47%); Blood Pressure Control <140/90 (below 61%).

HCBS Services: Opportunity for improvement was seen for two PMs assessing HCBS waiver services quality of care. These include:

- Average/low percentages were seen throughout the evaluation period:
  - Percent of waiver participants whose service plans addressed their assessed needs and capabilities as indicated in the assessment – in three out of the seven waiver types (I/DD: <78%; TBI: ≤77%; and Autism: ≤37%); and
  - Percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan – two out of the seven waiver types (TBI: ≤77%; and Autism: ≤38%).

Long Term Care –NF: Opportunity for improvement was seen for one PM assessing the quality of long-term care provided by nursing facilities. This includes:

- Increased rate in the most recent year compared to the baseline – Members discharged from a NF who had a hospital admission within 30 days.

Member Surveys: Opportunity for improvement was seen for the following PMs:

CAHPS Survey:

- Average rates throughout the five-year period were seen for one PM assessing members perception of provider treatment among the adult population:
  - High rating (rating of 8, 9, or 10) for all health care received in last six months – rates were between 73% and 75% throughout the five-year period.

MH Survey:

- The following measures showed lower rates (<81%) throughout the evaluation period indicating an opportunity for improvement:
  - Rates were ≤79.3% – Adults – As a direct result of the services I received, I am better able to deal with a crisis.
  - Rates were ≤75.9% – SED Waiver Youth and Young Adults, family/member responding – As a result of services I received, I am better at handling daily life/As a result of the services my child and /or family member received, my child is better at handling daily life.
- The following measure showed lower rates throughout the evaluation period, and the most recent rate was comparable to the baseline rate (2012):
  - Rates were ≤73.5% during the evaluation period – SED Waiver Youth and Young Adults, family/member responding – As a direct result of the services my child and/or family (I) received, my child is (I am) better able to do things he or she wants (I want) to do.

SUD Survey:

- Although high ratings of counselors as very good/good over the evaluation period were seen, there was a significant decrease in 2017 compared to 2014.

Provider Survey: The following opportunities for improvement were seen:

- Although Sunflower had significant improvement, only around half of their General providers responded they were satisfied with Sunflower's commitment to high quality care for their members.
- Less than half of UnitedHealthcare's General providers responded they were satisfied with the MCO's commitment to high quality care, and there was not a significant change in 2017 compared to 2014.

Grievances: The following opportunity for improvement was seen:

- Ongoing attention to MCOs' accuracy and consistency in categorization of grievances, as well as reconciliation of data between reports is warranted.

Coordination and Integration of Care

Care Management for Members Receiving HCBS Services: Opportunities for improvement were seen among two PMs assessing care management among members receiving HCBS services. These include:

- Average/low percentages were seen throughout the evaluation period for the following PMs:
  - For five out of seven waiver types (I/DD, PD, FE, TBI, and Autism) – Percent of HCBS Waiver participants with documented change in needs whose service plans were revised, as needed, to address the change; and
  - Percent of HCBS Waiver participants, ages 2–20, with annual dental visits (<54%).
- Average/low percentages were seen throughout the evaluation period for two out of seven waiver types (SED and Autism) – Percent of HCBS Waiver participants who had assessments completed that included physical, behavioral, and functional components to determine their needs.
- Autism Waiver type – The Percent of HCBS Waiver participants with documented change in needs whose service plans were revised, as needed, to address the change were consistently very low in last four-years (<16%).

Member Surveys – CAHPS: Opportunity for improvement was seen for two PMs related to the members' perception of care and treatment:

- Average rates among both child populations:
  - Rates were between 54.2% and 58.2% throughout the five years – Did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?
  - Rates were between 54.1% and 63.2% throughout the five years – Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?

Member Surveys – MH: The following measure showed a statistically significant decreasing trend over the six-year period and a reduction in the 2018 rate when compared to baseline (not statistically significant):

- Adults – I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone lines, etc.).

The following measure showed lower rates over the evaluation period, and the most recent rate was comparable to the baseline but higher:

- Rates were ≤79.3% during the evaluation period – SED Waiver Youth and Young Adults, family/member responding – My family got as much help as we needed for my child.

Member Surveys – SUD: Opportunity for improvement was seen for two PMs related to the member perceptions of SUD treatment.

- Rates for the PM related to the coordination of care between the SUD counselor and the primary care provider were at or below 70% throughout the four-year evaluation period.
- Only around two-thirds of SUD survey respondents indicated they had a primary care provider.

Provider Survey: The following opportunities for improvement were seen:

- While each MCO survey included the same question related to coordination of care, there were differences in the provider population inclusion among the MCOs that impacted the ability to

compare between MCOs. Statistical significance testing was appropriate for certain time-periods for individual MCOs.
- Rates of General provider satisfaction with obtaining pre-certifications/authorizations for Sunflower and UnitedHealthcare were ≤50% across included measurement years.

Cost of Care

Costs: The following opportunities for improvement were seen:
- The PMPM service expenditures for the most recent year for two populations (pregnant women and other) decreased.

Access to Care

Provider Network – GeoAccess Measures: The following opportunities for improvement were seen:
- The largest decrease seen was for the provider type Optometry for the number of providers and provider locations; Neonatology and Nephrology, have a higher number of Non-Urban counties with 0% access.
- Most of the Non-Urban counties without access are for the provider types Neonatology, Physical Medicine/Rehab, Plastic Reconstructive Surgery, Gastroenterology, Podiatry, and Pulmonary Disease; Urban counties were without access to Plastic & Reconstructive Surgery, and Neonatology.
- There is a wide gap in reporting of availability of TBI-related services.
- The HCBS service, Speech Therapy – Autism Waiver and the I/DD provider service, Supported Employment Services had the lowest number of Kansas counties with 2 or more providers.
- Improved reporting is needed for Provider After-hour Access and Annual Provider Appointment Standards Access.

Member Surveys – CAHPS: Though, rates for all the measures seen in the most recent year among the adult population were above 82%, further improvement could be achieved indicating an opportunity for improvement in the future.

Member Surveys – MH: The following measure showed a statistically significant declined rate in 2018 compared to baseline (2011):
- Adults – I was able to get all the services I thought I needed.

Member Surveys – SUD: The following opportunities for improvement were seen:
- Up to one-fifth of members were placed on a waiting list with about two in five members having to wait three weeks or longer;
- Although satisfaction remained above 80% in 2017, there was a significant decrease compared to baseline in satisfaction with getting an appointment as soon as the member wanted.
- 10% to 19% had to wait longer than 48 hours to see a counselor for an urgent appointment.

Provider Survey: The following opportunities for improvement were seen:
- Sunflower's and UnitedHealthcare's General and BH providers' satisfaction with availability of specialists remained below 50% in the most recent measurement year.

Grievances: The following opportunity for improvement was seen:
- Ongoing attention to MCOs' accuracy and consistency in categorization of grievances, as well as reconciliation of data between reports is warranted.

Ombudsman Office Program

Calls and Assistance: The following opportunities for improvement were seen:

- Timeliness in response to the contacts can be improved further in the future.
- Collection of information on the timely complete resolution of the inquiries by the Ombudsman Office and other appropriate entities.

Efficiency

Systems: The following opportunities for improvement were seen:

- The following utilization measure showed a slight increase in rates in the most recent year (2017) compared to the baseline (2014). The goal is to decrease the rate for this measure:
  - HCBS and MH ED Visits (including dual eligible members) – PD Waiver members
  - While rates for most of the subgroups in all three measures were maintained throughout the evaluation period, there is opportunity to further improve (reduction in rates) the rates in all subgroups.
- While the four process timeliness metrics not meeting 100% requirements had rates over 99%, exploration of the reasons standards were not met is warranted to identify whether a system improvement is needed.

Member Surveys: The following opportunities for improvement were seen:
CAHPS Survey: Though, rates for the measure in the most recent year among the child and adult populations were above 81%, further improvement could be achieved indicating an opportunity for improvement in the future.
MH survey: Opportunities for improvement were not seen.
SUD Survey: The members' ratings in 2017 for how well their SUD counselor clearly communicated was significantly lower (p<.05) than in 2014.

UCC Pool

Opportunities for improvement were not seen.

DSRIP:

- Lessons Learned and Areas for Improvement are as follows:
  - During selection and planning of the project, more fully address the adequacy of the projected number of project participants and consider contingency plans for participant recruitment strategies, project interventions and project participant (providers and patients) withdrawals mid-project, to improve project success.
  - Dedicate more time up front to the development of clear measures and plans for data collection and analysis to improve consistency and accuracy of reported results.
  - Explain reasons for data changes over time, being as specific as possible (e.g., recalculating after allowance for claim lag, identifying an error in an Excel formula, etc.). After allowance for claims lag or other known data lags, past analysis and reported results should be set and saved, with no further recalculations allowed.

Recommendations for the State and MCOs Based on the Final KanCare Evaluation

Physical Health – HEDIS Measures (Quality of Care)

- MCOs should pay attention to improving results for HEDIS measures that have been identified by CMS as core quality measures, particularly where rates are average/low, and results were below the 25th Quality Compass percentile in 2017.

SUD Services – NOMS Data (Quality of Care)

- MCOs should explore opportunities for improvement in the two measures with low rates (<50%), "members employed at time of discharge from SUD services" and "members receiving SUD services attending self-help programs."

Mental Health Services – NOMS Data (Quality of Care)

- Future improvement efforts are needed for two measures that showed statistically significant declining trends over time and significantly lower rates in the most recent year compared to the baseline (adults with SPMI employed and adults with SPMI homeless at the beginning of the quarter housed by the end of the quarter).

Healthy Life Expectancy (Quality of Care)

- MCOs should explore researched based strategies to improve the HEDIS rates for diabetes monitoring for people with schizophrenia and diabetes (SMD) since the rates remained below 66% during the evaluation period.
- Based on consistent average/low rates for the prevention and treatment/recovery measures (cancer screening and adolescent immunizations) among the PD, I/DD, and SMI members, improvement efforts are needed.

HCBS Waiver Services (Quality of Care)

- MCOs should focus on improvement efforts for members in the Autism Waiver due to the low rate (37%) for the following measures:
  - Percent of HCBS Waiver participants whose service plans addressed their assessed needs and capabilities as indicated in the assessment; and
  - Percent of HCBS Waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan.

Long Term Care: Nursing Facilities (Quality of Care)

- Due to the statistically significant increase in the percentage of members discharged from a NF who had a hospital admission within 30 days (most recent year compared to the baseline) improvement efforts are needed to decrease the number of hospital admissions.

Care Management for Members Receiving HCBS Services (Care Coordination)

- MCOs should focus on improvement efforts for members in the Autism Waiver due to the low rate (22%) for the measure "percent of HCBS Waiver participants percent of participants with documented change in needs whose service plans were revised, as needed, to address the change."
- MCOs should explore opportunities for improvement in the HEDIS-like measure for the annual dental visits due to the rates remaining low (<54%).

Provider Network – GeoAccess (Access to Care)

- MCOs should revise, where appropriate, their GeoAccess mapping and specific counts of access to be more to be more reflective of the members accessing the service (e.g., Obstetrician/Gynecologist (OB/GYN) – include only females and neonatology – infants).
- The State should consider requiring the MCOs to include in GeoAccess mapping, the availability of each currently unmapped HCBS provider service. At a minimum, the MCOs should provide a list of counties with limited access to specific HCBS services (reported, as of 2018, by counts and not by county names).
- The State follow up with the MCOs to clarify the availability of the TBI-related HCBS service providers.

- MCOs continue work to increase HCBS providers in Kansas counties where there are less than 2 or more providers with emphasis on Adult Daycare and Speech Therapy – Autism Waiver and TBI Waiver.
- MCOs continue work to increase I/DD providers in Kansas counties that do not have at least two providers with emphasis on Supportive Employment Services, Wellness Monitoring, and Day Support.
- MCOs should ensure their surveys have an adequate number of participants to achieve meaningful and generalizable results wherever possible.
- MCOs should review and address in future reports KFMC's questions raised regarding vendors' processes and reports for Access related surveys.
- In contacting practices, appointment availability should be based on the provider in the random sample and not based on availability from any of many providers in the practice.
- MCOs should follow up with all providers identified as non-compliant in after-hours access and appointment availability, with priority attention to those who have been non-compliant in more than one year.
- MCOs should include in their appointment availability surveys not only routine, urgent, and emergent appointment access, but also, where applicable, pregnancy-related appointments by trimester and high risk.
- For after-hours access and appointment availability surveys, the State should consider creating a standardized report template and reporting tool and requiring the MCOs to have a more standardized methodology.

Member Surveys: CAHPS Survey Measures (Quality of Care, Coordination of Care and Access to Care)

- MCOs should ensure their surveys have an adequate number of participants to achieve meaningful and generalizable results wherever possible.
- MCOs should review and address in future reports KFMC's questions raised regarding vendors' processes and reports for Access related surveys.

Member Surveys: MH Survey Measures (Quality of Care, Coordination of Care and Access to Care)

- Explore methods to increase positive results in the following performance measures for the applicable survey subgroups:
  a. SED Waiver Youth and Young Adults:
     i. Better ability to handle daily life or control life; and do things they want to do. (Quality of Care)
     ii. The member/family feeling like they got as much help as they needed. (Access to Care)

  b. Adults:
     i. Being better able to deal with crisis (Quality of Care)
     ii. Feeling like they decided their treatment goals (Quality of Care)
     iii. Being able to see a psychiatrist when they want to (Access to Care)
     iv. Explore ways to increase members being encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.) and to ensure rates do not continue to decline over time. (Coordination of Care).

Member Surveys: SUD Survey Measures (Quality of Care, Coordination of Care and Access to Care)

- Though there were high quality scores for SUD counselors, MCOs should monitor future rates and assess the need for improvements, due to the significant decrease in 2017 quality scores compared to 2014 (94.3%) ($p<.05$).

- MCOs should explore and implement methods to help ensure members receiving SUD services know and access their primary care provider.
- MCOs should work with SUD counselors to increase their obtaining "releases of information" to coordinate care with the primary care provider.
- MCOs should review areas of need based on the locations or regions that had members waiting longer than 48 hours for an urgent appointment or were put on a wait list for an initial appointment.

Provider Survey Measures: (Quality of Care, Coordination of Care and Access to Care)

- MCOs should explore methods to increase providers' satisfaction with the MCOs' commitment to high quality care for their members, and for obtaining pre-certifications/authorizations.
- MCOs should ensure their surveys have an adequate number of participants to achieve meaningful and generalizable results wherever possible.

Grievances: Grievance Reporting Measures (Quality of Care and Access to Care)

- Continue to review MCOs' accuracy and consistency in categorization of grievances, as well as reconciliation of data between reports.

Systems (Efficiency)

- For all KanCare members, waiver populations (TBI, FE, I/DD, and PD), and members receiving MH services, continue to look for ways to reduce HCBS and MH emergency ED visits, HCBS inpatient admissions, and HCBS readmissions within 30 days of discharge.

Overall Recommendations

- The current list of the performance measures should be reviewed to identify a set of standard, robust and comparable measures that have agreed-upon specifications/definitions and data collection methodologies/strategies, as well as established data collection systems. This will assist in implementing the program evaluation by conducting consistent and accurate monitoring of these measures in an ongoing manner. This will help in identifying the patterns and continuous assessment of the outcomes of the KanCare Program.
- The measures from the current list should also be identified that are still developmental in nature and require further discussions for reaching a consensus on the valid specifications/definitions of their numerators and denominators, identifying standard data collection methodologies/strategies, as well as creating/improving data collection/tracking systems. These measures could be used for the program evaluation later once agreed-upon definitions and data collection methodologies are identified and a robust system to collect accurate data are available.

- Some of the subcategories within multiple evaluation categories, such as Grievances, should be assessed by examining the measures that are more qualitative in nature. This will assist in classifying the issues raised by the providers and beneficiaries into groups that can be further examined using qualitative data analysis methods for identifying similar and dissimilar themes. This information will help the state and MCOs to work on the broader system changes to improve the care provided to the beneficiaries in addition to the resolution of day-to-day person-related issues. The trainings of the MCO staff for application of the qualitative data analysis methods will be needed to obtain the information on the qualitative themes from assessment of these PMs.

Interpretations, Policy Implications, and Interactions with Other State Initiatives

The State Quality Strategy – as part of the comprehensive quality improvement strategy for the KanCare

program – as well as the Quality Assurance and Performance Improvement (QAPI) plans of the KanCare MCOs, supported strong, high quality performance of the program. Kansas Medicaid long-range planning, including the KanCare 2.0 Quality Strategy, was guided by information collected from KanCare MCOs and State reporting, quality monitoring, onsite reviews and other KanCare contract monitoring results; external quality review findings and reports; feedback from State and Federal agencies, the KanCare MCOs, Medicaid providers, Medicaid members, and public health advocates.

The key aspects regarding the **approach of the KanCare Program** are highlighted in Figure ES-12.

Highlights of KanCare Program Approach

- Collaborative approach with KanCare MCOs, providers, policy makers, reviewers, and others.
- Establishment of the KDHE and KDADS Senior leadership committee jointly responsible for comprehensive oversight.
- The KanCare Steering Committee included the senior leadership, as well as program and quality managers from both agencies, to initiate and review policies or program changes.
- Collaborative work with MCOs to provide ongoing guidance and program direction for reporting of PMs.
- Use of nationally standardized PMs reported by the MCOs for the KanCare program evaluation.
- Regular meetings with MCO staff, relevant cross-agency program management staff, and EQRO staff to work on KanCare operational details to support the quality strategy and to ensure that quality activities were occurring consistent with Section 1115(a) standard terms and conditions, the KanCare quality management strategy and KanCare contract requirements.
- All products were distributed to relevant cross-agency program and financial management staff.
- The State engaged in extensive outreach and bi-directional communication through multiple avenues, including routine and issue-specific meetings with a broad range of providers, associations, advocacy groups, consumers, and other interested stakeholders.
- An extensive training program on Managed Care developed and provided by the State.
- The state required MCOs to convene Member Advisory Committees and conduct regular joint MCO provider trainings.

Figure ES-12. Summary of KanCare Program Approach

KanCare Program included **MCO-led and State-led initiatives** that provided insights for adoption of strategies in the future. These initiatives are described in the Results section. A few examples of these initiatives are presented in Figure ES-13 and ES-14.

Examples of the MCO-Led Initiatives

- **Value-Added Benefits from each MCO, at no cost to the State.** Examples: Adult Dental Care; Member Incentive Program; Mail Order Over The Counter (OTC) benefit; and Comprehensive Medication Review; Pharmacy Consultation; Rewards for Preventive Visits, Completion of Programs, and HealthCare Follow-up; Weight Watcher Vouchers; and Pediatric Obesity Classes.
- **MCO Performance Improvement Projects (PIPs) prescribed or approved by the State.** Examples: Pre-diabetes (joint MCO PIP); HPV vaccination (joint MCO PIP); and Well-child visit rates in the third, fourth, fifth and sixth years of life.
- **Other MCO Programs/Initiatives.** Examples: Community Health Workers; Transitioning youth services; Parent Management Training – Oregon Model; Farmers Market vouchers; Smoking cessation programs; Disease management programs.
- **MCOs' Value Based Provider Incentive Programs.** Example include: Behavioral Health Incentive Program; Primary Care Provider Incentive; and Value-based models in major urban, rural and frontier communities.

Figure ES-13. KanCare Program MCO-Led Initiatives

Summary of State-Led Initiatives

- **PCMH/Health Homes:** 1) The DSRIP program has included a focus on PCMH through the two Children's Mercy Hospital projects; 2) The KDHE Health Home initiative provided care coordination services for KanCare members with SMI and was effective July 2014 through June 2016; 3) A legislative proviso passed in 2018 directed KDHE to implement a health homes program, OneCare Kansas. The program is scheduled to launch January 1, 2020.
- **Health Information Technology: Electronic Health Records.** KDHE implemented the Kansas Medicaid EHR Incentive Program (now called Promoting Interoperability Program) in early 2012. The program focuses on interoperability and improving patient access to health information. Educational webinars and individual technical assistance are also provided to clinicians through this program.
- **Health Information Technology: Telehealth and Telemedicine.** In 2013, KDHE allowed certain mental health services to be billed with a telemedicine modifier. In 2017, CMS created a new place of service code for telemedicine to be used by the physician or practitioner furnishing telemedicine services from a distant site. In 2018, billing codes were allowed for reporting synchronous (real-time) telemedicine services; procedures involve electronic communication using interactive telecommunications equipment that includes, at a minimum, audio and video. Effective December 1, 2018, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) may function as both the originating site and distant site when furnishing services through telemedicine (Indian Health Centers were added in spring 2019). This will improve access to quality health care in rural and frontier areas of the State.
- **Other Technological Improvements:** A system upgrade to the Kansas Modular Medicaid System (KMMS) Provider Enrollment Wizard was completed on December 31, 2018. With the system upgrade, all KanCare MCO enrollments must now begin with KMAP and be entered through the Provider Enrollment Wizard. The upgraded Provider Enrollment Wizard will support a bidirectional exchange of provider data between the MCOs and KMAP

Figure ES-14. KanCare Program State-Led Initiatives

The **policies and processes** developed in response to KanCare data or identified needs include:

- **Smoking Cessation:** Effective with dates of service on and after January 1, 2014, smoking cessation products were covered by KMAP. In January 2017, a KMAP bulletin reminded providers of several covered smoking cessation products. Effective with processing dates on or after May 15, 2017, and retroactive to dates of service on and after October 1, 2016, providers could bill for smoking cessation counseling for pregnant women when billed with certain other codes. Effective with dates of service on and after July 1, 2018, cessation counseling became available as a Medicaid billable service to all Medicaid populations.

- **Children and Youth in KanCare and Foster Care:** An issue was identified with the distribution of KanCare membership cards upon entry into foster care due to the timing of transfers from emergency placements to foster homes. The MCOs agreed to distribute two KanCare membership cards. One card is sent to DCF and one to the Foster Home. The process for completing a "release of information" to allow for sharing of information to the Foster Care contractor (DCF subcontractor not considered the provider) was also developed, the MCOs developed and distributed a desk-aid for the DCF contractors containing contact information by question/issue type.

Lessons Learned and Recommendations for Other States Interested in Implementing a Similar Approach

Lessons learned from the KanCare Demonstration are summarized below. The State has considered these lessons while designing KanCare 2.0 and the new MCO contracts.

- A considerable time and collaborative effort was needed among KDHE, KDADS, the MCOs, the EQRO and other consultants to streamline and standardize measurement and reporting processes.
- Multiple revisions of the reports such as categorization of grievances and geo-access/provider network reports are needed for increased standardization and reporting accuracy.

- Complexity of the data, populations and measurement processes, discrepancies in measurement analysis and reporting between MCOs and/or between remeasurements impacted the ability to compare some results between years and to aggregate MCO data for overall program review.
- Although discrepancies and data issues are less likely with standardized measures, such as HEDIS and CAHPS where NCQA certified vendors are used, issues can and did occur with applying State specific requirements for population inclusion, stratification and reporting.
- The State and EQRO have concluded the number of required MCO reports and measurements was too much to fully synthesize and likely not useful to the program management and evaluation.
- Concerns regarding MCO-provided care coordination were identified including member awareness of a care coordinator, inability to contact care coordinator easily, high turnover, large caseloads and lack of expertise among care coordinators to serve some specific populations.
- More MCO Provider Relations staff, particularly with increased direct provider contact, are needed.

Recommendations for other states interested in implementing a similar approach are included here:

- Provide multiple opportunities for bi-directional communication with MCOs, providers, consumers, and related associations, to share and receive information.
- Offer multiple opportunities for training providers, consumers, stakeholders, MCO staff about the program, background/history, populations served, services provided, etc.
- Require MCOs to conduct routine joint provider trainings.
- Encourage collaboration between MCOs and with other entities, such as Drug Utilization Review Board, Foster Care Agencies, providers and other key entities.
- Require MCOs to convene Member Advisory Committees.
- Ensure Care Coordination has adequate local community presence.
- Require MCOs to have more key personnel, especially provider and member advocates, as well as coordinators for specific populations or issues (EPSDT Coordinator, Foster Care Coordinator, etc.).
- Request the MCOs propose Value-Added services in their request for proposal (RFP) responses.
- Require MCOs to include plans for Value-Based Purchasing in their RFP responses.
- Require MCOs to use similar processes to increase understanding and decrease provider burden.
- Ensure the information provided to members and providers are clear and easy to understand.
- Make State expectations of the MCOs clear and well-known, such as for contract audits.
- Build audit tool on the last one completed to ensure all previous concerns are addressed.
- Readiness reviews for new MCOs are critical.
- Limit requirements for routine reports to those that will be routinely used for management and oversight; link requested data more specifically to the State Quality Strategy.
- Use regularly established measures in the demonstration evaluation design.
- Develop a process for closing the loop on recommended/needed changes to help ensure identified issues are appropriately handled and do not repeat over time.
- Establish a process for documenting and communicating changes to analytic methodologies, or policies and procedures that impact measurement results and the appropriateness of comparisons between subgroups and across measurement periods.
- Devote sufficient time up front to defining measures, developing analytic plans, ensuring clarity and assessing MCOs' interpretation of analytic methodologies to help limit subsequent analytic and reporting revisions. Changes in methodology impact the ability to compare results over time, and thus impact the ability to make conclusions regarding the program.
- Encourage collaboration between MCOs and with other State programs that work to improve similar health concerns.

End of Executive Summary

KanCare Final Evaluation Report
Evaluation of the State of Kansas Medicaid Section 1115(a) Demonstration Waiver – KanCare
January 2013–December 2018
April 26, 2019

Introduction

This report presents the final evaluation findings and fulfills the requirements in Number 75(b) of the Special Terms and Conditions (STCs) for the State of Kansas Medicaid section 1115(a) demonstration proposal, entitled KanCare (Waiver Number: 11-W-00283/7) authorized under Section 1115(a) of the Social Security Act. KanCare operates concurrently with the State's section 1915(c) Home and Community Based Services (HCBS) Waivers.

The Final 2013–2018 Evaluation Report is organized around the eight evaluation categories specified in the KanCare approved Evaluation Design (Attachment A). The report includes following sections:

- **Executive Summary:** Provides a synopsis of the evaluation methodology and results.
- **Background:** The section provides the information about the KanCare demonstration.
- **Evaluation Questions and Hypotheses:** The section describes KanCare evaluation questions and hypotheses.
- **Evaluation Methodology and Methodological limitations:** The section describes the KanCare evaluation design, target and comparison populations, evaluation period, evaluation measures, data sources, and analytic methods. The section also provides limitations to the study design, data sources/collection, and analyses.
- **Results:** The section is organized around eight categories of the KanCare Evaluation Design and provides data along with interpretations to show whether goals and hypotheses of the demonstrations were achieved.
- **Conclusions and Recommendations for the State and Managed Care Organizations (MCOs):** The section presents the conclusions about the evaluation results, outcomes, impacts and opportunities for improvements.
- **Interpretations, Policy Implications and Interactions with Other State initiatives; Lesson Learned and Recommendations:** The section discusses the KanCare demonstration within an overall Medicaid context and long-range planning. The section also discusses lessons learned from the KanCare demonstration and recommendations related to current strategies and future opportunities.

Background Information

In 2011, the State of Kansas identified the need to reform the Kansas Medicaid program to control costs and improve patients' health and wellness outcomes. The need for this reform was deemed crucial due to considerable increase in the program's costs across all population groups served. During the period of 2000 through 2010, a growth in Kansas Medicaid costs at an annual rate of 7.4 percent was seen.[1] The

reasons for escalating costs included increases in member enrollment, spending per person, and a continuing increase in the number of older Kansans with an age acquired disability. In addition, the Kansas Medicaid program had not previously focused on health and wellness outcomes. It was determined that a focus on quality of care, improvement in health and wellness outcomes, increased accountability in the services provided by the state, and investment in prevention, care coordination, and evidence-based practice was needed. The need to address these focus areas was also corroborated by the feedback provided by the public and stakeholders across the state.[1] The State determined that short-term solutions such as provider rate cuts and tweaks of eligibility requirements could not address the enormity of the issue over time.[1] Thus, to address these issues, the State developed a comprehensive Medicaid reform plan. The goals of the reform plan included: 1) improving the quality of care of Kansans receiving Medicaid; 2) controlling costs of the program; and 3) long-lasting reforms that improve the quality of health and wellness for Kansans. To meet these goals, the State's 1115(a) Demonstration Waiver was designed. The cornerstone of this reform plan was "KanCare," an integrated care system, which focused on improving health outcomes for Kansans and controlling the escalating Medicaid costs over time.[1]

On August 6, 2012, the State of Kansas submitted a proposal to the Centers of Medicare and Medicaid Services (CMS) to seek Medicaid Section 1115(a) Demonstration Waiver authority, entitled KanCare, to fundamentally reform Medicaid in Kansas with a focus to improve health outcomes and establish financial responsibility. The request was approved by the CMS on December 27, 2012, effective from January 1, 2013, through December 31, 2017.[2]

On August 19, 2013, the State submitted a request to CMS for an amendment to the KanCare demonstration which included providing Long-term Services and Supports (LTSS) for individuals with an intellectual or developmental disability (I/DD) through KanCare managed care plans HCBS–I/DD; establishing a supplemental security income pilot program to support employment and alternatives to Medicaid; and a change in the timeline for the Delivery System Reform Incentive Payment Program (DSRIP) Pool.[2] CMS approved the LTSS integration of the I/DD population on January 29, 2014, and approved amendments to the HCBS I/DD Waiver in a letter dated February 3, 2014.[3] CMS also approved the DSRIP delay amendment on September 20, 2013.[3] The State withdrew the proposed change regarding establishing a supplemental security income pilot program to support employment and alternatives to Medicaid on July 24, 2017.[3]

In July 2017, the State of Kansas requested, from CMS, a one-year extension of the current KanCare demonstration, including the Uncompensated Care Cost (UCC) Pool and the DSRIP Program Pool for the period of January through December 2018. The State did not request any changes to the demonstration for the one-year extension period.[2] On October 13, 2017, CMS approved this extension request for the period January 1, 2018 through December 31, 2018.[4] The final KanCare Evaluation described in this report covers the time-period of six years, January 2013 through December 2018.

KanCare Section 1115(a) Demonstration Waiver Program Overview

The State of Kansas implemented the KanCare Section 1115(a) Demonstration Waiver program from January 2013 through December 2018.

KanCare, an integrated managed care Medicaid program, serves the State of Kansas through a coordinated approach. The goal of KanCare is to provide efficient and effective health care services and ensure coordination of care and integration of physical and behavioral health services with each other

and with HCBS. It is indicated by CMS, that states can reduce Medicaid program costs, as well as, can have better management of the health services' utilization by contracting with various types of the MCOs for providing Medicaid program health care services to the beneficiaries.[5] State of Kansas decided to contract with multiple MCOs to ensure: 1) provision of efficient and effective health care services to the populations covered by the Medicaid and Children's Health Insurance Program (CHIP) in Kansas; and 2) the coordination of care and integration of physical health (PH) and behavioral health (BH) services with each other and with HCBS. Three MCOs, Amerigroup Kansas, Inc. (Amerigroup or AGP), Sunflower Health Plan of Kansas (Sunflower or SHP), and UnitedHealthcare Community Plan of Kansas (UnitedHealthcare or UHC), served the KanCare program from January 2013 through December 2018.[2]

KanCare operates concurrently with the State's section 1915(c) HCBS Waivers and together provide the authority necessary for the State to require enrollment of almost all Medicaid beneficiaries (including the aged, people with disabilities, and some dually eligible individuals) across Kansas into a managed care delivery system to receive state plan and waiver services. This represents an expansion of the state's previous managed care program, which consisted of HealthWave (managed care organization) and HealthConnect Kansas (primary care case management), and provided services to children, pregnant women, and parents in the state's Medicaid and CHIP programs as well as carved out managed care entities that separately covered mental health and substance use disorder (SUD) services.[1,2]

KanCare also includes a safety net care pool (also referred as UCC pool) to support certain hospitals that incur uncompensated care costs for Medicaid beneficiaries and the uninsured, and to provide incentives to hospitals for programs that result in delivery system reforms that enhance access to health care and improve the quality of care. The UCC Pool consists of two sub-pools, the Health Care Access Improvement Program Pool (HCAIP) and the Large Public Teaching Hospital/Border City Children's Hospital Pool LPTH/BCCH). The UCC Pool provides payments to hospitals to cover hospital costs of uncompensated care provided to Medicaid-eligible or uninsured individuals.[1,2]

KanCare also includes a DSRIP Program Pool, which aims to advance the goals of access to services and healthy living by specifically focusing on incentivizing projects that increase access to integrated delivery systems and projects that expand successful models for prevention and management of chronic and complex diseases. Participating hospitals work with community partners statewide to implement projects that have measurable milestones for improvements in infrastructure, processes, and healthcare quality.[1,2] The DSRIP program in Kansas includes two major hospitals, Children's Mercy Hospital (CMH) and Clinics and The University of Kansas Hospital (UKHS). The two hospital systems are major medical service providers to Kansas and Missouri residents. Each hospital system is implementing two projects selected from a catalog of five projects approved by CMS and the Kansas Department of Health and Environment (KDHE) that target specific needs of Kansas residents who are receiving Medicaid services or are uninsured. The Kansas DSRIP projects, originally planned to be implemented as four-year projects from 2014 through 2017, are now three-year projects that began in 2015.[2]

During these six-year period, the KanCare demonstration was aimed to:

- Maintain Medicaid state plan eligibility;
- Maintain Medicaid state plan benefits;
- Allow the state to require eligible individuals to enroll in MCOs to receive covered benefits through such MCOs, including individuals on HCBS Waivers, except:
    - American Indian/Alaska Natives are presumptively enrolled in KanCare but will have the option of affirmatively opting-out of managed care.

- Provide benefits, including LTSS and HCBS, via managed care; and
- Create a UCC Pool to support hospitals that provide uncompensated care to Medicaid beneficiaries and the uninsured.

Goals of KanCare Demonstration

The KanCare demonstration assisted the State' goals to:

- Provide integration and coordination of care across the whole spectrum of health to include PH, BH, and LTSS/HCBS;
- Improve the Quality of Care (QOC) Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes);
- Control Medicaid costs by emphasizing health, wellness, prevention and early detection as well as integration and coordination of care; and
- Establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms as well.

KanCare Performance Objectives

The State, through an extensive public and stakeholder consultation process, also identified five KanCare performance objectives and outcome goals to be reached through the comprehensive managed care contracts. These objectives include the following:

- Measurably improve health care outcomes for members in the areas including: diabetes, coronary artery disease, prenatal care, and BH;
- Improve coordination and integration of PH care with BH care;
- Support members' desires to live successfully in their communities;
- Promote wellness and healthy lifestyles; and
- Lower the overall cost of health care.

Evaluation of KanCare Program Progress Over Six-Year Period

Quarterly and Annual Evaluation

Throughout the six-year period, the State has continually assessed and summarized the progress towards demonstration goals and other successes achieved by the KanCare program. This assessment was done on a quarterly and annual basis. The information included in the KanCare Program Quarterly and Annual Reports was contributed by the External Quality Review Organization ([EQRO] Kansas Foundation for Medical Care, Inc. [KFMC]) reports, MCO reports, and other quality assurance and monitoring activities.[2,6]

Final Six-Year Evaluation

In addition, a final evaluation of the KanCare program that covered the time-period of six years, January 2013 through December 2018, was conducted to measure the effectiveness and usefulness of the demonstration as a model to help shape healthcare delivery and policy in state and national level. KFMC has completed this final evaluation in accordance with the approved Evaluation Design.[6] KFMC has presented the results of the final evaluation in this report. The methodology, results, conclusions, and recommendations of this evaluation are described in the subsequent sections of this report.

Evaluation Questions and Hypotheses

Under the terms of the KanCare Section 1115(a) demonstration, the State submitted a draft Evaluation Design for the evaluation of the demonstration on April 26, 2013 for CMS approval. CMS provided comments on the draft KanCare Evaluation Design on June 25, 2013. After discussing the comments with CMS and gathering additional input from stakeholders, Kansas submitted the final KanCare Evaluation Design to CMS on August 24, 2013. CMS approved the KanCare Evaluation Design on September 11, 2013.[2]

After submission of the final KanCare Evaluation Design, Kansas began implementation of the evaluation design as described in the approved document. Kansas contracted with KFMC to serve as the independent evaluator for the KanCare demonstration.

Kansas has submitted updates on the progress related to the implementation of the KanCare Evaluation Design in each of the quarterly and annual reports. Kansas also submitted to CMS a revised KanCare Evaluation Design in March 2015, and CMS did not identify any concerns with this revised KanCare Evaluation Design.[2]

Evaluation Questions/Hypotheses

To evaluate the progress towards and success in achieving the KanCare Goals and Performance Objectives, the approved KanCare Evaluation Design included the following evaluation questions/hypotheses:

1. By holding MCOs to outcomes and performance measures (PM), and tying measures to meaningful financial incentives, the State will improve health care quality and reduce costs;
2. The KanCare model will reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired;
3. The State will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between PH, BH, and LTSS; and
4. KanCare will provide integrated care coordination to individuals with developmental disabilities, which will improve access to health services and improve the health of those individuals.

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Alignment of Evaluation Hypotheses with the KanCare Program Goals and Performance Objectives

These hypotheses were formulated to address the four goals of the KanCare program. In addition, these hypotheses were aligned with five KanCare program performance objectives and outcomes to be reached through the comprehensive managed care contracts.

KanCare Goals	KanCare Evaluation Hypotheses
1. Provide integration and coordination of care across the whole spectrum of health to include PH, BH, and LTSS/HCBS; 2. Improve the quality of care Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance; 3. Control Medicaid costs by emphasizing health, wellness, prevention and early detection as well as integration and coordination of care; and 4. Establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms.	1. By holding MCOs to outcomes and performance measures, and tying measures to meaningful financial incentives, the State will improve health care quality and reduce costs; 2. The KanCare model will reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired; 3. The State will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between PH, BH, and LTSS; and 4. KanCare will provide integrated care coordination to individuals with developmental disabilities, which will improve access to health services and improve the health of those individuals.
KanCare Performance Objectives	
1. Measurably improve health care outcomes for members in the areas including: diabetes, coronary artery disease, prenatal care, and BH; 2. Improve coordination and integration of PH care with BH care; 3. Support members' desires to live successfully in their communities; 4. Promote wellness and healthy lifestyles; 5. Lower the overall cost of health care.	

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Methodology

KFMC conducted the final comprehensive evaluation in accordance with the KanCare Evaluation Design approved in 2013.[6] The purpose of the evaluation was to measure the effectiveness and usefulness of the demonstration as a model to help shape healthcare delivery and policy at the state and national level.[6] This final evaluation incorporated the results that were obtained each year by monitoring the progress towards goals and other successes achieved by the KanCare program (quarterly and annual results reported each year by the State).[2]

The KanCare evaluation was designed in accordance with the evaluation criteria outlined in the comprehensive KanCare Program Medicaid State Quality Strategy and the CMS STC documents.[7,8] The evaluation methodology, as described in the KanCare Evaluation Design document, was applied for the final KanCare evaluation (see Attachment A).[6]

KanCare Program Evaluation Design

The evaluation design specifications were structured into eight categories in alignment with the KanCare demonstration goals, performance objectives, and evaluation hypotheses, as well as STC evaluation domains of focus, which include the impact of the KanCare program for each population regarding quality of care, coordination and cost of care; access to care, the impact of including LTSS (with sub-focus on HCBS) in the capitated managed care benefit; the Ombudsman program's assistance; efficiency, evaluation of the I/DD Pilot Project, lessons learned; and impact of the uncompensated care cost pool and the DSRIP pool. The eight evaluation design categories were organized into subcategories and appropriate PMs were assigned for each subcategory to examine the related evaluation hypotheses.

The evaluation design included baseline and cross-year comparisons, as well as an assessment of trends over time. For these comparisons, the first year of the KanCare demonstration, calendar year (CY)2013, served as a baseline year. In some instances, 2013/2014 data were used as baselines. Also, for some of the measures, pre-KanCare data (multi-year data) were used as the baseline. Use of pre-KanCare data as baselines was not considered appropriate where pre-KanCare and KanCare populations were too different. Since the first Evaluation Design submission, some proposed comparisons have been changed to better reflect availability of comparable data.

In addition, the evaluation method included analysis of performance measures by one or more of the stratified populations. Several performance measures were based on standardized Healthcare Effectiveness Data and Information Set (HEDIS) data analysis; therefore, these measures were also compared to the National Committee for Quality Assurance (NCQA) Quality Compass (QC) percentiles. Similarly, several measures based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys were also compared to the NCQA QC percentiles.

The KanCare program evaluation design is summarized in Figure 1:

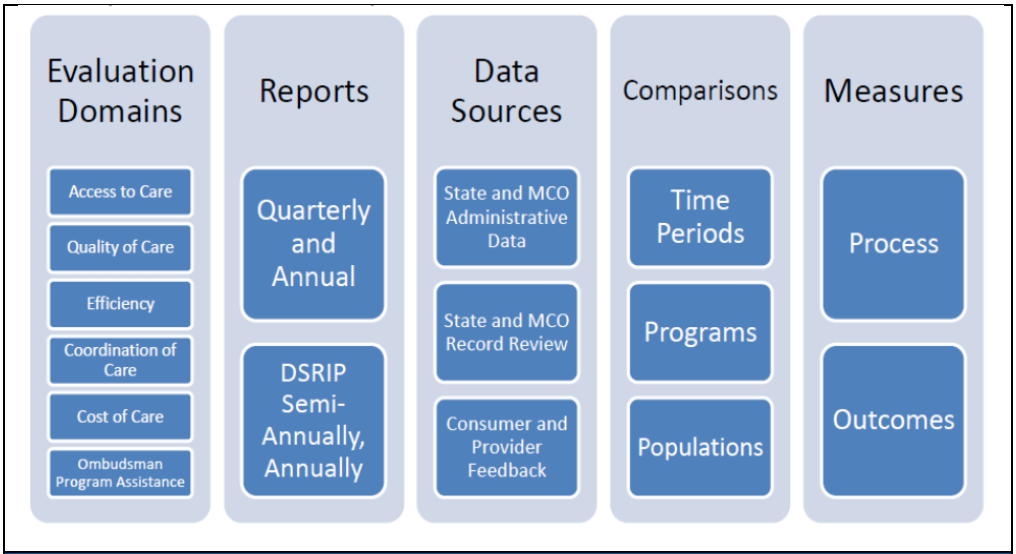

Figure 1. KanCare Program Evaluation Design

Source: State of Kansas KanCare Section 1115(a) Demonstration Waiver. Project No. 11-W-00283/7. Extension Application. July 31, 2017. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/ks-kancare-pa2.pdf.

Over the six-year KanCare demonstration period, PMs were evaluated each year on either a quarterly basis or an annual basis. Due to revisions in reporting requirements, program updates, and changes in the HEDIS measure specifications, a few measures were removed, and several measures in the 2013 KanCare Evaluation Design were added or were slightly revised in 2015.

Target and Comparison Populations

KFMC completed a review of initial background information determining demographics and characteristics of MCO enrollees to assist in providing context for the evaluation findings. The demographics and characteristics of MCO enrollees reviewed included age, gender, marital status, race, language, percentage below federal poverty line (% FPL), employment status, residential status, county (Urban, Semi-Urban, Densely-Settled Rural, Rural and Frontier), prevalence of chronic conditions, type of waiver, nursing facility (NF), SUD, and serious mental illness (SMI). The review showed the following preliminary enrollee numbers per strata (Table 1):

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Table 1. Demographics and Characteristics of MCOs	
	Number of Enrollees
Program Type	
Medicaid	323,869
CHIP	54,990
Race	
Black	52,022
White	291,279
Asian	8,551
Native American	6,475
Other	19,532
Ethnicity	
Hispanic	81,155
Non-Hispanic	296,704
Gender	
Female	202,860
Male	174,992
County	
Urban,	203,331
Semi-urban	58,443
Densely Settled Rural	73,567
Rural	28,874
Frontier	13,644

This initial review assisted in determining potential demographic data to be included in stratifications, based on apparent completeness of data. Thus, the evaluation process included analysis of PMs by one or more of the following stratified populations (wherever appropriate, and where data were available):

- Program – Title XIX (TXIX)/Medicaid and Title XXI (TXXI)/CHIP
- Age groups – particularly where stratified in HEDIS measures, waivers, and survey populations
- Waiver services:
  - Intellectual/Developmental Disability (I/DD)
  - Physically Disabled (PD)
  - Traumatic Brain Injury (TBI)
  - Technical Assistance (TA)
  - Serious Emotional Disturbance (SED)
  - Frail Elderly (FE)
  - Autism
- Providers
- County type (Urban/Semi-Urban, Densely-Settled Rural, Rural/Frontier)
- Those receiving mental health (MH) services
  - Serious and Persistent Mental Illness (SPMI)
  - Serious Mental Illness (SMI)
  - SED (waiver and non-waiver)
- Those receiving treatment for Substance Use Disorder (SUD)
- Those receiving Nursing Facility (NF) services

Baseline Data for Evaluation

In the first year of KanCare (2013), baseline data and data criteria were established and defined. The baseline data were used for all performance measures. For some of the measures, pre-KanCare data (CY2012 and CY2011) were available and were used as the baseline. Pre-KanCare data were not available for all measures; therefore, baselines for some measures were based on CY2013 data (for measures that require one year of data for the baseline) or CY2013/CY2014 data (for measures that require more than one year of data for the baseline).

Evaluation Period

The final evaluation of the KanCare program covered the time-period of six years, January 2013 through December 2018.

KanCare Program Evaluation Timeline for the Period of January 2013–December 2018

The final evaluation timeline is described in Figure 2.

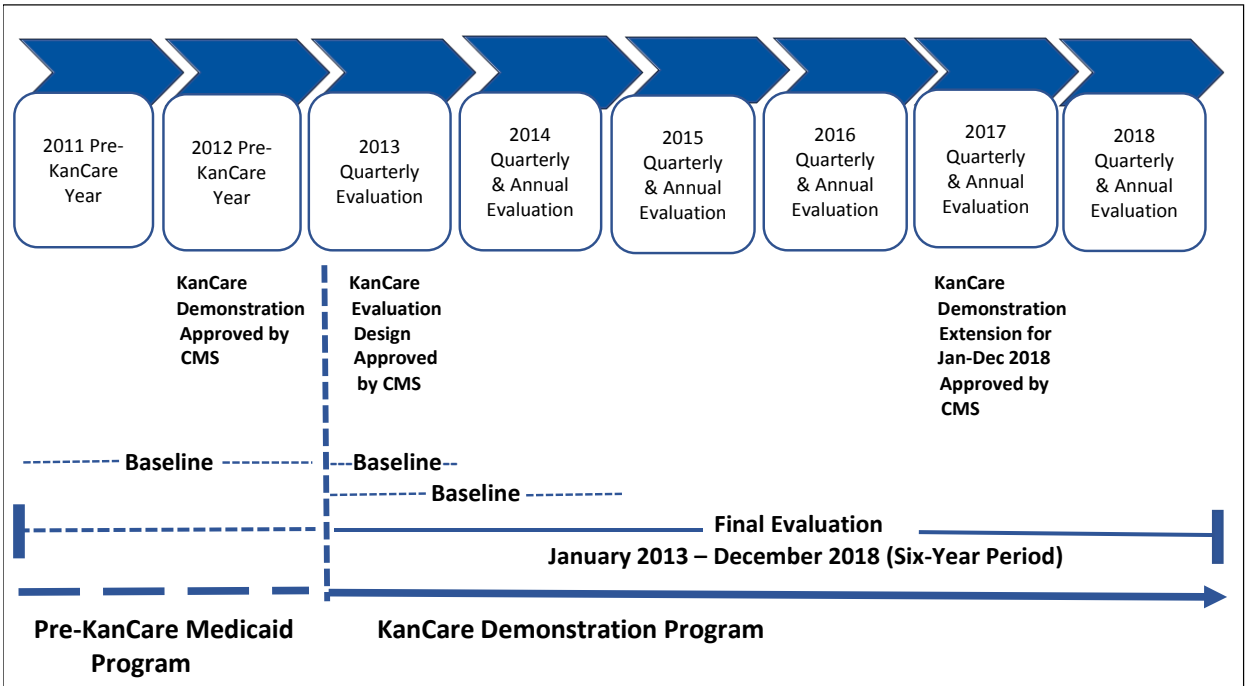

Figure 2. KanCare Program Evaluation Timeline

KanCare Evaluation Categories and Subcategories and Performance Measures

The KanCare Evaluation Design, includes over 100 PMs focusing on eight major categories with 27 subcategories.

KanCare Evaluation Categories and Subcategories

The evaluation design categories and related subcategories are described below in Table 2.

Table 2. Evaluation Design Categories and Subcategories
Quality of Care
(1) Physical Health
(2) Substance Use Disorder Services
(3) Mental Health Services
(4) Healthy Life Expectancy
(5) HCBS Waiver Services
(6) Long Term Care: Nursing Facilities
(7) Member Surveys – Quality
(8) Provider Survey
(9) Grievances
(10) Special Study: HCBS–CAHPS Survey
Coordination of Care (and Integration)
(1) Care Management for Members Receiving HCBS Services
(2) Special Study: HCBS – CAHPS Survey
(3) Care Management for Members with I/DD
(4) Member Survey – CAHPS
(5) Member Survey – Mental Health (MH) Survey
(6) Member Survey – SUD
(7) Provider Survey
Cost of Care
(1) Costs
Access to Care
(1) Provider Network – GeoAccess
(2) Member Survey – CAHPS
(3) Member Survey – MH
(4) Member Survey – SUD
(5) Provider Survey
(6) Grievances
(7) Special Study: HCBS – CAHPS Survey
Ombudsman Program
(1) Calls and Assistance
Efficiency
(1) Systems
(2) Member Surveys (CAHPS; MH; SUD)
Uncompensated Care Pool (UCC Pool)
Delivery system Reform Incentive Program (DSRIP)

Evaluation Measures

The quantitative and qualitative process and outcome measures were included in the evaluation design by focusing on the KanCare objectives, as well as the STCs.[6] The PMs were selected to provide evidence of the overall quality of care and specific services provided to each KanCare population group.[7] Additionally, the evaluation design included existing measures reviewing a range of ages, populations and programs to provide a broad representation of KanCare.[6] The measures included HEDIS measures (administrative and hybrid), HEDIS-like measures, National Outcome Measurement System (NOMS)

measures and other measures including service measures, administrative measures, consumer survey (CAHPS, MH, and SUD) measures and provider survey measures. HEDIS measures also included Payment for Performance (P4P) measures.

Performance measures for the '*Quality of Care'* category and its subcategories are described in Table 3.

Table 3. Performance Measures for Assessment of Evaluation Category: Quality of Care

Physical Health
Performance Measures: The following includes 18 HEDIS measures. • Adults' Access to Preventive/Ambulatory Health Services (AAP) • Adult Body Mass Index (BMI) Assessment (ABA) • Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication (ADD) • Annual Dental Visit (ADV) • Adolescent Well-Care Visits (AWC) • Controlling High Blood Pressure (CBP) • Comprehensive Diabetes Care (CDC) • Chlamydia Screening in Women (CHL) • Appropriate Testing for Children with Pharyngitis (CWP) • Follow-Up after Hospitalization for Mental Illness (FUH) • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) • Annual Monitoring for Patients on Persistent Medications (MPM) • Medication Management for People with Asthma (MMA) • Prenatal and Postpartum Care (PPC) • Appropriate Treatment for Children with Upper Respiratory Infection (URI) • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) • Well-Child Visits in the First 15 Months of Life (W15) • Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)
Substance Use Disorder Services
Performance Measures: The following measures are based on NOMS data for members who are receiving SUD services: • The number and percent of members receiving SUD services whose living arrangements improved • The number and percent of members receiving SUD services whose criminal justice involvement improved • The number and percent of members receiving SUD services whose drug and/or alcohol use decreased • The number and percent of members receiving SUD services attending self-help meetings during reporting period • The number and percent of members receiving SUD services whose employment status was improved or maintained
Mental Health Services
Performance Measures: The following measures are based on NOMS data for members who are receiving mental health services, including adults with SPMI and youth experiencing SED: • The number and percent of adult members with SPMI identified as receiving MH services • The number and percent of KanCare members, diagnosed with SPMI, who were competitively employed • The number and percent of adults with SPMI who were homeless at the beginning of the reporting period that were housed by the end of the reporting period • The number and percent of youth experiencing SED identified as receiving MH services • The number and percent of youth experiencing SED who experienced improvement in their residential status • The number and percent of youth experiencing SED who maintained their residential status • The number and percent of KanCare youth receiving MH services with improvement in their Child Behavior Checklist (CBCL Competence T-scores) • The number and percent of members utilizing inpatient mental health services

Table 3. Performance Measures for Assessment of Evaluation Category: Quality of Care

Healthy Life Expectancy

Performance Measures:

Health Literacy: Measures are based on questions related to health literacy in the Adult and Child CAHPS Surveys.

Adult Members: *In the last 6 months,*

- Did you and a doctor or other health provider talk about specific things you could do to prevent illness?
- How often did your personal doctor explain things in a way that was easy to understand?
- How often did your personal doctor listen carefully to you?
- Did you and a doctor or other health provider talk about starting or stopping a prescription medicine?
  If yes: When you talked about starting or stopping a prescription medicine,
  - Did a doctor or other health provider talk about the reasons you might want to take a medicine?
  - Did a doctor or other health provider talk about the reasons you might not want to take a medicine?
  - Did a doctor or other health provider ask you what you thought was best for you?

Child Members – General Child (GC) and Children with Chronic Conditions (CCC): *In the last 6 months,*

- Did you and your child's doctor or other health provider talk about specific things you could do to prevent illness in your child?
- How often did your child's personal doctor explain things about your child's health in a way that was easy to understand?
- How often did your child's personal doctor listen carefully to you?
- Did you and your child's doctor or other health provider talk about starting or stopping a prescription medicine for your child?
  If yes: When you talked about your child starting or stopping a prescription medicine,
  - Did a doctor or other health provider talk about the reasons you might want your child to take a medicine?
  - Did a doctor or other health provider talk about the reasons you might not want your child to take a medicine?
  - Did a doctor or other health provider ask you what you thought was best for your child?
- How often did your child's personal doctor explain things in a way that was easy for your child to understand?
- How often did you have your questions answered by your child's doctors or other health providers?

Flu Shots for Adults: The measure is based on the following CAHPS Survey question:

- Have you had either a flu shot or flu spray in the nose since July 1, [previous year]?

Smoking Cessation: The measure is based on the following CAHPS Survey questions:

- Do you now smoke cigarettes or use tobacco: every day, some days, or not at all?
  If "every day" or "some days": 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?
  - How often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco?
  - 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?

Healthy Life Expectancy – HEDIS Measure: The following HEDIS measure is included:

- Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

Healthy Life Expectancy for Persons with SMI, I/DD, and PD: The following prevention and treatment/recovery measures are described as "HEDIS-like" in that HEDIS criteria are used for each performance measure, but the HEDIS programming is adapted to include only those populations that meet eligibility criteria and are also I/DD, PD, or SMI:

- Prevention – Screening and Vaccinations Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Immunizations for Adolescents – Combination 2 (IMA)
- Treatment/Recovery:
  - Comprehensive Diabetes Care (CDC) (Hemoglobin A1c [HbA1c] Testing; Eye Exam; Medical Attention for Nephropathy; HbA1c Control <8.0; and Blood Pressure <140/90)

Home and Community Based Services (HCBS) Waiver Services

Performance Measures:

- The number of KanCare members receiving PD, TBI, or I/DD Waiver services who were eligible for Working Healthy and receiving services through the Work Opportunities Reward Kansans (WORK) program.
- Percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment

Table 3. Performance Measures for Assessment of Evaluation Category: Quality of Care
• Percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan
Long Term Care: Nursing Facilities
Performance Measures: • Percentage of Medicaid NF claims denied by the MCO • Percentage of NF members who had a fall with a major injury • Percentage of members discharged from a NF who had a hospital admission within 30 days • Number of Person Centered Care Homes as recognized by the PEAK program (Promoting Excellent Alternatives in Kansas) in the MCO network
Member Surveys – Quality of Care
Performance Measures: <u>Adult Members and Child Members (GC and CCC):</u> **Member Perceptions of Provider Treatment:** The measures are based on questions in the CAHPS Survey • Rating of personal doctor. • Rating of health care. • Rating of health plan. • Rating of specialist seen most often. • Doctor respected member comments. • Doctor spent enough time with the member. **Member Perceptions of Mental Health Provider Treatment:** The **m**easures are based on questions in the MH Survey • If I had other choices, I would still get services from my mental health providers. • My mental health providers helped me obtain information I needed so that I could take charge of managing my illness. • I, not my mental health providers, decided my treatment goals. • I felt comfortable asking questions about my treatment and medication. • My mental health providers spoke with me in a way I understood. • As a direct result of services I received, I am better able to control my life. • As a direct result of services I received, I am better able to deal with crisis. • As a direct result of services I received, I am better able to do things that I want to do. **Member Perceptions of SUD Services:** The measures are based on questions in the SUD Survey • Overall, how would you rate the quality of service you have received from your counselor? • How would you rate your counselor on involving you in decisions about your care? • Since beginning treatment, in general are you feeling much better, better, about the same, or worse?
Provider Survey – Quality of Care
Performance Measure: **Provider Perceptions of Beneficiary Quality of Care:** The measure is based on questions in the MCOs' Provider Surveys • Please rate your satisfaction with the MCO's demonstration of their commitment to high quality of care for their members.
Grievances Related to Quality of Care
Performance Measure: • Compare/track number of grievances related to quality

Performance measures for the *'Coordination of Care (and Integration)*' category and its subcategories are described in Table 4.

Table 4. Performance Measures for Assessment of Evaluation Category: Coordination of Care (and Integration)
Care Management for Members Receiving HCBS Services
Performance Measures: • Percent of HCBS Waiver participants with a documented change in needs whose service plans were revised, as needed, to address the change. • Percent of HCBS Waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs.

Table 4. Performance Measures for Assessment of Evaluation Category: Coordination of Care (and Integration)

HCBS HEDIS-like Measures: The following HEDIS measures included:

- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Annual Dental Visits (ADV)
- Emergency Department Utilization (EDU).

Special Study: HCBS–CAHPS Survey

Performance Measure:

- Helpful targeted case manager; transportation; social and community integration.

Care Management for Members with Intellectual/Developmental Disability (I/DD)

Performance Measures:

- Relationship building/shared understanding between MCOs and I/DD system

Member Survey – Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

Performance Measures:

Member Perceptions of Care and Treatment in Medicaid and CHIP Populations:

Adult Members: *In the last 6 months,*

- Did you get care from a doctor or other health provider besides your personal doctor?
- How often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?
- Did you make any appointments to see a specialist?
- How often did you get an appointment to see a specialist as soon as you needed?
- How often was it easy to get the care, tests, or treatment you needed?

Child Members – GC and CCC: *In the last 6 months,*

- Did your child get care from a doctor or other health provider besides his or her personal doctor?
- How often did your child's personal doctor seem informed and up-to-date about the care your child got from these doctors or other health providers?
- Did you make any appointments for your child to see a specialist?
- How often was it easy to get appointments for your child with specialists?
- How often was it easy to get the care, tests, or treatment you thought your child needed through his or her health plan?
- Did your child get care from more than one kind of health care provider or use more than one kind of health care service?
- Did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?
- Did you need your child's doctors or other health providers to contact a school or daycare center about your child's health or health care?
- Did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?
- Does your child have any medical, behavioral, or other health conditions that have lasted more than 3 months?
- Does your child's personal doctor understand how these medical, behavioral or other health conditions affect your child's day-to-day life?
- Does your child's personal doctor understand how your child's medical, behavioral or other health conditions affect your family's day-to-day life?
- Did you get or refill any prescription medicines for your child?
- Was it easy to get prescription medicines for your child through his or her health plan?
- Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?

Member Survey – Mental Health (MH) Surveys

Performance Measures:

Perception of Care Coordination for Members Receiving MH Services:

Perception of the members that they were able to access all the services they thought they needed:

- I was able to get all the services I thought I needed.
- My family got as much help as we needed for my child.

Perception of the members regarding encouragement to use consumer-run programs:

- I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).

Table 4. Performance Measures for Assessment of Evaluation Category: Coordination of Care (and Integration)
Member Survey – Substance Use Disorder (SUD) Surveys
Performance Measures: **Care Coordination by SUD Populations:** • Has your counselor requested a release of information for this other substance abuse counselor who you saw? • Has your counselor requested a release of information for and discussed your treatment with your medical doctor?
Provider Survey
Performance Measures: **Provider Satisfaction Regarding Coordination of Care:** • Satisfaction with obtaining precertification and/or authorization for members.

Performance measures for the *'Cost of Care'* category are described in Table 5.

Table 5. Performance Measures for Assessment of Evaluation Category: Cost of Care
Costs
Performance Measures: • Comparison of Pre-KanCare and KanCare Service Utilization • Per Member Per Month (PMPM) Average Annual Service Expenditures

Performance measures for the '*Access to Care'* category and its subcategories are described in Table 6.

Table 6. Performance Measures for Assessment of Evaluation Category: Access to Care
Provider Network – GeoAccess
Performance Measures: • Percent of counties covered within access standards, by provider type (physicians, hospital, eye care, dental, ancillary [physical therapy {PT}, occupational therapy {OT}, x-ray, and lab], and pharmacy). ○ Access to provider types in Urban and Semi-Urban Counties. ○ Access to provider types in Frontier/Rural/Densely-Settled Rural (Non-Urban) Counties. • Average distance to a BH provider: ○ Urban/Semi-Urban Counties ○ Densely-Settled Rural Counties ○ Frontier/Rural Counties • Percent of counties covered within access standards for BH: ○ Urban/Semi-Urban Counties ○ Densely-Settled Rural Counties ○ Frontier/Rural Counties • HCBS – Counties with access to at least two providers by provider type and services • Provider Open/Closed Panel Report • Provider After-Hour Access (24 hours per day/7 days per week) • Annual Provider Appointment Standards Access (In-office wait times; Emergent, urgent and routine appointments; Prenatal care – first, second, third trimester and high risk)
Member Survey – CAHPS Surveys
Performance Measures: <u>Adult Members and Child Members – GC and CCC:</u> **Appointment Availability:** *In the last 6 months,* • Did you (your child) have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office? • When you needed care right away, how often did you (for your child) get care as soon as you (your child) needed? • Did you make any appointments for a check-up or routine care (for your child) at a doctor's office or clinic? • Not counting the times you needed care right away, how often did you get an appointment (for your child) for a check-up or routine care at a doctor's office or clinic as soon as you (your child) needed?

Table 6. Performance Measures for Assessment of Evaluation Category: Access to Care
• How often was it easy to get the care, tests, or treatment you (your child) needed? • Did you make any appointments (for your child) to see a specialist? • How often did you get an appointment (for your child) to see a specialist as soon as you needed?
Member Survey – MH Surveys
Performance Measures: **Member Perceptions of Access to MH Services:** • Provider availability as often as member felt it was necessary • Ability to get services during a crisis • Services were available at times that were good for the member • Ability to see a psychiatrist when the member wanted to • Ability to get all the services the members thought they needed • Timely availability of medication • Provider return of calls within 24 hours
Member Survey – SUD Surveys
Performance Measures: **Perceptions of Access to Care for Members Receiving SUD Services:** • Thinking back to your first appointment for your current treatment, did you get an appointment as soon as you wanted? • For urgent problems, how satisfied are you with the time it took you to see someone? • For urgent problems, were you seen within 24 hours, 24 to 48 hours, or did you wait longer than 48 hours? • Is the distance you travel to your counselor a problem or not a problem? • Were you placed on a waiting list? • If you were placed on a waiting list, how long was the wait?
Provider Survey
Performance Measure: • Provider satisfaction with the availability of specialists
Grievances
Performance Measure: • Compare/track number of access-related grievances over time, by population type.

Performance measures for the '*Ombudsman Program'* category are described in Table 7.

Table 7. Performance Measures for Assessment of Evaluation Category: Ombudsman Program
Calls and Assistance
Performance Measures: • Evaluate for trends regarding types of questions and grievances submitted to Ombudsman's Office. • Track number and type of assistance provided by the Ombudsman's Office.

Performance measures for the '*Efficiency'* category are described in Table 8.

Table 8. Performance Measures for Assessment of Evaluation Category: Efficiency
Systems
Performance Measures: • Emergency Department (ED) Visits • Inpatient Hospitalizations • Inpatient Readmissions within 30 days of inpatient discharge • Quantify system design innovations implemented by KanCare such as: Person-Centered Medical Homes, Electronic Health Record use, Use of Telehealth, and Electronic Referral Systems • Timely resolution of grievances and Compare/track number of access-related grievances over time, by population type • Timeliness of claims processing

Table 8. Performance Measures for Assessment of Evaluation Category: Efficiency
Member Surveys
Performance Measures: Adult Members and Child Members –GC and (CCC: **Efficiency Measures Based on the CAHPS Survey Questions:** • In the last 6 months, did you get information or help from your (child's) health plan's customer service? • In the last 6 months, how often did your (child's) health plan's customer service give you the information or help you needed? **Efficiency Measure Based on the MH Survey Question:** • My mental health providers returned my calls in 24 hours. **Efficiency Measure Based on the SUD Survey Question:** • How would you rate your counselor on communicating clearly with you?

The performance measure for the '*Uncompensated Care Cost Pool*' category is described in Table 9.

Table 9. Performance Measure for Assessment of Evaluation Category: Uncompensated Care Cost Pool
Comparison of Medicaid Days for Uncompensated Care Cost Pool hospitals to UCC Pool Payments
Performance Measure: • Number of Medicaid Days for UCC Pool hospitals compared to UCC Pool Payments

Performance measures for the '*DSRIP*' category are described in Table 10.

Table 10. Performance Measures for Assessment of Evaluation Category: DSRIP
Children's Mercy Hospital
• **Expansion of Patient-Centered Medical Homes (PCMH) and Neighborhoods** Infrastructure Milestones Process Milestones Quality and Outcome Milestones Population Focused Improvements Partner and Trailblazer Valuations Evaluation Design Table Goals and Metrics • **Improving Coordinated Care for Medically Complex Patients (Beacon Program)** Infrastructure Milestones Process Milestones Quality and Outcome Milestones Population Focused Improvements Partner and Trailblazer Valuations Evaluation Design Table Goals and Metrics
University of Kansas Health System
• **STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis** Infrastructure Milestones Process Milestones Quality and Outcome Milestones Population Focused Improvements Partner and Trailblazer Valuations Evaluation Design Table Goals and Metrics • **Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC)** Infrastructure Milestones Process Milestones Quality and Outcome Milestones Population Focused Improvements Partner and Trailblazer Valuations Evaluation Design Table Goals and Metrics

Data Sources

The evaluation process included assessment of quantitative and qualitative process and outcome measures; therefore, a variety of data sources were used to obtain data on process and outcome measures. KDHE-DHCF, and the Kansas Department for Aging and Disability Services (KDADS) provided data from the State tracking systems and databases. In addition, MCOs providing KanCare/Medicaid services also provided the data for the evaluation (MCO reports) and the hospitals in the DSRIP program provided project reports for review. Given the comprehensiveness of the State Quality Strategy and required reporting and monitoring, a large portion of the data were drawn from existing reports. The data sources included:

- Administrative data (e.g., financial data; claims; encounters; nursing home Minimum Data Set [MDS]; Addiction and Prevention Services' Kansas Client Placement Criteria [KCPC] database; Mental Health Automated Information Management Systems [AIMS]; etc.);
- Medical and Case Records;
- Consumer and provider feedback (surveys, grievances, Ombudsman reports).

Existing reports used to obtain evaluation data included:

- Quantitative PM reports using administrative and medical/case record information:
  - HEDIS®
  - MH measures, including SED Waiver reports and NOMS
  - NF measures
  - SUD measures
  - HCBS Waiver reports (e.g., I/DD; PD; TBI)
  - Case record reviews
  - Access reports
  - Financial reports
  - DSRIP reports
- Qualitative reports using surveys, and other forms of self-reported data:
  - CAHPS®
  - Mental Health Statistical Improvement Program (MHSIP) Consumer Survey
  - SUD consumer survey
  - Provider Survey
  - KCPC database contains member self-reported data
  - AIMS database includes some self-reported data
  - Care Manager feedback and surveys
  - Grievance reports

Data sources for the assessment of performance measures in categories and subcategories of the Evaluation Design are summarized in Table 11.

Table 11. Data Sources for Assessment of Performance Measures by Evaluation Design Categories and Subcategories

Evaluation Design Categories and Subcategories	Data Sources
Quality of Care	
• Physical Health	• MCO HEDIS reports.
• Substance Use Disorder Services	• KCPC database.
• Mental Health Services	• AIMS and MMIS system; MCO reports; Inpatient Screening database.
• Healthy Life Expectancy	• CAHPS Surveys; HEDIS reports.

Table 11. Data Sources for Assessment of Performance Measures by Evaluation Design Categories and Subcategories	
Evaluation Design Categories and Subcategories	**Data Sources**
• HCBS Waiver Services • Long Term Care: Nursing Facilities • Member Surveys – Quality • Provider Survey • Grievances	• MCO Case management database; Record Review. • MCO reports; KDADS Nursing Home MDS data reports; MCO Claims data reports. • MCO CAHPS Survey reports; MHSIP Survey reports; SUD Consumer Survey Reports. • Provider Survey reports. • Grievance reports.
Coordination of Care (and Integration) • Care Management for Members Receiving HCBS Services • Member Survey – CAHPS • Member Survey – MH • Member Survey – SUD • Provider Survey	 • Case Audits by state or its contractor/agent; HEDIS reports; HEDIS-like data • MCO CAHPS Survey reports. • MHSIP Survey (conducted by KFMC) • MCO SUD Survey reports. • MCO reports
Cost of Care • Costs	 • Financial; Claims; Encounter Data.
Access to Care • Provider Network – GeoAccess • Member Survey – CAHPS • Member Survey – MH • Member Survey – SUD • Provider Survey • Grievances	 • MCO Geo-Access reports. • MCO CAHPS Survey reports. • MHSIP Survey reports. • MCO SUD Survey reports. • Provider survey reports. • MCO Grievance reports.
Ombudsman Program • Calls and Assistance	 • Ombudsman report.
Efficiency • Systems • Member Surveys (CAHPS, MH, SUD)	 • KDADS, KDHE and MCO reports; Claims; Encounters. • MCO CAHPS Survey reports; MHSIP Survey (conducted by KFMC); MCO SUD Survey reports.
Uncompensated Care Pool	• KDHE reports
DSRIP	• Hospital project reports • MCO HEDIS reports

Analytic Methods

Over the six-year demonstration period, baseline and cross-year comparisons of the quantitative and qualitative process and outcome performance measures assisted in the monitoring of the progress of the KanCare program towards achieving its goals and objectives.

The overall analytic approach included:

- Comparison of 2018/2017 percentages/rates with the baseline percentages/rates (pre-KanCare [2011/2012], 2013, or 2013/2014).
- Comparison of KanCare QC percentiles for HEDIS and CAHPS measures with national QC percentiles.
- Trend analysis across the six-year demonstration program period.

In the report, if the rates for measures remained consistently high or low in the appropriate direction throughout the evaluation period, then they were identified and labelled as "*maintained.*"

Comparison of 2018/2017 Percentages/Rates with the Baseline Percentages/Rates

The descriptive statistics (percentages/rates) were calculated for the overall KanCare population. Appropriate numerators and denominators for the performance measures in each evaluation category were used for these analyses. For comparisons with the baseline, appropriate statistical tests such as Fisher's Exact and Pearson Chi-Square tests were applied. The $p<.05$ was used to determine the statistical significance of the comparison results. For P4P HEDIS measures, a 5% absolute improvement was examined by comparing percentages/rates for the most recent year as per availability of data with the baseline. For some of the measures, where inferential statistical testing could not be done, comparison of the most recent and baseline numbers/percentages was based on descriptive data and assessment of absolute differences was conducted without applying statistical testing.

In addition to the overall KanCare population, the evaluation was structured to identify any variability among the demographic groups (age groups, county type), the GC population including TXIX/Medicaid and TXXI/CHIP program members and the CCC population including TXIX/Medicaid and TXXI/CHIP program members, waiver services, providers, members receiving MH services, SUD treatment and receiving NF services (wherever appropriate, and where data were available).

Comparison of the KanCare QC Percentiles for the HEDIS and CAHPS Measures with the National QC Percentiles

As mentioned above, several HEDIS measures were used in the evaluation process. HEDIS measures are developed, tracked, and reported by the NCQA; results for the MCOs are compiled annually. The NCQA QC reports national averages and percentiles (QCs ranging from 5^{th} to 95^{th}) annually that provide benchmarks for MCO comparisons, helping identify healthcare service area strengths and opportunities for improvement. In this report, the QC percentiles (aggregates across MCOs) for HEDIS measures were compared with the QC national and average percentiles to assess the performance of the KanCare program.

The MCOs' CAHPS survey results were also compiled annually and compared with the QC national and average percentiles. To assess the performance of the KanCare program, these comparisons were provided across KanCare years and with pre-KanCare rates when possible.

Trend Analysis Across Six-Year Demonstration Program Period

For examining the pattern in the performance measures (time series data) over the six-year program period, the trend analysis was conducted using Mantel Haenszel Chi-Square test with the $p<.05$ for assessing statistical significance of the results.

Additional Details of Analysis Process for Assessment of the HEDIS, HEDIS-like, NOMS, CAHPS, MH Survey, Provider Network–GeoAccess Measures, Ombudsman Program and DSRIP.

Analysis of HEDIS and HEDIS-like Measures

HEDIS 2014 (CY2013) administrative and hybrid data from claims and medical record review were used as the baseline for most HEDIS and HEDIS-like measures. For the baselines for multi-year measures, the HEDIS 2015 data (including CY2013 and CY2014) were used. For some of the measures (CDC, W15, W34, AAP and PPC), the pre-KanCare CY2012 HEDIS data were available; however, KanCare data from 2013/2014 were used for the baseline as the KanCare population included members receiving waiver services and was not directly comparable to the pre-KanCare population.

Administrative HEDIS data included all KanCare members from each MCO who met HEDIS eligibility criteria for each measure. Since these measures included all eligible members, KFMC combined the numerators and denominators for the three MCOs to assess the aggregate annual percentages. Hybrid HEDIS data were based on samples of eligible members and included both administrative data and medical record review. As the hybrid HEDIS data were based on samples from each MCO, the aggregate data for hybrid measures were weighted to adjust for any differences in population and sample sizes. Some performance measures were composite HEDIS measures that were composed of multiple metrics. For these measures, all corresponding metrics were individually assessed for the statistically significant differences for making conclusions about the measure (e.g., CDC, WCC).

Analysis of National Outcome Measurement System Data

The performance measures for two evaluation categories, SUD Services and MH Services, were based on NOMS data. For these measures, pre-KanCare (CY2012) data were used as the baselines.

For SUD measures, members might have been counted more than once, as they might have been discharged from SUD treatment in one month, and re-entered treatment later in the quarter or year (i.e., counted more than once in a quarter or counted in more than one quarter). Denominators for these measures represented the number of times members were discharged from SUD treatment during the quarter. The actual number of individual members who received SUD services each year were not reported.

For evaluation of MH measures, the pre-KanCare (CY2012) NOMS data for members who received MH services were used as baselines. The data for MH measures might have been based on counts with members being included in more than one quarter of data, as their status related to a performance measure might have been changed throughout the year. In addition, members might also have more than one inpatient admission during the year.

Analysis of CAHPS Survey Measures

Several performance measures for the evaluation categories were based on questions from the CAHPS surveys (Adult and Child surveys), which were conducted nationally. The CAHPS survey is a nationally standardized survey tool sponsored by the Agency for Health Care Research and Quality (AHRQ) and co-developed with NCQA. The overall objective of the CAHPS surveys was to capture accurate and complete information about consumer-reported experiences with health care. Specifically, the survey aims to measure how well MCOs were meeting their members' expectations and goals, to determine which areas of service have the greatest effect on members' overall satisfaction, and to identify areas of opportunity for improvement that could aid the MCOs in increasing the quality of provided care. When administered properly, CAHPS surveys provide information regarding the access, timeliness and/or quality of health care services provided to health care consumers.

All three MCOs were contractually required by the State to conduct CAHPS surveys and submit results to the NCQA. Since the launch of KanCare in January of 2013, CAHPS surveys have been conducted annually by the KanCare MCOs and validated by the Kansas Foundation for Medical Care (KFMC).

The State directed each MCO to conduct separate valid surveys from five populations: Adults, GC – TXIX/Medicaid, GC – TXXI/CHIP, CCC – TXIX, and CCC – TXXI.

The analysis of data for the measures based on CAHPS surveys were based on the aggregated percentage of positive responses as reported in the CAHPS surveys conducted by the three MCOs. Overall scores were compared with the national scores. Comparison of the rates for the most recent year and baseline was conducted. Aggregated data from the 2014 CAHPS surveys were used as the baseline. Trend analysis was also conducted. In addition, CAHPS survey results were also compared with the QC national percentiles.

Some of the measures were based on CAHPS survey questions focusing on the "rating" provided by the respondents on different aspects of the quality of care they received. For these questions, ratings were based on a scale from zero to 10, with 10 being the "best possible" and zero the "worst possible." Positive response for these rating questions were based on combining results for selections of "8," "9," or "10", and then weighted by MCO population for aggregating the results.

Analysis of Mental Health Survey Measures

Mental Health Survey measures were based on responses to the Mental Health Surveys. These surveys were conducted each year since 2010 by KFMC. Each year's survey was conducted among a random sample of KanCare members who received one or more MH services in the prior six-month period of each survey year. The MHSIP Youth Services Survey for Families and Adult Consumer Survey tools, as modified by KFMC per State guidance over the past eight years, were used for these surveys. From 2011 to 2017, the Youth Services Survey was also used. Survey results were reported by adults, youth (family members completing the survey, with separate questions completed by youth ages 12–17), and youth and young adults receiving SED Waiver services. Survey results were analyzed annually for statistical significance and trends over time, including comparison of survey results in 2011 and 2012 (pre-KanCare) with survey results in 2013–2018 (KanCare).

Analysis of Provider Survey Measures

For provider surveys in 2014 and subsequent years in KanCare, the MCOs were directed to include three questions related to quality, timeliness, and access. These three questions and response options were required to be worded identically on each of the MCOs' surveys to allow comparison and ability to better assess the overall program and trends over time.

From CY2013 to CY2017, two of the MCOs, Sunflower and UnitedHealthcare, administered separate surveys to their BH providers. However, in September 2018, Cenpatico was transitioned to Sunflower; therefore, a separate survey was not conducted in 2018. The MCOs were asked to include these three questions on their BH surveys as well.

Unlike other sections of the KanCare Evaluation Report where data for the three MCOs were aggregated, data for the provider survey responses were reported separately by MCO. This is due in part to the separate surveying of BH providers. The primary reason, however, is that the three questions are MCO-specific related to provider perceptions of each MCO's unique preauthorization processes, availability of specialists, and commitment to quality of care.

Analysis of Provider Network – GeoAccess

Results for the Provider – Network GeoAccess performance measures were based on reports and GeoAccess maps submitted to the State by the three MCOs, summarizing provider access. Amerigroup's contract ended December 31, 2018, and the State limited the amount of data Amerigroup was required to submit. For some of the performance measures, no data were available for comparison from 2012 (pre-KanCare); for some measures the reporting began in January 2014; and for 2018, complete data,

the State Provider Network feedback report for Quarter (Q)3 and Q4 2018, and the GeoAccess map was not available for Amerigroup. For tracking two of the performance measures, no tracking report templates were required of the MCOs by the State. This is due in part to differing methods and systems used by the MCOs for monitoring provider adherence to these standards. Also, in 2014, one MCO changed its method for evaluating after-hours coverage compliance. Therefore, for some performance measures, data were only available for three to five years of the evaluation period.

Due to issues identified in the MCO Provider Network reporting, KDHE provided clear guidelines as to how data should be reported and directed the MCOs to make corrections based on these guidelines. Additional guidance was also provided to MCO staff related to reporting the numbers and locations of primary care providers. Due to corrections that were implemented in the reporting processes, the number of primary care and internal medicine providers and locations were excluded from portions of the KanCare Evaluation reporting in 2017 and 2018. The State began the process with reviewing the MCOs' Q4 2017 Provider Network Report. In addition to the provider record issues, KDHE is working with the MCOs to begin collecting data during provider credentialing/recredentialing for the fields: "Missing Data," "Inconsistent /Incongruent Data," and "Invalid Data." Results should be interpreted cautiously due to the changes made in provider network reporting and not knowing, at this time, what impact it had on reporting. Also, it is not known at this time what impact, if any, this will have on GeoAccess reporting.

For these performance measures, inferential statistical testing for examining trends over time and for comparison of data for the recent year with the baseline was not conducted. The results for these performance measures, when assessed for the timeframe available and comparisons of recent year data with the baseline, were drawn from the available descriptive data.

Analysis and Reporting of a Subset of Performance Measures on Quarterly Basis:

A subset of the annual PMs was selected to be assessed and reported quarterly during each year of the KanCare program. For each quarter, data from the three MCOs were combined wherever possible to better assess the overall impact of the KanCare program. The following measures that were assessed every year on a quarterly basis are described in Table 12:

Table 12. Quarterly Assessment of a Subset of Performance Measures by Evaluation Design Categories and Subcategories

Evaluation Categories and Subcategories	Performance Measures
Evaluation Category: Quality of Care **Subcategory:** Grievances Related to Quality of Care	• Number of grievances related to quality over time, by population.
Evaluation Category: Access to Care **Subcategory:** Grievances	• Number of access-related grievances over time, by population categories.
Evaluation Category: Ombudsman Program **Subcategory:** Calls and Assistance	• Types of questions and grievances submitted to the Ombudsman's office. • Number and type of assistance provided by the Ombudsman's office. • Timeliness of inquiry response and resolution by Ombudsman's office and other involved entities.
Evaluation Category: Efficiency **Subcategory:** Systems	• Timely resolution of member and provider customer service inquiries. • Timeliness of claims processing. • Timeliness of grievance resolution.

Analysis of the Performance Measures for the Ombudsman Program:

Ombudsman Office assistance is provided by the Ombudsman, three office staff (noted on the Ombudsman website, www.KanCare.ks.gov/kancare-ombudsman-office), and six trained volunteers at two satellite offices. The Ombudsman's Office is in Topeka, with satellite offices in Wichita (Sedgwick County) and Olathe (Johnson County). Assistance is provided by phone and in-person, including assistance completing Medicaid applications.

Information (as well as volunteer applications) is provided through the Ombudsman's Office website in-person, phone calls, mail, and email. A wide variety of resources are available on the KanCare Ombudsman website, including forms, fact sheets, application and documentation checklists, information on where to find additional assistance, information on applying for eligibility and renewal, and grievance and appeal process.

As delineated in the CMS Kansas STC, revised in January 2014, the Ombudsman's Office data to be tracked include the date of incoming requests (and date of any change in status); contact method; the volume and types of requests for assistance; the time required to receive assistance from the Ombudsman (from initial request to resolution); the issue(s) presented in requests for assistance; the health plan involved in the request, if any; the geographic area of the beneficiary's residence; waiver authority if applicable (I/DD, PD, etc.); current status of the request for assistance, including actions taken by the Ombudsman; and the number and type of education and outreach events conducted by the Ombudsman. The results for the PMs for this evaluation category were based on available descriptive data. No inferential statistical testing was conducted for this evaluation.

Analysis of the DSRIP Program:

The Kansas DSRIP program, launched in 2015, includes four projects conducted by two major hospital systems, CMH and the UKHS. UKHS implemented two projects, STOP Sepsis and SPARCC. CMH projects include *Beacon Program* and *Expansion of PCMH*. Each project contains Infrastructure Milestones (Category 1), Process Milestones (Category 2), Quality and Outcome Milestones (Category 3), and Population Focused Metrics (Category 4), Partner and Trailblazer Valuations, and additional Evaluation Design Table Goals and Metrics. The hospital project teams, KDHE and KFMC met, in-person or via conference call, two to three times per year for cross-hospital collaborative learning, and one-on-one technical assistance. KFMC and KDHE are available to the hospitals for technical assistance as needed. CMH and UKHS submit annual project reports and semi-annual progress reports. While the majority of Category 3 and 4 metrics are annual measurements, the semi-annual deliverable reports on changes and updates to project activities and the remaining milestones and metrics. KFMC evaluates the hospitals' semi-annual and annual reports, including for completeness, accuracy, comparisons of results over time, progression towards outcome, and process goals. KFMC develops and submits to KDHE semi-annual and annual evaluation reports containing review findings and recommendations. The reports are shared with the hospitals, and KFMC offers to review the findings and recommendations with the hospitals.

Special Studies – 2019 Kansas HCBS–CAHPS Survey

KFMC proposed to conduct an optional special study to examine the quality of care and care coordination/access to care aspects among beneficiaries receiving home and community based long-term services and supports through the KanCare Program. In the fall of 2018, KFMC contracted with Vital Research (VR) to conduct the 2019 Kansas HCBS–CAHPS Survey to assess the perceptions/ experiences of the beneficiaries receiving HCBS services regarding the quality of care, coordination of care and access to care provided through HCBS services.

The standard HCBS CAHPS Survey instrument developed by CMS for state Medicaid programs to learn about beneficiaries' experience receiving their home and community based long-term services and supports was used for this study. In addition to standard sections of survey, KFMC and the KDADS opted to include the Supplemental Employment Module with 21 questions about the participant's employment status, whether he/she has a job coach, their experience with this job coach, etc. KFMC/ KDADS also included additional adjustments to the survey's administration. First, KFMC/KDADS tailored the Case Manager section of the survey to specify the two types of case managers that serve the waiver groups being surveyed. The case manager section was first specified to the "Targeted Case Manger" who serves I/DD waiver recipients. The survey questions remained the same as the original HCBS CAHPS survey but were to be answered only by I/DD Waiver recipients. Second, KFMC/KDADS repeated the case manager questions for all four waiver groups (FE, TBI, PD, and I/DD) to answer, but specified that respondents were to answer these questions regarding their "MCO Care Coordinator." These survey questions also remained the same as the original HCBS CAHPS Case Manager survey questions. KFMC/ KDADS also added three Supplemental Access Questions regarding waiver recipients' access to medical care. All respondents and/or proxies were asked these questions. VR added an additional step for interviewers to indicate whether the member or a proxy answered each individual survey item. This will provide a side-by-side analysis of any statistically significant differences that may have occurred in responses provided by members versus proxy respondents. VR screened and recruited 12 Field Interviewers throughout the state of Kansas to conduct the HCBS CAHPS in-person interviews. VR trained the selected interviewers. VR selected one Field Interviewer to also act as a Quality Assurance Mentor (QAM) throughout data collection.

Prior to the start of data collection, KDADS provided information for the 18,609 members who receive services and supports from the Frail Elderly Waiver program, I/DD Waiver program, Physical Disability Waiver program, and Traumatic Brain Injury Waiver program. Upon receipt of this information, both VR, KFMC and KDADS audited the data to exclude recipients who did not have a phone number, lived outside of Kansas, or were surveyed within the last year. With these exclusions, VR then created a randomized sample of 1,200 members to participate in the 2019 HCBS–CAHPS survey project. With an overall target of 400 completed interviews, VR is collecting survey data on 172 interviews with I/DD recipients, 96 with FE recipients, nine with TBI recipients, and 123 with PD recipients. VR printed and mailed the first batch of KDADS/KFMC-approved pre-notification letters with Frequently Asked Questions (FAQs) to 613 members in the sample. VR then mailed pre-notification letters and FAQs to the second batch of 587 sampled members. Data collection began on January 31, 2019 and is still ongoing. For quality assurance monitoring, VR trained one QAM to conduct field interview observations. These observations include evaluation of interviewing skills, adherence to the survey protocol, and Health Information Portability and Accountability Act (HIPAA)/Health Information Technology for Economic and Clinical Health Act (HITECH) compliance. The QAM also enters survey responses into her tablet while observing the actual interview being conducted by the Field Interviewer, ensuring fidelity of data between interviewers.

The Kansas HCBS–CAHPS survey data will be analyzed in four sections: Survey respondent characteristics (e.g., demographic data) such as gender, age, and education level of respondents; descriptive statistics (e.g., frequencies) for each of the individual survey items; the CAHPS Macro Analysis; and, key findings and recommendations. The CAHPS Macro Analysis will contain significance testing of the 19 survey measures embedded in the HCBS CAHPS survey that have been endorsed by the National Quality Forum. These 19 measures are comprised of seven composite, or scale, measures that are each a combination of survey questions around a similar topic, as well as 12 measures that are comprised of a single survey

question. This section will provide scores for the 19 measures, which will be divided into five categories: composite/scale measures, global ratings, recommendation measures, unmet needs measures, and a physical safety measure. Based upon the findings revealed by the descriptive statistics and the CAHPS Macros Analysis, VR will conduct further analyses to derive key findings and recommendations for KFMC/KDADS to consider regarding the supports and services KDADS provides to the FE, I/DD, PD, and TBI Waiver groups.

At the time of preparation of this evaluation report, the data collection for the survey was completed for 194 respondents. For this report, the preliminary data were reviewed, and the preliminary findings were summarized. The preliminary findings are described in the Results Section of the report under *Quality of Care, Coordination & Integration of Care and Access to Care* categories.

Methodological Limitations

This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

A few methodological and analytical challenges/caveats were encountered in the final evaluation of the KanCare program and are as follows:

- A variety of data sources were used for the evaluation of the performance measures. The analyses of different performance measures were dependent on the data source methodology and timing of data collection, as well as lag time in availability of data.
- Data from different sources were available for different timelines. For example, the data for the PMs based on HEDIS results were available for the years 2013 through 2017, whereas, data for the measures based on the questions from CAHPS member surveys were available for the years 2014 through 2018. Due to the different timelines for the data availability from these sources, the analyses examining the trends could not be conducted for the same period for all measures. Similarly, the years constituting the baseline and most current year could not be the same for the comparison of PM rates due to differences in the timelines for availability of data from these sources.
- The trend and comparison analyses for certain PMs were affected (e.g., break in trending, comparison of trends for fewer years) by the changes over time in the data collection methodology, definition/specifications of the measures, survey questions and guidelines for data collection.
- Modification in the data tracking systems overtime also contributed to the limitation of data analyses to be done for the same period for all measures.
- The pre-KanCare data could not be used as the baseline for most of the measures due to differences in beneficiary populations, MCOs, and design of the program (pre-KanCare and KanCare).
- Convenient survey design for certain surveys limited the analyses to the examination of descriptive data only.
- Small numbers for the numerators and denominators for the calculation of rates for certain measures limited the application of inferential statistical testing, requiring use of descriptive data to assess these measures.
- Due to changes made in the MCO Provider Network reporting processes, the number of primary care and internal medicine providers and locations were excluded from portions of the KanCare Evaluation reporting in 2017 and 2018.

- Annual measurement recalculation using "refreshed" data for previously reported years affects past comparisons and conclusions. After allowance for claims lag or other known data lags, past analyses and reported results should be set and saved, with no further recalculations allowed, unless an error needs correction. If historical changes are necessary, reasons should be noted to allow the evaluator to assess the impact of any changes.
- Some hospital DSRIP analyses of patient self-reported information at different points in time, for pre- and post- measurement comparisons did not limit follow-up measurement to self-reports from the same people that reported for the baseline.
- Some hospital DSRIP reports contained data discrepancies within reports and between reports over time; specific explanations were not always provided.
- The Special Study – 2019 Kansas HCBS–CAHPS Survey was still in process of collecting data at the time of preparation of this report; therefore, only preliminary data were assessed. Complete data were not available, therefore final conclusions were not included in this report.

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Results

Evaluation Category: Quality of Care

Goals, Performance Objectives, and Hypotheses for Quality of Care Subcategories:

- **Goal:**
  - Improve the quality of care Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes).
- **Performance Objectives:**
  - Measurably improve health care outcomes for members in areas including: diabetes; coronary artery disease; prenatal care; and BH.
  - Improve coordination and integration of PH care with BH care.
  - Support members successfully in their communities.
  - Promote wellness and healthy lifestyles.
- **Hypotheses:**
  - By holding MCOs to outcomes and performance measures, and tying measures to meaningful financial incentives, the State will improve health care quality and reduce costs.
  - The State will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between PH, BH, MH, SUD, and LTSS.

The PMs addressing ten subcategories were monitored to assess the improvement in the quality of care received by KanCare program beneficiaries. The final evaluation results showed improvement in the quality of care provided to Kansas Medicaid beneficiaries through the KanCare program over the six-year period (Figure 3).

The summaries and detailed results of the evaluation for each of the ten subcategories of the *Quality of Care* category, over a period of six years, are described in the following Quality of Care findings.

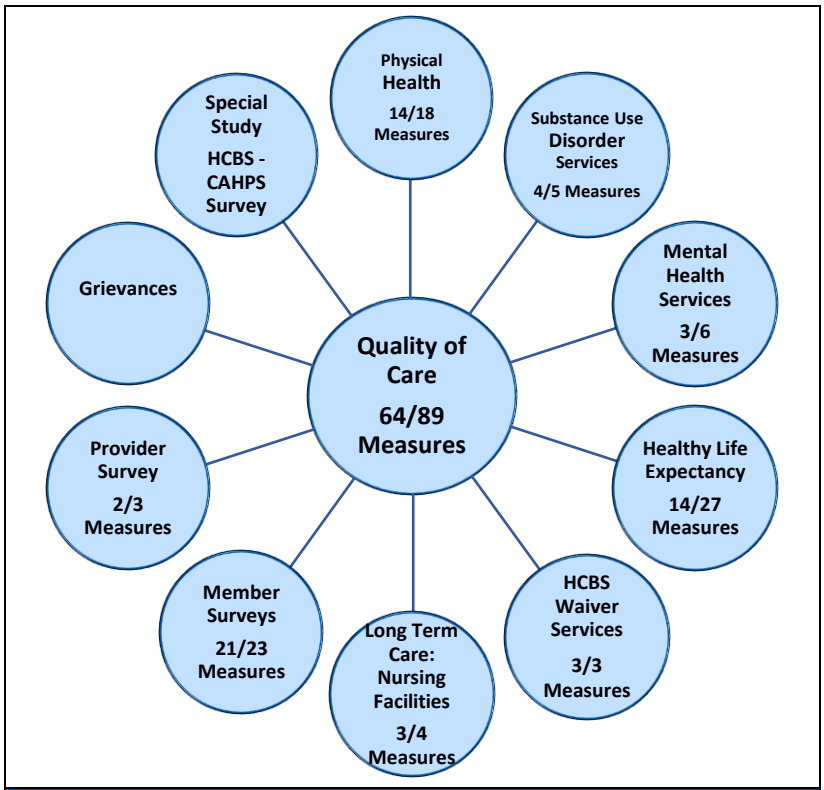

Figure 3. Improved/Maintained Measures for the Quality of Care Subcategories

1) Physical Health – HEDIS Measures

Evaluation Summary

The results from the evaluation of HEDIS measures are summarized in Tables 13 and 14.

The data for the eighteen HEDIS measures related to **Physical Health Care** were available for five years of the evaluation period. These data were examined to assess improvement in this subcategory of the KanCare *Quality of Care* (Tables 13 and 14) category. Several PMs showed statistically significant improvements in the trends over time and in the rates for the most recent year compared to the baseline. These results are summarized in Figure 4.

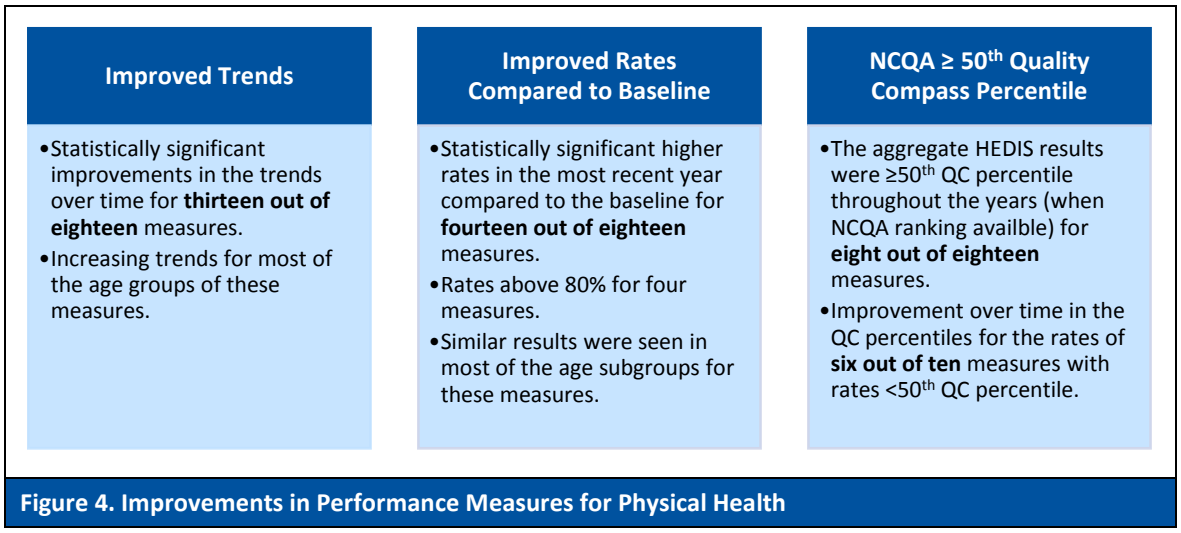

Figure 4. Improvements in Performance Measures for Physical Health

The following measures showed statistically significant improvement in the trends, as well as higher rates in the most recent year compared to the baseline:

- Annual dental visits among members ages 2–20 years (ADV);
- Adult BMI assessment among members ages 18 years and older (ABA);
- Weight assessment and counseling for nutrition and physical activity including weight assessment/BMI, counseling for nutrition and counseling for physical activity for children/ adolescents ages 3–17 years (WCC). Please note, this measure has three components. All three components showed increasing trends and higher rates in the recent year compared to the baseline;
- Follow-up after hospitalization for mental illness, within seven days of discharge (FUH);
- Adolescent well care visits (ages 12–21 years) (AWC);
- Well-child visits in third, fourth, fifth and sixth year of life (ages 3–6 years) (W34);
- Well-child visits in the first 15 months of life (3 visits, 4 visits, 5 visits, 6 or more visits) (W15);
- Controlling high blood pressure (CBP);
- Comprehensive diabetes care (CDC). Please note, this measure is based on six metrics. The trend analysis and comparison of rates in the most recent year compared to the baseline showed improvement in appropriate directions for all six metrics;
- Appropriate testing for children with pharyngitis (CWP);
- Medication management for people with asthma (MMA);
- Annual monitoring for patient on persistent medications (MPM); and
- Appropriate treatment for children with upper respiratory infection (URI).

The rates above 50% were seen for all these measures, except for medication management for people with asthma (below 40%).

The rates above 80% were seen in the most recent year for following four measures:

- Adults' access to preventive/ambulatory health services (AAP);
- Adult BMI assessment among members ages 18 years and older (ABA);
- Annual monitoring for patient on persistent medications (MPM); and
- Appropriate treatment for children with upper respiratory infection (URI).

Decreasing trends for two out of eighteen measures were seen. These included:

- Adults' access to preventive/ambulatory health services (AAP); and
- Initiation and engagement in alcohol or other drug dependence treatment (IET).

Though decreasing trends were seen for the adults' access to preventive/ambulatory health services (AAP), its rate for the most recent year was considerably high and above 85%. In addition, a statistically significant increasing trend was seen for this measure in the age group 65 years and older. The lower rates (below 40%) were seen continuously throughout the evaluation period for the IET measure with the lowest rate for engagement in treatment for alcohol or other drug dependence. In addition, most recent rates for both aspects of this measure (initiation and engagement in treatment) were significantly lower than the baseline rates (statistically significant differences).

No statistically significant change was observed in the trends over the five-year period for the following three measures:

- Prenatal and postpartum care (PPC);
- Chlamydia screening in women ages 16–24 years (CHL); and
- Follow-up care for children prescribed Attention Deficit Hyperactivity Disorder (ADHD) medication (ADD).

Along with no significant change over time, the rates in the most recent year for Prenatal and postpartum (PPC), were below 80%. The rates for the follow-up care for children prescribed ADHD medication measure (initiation phase and continuation and maintenance phase) in the most recent year were higher compared to the baseline (statistically significant difference).

Though most of the PH measures showed increasing trends over time, however improvements could be made in the rates to further strengthen the quality of care provided to the beneficiaries. Thus, the assessment of the eighteen performance measures indicated that the ***quality of care addressing PH care*** had shown improvement over time.

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Table 13. Physical Health HEDIS Measures, CY2013 – CY2017

Measure	HEDIS Aggregated Results					Quality Compass ≥50th Percentile*				
	2013	2014	2015	2016	2017	2013	2014	2015	2016	2017
Adults' Access to Preventive/Ambulatory Health Services (AAP)										
Ages 20–44	85.4%	84.3%	83.7%	82.6%	83.6%	↑	↑	↑	↑	↑
Ages 45–64	92.2%	92.4%	92.3%	91.3%	90.7%	↑	↑	↑	↑	↑
Ages 65 and older	89.5%	88.6%	89.7%	90.1%	90.9%	↑	↑	↑	↑	↑
Total – Ages 20 and older	88.4%	87.5%	87.1%	86.2%	86.7%	↑	↑	↑	↑	↑
Annual Dental Visit (ADV)										
Ages 2–3	40.8%	41.2%	42.8%	45.8%	46.6%	↑	↑	↑	↑	↑
Ages 4–6	66.3%	65.7%	66.2%	69.2%	70.7%	↑	↑	↑	↑	↑
Ages 7–10	70.7%	70.1%	70.4%	72.7%	73.7%	↑	↑	↑	↑	↑
Ages 11–14	62.8%	62.8%	63.2%	66.4%	67.7%	↑	↑	↑	↑	↑
Ages 15–18	53.9%	53.5%	54.1%	57.2%	58.7%	↑	↑	↑	↑	↑
Ages 19–20	31.5%	30.2%	34.7%	33.1%	33.9%	↓	↓	↑	↓	↓
Total – Ages 2–20	60.3%	60.0%	60.9%	63.7%	64.8%	↑	↑	↑	↑	↑
Initiation in Treatment for Alcohol or other Drug Dependence (IET)^ *(CMS Core Quality Measure)*										
Ages 13–17	49.0%	50.8%	46.4%	50.2%	43.6%	↑	↑	↑	↑	^
Ages 18 and older	40.9%	41.3%	37.7%	40.1%	34.7%	↑	↑	↓	↓	^
Total – Ages 13 and older	42.1%	42.6%	38.9%	41.4%	35.8%	↑	↑	↑	↑	^
Engagement in Treatment for Alcohol or other Drug Dependence (IET)^ *(CMC Core Quality Measure)*										
Ages 13–17	32.5%	31.0%	26.8%	27.5%	23.6%	↑	↑	↑	↑	^
Ages 18 and older	12.2%	12.1%	10.7%	12.4%	10.4%	↑	↑	↑	↑	^
Total – Ages 13 and older	15.2%	14.8%	12.9%	14.3%	12.0%	↑	↑	↑	↑	^
Prenatal and Postpartum Care (PPC) *(CMS Core Quality Measure)*										
Prenatal Care	71.4%	70.4%	67.4%	68.4%	69.3%	↓	↓	↓	↓	↓
Postpartum Care	58.5%	55.8%	57.5%	58.0%	61.1%	↓	↓	↓	↓	↓
Chlamydia Screening in Women (CHL) *(CMS Core Quality Measure)*										
Ages 16–20	42.4%	41.0%	41.3%	41.0%	39.6%	↓	↓	↓	↓	↓
Ages 21–24	55.6%	54.5%	53.5%	52.8%	54.5%	↓	↓	↓	↓	↓
Total – Ages 16–24	46.1%	45.4%	45.8%	45.3%	45.1%	↓	↓	↓	↓	↓
Adult BMI Assessment (ABA) *(CMS Core Quality Measure)*										
		72.2%	77.6%	80.9%	86.5%		↓	↓	↓	↓
Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents *(CMS Core Quality Measure)*										
Weight Assessment/BMI for Children and Adolescents (WCC)										
Ages 3–11	33.7%	44.3%	48.9%	55.5%	64.3%	↓	↓	↓	↓	↓
Ages 12–17	36.6%	47.3%	48.1%	56.9%	65.6%	↓	↓	↓	↓	↓
Total – Ages 3–17	34.7%	45.3%	48.6%	56.0%	64.7%	↓	↓	↓	↓	↓
Counseling for Nutrition for Children and Adolescents (WCC)										
Ages 3–11	47.4%	50.8%	50.6%	55.4%	60.6%	↓	↓	↓	↓	↓
Ages 12–17	46.0%	47.0%	45.7%	53.1%	56.7%	↓	↓	↓	↓	↓
Total – Ages 3–17	46.9%	49.5%	49.1%	54.7%	59.2%	↓	↓	↓	↓	↓
Counseling for Physical Activity for Children and Adolescents (WCC)										
Ages 3–11	39.6%	43.5%	43.3%	47.9%	51.9%	↓	↓	↓	↓	↓
Ages 12–17	53.1%	50.6%	48.3%	58.6%	57.8%	↓	↓	↓	↓	↓
Total – Ages 3–17	44.0%	45.8%	44.9%	51.5%	53.9%	↓	↓	↓	↓	↓

*↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile
^Quality Compass identified "Break in Trending" due to specification changes from prior year
†Quality Compass identified "Trend with Caution" due to specification changes from prior year

Table 13. Physical Health HEDIS Measures, CY2013 – CY2017 (Continued)

Measure	HEDIS Aggregated Results					Quality Compass ≥50th Percentile*				
	2013	2014	2015	2016	2017	2013	2014	2015	2016	2017
Follow-Up after Hospitalization for Mental Illness, within seven days of discharge (FUH)^ *(CMS Core Quality Measure)*										
	61.0%	56.2%	62.8%	64.4%	59.0%	↑	↑	↑	↑	^
Follow-Up Care for Children Prescribed ADHD Medication (ADD)‡ *(CMS Core Quality Measure)*										
Initiation Phase		48.0%	50.7%	52.2%	49.5%		↑	↑	↑	‡
Continuation & Maintenance Phase		54.8%	61.2%	61.4%	57.5%		↑	↑	↑	‡
Adolescent Well Care Visits (AWC) ***(CMS Core Quality Measure)***										
	43.6%	46.7%	46.8%	47.7%	**53.3%**	↓	↓	↓	↓	↓
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) *(CMS Core Quality Measure)*										
	63.4%	65.9%	64.8%	67.3%	**71.0%**	↓	↓	↓	↓	↓
Well-Child Visits in the First 15 Months of Life (W15) *(CMS Core Quality Measure)*										
0 visits		4.2%	3.0%	3.4%	**2.9%**		↑†	↑†	↑†	↑†
1 visit		4.4%	3.3%	3.5%	**3.4%**		↑†	↑†	↑†	↑†
2 visits		6.0%	4.8%	4.8%	**4.1%**		↑†	↑†	↑†	↑†
3 visits		7.1%	6.5%	5.5%	**6.5%**		↑†	↑†	↑†	↑†
4 visits		12.3%	9.1%	8.6%	**8.0%**		↑	↓	↓	↓
5 visits		16.8%	14.5%	15.5%	**14.4%**		↓	↓	↓	↓
6 or more visits		49.3%	58.7%	58.6%	**60.7%**		↓	↓	↓	↓
Controlling High Blood Pressure (CBP) *(CMS Core Qualilty Measure)*										
	47.3%	51.5%	48.2%	52.1%	**53.6%**	↓	↓	↓	↓	↓
Comprehensive Diabetes Care (CDC)										
HbA1c Testing *(CMS Core Quality Measure)*	83.1%	84.8%	84.9%	85.8%	**86.2%**	↓	↓	↓	↓	↓
Eye Exam (Retinal)	50.1%	58.6%	62.5%	64.4%	**62.4%**	↓	↑	↑	↑	↑
Medical Attention for Nephropathy	75.8%	76.8%	89.2%	87.2%	**88.8%**	↓	↓	↓	↓	↓
HbA1c Control (<8.0%)	39.0%	39.3%	46.6%	51.0%	**55.0%**	↓	↓	↓	↑	↑
HbA1c Poor Control (>9.0%) *(CMS Core Quality Measure)*	54.4%	52.9%	45.4%	41.1%	**35.3%**	↓	↓	↓	↓	↓
Blood Pressure Control (<140/90)	53.1%	52.6%	58.8%	57.9%	**61.1%**	↓	↓	↓	↓	↓
Appropriate Testing for Children with Pharyngitis (CWP)										
	51.6%	52.2%	55.1%	61.2%	**68.6%**	↓	↓	↓	↓	↓
Medication Management for People with Asthma (MMA) *(CMS Core Quality Measure in 2013-2017)*										
5–11 years of age		27.4%	29.1%	31.7%	**38.0%**		↑	↑	↑	↑
12–18 years of age		24.1%	26.6%	31.9%	**36.4%**		↑	↑	↑	↑
19–50 years of age		39.6%	38.3%	41.4%	**46.6%**		↑	↑	↑	↑
51–64 years of age		53.0%	55.1%	60.1%	**60.2%**		↑	↑	↑	↑
Total – Ages 5–64		28.1%	29.9%	33.7%	**39.2%**		↓	↓	↑	↑
Annual Monitoring for Patients on Persistent Medications (MPM)^ *(CMS Core Quality Measure)*										
	84.9%	89.7%	90.2%	89.5%	**90.0%**	↓	↑	↑	↑	^
Appropriate Treatment for Children with Upper Respiratory Infection (URI)										
	71.9%	73.5%	76.3%	79.2%	**81.9%**	↓	↓	↓	↓	↓

*↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile
^Quality Compass identified "Break in Trending" due to specification changes from prior year
†HEDIS rates greater than 50th percentile that indicate poor performance

The aggregate HEDIS rates for CY2016/CY2017 and baseline year (CY2013/CY2014) were also examined. These rates along with the percentage point differences among them are shown in Table 14.

Table 14. Aggregate HEDIS Measures – Comparison of Rates with the Baseline			
HEDIS Quality of Care Measures	**Baseline Rate**	**2016/2017 Rate**	**Percentage Point Difference**
Adults' Access to Preventive/Ambulatory Health Services, ages 20 years and older (AAP)	**2013**	**2017**	
	88.4%	86.7%	-1.7*
Annual Dental Visit, ages 2-20 years (ADV)	**2013**	**2017**	
	60.3%	64.8%	+4.5*
Initiation in Treatment for Alcohol or Other Drug Dependence, ages 13 years and older (IET)	**2013**	**2016**	
	42.1%	41.4%	-0.7*
Engagement in Treatment for Alcohol or Other Drug Dependence, ages 13 years and older (IET)	**2013**	**2016**	
	15.2%	14.3%	-0.9*
Prenatal and Postpartum Care (PPC)	**2013**	**2017**	
Prenatal Care	71.4%	69.3%	-2.1
Postpartum Care	58.5%	61.1%	+2.6
Chlamydia Screening in Women, ages 16-24 years (CHL)	**2013**	**2017**	
	46.1%	45.1%	-1.0
Adult BMI Assessment, ages 18 years and older (ABA)	**2014**	**2017**	
	72.2%	86.5%	+14.3*
Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents, ages 3-17 years (WCC)	**2013**	**2017**	
• Weight Assessment/BMI for Children and Adolescents	34.7%	64.7%	+30.0*
• Counseling for Nutrition for Children and Adolescents	46.9%	59.2%	+12.3*
• Counseling for Physical Activity for Children and Adolescents	44.0%	53.9%	+9.9*
Follow-Up after Hospitalization for Mental Illness, within seven days of discharge (FUH)	**2013**	**2016**	
	61.0%	64.4%	+3.4*
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	**2014**	**2016**	
Initiation Phase	48.0%	52.2%	+4.2*
Continuation & Maintenance Phase	54.8%	61.4%	+6.6*
Adolescent Well Care Visits, ages 12-21 years (AWC)	**2013**	**2017**	
	43.6%	53.3%	+9.7*
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life, ages 3-6 years (W34)	2013	2017	
	63.4%	71.0%	+7.6*
Well-Child Visits in the First 15 Months of Life (W15)	**2014**	**2017**	
• 6 or more visits	49.3%	60.7%	+11.4*
Controlling High Blood Pressure (CBP)	2013	2017	
	47.3%	53.6%	+6.3*
Comprehensive Diabetes Care (CDC)	**2013**	**2017**	
• HbA1c Testing	83.1%	86.2%	+3.1*
• Eye Exam	50.1%	62.4%	+12.3*
• Medical Attention for Nephropathy	75.8%	88.8%	+13.0*
• HbA1c Control (<8.0%)	39.0%	55.0%	+ 16.0*
• HbA1c Poor Control (>9.0%)	54.4%	35.3%	-19.0*
• Blood Pressure Control (<140/90)	53.1%	61.1%	+8.0*
Appropriate Testing for Children with Pharyngitis (CWP)	**2013**	**2017**	
	51.6%	68.6%	+17.0*
Medication Management for People with Asthma, ages 5-64 years (MMA)	**2014**	**2017**	
	28.1%	39.2%	+11.1*
Annual Monitoring for Patients on Persistent Medications, ages 18 years and older (MPM)	**2013**	**2016**	
	84.9%	89.5%	+4.6*
Appropriate Treatment for Children with Upper Respiratory Infection, (URI)	**2013**	**2017**	
	71.9%	81.9%	+10.0*
* Pearson Chi-Square $p<.05$ (Statistically Significant Results)			

Evaluation Results for the Physical Health Performance Measures

Adults' Access to Preventive/Ambulatory Health Services (AAP)

This measure tracked annual preventive/ambulatory visits (Figure 5). The measure was assessed in the total Medicaid population, as well as in three age groups (20–44 years; 45–64 years; and 65 years and older) from CY2013 to CY2017 (most current available data reported by the 2018 HEDIS report). From 2013 to 2017, a statistically significant increasing trend was seen in the percentages of the annual preventive/ambulatory visits among 65 years and older members (p<.001). However, among the total Medicaid population, as well as among the age groups 20–44 years and 45–64 years, rates were high, but a statistically significant decreasing trend was seen over this period (p<.001). The rate for the 65 years and older age group in 2017 was significantly higher than the baseline rate (p<.001).

The aggregate HEDIS results for the AAP measure from CY2013 through CY2017 were above the 50th QC percentile for the total Medicaid population and for each of the age groups. For the total population, aggregate HEDIS results remained above the 75th QC percentile throughout the evaluation period. When assessed for each age group, an improvement in HEDIS results was seen in the age groups 20–44 years (>75th QC percentile) and 65 years and older years (>66.67th QC percentile) in the recent year. In the age group 45–64 years, a decline in QC ranking was seen for the HEDIS result in the recent year compared to the baseline year (>90th QC percentile), though, it was still above the 75th QC percentile.

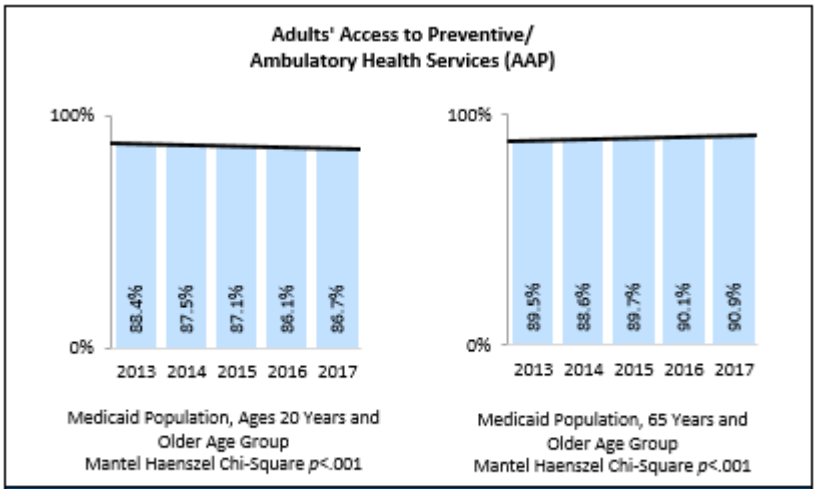

Figure 5. HEDIS AAP Trend CY2013–CY2017

Annual Dental Visit (ADV)

This measure tracked annual dental visits among the combined Medicaid and CHIP population (2–20 years old) from CY2013 to CY2017 (Figure 6); it was also a P4P measure from 2016–2017 for Ages 2–20. The measure was also examined in six age subgroups (2–3 years; 4–6 years; 7–10 years; 11–14 years; 15–18 years; and 19–20 years) over this period. From 2013 to 2017, statistically significant increasing trends were seen in the percentages of the annual dental visits among combined Medicaid and CHIP population, as well as in all six age groups mentioned above (p<.001). The annual dental visit rate in the total combined population for 2017 was significantly higher than the baseline rate (p<.001). The rates for all age groups in 2017 was significantly higher than the respective baseline rates (p<.001). The aggregate HEDIS results for CY2013 through CY2017 were above the 50th QC percentile for the total Medicaid and CHIP combined population and for all age groups except members in the age group of 19–20 years old, with the improvement seen from 2013 onwards in

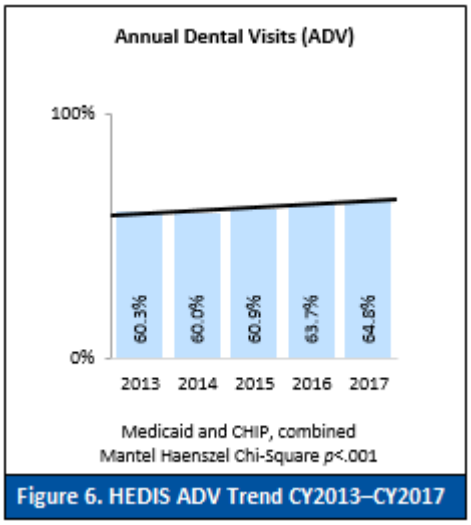

Figure 6. HEDIS ADV Trend CY2013–CY2017

the combined Medicaid and CHIP population. Similar patterns were seen in all age groups except the age group 19–20 years. The QC percentiles were above the 75th percentile among the total combined population and the age group 7–10 years, whereas it was above the 66.67th percentile among the age groups 2–3 years, 4–6 years, 11–14 years, and 15–18 years.

Initiation and Engagement in Treatment for Alcohol or Other Drug Dependence (IET) *(CMS Core Quality Measure)*

This measure tracked IET rates for the total combined Medicaid and CHIP population (13 years and older) from CY2013 to CY2016 (Figure 7). The measure was also examined in the two age subgroups (13–17 years, and 18 years and older) over this period. Due to specification changes in the measure in 2017 from prior years, the trend over time for this measure (for initiation of and engagement in treatment) was assessed from 2013 through 2016. Due to this reason, a trending break in the assessment of QC percentiles was also seen.

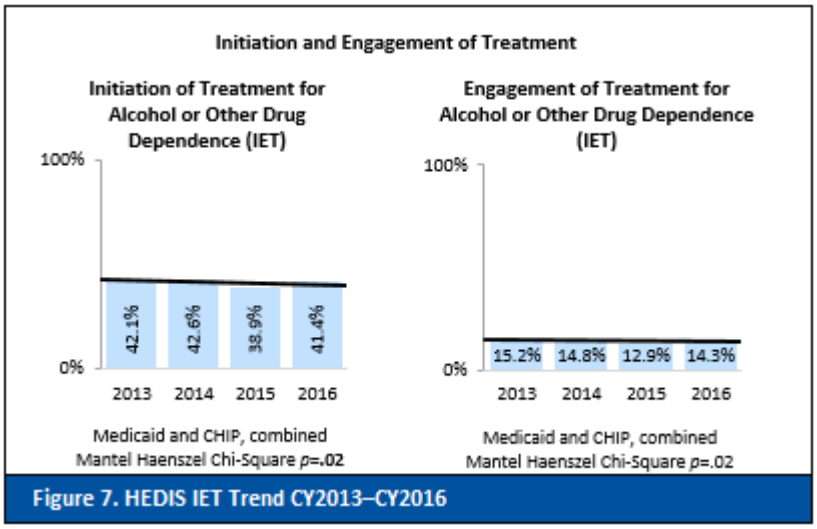

Figure 7. HEDIS IET Trend CY2013–CY2016

During this period, statistically significant declining trends were seen in the rates of the **treatment initiation** for alcohol or other drug dependence among the total combined Medicaid and CHIP population (p=.02), as well as in the age group 18 years and older (p=.03). The rates for the total combined population and age group 18 years and older in 2016 were significantly lower than the baseline rate (p<.001). The trend for the QC ranking was also assessed for the period of 2013 to 2016. The aggregate HEDIS results for CY2013 through CY2016 were above the 50th QC percentile for the total combined Medicaid and CHIP population and for the age group 13–17 years.

During this period, statistically significant declining trends were also seen in the rates of the **treatment engagement** for alcohol or other drug dependence in the total combined Medicaid and CHIP population (p=.02), as well as for the age group 13–17 years (p<.01). The rate for the total combined population in 2016 was significantly lower than the baseline rate (p<.001). Similarly, the rates for both age groups in 2016 were significantly lower than the baseline rate (p=.01). The aggregate HEDIS results for CY2013 through CY2016 were above the 50th QC percentile for the total combined Medicaid and CHIP population, as well as for both age groups. In the age group 13–17 years, the rates were above the 90th QC percentile throughout the four-year period.

Prenatal and Postpartum Care (PPC) (P4P – Prenatal Care) *(CMS Core Quality Measure)*

This measure tracked PPC rates among combined Medicaid and CHIP population from CY2013 to CY2017. The aggregate PPC rates were based on weighted hybrid data. The PPC rates did not show statistically significant trends over the five-year period. Also, no statistically significant differences were seen in the 2017 rates compared to the baseline rates. The aggregate HEDIS results for PPC for the total combined Medicaid and CHIP population throughout five years were below the 50th QC percentile. The

HEDIS results for prenatal care were below the 25th QC percentiles throughout, with further decline to the <10th QC percentile in recent years. The HEDIS results for postpartum care were below the 50th QC percentile throughout the five years and was <33.33rd QC percentile in the most recent year.

Chlamydia Screening in Women (CHL) *(CMS Core Quality Measure)*

This measure tracked CHL rates among total Medicaid and CHIP combined populations, age 16–24 years, from CY2013 to CY2017. The CHL rates were also examined in two age groups (16–20 years and 21–24 years) over the five-year period. From 2013 to 2017, CHL rates did not show any significant change in the trend among the total combined Medicaid and CHIP population, as well as in the age group 21–24 years. Also, no statistically significant differences were seen in the 2017 rates compared to the baseline rates for the total combined population and the age group 21–24 years. However, a declining trend was seen in the rates for the age group 16–20 years (p<.01). The rate in this age group was significantly decreased in 2017 compared to the baseline rate (p=.01).

The aggregate HEDIS results for CY2013 through CY2017 were below the 50th QC percentile for the total combined Medicaid and CHIP population, as well as for both age groups. During the five-year period, the CHL rates were below the 25th QC percentile in the total combined Medicaid and CHIP population with further decline to the <10th QC percentile in the most recent year. A similar pattern was seen among both age groups, with the HEDIS results at the <10th QC percentile among the age group 16–20 years in the recent years.

Adult BMI Assessment (ABA) *(CMS Core Quality Measure)*

This measure tracked ABA rates among the Medicaid and CHIP combined populations, age 18 years and older, from CY2014 to CY2017 (Figure 8). Data for this measure were based on aggregate weighted hybrid HEDIS data. From 2014 to 2017, a statistically significant increasing trend was seen in the percentages of the ABA among the combined Medicaid and CHIP population (p<.001). The ABA rate in the combined population was significantly higher in 2017 compared to 2013 (p<.001).

The aggregate HEDIS results for the ABA measure from CY2014 through CY2017 were below the 50th QC percentile. However, improvement was seen from the <25th QC percentile at the baseline to the <50th percentile in the recent year.

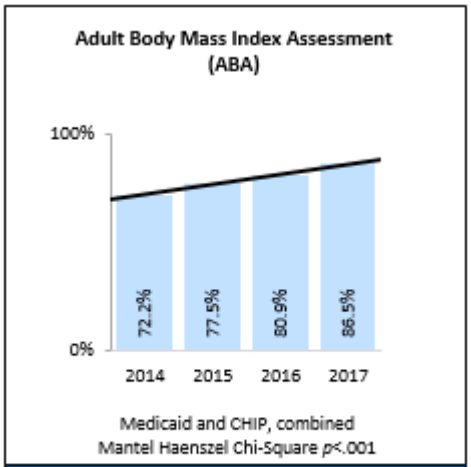

Figure 8. HEDIS ABA Trend CY2014–CY2017

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) *(CMS Core Quality Measure)*

This measure tracked WCC rates among the combined Medicaid and CHIP population, age 3–17 years, from CY2013 to CY2017 (Figure 9). These rates were also monitored for two age groups, 3–11 years, and 12–17 years, over this period. It included three components.

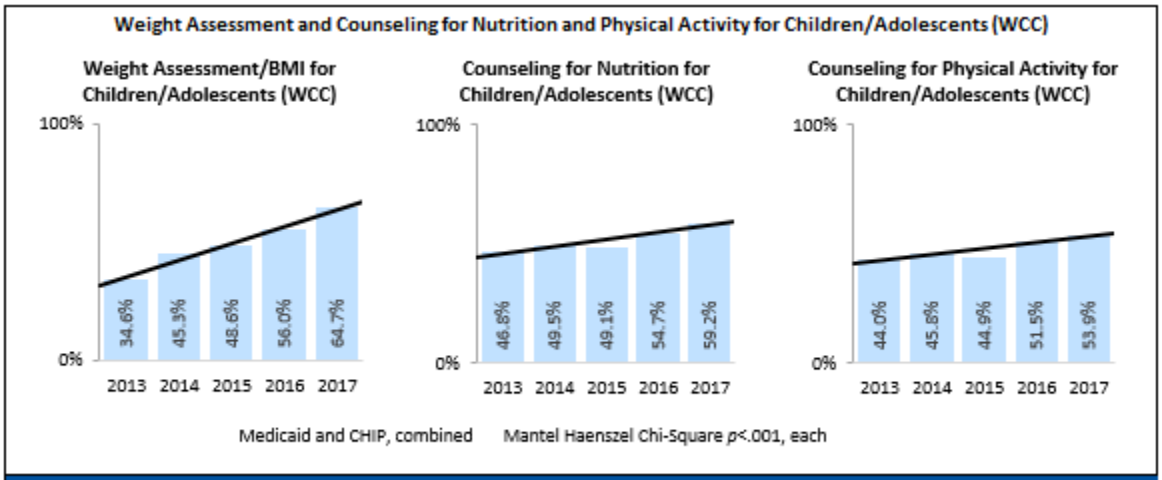

Figure 9. HEDIS WCC Trend CY2013–CY2017

- **Weight Assessment/BMI Rates for Children/Adolescents**
  Weight Assessment/BMI rates among children and adolescents, age 3–17 years (the total combined Medicaid and CHIP population), as well as in two age groups showed statistically significant increasing trends (p<.001). In 2017, a three-fold increase was seen in the rate for the total combined population and in two age groups with the 2017 rates significantly higher than the baseline rates (p<.001).

  The aggregate HEDIS results for this measure over the five-year period were below the 50th QC percentile for the total combined population and two age groups. Throughout this period, results for the total combined population and two age groups were <25th QC percentile, except for the 2017 rate for the age group 12–17 years, which was below the 33.33rd QC percentile.

- **Counseling for Nutrition for Children/Adolescents**
  The rates for the Counseling for Nutrition measure among children and adolescents, age 3–17 years (the combined Medicaid and CHIP population), as well as in two age groups showed statistically significant increasing trends in the total combined population and both age groups (p<.001). The rate in the total combined population was significantly higher in 2017 compared to the baseline (p<.001). A similar statistically significant increase was also seen in rates for both age groups (3–11 years: p<.001; 12–17 years: p<.01).

  The aggregate HEDIS results for this measure over the five-year period were below the 50th QC percentile for the total combined population and two age groups. Throughout this period, results for the total combined population and two age groups were below the 25th QC percentile, except for the age group 12–17 years in 2017 with the rate <33.33rd QC percentile.

- **Counseling for Physical Activity for Children/Adolescents**
  The rates for the Counseling for Physical Activity measure among children and adolescents, age 3–17 years (the total combined Medicaid and CHIP population), as well as in two age groups showed statistically significant increasing trends (the total combined population and the age group 3–11 years: p<.001; age group 12–17 years: p=.03). The rate for the total combined population was significantly higher in 2017 compared to the baseline (p<.001). Similarly, the rates for both age groups were also significantly higher in 2017 compared to the baseline (3–11 years: p<.001; age

group 12–17: *p*=.01). The aggregate HEDIS results for this measure, over the five-year period, were below the 50th QC percentile for the total combined population and two age groups. In recent years, results for the total combined population and two age groups were below the QC 33.33rd percentile.

Follow-up after Hospitalization for Mental Illness, within seven days of discharge (FUH) *(CMS Core Quality Measure)*

From 2013 to 2016, rates for the measure FUH for Mental Illness, within seven days of discharge among the combined Medicaid and CHIP population showed a statistically significant increasing trend (p<.001) (Figure 10); it was also a P4P measure from 2014–2015. The rate for the total combined population was significantly higher in 2016 compared to the baseline year (*p*<.001). The aggregate HEDIS results were above the 50th QC percentile throughout this period. In recent years, the rates were >75th QC percentile.

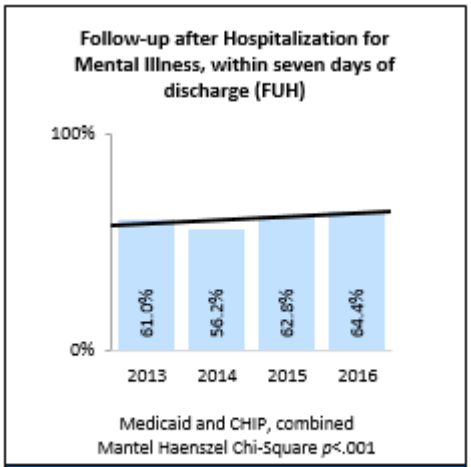

Figure 10. HEDIS FUH Trend CY2013–CY2016

Follow-Up Care for Children Prescribed ADHD Medication (ADD) *(CMS Core Quality Measure)*

The measure is based on aggregate weighted administrative HEDIS data and tracked the follow-up care for children, ages 6–12, diagnosed with ADHD among whom ADHD medication was prescribed. The measure was assessed in the combined Medicaid and CHIP population. CY2014 data constituted the baseline for the measure. The rates were examined for two phases (Initiation Phase and Continuation & Maintenance Phase). No significant change in the trends from CY2014 through CY2016 were seen in the rates for both phases. The rates for both phases in 2016 were significantly higher compared to the baseline (*p*<.01). The aggregate HEDIS results for this measure for both phases throughout the three-year period were above the 50th QC percentile.

Adolescent Well Care Visits (AWC) (CMS Core Quality Measure)

The measure tracked Well Care Visits among adolescents, ages 12–21 years, in the combined Medicaid and CHIP population (Figure 11). A statistically significant increasing trend was seen for this measure during the five-year period (*p*<.001). The rate was significantly higher in CY2017 compared to the baseline (*p*<.001). The aggregate HEDIS results for this measure throughout the five years were below the 50th QC percentile.

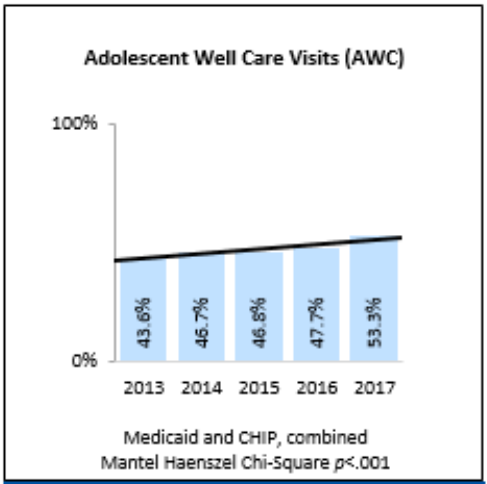

Figure 11. HEDIS AWC Trend CY2013–CY2017

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) (P4P in 2017 and 2018) (CMS Core Quality Measure)

The measure tracked Well-Child Visits among children, ages 3–6 years, in the combined Medicaid and CHIP population (Figure 12). A statistically significant increasing trend was seen for this measure during the five-year period (p<.001). The rate was significantly higher in CY2017 compared to the baseline (p<.01). The aggregate HEDIS results for this measure throughout the five years were below the 50th QC percentile; however, an improvement was seen from the results <25th QC percentile at the baseline to the <50th QC percentile in the most recent year.

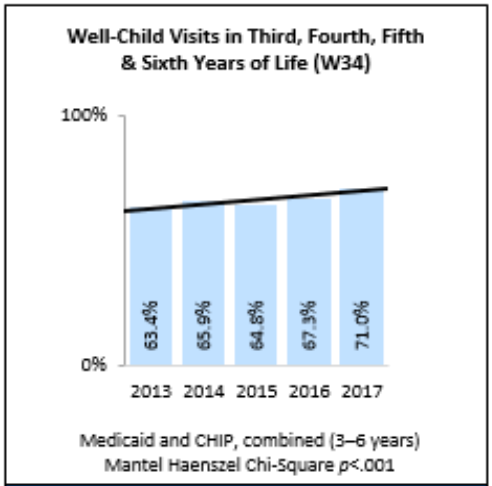

Figure 12. HEDIS W34 Trend CY2013–CY2017

Well-Child Visits in the First 15 Months of Life (W15) (CMS Core Quality Measure)

This measure tracked the number of well-child visits among children in the first 15 months of their life after post-delivery hospital discharge among the combined Medicaid and CHIP population (Figure 13). Data were based on aggregated weighted administrative HEDIS data. CY2014 constituted the baseline year for this measure. The data were examined in six subgroups based on the number of visits (0 Visits; 1 Visit; 2 Visits; 3 Visits; 4 Visits; 5 Visits; and 6 or More Visits). Statistically significant increasing trends were seen for 3 or more visits (p=.01); 4 or more visits (p=.01); 5 or more visits (p<.001); and 6 or more visits (p<.001). The rate for the 6 or more visits was higher in CY2017 compared to the baseline (p<.001).

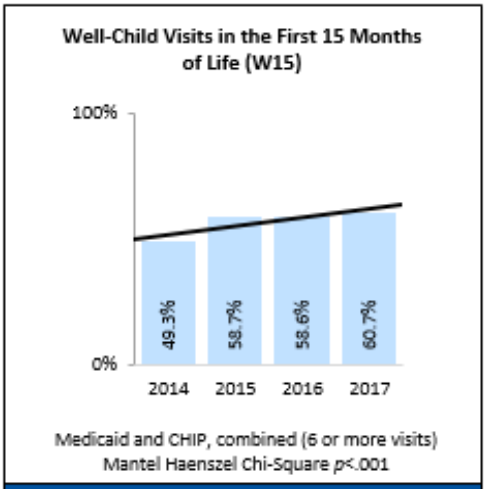

Figure 13. HEDIS W15 Trend CY2014–CY2017

The ranking for the QC percentiles must be interpreted differently for this measure; being >75th percentile for "0 visits," for example is not a positive result, whereas being above the 75th percentile for "6 or more visits" would be a positive result. In three out of four years, including the most recent year, the aggregate HEDIS results for "0 Visits" were at the >75th QC percentile, whereas for "6 or More Visits" were at the <50th QC percentile with <33.33rd QC percentile in the most recent year.

Controlling High Blood Pressure (CBP) *(CMS Core Quality Measure)*

The measure was tracked for the Medicaid population (Figure 14). The rate was based on weighted hybrid data. A statistically significant increasing trend was seen for this measure during the five-year period (p<.01). The rate for 2017 was significantly higher than the baseline (p<.01). The aggregate HEDIS results for this measure throughout the five

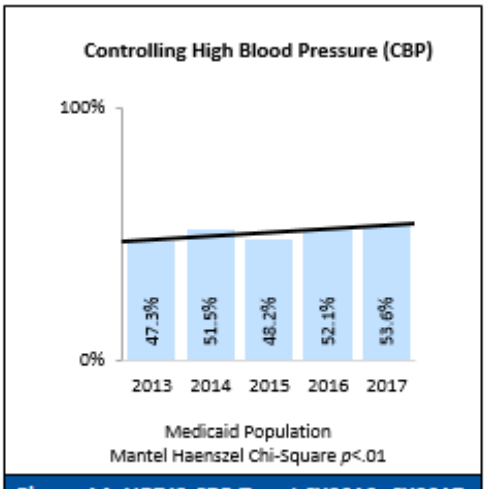

Figure 14. HEDIS CBP Trend CY2013–CY2017

years were below the 50th QC percentile; however, an improvement was seen from the <25th percentile in 2013 to the <50th QC percentile in 2017.

Comprehensive Diabetes Care (CDC) (*HbA1c Testing and HbA1c Poor Control [>9.0%] are CMS Core Quality Measures)*

This measure is a composite HEDIS measure composed of six metrics, each reported by MCOs based on hybrid data (Figure 15). The measure tracked comprehensive diabetes care (CDC) among members, ages 18–75 years, in the Medicaid population. The five-year trends examined for the 6 metrics of the measure showed statistically significant changes in appropriate directions thus indicating improvement in comprehensive diabetes care.

- **HbA1c Testing**
  A statistically significant increasing trend was seen for this measure over the five-year period (p<.01). The rate in CY2017 was significantly higher than the baseline (p<.04). The aggregate HEDIS results for this measure throughout the five-year period were below the 50th QC percentile.
- **Eye Exam (Retinal)**
  A statistically significant increasing trend was seen for this measure over the five-year period (p<.001). The rate for CY2017 was significantly higher compared to the baseline (p<.001). The aggregate HEDIS results for this measure have improved from the baseline, with >66.67th QC percentile in the most recent year.
- **Medical Attention for Nephropathy**
  A statistically significant increasing trend was seen for this measure over the five-year period (p<.001). The rate for CY2017 was significantly higher compared to the baseline (p<.001). The aggregate HEDIS results for this measure had declined from the baseline. The aggregate HEDIS results were <33.33rd QC percentile in the most recent year.
- **HbA1c Control (<8.0%)**
  A statistically significant increasing trend was seen for this measure over the five-year period (p<.001). The rate for CY2017 was significantly higher compared to the baseline (p<.001). The aggregate HEDIS results for this measure have improved over the five-year period. The aggregate HEDIS results were >66.67th QC percentile in the most recent year.
- **HbA1c Poor Control (>9.0%)**
  For this metric, the goal is to have a lower rate and higher QC percentile. A statistically significant decreasing trend was seen for this measure during the five-year period (p<.001). The rate for CY2017 was significantly lower compared to the baseline (p<.001). The aggregate HEDIS results for this measure have improved over the five-year period. In 2017, the aggregate HEDIS results were ≥50th QC percentile.
- **Blood Pressure Control**
  A statistically significant increasing trend was seen for this measure during the five-year period (p<.001). The rate for CY2017 was significantly higher compared to the baseline (p<.001). The aggregate HEDIS results for this measure have improved from the baseline and were <50th QC percentile in the most recent year.

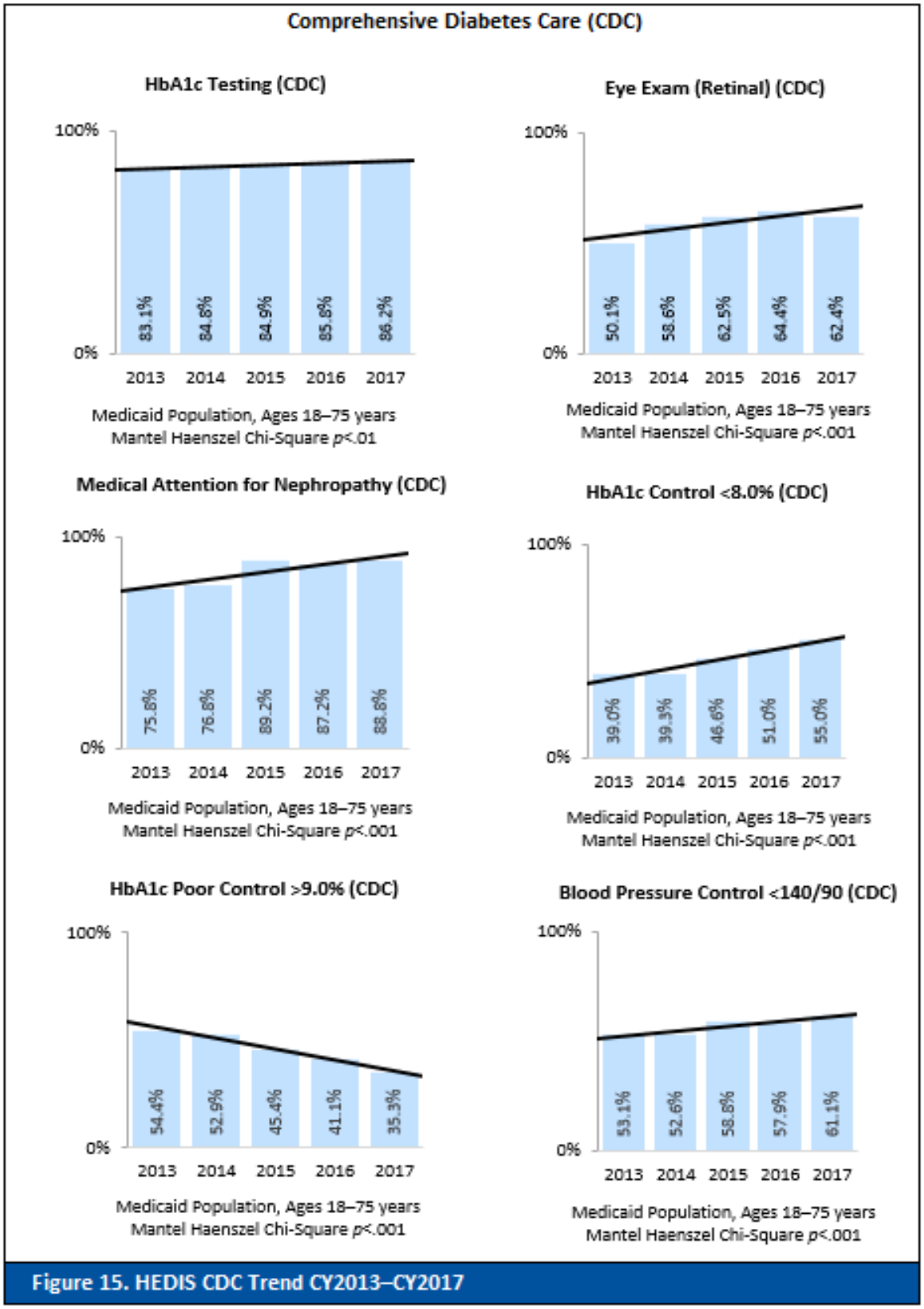

Figure 15. HEDIS CDC Trend CY2013–CY2017

Appropriate Testing for Children with Pharyngitis (CWP)

The measure was based on aggregate administrative HEDIS data and tracked appropriate testing for children with pharyngitis (CWP) in the combined Medicaid and CHIP population (Figure 16). A statistically significant increasing trend was seen for this measure over the five-year period (p<.001). The rate for CY2017 was significantly higher compared to the baseline (p<.001). However, the aggregate HEDIS results for this measure were below the 50th QC percentile throughout the five years and were <25th QC percentile in recent years.

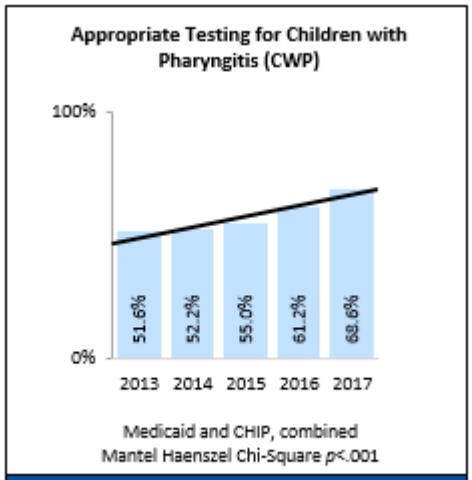

Figure 16. HEDIS CWP Trend CY2013–CY2017

Medication Management for People with Asthma (MMA) *(CMS Core Quality Measure 2014–2016)*

Data were based on aggregated weighted administrative HEDIS data (Figure 17). CY2014 constituted the baseline for the measure. The measure was tracked in the combined Medicaid and CHIP population. In addition to the rate among the total combined Medicaid and CHIP population, ages 5–64 years, the rates were also examined in the four age groups. A statistically significant increasing trend in the rate for the total combined population was seen over the five-year period (p<.001). The rate for the total combined population for 2017 was significantly higher compared to the baseline (p<.001). The significant trends in this period were also seen for the three age groups (5–11 years: p<.001; 12–18 years: p<.001; and 19–50 years: p<.01. The significantly higher rates for these three age groups were seen in 2016 compared to the baseline (5–11 years and 12–18 years: p<.001; 19–50 years: p=.01). In the most recent years, the aggregate HEDIS results for this measure were ≥ 50th QC percentile for the rate for the total combined population and >75th QC percentile for all four age groups.

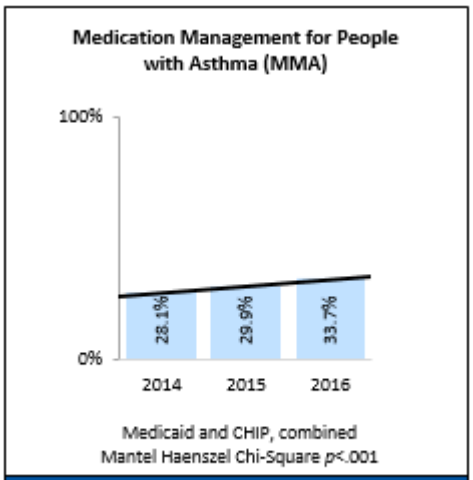

Figure 17. HEDIS MMA Trend CY2014–CY2016

Annual Monitoring for Patients on Persistent Medications (MPM) *(CMS Core Quality Measure)*

The measure was tracked in the Medicaid population, age 18 years and older; it was also a P4P measure from 2014–2016 (Figure 18). The aggregate rate was based on administrative data. Due to specification changes in the measure in 2017 from the prior years, the trend over time for this measure was assessed from 2013 through 2016. Due to this reason, a trending break in assessment of QC percentiles was also seen. A statistically significant increasing trend was seen for this measure over the 4-year period (p<.001). The rate for the total combined population was significantly higher compared to the baseline (p<.001). The aggregate HEDIS results for this measure have improved from the baseline and were >66.67th QC percentile in the most recent year.

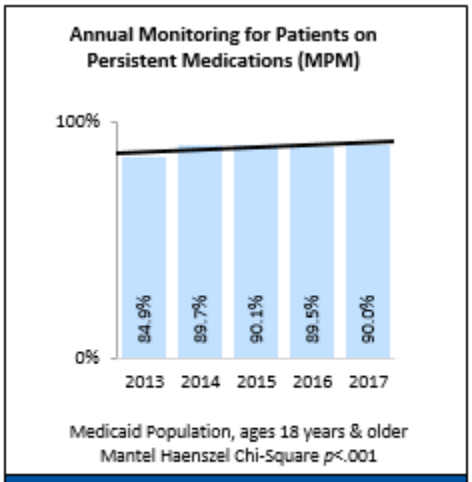

Figure 18. HEDIS MPM Trend CY2013–CY2017

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

The measure was tracked for the combined Medicaid and CHIP population (Figure 19). The aggregate rate was based on administrative data. A statistically significant increasing trend was seen in the rate over the five-year period (p<.001). The rate for the total combined population was significantly higher in the recent year compared to the baseline (p<.001). However, the aggregate HEDIS results for this measure remained below the 50th QC percentile throughout the five-year period; but, have improved from the baseline. In the most recent year, the results were <25th QC percentile.

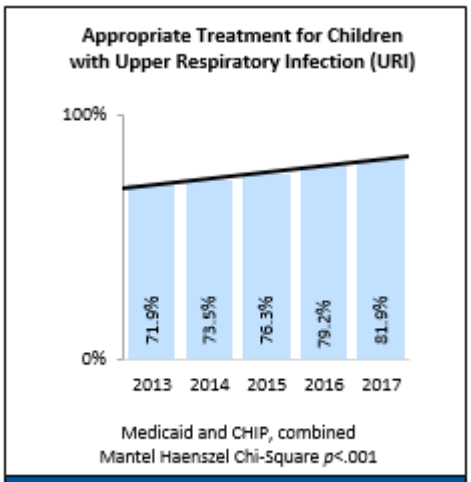

Figure 19. HEDIS URI Trend CY2013–CY2017

2) Substance Use Disorder Services

The NOMS data for the five measures related to **Substance Use Disorder Services** were available from 2012–2018. These data were examined to assess improvement in this subcategory of the KanCare *Quality of Care.*

Evaluation Summary

The SUD services subcategory was assessed for improvement in five PMs: improvement in living arrangements, reduction in arrests, reduction in drug and alcohol use, attendance at self-help meetings, and employment status. These measures include members who were receiving SUD services. The 2012–2018 data for the five measures assessing SUD services for members are presented in Table 15.

The results from the evaluation of these measures are summarized below in Figure 20.

Improved/Maintained Trends/Rates	Improved Rates Compared to Baseline
•Statistically significant improvement in the trend over time for one of the five measures. •Rates above 90% for three measures throughout the six-year period.	•Statistically significant higher rate in the most recent year compared to the baseline for one of the five measures.

Figure 20. Improved/Maintained Performance Measures for Substance Use Disorder Services

The following measure showed a statistically significant improvement in the trend over the six-year period, as well as higher rate in the most recent year compared to the baseline:

- The number and percent of members receiving SUD services whose employment status was improved or maintained.

Despite the improvement in the trend as well as the rate for the most recent year, this measure showed low rates throughout the six-year period (<50%), indicating opportunity for further improvement.

Though, no statistically significant improvement in the trends for the following three measures for the members using SUD services were seen; however, their rates were consistently high and maintained throughout the six-year period showing high quality of care received by KanCare beneficiaries:

- The number and percent of members receiving SUD services whose living arrangements improved;
- The number and percent of members receiving SUD services whose criminal justice involvement improved; and
- The number and percent of members receiving SUD services whose drug and/or alcohol use decreased.

The following measure did not show any improvement in the trend over time, and the rates remained consistently low throughout the evaluation period showing opportunity for improvement in the future:

- The number and percent of members receiving SUD services attending self-help meetings during reporting period (<46%).

Although only one measure related to the SUD services assessing the *quality of care* showed improvement in trend over time, several of the measures remained high throughout the evaluation period showing their contribution to the high *quality of care* provided to the members receiving SUD services. One measure did not show any improvement in the trend over time, as well as its rates were consistently low throughout the evaluation period showing opportunity for improvement in the future.

Table 15. Performance Measures for Members Receiving Substance Use Disorder Services (SUD), Annual Quarterly Average, CY2012–CY2018

	Pre-KanCare	KanCare					
	2012	2013	2014	2015	2016	2017	2018
Members in stable living situations at time of discharge from SUD services	99.0%	99.1%	99.3%	98.9%	96.9%	96.4%	97.9%
Members without arrests during reporting period (criminal justice involvement decreased)	99.0%	99.3%	98.9%	98.9%	98.5%	99.3%	99.3%
Members abstinent from alcohol and other drugs at time of discharge from SUD services	95.3%	94.2%	95.5%	93.5%	90.8%	91.3%	93.4%
Members receiving SUD services attending self-help programs	59.9%	42.3%	44.5%	39.5%	39.0%	41.3%	45.2%
Members employed at time of discharge from SUD services	29.7%	31.8%	34.9%	41.8%	38.3%	45.7%	49.1%

Evaluation Results for the Substance Use Disorder Services Performance Measures

The number and percent of members receiving SUD services whose living arrangements improved

This measure tracked the percentage of members in stable living conditions at the time of discharge from SUD services. The denominator for this measure was an annual quarterly average and included those whose living arrangement details were collected by KDADS in the KCPC state tracking system. For this measure, pre-KanCare (2012) data were used as the baseline.

Although no statistically significant improvement was seen in the trends over the six-year period for this measure, the rates were consistently high and maintained throughout this period (>96%). In addition, no statistically significant difference was seen in the rate for most recent year compared to the baseline.

The number and percent of members receiving SUD services whose criminal justice involvement improved
This measure tracked the percentage of members without arrests at the time of discharge from SUD services. The denominator for this performance measure is an annual quarterly average and the numerator is based on the 30 days prior to discharge from the SUD services. For this measure, pre-KanCare (2012) data were used as the baseline.

Although no statistically significant improvement was seen in the trends over the six-year period for this measure, the rates were consistently high and maintained throughout this period (>98%). In addition, no statistically significant difference was seen in the rate for the most recent year compared to the baseline.

The number and percent of members receiving SUD services whose drug and/or alcohol use decreased
This measure tracked the percentage of members who were abstinent from alcohol and other drugs when they were discharged from the SUD services. For this measure, pre-KanCare (2012) data were used as the baseline.

Although no statistically significant improvement was seen in the trends over the six-year period for this measure, the rates were consistently high and maintained throughout this period (>90%). In addition, no statistically significant difference was seen in the rate for the most recent year compared to the baseline.

The number and percent of members receiving SUD services attending self-help meetings during reporting period
This measure tracked the percentage of members who were attending self-help programs when they were discharged from the SUD services. For this measure, pre-KanCare (2012) data were used as the baseline.

No statistically significant improvement was seen in the trends over the six-year period for this measure. The rates were low throughout the evaluation period (<46%). The rate for the most recent year was significant lower compared to the baseline (p=.01). Therefore, efforts are needed to improve the rate for this measure.

The number and percent of members receiving SUD services whose employment status was improved or maintained
This measure tracked the percentage of members who were employed when they were discharged from the SUD services. For this measure, pre-KanCare (2012) data were used as the baseline.

A statistically significant increasing trend was seen in the rate over the six-year period (p<.001). The rate for the most recent year was significantly higher compared to the baseline (p<.001). Though rates in most recent years showed improvement; however, were consistently low throughout the evaluation period (<50%). The efforts are needed to further improve the rate for this measure.

3) Mental Health Services

Evaluation Summary

The MH services subcategory was assessed for improvement in the quality of care among adults with SPMI and among youth with SED. Among members with SPMI, the measures monitored the

improvement related to members identified as receiving SPMI services, improvement in housing status, and improvement in employment status. Among youth with SED, the measures assessed for improvement for youth identified as receiving SED services included improvement or maintenance of residential status, improvement in CBCL competence scores. In addition, one measure assessed reduction of inpatient psychiatric services among KanCare members. All these measures were based on NOMS data.

The results from the evaluation of these measures are summarized below in Figure 21.

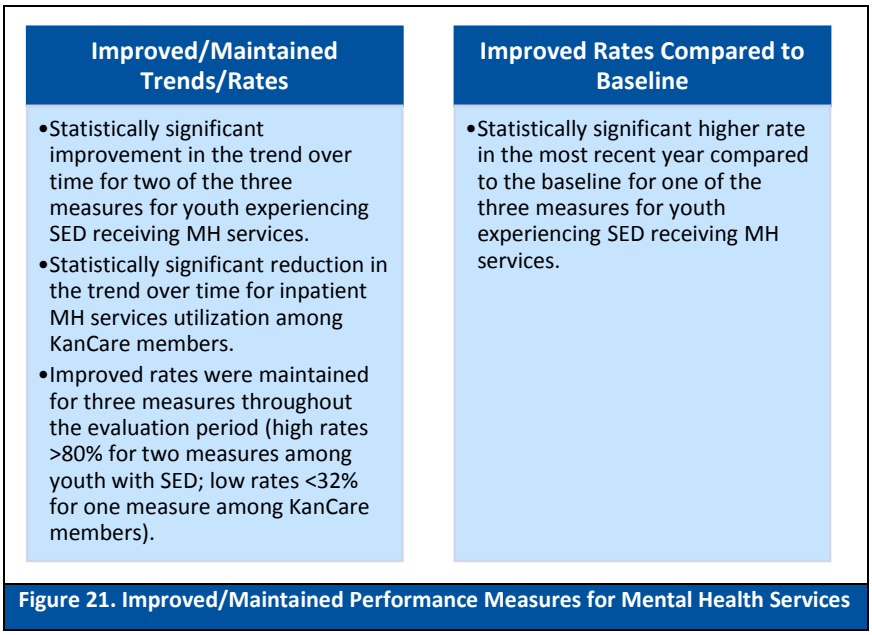

Figure 21. Improved/Maintained Performance Measures for Mental Health Services

The data for the two measures for the adult members with SPMI receiving MH services are presented in Table 16 below. The data for the three measures for the youth experiencing SED receiving MH services are presented in Table 17 and 18 below. The data for the inpatient psychiatric services among KanCare members are presented in Table 19.

The following measure showed statistically significant improvement in the trend over the four-year period, as well as higher rate in the most recent year compared to the baseline:

- The number and percent of youth with SED who were identified as receiving mental services (proxy measure).

The following measures showed statistically significant improvements in the trend over the six-year period:

- The number and percent of youth with SED with improvement in their residential status; and
- The number and percent of KanCare members utilizing inpatient MH services.

The following measures showed consistently improved rates throughout the evaluation period:

- The number and percent of youth with SED with improvement in their residential status (>80%);
- The number and percent of youth with SED who maintained their residential status (>98%); and
- The number and percent of KanCare members utilizing inpatient MH services (0.3% or less).

Despite the maintained high rates throughout the evaluation period, a statistically significant decline in trend over time, as well as lower rate in the most recent year compared to baseline were seen for the measure “number and percent of youth with SED who maintained their residential status”. This rate should be monitored carefully in future.

The following measures showed consistently lower rates throughout the evaluation period without showing any significant change in the trends over time:

- The number and percent of adults with SPMI who were competitively employed (<17%).

The following measures showed statistically significant declining trends over time and significantly lower rates in the most recent year compared to the baseline:

- The number and percent of adults with SPMI who were identified as receiving necessary services (proxy measure); and
- The number and percent of adults with SPMI who were homeless at the beginning of the reporting period that were housed by the end of reporting period.

Although some of the MH service measures assessing the *quality of care* showed improvements in trends over time, improvements could be made in the rates to further strengthen the quality of care provided to the adults with SPMI and youth with SED. Several measures showed declining trends, as well lower rates throughout the evaluation period showing opportunities for improvement in the provision of MH services for the adults with SPMI and youth with SED.

Evaluation Results for the Mental Health Services Performance Measures among adults with SPMI and youth with SED

Mental Health Services Performance Measures among adults with SPMI

The data for the measures for the adult members with SPMI receiving MH services are presented in Table 16.

Table 16. Performance Measures for Adult Members with Severe and Persistent Mental Illness (SPMI), Annual Quarterly Average, CY2012–CY2018

	Pre-KanCare	KanCare					
	2012	2013	2014	2015	2016	2017	2018
Adults with SPMI competitively employed*	13.4%	12.3%	15.6%	16.3%	15.9%	15.6%	15.4%
Adults with SPMI who were homeless at the beginning of the quarter housed by the end of the quarter	45.7%	58.0%	49.1%	44.2%	33.7%	25.0%	25.5%

*Compare with caution due to change in methodology (2013 and 2014).

The number and percent of adults with SPMI who had increased access to services

This measure based on NOMS data was to be assessed among adult members with SPMI who received MH services; it was also a P4P measure from 2014–2015.

The measures for "percentage of adults with SPMI who had increased access to services" required denominator data on the number of members with SPMI and numerator data on the number of those members who had their access to services improved to calculate the rates for these measures.

Historically, the State has been tracking the number of individuals with SPMI identified as receiving MH services. Thus, available data could be used to calculate the rate for the measure "members identified as receiving SPMI services" using the denominator consisting of the number of adult KanCare members who were last assigned to the MCO, and the numerator consisting of the number of those members

with SPMI who were enrolled for services with a Community Mental Health Center (CMHC) during the quarter.

The numerator and denominator data for the calculation of the measure included in the evaluation design "the number and percent of adults with SPMI who had increased access to services", were not available therefore, the measure could not be calculated. In place of this measure, the proxy measure "adult members identified as receiving SPMI services" had been used in this report.

Due to a statewide change in screening policy, comparison of rates for this proxy measure was done for the period of 2015 through 2018. The rate for 2015 was used as the baseline.

The percent of KanCare members with SPMI who were identified as receiving necessary services (proxy measure) was 5.1% in 2018. A statistically significant declining trend was seen over the four-year period (p<.01). In addition, the rate for the most recent year was significantly lower compared to the baseline (p<.01). In the future, efforts are needed to improve the rate of the members with SPMI receiving services.

The number and percent of KanCare Adults, diagnosed with SPMI, who were competitively employed
This measure, based on NOMS data, was assessed among adult members with SPMI who received MH services; it was also a P4P measure from 2014–2015. The measure tracked the employment rates among adult members with SPMI receiving MH services during one or more quarters of the annual time period. Due to a statewide change in screening policy, comparison of rates for this measure was done for the period of 2015 through 2018. The rate for 2015 was used as the baseline.

No statistically significant change in trend over the period of four years (2015–2018) was seen. No statistically significant change was seen in the rate for the most recent year compared to the baseline. The rates for this measure remained consistently low during this period. In the future, efforts are needed to improve the employment rate among the members with SPMI.

The number and percent of adults with SPMI who were homeless at the beginning of the reporting period that were housed by the end of the reporting period
This measure, based on NOMS data, was assessed among adult members with SPMI who received MH services. The measure tracked the housing status at the end of each quarter among adult members who were homeless at the beginning of that quarter. The rate for 2012 (pre-KanCare) was used as the baseline for the comparison with the rate in most recent year.

A statistically significant declining trend over the period of six years was seen (p<.001). The rates for this measure remained consistently low during the six-year period. The rate for the most recent year was significantly lower than the baseline (p<.01). In the future, efforts are needed to improve the housing status among the members with SPMI who were homeless.

<u>Mental Health Service Performance Measures for Youth Experiencing SED</u>
The data for the three measures for the youth experiencing SED receiving MH services are presented in Tables 17 and 18 below.

Table 17. Performance Measures for Youth Experiencing Serious Emotional Disturbances (SED), Annual Quarterly Average, CY2012–CY2018							
	Pre-KanCare	KanCare					
	2012	2013	2014	2015	2016	2017	2018
Youth experiencing SED with improved housing status	81.7%	80.6%	81.3%	84.9%	89.3%	90.1%	85.5%
Youth with SED that maintained residential status	94.9%	98.7%	99.3%	98.9%	98.3%	98.4%	98.2%

The number and percent of youth experiencing SED who had increased access to services
This measure, based on NOMS data, was to be assessed among youth members with SED who received MH services; it was also a P4P measure from 2014–2015.

The measures for "percentage of youth experiencing SED who had increased access to services" required denominator data on the number of members with SED and numerator data on the number of those members who had their access to services increased to calculate the rates for these measures.

Historically, the State has been tracking the number of youth with SED identified as receiving MH services. Thus, available data could be used to calculate the rate for the measure "youth identified as receiving SED services" using the denominator consisting of the number of KanCare youth members who were last assigned to the MCO, and the numerator consisting of the number of those youth members with SED who were enrolled for services with a CMHC during the quarter.

The numerator and denominator data for the calculation of the measure included in the evaluation design "the number and percent of youth with SED who had increased access to services," were not available therefore, the measure could not be calculated. In place of this measure, the proxy measure "youth identified as receiving SED services" had been used in this report.

Due to a change in the data collection policies in 2015, the comparison of rates for this proxy measure was done for the period of 2015 through 2018. The rate for 2015 was used as the baseline.

The percent of youth with SED who were identified as receiving necessary services (proxy measure) was 6.0% in 2018. A statistically significant increasing trend was seen over the four-year period ($p<.001$). In addition, the rate for the most recent year was significantly higher compared to the baseline ($p<.001$).

The number and percent of youth experiencing SED who experienced improvement in their residential status
This measure, based on NOMS data, was assessed among youth members experiencing SED. The measure tracked the percentage of youth experiencing SED with improvement in their residential status during the quarterly measurement period. For this measure, the denominator was measured from the beginning of this period and the numerator was measured at the end of this period.

The rate for 2012 (pre-KanCare) was used as the baseline for the comparison with the rate in most recent year.

A statistically significant increasing trend was seen over the six-year period (p<.01). Though the rate for the most recent year was not significantly different compared to the baseline, the percentages were high throughout this period (>80%).

The number and percent of youth experiencing SED who maintained their residential status
This measure, based on NOMS data, was assessed among youth members experiencing SED. The measure tracked the percentage of youth experiencing SED who maintained their residential status during the quarterly measurement period. For this measure, the denominator was measured from the beginning of this period and the numerator was measured at the end of this period.

The rate for 2012 (pre-KanCare) was used as the baseline for the comparison with the rate in most recent year.

A statistically significant declining trend was seen over the six-year period (p<.001). The rate for the most recent year was significantly lower compared to the baseline (p<.001). Although a significant decline was seen in trend over time, the percentages were high throughout this period (>98%).

The number and percent of KanCare youth receiving MH services with improvement in their Child Behavior Checklist (CBCL Competence T-scores)
This measure is for SED youth who are receiving community-based services (CBS). The rates are based on two separate six-month measurements (S1 and S2) and reflect improvement in the most recent CBCL competence scores (Table 18). Each year the measurements start over; however, SED youth with a competence score that remains below 40 can be in the denominator of both S1 and S2 during the same annual measurements. The State reported the "total competence" score is based on a scale of 10 through 80 and also stated, "*for the SED waiver eligibility, a minimum score of 70 must be achieved on any of the 3 subscales to qualify*."

Table 18. Number and Percent of SED/CBS Youth with Improvement in their Child Behavior Checklist (CBCL) Scores, CY2012–CY2018

	Pre-KanCare		KanCare											
	2012		2013		2014		2015		2016		2017		2018	
	S1	S2	S1	S2*	S1	S2	S1	S2	S1	S2	S1	S2	S1	S2
Numerator: Number of SED/CBS youth with increased total competence score	1,313	1,170	1,466		912	785	958	886	686	506	628	554	341	345
Denominator: Number of SED/CBS youth with prior competence score less than 40	2,490	2,207	2,796		1,705	1,513	1,804	1,666	1,297	1,860	2,160	2,221	1,420	1,395
Percent of SED/CBS youth with improvement in their most recent CBCL competence score	52.7%	53.0%	52.4%		53.5%	51.9%	53.1%	53.2%	52.9%	27.2%	29.1%	24.9%	24.0%	24.7%

* No data available

During the pre-KanCare measurement year (2012) and through S1 of 2016, the percentage of SED youth with improvement in their CBCL scores (S1 and S2) were relatively comparable and greater than 50%. In 2016, there was a twenty-six percentage point decrease between the S1 and S2 measurements, which may in part be attributed to changes in the reporting methodology. The rates for improvement in the CBCL scores stayed lower for the two remaining annual evaluation periods (2017 and 2018) and ranged from 24.0% to 29.1%. In the most recent year, no change was seen in the scores for S1and S2 periods. In future, efforts are needed to improve this measure.

The number and percent of members utilizing inpatient mental health services
This measure tracked the rate of members utilizing inpatient MH services; it was also a P4P measure from 2014–2015. The denominator included eligible members at the end of each quarter. The data for this measure are described in Table 19 below.

Table 19. Number and Percent of Members Utilizing Inpatient Mental Health Services – Annual Quarterly Average, CY2012–CY2018

	Pre-KanCare	KanCare					
	2012	2013	2014	2015	2016	2017	2018
Numerator: Number of members with an inpatient mental health admission during the quarter	1,560	1,298	1,306	1,020	975	999	866
Denominator: Number of members	391,444	406,731	418,610	413,145	437,602	396,339	355,423
Members utilizing inpatient mental health services	0.4%	0.3%	0.3%	0.2%	0.2%	0.3%	0.2%
Rate per 10,000	39.9	31.9	31.2	24.7	22.3	25.2	24.4

A statistically significant declining trend was seen over the six-year period (p<.001). The rate for the most recent year was significantly lower compared to the baseline (p<.001). The rates were low throughout the six-year period (0.3% or lower).

4) Healthy Life Expectancy

Evaluation Summary
The Healthy Life Expectancy subcategory was assessed for the improvement in the measures related to the health literacy, and prevention and treatment/recovery aspects among the child and adult populations. The prevention and treatment/recovery aspects were assessed among the members with schizophrenia, and among members with SMI, I/DD, and PD.

The health literacy, and prevention and treatment measures among the child and adult populations were based on the adult and child CAHPS survey questions; the prevention and treatment/recovery measure among members with schizophrenia was based on a HEDIS measure; and the prevention and treatment/ recovery measure among members with SMI, I/DD, and PD were based on the HEDIS-like measures. The results from the evaluation of these measures are summarized below.

Health Literacy and Prevention/Treatment in Child and Adult Populations: Measures Based on Questions in the CAHPS Survey
The 2014–2018 data for nine child and twelve adult CAHPS survey questions assessing the health literacy and prevention/treatment aspects are presented in Table 20. The child measures were assessed in both General Child (GC – Title XIX and XXI) and Children with Chronic Conditions (CCC – Title XIX and XXI) populations.

Several of these measures for the child and adult populations were consistently high throughout the five-year period showing high quality of care received by KanCare beneficiaries during this period. The measures showing statistically significant improvements in trends over time and in the rates for the most recent year compared to the baseline are summarized in Figure 22 below.

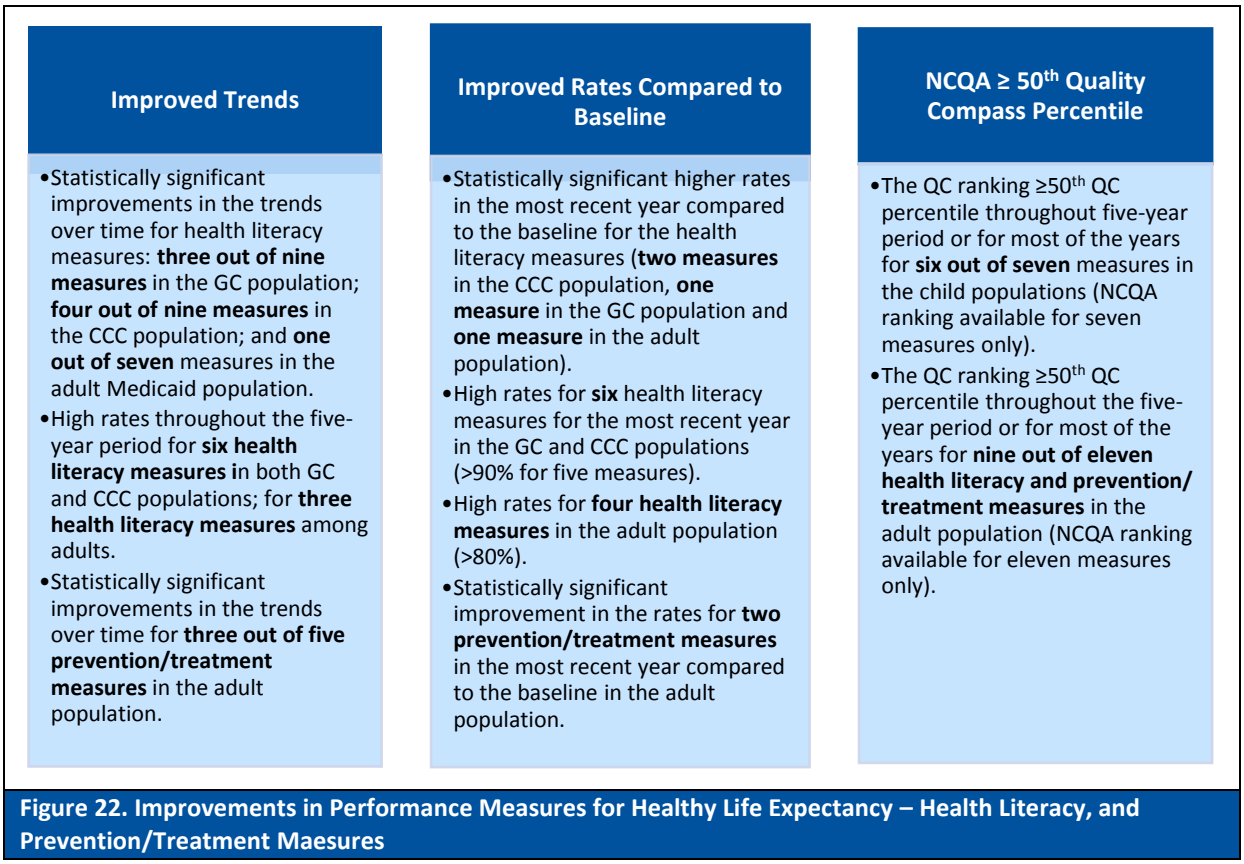

Figure 22. Improvements in Performance Measures for Healthy Life Expectancy – Health Literacy, and Prevention/Treatment Maesures

The following measures showed statistically significant improvement in trends over the five-year period and improved rates in 2018 compared to the baseline among the child and adult populations.

- Improved trends over the five-year period in the health literacy measures among the child populations:
  - Among both the GC and CCC populations – Did you and a doctor or other health provider talk about specific things you could do to prevent illness (in your child)?
  - Among both the GC and CCC populations – How often did your child's personal doctor explain things about your child's health in a way that was easy to understand?
  - Among both the GC and CCC populations – How often did your child's personal doctor listen carefully to you?
  - Among the CCC population (2015–2018) – When you talked about (your child) starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you (your child)?
- Improved rates for the health literacy measures in 2018 compared to the baseline among the child populations:
  - Among both the GC and CCC populations – How often did your child's personal doctor explain things in a way that was easy for your child to understand?
  - Among the CCC population – How often did your child's personal doctor listen carefully to you?
- Improved trends over the five-year period in the health literacy and prevention/treatment measures among the adult population:
  - How often did your personal doctor listen carefully to you?
  - Do you now smoke cigarettes or use tobacco: every day, some days, or not at all?

  - If you smoke every day/some days, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco?
  - If you smoke every day/some days, 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?
- Improved rates for the health literacy and prevention/treatment measures in 2018 compared to the baseline among the adult population:
  - Higher rate compared to baseline: How often did your personal doctor listen carefully to you?
  - Higher rate compared to baseline: If you smoke every day/some days, 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? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.
  - Lower rate compared to baseline (lower rate shows improvement): Do you now smoke cigarettes or use tobacco: every day, some days, or not at all?

Though no statistically significant improvement was seen in the trends over the five-year period for some measures among child and adult populations, the rates for these measures were consistently high throughout this period. As high rates for these measures were maintained throughout the evaluation period, therefore they indicated high quality of care received by KanCare beneficiaries in this period. These measures were as follows:

- Health literacy measures with high rates during 2014–2018 without showing improvement in trends over time among the child populations:
  - Among both the GC and CCC populations, rates were above 93% (2015–2018) – When you talked about your child starting or stopping a prescription medicine, did you and a doctor or other health provider talk about the reasons you might want to take a medicine?
  - Among both the GC and CCC populations, rates were above 91% – How often did your child's personal doctor explain things in a way that was easy for your child to understand?
  - Among both the GC and CCC populations, rates were above 89% – How often did you have your questions answered by your child's doctors or other health providers?
  - Among the GC population, rates were above 80% (2015–2018) – When you talked about (your child) starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?
- Health literacy and prevention/treatment measures with high rates during 2014–2018 without showing improvement in trends over time among the adult population:
  - Rates were above 91% – In the last six months, how often did your personal doctor explain things in a way that was easy to understand?
  - Rates were above 91% – When you talked about starting or stopping a prescription medicine, did you and a doctor or other health provider talk about the reasons you might want to take a medicine?

The following measures showed average/low rates throughout the five-year period among the child and adult populations indicating an opportunity for improvement in the future:

- Health literacy measures showing average/low rates during 2015–2018 among the child population:
  - Rates were below 34% in the GC population and below 54% in the CCC population – Did you and your child's doctor or other health provider talk about starting or stopping a prescription medicine for your child?

  - Rates were below 78% in the GC population and below 82% in the CCC population – When you talked about your child starting or stopping a prescription medicine, did you and a doctor or other health provider talk about the reasons you might not want your child to take a medicine?
- Health literacy and prevention/treatment measures showing average/low rates during 2014–2018 among the adult population:
  - Rates were below 72% – Did you and a doctor or other health provider talk about specific things you could do to prevent illness?
  - Rates were below 55% (2015–2018) – Did you and a doctor or other health provider talk about starting or stopping a prescription medicine?
  - Rates were below 82% (2015–2018) – When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?
  - Rates were below 51% – Have you had either a flu shot or flu spray in the nose since July 1, [previous year]?
  - Rates were below 80% (except one year when it was 80%) – How often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

The prevention/treatment measures among adults showed consistently lower rates. The rates for receiving influenza vaccine not only remained low throughout this period, but also did not show any improvement over time. Though, a declining trend in the percentage of members who were current smokers (smoked every day/some days) was seen, however as shown by these percentages, about one-third of the Medicaid adult population were current smokers. In addition, the rates for two measures related to the health providers efforts for assisting these current smokers with the cessation treatment remained low throughout the five-year period. Thus, efforts needed to be focused on the improvement of the rates for these measures.

The evaluation of the health literacy measures among the child (GC and CCC) and adult populations, as well as prevention/treatment measures among the adult population based on the CAHPS survey questions showed that the rates for several of these measures were either improved or remained high over time thus indicating the high quality of care received by KanCare beneficiaries. The evaluation findings also highlighted opportunities for improvement in certain measures to further strengthen the quality of care for the beneficiaries.

Prevention and Treatment/Recovery Measure among Members with Schizophrenia –HEDIS measure.
The HEDIS measure assessed to monitor prevention and treatment/recovery aspect among members with schizophrenia included diabetes monitoring for people, ages 18–64 years, with Diabetes and Schizophrenia (SMD). The results from the final evaluation of this measure are summarized below.

- No statistically significant change in trend over the five-year period (2013–2017) was seen for this measure.
- The rates remained below 66% through this period.
- No statistically significant difference was seen in the 2017 rate (63.7%) compared to the baseline (62.9%).
- The QC ranking remained <25th QC percentile for most of the years during the evaluation period including the most recent year.

As no improvement was seen over the evaluation period for this measure indicating opportunity for the improvement. Thus, efforts are needed to improve the diabetes monitoring among people with schizophrenia.

Prevention and Treatment/Recovery Measure among Members with SMI, I/DD, and PD: HEDIS-like Measures

The results from the final evaluation of the HEDIS-like measures related to the prevention and treatment/recovery among the members in the PD, I/DD, and SMI populations are summarized in Figure 23.

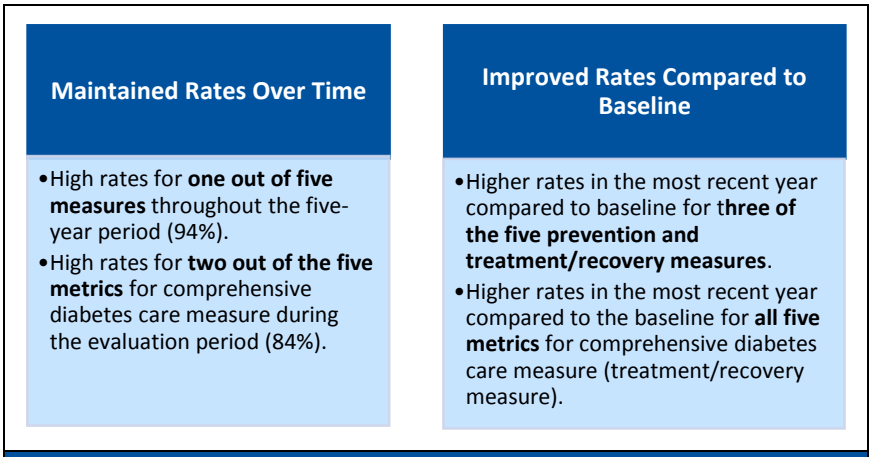

Figure 23. Improved/Maintained Performance Measures for Healthy Life Expectancy – Prevention/Treatment/Recovery Measures Among Members with PD, I/DD, and SMI

- The following prevention measure remained consistently high throughout the five-year evaluation period showing its contribution to the high quality of care received by KanCare members among PD, I/DD, and SMI populations:
  - Adults' access to preventive ambulatory health services (>94%).
- The two metrics for the Comprehensive Diabetes Care measure (treatment/recovery measure) remained consistently high during the evaluation period in the members among PD, I/DD, and SMI populations:
  - HbA1c testing (>84% throughout the five years); and
  - Medical attention for nephropathy (>87% in most recent years).
- Higher rates in the most recent year compared to the baseline were seen for the following prevention and treatment/recovery measures among the members in the PD, I/DD, and SMI populations:
  - Breast Cancer Screening (2016 compared to 2014);
  - Cervical Cancer Screening (2017 compared to 2014); and
  - Comprehensive Diabetes Care (for 3 metrics: 2017 compared to 2013; for two metrics: 2015 compared to 2013).
- Consistently average/low rates throughout the evaluation period were seen for the following three prevention measures assessed among members among PD, I/DD, and SMI populations:
  - Breast Cancer Screening (<52%);
  - Cervical Cancer Screening (<53%); and
  - Immunization rate for Combination 2 Vaccine (25.3%).
- Consistently average/low rates throughout the evaluation period were seen for the following three metrics for the comprehensive diabetes care among members among PD, I/DD and SMI populations (treatment/recovery measure):
  - *Eye Exam – Retinal (below 68%);*
  - *HbA1c Control <8.0% (below 47%); and*
  - *Blood Pressure Control <140/90 (below 61%).*

The three out of four prevention measures (cancer screening and adolescent immunization) assessed for the members among the PD, I/DD and SMI populations showed consistently average/lower rates. In addition, the rates for three metrics for the treatment/recovery measure (comprehensive diabetes care) assessed for the members of these populations were also consistently average/low throughout the evaluation period. Thus, efforts needed to be focused on the improvement of the rates for these measures.

The evaluation of the prevention and treatment/recovery measures among PD, I/DD and SMI populations highlighted opportunities for improvement to improve the quality of care for the beneficiaries.

Evaluation Results for the Health Life Expectancy Performance Measures

Health Literacy: CAHPS Survey Measures Among Child and Adult Populations

The *Health Literacy* aspect of the *Healthy Life Expectancy* subcategory among the child members (GC population – TXIX and TXXI), and the CCC population (TXIX and TXXI) were assessed by nine measures based on the CAHPS Survey questions. For the adult Medicaid population, seven measures based on the CAHPS Survey were assessed (Table 20).

Table 20. Healthy Life Expectancy – CAHPS Survey Quality of Care Questions, CY2014–CY2018

Question	Pop	Weighted % Positive Responses					Quality Compass ≥50th Percentile*				
		2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
Health Literacy – Child Populations (General Population and CCC Population)											
In the last 6 months…											
Did your child's doctor or other health provider talk about specific things you could do to prevent illness (in your child)?	GC	70.7%	67.1%	67.3%	70.2%	72.1%	↓	↓	↓	↓	↓
	CCC	73.3%	71.6%	71.4%	74.4%	77.1%	↓	↓	↓	↓	↓
How often did your child's personal doctor explain things about your child's health in a way that was easy to understand?	GC	95.5%	94.9%	95.2%	95.8%	96.6%	↑	↑	↑	↑	↑
	CCC	95.3%	95.6%	95.1%	96.6%	96.7%	↑	↑	↓	↑	↑
How often did your child's personal doctor listen carefully to you?	GC	95.7%	95.2%	94.5%	96.8%	96.3%	↑	↑	↓	↑	↑
	CCC	94.4%	94.9%	94.7%	96.6%	96.2%	↑	↑	↑	↑	↑
Did you and your child's doctor or other health provider talk about starting or stopping a prescription medicine (for your child)?	GC	31.9%	33.3%	33.1%	34.2%	33.9%					
	CCC	51.3%	50.7%	53.1%	53.2%	52.2%					
Did you and a doctor or other health provider talk about the reasons you might want your child to take a medicine?	GC	98.3%	94.8%	96.6%	93.8%	94.4%		↑	↑	↑	↑
	CCC	98.2%	96.7%	97.8%	96.4%	96.3%		↑	↑	↑	↓
Did you and a doctor or other health provider talk about the reasons you might not want your child to take a medicine?	GC	77.4%	68.0%	69.5%	67.9%	69.3%		↑	↑	↑	↑
	CCC	81.5%	76.8%	74.8%	73.8%	74.7%		↑	↓	↑	↑
When you talked about (your child) starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for your child?	GC	77.7%	80.0%	80.8%	80.7%	82.9%	↑	↑	↑	↑	↑
	CCC	83.5%	86.0%	82.5%	85.9%	87.3%	↑	↑	↓	↑	↑
How often did your child's personal doctor explain things in a way that was easy for <u>your child</u> to understand?	GC	91.1%	91.4%	92.5%	94.4%	94.6%					
	CCC	92.4%	92.1%	92.8%	93.6%	94.7%					
How often did you have your questions answered by your child's doctors or other health providers?	GC	89.6%	89.3%	90.0%	90.6%	89.3%					
	CCC	90.9%	91.9%	91.1%	93.0%	92.4%	↑	↑	↑	↑	↑
Health Literacy – Adult Population											
In the last 6 months…											
Did you and a doctor or other health provider talk about specific things you could do to prevent illness?	Adult	71.6%	68.0%	70.1%	70.8%	71.8%	↓	↓	↓	↓	↓

*↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile
^Answer choices changed from "A lot, Some, A little, Not all" in 2014 to "Yes, No" in 2015.
† ≥50th Quality Compass percentile for this metric represent poor performance compared to national rates

Table 20. Healthy Life Expectancy – CAHPS Survey Quality of Care Questions, CY2014–CY2018 (Continued)

Question	Pop	Weighted % Positive Responses					Quality Compass ≥50th Percentile*				
		2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
Health Literacy – Adult Population (Continued)											
In the last 6 months…											
In the last six months, how often did your personal doctor explain things in a way that was easy to understand?	Adult	91.9%	91.8%	93.0%	93.0%	92.4%	↑	↑	↑	↑	↑
In the last six months, how often did your personal doctor listen carefully to you?	Adult	89.7%	91.2%	91.5%	92.5%	93.3%	↓	↑	↑	↑	↑
Did you and a doctor or other health provider talk about starting or stopping a prescription medicine?	Adult	53.5%	52.9%	50.2%	54.0%	52.6%					
Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?	Adult	^	91.0%	93.3%	93.1%	93.6%		↓	↑	↑	↑
Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?	Adult	^	72.3%	68.9%	69.2%	71.5%		↑	↑	↑	↑
When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?	Adult	75.9%	79.5%	79.4%	75.8%	81.7%	↓	↑	↑	↓	↑
Flu Shots – Adult Population											
Have you had either a flu shot or flu spray in the nose since July 1, [previous year]?	Adult	47.5%	46.5%	43.7%	48.8%	50.5%		↑	↑	↑	↑
Smoking Cessation – Adult Population											
Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	Adult	37.5%	33.5%	32.2%	33.2%	31.9%	↑†	↑†	↑†	↑†	↑†
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?	Adult	75.7%	76.2%	79.5%	80.0%	78.8%	↓	↓	↑	↑	↑
How often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.	Adult	48.3%	43.2%	46.1%	51.2%	52.2%	↑	↓	↓	↑	↑
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? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.	Adult	38.6%	37.5%	44.4%	48.4%	46.0%	↓	↓	↑	↑	↑

*↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile
^Answer choices changed from "A lot, Some, A little, Not all" in 2014 to "Yes, No" in 2015.
† ≥50th Quality Compass percentile for this metric represent poor performance compared to national rates

The following four measures were assessed in both child (GC and CCC), as well as adult populations. Five-year trends (2014–2018) were examined for these measures (when appropriate a four-year trend was examined). The rates in the most recent year were compared to the baseline rates among the child and adult populations. The QC rankings for these measures were also seen.

In the last six months, did you and a (your child's) doctor or other health provider talk about specific things you could do to prevent illness (in your child)?

The measure was tracked for both child and adult populations by assessing the percentage of *"Yes" responses* to the survey question (Figure 24).

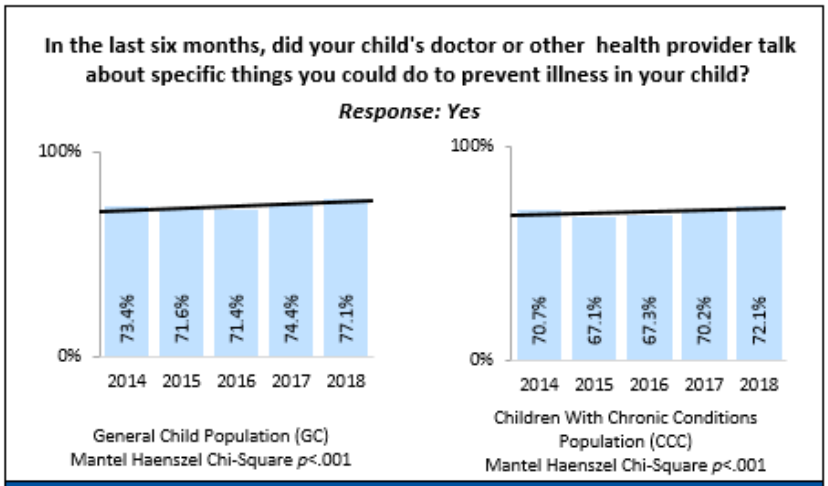

Figure 24. CAHPS GC – CCC Question 8, CY2014–CY2018

Statistically significant increasing trends were seen in the rates over the five-year period for both GC and CCC populations (p<.001). The rate for the CCC population was significantly higher in 2018 compared to the baseline (p<.01). The comparison of 2018 and baseline rates for the GC population did not show a statistically significant difference. The QC rankings for both child populations remained low throughout the five-year period (below the 50th QC percentile among the GC population and below the 25th QC percentile for the CCC population).

No statistically significant trend was seen over the five-year period for this measure among adult members. The comparison of 2018 and baseline rates for adults did not show a statistically significant difference. The QC ranking for this measure among adults remained below the 50th QC percentile throughout the five-year period.

In the last six months, how often did your (child's) personal doctor explain things (about your child's health) in a way that was easy to understand?

The measure was tracked for both child and adult populations by assessing the percentages of *"Always/ Usually" responses* to the survey question (Figure 25).

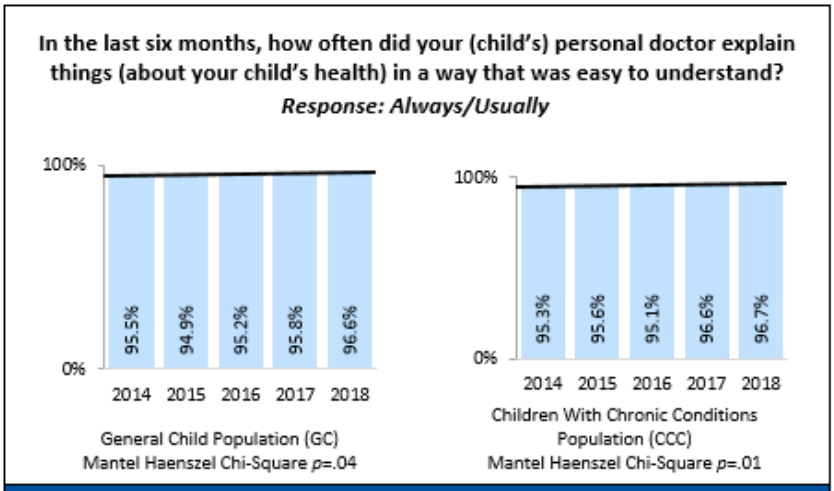

Figure 25. CAHPS GC – CCC Question 32, CY2014–CY2018

Statistically significant increasing trends were seen in the rates over the five-year period for both GC (p=.04) and CCC (p=.01) populations. High rates for both populations

were seen throughout this period (>94%). The rate for the CCC population was significantly higher in 2018 compared to the baseline (p=.02). The comparison of 2018 and baseline rates for the GC population did not show a statistically significant difference. The QC ranking for this measure among the GC population remained ≥50th QC percentile throughout the five-year period and for most of the years in this period for the CCC population.

Though, no statistically significant trend was seen in the rates over the five-year period for the adult population, the rates were considerably high throughout the five-year period (above 91%). The comparison of 2018 and baseline rates for adults did not show a statistically significant difference. The QC ranking for this measure among adults remained ≥50th QC percentile throughout the five-year period.

In the last six months, how often did your (child's) personal doctor listen carefully to you?
The measure was tracked for both child and adult populations by assessing the percentages of *"Always/ Usually" responses* to the survey question (Figure 26).

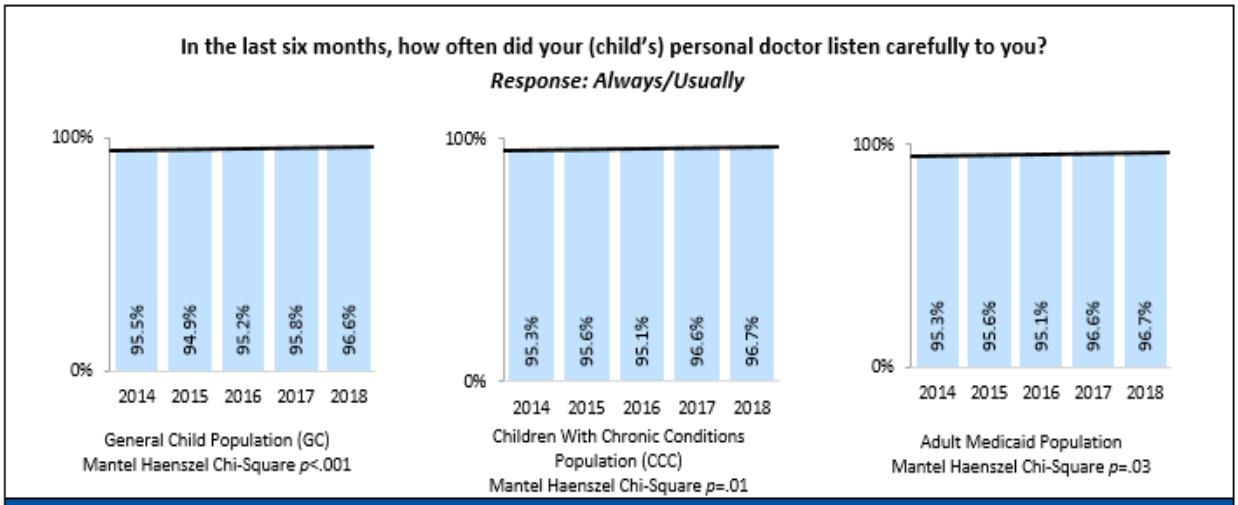

Figure 26. CAHPS GC – CCC Question 33, Adult Question 18, CY2014–CY2018

Statistically significant increasing trends were seen in rates over the five-year period for both of the GC and CCC populations (p<.001). The rate for the CCC population was significantly higher in 2018 compared to the baseline (p=.01). The comparison of 2018 and baseline rates for the GC population did not show a statistically significant difference. The QC ranking remained ≥ 50th QC percentile for the CCC population throughout the five-year period and for most of the years in this period for the GC population.

A statistically significant increasing trend was seen in the rates over the five-year period for the adult population (p=.03). The rate for 2018 was significantly higher compared to the baseline (p<.01). The QC ranking among adults remained ≥50th QC percentile from 2015 onwards.

In the last six months, did you and a (your child's) doctor or other health provider talk about starting or stopping a prescription medicine (for your child)?
The measure was tracked for both child and adult populations by assessing the percentage of *"Yes" responses* to the survey question.

No statistically significant trend was seen over the four-year period for this measure among both child populations. The rates for both populations remained low throughout this period. The comparison of 2018 and baseline rates for both child populations did not show statistically significant differences. The QC ranking was not provided by NCQA for this measure.

No statistically significant trend was seen over the four-year period for this measure for the adult population. The rates remained low throughout this period. The comparison of 2018 and baseline rates for adults did not show statistically significant differences. The QC ranking was not provided by NCQA for this measure.

Among those who responded *"Yes"* to this question, the following three questions were further assessed:

- **Did a doctor or other health provider talk about the reasons you might want (your child) to take a medicine?**
  The measure was tracked for both child and adult populations by assessing the percentage of *"Yes" responses* to the survey question (Figure 27).

  A statistically significant decreasing trend was seen in the rates over the four-year period for the GC population (p=.03). Though, no statistically significant trend was seen in the rates over the five-year period for the CCC population, the rates were considerably high throughout this period (above 96%). The comparison of 2018 and baseline rates (2015) for both GC and CCC populations did not show statistically significant differences. The QC ranking remained ≥ 50th QC percentile for the GC population throughout this period. However, in the recent year, the QC ranking for the CCC population declined and was <50th QC percentile.

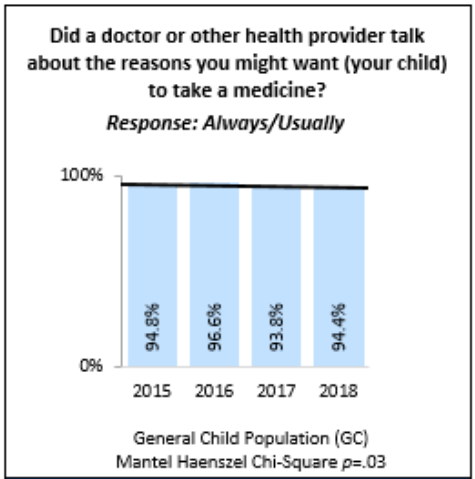

Figure 27. CAHPS GC Question 11, CY2015–CY2018

  Though, no statistically significant trend was seen in the rates over the four-year period for the adult population, the rates were considerably high throughout the four-year period (above 91%). The comparison of 2018 rate with the baseline (2015) for adults did not show a statistically significant difference. The QC ranking among adults remained ≥ 50th QC percentile in recent years.

- **Did a doctor or other health provider talk about the reasons you might not want (your child) to take a medicine?**
  The measure was tracked for both child populations (GC and CCC) and the adult population by assessing the percentage of *"Yes" responses* to the survey question.

  No statistically significant trends were seen over the four-year period for both GC and CCC populations. The comparison of 2018 and baseline rates (2015) for both GC and CCC populations did not show statistically significant differences. The QC ranking among the GC population remained ≥50th QC percentile throughout the four-year period, and for recent years among the CCC population.

  No statistically significant trend was seen over the four-year period for this measure for the adult population. The comparison of the 2018 rate with the baseline (2015) did not show a statistically

significant difference. The QC ranking among adults remained ≥50th QC percentile throughout the four-year period.

- **Did a doctor or other health provider ask you what you thought was best for you (your child)?**
  The measure was tracked for both child populations (GC and CCC) and the adult population by assessing the percentage of *"Yes" responses* to the survey question (Figure 28).

  A statistically significant increasing trend was seen in the rates over the four-year period for the CCC population (p<.01). Though, no statistically significant trend was seen in the rates over the four-year period for adult members, the rates were considerably high throughout the five-year period (above 77%). The comparison of 2018 and baseline rates for both GC and CCC populations did not show statistically significant differences. The QC ranking remained ≥50th QC percentile throughout four-year period for the GC population and in recent years for the CCC population.

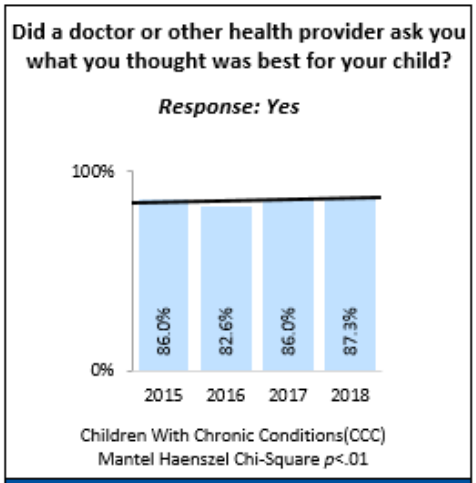

Figure 28. CAHPS CCC Question 13, CY2015–CY2018

  No statistically significant trend was seen in the rates over the four-year period for the adult population. The comparison of 2018 and baseline rates for adults did not show a statistically significant difference. The QC ranking among adults was ≥50th QC percentile in the most recent year.

In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for your child to understand?
The measure was tracked for both child populations (GC and CCC) by assessing the percentages of *"Always/Usually" responses* to the survey question.

Though, no statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations, the rates were considerably high throughout this period (above 91%). The 2018 rates were higher than the baseline rates for both GC and CCC populations (GC: p<.001; CCC: p=.01). The QC ranking was not provided by NCQA for this measure.

In the last six months, how often did you have your questions answered by your child's doctors or other health providers?
The measure was tracked for both child populations (GC and CCC) by assessing the percentages of *"Always/Usually" responses* to the survey question.

Though, no statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations, the rates were considerably high throughout this period (above 89%). The comparison of 2018 and baseline rates did not show any statistically significant differences for both GC and CCC populations. The QC ranking remained ≥50th QC percentile throughout five-year period for the CCC population.

Flu Shots for Adults: Adult CAHPS Survey Measures

Have you had either a flu shot or flu spray in the nose since July 1, [previous year]? *(CMS Core Quality Measure)*

The measure was tracked for the adult population by assessing the percentage of *"Yes" responses* to the survey question; it was also a P4P measure from 2014–2015.

No statistically significant increasing trend was seen in the rates over the four-year period for the adult Medicaid population. The rates were low throughout this period (below 51%). The comparison of 2018 and baseline rates did not show any statistically significant difference. The QC ranking remained ≥50th QC percentile throughout four-year period.

Smoking Cessation: Adult CAHPS Survey Measures (CMS Core Quality Measure)

Do you now smoke cigarettes or use tobacco: every day or some days, or not at all?

The measure was tracked for the adult population by assessing the percentage of *"Every day/Some days" responses* to the survey question.

A statistically significant declining trend was seen in the rates over the five-year period for the adult Medicaid population (p=.01). The 2018 rate was significantly lower than the baseline (p<.01). Despite the declining trends showing improvement in this measure, the rates throughout this period showed that about one-third of the Medicaid adult population currently smokes cigarettes. The QC ranking remained ≥50th QC percentile throughout the five-year period showing consistently poor performance compared to the national rates.

Among adult members who responded ***"Every day/Some days"*** to this question, the following three questions were further assessed:

- ***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?**
  The measure was tracked for the adult population by assessing the percentages of *"Always/Usually" responses* to the survey question; it was also a P4P measure from 2014–2015.

  No statistically significant trend was seen over the five-year period. The rates remained in the range of 75.7%–80% during this period. The comparison of the 2018 and baseline rates did not show any statistically significant difference. The QC ranking remained ≥50th QC percentile in the recent years.

- ***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? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.**
  The measure was tracked for the adult population by assessing the percentages of *"Always/Usually/ Sometimes" responses* to the survey question (Figure 29).

  A statistically significant increasing trend was seen in the rates over the five-year period for the adult Medicaid population (p=.03). Despite the increasing trend over

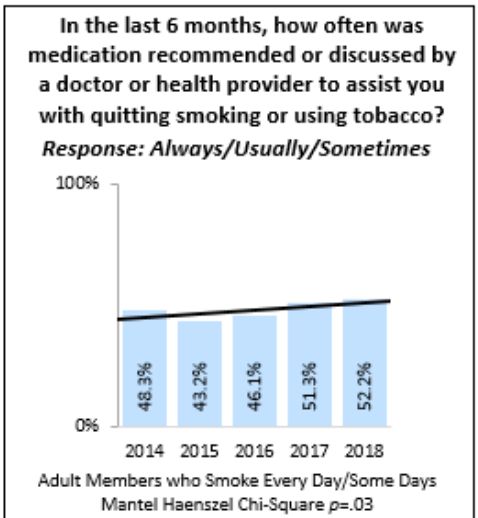

Figure 29. CAHPS Adult Question 41, CY2014– CY2018

time, the rates remained low throughout this period. The comparison of the 2018 and baseline rates did not show any statistically significant difference. The QC ranking remained ≥50th QC percentile in the recent years.

- ***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? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.** The measure was tracked for the adult population by assessing the percentages of *"Always/Usually/ Sometimes" responses* to the survey question (Figure 30).

  A statistically significant increasing trend was seen in the rates over the five-year period for the adult Medicaid population (p<.01). Despite the increasing trend over time, the rates remained low throughout this period. The rate for the 2018 was significantly higher compared to the baseline rate (p=.02). The QC ranking remained ≥50th QC percentile in the recent years.

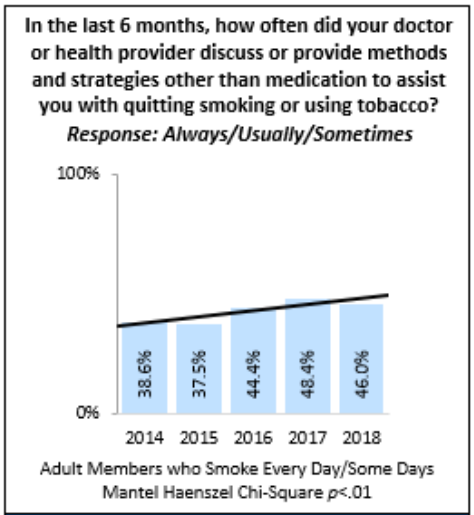

Figure 30. CAHPS Adult Question 42, CY2014– CY2018

Evaluation Results for the Healthy Life Expectancy HEDIS Measure

Diabetes monitoring for people with Diabetes and Schizophrenia (SMD)

This measure tracked members with schizophrenia and diabetes, ages 18–64 years, who had diabetes screening tests during the measurement year. No statistically significant change in trend over the five-year period (2013–2017) was seen for this measure. The rates remained below 66% through this period. No statistically significant difference was seen in the 2017 rate (63.7%) compared to the baseline (62.9%). The QC ranking remained <25th QC percentile for most of the years during the evaluation period including the most recent year.

Evaluation Results for the Healthy Life Expectancy for Persons With SMI, I/DD, and PD: Prevention and Treatment/Recovery HEDIS-like Measures

Four HEDIS-like measures were assessed to evaluate the prevention aspect of the healthy life expectancy among persons with PD, I/DD, and SMI. These included: breast cancer screening; cervical cancer screening; adult's access to preventive ambulatory health services; and adolescent Combination 2 vaccination. One measure, the comprehensive diabetes care, assessed the treatment/recovery aspect of the healthy life expectancy among persons with PD, I/DD, and SMI. The four of these measures are presented in Table 21 below.

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Table 21. HEDIS-like Measures – PD, I/DD, SMI Populations, CY2013–CY2017					
	2013	2014	2015	2016	2017
Breast Cancer Screening	31.0%	47.0%*	50.5%*	51.6%*	52.1%*^
Cervical Cancer Screening	47.0%	48.8%†	52.1%†	51.8%†	50.9%†
Adults' Access to Preventive/Ambulatory Health Services	95.6%	95.2%	94.9%	95.3%	94.5%
Comprehensive Diabetes Care					
HbA1c Testing	84.4%	86.5%	87.6%	86.2%	85.0%
Eye Exam (retinal) Performed	58.7%	63.7%	66.5%	67.3%	66.8%
Medical Attention for Nephropathy	77.8%	75.2%	90.8%	87.6%	89.3%
HbA1c Control (<8.0%)	38.1%	38.0%	46.5%	52.8%‡	56.7%‡
Blood Pressure Control (<140/90)	57.0%	51.0%	60.2%	52.1%‡	62.5%‡

* Multi-year measure – Includes members who were screened within a 27 month time period prior to the end of the measurement year.
^ Measure assessed from 2014 through 2016 due to HEDIS specification changes.
† Multi-year measure – Includes members who were screened during the measurement year or two years prior.
‡ Aggregated rate for two MCOs. Data reported for the third MCO in 2016 and 2017, was based on administrative data, and these metrics require medical record review.

Breast Cancer Screening *(CMS Core Quality Measure)*

The measure tracked breast cancer screening among women, ages 50–74 years, among PD, I/DD, and SMI populations; it was also a P4P measure from 2014–2015. The breast cancer screening measure is a multi-year measure, which includes screenings from prior years. Due to HEDIS specification changes, the measure was assessed from 2014 through 2016. The descriptive data were assessed for this measure. The rates for the three-year period remained below 52%, with slight increase in the recent year compared to the baseline.

Cervical Cancer Screening *(CMS Core Quality Measure)*

The measure tracked cervical cancer screening among women, ages 21–64 years, among PD, I/DD and SMI populations; it was also a P4P measure from 2014–2015. The cervical cancer screening measure is a multi-year measure, which includes screenings from prior years. The data were available for the calculation of this measure for the years 2014 through 2017. The descriptive data were assessed for this measure. The rates for the four-year period remained below 53%, with slight increase in the recent year compared to the baseline.

Adults' Access to Preventive/Ambulatory Health Services

This measure tracked the number of adult members, ages 20 and older, among PD, I/DD, and SMI populations who were reported to have had an ambulatory preventive care visit during the measurement year; it was also a P4P measure from 2014–2015. The measure was assessed over the period of five years (2013–2017). The descriptive data were assessed for this measure. Throughout the five-year period, the high rates were maintained (>94%).

Immunizations for Adolescents – Combination 2 (HEDIS-like Measure (IMA)

The Combination 2 vaccine includes meningococcal conjugate vaccine (1 dose); tetanus, diphtheria toxoids and acellular pertussis (Tdap, 1 dose); and human papillomavirus (HPV, vaccine series). The data for this measure were collected by the MCOs in 2017 measurement year. The measure tracked Combination 2 immunization rates among adolescents, ages 13 years, in PD, I/DD and SMI populations. The 2017 rate was considerably low (25.3%).

Comprehensive Diabetes Care

The measure tracked comprehensive diabetes care among the members with diabetes in the PD, I/DD and SMI populations; it was also a P4P measure from 2014–2015. The measure was based on five metrics including HbA1c Testing, Eye Exam (Retinal), Medical Attention for Nephropathy, HbA1c Control <8.0, and Blood Pressure Control <140/90.

The results for these five metrics are summarized below.

- **HbA1c Testing *(CMS Core Quality Measure)***
  The data were available for this metric for 2013–2017. The descriptive data were assessed for this measure. Throughout the five-year period, the rates remained high (>84%). The rate in the most year was slightly higher compared to the baseline (0.6 percentage-point difference).
- **Eye Exam (Retinal)**
  The data were available for this metric for 2013–2017. The descriptive data were assessed for this measure. Throughout the five-year period, the rates remained average (<68%). The rate in the most year was higher compared to the baseline (8.1 percentage-point difference).
- **Medical Attention for Nephropathy**
  The data were available for this metric for 2013–2017. The descriptive data were assessed for this measure. Throughout the five-year period, the rates were higher in the most recent years (>87%). The rate in the most year was higher compared to the baseline (11.5 percentage-point difference).
- **HbA1c Control <8.0%**
  The data were available for this metric for 2013–2015. The descriptive data were assessed for this measure. Throughout the three-year period, the rates remained low (<47%). The rate in the most recent year was higher compared to the baseline (8.4 percentage–point difference).
- **Blood Pressure Control <140/90**
  The data were available for this metric for 2013–2015. The descriptive data were assessed for this measure. Throughout the three-year period, the rates were average (<61%). The rate in the most recent year was higher compared to the baseline (3.2 percentage–point difference).

5) Home and Community Based Services (HCBS) Waiver Services

Evaluation Summary

Three PMs were included in the quality of care assessment for HCBS waiver services. The results from the final evaluation of these measures are summarized below (Figure 31).

- The numbers/percentages remained maintained for the following measures throughout the evaluation period:
  - Number of KanCare members receiving PD, TBI, or I/DD waiver services who are participating in the WORK program (2017–2018);

Improved/Maintained Number/Percentages Over Time	Improved Number/Percentgaes Compared to Baseline
•Maintained the **number of participa**nts in the WORK Program throughout the evaluation period. •Maintained percentages for **six out of the seven waiver types** in two measures. •High percentages for **five out of the seven waiver types** for one measure and for **four out of the seven waiver types** for another measure (>80%).	•Higher **number of participants** in the WORK Program in the most recent year compared to the baseline. •Higher percentages in the most recent year compared to the baseline for **six out of the seven waiver types for two measures.**

Figure 31. Improved/Maintained Performance Measures for the Home and Community Based Services (HCBS) Waiver Services

  - Percent of waiver participants whose service plans addressed their assessed needs and capabilities as indicated in the assessment – six out of seven waiver types (I/DD, PD, FE, TBI, TA, and Autism) (2016–2017); and
  - Percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan – six out of seven waiver types (I/DD, PD, FE, TBI, TA, and SED) (2016–2017).
- Improved numbers/percentages were seen in the most recent year compared to the baseline for the following measures:
  - Number of KanCare members receiving PD, TBI, or I/DD waiver services who are participating in the WORK program (2017–2018);
  - Percent of waiver participants whose service plans addressed their assessed needs and capabilities as indicated in the assessment – six out of the seven waiver types (I/DD, PD, FE, TBI, TA, and Autism) (2016–2017); and
  - Percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan – six out of the seven waiver types (I/DD, PD, FE, TBI, TA, and SED) (2016–2017).
- High numbers/percentages were seen in the most recent year for the following measures:
  - Percent of waiver participants whose service plans addressed their assessed needs and capabilities as indicated in the assessment – four out of the seven waiver types (PD, FE, TA, and SED) (>80%); and
  - Percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan – five out of the seven waiver types (I/DD, PD, FE, TA, and SED) (>80%).
- Average/low percentages were seen throughout the evaluation period for the following measures:
  - Percent of waiver participants whose service plans addressed their assessed needs and capabilities as indicated in the assessment – three out of the seven waiver types (I/DD, TBI and Autism); and
  - Percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan – two out of the seven waiver types (TBI and Autism).

Improvements were seen in the measures assessing the quality of care for the HCBS Waiver members. However, evaluation findings also showed areas for the improvement in the services received by some of the waiver types (TBI and Autism). The percentages for both measures among members in the Autism waiver type were very low throughout the evaluation period indicating efforts are especially needed to improve the quality of care provided to these members.

Evaluation Results for the HCBS Waiver Services

The number of KanCare members receiving PD, TBI, or I/DD waiver services who are participating in the WORK program.

This PM tracked the number of members receiving PD, TBI, or I/DD Waiver services who were eligible for Working Healthy program and receiving services through the WORK program; it was also a P4P measure from 2014–2015. The WORK program includes personal services and other services to assist employed persons with disabilities eligible for Working Healthy program. The data for the years 2014 and 2015 were available for only PD and TBI waiver members, therefore not included in the final evaluation. The data were available for participants receiving PD, TBI or I/DD for the years 2017 and 2018 and were included in the final evaluation.

In 2018, total number of WORK Program participants was 301 (150 PD, 16 TBI, and 135 I/DD waiver members); in 2017, total number of the participants was 282 (142 PD, 15 TBI, and 125 I/DD waiver members). Thus, the total number of WORK program participants remained fairly consistent in two years.

Percent of HCBS Waiver participants whose service plans addressed their assessed needs and capabilities as indicated in the assessment

The measure tracked the percentage of the HCBS Waiver participants whose service plans addressed their assessed needs and capabilities. These data were collected by the MCOs. These data by the waiver types are presented in Table 22. In 2015, as part of remediation efforts, KDADS was in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and was planning to develop a policy to provide clear direction on the plan of care development process (2016 KanCare Evaluation Annual Report). The descriptive data for this measure were assessed for the years 2016 and 2017 for the final evaluation reported here.

Table 22. Percent of HCBS Waiver Participants Whose Service Plans Addressed their Assessed Needs and Capabilities, CY2013–CY2017

Waiver	2013*	2014*	2015*	2016	2017
Intellectual/Developmental Disability (I/DD)	99%	78%	48%	68%	77%
Physical Disability (PD)	86%	87%	59%	76%	84%
Frail Elderly (FE)	87%	86%	61%	77%	81%
Traumatic Brain Injury (TBI)	72%	73%	45%	72%	77%
Technical Assistance (TA)	96%	96%	59%	73%	83%
Serious Emotional Disturbance (SED)	92%	90%	97%	94%	92%
Autism	59%	68%	46%	36%	37%

*Compare with caution due to change in methodology.

In 2017, the percentages of HCBS Waiver participants whose service plans addressed their assessed needs and capabilities were high for six out of the seven waiver types (>80%), whereas it was low (37%) for only one wavier type (Autism). The percentages were higher in 2017 compared to 2016 for six out of the seven waiver types. Though the percentage was lower in 2017 compared to 2016 for the SED waiver type, it remained above 91%.

Percent of HCBS Waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan

The measure tracked the percentage of the HCBS Waiver participants who received services in the type, scope, amount, duration and frequency as specified in the services plans. These data were collected by the MCOs. These data by the waiver types are presented in Table 23. In 2015, as part of remediation efforts, KDADS was in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and was planning to develop a policy to provide clear direction on the plan of care development process (2016 KanCare Evaluation Annual Report). The descriptive data for this measure were assessed for the years 2016 and 2017 for the final evaluation reported here.

Table 23. Percent of HCBS Waiver Participants who Received Services in the Type, Scope, Amount, Duration, and Frequency Specified in their Service Plan, CY2013–CY2017					
Waiver	**2013***	**2014***	**2015***	**2016**	**2017**
Intellectual/Developmental Disability (I/DD)	98%	92%	68%	77%	81%
Physical Disability (PD)	85%	95%	72%	81%	86%
Frail Elderly (FE)	87%	92%	72%	83%	86%
Traumatic Brain Injury (TBI)	70%	87%	56%	72%	77%
Technical Assistance (TA)	100%	98%	74%	80%	83%
Serious Emotional Disturbance (SED)	13%	93%	98%	90%	94%
Autism	50%	86%	49%	38%	37%
*Compare with caution due to change in methodology.					

In 2017, the percentages of HCBS Waiver participants who received the services in the type, scope, amount, duration and frequency as specified in the services plans were high for five out of the seven waiver types (>80%), whereas percentage was average for one type (TBI) and low for another wavier type (Autism). The percentages were higher in 2017 compared to 2016 for six out of the seven waiver types. The percentages for both years were low for Autism Waiver type (<39%).

6) Long Term Care – Nursing Facilities

Evaluation Summary

Four PMs were included in the quality of care assessment for NFs. The results from the final evaluation of these measures are summarized below (Figure 32).

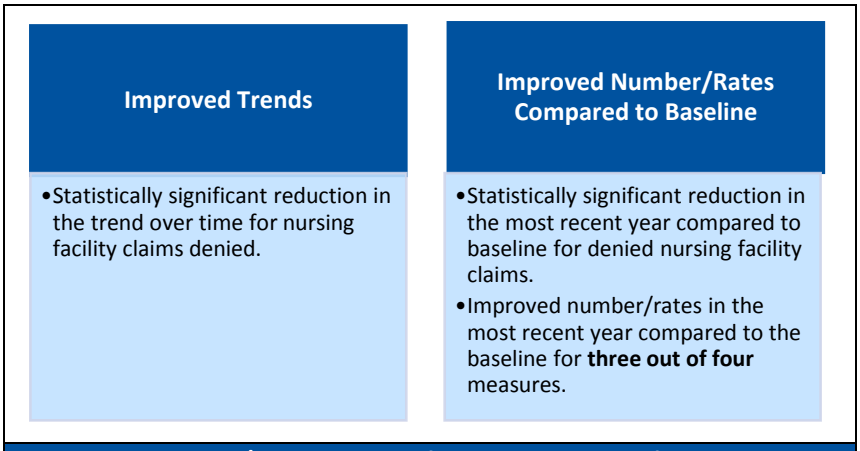

Figure 32. Improved/Maintained Performance Measures for Long-term Care – Nursing Facilities

The following measure showed a statistically significant improvement (reduction) in the trend over the six-year period (2012–2017), as well as a reduction in the most recent year compared to the baseline (2012):

- The percentage of Medicaid NF claims denied by the MCO.

The following measure showed an improved number in the most recent year compared to the baseline for the following measure:

- Person-Centered Care Homes as recognized by the PEAK program in the MCO network.

The following measure showed consistently maintained rates throughout the six-year evaluation period; however, there was only slight improvement in the most recent year compared to the baseline:

- Percentage of NF members who had a fall with a major injury (.08 percentage-point increase in 2017 compared to 2012).

The following measure showed a statistically significant increase in the rate for the most recent year compared to the baseline indicating an opportunity for improvement:

- Percentage of members discharged from a NF who had a hospital admission within 30 days.

Improvements were seen in the performance measures for the Long-term Care – nursing facilities in the reduction of denied nursing facility claims and in the number of Percent-Centered Care Homes recognized by the PEAK program. The percentage of NF members who had a major injury fall was low throughout the evaluation period. In the measure for members discharged from a NF who had a hospital admission within 30 days, the rate increased in the most recent year compared to the baseline. This shows improvement is needed to improve the quality of care for these members.

Evaluation Results for the Long-term Care – Nursing Facilities Performance Measures

Four measures were assessed for the evaluation of this subcategory. The data for two of these measures are presented in Table 24 below.

Table 24. Long-term Care: Nursing Facility Performance Measures, CY2012–CY2017

	Pre - KanCare	KanCare				
	2012	2013	2014	2015	2016	2017
Nursing facility claims denied	11.5%	13.5%	10.4%	13.2%	13.4%	10.1%
Hospital admissions within 30 days after nursing facility discharge	7.2%	12.0%	12.7%	12.0%	13.3%	12.8%

Percentage of Medicaid NF claims denied by the MCO

This measure tracked the percentage of NF claims denied; it was also a P4P measure in 2014. The data for 2012 (pre-KanCare) were used as baseline for this measure. For this measure, a statistically significant reduction was seen in the rate for the most recent year compared to the baseline (p<.001). The measure also showed a statistically significant reduction in the trend over the evaluation period (p<.001).

Percentage of members discharged from a NF who had a hospital admission within 30 days

This measure tracked the percentage of members discharged from a NF who had a hospital admission within 30 days; it was also a P4P measure from 2014–2018. The data for 2012 (pre-KanCare) were used as baseline for this measure. The percentage of NF Medicaid members who were readmitted to a hospital after being discharged from a NF had a statistically significant increase in the recent year compared to the baseline (p<.001). No statistically significant change was observed in the trend over the evaluation period.

Percentage of NF members who had a fall with a major injury

The data for 2012 (pre-KanCare) were used as baseline for this measure; it was also a P4P measure from 2014–2015. No statistically significant change was seen in the percentage of members with a major injury fall in the most recent year compared to the baseline (2018: 0.54%; 2012: 0.62%). Rates for this measure have been consistent during the evaluation period (2013 to 2018), remaining below 0.57%. The State encouraged the MCOs to work together and with State agencies to ensure nursing facilities throughout Kansas are continuing to implement fall prevention practices.

Number of Person-Centered Care Homes as recognized by the PEAK program in the MCO network (P4P 2014)

The data for 2013 were used as baseline for this measure. Peak is a Medicaid pay-for-performance program offered by KDADS. The Kansas State University Center on Aging administers the program on behalf of KDADS. The goal of the program is to improve the quality of life for residents living in Kansas nursing facilities and is designed to reward organizational change through the adoption of person-centered care practices. PEAK program data are used to identify nursing facilities designated as Person-Centered Care Homes, along with MCO provider files to verify inclusion in the network.

Nursing facilities in the PEAK program are evaluated at the end of a fiscal year and awarded Levels 3–5 for the next fiscal year. Levels 4 and 5 homes are evaluated every other year. Descriptive data were assessed for this measure for the period of six-years. The number of Person-Centered Care Homes increased in the most recent year compared to the baseline (FY2018: 13 PCCHS; FY2013: 8 PCCHS).

7) Member Surveys – Quality of Care

The *Member Surveys – Quality of Care* subcategory was assessed for the improvement in the measures related to the member perception of provider treatment of child and adult population, member perception of MH provider treatment, and member perception of SUD services.

The measures related to the member perception of provider treatment among child and adult populations were based on the adult and child CAHPS Survey; the measures related to the member perception of MH provider treatment were based on the MH Survey; and the measures related to the member perception of SUD services were based on the SUD Survey. The results from the evaluation of these measures are summarized below.

Member Perceptions of Provider Treatment: Measures based on questions in the Child and Adult CAHPS Surveys

Evaluation Summary

The 2014–2018 data for six child and adult CAHPS survey measures related to the member perception of provider treatment among the child and adult populations are presented in Table 25. The child measures were assessed in both GC (Title XIX and XXI) and CCC (Title XIX and XXI) populations.

Several of these measures for child and adult populations were consistently high throughout the five-year period showing high member satisfaction with the quality of care received by the KanCare beneficiaries during this period. The measures showing statistically significant improvements in the trends over time and in the rates for the most recent year compared to the baseline are summarized in Figure 33 below.

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Improved Trends	Improved Rates Compared to Baseline	NCQA ≥50th Quality Compass Percentile
•Statistically significant improvements in the trends over time for **five out of six measures** in the GC population; for **four out of six measures** in the CCC population; and **one out of six measures** in the adult Medicaid population. •High rates throughout the five-year period for **six measures** among both GC and CCC populations. •High rates throughout the five-year period for **four out of six measures** among the adult population.	•Statistically significant higher rates in the most recent year compared to the baseline for **one measure** in the CCC population. •Rates for all **six measures** among both GC and CCC populations were >80% (**two measures** >90%) in all five years. •High rates for **four measures** among the adult population were >80% (**two measures** >90%) in all five years.	•The QC ranking ≥50th QC percentile throughout the five-year period or for most of the years for **six measures** among the GC population; for **five measures** among the CCC population; and for **four measures** among the adult population. •The QC ranking >75th QC percentile in the most recent year for high rating of specialist seen most often among the GC population; >66.67th QC percentile in the most recent year for the rate for personal doctor spending enough time with the child among both of the GC and CCC populations.

Figure 33. Improvements in the Performance Measures for the Member Perceptions of Provider Treatment (CAHPS Survey)

The following measures showed statistically significant improvement in the trends over the five-year period and improved rates in 2018 compared to the baseline among child and adult populations:

- Improved trends over the five-year period in the rates of the member perception of provider treatment measures among child populations:
  - Among both the GC and CCC populations – high rating (rating of 8, 9, or 10) for all health care received by the child in last six months.
  - Among both the GC and CCC populations – How often did your child's personal doctor show respect for what you had to say?
  - Among both the GC and CCC populations – How often did your child's personal doctor spend enough time with your child?
  - Among the GC population – high rating (rating of 8, 9, or 10) for the child's personal doctor.
  - Among the GC population – high rating (rating of 8, 9, or 10) for the specialist most often seen for the child.
  - Among the CCC population – high rating (rating of 8, 9, or 10) for the child's health plan.
- Improved rates for the member perception of provider treatment measures in 2018 compared to the baseline among child populations:
  - Among the CCC population – How often did your child's personal doctor spend enough time with you (your child)?
- Improved trends over the five-year period in the member perception of provider treatment measures among adult population
  - High rating (rating of 8, 9, or 10) for the health plan.

Though no statistically significant improvement was seen in the trends over the five-year period for some measures among child and adult populations, the rates for these measures were consistently high throughout this period. The high rates maintained throughout indicated high satisfaction of the

members with these aspects. The high member satisfaction with this aspect contributed to the high member satisfaction with the quality of care during this period.

- Measures with high rates during 2014–2018 without showing improvement in the trends over time among the child populations:
  - Among the GC population, rates were above 86% – high rating (rating of 8, 9, or 10) for the child's health plan.
  - Among the CCC population, rates were above 87% – high rating (rating of 8, 9, or 10) for the child's personal doctor.
  - Among the CCC population, rates were above 83% – high rating (rating of 8, 9, or 10) for the specialist most often seen for the child.
- Measures with high rates during 2014–2018 without showing improvement in the trends over time among the adult population:
  - Rates were above 79.5% – high rating (rating of 8, 9, or 10) for the personal doctor.
  - Rates were above 83% – high rating (rating of 8, 9, or 10) for the specialist most often seen.
  - Rates were above 91% – How often did your personal doctor show respect for what you had to say?
  - Rates were above 88% – How often did your personal doctor spend enough time with you?

The following measure showed average rates throughout the five-year period among the adult population indicating an opportunity for improvement in the future:

- Measures showing average rates among the adult population:
  - Rates were between 73% and 75% throughout the five-year period – high rating (rating of 8, 9, or 10) for all health care received in last six months.

The final evaluation of the measures related to the members' perception of the provider treatment, including rating of the health care received, health plan, personal doctor and specialist most often seen, based on the child and adult CAHPS survey questions showed that these measures contributed to the high quality of care received by the KanCare beneficiaries. The evaluation findings also highlighted opportunities for improvement in one aspect of this subcategory among the adult population to further strengthen the quality of care for the beneficiaries.

Evaluation Results for the Member Perceptions of Provider Treatment (CAHPS Survey)

The *Member Perceptions of Provider Treatment* aspect of the *Member Survey - Quality* subcategory was assessed by six measures among child members (GC population – TXIX and TXXI, and CCC population – TXIX and TXXI) and the adult Medicaid population. These measures were based on the CAHPS Survey questions. (Table 25).

A five-year trend for these measures was examined from 2014 through 2018 (when appropriate a four-year trend was examined). The most recent rates were also compared to the baseline rates. The Quality Compass rankings were also examined.

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Table 25. Member Survey – CAHPS Survey Quality of Care Questions, CY2014–CY2018

Question	Pop	Weighted % Positive Responses					Quality Compass ≥50th Percentile^				
		2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
Rating of Health Care, Health Plan, Personal Doctor, and Specialaist Seen Most Frequently in the Last Six Months											
Using any number from 0 to 10, where 0 is the worst rating possible and 10 is the best rating possible:											
What number would you use to rate all your (your child's) health care in the last 6 months? *(Rating 8, 9, or 10)*	**Adult**	73.5%	73.9%	74.1%	74.5%	74.7%	↑	↑	↑	↑	↓
	GC	87.5%	85.7%	87.7%	88.5%	88.3%	↑	↑	↑	↑	↑
	CCC	84.8%	84.5%	84.9%	87.1%	86.9%	↑	↑	↑	↑	↑
What number would you use to rate your (your child's) health plan? *(Rating 8, 9, or 10)*	**Adult**	72.5%	73.4%	76.5%	75.7%	77.8%	↓	↓	↑	↓	↑
	GC	86.8%	87.6%	88.7%	87.7%	88.5%	↑	↑	↑	↑	↑
	CCC	81.1%	83.5%	85.2%	86.0%	85.4%	↑	↑	↑	↑	↑
What number would you use to rate your (your child's) personal doctor? *(Rating 8, 9, or 10)*	**Adult**	79.6%	81.5%	80.5%	83.0%	83.4%	↑	↑	↓	↑	↑
	GC	88.5%	87.9%	88.7%	90.5%	90.3%	↑	↓	↑	↑	↑
	CCC	87.7%	87.7%	87.9%	89.4%	88.9%	↑	↑	↓	↑	↓
We want to know your rating of the specialist you (your child) saw most often in the last 6 months. What number would you use to rate that specialist? *(Rating 8, 9, or 10)*	**Adult**	80.0%	80.3%	80.6%	82.7%	82.4%	↓	↓	↓	↑	↓
	GC	85.6%	82.9%	87.9%	88.5%	90.7%	↑	↓	↑	↑	↑
	CCC	85.5%	83.9%	87.0%	86.9%	85.9%	↓	↓	↑	↑	↓
Perceptions Regrading Whether Doctor Respected the Members' Comments and Spent Enough time with Members											
In the last 6 months…											
How often did your (your child's) personal doctor show respect for what you had to say?	**Adult**	91.9%	92.5%	93.4%	93.3%	94.0%	↑	↑	↑	↑	↑
	GC	96.7%	96.0%	96.0%	97.6%	96.8%	↑	↑	↑	↑	↑
	CCC	94.4%	95.8%	95.6%	97.2%	96.5%	↓	↑	↓	↑	↑
How often did your (your child's) personal doctor spend enough time with you (your child)?	**Adult**	89.0%	89.4%	89.7%	91.2%	90.3%	↑	↑	↑	↑	↑
	GC	90.4%	89.7%	91.0%	92.0%	91.4%	↑	↑	↑	↑	↑
	CCC	90.6%	91.3%	91.4%	92.9%	93.3%	↓	↓	↑	↑	↑

^↑Signifies Quality Compass ranking >50th percentile; ↓Signifies Quality Compass ranking <50th percentile

The four questions were *"rating"* questions, where survey respondents were asked to rate their (or their child's) health care, health plan, personal doctor and the specialist seen most frequently. The rating was based on a scale from zero to 10, with 10 being the *"best possible"* and zero the *"worst possible."* Positive responses based on a rating of 8, 9, or 10 for these questions were assessed. An additional two questions assessed whether the doctor respected the members' comments and spent enough time with the member.

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Rating of Health Care: What number would you use to rate all your (your child's) health care in the last 6 months?

The rating of 8, 9, or 10 was assessed for this measure in the child (GC and CCC) and adult populations (Figure 34).

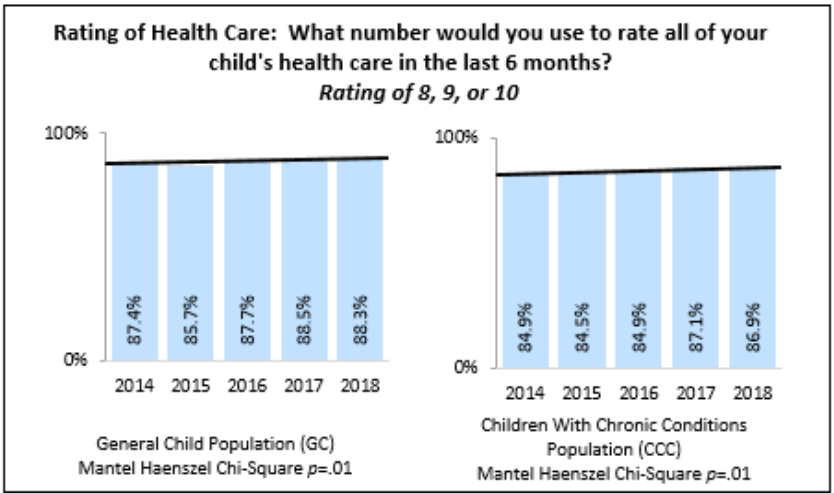

Figure 34. CAHPS GC – CCC Question 14, CY2014–CY2018

A statistically significant increasing trend was seen in the rates over the five-year period for both GC and CCC populations (p=.01). Considerably high rates were seen throughout the period. The comparison of 2018 and baseline rates for both GC and CCC populations did not show statistically significant differences. The QC ranking remained ≥50th QC percentile throughout the five-year period for both child populations.

No statistically significant trend was seen in the rates over the five-year period for the adult population. The comparison of 2018 and baseline rates for adults did not show a statistically significant difference. The QC ranking among adults was below the 50th QC percentile in the most recent year; however, it remained ≥50th QC percentile in most of the years for this period.

Rating of Health Plan: What number would you use to rate your (your child's) health plan?

The rating of 8, 9, or 10 was assessed for this measure in the child (GC and CCC) and adult populations (Figure 35).

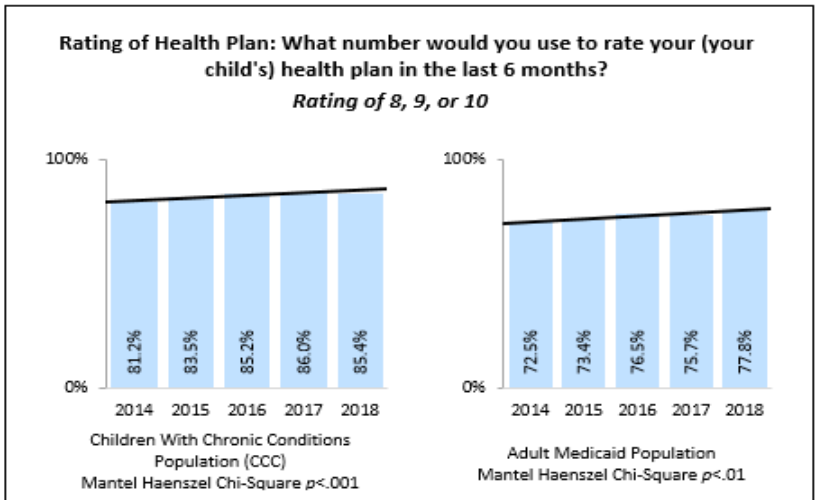

Figure 35. CAHPS CCC Question 54, Adult Question 35, CY2014–CY2018

A statistically significant increasing trend was seen in the rates over the five-year period for the CCC population (p<.001). Though no statistically significant trend was seen in the rates over five-year period for GC population, the rates were considerably high throughout this period (above 81%). The comparison of 2018 and baseline rates for both GC and CCC populations did not show statistically significant differences. The QC ranking remained ≥50th QC percentile throughout the five-year period for the GC and CCC populations.

A statistically significant increasing trend was seen in the rates over the five-year period for the adult population (p<.01). The comparison of 2018 and baseline rates for adults did not show a statistically

significant difference. The QC ranking among adults was below the 50th QC percentile in most of the years for this period.

Rating of Personal Doctor: What number would you use to rate your (your child's) personal doctor?
The rating of 8, 9, or 10 was assessed for this measure in the child (GC and CCC) and adult populations (Figure 36).

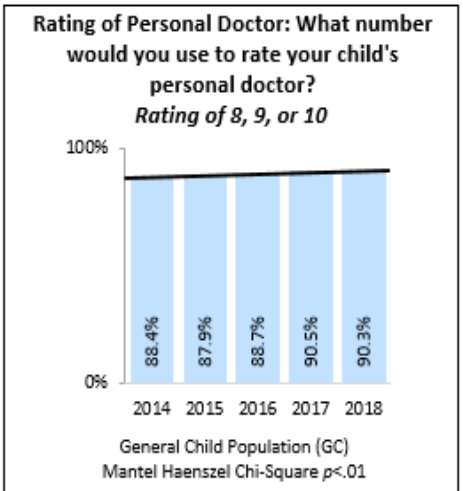

Figure 36. CAHPS GC Question 41, CY2014–CY2018

A statistically significant increasing trend was seen in the rates over the five-year period for the GC population (p<.01). While no statistically significant trend was seen in the rates over this period for the CCC population, the rates were considerably high throughout these years (above 87%). The comparison of 2018 and baseline rates for both GC and CCC populations did not show statistically significant differences. The QC rankings among the GC and CCC populations were ≥50th QC percentile in most of the years for this period.

Though, no statistically significant trend was seen in the rates over the five-year period for the adult population, the rates were considerably high throughout this period (above 79%). The comparison of 2018 and baseline rates for the adult population did not show a statistically significant difference. The QC rankings among the adult population were ≥50th QC percentile in most of the years for this period.

Rating of Specialist Seen Most Often: We want to know your rating of the specialist you (your child) saw most often in the last 6 months. What number would you use to rate that specialist?
The rating of 8, 9, or 10 was assessed for this measure in the child (GC and CCC) and adult populations (Figure 37).

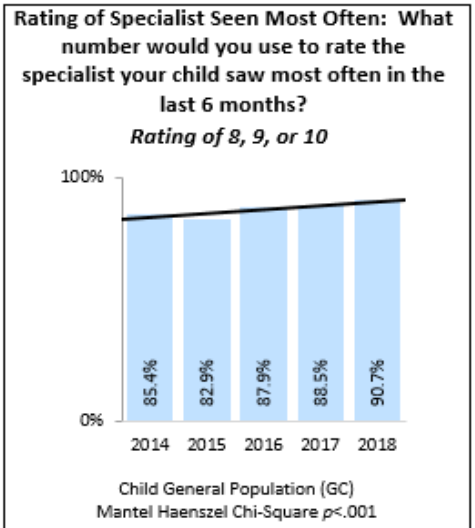

Figure 37. CAHPS GC Question 48, CY2014–CY2018

A statistically significant increasing trend was seen in the rates over the five-year period for the GC population (p<.001). Though no statistically significant trend was seen in the rates over this period for the CCC population, the rates were considerably high throughout these years (above 83%). The comparison of 2018 and baseline rates for both the GC and CCC populations did not show statistically significant differences. The QC rankings among the GC population were ≥50th QC percentile in most of the years for this period (>75th QC percentile in most recent year). However, rankings were <50th QC percentile among the CCC population.

While no statistically significant trend was seen in the rates over the five-year period for the adult population, the rates were considerably high throughout this period (above 80%). The comparison of 2018 and baseline rates for adults did not show a statistically significant difference. The QC rankings among the adult population were below the 50th QC percentile in most of the years for this period.

How often did your (your child's) personal doctor show respect for what you had to say?

The measure was tracked for the child (GC and CCC) and adult populations by assessing the percentages of *"Always/Usually" responses* to the survey question (Figure 38).

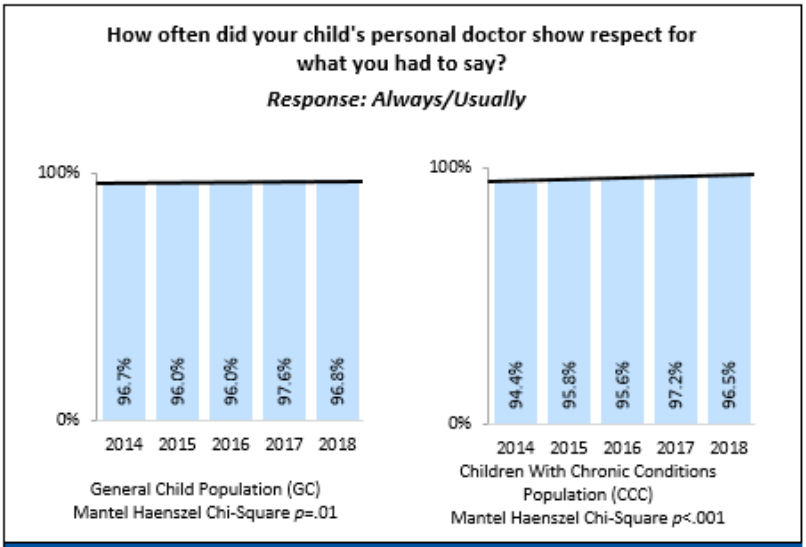

Figure 38. CAHPS GC – CCC Question 34, CY2014–CY2018

Statistically significant increasing trends were seen in the rates over the five-year period for both GC and CCC populations (GC population: p=.01; CCC population: p<.001). The rate for 2018 was significantly higher compared to the baseline rate for the CCC population (p<.01). The comparison of 2018 and baseline rates for the GC population did not show a statistically significant difference. The QC rankings were ≥50th QC percentile throughout this period among the GC population and in recent years among the CCC population.

Though no statistically significant trend was seen in the rates over the five-year period for the adult population, the rates were considerably high throughout this period (above 91%). The comparison of 2018 and baseline rates for adults did not show a statistically significant difference. The QC rankings among adult population were ≥50th QC percentile throughout this period.

How often did your (your child's) personal doctor spend enough time with you (your child)?

Statistically significant increasing trends were seen in the rates over the five-year period for both GC and CCC populations (GC population: p<.001; CCC population: p<.01). The rate for 2018 was significantly higher compared to the baseline rate for the CCC population (p<.01), whereas no statistically significant difference was seen for the GC population. The QC rankings were ≥50th QC percentile throughout this period among the GC population, and in recent years among the CCC population. The QC rankings for this measure were >66.67th QC percentile in the most recent year among both populations (Figure 39).

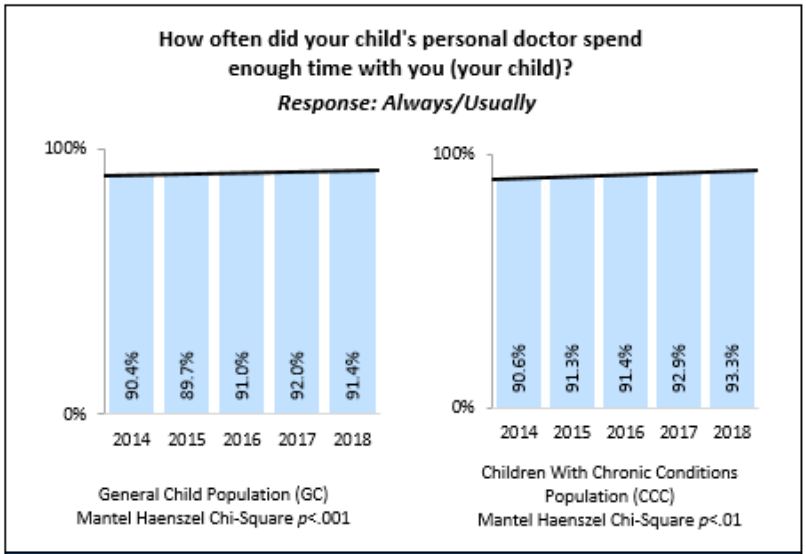

Figure 39. CAHPS GC – CCC Question 37, CY2014–CY2018

The rates for the adult population were considerably high throughout this period (above 89%), although no statistically significant trend was seen in the rates over the five-year period. The comparison of 2018 and baseline rates for adults did not show a statistically significant difference. The QC rankings among the adult population were ≥50th QC percentile throughout this period.

Member Perceptions of Mental Health Provider Treatment: Measures based on questions in the MH Survey

Evaluation Summary

The 2011–2018 data for eight MH survey measures related to the member perception of MH provider treatment among the Adult, Youth, and SED Waiver youth and young adult populations are presented in Table 26. Member perceptions of MH provider treatment are based on responses to MH surveys conducted from 2011 to 2018 of a random sample of KanCare members who received one or more MH services in the prior six-month period of each survey year. The MHSIP Youth Services Survey for Families and Adult Consumer Survey tools were used for this project. From 2011 to 2017, the Youth Services Survey was also used.

The General Youth (ages 12–17), youth responding; SED Waiver Youth (ages 12–17), youth responding; and SED Waiver Youth and Young Adults, family/member responding subgroups were assessed 2011 through 2017 and the Youth (ages 0–17), family responding, and Adult subgroups were assessed 2011 through 2018 (at the State's request).

The measures showing statistically significant improvements in the trends over time and in the rates for the most recent year compared to the baseline are summarized in Figure 40.

Improved Trends	Improved Rates Compared to Baseline
•Statistically significant improvement in the trends over time for **two out of eight measures** in the SED Waiver Youth (ages 12–17), youth responding survey subgroup. •High rates (>90%) throughout the eight-year period for **three out of eight measures** among all survey subgroups for one measure; the Youth (ages 0–17), family responding and SED Waiver Youth and Young Adult, family/member responding for the second measure; and Youth (0–17), family responding for the third measure.	•Statistically significant higher rates in the most recent year compared to the baseline for **two out of eight measures** in the Adult and General Youth (ages 12–17), youth responding, survey subgroups. •Consistently maintained rates for **six out of eight measures** among all survey subgroups for one measure; the Adult survey subgroup for three measures; and Adults, Youth (ages 0–17), family responding, and SED Waiver Youth and Young Adults, family/member responding, survey subgroups for the fifth measure; and all were >80% in all seven/eight years.

Figure 40. Improved/Maintained Performance Measures for the Members Perception of Mental Health Provider Treatment (MH Survey)

One measure, had high rates (>90%) for all survey subgroups throughout the evaluation period, whereas two other measures, had high rates throughout the evaluation period for Youth (ages 0–17), family responding, and SED Waiver Youth and Young Adult, family/member responding. Several of the measures that included the Adult; General Youth and SED Waiver Youth (ages 12–17), youth responding; Youth (ages 0–17), family responding; and SED Waiver Youth and Young Adult, family/member responding survey subgroup populations were consistently maintained in the range of 74.8%–94.5% throughout the evaluation period showing their contribution to the quality of care received by the KanCare beneficiaries during this period.

The following measures showed statistically significant improvement in trends and improved rates in the most recent year compared to the baseline:

- Improved trends or improved rates compared to baseline:
  - SED Waiver Youth (ages 12–17), youth responding – My mental health provider spoke with me in a way that I understood.
  - SED Waiver Youth (ages 12–17), youth responding and General Youth (ages 12–17), youth responding – I, not my mental health provider, chose my treatment goals.
- Improved rate in 2018 compared to baseline: Adults – As a direct result of the services I received, I am better able to do things I want to do.

The following measures showed consistently high rates (>90%) over the evaluation period, although there was no statistically significant improvement:

- Rates were ≥93.1% – SED Waiver Youth and Young Adults, family/member responding – I helped to choose my child's treatment goals/I, not my mental health providers, decided my treatment goals.
- Rates ranged from 90.0% to 96.3% – Adults and General Youth (ages 12–17) – My mental health provider spoke with me in a way that I understood.
- Rates were ≥90.4% – Youth (ages 0–17), family responding – I have people I am comfortable talking with about my child's problems.

The following measures showed consistently maintained rates throughout the evaluation period without statistically significant improvement over time:

- Rates were at or above 85.0% – Adults – If I had other choices, I would get services from my mental health providers.
- Rates were at or above 78.6% – Adults – I, not my mental health providers, decided my treatment goals.
- As a result of services I received, I am better at handling daily life/As a result of the services my child and /or family member received, my child is better at handling daily life:
  - Rates were ≥85.3% – General Youth (ages 12–17), youth responding
  - Rates were ≥79.6% – SED Waiver Youth (ages 12–17), youth responding
  - Rates were ≥77.8% – Youth (ages 0–17), family responding
- Rates were ≥80.0% during the evaluation period; however, the most current rate was lower than the baseline (2011 and 2012) – Youth (ages 0–17), family responding – As a direct result of the services my child and/or family received, my child is better able to do things he or she wants to do.
- Rates were ≥85.9% and greater than 90% in four of six years – Adults – I felt comfortable asking questions about my treatment and medication.
- Rates were ≥87.7% – SED Waiver Youth and Young Adults, family/member responding – I have people I am comfortable talking with about my child's problems.
- Rates were ≥82.7% – Adults – My mental health providers helped me obtain information I needed so that I could take charge of managing my illness.
- Rates were ≥74.8% – Adults – As a direct result of the services I received, I am better able to control my life.
- Rates were ≥90.5% – Youth (ages 0–17), family responding – I helped to choose my child's treatment goals.

The following measures showed lower rates (<81%) throughout the evaluation period indicating an opportunity for improvement:

- Rates were ≤79.3% – Adults – As a direct result of the services I received, I am better able to deal with a crisis.
- Rates were ≤75.9% – SED Waiver Youth and Young Adults, family/member responding – As a result of services I received, I am better at handling daily life/As a result of the services my child and /or family member received, my child is better at handling daily life.

The following measure showed lower rates throughout the evaluation period, and the most recent rate was comparable to the baseline rate (2012):

- Rates were ≤73.5% during the evaluation period – SED Waiver Youth and Young Adults, family/member responding – As a direct result of the services my child and/or family (I) received, my child is (I am) better able to do things he or she wants (I want) to do.

Several measures, related to the members' perception of MH provider treatment, showed their contribution to the improved quality of care for the beneficiaries. However, five measures within the SED Waiver Youth and Young Adult survey subgroup population showed opportunities for improvement to strengthen the quality of care provided to the members receiving MH services.

Evaluation Results for the Member Perceptions of Mental Health Provider Treatment (MH Survey)

The performance measures, yearly rate, and statistical testing for trends overtime and in the most recent year (2017 or 2018) compared to baseline (2011 and 2012) are presented in Table 26.

Table 26. Mental Health Survey – Quality-Related Questions

	Year	Rate (0% – 100%)	Numerator/ Denominator	95% Confidence Interval	Comparison of Most Current Year to Baseline and Pre-KanCare	Trend 5/6-Year*	Trend 7/8-Year*
	Adults (Age 18+)^						
If I had other choices, I would still get services from my mental health providers.	2018	86.1%	273 / 318	81.9% – 89.5%			
	2017	89.0%	345 / 388	85.5% – 91.8%			
	2016	85.0%	246 / 289	80.4% – 88.7%			
	2015	88.4%	336 / 380	84.8% – 91.3%			
	2014	89.4%	720 / 805	87.1% – 91.4%			
	2013	88.3%	911/1,034	86.2% – 90.1%			
	2012	84.4%	232 / 275	79.6% – 88.2%			
	2011	88.3%	263 / 298	84.1% – 91.5%			
	Adults (Age 18+)^						
As a direct result of the services I received, I am better able to deal with crisis.	2018	78.6%	242 / 308	73.7% – 82.9%			
	2017	77.2%	285 / 369	72.7% – 81.2%			
	2016	69.2%	192 / 277	63.6% – 74.4%			
	2015	79.3%	279 / 352	74.8% – 83.3%			
	2014	78.7%	602 / 765	75.7% – 81.5%			
	2013	79.1%	780 / 987	76.4% – 81.5%			
	2012	71.4%	182 / 255	65.5% – 76.6%			
	2011	80.4%	221 / 275	75.2% – 84.6%			

* 5-Year/7-Year trend is 2011 to 2017 and 6-Year/8-Year trend is 2011 to 2018

^ Adults (Age 18+) and Youth (Ages 0–17), Family Responding, subgroups were assessed 2011–2018

ǂ General Youth (Ages 12–17), Youth Responding; SED Waiver Youth (Ages 12–17), Youth Responding; and SED Waiver Youth and Young Adult, Family/Member Responding subgroups were assessed 2011–2017.

Table 26. Mental Health Survey – Quality-Related Questions (Continued)

	Year	Rate (0% – 100%)	Numerator/ Denominator	95% Confidence Interval	Comparison of Most Current Year to Baseline and Pre-KanCare	Trend 5/6-Year*	Trend 7/8-Year*
My (my child's) mental health providers spoke with me in a way that I understood.	**Adults (Age 18+)^**						
	2018	93.3%	308 / 330	90.0% – 95.6%			
	2017	94.8%	381 / 402	92.1% – 96.6%			
	2016	90.0%	266 / 295	86.0% – 92.9%			
	2015	95.3%	368 / 386	92.7% – 97.1%			
	2014	93.6%	765 / 817	91.7% – 95.1%			
	2013	94.3%	1,002/1,063	92.8% – 95.6%			
	2012	91.5%	257 / 281	87.6% – 94.2%			
	2011	93.4%	282 / 302	89.9% – 95.7%			
	General Youth (Ages 12–17), Youth Responding†						
	2017	94.7%	212 / 224	90.8% – 97.0%			
	2016	94.4%	148 / 157	89.5% – 97.2%			
	2015	93.9%	137 / 146	88.6% – 96.9%			
	2014	95.5%	290 / 303	92.5% – 97.4%			
	2013	96.3%	495 / 515	94.2% – 97.7%			
	2012	98.0%	97 / 99	92.5% – 99.9%			
	2011	97.0%	131 / 135	92.4% – 99.1%			
	SED Waiver Youth (Ages 12–17), Youth Responding†						
	2017	95.8%	186 / 194	91.8% – 98.0%			.03↑
	2016	95.5%	158 / 165	91.0% – 97.9%			
	2015	97.4%	147 / 151	93.3% – 99.2%			
	2014	96.9%	183 / 189	93.2% – 98.7%			
	2013	93.8%	213 / 227	89.8% – 96.3%			
	2012	92.0%	126 / 137	86.1% – 95.6%			
	2011	92.1%	116 / 126	85.9% – 95.8%			
	Youth (Ages 0–17), Family Responding^						
	2018	98.1%	399 / 407	96.2% – 99.1%			
	2017	97.7%	476 / 487	95.9% – 98.8%			
	2016	97.5%	323 / 331	95.1% – 98.8%			
	2015	98.8%	324 / 328	96.9% – 99.7%			
	2014	97.5%	766 / 786	96.1% – 98.4%			
	2013	97.3%	950 / 981	96.1% – 98.2%			
	2012	97.8%	262 / 268	95.1% – 99.1%			
	2011	96.7%	327 / 338	94.2% – 98.2%			
	SED Waiver Youth and Young Adults, Family/Member Responding†						
	2017	97.9%	400 / 408	96.0% – 99.0%			
	2016	98.0%	324 / 331	95.8% – 99.1%			
	2015	97.9%	329 / 336	95.7% – 99.1%			
	2014	98.2%	414 / 422	96.4% – 99.2%			
	2013	97.4%	476 / 488	95.5% – 98.5%			
	2012	97.8%	314 / 321	95.5% – 99.0%			
	2011	97.2%	278 / 286	94.4% – 98.6%			

* 5-Year/7-Year trend is 2011 to 2017 and 6-Year/8-Year trend is 2011 to 2018

^ Adults (Age 18+) and Youth (Ages 0–17), Family Responding, subgroups were assessed 2011–2018

† General Youth (Ages 12–17), Youth Responding; SED Waiver Youth (Ages 12–17), Youth Responding; and SED Waiver Youth and Young Adult, Family/Member Responding subgroups were assessed 2011–2017.

Table 26. Mental Health Survey – Quality-Related Questions (Continued)

	Year	Rate (0% – 100%)	Numerator/ Denominator	95% Confidence Interval	Comparison of Most Current Year to Baseline and Pre-KanCare	Trend 5/6-Year*	Trend 7/8-Year*
I helped to choose my child's treatment goals. (I, not my mental health providers, decided my treatment goals.)	**Adults (Age 18+)^**						
	2018	80.6%	250 / 311	75.8% – 84.6%			
	2017	83.2%	311 / 374	79.1% – 86.7%			
	2016	78.6%	219 / 278	73.4% – 83.0%			
	2015	85.1%	303 / 356	81.1% – 88.5%			
	2014	84.0%	655 / 780	81.3% – 86.5%			
	2013	81.8%	809 / 989	79.3% – 84.1%			
	2012	77.0%	198 / 257	71.5% – 81.8%			
	2011	83.7%	237 / 283	79.0% – 87.6%			
	General Youth (Ages 12–17), Youth Responding‡						
	2017	90.5%	198 / 219	85.8% – 93.8%			
	2016	84.6%	128 / 151	77.9% – 89.5%			
	2015	91.0%	127 / 140	84.9% – 94.8%			
	2014	84.1%	255 / 302	79.5% – 87.8%			
	2013	88.8%	448 / 509	85.6% – 91.4%			
	2012	81.6%	80 / 98	72.7% – 88.1%	.03↑		
	2011	86.8%	112 / 129	79.8% – 91.7%			
	SED Waiver Youth (Ages 12–17), Youth Responding‡						
	2017	88.4%	166 / 188	83.0% – 92.3%			.01↑
	2016	86.8%	140 / 161	80.6% – 91.2%			
	2015	92.3%	135 / 146	86.7% – 95.7%			
	2014	86.9%	169 / 194	81.4% – 91.0%			
	2013	82.2%	183 / 222	76.7% – 86.7%			
	2012	81.3%	109 / 134	73.9% – 87.1%			
	2011	83.5%	101 / 121	75.8% – 89.1%			
	Youth (Ages 0–17), Family Responding^						
	2018	92.8%	360 / 388	89.7% – 95.0%			
	2017	92.9%	436 / 469	90.2% – 94.9%			
	2016	92.5%	288 / 311	89.0% – 95.0%			
	2015	92.7%	289 / 312	89.2% – 95.1%			
	2014	92.2%	689 / 750	90.0% – 93.9%			
	2013	90.5%	847 / 937	88.4% – 92.2%			
	2012	91.6%	229 / 250	87.4% – 94.5%			
	2011	90.7%	294 / 324	87.1% – 93.5%			
	SED Waiver Youth and Young Adults, Family/Member Responding‡						
	2017	94.3%	376 / 397	91.5% – 96.2%			
	2016	94.3%	301 / 318	91.2% – 96.4%			
	2015	95.0%	310 / 327	92.1% – 97.0%			
	2014	95.8%	395 / 412	93.3% – 97.4%			
	2013	93.1%	451 / 483	90.5% – 95.1%			
	2012	96.1%	303 / 315	93.3% – 97.8%			
	2011	93.8%	264 / 281	90.2% – 96.1%			

* 5-Year/7-Year trend is 2011 to 2017 and 6-Year/8-Year trend is 2011 to 2018

^ Adults (Age 18+) and Youth (Ages 0–17), Family Responding, subgroups were assessed 2011–2018

‡ General Youth (Ages 12–17), Youth Responding; SED Waiver Youth (Ages 12–17), Youth Responding; and SED Waiver Youth and Young Adult, Family/Member Responding subgroups were assessed 2011–2017.

Table 26. Mental Health Survey – Quality-Related Questions (Continued)

	Year	Rate (0% – 100%)	Numerator/ Denominator	95% Confidence Interval	Comparison of Most Current Year to Baseline and Pre-KanCare	Trend 5/6-Year*	Trend 7/8-Year*
As a direct result of the services I received, I am better able to control my life.	**Adults (Age 18+)^**						
	2018	82.0%	263 / 321	77.4% – 85.8%			
	2017	82.0%	316 / 385	77.9% – 85.6%			
	2016	74.8%	213 / 284	69.4% – 79.5%			
	2015	83.8%	309 / 369	79.7% – 87.2%			
	2014	84.9%	669 / 788	82.2% – 87.2%			
	2013	83.0%	851/1,025	80.6% – 85.2%			
	2012	76.4%	204 / 267	70.9% – 81.1%			
	2011	86.5%	250 / 289	82.1% – 90.0%			
As a result of services I received, I am better at handling daily life.	**General Youth (Ages 12–17), Youth Responding†**						
	2017	86.0%	191 / 222	80.8% – 90.0%			
	2016	85.3%	131 / 154	78.8% – 90.1%			
	2015	87.0%	127 / 146	80.5% – 91.6%			
	2014	86.0%	260 / 302	81.6% – 89.5%			
	2013	88.6%	450 / 510	85.3% – 91.2%			
	2012	88.8%	87 / 98	80.8% – 93.8%			
	2011	83.1%	108 / 130	75.6% – 88.6%			
	SED Waiver Youth (Ages 12–17), Youth Responding†						
	2017	85.5%	164 / 192	79.8% – 89.9%			
	2016	85.9%	140 / 163	79.7% – 90.5%			
	2015	83.0%	124 / 149	76.1% – 88.2%			
	2014	84.1%	158 / 187	78.1% – 88.7%			
	2013	79.6%	176 / 221	73.8% – 84.3%			
	2012	82.4%	112 / 136	75.0% – 87.9%			
	2011	90.1%	109 / 121	83.3% – 94.4%			
As a direct result of the services my child and/or family received, my child is better at handling daily life.	**Youth (Ages 0–17), Family Responding^**						
	2018	79.6%	314 / 396	75.3% – 83.2%			
	2017	82.9%	397 / 478	79.3% – 86.0%			
	2016	77.8%	252 / 324	72.9% – 82.0%			
	2015	82.0%	265 / 323	77.4% – 85.8%			
	2014	79.6%	606 / 764	76.6% – 82.3%			
	2013	82.1%	772 / 948	79.5% – 84.4%			
	2012	81.0%	205 / 253	75.7% – 85.4%			
	2011	79.4%	258 / 325	74.6% – 83.4%			
	SED Waiver Youth and Young Adults, Family/Member Responding†						
	2017	74.0%	294 / 397	69.5% – 78.1%			
	2016	75.9%	243 / 323	70.9% – 80.2%			
	2015	71.5%	233 / 326	66.4% – 76.1%			
	2014	72.0%	297 / 407	67.4% – 76.1%			
	2013	74.4%	355 / 477	70.3% – 78.1%			
	2012	75.6%	241 / 319	70.6% – 80.0%			
	2011	79.2%	227 / 286	74.2% – 83.5%			
My mental health providers helped me obtain information I needed so that I could take charge of managing my illness.	**Adults (Age 18+)^**						
	2018	87.0%	269 / 310	82.8% – 90.3%			
	2017	86.7%	328 / 378	82.9% – 89.8%			
	2016	82.7%	230 / 278	77.8% – 86.7%			
	2015	86.3%	315 / 365	82.4% – 89.5%			
	2014	86.8%	675 / 778	84.2% – 89.0%			
	2013	87.6%	891/1,020	85.4% – 89.4%			
	2012	81.6%	213 / 261	76.4% – 85.9%			
	2011	89.3%	258 / 289	85.1% – 92.4%			

* 5-Year/7-Year trend is 2011 to 2017 and 6-Year/8-Year trend is 2011 to 2018

^ Adults (Age 18+) and Youth (Ages 0–17), Family Responding, subgroups were assessed 2011–2018

† General Youth (Ages 12–17), Youth Responding; SED Waiver Youth (Ages 12–17), Youth Responding; and SED Waiver Youth and Young Adult, Family/Member Responding subgroups were assessed 2011–2017.

Table 26. Mental Health Survey – Quality-Related Questions (Continued)

	Year	Rate (0% – 100%)	Numerator/ Denominator	95% Confidence Interval	Comparison of Most Current Year to Baseline and Pre-KanCare	Trend 5/6-Year*	Trend 7/8-Year*
As a direct result of the services my child and/or family (I) received, my child is (I am) better able to do things he or she wants (I want) to do.							
	Adults (Age 18+)^						
	2018	80.6%	251 / 312	75.9% – 84.6%			
	2017	77.1%	294 / 381	72.6% – 81.1%			
	2016	69.3%	195 / 280	63.6% – 74.4%			
	2015	78.9%	290 / 368	74.4% – 82.8%			
	2014	74.3%	581 / 782	71.1% – 77.3%			
	2013	77.7%	786/1,012	75.0% – 80.2%			
	2012	70.1%	185 / 264	64.3% – 75.3%	<.01 +		
	2011	82.4%	238 / 289	77.5% – 86.3%			
	Youth (Ages 0–17), Family Responding^						
	2018	80.0%	310 / 388	75.7% – 83.7%			
	2017	82.9%	393 / 474	79.2% – 86.0%			
	2016	80.7%	255 / 317	76.0% – 84.7%			
	2015	84.5%	268 / 317	80.1% – 88.1%			
	2014	80.7%	606 / 751	77.8% – 83.4%			
	2013	84.3%	780 / 930	81.8% – 86.5%			
	2012	85.0%	215 / 253	80.0% – 88.9%			
	2011	84.1%	264 / 314	79.6% – 87.7%			
	SED Waiver Youth and Young Adults, Family/Member Responding†						
	2017	73.4%	290 / 395	68.8% – 77.5%			
	2016	73.5%	231 / 316	68.3% – 78.1%			
	2015	69.9%	227 / 324	64.7% – 74.7%			
	2014	71.1%	290 / 405	66.6% – 75.3%			
	2013	73.5%	349 / 475	69.4% – 77.3%			
	2012	72.3%	229 / 317	67.1% – 76.9%			
	2011	76.5%	210 / 275	71.1% – 81.1%			
I felt comfortable asking questions about my treatment and medication.							
	Adults (Age 18+)^						
	2018	89.8%	294 / 328	86.0% – 92.6%			
	2017	91.2%	360 / 395	87.9% – 93.6%			
	2016	85.9%	245 / 285	81.3% – 89.5%			
	2015	94.5%	358 / 379	91.7% – 96.4%			
	2014	90.7%	733 / 808	88.5% – 92.5%			
	2013	91.1%	959/1,052	89.2% – 92.7%			
	2012	87.5%	244 / 279	83.0% – 90.9%			
	2011	93.6%	278 / 297	90.2% – 95.9%			
I have people I am comfortable talking with about my child's problems.							
	Youth (Ages 0–17), Family Responding^						
	2018	91.9%	374 / 407	88.8% – 94.2%			
	2017	91.6%	431 / 470	88.8% – 93.8%			
	2016	91.5%	289 / 316	87.9% – 94.2%			
	2015	92.5%	300 / 324	89.0% – 94.9%			
	2014	90.4%	688 / 761	88.1% – 92.3%			
	2013	91.6%	871 / 954	89.7% – 93.2%			
	2012	93.1%	244 / 262	89.3% – 95.7%			
	2011	92.6%	301 / 325	89.2% – 95.0%			
	SED Waiver Youth and Young Adults, Family/Member Responding†						
	2017	89.0%	360 / 404	85.6% – 91.7%			
	2016	89.9%	289 / 322	86.1% – 92.8%			
	2015	87.7%	288 / 328	83.7% – 90.9%			
	2014	88.0%	366 / 417	84.5% – 90.8%			
	2013	89.1%	423 / 475	85.9% – 91.6%			
	2012	87.5%	281 / 321	83.4% – 90.7%			
	2011	89.4%	254 / 284	85.3% – 92.5%			

* 5-Year/7-Year trend is 2011 to 2017 and 6-Year/8-Year trend is 2011 to 2018
^ Adults (Age 18+) and Youth (Ages 0–17), Family Responding, subgroups were assessed 2011–2018
† General Youth (Ages 12–17), Youth Responding; SED Waiver Youth (Ages 12–17), Youth Responding; and SED Waiver Youth and Young Adult, Family/Member Responding subgroups were assessed 2011–2017.

If given other choices, the member would still get services from their most recent mental health provider.
For Adult members, the rates maintained throughout the six-year period, ranging from 86.1% (2018) to 89.4% (2014).

Received help from provider in obtaining information to assist in managing their health.
For Adult members, the rates maintained throughout the six-year period, ranging from 82.7% (2016) to 87.0% (2018).

Member choice of treatment goals.
From 2011 to 2018, of Adult members who had a lower positive response percentage than the Youth (ages 0–17), family responding subgroup. Youth (ages 0–17), family responding (2011 to 2018) and SED Waiver Youth and Young Adults (2011 to 2017) positive responses have been 90% or above each year. For General Youth (ages 12–17), youth responding positive responses significantly increased in 2017 to 90.5% from 81.6% in 2012 (p=.03). For SED Waiver youth (ages 12–17), youth responding, from 2011 to 2017, a statistically significant increasing trend was seen in the percentages (p=.01).

Comfort in asking questions about treatment, medication, and/or children's problems.
For Adult members, there was greater than 90% positive response in five of the eight years. For Youth (ages 0–17), family responding, rates have consistently been greater than 90% since 2011. For SED Waiver Youth and Young Adults, rates were generally comparable over the 7-year period, ranging from 87.5% in 2012 to 89.9% in 2016.

Understandable communication from provider with member
Adults; General Youth (ages 12–17), youth responding; SED Waiver Youth (ages 12–17), youth responding; Youth (ages 0–17), family responding; and SED Waiver Youth and Young Adults positive responses have been 90% or above during the evaluation period, with no statistically significant differences from the current year to baseline. For SED Waiver Youth (ages 12–17), youth responding, from 2011 to 2017, a statistically significant increasing trend was seen in the percentages (p=.03).

Better control of daily life due to services provided.
The rates for SED Waiver Youth and Young Adults, family/member responding, have been lower and ranged from 71.5% in 2015 to 79.2% in 2011. The rates for Adults, General Youth (ages 12–17), youth responding, SED Waiver Youth (ages 12–17), youth responding, and Youth (ages 0–17), family responding ranged from 74.8% in 2016 to 90.1% in 2011.

Better ability to deal with crisis, as a direct result of services provided.
For Adult members, rates have been relatively low, ranging from 69.2% (2016) to 80.4% (2011).

Better able to do things the member wants to do, as a direct result of services provided.
Adult member positive responses significantly increased in 2018 to 80.6% from 70.1% in 2012 (p<.01). For Youth (ages 0–17), family responding, positive responses have maintained throughout the six-year period, ranging from 80.0% in 2018 to 84.5% in 2015. Rates for SED Waiver Youth and Young Adults have been relatively low, ranging from 69.9% in 2015 to 76.5% in 2011.

Member Perceptions of SUD Services: Quality of Care Measures are based on questions in the SUD Survey

Evaluation Summary

The member perceptions of the of SUD services were assessed by three measures based on the SUD Survey questions. The SUD surveys were conducted by the MCOs on an annual basis from 2014 through 2017.

All three measures related to the members' perceptions with regard to the rating of the quality of the service received from the counselor, rating of the counselor for involving members in decisions about their care, and whether they are feeling better since beginning treatment, consistently showed high rates through the four-year period indicating high satisfaction with SUD services provided to them through the KanCare program (Figure 41).

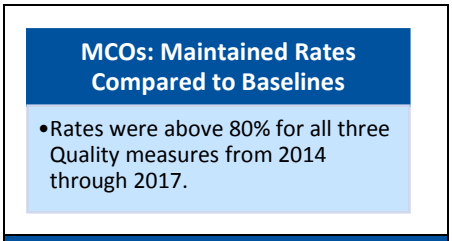

Figure 41. Improvement/Maintained Quality of SUD Services (SUD Member Survey)

- Members rated the quality of services received from their counselor consistently high (>88%) from 2014 through 2017.
- Members highly rated (>87%)their counselors involving them in decisions about their care as very good/good throughout the four-year period.
- Throughout the four years, a high rate of members responded they were feeling much better or better since beginning treatment (>84%).

Evaluation Results for the SUD Services (SUD Survey)

Overall, how would you rate the quality of service you have received from your counselor?
Survey respondents highly rated the quality of service received from their counselor as very good/good throughout the four years, with 2017 being the lowest rate. Quality was rated significantly less in 2017 (88.2%) than in 2014 (94.3%) ($p<.05$).

How would you rate your counselor on involving you in decisions about your care?
In 2017, 87.4% of the members surveyed rated counselor involvement of members in decisions about their care as very good or good. The rates consistently remained high throughout the four-year period (>87%) and there was no statistically significant difference between 2017 and 2014.

Since beginning treatment, in general are you feeling much better, better, about the same, or worse?
In 2017, 84.0% of the members surveyed responded they were feeling much better or better since beginning treatment. The rates consistently remained high throughout the four-year period and there was no statistically significant difference between 2017 and 2014.

9) Provider Survey

Evaluation Summary

The Quality of Care aspect of the Provider Survey subcategory was assessed with one measure. Providers were asked, ***"Please rate your satisfaction with (MCO name's) demonstration of their commitment to high quality of care for their members."*** Results are summarized in Figure 42.

The provider survey data for this measure were available for varying time periods from the MCOs. While each MCO survey included the same question related to quality, differences in the provider population inclusion among the MCOs (general provider and BH provider) impacted the ability to compare between MCOs. Statistical significance testing was appropriate for certain time-periods for individual MCOs.

Amerigroup had a significantly higher rate of providers (General and BH) satisfied with the MCO's commitment to high quality care in 2018 compared to 2014 ($p<.05$). Likewise, they had a significantly lower rate of neutral ($p<.05$) and dissatisfied ($p<.05$) provider responses in 2018 compared to 2014.

Sunflower's rate of General providers satisfied with the MCO's commitment to high quality care was significantly higher in 2017 compared to 2014 ($p<.05$). Likewise, they had a significantly lower rate of General provider dissatisfaction with their commitment to high quality care in 2017 compared to 2014 ($p<.05$), while there was not a significant difference in the neutral responses. There was no statistically significant change in Sunflower's BH provider satisfaction with their commitment to high quality care in 2017 compared to 2015 (this question was not included in the 2014 BH survey).

MCO: Improved Rates Compared to Baselines
• Two of the three MCOs had statistically significant higher rates of providers' perception of their commitment to high quality care. Amerigroup had a significantly higher rate ($p<.05$) of providers (general and BH) being very or somewhat satisfied with the MCO's commitment to high quality of care for their members, in 2018 compared to 2014. Sunflower had a statistically significant improvement ($p<.05$) in general provider satisfaction with the MCO's commitment to high quality care, in 2017 compared to 2014 (unable to compare to 2018).

Figure 42. Improvements in the Rate of Providers "Very" or "Somewhat" Satisfied with the MCO's Commitment to High Quality Care (Provider Survey)

Although Sunflower had significant improvement, only around half of their General providers responded they were satisfied with Sunflower's commitment to high quality care for their members. Less than half of UnitedHealthcare's General providers responded they were satisfied with the MCO's commitment to high quality care, and there was not a significant change in 2017 compared to 2014.

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Evaluation Results for the Provider Survey Measure (Quality)

The results are presented in Table 27.

Amerigroup conducted one annual survey for General and BH providers combined. In 2018, the rate of satisfaction with Amerigroup's commitment to high quality care was significantly higher (p<.05) in 2018 (70.6%) compared to 2014 (50.9%). Correspondingly, there were significantly fewer neutral (p<.05) and dissatisfied (p<.05) providers in 2018 compared to 2014.

In 2018, **Sunflower** changed their methodology to combine the BH and General providers into one survey population. Comparisons to 2018 were not appropriate due to the change in methodology.

General provider satisfaction with Sunflower's commitment to high quality care was significantly higher in 2017 (51.1%) compared to 2014 (37.5%) (p<.05). Likewise, General providers reported significantly less dissatisfaction in 2017 compared to 2014 (p<.05), while the difference in neutral responses was not statistically significant.

UnitedHealthcare conducted an annual survey of General providers and a separate BH provider survey through Optum.

Table 27. Provider Satisfaction with MCO's Commitment to High Quality of Care for their Members, CY2014–CY2018

MCO Provider Survey Type	2014	2015	2016	2017	2018
	Very or Somewhat Satisfied				
Amerigroup*	50.9%	62.8%	60.9%	65.2%	70.6%
Sunflower *(General Provider)*	37.5%	47.1%	50.8%	51.1%	54.6%‡
Cenpatico *(Behavioral Health)*	†	51.6%	48.8%	35.3%	
UnitedHealthcare *(General Provider)*	^	44.7%	40.3%	41.3%	¶
Optum *(Behavioral Health)*	54.7%	59.4%	55.9%	53.2%	49.3%
	Neither Satisfied nor Dissatisfied				
Amerigroup*	30.4%	23.4%	22.8%	23.3%	18.8%
Sunflower *(General Provider)*	45.0%	41.0%	38.9%	39.0%	31.6%‡
Cenpatico *(Behavioral Health)*	†	41.3%	44.2%	44.1%	
UnitedHealthcare *(General Provider)*	^	40.8%	44.4%	38.7%	¶
Optum *(Behavioral Health)*	36.9%	34.7%	35.2%	38.0%	39.2%
	Very or Somewhat Dissatisfied				
Amerigroup*	18.8%	13.8%	16.3%	11.5%	10.6%
Sunflower *(General Provider)*	17.6%	11.9%	10.3%	9.9%	13.8%‡
Cenpatico *(Behavioral Health)*	†	7.2%	7.0%	20.6%	
UnitedHealthcare *(General Provider)*	^	14.5%	15.3%	20.0%	¶
Optum *(Behavioral Health)*	8.4%	5.9%	9.0%	8.9%	11.5%
	Total Responses				
Amerigroup*	283	427	215	365	303
Sunflower *(General Provider)*	251	293	311	182	174‡
Cenpatico *(Behavioral Health)*	†	126	172	34	
UnitedHealthcare *(General Provider)*	^	76	72	75	26
Optum *(Behavioral Health)*	84	101	145	158	148

*Amerigroup included BH Providers in their General Provider Survey.

^UnitedHealthcare results for 2014 cannot be determined due to a typographical error in the survey instrument that included "Somewhat satisfied" twice and excluded "Somewhat dissatisfied."

†Question was not asked in the Cenpatico survey in 2014.

‡Cenpatico BH transitioned to Sunflower; 2018 provider survey included both General and BH providers. Compare with caution due to change in method.

¶Denominator too small to report data.

In 2018, the number of General provider responses was too low to be valid and results from 2014 could not be compared due to a typographical error in the survey instrument. In 2017 compared to 2015,

there were no statistically significant changes for the General provider survey responses (below 50%) or BH provider responses (less than 60%).

10) Grievances

Evaluation Summary

The MCOs report grievances by category through quarterly Grievance and Appeal reports (GAR), as well as in the quarterly STC report through 2016.

Due to MCO inconsistencies and grievance mis-categorizations, as well as the State's report improvements and definition clarifications, baseline to current comparisons are not possible. Generally, around 8% to 15% of grievances appear to be related to quality of care (Figure 43).

Grievance Improvements
• KDHE has focused efforts on improvements in reporting templates, grievance category details, clarifications and training to MCO staff, addressing internal and EQRO reviews/ recommendations to improve reporting consistency.

Figure 43. Improved/Maintained Performance Measures for Grievances (Quality of Care Grievances)

Evaluation Results for Grievances – Quality of Care

KFMC's quarterly KanCare evaluation reports included detailed review of the grievance reports, primarily regarding inconsistencies between MCOs and between reports (GAR and STC), as well as MCO mis-categorization of grievances. The State spent considerable effort addressing inconsistencies between MCOs and between reports since 2013. Reporting requirements and templates have changed, and new grievance categories have been added. The State has clarified category definitions and provided additional training to the MCOs to increase consistency in reporting, primarily categorization of grievance type. Due to the various data discrepancies, comparisons are not possible. However, it generally appears around 8% to 15% of grievances are related to quality of care.

11) Special Study – 2019 Kansas HCBS–CAHPS Survey – Quality

Evaluation Summary

A special study, 2019 Kansas HCBS-CAHPS Survey (optional study) was conducted by KFMC among HCBS waiver recipients across the state of Kansas. At the time of preparation of this evaluation report, the data collection for the survey was completed for 194 respondents (target sample is 400 members). For this report, the preliminary data were reviewed to summarize the preliminary findings from the survey. The assessment of the *Quality of Care* aspect of the beneficiaries' experience receiving their home and community based long-term services and supports was based on three performance measures comprised of multiple questions and respective composite scores.

High percentages for the composite scores for all three performance measures (≥79%) were seen. High percentages for several individual questions related to these three performance measures (≥77%) were seen. Average percentages were seen for few individual questions (between 62% to 75%).

Though preliminary data showed positive results, definite conclusions could not be made at this point.

Preliminary Evaluation Results for the Special Study – 2019 Kansas CAHPS – HCBS Survey

In the fall of 2018, KFMC contracted with Vital Research to conduct the 2019 Kansas HCBS-CAHPS Survey among 400 HCBS waiver recipients across the state of Kansas. At the time of preparation of this report,

the data collection was in progress with completion of interviews with 194 respondents. Preliminary data based on responses from 194 respondents was examined and reported here.

The preliminary data on the following survey questions were examined to assess the *Quality of Care* aspect of the beneficiaries' experience receiving their home and community based long-term services and supports.

- Reliable and helpful staff/homemakers:
  For this measure, the percentages of the positive responses for six individual questions and a composite score based on these six questions were assessed (staff come to work on time; staff work as long as they suppose to; someone inform them if staff cannot come; make sure they have enough privacy dressing, showering or bathing; homemakers come on time; and homemakers work as long as they suppose to).

  The percentages represented the highest positive responses to five questions *("Always")* and "Yes" response to one question.

  High percentages were seen for the composite score and four questions related to the helpfulness of staff/homemaker (≥79%), whereas average percentages were seen for two questions on whether staff or homemakers come to work on time (75% and 62%, respectively).

- Staff/homemakers listen and communicate well:
  For this measure, the percentages of the positive responses for eleven individual questions and a composite score based on these eleven questions were assessed (staff/homemakers treat the individual with respect; staff/homemakers explanation was hard to understand because of their accent/way they speak English; staff/homemakers treat you the way you want them to; staff explain things in a way that is easy to understand; staff/homemakers listen carefully; and staff/homemakers know what kind of help is needed). The percentages represented the highest positive response to nine questions ("Always" for seven; "Never" for two questions) and "Yes" response to two questions.

  High percentages were seen for the composite score and seven questions regarding treatment with respect, communication understandability, understandability of tasks needed (≥77%), whereas average percentages were seen for four questions on whether staff/homemakers listen carefully and whether staff/homemakers treat you the way you wanted them to (69%–75%).

- Personal safety and respect:
  For this measure, the percentages of the positive responses for three individual questions and a composite score based on these three questions were assessed (was there someone to talk to if someone hurt you or did something to you that you didn't like; staff took money or things without asking you first; and staff yelled, swore, or cursed at you). The percentages represented the *"Yes"* response to one question and *"No"* response to two questions.

  High percentages were seen for the composite score and all three questions (≥91%).

Evaluation Category: Coordination of Care (and Integration)

Goals, Performance Objectives, and Hypotheses for Coordination of Care Subcategories:

- **Goal:**
  - Provide integration and coordination of care across the whole spectrum of health to include PH, BH, MH, SUD, and LTSS.
- **Performance Objectives:**
  - Improve coordination and integration of PH care with BH care.
  - Support members successfully in their communities.
- **Hypothesis:**
  - The KanCare model will reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired.

Performance measures related to each of the seven subcategories were evaluated to assess the improvement in the coordination and integration of care received by KanCare program beneficiaries. The evaluation results showed improvement in the coordination (and integration) of care provided to Kansas Medicaid beneficiaries through the KanCare program (Figure 44).

The summaries and detailed results of the evaluation for each of the seven subcategories for *Coordination (& Integration) of Care* are described below:

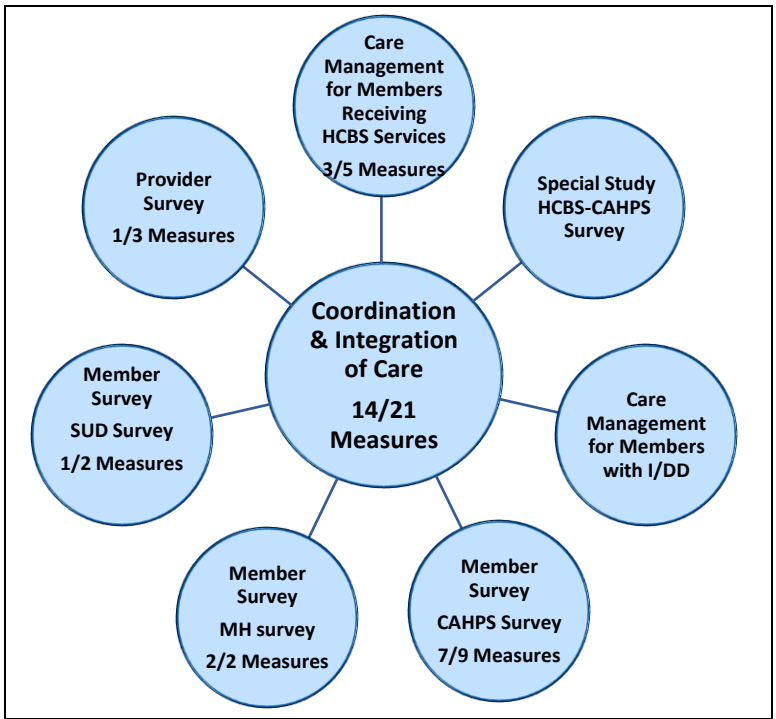

Figure 44. Improved/ Maintained Measures for the Coordination & Integration of Care Subcategories

1) Care Management for Members Receiving HCBS Services

Evaluation Summary

Care management for members receiving HCBS waiver services was assessed by evaluating five PMs (three of the five were HCBS HEDIS-like measures). The results from the final evaluation of these measures are summarized below (Figure 45).

Improved/Maintained Percentages/Rate Over Time	Improved Percentages/Rate Compared to Baseline
•Maintained percentages for two measures in most of the waiver types (for **six out of the seven waiver types for one measure** and for **four out of the seven waiver types** in another measure). •High percentages for two measures in multiple waiver types - **five out of the seven waiver types** in one measure (>88%) and for **two of the seven waiver types** in another measure (>82%). •A high rate for **one out of three** HEDIS-like measures (>91%).	•Higher percentage in the most recent year compared to baseline for two measures in most of the waiver types (for **six out of the seven waiver types** in one measures and for **four out of the seven waiver types** in another measure). •Higher/improved rates in the most recent year compared to the baseline for **all three** HEDIS-like measures.

Figure 45. Improved/Maintained Performance Measures for Case Management for the Members Receiving HCBS Services

- The percentages remained maintained for the following measures throughout the evaluation period:
  - Percent of the HCBS Waiver participants who had assessments completed that included physical, behavioral, and functional components to determine their needs – six out of seven waiver types (I/DD, PD, FE, TBI, TA, and Autism) (2016–2017);
  - Percent of the HCBS Waiver participants with documented change in needs whose service plans were revised, as needed, to address the change – four out of seven waiver types (I/DD, FE, TA, and Autism) (2016–2017);
  - Percent of the HCBS Waiver participants, ages 20 and older, with adults' access to preventive/ambulatory health services (2013–2016);
  - Percent of HCBS Waiver participants, ages 2–20, with an annual dental visit (2013–2016); and
  - Percent of the HCBS Waiver participants, ages 18 and older, with ED visits (2013–2016).
- Improved percentages were seen in the most recent year compared to the baseline for the following measures:
  - Percent of the HCBS Waiver participants who had assessments completed that included physical, behavioral, and functional components to determine their needs – six out of seven waiver types (I/DD, PD, FE, TBI, TA, and Autism) (2016–2017);
  - Percent of the HCBS Waiver participants with documented change in needs whose service plans were revised, as needed, to address the change – four out of seven waiver types (I/DD, FE, TA, and Autism) (2016–2017);
  - Percent of the HCBS Waiver participants, ages 20 and older, with adults' access to preventive/ambulatory health services (2013–2016);
  - Percent of HCBS Waiver participants, ages 2–20, with an annual dental visit (2013–2016); and
  - Percent of the HCBS Waiver participants, ages 18 and older, with ED visits (2013–2016).

- High percentages were seen in the most recent year for the following measures:
  - Percent of HCBS Waiver participants who had assessments completed that included physical, behavioral, and functional components to determine their needs – five out of the seven waiver types (I/DD, PD, FE, TBI, and TA) (>88%);
  - Percent of HCBS Waiver participants with documented change in needs whose service plans were revised, as needed, to address the change – two out of the seven waiver types (TA and SED) (>82%); and
  - Percent of the HCBS Waiver participants, ages 20 and older, with adults' access to preventive/ambulatory health services (>91%).
- Average/low percentages were seen throughout the evaluation period for the following measures:
  - Percent of HCBS Waiver participants who had assessments completed that included physical, behavioral, and functional components to determine their needs – two out of the seven waiver types (SED and Autism);
  - Percent of HCBS Waiver participants with documented change in needs whose service plans were revised, as needed, to address the change – five out of seven waiver types (I/DD, PD, FE, TBI, and Autism); and
  - Percent of HCBS Waiver participants, ages 2–20, with annual dental visits (<54%).

In comparing the two PMs assessed for care management among members receiving HCBS services, the measure "participants with documented change in needs whose service plans were revised, as needed, to address the change" showed more opportunities for future improvements. Five of the waiver types in the most recent year had percentages that were average (I/DD, PD, FE, and TBI) or low (Autism). In comparison, for the measure "participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs," only two waiver types had percentages in the most recent year that were average (SED and Autism).

For the HCBS HEDIS-like measure "adults' access to preventive/ambulatory health services" the percentage of HCBS participants receiving these services during the final evaluation period was high (>91%). However, the percentage was much lower (<52%) for HCBS participants receiving annual dental visits, showing an opportunity for improvement.

Evaluation Results for Performance Measures Related to Coordination of Care

Percent of HCBS Waiver participants with documented change in needs whose service plans were revised, as needed, to address the change

This measure tracked the percentage of the HCBS Waiver participants with documented change in needs whose service plans were revised, as needed, to address the change. These data were collected by the MCOs. The data are presented in Table 28 by seven waiver types. In 2015, as part of remediation efforts, KDADS was in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and was planning to develop a policy to provide clear direction on the plan of care development process (2016 KanCare Evaluation Annual Report). The descriptive data for this measure were assessed for the years 2016 and 2017 for the final evaluation reported here.

Table 28. Percent of HCBS Waiver Participants with Documented Change in Needs Whose Service Plans were Revised, as Needed, to Address the Change, CY2013–CY2017					
Waiver	**2013***	**2014***	**2015***	**2016**	**2017**
Intellectual/Developmental Disability (I/DD) Waiver	97%	23%	28%	28%	60%
Physical Disability (PD) Waiver	75%	39%	53%	65%	62%
Frail Elderly (FE) Waiver	78%	38%	54%	65%	67%
Traumatic Brain Injury (TBI) Waiver	53%	38%	38%	67%	57%
Technical Assistance (TA) Waiver	92%	42%	75%	60%	83%
Serious Emotional Disturbance (SED) Waiver	85%	86%	88%	83%	83%
Autism Waiver	45%	11%	11%	16%	22%
*Compare with caution due to change in methodology.					

In 2017, the percentages of the HCBS Waiver participants whose service plans addressed their assessed needs and capabilities were high for two out of the seven waiver types (>82%), average for four waiver types (<68%), and low (22%) for one wavier type (Autism). The percentages were higher in 2017 compared to 2016 for four of the waiver types (I/DD, FE, TA and Autism). Members receiving services in the PD Waiver and TBI Waiver had lower rates (<63%) in 2017 compared to 2016. For one waiver type (SED), the percentages in 2017 and 2016 were the same.

Percent of HCBS Waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs

This measure tracked the percentage of the HCBS Waiver participants who had assessments completed that included physical, behavioral, and functional components to determine their needs. These data were collected by the MCOs. The data are presented in Table 29 by seven waiver types. In 2015, as part of remediation efforts, KDADS was in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and was planning to develop a policy to provide clear direction on the plan of care development process (2016 KanCare Evaluation Annual Report). The descriptive data for this measure were assessed for the years 2016 and 2017 for the final evaluation reported here.

Table 29. Percent of HCBS Waiver Participants who had Assessments Completed by the MCO that Included Physical, Behavioral, and Functional Components to Determine the Member's Needs, CY2014–CY2017				
Waiver	**2014***	**2015***	**2016**	**2017**
Intellectual/Developmental Disability (I/DD) Waiver	78%	58%	82%	92%
Physical Disability (PD) Waiver	87%	66%	83%	92%
Frail Elderly (FE) Waiver	87%	70%	86%	89%
Traumatic Brain Injury (TBI) Waiver	71%	65%	86%	89%
Technical Assistance (TA) Waiver	95%	75%	87%	95%
Serious Emotional Disturbance (SED) Waiver	92%	54%	71%	68%
Autism Waiver	68%	48%	60%	69%
*Compare with caution due to change in methodology.				

In 2017, the percentages of HCBS Waiver participants who had assessments completed that included physical, behavioral, and functional components to determine their needs were high for five of the seven waiver types (>88%) and average for the other two waiver types (<70%). The percentages were higher in 2017 compared to 2016 for six waiver types, whereas the rate decreased in 2017 compared to 2016 by three percentage points for the members receiving services in the SED Waiver.

HCBS HEDIS-like Measures Related to Coordination of Care

Three HEDIS-like measures were assessed for the evaluation of coordination of care in the HCBS population. These measures included: adults' access to preventive/ambulatory health services; annual dental visits; and ED visits. Data for these measures are presented in Table 30 below.

Table 30. HEDIS-like Measures – HCBS Populations, CY2013–CY2017

	2013	2014	2015	2016	2017*
Adults' Access to Preventive/Ambulatory Health Services	92.0%	93.1%	94.0%	94.1%	95.1%
Annual Dental Visits	49.4%	49.0%	51.6%	51.6%	53.2%
Decrease in Number of Emergency Department Visits^ *(Visits/1000 member months)*	77.58	78.06	79.64	71.55	75.90

*Compare with caution due to change in methodology.
^The goal for this measure is to decrease the rate.

Increase preventive care – Adults' Access to Preventive/Ambulatory Health Services – HEDIS-like Measure

This measure tracked adults' access to preventive/ambulatory health services, ages 20 and older, among the HCBS Waiver population; it was also a P4P measure from 2014–2015. Effective in 2017, members enrolled in both Medicaid and Medicare (dual eligibility) were included in the HCBS population for this measure. Due to this change, data were available for the final evaluation from 2013 through 2016. Descriptive data were used in the assessment of this measure. The rates for this four-year period remained high (>91%) with a 2.1 percentage-point increase in the most recent year compared to the baseline.

Increase in Annual Dental Visits – HEDIS-like Measure

This measure tracked annual dental visits for members ages 2–20, among the HCBS Waiver population; it was also a P4P measure from 2014–2015. Effective in 2017, members enrolled in both Medicaid and Medicare (dual eligibility) were included in the HCBS population for this measure. Due to this change, data were available for the final evaluation from 2013 through 2016. Descriptive data were used in the assessment of this measure. The rates for this four-year period remained low (<54%); however, there was a small percentage-point increase (2.2) in the most recent year compared to the baseline.

Decrease in number of Emergency Department Visits – HEDIS-like Measure

This measure tracked ED visits for members, ages 18 years and older, among the HCBS Waiver population; it was also a P4P measure from 2014–2015. As per HEDIS criteria, this metric is reported as a rate based on visits per 1,000 member-months. Effective in 2017, members enrolled in both Medicaid and Medicare (dual eligibility) were included in the HCBS population for this measure. Due to this change, data were available for the final evaluation from 2013 through 2016. Descriptive data were used in the assessment of this measure. The ED visit rate per 1,000 member-months decreased from the most recent year compared to the baseline.

2) Special Study – 2019 Kansas HCBS-CAHPS Survey – Coordination of Care

Evaluation Summary

A special study, 2019 Kansas HCBS CAHPS Survey (optional study) was conducted among HCBS waiver recipients across the state of Kansas. At the time of preparation of this evaluation report, the data collection for the survey was completed for 194 respondents (target sample is 400 members). For this report, the preliminary data were reviewed to summarize the preliminary findings from the survey. The assessment of the *Coordination of Care* aspect of the beneficiaries' experience receiving their home and community based long-term services and supports was based on five performance measures comprised of multiple questions and respective composite scores.

High percentages for the composite scores were seen for three performance measures (≥76%). High percentages were seen for several individual questions related to these five performance measures (≥76%). Average percentages were seen for two composite scores and a few individual questions (between (39%-64%).

Though preliminary data showed positive results, definite conclusions could not be made at this point.

Preliminary Evaluation Results for the Special Study – 2019 Kansas CAHPS – HCBS Survey

The Special Study – 2019 Kansas CAHPS – HCBS Survey also focused on the *Coordination of Care* aspect of the beneficiaries' experience receiving their home and community based long-term services and supports. Preliminary data based on responses from 194 respondents was examined and reported below for this subcategory.

- Targeted case manager is helpful:
  For this measure, the percentages of the positive responses for three individual questions and a composite score based on these three questions were assessed (could contact the case manager when you needed to; case manager worked with you when you asked for help with getting or fixing equipment; and case manager worked with you when you asked for help with getting other changes to your services). The percentages represented the *"Yes"* response to three questions. The first question in this series established whether follow-up questions were applicable to the respondent or not.

  High percentages were seen for the composite score and three questions related to the helpfulness of the targeted case manager (≥94.4%).

- MCO care coordinator is helpful:
  For this measure, the percentages of the positive responses for three individual questions and a composite score based on these three questions were assessed (could contact the case manager when you needed to; case manager worked with you when you asked for help with getting or fixing equipment; and case manager worked with you when you asked for help with getting other changes to your services). The percentages represented the *"Yes"* response to three questions. The first question in this series established whether follow-up questions were applicable to the respondent or not.

  High percentages were seen for the composite score and three questions related to the helpfulness of the MCO case coordinator (≥76%).

- Choosing the services that matter to you:
  For this measure, the percentages of the positive responses for two individual questions and a composite score based on these two questions were assessed (did your service plan include all the things that are important to you; did you feel staff knew what was on your service plan, including things that are important to you). The percentages represented the *"All the things that are important"* and *"Yes"* responses to these questions.

  A high percentage was seen for the question regarding whether members feel staff knew what was on their service plan, including things that are important to them (87%). An average percentage were seen for the composite score (71%) and one question assessing this performance measure (54%).

- Transportation to medical appointments:
  For this measure, the percentage of the positive responses for three individual questions and a composite score based on these three questions were assessed (ride was available for medical appointments; ride was easy to get in and out of; and ride arrived on time to pick you up). The percentages represented the *"Always"* and *"Yes"* responses to these questions.

  High percentages were seen for the composite score and two questions (≥84%). An average percentage was seen for one question on whether the ride arrived on time to pick you up (71%). It will be important to see the percentage for this question as some doctor's offices cancel the appointment if the patient does not arrive within 15 minutes of the scheduled appointment time. If final results from the survey are similar to the preliminary results, then efforts will be needed to improve this coordination of care aspect.

- Planning your time and activities (social and community integration):
  For this measure, the percentages of the positive responses for six individual questions and a composite score based on these six questions were assessed (ability to get together with family who live nearby; ability to get together with friends who live nearby; ability to do things in the community; have enough help from staff to do things in the community; decided what to do with your time each day; and decided when to do things each day). The percentages represented the *"Always"* and *"Yes"* to these questions.

  High percentages were seen for only two questions (≥93%). Average/low percentages were seen for the composite score (66%) and four questions (39%–64%). If the final results from the survey are similar to the preliminary results, then efforts will be needed to improve the coordination of care/social and community integration aspect for the members.

3) Care Management for Members with Intellectual or Developmental Disability (I/DD)

***Objectives of the Care Management for Members with Intellectual or Developmental Disability (I/DD) Pilot Project, as developed by* the blue-ribbon panel of I/DD stakeholders[10]**

- Relationship building/shared understanding between MCOs and I/DD system
- Defining how services/service delivery will look under KanCare
- Developing/testing billing processes for January 1, 2014 inclusion

Evaluation Summary

While people using I/DD services came into the KanCare program on January 1, 2013 for all non-HCBS services, their long-term services and supports were initially carved out. The State was able to offer a voluntary pilot project for I/DD members and preparation began in July 2012 with KDADS' assembly of the I/DD Advisory Committee. KDADS launched the KanCare Pilot Project for persons with I/DD during the spring of 2013. Over 500 individuals receiving services through the Home and Community Based Services (HCBS) waiver and approximately 25 service providers volunteered to be enrolled in the KanCare I/DD Pilot Project. The primary objective of the I/DD Pilot Project was to prepare the I/DD population being served by the HCBS I/DD Waiver for full inclusion in KanCare by January 1, 2014 (Figure 46).

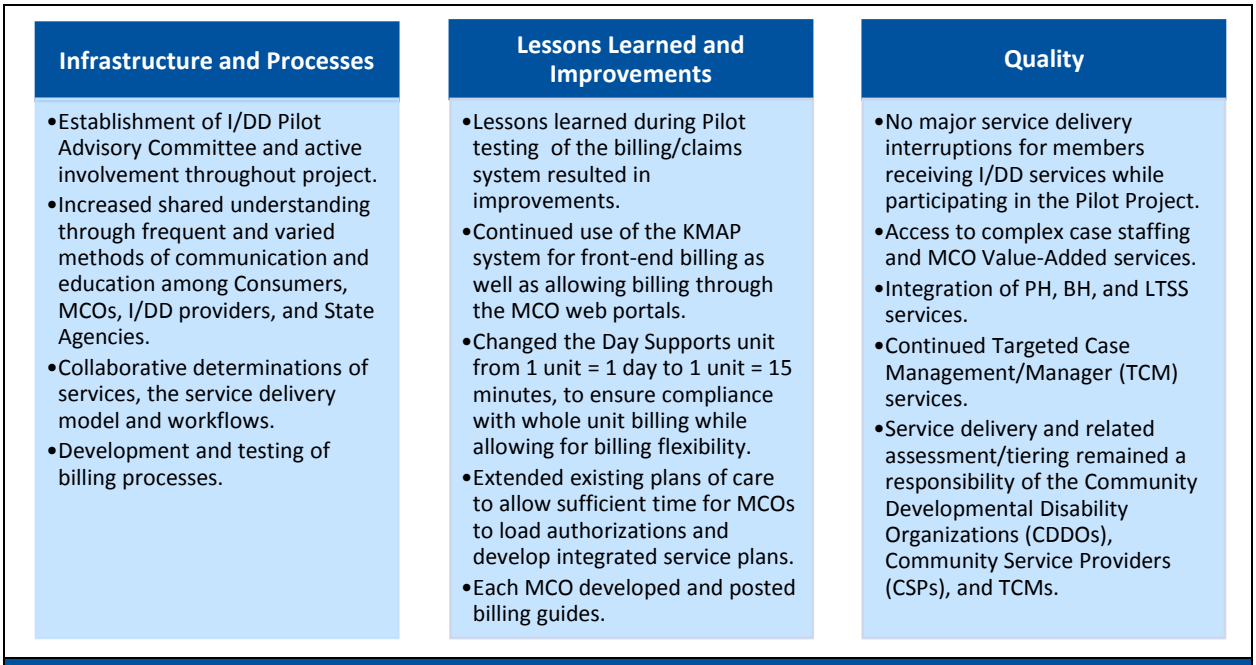

Figure 46. Successes of KanCare I/DD Pilot Project

The I/DD Advisory Committee was an integral partner to the State and MCOs throughout the Pilot timeframe. Members, providers, MCOs and the State had frequent and varied opportunities to engage in shared learning, giving and receiving feedback and information. The I/DD Advisory Committee developed the pilot project objectives and design, which included development of work flows for many current waiver services and TCM system processes such as entrance into and application for I/DD services, the eligibility process, access to supports, extraordinary funding, gatekeeping and appeal processes.

The State noted Pilot members did not experience major service delivery interruptions while in the Pilot Project. They had access to complex case staffing and opportunities to integrate critical physical and BH services with the long-term supports and services on the HCBS-I/DD program. Lessons learned were used to improve the program and billing system.

Evaluation Results for the Care Management Pilot Project for Members with I/DD

The State provided the following information regarding the activities and results of the Pilot in their Annual Report to CMS Regarding Operation of 1115(a) Waiver Demonstration Program – Year Ending 12.31.13. [10]

Relationship building/shared understanding between MCOs and the I/DD system

The following activities occurred to build connections and understanding:

- I/DD Pilot Committee biweekly meetings, which included representatives from targeted case managers, CDDOs, CSPs, and KDADS.
- Twice weekly Provider Lunch and Learn calls; the MCOs answered questions and provided information about billing, person centered planning process, the role of the care coordinator, and communication with providers and CDDOs.
- A weekly call for consumers, guardians, friends and family members with the KanCare Ombudsman and the MCOs provided information and answered questions.
- MCO Care Coordinators met with several I/DD system Targeted Case Managers and discussed the roles of both the Care Coordinators and the TCMs.
- Also, members of the Employment First Work Group met with the MCOs and the Pilot Advisory Committee to discuss challenges related to increasing the numbers of people with disabilities obtaining employment in integrated/competitive work settings.
- The MCOs and Pilot Advisory Committee also met with members of the Challenging Behaviors Work Group to discuss issues related to supporting persons who demonstrate difficult to manage behaviors.
- The State, MCOs and Pilot Advisory Committee held informational meetings in Garden City, Arkansas City/Winfield, Parsons, Great Bend and Lawrence (MCOs, State staff and Advisory Committee hosted) with more than 100 participants, providers and TCMs.
- There was collaborative development of KanCare informational materials for consumers.
- Additional educational sessions were hosted by KDADS, including education from national advocates to State and MCOs about I/DD and managed care. They also hosted a listening information session for stakeholders and Pilot Workgroup members to learn more about I/DD on the national stage and how the system could be improved in Kansas under KanCare.

Define how services/service delivery will look under KanCare

The following are activities and outcomes of the collaborative determinations of the services and service delivery model:

- It was agreed the service delivery and the assessment/tiering for those services would remain a responsibility of the CDDOs, CSPs, and TCMs. Several meetings between the CDDOs and MCOs were instrumental in developing detailed workflows and agreements between the MCO and CDDO related to HCBS-IDD access, communication, and program development after implementation.
- Targeted Case Management services were retained for members receiving I/DD services. As such, the I/DD Pilot reviewed the role and responsibilities of TCM and aligned the definitions and work of the TCM with CMS regulations. Roles of the TCM and Care Coordinator were finalized in the fourth quarter of the Pilot.
- I/DD Waiver recipients in the KanCare I/DD Pilot Project were able to take advantage of the Value-Added Services available through the MCO Health Plans. Limited Care Coordinator interaction with Pilot members occurred at the beginning of the third quarter. Pilot members did not experience major service delivery interruptions while in the Pilot Project, and they had access to complex case staffing and opportunities to integrate LTSS, PH, and BH services.

- The I/DD Pilot Advisory Committee focused efforts on developing the claims/billing system and workflows, including the development and transmission of the plans of care to the MCOs. Workflows included the Person-Centered Planning process and development of the Integrated Service Plan, which was reviewed by CMS.

Develop/Test billing processes for January 1, 2014 inclusion

- Establishing and testing billing processes for I/DD services under KanCare, prior to the January 1, 2014 implementation, was the focus of the Pilot Advisory Committee.
- The I/DD billing system interfaces were tested by having pilot service providers bill and receive payment, for services provided to pilot participants. The Pilot providers could continue to bill as they had through Kansas Medical Assistance Program (KMAP) or, once they had been trained by the MCO, they had the option to bill directly through the MCOs' portals. Provider feedback on the process allowed the MCOs to improve their systems. The State noted testing provided valuable insight into areas for improvement in the technical development of pilot billing/claims system, which included continuing to use the KMAP system for front-end billing as well as allowing billing through the MCO web portals. The four common claims and billing issues identified were missing authorizations, date span billing, third party liability and client obligation.
- Providers received training regarding the process prior to initial claims billing. Development of the billing pilot for I/DD LTSS revealed issues in the fee-for-service system related to partial billing of whole units for Day Supports and Targeted Case Management. Training was conducted with community service providers. The Day Supports unit changed from 1 unit = 1 day to 1 unit = 15 minutes. This change was made to ensure compliance with whole unit billing and continued to allow community service providers the billing flexibility to which they were accustomed. This change was announced on October 15, 2013 and became effective on January 1, 2014.
- The Pilot providers participated in bi-weekly teleconferences with the MCOs to discuss payment and billing related issues for potential resolutions. Each MCO designated one respondent for Pilot providers who generally responded to inquiries within 48 hours and assisted providers in connecting with MCO billing trainings and provider representatives. To minimize billing issues related to plans of care, all plans of care that were in approved status as of December 27, 2013, were extended until March 31, 2014 to ensure the MCOs had sufficient time to load authorizations into their systems and develop integrated service plans for individuals with January, February and March birthdates.
- Approximately $3.9 million dollars were paid on 4,130 of the 5,135 claims that were billed on or before December 31, 2013. MCOs and Providers worked proactively to address billing and claims issues by highlighting key areas of concern and meeting with the MCOs regularly to discuss their concerns. The MCOs hosted several weekly trainings for billing and worked with providers on completing contracting and credentialing to ensure a smooth transition after the continuity of care period ends.
- Each MCO has developed a billing guide to address common billing issues and provide basic billing information. Those documents have been shared with providers on the State websites.
- Communication and training opportunities continued in 2014 to ensure smooth billing.

4) Member Survey – Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Member Perceptions of Care and Treatment in Medicaid and CHIP populations: Measures based on questions in the Child and Adult CAHPS Survey

The measures for this subcategory of *Coordination of Care* were assessed to examine the improvement in member perception of care and treatment of the child and adult population. The evaluation results of these measures are summarized below.

Evaluation Summary

The data for fifteen CAHPS survey questions related to member perception of care and treatment among the child populations were used for the evaluation of this subcategory. Out of these 15 questions, six established whether the specific follow-up question is applicable to the respondent or not. Thus, eight follow-up questions provided the needed information. In addition to these eight questions, one question was also included in the evaluation of this subcategory among the child populations. Similarly, data for fifteen CAHPS survey questions related to the member perception of care and treatment were used for the adult population; three questions provided the information with two follow-up questions based on two specific initial questions, along with a stand-alone question. These data were available for 2014–2018 and are presented in Table 31. The child measures were assessed in both GC and CCC populations.

Most of the measures for the child and adult populations were consistently high throughout the five-year period showing high member satisfaction with the care and treatment aspect of the coordination of care received by KanCare beneficiaries during this evaluation period. Most of these measures were high throughout the period, and statistically significant increasing trends were seen for a few measures. The measures showing statistically significant improvements in the trends over time and in the rates for the most recent year compared to the baseline are summarized in Figure 47.

Improved Trends	Improved Rates Compared to Baseline	NCQA ≥50th Quality Compass Percentile
• Statistically significant improvements in the trends over time for **two out of nine** measures in the GC population, and for **one out of nine** measures in the CCC population. • High rates throughout five-year period for **seven out of nine measures** in both GC and CCC populations. • Though statistically significant trends were not seen, there were high rates throughout the five-year period for **three out of three measures** in the adult population.	• Statistically significant higher rates in the most recent year compared to the baseline for **one measure** in the GC population and for **three measures** for the CCC population. • Rates for **seven measures** among both GC and CCC populations were >81% (**five measures** above 91%) in all five years. • High rates for **all three measures** among the adult population were >80 in all five years.	• the QC ranking was available for the three measures among the GC population, for nine measures among the CCC population, and for three measures among the adult population. The QC ranking ≥50th QC percentile throughout five-year period or for most of the years for **all three measures** among the GC population; for **seven out of nine measures** among the CCC population; and for **all three measures** among the adult population.

Figure 47. Improvements in Performance Measures for Member Perceptions of Care and Treatment (CAHPS Survey)

The following measures showed statistically significant improvement in trends in the five-year period and improved rates in 2018 compared to the baseline among child populations:

- Improved trends over the five-year period in the rates of the member perception of care and treatment measures among child populations:
  - Among the GC population – In the last six months, how often did you get an appointment (for your child) to see a specialist as soon as you needed?
  - Among the GC population – How often was it easy to get the care, tests, or treatment you (your child) needed?
  - Among the CCC population – Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?
- Improved rates for the member perception of care and treatment measures in 2018 compared to the baseline among the child populations:
  - Among the GC and CCC populations – Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?
  - Among the CCC population – Did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?
  - Among the CCC population – Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?

Though, no statistically significant improvement was seen in the trends over the five-year period for most of the measures among child and adult populations, the rates for these measures were consistently high throughout this period. High rates were maintained throughout showing high satisfaction of the members with these aspects. These results indicated high member satisfaction with the coordination (and integration) of care provided to KanCare beneficiaries in this period.

- Measures with high rates during 2014–2018 without showing improvement in trends over time among child populations included:
  - Among the GC and CCC populations, rates were above 80% – How often did your (child's) personal doctor seem informed and up-to-date about the care you (your child) got from these doctors or other health providers?
  - Among the GC and CCC populations, rates were above 91% – Did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?
  - Among the GC and CCC populations, rates were above 91% – Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?
  - Among the GC and CCC populations, rates were above 88% – Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your family's day-to-day life?
  - Among the GC population, rates were above 93% – How often was it easy to get prescription medicines for your child through his or her health plan?
  - Among the CCC population, rates were above 83% – In the last six months, how often did you get an appointment (for your child) to see a specialist as soon as you needed?
  - Among the CCC population, rates were above 91% – How often was it easy to get the care, tests, or treatment you (your child) needed?
- Measures with high rates during 2014–2018 without showing improvement in trends over time among the adult population:
  - Rates were above 82% – How often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

- Rates were above 81% – In the last six months, how often did you get an appointment to see a specialist as soon as you needed?
- Rates were above 87% – How often was it easy to get the care, tests, or treatment you (your child) needed?

The following measure showed average rates throughout the five-year period among both child populations indicating opportunity for improvement in the future:

- Measures showing average rates among both child populations:
  - Rates were between 54.2% and 58.2% throughout the five years – Did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?
  - Rates were between 54.1% and 63.2% throughout the five years – Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?

The overall evaluation of the measures related to the members' perception of the care and treatment, based on the child and adult CAHPS survey questions showed that these measures contributed to the high coordination (and integration) of care provided to KanCare beneficiaries. The evaluation findings also highlighted opportunities for improvement in two aspects of this subcategory among the child population to further strengthen the overall coordination and integration of care provided to the beneficiaries.

Evaluation Results for the Member Perceptions of Care and Treatment (CAHPS Survey)

The *Member Perceptions of Care and Treatment* aspect of the *Member Survey – Coordination of Care* subcategory was assessed by fifteen measures among child members (GC population – TXIX and TXXI), and CCC population – TXIX and TXXI) and by five measures in the adult Medicaid population based on CAHPS Survey questions (Table 31).

A five-year trend for this measure was examined from 2014 through 2018 for three populations. The most recent rates for three populations were compared to baseline rates. The Quality Compass rankings for this measure were also seen.

Table 31. Member Survey – CAHPS Coordination of Care Questions, CY2014–CY2018

Question	Pop	% Positive Responses					Quality Compass ≥50th Percentile^				
		2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
Member Perceptions of Care and Treatment – Child Members (General and CCC Population)											
Did your child get care from more than one kind of health care provider or use more than one kind of health care service?	GC	22.3%	24.5%	21.9%	23.9%	24.6%					
	CCC	46.2%	48.0%	45.3%	47.4%	50.4%					
Did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?	GC	56.7%	56.4%	54.2%	56.7%	55.7%					
	CCC	57.9%	58.2%	57.5%	57.2%	56.9%	↓	↓	↓	↓	↓
Did you need your child's doctors or other health providers to contact a school or daycare center about your child's health or health care?	GC	10.4%	11.2%	10.2%	10.4%	12.1%					
	CCC	16.6%	17.3%	16.7%	17.5%	17.6%					
Did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?	GC	91.1%	92.5%	94.5%	91.4%	92.2%					
	CCC	96.5%	93.1%	94.9%	94.6%	93.2%	↑			↑	↓

^↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile

Table 31. Member Survey – CAHPS Coordination of Care Questions, CY2014–CY2018 (Continued)

Question	Pop	% Positive Responses					Quality Compass ≥50th Percentile^				
		2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
Member Perceptions of Care and Treatment – Child (General and CCC) and Adult Populations											
Does your child have any medical, behavioral, or other health conditions that have lasted more than 3 months?	GC	24.5%	28.6%	26.7%	27.0%	28.8%					
	CCC	77.2%	76.8%	74.8%	74.6%	75.4%					
Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?	GC	92.9%	92.4%	91.6%	92.8%	93.8%					
	CCC	92.3%	92.4%	92.1%	92.3%	94.1%	↓	↓	↓	↓	↑
Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your family's day-to-day life?	GC	92.5%	88.8%	89.6%	91.0%	91.7%					
	CCC	90.3%	89.1%	89.2%	89.6%	90.9%	↑	↓	↓	↑	↑
In the last 6 months, did you get or refill any prescription medicines for your child?	GC	50.8%	53.0%	50.3%	52.6%	52.3%					
	CCC	86.5%	86.0%	84.1%	86.2%	84.8%					
How often was it easy to get prescription medicines for your child through his or her health plan?	GC	95.2%	93.1%	94.4%	93.4%	93.5%					
	CCC	94.7%	93.2%	94.4%	94.6%	93.6%	↑	↑	↑	↑	↑
Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?	GC	56.7%	59.5%	54.1%	60.0%	61.0%					
	CCC	57.6%	59.7%	57.0%	60.4%	63.2%	↓	↑	↓	↑	↑
In the last 6 months…											
Did you (your child) get care from a doctor or other health provider besides your (his or her) personal doctor?	Adult	62.0%	61.4%	60.9%	65.3%	**60.6%**					
	GC	39.5%	44.1%	39.6%	43.3%	**45.8%**					
	CCC	58.3%	60.7%	59.1%	59.3%	**63.3%**					
How often did your (child's) personal doctor seem informed and up-to-date about the care you (your child) got from these doctors or other health providers?	Adult	83.0%	82.7%	85.0%	84.6%	**83.8%**	↑	↑	↑	↑	↑
	GC	81.9%	82.3%	81.5%	84.9%	**81.4%**	↑	↑	↓	↑	↓
	CCC	80.5%	83.3%	80.5%	81.0%	**82.9%**	↓	↑	↓	↓	↓
Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments (for your child) to see a specialist?	Adult	43.0%	46.5%	44.3%	46.8%	**45.3%**					
	GC	17.9%	19.4%	17.9%	19.5%	**21.4%**					
	CCC	38.4%	39.5%	39.8%	40.7%	**43.2%**					
How often did you get an appointment (for your child) to see a specialist as soon as you needed?	Adult	84.8%	81.7%	86.2%	82.9%	**83.1%**	↑	↑	↑	↑	↑
	GC	83.2%	84.6%	79.8%	87.6%	**85.2%**	↑	↑	↓	↑	↑
	CCC	85.3%	83.3%	86.0%	87.0%	**86.2%**	↑	↑	↑	↑	↑
How often was it easy to get the care, tests, or treatment you (your child) needed?	Adult	87.6%	88.1%	87.1%	88.0%	**87.1%**	↑	↑	↑	↑	↑
	GC	93.4%	92.0%	92.1%	93.0%	**93.7%**	↑	↑	↑	↑	↑
	CCC	93.0%	91.9%	92.4%	93.6%	**93.2%**	↑	↑	↑	↑	↑

^↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile

The following five measures were assessed in both child and adult populations.

In the last six months, did you get care from a doctor or other health provider besides your personal doctor?
The measure was tracked for the child (GC and CCC) and adult populations by assessing the percentages of *"Yes" response* to the survey question.

No statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations. The rate for 2018 was significantly higher compared to the baseline rate for both GC and CCC populations (p<.001). The QC rankings for this measure were not provided by the NCQA.

No statistically significant trend was seen in the rates over the five-year period for the adult population. The comparison of 2018 and the baseline rates for adults did not show a statistically significant difference. The QC rankings for this measure were not provided by the NCQA.

Among those who responded ***"Yes"*** to this question, the following question was further assessed:

- **In the last six months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?**
  The measure was tracked for the child (GC and CCC) and adult populations by assessing the percentages of *"Always/Usually" responses* to the survey question.

  Though, no statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations, the rates were considerably high throughout this period (above 80%). The comparison of 2018 and baseline rates for both GC and CCC populations did not show statistically significant differences. The QC rankings among the GC population were below the 50th QC percentile in the most recent year. The QC rankings among the CCC population was below the 50th QC percentile for most of the years in this period.

  Though, no statistically significant trend was seen in the rates over the five-year period for the adult population, the rates were considerably high throughout this period (above 82%). The comparison of 2018 and baseline rates for adults did not show a statistically significant difference. The QC rankings among the adult population were ≥50th QC percentile throughout this period.

In the last six months, did you make any appointments to see a specialist?
The measure was tracked for the child (GC and CCC) and adult populations by assessing the percentages of *"Yes" response* to the survey question.

No statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations. The rate for 2018 was significantly higher compared to the baseline rate for both GC and CCC populations (p<.001). The QC rankings were not provided by the NCQA.

No statistically significant trend was seen in the rates over the five-year period for the adult population. The comparison of 2018 and baseline rates for adults did not show a statistically significant difference. The QC rankings for this measure were not provided by the NCQA.

Among those who responded ***"Yes"*** to this question, the following question was further assessed:

- **In the last six months, how often did you get an appointment (for your child) to see a specialist as soon as you needed?**
  The measure was tracked for the child (GC and CCC) and adult populations by assessing the percentages of *"Always/Usually" responses* to the survey question (Figure 48).

  A statistically significant increasing trend was seen in the rates over the five-year period for the GC population (p<.01). Though, no statistically significant trend was seen in the rates over the five-year period for the CCC population, the rates were considerably high throughout this period (above 83%). The comparison of 2018 and baseline rates for both GC and CCC populations did not show statistically significant differences. The QC rankings among the CCC population were ≥50th QC percentile throughout this period and for most of the years among the GC population.

  No statistically significant trend was seen in the rates over the five-year period for the adult population. The comparison of 2018 and baseline rates for adults did not show a statistically significant difference. The QC rankings among the adult population were ≥50th QC percentile throughout this period.

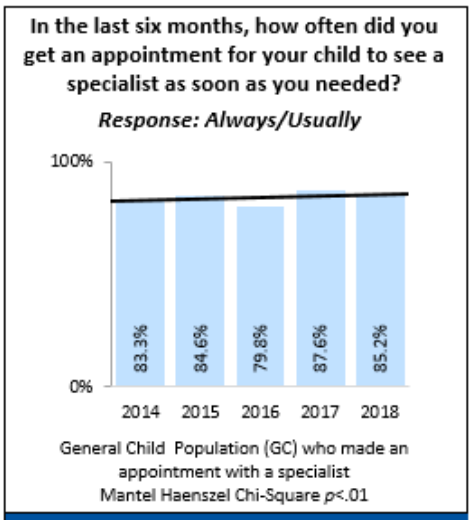

Figure 48. CAHPS GC Question 46, CY2014–CY2018

In the last six months, how often was it easy to get the care, tests, or treatment you needed?

The measure was tracked for the child (GC and CCC) and adult populations by assessing the percentages of *"Always/Usually" responses* to the survey question (Figure 49).

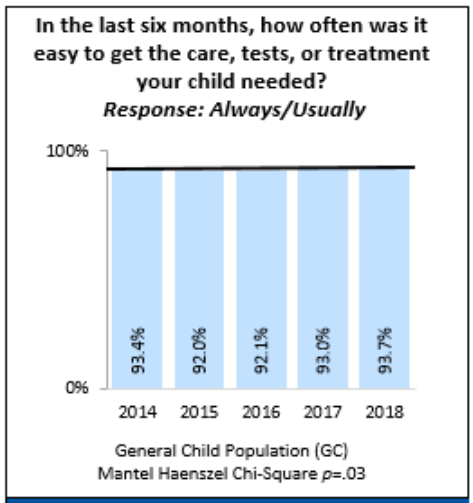

Figure 49. CAHPS GC Question 15, CY2014–CY2018

A statistically significant increasing trend was seen in the rates over the five-year period for the GC population (p=.03). Though, no statistically significant trend was seen in the rates over five-year period for the CCC population, the rates were considerably high throughout this period (above 91%). The comparison of 2018 and baseline rates for both GC and CCC populations did not show statistically significant differences. The QC rankings among both GC and CCC populations were ≥50th QC percentile throughout this period.

No statistically significant trend was seen in the rates over the five-year period for the adult population. The comparison of 2018 and baseline rates for adults did not show a statistically significant difference; however, the rates were considerably high throughout this period (above 87%). The QC rankings among the adult population were ≥50th QC percentile throughout this period.

The following ten measures were assessed in child populations (GC and CCC) only:

***In the last six months,* did your child get care from more than one kind of health care provider or use more than one kind of health care service?**
The measure was tracked for the child (GC and CCC) populations by assessing the percentages of *"Yes" response* to the survey question.

No statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations. The rates for 2018 was significantly higher compared to the baseline rate for both GC and CCC populations (GC: p=.03; CCC: p<.01). The QC rankings were not provided by the NCQA.

Among those who responded ***"Yes"*** to this question, the following question was further assessed:

- **In the last six months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?**
  The measure was tracked for the child (GC and CCC) populations by assessing the percentages of *"Yes" responses* to the survey question.

  No statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations. The rates were low throughout this period. The comparison of 2018 and baseline rates for both GC and CCC populations did not show statistically significant differences. The QC rankings among the CCC population were below the 50th QC percentile throughout this period (not available for the GC population).

In the last six months, did you need your child's doctors or other health providers to contact a school or daycare center about your child's health or health care?
The measure was tracked for the child (GC and CCC) populations by assessing the percentages of *"Yes" responses* to the survey question.

No statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations. The comparison of 2018 and baseline rates for both GC and CCC populations did not show statistically significant differences. The QC rankings were not provided by the NCQA.

Among those who responded ***"Yes"*** to this question, the following question was further assessed:

- **In the last six months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?**
  The measure was tracked for the child (GC and CCC) populations by assessing the percentages of *"Yes" responses* to the survey question.

  Though, no statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations, the rates were considerably high throughout this period (above 91%). The rate for 2018 was significantly higher compared to the baseline rate for the CCC population (p=.04). The comparison of 2018 and baseline rates for the GC population did not show a statistically significant difference. The QC ranking among the CCC population was below the 50th QC percentile in the most recent year.

Does your child have any medical, behavioral, or other health conditions that have lasted more than 3 months?
The measure was tracked for the child (GC and CCC) populations by assessing the percentages of *"Yes" responses* to the survey question.

No statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations. The rate for 2018 was significantly higher compared to the baseline rate for the GC population ($p<.001$), whereas no statistically significant difference was seen for the CCC population. The QC rankings were not provided by the NCQA.

Among those who responded ***"Yes"*** to this question, the following two questions were further assessed:

- **Does your child's personal doctor understand how these medical, behavioral or other health conditions affect your child's day-to-day life?**
  The measure was tracked for the child (GC and CCC) populations by assessing the percentages of *"Yes" responses* to the survey question.

  Though, no statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations, the rates were considerably higher in both populations throughout this period (above 90%). The rate for 2018 was significantly higher compared to the baseline rate for the CCC population ($p=.03$), whereas no statistically significant difference was seen for the GC population. The QC ranking among the CCC population was ≥50th QC percentile in the most recent year.

- **Does your child's personal doctor understand how your child's medical, behavioral or other health conditions affect your family's day-to-day life?**
  The measure was tracked for the child (GC and CCC) populations by assessing the percentages of *"Yes" responses* to the survey question.

  Though, no statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations, the rates were considerably higher in both populations throughout this period (above 88%). The comparison of 2018 and baseline rates for the GC and CCC populations did not show statistically significant differences. The QC ranking among the CCC population was ≥50th QC percentile in the most recent years.

In the last six months, did you get or refill any prescription medicines for your child?
The measure was tracked for the child (GC and CCC) populations by assessing the percentages of *"Yes" responses* to the survey question.

No statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations. The comparison of 2018 and baseline rates for the GC and CCC populations did not show statistically significant differences. The QC rankings were not provided by the NCQA.

Among those who responded ***"Yes"*** to this question, the following two questions were further assessed:

- **Was it easy to get prescription medicines for your child through his or her health plan?**
  The measure was tracked for the child (GC and CCC) and adult populations by assessing the percentages of *"Always/Usually" responses* to the survey question.

  Though, no statistically significant trend was seen in the rates over five-year period for both GC and CCC populations, the rates were considerably higher in both populations throughout this period (above 93%). The rate for 2018 was significantly lower compared to the baseline rate for the GC population ($p=.03$), where no statistically significant difference was seen for the CCC population. The QC ranking among the CCC population was ≥50th QC percentile throughout five-year period.

- **Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?**
  The measure was tracked for the child (GC and CCC) populations by assessing the percentages of *"Yes" responses* to the survey question (Figure 50).

  A statistically significant increasing trend was seen in the rates over the five-year period for the CCC population (p<.001). No statistically significant trend was seen in the rates over five-year period for the GC population. The rate for 2018 was significantly higher compared to the baseline rate for both GC and CCC populations (GC population: p=.01; CCC population: p<.001). The QC ranking among the CCC population was ≥50th QC percentile in the most recent years.

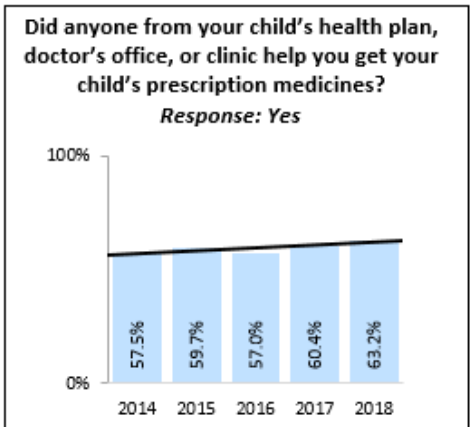

Figure 50. CAHPS CCC Question 57, CY2014–CY2018

5) Member Survey - Mental Health (MH)

The MH Surveys conducted from 2011 through 2018 are described in the evaluation category "Quality of Care," subsection 8 "Member Survey – Quality of Care" performance measure "Member Perceptions of Mental Health Provider Treatment."

Member Perception of Care Coordination: Measures based on questions in the MH Survey

Evaluation Summary

The 2011–2018 data for two MH survey measures related to perception of Care Coordination for members receiving mental services among the Adult, Youth, and SED Waiver youth and young adult populations are presented in Table 32. Member perceptions of care coordination are based on responses to MH surveys conducted from 2011 to 2018.

The General Youth and SED Waiver Youth (ages 12–17), youth responding; and SED Waiver Youth and Young Adults, family/member responding subgroups were assessed 2011 through 2017 and the Youth (ages 0–17), family responding, and Adult subgroups were assessed 2011 through 2018 (at the State's request).

The measures showing statistically significant improvements in the trends over time and in the rates for the most recent year compared to the baseline are summarized in Figure 51.

Improved Trends	Improved Rates Compared to Baseline
•Statistically significant improvement in the trends over time (2011 to 2017) and (2013 to 2017) for **one out of two measures** in the SED Waiver Youth (ages 12–17), youth responding, survey subgroups.	•2018 rates for **one out of two measures** were improved compared to the baseline rate among the SED Waiver Youth (ages 12–17), youth responding, and SED Waiver Youth and Young Adults, family/member responding, survey subgroups and were ≥79.3%.

Figure 51. Improved/Maintained Performance Measures for Perception of Care Coordination for Members Receiving Mental Health Services (MH Survey)

One measure that included the Adult; General Youth (ages 12–17), youth responding; and Youth (ages 0–17), family responding, survey subgroup populations, were

consistently maintained in the range of 79.7%–87.5% throughout the seven-year and eight-year period showing their contribution to the coordination of care received by the KanCare beneficiaries during this period.

The following measure showed a statistically significant improvement in the trend over the seven-year period and a significantly improved rate in 2018 compared to 2013:

- SED Waiver Youth (ages 12–17), youth responding – I was able to get all the services I thought I needed.

The following measure showed a statistically significant decrease and subsequent increase when comparing the most recent year to the baseline (2011 and 2012, respectively):

- Adults – I was able to get all the services I thought I needed.

The following measure showed consistently maintained rates over the evaluation period without statistically significant improvement:

- Youth (ages 0–17), family responding, and General Youth (ages 12–17), youth responding – I was able to get all the services I thought I needed/My family got as much help as we needed for my child.

The following measure showed a statistically significant decreasing trend over the six-year period and a reduction in the 2018 rate when compared to baseline (not statistically significant):

- Adults – I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone lines, etc.).

The following measure showed lower rates over the evaluation period, and the most recent rate was comparable to the baseline but higher:

- Rates were ≤79.3% during the evaluation period – SED Waiver Youth and Young Adults, family/member responding – My family got as much help as we needed for my child.

The two measures related to the members' perception of care coordination showed their contribution to the improved coordination of care for the beneficiaries. However, one measure, within the SED Waiver Youth and Young Adult, family/member responding survey subgroup population, showed opportunities for improvement to strengthen the quality of care provided to the members receiving MH services.

Evaluation Results for the Members Perceptions of Care Coordination: Measures Based on Questions in the MH Survey

The performance measures, yearly rate, and statistical testing for trends overtime and in the most recent year (2017 or 2018) compared to baseline (2011 and 2012) are presented in Table 32.

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Table 32. Mental Health Survey – Questions Related to Coordination of Care

	Year	Rate (0% – 100%)	Numerator/ Denominator	95% Confidence Interval	Comparison of Most Current Year to Baseline and Pre-KanCare	Trend 5/6-Year*	Trend 7/8-Year*
I was able to get all the services I thought I needed.	**Adults (Age 18+)^**						
	2018	85.8%	276 / 322	81.5% – 89.2%			
	2017	83.9%	335 / 399	79.9% – 87.2%			
	2016	80.7%	235 / 290	75.8% – 84.9%			
	2015	84.9%	325 / 383	81.0% – 88.2%			
	2014	86.5%	704 / 814	84.0% – 88.7%			
	2013	86.0%	917/1,066	83.8% – 87.9%			
	2012	78.8%	219 / 278	73.6% – 83.2%	.02 +		
	2011	91.3%	274 / 300	87.6% – 94.1%	.03 -		
	General Youth (Ages 12–17), Youth Responding†						
	2017	84.3%	187 / 222	78.9% – 88.5%			
	2016	83.1%	126 / 152	76.3% – 88.3%			
	2015	87.5%	126 / 144	81.0% – 92.1%			
	2014	83.8%	260 / 309	79.2% – 87.5%			
	2013	82.8%	427 / 518	79.1% – 86.0%			
	2012	85.0%	85 / 100	76.6% – 90.8%			
	2011	85.1%	114 / 134	78.0% – 90.2%			
	SED Waiver Youth (Ages 12–17), Youth Responding†						
	2017	83.0%	160 / 193	77.0% – 87.7%		<.01↑	.03↑
	2016	79.3%	127 / 161	72.3% – 84.9%			
	2015	81.5%	123 / 151	74.6% – 86.9%			
	2014	74.8%	138 / 184	68.0% – 80.5%			
	2013	71.8%	165 / 229	65.7% – 77.2%	<.01↑		
	2012	76.3%	103 / 135	68.4% – 82.7%			
	2011	77.6%	97 / 125	69.5% – 84.1%			
My family got as much help as we needed for my child.	**Youth (Ages 0–17), Family Responding^**						
	2018	82.3%	327 / 398	78.2% – 85.7%			
	2017	83.5%	405 / 485	79.9% – 86.5%			
	2016	82.2%	264 / 320	77.6% – 86.0%			
	2015	86.3%	278 / 322	82.1% – 89.6%			
	2014	79.7%	609 / 766	76.7% – 82.4%			
	2013	83.2%	799 / 966	80.7% – 85.4%			
	2012	82.9%	213 / 257	77.8% – 87.0%			
	2011	84.2%	278 / 330	79.9% – 87.8%			
	SED Waiver Youth and Young Adults, Family/Member Responding†						
	2017	79.3%	319 / 403	75.0% – 83.0%			
	2016	77.6%	253 / 325	72.7% – 81.8%			
	2015	78.9%	260 / 330	74.2% – 83.0%			
	2014	76.4%	318 / 413	72.0% – 80.2%			
	2013	75.2%	363 / 482	71.1% – 78.8%			
	2012	77.3%	248 / 321	72.4% – 81.6%			
	2011	77.4%	220 / 284	72.2% – 81.9%			
I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	**Adults (Age 18+)^**						
	2018	79.1%	227 / 287	74.0% – 83.5%		.04 ↓	
	2017	80.7%	274 / 340	76.2% – 84.6%			
	2016	78.7%	207 / 264	73.3% – 83.2%			
	2015	80.4%	278 / 346	75.9% – 84.3%			
	2014	82.3%	589 / 716	79.4% – 84.9%			
	2013	83.4%	802 / 962	80.9% – 85.6%			
	2012	76.7%	191 / 249	71.1% – 81.5%			
	2011	82.3%	214 / 260	77.2% – 86.5%			

* 5-Year/7-Year trend is 2011 to 2017 and 6-Year/8-Year trend is 2011 to 2018
^ Adults (Age 18+) and Youth (Ages 0–17), Family Responding, subgroups were assessed 2011–2018
† General Youth (Ages 12–17), Youth Responding; SED Waiver Youth (Ages 12–17), Youth Responding; and SED Waiver Youth and Young Adult, Family/Member Responding subgroups were assessed 2011–2017.

Perception that the members were able to access all of the services they thought they needed
Adult members had a significantly higher percentage of positive responses in 2018 (85.8%) than in 2012 (78.8%; *p*=.02) and significantly lower than 2011 (91.3%; *p*=.03). For General Youth, (ages 12–17), youth responding, the 2017 positive response percentage was 84.3%, and over the 7-year period, ranged from 82.8% in 2013 to 87.5% in 2015. For SED Waiver youth (ages 12–17), youth responding, the 2017 rate (83.0%) was the highest rate in the 7-year period and was significantly higher than the rate in 2013 (71.8%, *p*<.01). A 7-year positive increasing trend from 2011 (77.6%) to 2017 (83.0%) and 5-year trend from 2013 (71.8%) to 2017 (83.0%) was significant (*p*=.03 and *p*<.01, respectively). For Youth (ages 0–17), family responding, the rate in 2018 was 82.3% and the rates maintained over the eight-year period. For SED Waiver youth and young adults, the rates maintained over the seven-year period, ranging from 75.2%–78.9%.

I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.)
For Adult members, the rate in 2018 was 79.1%; from 2013 to 2018, a statistically significant decreasing trend was seen in the percentages (*p*=.04).

6) Member Survey – Substance Use Disorder (SUD)

Evaluation Summary

Member perceptions of SUD treatment were assessed for the improvement in Coordination of Care among members using SUD services (Table 33, Figure 52). The measures for this subcategory of *Coordination of Care* were based on the SUD Survey questions related to counselors requesting releases of information.

MCOs: Improved or Maintained Rates Compared to Baselines

- One of two measures improved to greater than 80% in 2015 and was maintained through the most recent evaluation period.

Figure 52. Improveed/Maintained Performance Measures for SUD Care Coordination (SUD Member Survey)

KanCare members receiving SUD services were surveyed each year from 2014–2017. The survey was a convenience survey administered in May through August in 2017 through face-to-face interviews, mail, telephone, and provider-initiated at time of visit/treatment.

SUD counselors increased their requests for members to sign “release of information” forms to allow the counselor to share information with other SUD counselors seen by the member. Results for the SUD question related to Coordination of Care between the SUD counselor and the primary care provider were at or below 70% throughout the four-year evaluation period. Furthermore, only around two-thirds of SUD survey respondents indicated they had a primary care provider. The measures show room for improvement in Coordination of Care.

Evaluation Results for the SUD Services (SUD Survey)

The data for the survey questions are presented in Table 33 below.

Table 33. SUD Survey - Questions Related to Coordination of Care, CY2014–CY2017				
	CY2014	CY2015	CY2016	CY2017
In the last year, have you received services from any other substance use counselor in addition to your current counselor? *(Percentage of "Yes" responses)*	35.7%	34.8%	44.3%	36.7%
If yes to previous question: Has your current counselor asked you to sign a "release of information" form to share details about your visit(s) with the other substance use counselor who you saw? *(Percent of "Yes" responses)*	60.3%	85.1%	82.4%	81.4%
Thinking about the coordination of all your health care, do you have a primary care provider or medical doctor?* *(Percentage of "Yes" responses)*	64.9%	64.4%	66.4%	65.6%
If yes to previous question: Has your counselor asked you to sign a "release of information" form to allow him/her to discuss your treatment with your primary care provider or medical doctor? *(Percentage of "Yes" responses)*	52.5%	69.8%	70.4%	65.8%
*Denominator for question includes "Don't know/No opinion" responses in addition to "Yes" and "No" responses.				

Around one-third of survey respondents receiving services from an SUD counselor also received SUD services from another counselor. Over 80% of survey respondents receiving services from another SUD counselor reported receiving a request from their counselor to sign a "release of information" form to allow the counselors to share information; this was an improvement from 60% in 2014.

Only around two-thirds of survey respondents reported having a primary care provider or medical doctor. Of those that responded they have a medical provider, 70% or less noted they were asked by their SUD counselor to sign a "release of information" form to allow discussion of the members' treatment between the two providers.

7) Provider Survey

Evaluation Summary

The Coordination of Care aspect of the Provider Survey subcategory was assessed with one measure. Providers were asked to rate their "***satisfaction with obtaining precertification or authorization for their members.***" Results are summarized in Table 34. As previously noted, the provider survey data available for this measure were available for varying time periods by MCO. (Figure 53)

While each MCO survey included the same question related to coordination of care, there were differences in provider population inclusion among the MCOs that impacted the ability to compare between MCOs. Statistical significance testing was appropriate for certain time-periods for individual MCOs.

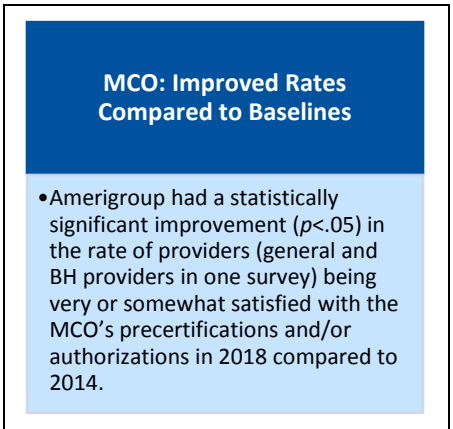

Figure 53. Improvements in the Rate of Providers "Very" or "Somewhat" Satisfied with the MCO's Precertifications or Authorizations for their Members (Provider Survey)

Amerigroup's surveyed providers (General and BH) responded with higher satisfaction regarding the MCO's pre-certifications/authorizations in 2018 compared to 2014 (p<.05). They also responded with fewer neutral (p<.05) and fewer dissatisfied (p<.05) responses in 2018 compared to 2014.

There were no significant differences in General or BH provider satisfaction with Sunflower's or UnitedHealthcare's pre-certifications/authorizations. All General provider satisfaction rates for both MCOs were ≤50% in all measurement years.

Table 34. Provider Satisfaction with Obtaining Precertification and/or Authorization for their Members, CY2014–CY2018

MCO Provider Survey Type	2014	2015	2016	2017	2018
	Very or Somewhat Satisfied				
Amerigroup*	53.3%	61.2%	51.7%	62.5%	65.0%
Sunflower *(General Provider)*	38.2%	39.8%	46.1%	42.5%	50.9%†
Cenpatico *(Behavioral Health)*	63.4%	42.5%	32.3%	57.6%	
UnitedHealthcare *(General Provider)*	^	50.0%	41.7%	44.0%	¶
Optum *(Behavioral Health)*	52.3%	58.4%	51.4%	52.9%	41.9%
	Neither Satisfied nor Dissatisfied				
Amerigroup*	23.9%	18.1%	19.7%	18.4%	16.9%
Sunflower *(General Provider)*	32.8%	36.4%	38.2%	34.1%	28.9%†
Cenpatico *(Behavioral Health)*	26.9%	44.1%	58.7%	36.4%	
UnitedHealthcare *(General Provider)*	^	27.6%	33.3%	26.7%	¶
Optum *(Behavioral Health)*	34.5%	36.6%	39.7%	40.8%	48.6%
	Very or Somewhat Dissatisfied				
Amerigroup*	22.8%	20.7%	28.7%	19.1%	18.1%
Sunflower *(General Provider)*	29.0%	23.8%	15.7%	23.5%	20.2%†
Cenpatico *(Behavioral Health)*	9.6%	13.4%	9.0%	6.1%	
UnitedHealthcare *(General Provider)*	^	22.4%	25.0%	29.3%	¶
Optum *(Behavioral Health)*	13.1%	5.0%	8.9%	6.4%	9.5%
	Total Responses				
Amerigroup*	272	397	178	309	243
Sunflower *(General Provider)*	241	269	293	179	173†
Cenpatico *(Behavioral Health)*	52	127	167	33	
UnitedHealthcare *(General Provider)*	66	76	72	75	26
Optum *(Behavioral Health)*	84	101	146	157	148

*Amerigroup included BH Providers in their General Provider Survey
^UnitedHealthcare results for 2014 cannot be determined due to a typographical error in the survey instrument that included "Somewhat satisfied" twice and excluded "Somewhat dissatisfied."
† Cenpatico BH transitioned to Sunflower; 2018 provider survey included both General and BH providers. Compare with caution due to change in method.
¶ Denominator too small to report data.

Evaluation Results for the Provider Survey Measures (Pre-certifications/Authorizations)

Amerigroup

In 2018, 65.0% of surveyed providers reported they were very or somewhat satisfied with Amerigroup precertification and/or authorization, which was significantly higher than 2014 (p<.05). Correspondingly, there were significantly less neutral (p<.05) and dissatisfied (p<.05) responses in 2018 compared to 2014.

Sunflower

There were no statistically significant differences in rates of General or BH provider satisfaction/dissatisfaction or neutral responses regarding Sunflower's precertification and/or authorization in 2017 compared to 2014.

UnitedHealthcare

There were no statistically significant changes for the General provider survey responses (2017 compared to 2015) or BH provider responses (2018 compared to 2014).

Evaluation Category: Cost of Care

Goals, Performance Objectives, and Hypotheses for Coordination of Care Subcategories:

- **Goal:**
  - Control Medicaid costs by emphasizing health, wellness, prevention and early detection, as well as integration and coordination of care.
- **Performance Objectives:**
  - Promote wellness and healthy lifestyles
  - Lower the overall cost of health care.
- **Hypothesis:**
  - By holding MCOs to outcomes and performance measures, and tying measures to meaningful financial incentives, the state will improve health care quality and reduce costs.

Performance measures related to the subcategory were evaluated to assess the impact on the cost of care received by the KanCare program beneficiaries. Results of the overall evaluation for the period of six years are summarized below:

1) Costs

Evaluation Summary

The data for these measures are provided by KDHE. Due to "claims lag," i.e., the time allowed for providers to submit claims and the time allowed for the MCOs to process the claims), complete data was available through 2017. Both PMs showed improvement in an appropriate direction, increased utilization for six services and decreased utilization for three services, as well as an increase in the PMPM service expenditures for the most recent year for four out of the six populations compared to the baseline year.

Use of inpatient services, outpatient non-ED and outpatient ED use was lower in 2017 compared to 2012.

Evaluation Results Comparison of Pre-KanCare and KanCare Service Utilization

Table 35 shows a comparison of the annual number of services used by those eligible for Medicaid services pre-KanCare in 2012 with services used by KanCare members in 2017.

Table 35. Comparison of Pre-KanCare (2012) and KanCare (2017) Service Utilization

Type of Service	% Utilization Difference
Non-Emergency Transportation	61.4%
Home & Community-Based Services	1.1%
Vision	25.3%
Dental	3.6%
Primary Care Physician	3.0%
Inpatient	-18.6%
Outpatient, Non-Emergency Room	-8.0%
Outpatient Emergency Room	-5.8%
Pharmacy	3.0%

Utilization for six of the nine services was higher in 2017 compared to 2012, with transportation and vision services having the largest increase in utilization.

Services with decreased utilization include Inpatient Hospitalization, Non-Emergency Outpatient visits, and Emergency Room Outpatient visits. Decreases in utilization of these services are a positive outcome. In 2017, KDHE reported that, due to increased member months in 2016 from eligibility reconfiguration, utilization services fluctuated in comparison to the 2016 report, but a positive utilization trend continued to improve in comparison to 2012.

Per Member Per Month (PMPM) Average Annual Service Expenditures

The data for this measure was provided by KDHE. PMPM is the annual average monthly cost to provide care. *"Cost to provide care"* is based on encounters, i.e., payments to providers who have submitted claims for services, including FFS claims.

Table 36 shows the PMPM for CY2013 to CY2017 in total and by comparison groups.

Table 36. Per Member Per Month (PMPM) Service Expenditures by Medicaid Eligibility Group, CY2013–CY2017

Comparison Groups	2013	2014	2015	2016	2017
Children & Families	172	187	180	175	192
Waiver Services	1,869	2,053	2,027	2,063	2,078
Long Term Care	2,666	3,106	3,154	3,261	3,466
Aged, Blind, Disabled – SSI & Medically Needy	582	663	666	672	641
Pregnant Women	593	625	580	423	468
Other	505	486	516	471	476
Total	467	488	472	464	498

Due to claims lag, a certain portion of service costs in one year will be reflected in the PMPM the following year. As shown in Table 36, 2013 would appear to have lower PMPM when, in actuality, the differences are likely due to 2013 being the first year of KanCare, and some of the service costs in 2013 were paid in 2014.

In 2018, the following changes were made, by the State, in comparison groups to better reflect level of care by category:

- Members receiving PD or FE waiver services were included in *"Waiver Services"* instead of *"Long Term Care"* and Autism was removed.
- To the group *"Long Term Care,"* residential facilities providing children care for MH was added and PD, FE, and Child Institutions were removed.
- The *"Persons with Disabilities"* group did not change in criteria but was renamed *"Aged, Blind, Disabled – Supplemental Security Income (SSI) and Medically Needy."*
- Due to changes in funding for Refugee services in 2017, and to more accurately present annual changes in PMPM, *"Refugee Services"* were excluded from the *"Other"* category for all five years.

The five comparison population groups in the 2018 PMPM analysis consist of:

- **Children & Families:** Foster Care, Temporary Assistance for Families, Poverty Level Eligible, Medicaid-CHIP program, and CHIP;
- **Waiver Services:** PD, I/DD, FE, SED, TBI, TA, waiver populations;
- **Long Term Care:** NF, intermediate care facility for persons with I/DD, and residential facilities providing children care for MH;
- **Aged, Blind, and Disabled – SSI and Medically Needy**;
- Pregnant Women
- **Other:** Breast/Cervical Cancer and members participating in the WORK and Working Disabled programs.

Evaluation Category: Access to Care

Goals, Performance Objectives, and Hypotheses for Access to Care Subcategories:

- **Goal:**
  - Establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms as well.
- **Performance Objectives:**
  - Measurably improve health outcomes for members.
  - Support members successfully in their communities.
  - Promote wellness and healthy lifestyles.
  - Improve coordination and integration of PH care with BH care.
  - Lower the overall cost of health care.
- **Hypothesis:**
  - The state will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between PH, BH, MH, SUD, and LTSS.

Performance measures related to each of the six subcategories were evaluated to assess the improvement in the access to care among KanCare program beneficiaries. The evaluation results showed improvement in access to care among KanCare program beneficiaries over the evaluation period (Figure 54).

The summaries and detailed results of the evaluation for each of the seven subcategories for Coordination (& Integration) of Care are described below:

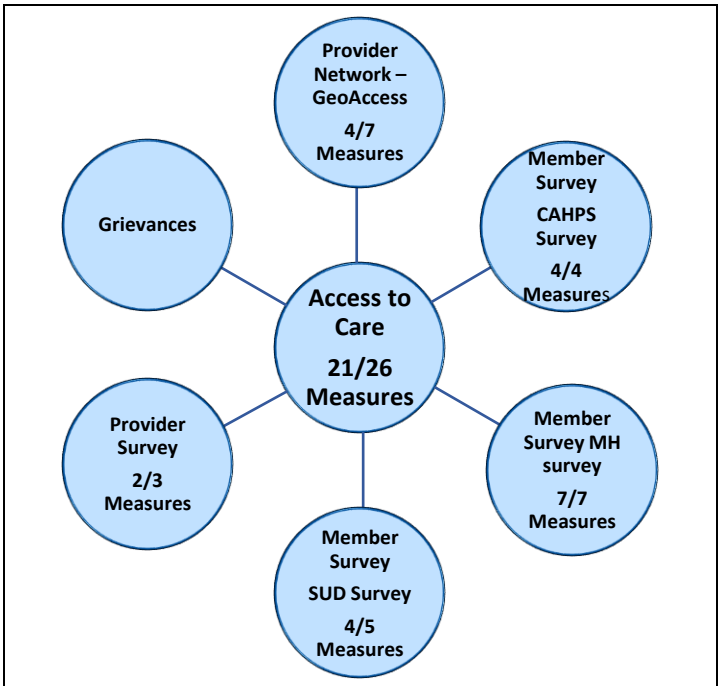

Figure 54. Improved/Maintained Measures for the Access to Care Subcategories

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1) Provider Network – GeoAccess

Evaluation Summary

The data for the seven measures related to Provider Network – GeoAccess were available for varying time periods of the evaluation period (2013–2018, 2013–2017, and 2014–2018). These data were examined to assess improvement in this subcategory of the KanCare *Access to Care*. Several performance measures and components of performance measures had improvement over time and in the most recent year compared to baseline. These results are summarized in Figure 55.

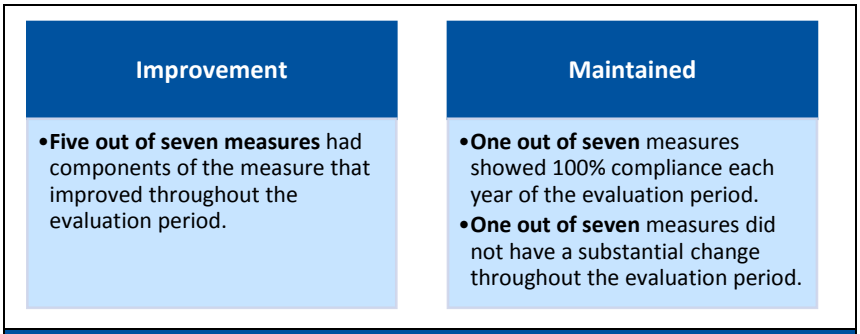

Figure 55. Improved/Maintained Performance Measures for Provider Network – GeoAccess

Most results should be interpreted cautiously due:

- To the changes the State required the MCOs to make in provider network reporting and not knowing at this time what impact it had on that reporting and on GeoAccess reporting.
- MCO and vendor descriptions of the survey sampling, methodology, survey conclusions, and comparisons to prior year survey results raised questions, about the conclusions reached for survey outcomes.

For the performance measures reviewed, the following areas had positive results and/or maintained throughout the evaluation period:

- The BH provider type had 100% access during the evaluation period and 2012 (pre-KanCare) for all of the 105 counties in Kansas.
- There was a 28% average increase in the number of BH providers in 2013 to 2018.
- For all county types, there did not appear to be substantial change overtime for the average distance to the closest BH provider/choice of BH provider.
- Corrections to the Provider Network and GeoAccess reports are beginning to provide more accurate counts for provider specialty availability, which also includes more accurate reporting of open/closed panels for providers.
- Incorrectly included records, duplicate entries, or apparent/presumed duplicate entries in Network Provider reporting, have decreased from 11% (Q4 2017) to 0.25% (Q4 2018).
- The largest increase in both number of providers and provider locations since 2013 were for the provider types PT, Obstetrician/Gynecologist (OB/GYN), Podiatry, and Gastroenterology, and Podiatry had one of the largest increases in number of providers.
- Since 2012, access to provider specialties has improved for members who were residents of any of the Frontier, Rural, and Densely-Settled Rural (Non-Urban) counties.
    - Access to the provider types Allergy, Gastroenterology, Neurosurgery, and Plastic and Reconstructive surgery in Non-Urban counties, have improved with access availability by at least one MCO since 2013.
    - The number of Non-Urban counties that had 0% access from any of the MCOs decreased from 16 provider types in 2012 (pre-KanCare) and 5 provider types in 2013 to 2 provider types in 2017.
- Fifteen of 29 provider types in Urban and Semi-Urban counties and 16 of 29 Non-Urban counties had a decrease in the percent not within access standards.

- All members who were residents of any of the 16 Urban/Semi-Urban counties had access to at least one provider in all provider types in 2012 (pre-KanCare) and since 2013 by at least one MCO.
- When comparing 2013 to 2017, two MCOs had at least two providers in all 105 Kansas counties for most of the HCBS services.
- Of the 14 I/DD provider services, in 2017, most of them had 2 or more providers in ≥100 Kansas counties from all three MCOs.
- For provider after-hours access surveys completed 2013 through 2018, the average rate of compliance was 84.6%.
- Overall, from 2016 to 2018, for the appointment availability access standards reported by all three MCOs, most rates ranged from 74.9%–100%.

From the performance measures reviewed, the following are noted opportunities for improvement:

- The provider type Eye Care – Optometry had one of the largest decreases both in number of providers and provider locations from 2013 to 2018.
- Ophthalmology and X-ray were among the provider types with the greatest decrease in number of providers, and General Surgery and OT were among those with the greatest decrease in provider locations.
- The provider types Neonatology and Nephrology, in 2017, have a higher number of Non-Urban counties with 0% access than in 2013.
- For Non-Urban counties, the most counties without access are for Neonatology, Physical Medicine/Rehab, Plastic Reconstructive Surgery, Gastroenterology, Podiatry, and Pulmonary Disease; for Urban and Semi-Urban counties the most without access are for Plastic & Reconstructive Surgery and Neonatology.
- In the GeoAccess report, there are some instances where it would be appropriate for the member population counts to be more reflective of the members accessing the service (e.g., OB/GYN – include only females and neonatology – infants).
- Information on the counties without access or limited access is not yet reported through GeoAccess mapping, and reports do not yet include names of counties that have less than two providers or no providers available, and do not indicate whether members needing these services are residents of the counties where there are no providers or less than two providers.
- There appears to be a wide gap in reporting of availability of TBI-related services that indicated a potential discrepancy in reporting by the MCOs and/or differences in defining the criteria required for service providers for these specialized services.
- Of the HCBS services, Speech Therapy – Autism Waiver continues to have the least number of counties with at least two providers available.
- For I/DD Provider Services, Supported Employment Services – Had the lowest number of Kansas counties with 2 or more providers in 2017.
- Related to Provider After-Hour Access and Annual Provider Appointment Standards Access:
  - A standardized report template and methodology, and interview tool is needed.
  - Survey questions related to in-office wait times need to be included and reported, and consistency is needed in including survey questions for prenatal care 1st – 3rd trimester and high-risk.
  - MCO and vendor descriptions of the survey sampling, methodology, survey conclusions, and comparisons to prior year survey results raised questions, about the conclusions reached for the survey outcomes.
- For the appointment availability access standards reported by the MCOs (rates are not always reflective of all MCOs, rather may apply to only one MCO):

- Urgent Care – Primary Care Provider/Physician (PCP) decreased to 63% in 2018 from 99% in 2016.
- Urgent Care areas <50% in 2018 included:
  - BH: 33% (new patients) and 38% (established patients)
  - Oncology: 39% for new patients

Throughout the evaluation period, improvement or maintenance was evident in the Provider Network – GeoAccess performance measures or components of the performance measures. The changes the State requested from the MCOs in network reporting are beginning to provide more accurate counts for provider specialty availability, and it is evident improvement has been made and will continue. However, additional and continued improvements could be made to further strengthen access to care provided to the beneficiaries. Thus, the assessment of the seven performance measures indicated that ***access to care regarding the Provider Network – GeoAccess*** has shown improvement over time.

Evaluation Results for the Provider Network – GeoAccess Performance Measures

Percent of Urban/Semi Urban and Densely-Settled Rural, Rural, and Frontier counties covered within access standards, by provider type (physicians, hospital, eye care, dental, ancillary [physical therapy, occupational therapy, x-ray, and lab], and pharmacy)

This measure tracked the percent of Urban and Semi Urban and Densely-Settled Rural, Rural, and Frontier counties covered within the State access standards, by the provider type. Due to issues identified in MCO Provider Network reporting, KDHE provided clear guidelines as to how data should be reported and directed the MCOs to make corrections based on these guidelines. Additional guidance has also been provided to MCO staff related to reporting the numbers and locations of primary care providers (see methodology for more details). Due to corrections that were implemented in the reporting processes, the number of primary care and internal medicine providers and locations were excluded from the KanCare Evaluation reporting in 2017 and 2018.

The State began the process with reviewing the MCOs' Q4 2017 Provider Network Report. In Quarter 4, 2017, KDHE reviewed an average of 68,520 records per MCO and identified 11% (average) were either incorrectly included records, duplicate entries or apparent/presumed duplicate entries. By Q4 2018, KDHE identified an average 0.25% of records reviewed (97,847 average per MCO) had the noted issues.

In addition to the provider record issues, KDHE is working with the MCOs to begin collecting data during provider credentialing/recredentialing for the fields: *"Missing Data," "Inconsistent/Incongruent Data,"* and *"Invalid Data."* Of the three categories, *"Missing Data"* had the highest percentage of records with data issues for the MCOs from Q4 2017 to Q4 2018. The following fields were among those with the highest percentages:

- Special Needs;
- Panel Count (where required);
- Panel Capacity (where required);
- KMAP ID & Service Location;
- Medicaid Member Count;
- Max Medicaid Member Count; and
- PCP.

Table 37, summarizes counts reported in the GeoAccess reports for 2013 compared to 2018.

The provider types with the largest increase in both number of providers and provider locations were PT, OB/GYN, Podiatry, and Gastroenterology. The provider type Eye Care – Optometry had one of the largest decreases both in number of providers and provider locations. Podiatry also had one of the largest increases in number of providers. Ophthalmology and X-ray were among the provider types with the greatest decrease in number of providers, and General Surgery and OT were among those with the greatest decrease in provider locations. However, increase or decrease in number of providers and locations should be interpreted cautiously due to the changes made in provider network reporting and not knowing at this time what impact, if any, this will have on GeoAccess reporting.

Table 37. Providers and Provider Locations by MCO and by Provider Type, CY2018 Compared to CY2013*

Provider Type	Number of Providers/ Number of Locations						Difference from 2013 to 2018		
	AGP		SHP		UHC		AGP	SHP	UHC
	2013	2018	2013	2018	2013	2018			
Physicians									
Allergy	**38** / 26	**69** / **84**	34 / 24	47 / 24	47 / **53**	51 / 27	+31 / +58	+13 / 0	+4 / +26
Cardiology	237 / 110	232 / 130	282 / 127	457 / 165	**360** / **220**	**483** / **201**	-5 / +20	+175 / +38	+123 / -19
Dermatology	36 / 33	**95** / **113**	31 / 19	44 / 28	**66** / **72**	64 / 42	+59 / +80	+13 / +9	-2 / -30
Gastroenterology	99 / 55	**379** / **296**	97 / 61	135 / 63	**128** / **92**	134 / 115	+280 / +241	+38 / +2	+6 / +23
General Surgery	262 / 149	**412** / **265**	267 / 165	363 / 194	**405** / **315**	379 / 182	+150 / +116	+96 / +29	-26 / -133
Hematology/Oncology	181 / 71	186 / 113	108 / 38	141 / 47	**230** / **193**	**271** / **133**	+5 / +42	+33 / +9	+41 / -60
Neonatology	64 / 11	52 / **28**	57 / 14	**77** / 17	**78** / **40**	58 / 18	-12 / +17	+20 / +3	-20 / -22
Nephrology	78 / 36	**115** / **62**	70 / 36	100 / 49	**104** / **64**	101 / 42	+37 / +26	+30 / +13	-3 / -22
Neurology	155 / 88	237 / **153**	201 / 97	296 / 108	**213** / **145**	**304** / 115	+82 / +65	+95 / +11	+91 / -30
Neurosurgery	39 / 34	75 / **50**	60 / 41	**93** / 40	**67** / **49**	79 / 37	+36 / +16	+33 / -1	+12 / -12
OB/GYN	337 / 159	**580** / **403**	326 / 158	455 / 212	**405** / **241**	466 / 205	+243 / +244	+129 / +54	+61 / -36
Ophthalmology	**589** / **184**	**203** / **280**	130 / 147	138 / 163	154 / 161	166 / 101	-386 / +96	+8 / +16	+12 / -60
Orthopedics	180 / 91	**306** / **196**	192 / 101	286 / 123	**287** / **204**	297 / 141	+126 / +105	+94 / +22	+10 / -63
Otolaryngology	84 / 55	**160** / **137**	83 / 52	109 / 51	**90** / **89**	123 / 57	+76 / +82	+26 / -1	+33 / -32
Physical Medicine/Rehab	43 / 34	**84** / **100**	60 / 44	80 / 51	**87** / **104**	**84** / 46	+41 / +66	+20 / +7	-3 / -58
Plastic & Reconstructive Surgery	31 / 21	**105** / **114**	29 / 23	53 / 38	**58** / **45**	52 / 29	+74 / +93	+24 / +15	-6 / -16
Podiatry	27 / 45	**311** / **298**	27 / 30	45 / 45	**71** / **122**	90 / 71	+284 / +253	+18 / +15	+19 / -51
Psychiatrist	303 / 183	**454** / **319**	**385** / 217	318 / 155	335 / **320**	379 / 313	+151 / +136	-67 / -62	+44 / -7
Pulmonary Disease	94 / 55	**190** / **139**	90 / 60	144 / 72	**128** / **92**	153 / 76	+96 / +84	+54 / +12	+25 / -16
Urology	67 / 50	**152** / **161**	80 / 51	99 / 60	**112** / **99**	135 / 62	+85 / +111	+19 / +9	+23 / -37
Total Provider/Provider Locations for Physicians	2,944 / 1,490	4,397 / 3,441	2,609 / 1,505	3,480 / 1,705	3,425 / 2,720	3,869 / 2,013			
Hospital									
Hospitals	**221** / **199**	142 / **185**	151 / 151	**162** / **163**	147 / 147	146 / 183	-79 / -14	+11 / +12	-1 / +36
Eye Care – Optometry									
Eye Care - Optometry	**754** / 408	**505** / **505**	436 / **459**	446 / 406	694 / 427	444 / 351	-249 / +97	+10 / -53	-250 / -76
Dental									
Dental Primary Care	**517** / **309**	431 / 297	399 / **309**	413 / **348**	512 / 290	**438** / 307	-86 / -12	+14 / +39	-74 / +17
Ancillary Services									
Physical Therapy	**473** / **315**	**782** / **479**	396 / 240	689 / 399	346 / 224	452 / 229	+309 / +164	+293 / +159	+106 / +5
Occupational Therapy	**531** / **599**	**555** / **415**	163 / 152	300 / 296	177 / 155	258 / 169	+24 / -184	+137 / +144	+81 / +14
X-ray	253 / 227	**320** / **284**	**380** / 199	165 / 172	151 / 153	26 / 93	+67 / +57	-215 / -27	-125 / -60
Lab	**259** / **239**	**318** / **282**	184 / 200	247 / 246	157 / 166	200 / 238	+59 / +43	+63 / +46	+43 / +72
Total Provider/Provider Locations for Ancillary Services	1,516 / 1,380	1,975 / 1,460	1,123 / 791	1,401 / 1,113	831 / 698	936 / 729			
Pharmacy									
Retail Pharmacy	**657** / 652	642 / 639	578 / **809**	**747** / **731**	570 / 593	657 / 651	-15 / -13	+169 / -78	+87 / +58

The numbers in **bold** represent the highest number of providers and locations reported.
*Excluding Primary Care and Internal Medicine Providers due to reporting process revisions and updates that were implemented in 2018.

The GeoAccess reports include access to services by county and county type, number of members in each county by MCO, and percentage of each county within prescribed mileage ranges, depending on the type of service. Percentages of access in each county are based on the number and location of providers and the number of members in the county. Of the 105 counties in Kansas, 16 are *"Urban"* or *"Semi-Urban"* and 89 are Non-Urban (21 *"Densely-Settled Rural,"* 32 *"Rural,"* and 36 *"Frontier"*).

In 2012 (pre-KanCare) and when comparing 2017 to 2013, all members who were residents of any of the 16 Urban/Semi-Urban counties had access to at least one provider in all provider types (see list of provider types in Table 37).

In 2012 (pre-KanCare), members who were residents of any of the Frontier, Rural, and Densely-Settled Rural (Non-Urban) counties did not have access to 16 provider types from any of the MCOs. The provider types included (number of counties in parenthesis): Dermatology (4), Gastroenterology (12), Neonatology (28), Nephrology (3), Neurology (20), Neurosurgery (36), OB/GYN, (6), Otolaryngology (3), Physical Medicine/Rehab (12), Plastic and Reconstructive Surgery (33), Podiatry (23), Psychiatrist (5), Urology (3), Eye Care – Optometry (7), Dental Primary Care (2), and OT (12).

In 2013 and 2017, 69.3% (261,791 and 273,640, respectively) of KanCare members were residents of Urban and Semi-Urban counties, and 30.7% (116,035 and 119,752, respectively) were residents of Frontier, Rural, or Densely-Settled Rural counties.

Table 38 reports the number of Non-Urban counties where 100% of the members in the county had no access to providers through any KanCare MCO in 2013 and 2017. Furthermore, in 2017, there were a total of 20 provider types where one or two MCOs do not offer access in some Non-Urban counties and 11 provider types in some Urban and Semi-Urban counties. For Non-Urban counties, the most counties without access are for Neonatology, Physical Medicine/Rehab, Plastic Reconstructive Surgery, Gastroenterology, Podiatry, and Pulmonary Disease; for Urban and Semi-Urban the most are for Plastic & Reconstructive Surgery and Neonatology. Since 2013, for Non-Urban counties, access to the provider types Allergy, Gastroenterology, Neurosurgery, and Plastic and Reconstructive surgery have improved with access availability by at least one MCO. In 2017, for Neonatology and Nephrology, there were more counties with no provider access from all three MCOs than in 2013.

Table 38. Non-Urban Counties with no Provider Access by Provider Type, CY2013 and CY2017*

Provider Type	Number of Non-Urban Counties with 0% Access (of 89 Counties)			
	2013		2017*	
	Non-Urban	# Members no Access	Non-Urban	# Members no Access
Physicians				
Allergy	1	753	0	0
Gastroenterology	3	1,314	0	0
Neonatology	7	2,246	13	5,073
Nephrology	0	0	2	562
Neurosurgery	2	561	0	0
Plastic & Reconstructive Surgery	4	1,551	0	0

* Data not available for Amerigroup, as Amerigroup's contract ended December 31, 2018, and the State limited the amount of data they were required to submit.

In 2013 and 2017, KanCare members who were residents of any of the Frontier, Rural, and Densely-Settled Rural (Non-Urban) counties had access to at least one provider for 24 provider types that included: Primary Care Provider, Cardiology, Dermatology, General Surgery, Hematology/Oncology, Internal Medicine, Neurology, OB/GYN, Ophthalmology, Orthopedics, Otolaryngology, Physical

Medicine/Rehab, Podiatry, Psychiatrist, Pulmonary Disease, Urology, Hospitals, Eye Exam – Optometry, Dental Primary Care, PT, OT, X-ray, Lab, and Retail Pharmacy.

In the GeoAccess report, some MCOs report the same number of members in each county as the number of members in their population. There are some instances where it would be appropriate for the member population counts to be more reflective of the members accessing the service (e.g., OB/GYN – include only females and neonatology – infants).

The 2018 corrections to the Provider Network and GeoAccess reports are beginning to provide more accurate counts for provider specialty availability. Since the changes in reporting were made by the State, some specialties have had an increase in the number of counties where there is no access to a provider specialty. However, since 2012, access has improved for members who were residents of Frontier, Rural, and Densely-Settled Rural (Non-Urban) counties.

In Table 39, the percentage of members, by county type, without access to provider types in 2013 and 2017 are listed by provider types. (Not included in the table is the BH provider type that had 100% access, based on distance standards.)

Urban and Semi-Urban

When comparing 2013 to 2017, the following was noted:

- The provider types Lab, X-ray, Optometry, Hospitals, and PT continued to meet the access distance standards.
- Fifteen of 29 provider types, had a decrease in the percent not within access standards. The most notable percentage point decrease was for Plastic and Reconstructive Surgery (13.1).
- The percentages for Dental and Internal Medicine stayed the same.

Table 39. Members not Within Access Distance Standards by Provider Type, CY2013 and CY2017*

Provider Type	% of all Members			
	Urban/ Semi-Urban		Non-Urban	
	2013	2017	2013	2017
Neonatology	19.9%	17.1%	36.8%	18.1%
Plastic/Reconstructive Surgery	23.7%	10.6%	24.0%	12.0%
Physical Medicine	4.6%	5.2%	12.1%	11.1%
Allergy	9.2%	5.4%	15.9%	3.7%
Neurosurgery	12.6%	5.6%	15.6%	2.9%
Podiatry	6.9%	3.9%	16.3%	6.5%
Gastroenterology	6.4%	2.8%	25.7%	8.8%
Dermatology	11.5%	5.3%	7.1%	1.9%
Pulmonary Disease	4.4%	2.2%	2.9%	5.8%
Hematology/Oncology	3.1%	1.7%	6.5%	5.4%
Nephrology	8.1%	3.2%	1.7%	1.9%
Dental	0.2%	0.2%	2.1%	7.1%
Cardiology	2.5%	2.8%	1.3%	0.1%
OB/GYN	2.2%	1.9%	3.1%	1.5%
Psychiatrist	1.2%	1.5%	1.3%	1.7%
Occupational Therapy	0%	0%	3.9%	3.6%
Retail Pharmacy	1.1%	1.4%	0.04%	0.005%
Otolaryngology	2.3%	1.1%	0.6%	0.3%
Lab	0%	0%	0.1%	2.6%
X-ray	0%	0%	0.2%	2.5%
Urology	0.9%	0.3%	1.6%	1.4%
Optometry	0%	0%	1.6%	2.1%
Neurology	0.6%	0.4%	1.6%	1.2%
Hospitals	0%	0%	0.2%	2.0%
Ophthalmology	0.2%	0.7%	0%	0.005%
Orthopedics	0.2%	0.1%	1.4%	0.6%
Physical Therapy	0%	0%	0.1%	0.2%
Primary Care Providers	0.03%	0.01%	0%	1.1%
Internal Medicine	0.1%	0.1%	0%	0%

*2018 data not available for Amerigroup, as Amerigroup's contract ended December 31, 2018, and the State limited the amount of data Amerigroup was required to submit.

- The provider types Physical Medicine, Cardiology, Psychiatrist, Retail Pharmacy, and Ophthalmology slightly increased.

Non-Urban

When comparing 2013 to 2017, the following was noted:

- The provider type Internal Medicine continued to meet the access distance standards.
- For 16 of 29 provider types, the percent not within the access standards decreased. The most notable percentage point decreases were for Neonatology (18.7), Gastroenterology (16.9), Neurosurgery (12.7), and Allergy (12.2).
- The percentage for Internal Medicine stayed the same.
- Eleven of 29 provider types slightly increased.

Average distance to a behavioral health provider for Urban/Semi-Urban, Densely-Settled Rural, and Rural and Frontier counties

This measure tracked average distance access standards for BH providers by county type. The data for the average distance to a BH provider were not available from 2012 (pre-KanCare) and were available for five years of the evaluation period. The average distance to BH providers, by county type, from 2013 to 2017 are described below. While other provider types are reported by Urban/Semi-Urban and by Densely-Settled Rural/Rural/ Frontier, access to BH providers is reported for Densely Settled Rural separately from Rural/Frontier counties. The access standards are one provider within 30 miles for Urban/Semi-Urban counties, 45 miles for Densely-Settled Rural counties, and 60 miles for Rural/Frontier counties. The number of BH providers ranged from an average of 2,481 in 2013 to 3,183 in 2018, a 28% increase.

Figure 56, details for 2013 to 2017, the average distance to BH providers by county type. For the average distance to the closest BH provider/choice of BH provider, for all county types, there did not appear to be a substantial change overtime.

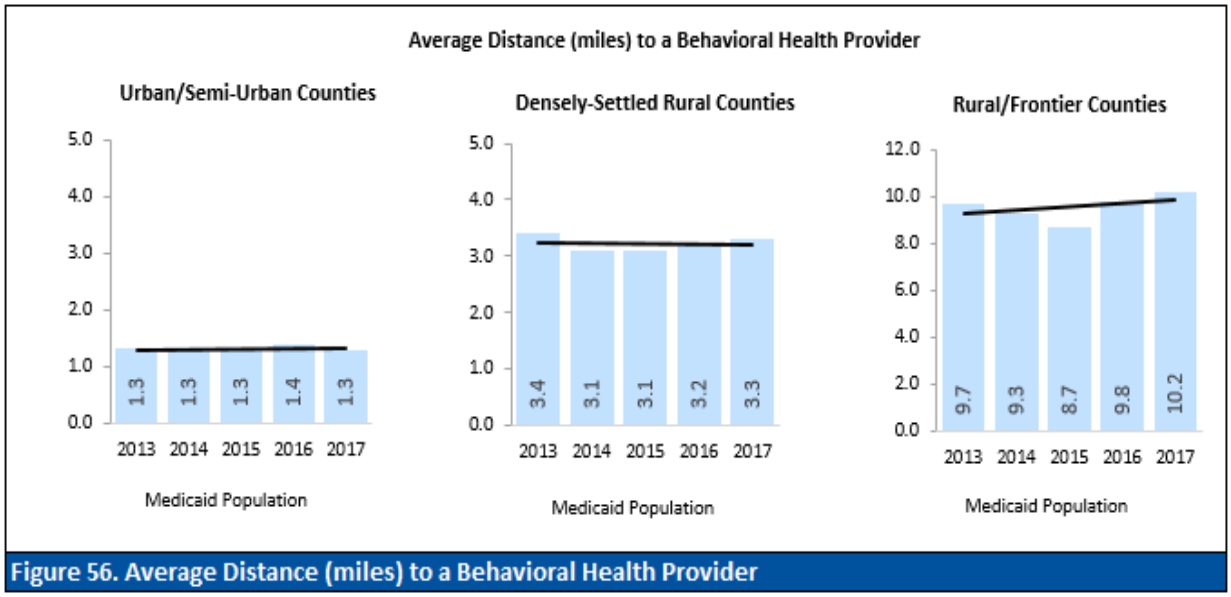

Figure 56. Average Distance (miles) to a Behavioral Health Provider

Percent of Urban/Semi Urban, Densely-Settled Rural, and Rural and Frontier counties covered within access standards for behavioral health

This measure tracked access standards for BH providers by county type. Data were available for five years of the evaluation period. The State access requirements are within 30 miles – Urban/Semi-Urban (16 counties); within 45 miles – Densely-Settled Rural (21 counties); and distance of 60 miles – Rural/Frontier (32 Rural and 36 Frontier counties). For all county types, based on MCO GeoAccess maps and data, these access standards were met each year 2013 to 2017 and 2012 (Pre-KanCare) for 100% of the 105 counties in Kansas.

Home and Community Based Services (HCBS) counties with access to at least two providers, by provider type and services

This measure tracked, for each provider type and service, counties with access to at least two providers for HCBS. The baseline for this measure is 2013 since no comparable pre-KanCare reports of HCBS provider type by county were identified for review. Unmapped provider types (not yet reported through GeoAccess mapping and reports) lack information on the counties without access or limited access and do not yet include names of counties that have less than two providers or no providers available, and do not indicate whether members needing these services are residents of the counties where there are no providers or less than two providers. If this information was provided by each MCO, members, program managers, and reviewers could more easily identify counties where services may be provided by one of the other MCOs, and alternatively whether none of the MCOs have providers in the particular county (and in neighboring counties). The MCO GeoAccess reports provide information on the total number of members in each county; however, the reports do not indicate whether members in sparsely populated counties need the services that are not commonly needed or available. Beginning in the fall of 2018, MCOs were required, by the State, to include in their quarterly Provider Network reports specific counties and HCBS services for which each MCO has contracts in place with specific HCBS providers.

Of the 27 HCBS services detailed in Table 40, five are for TBI Waiver-related services (behavioral, cognitive, occupational, physical, and speech therapy). Each year in the KanCare Evaluation Annual report it was discussed that there was a wide gap in reporting of availability of the TBI-related services that indicated a potential discrepancy in reporting by the MCOs and/or differences in defining the criteria required for service providers for these specialized services. In 2013, Amerigroup and Sunflower reported two or more service providers in all 105 counties and UnitedHealthcare ranged from 1 to 14 counties. Therefore, trending across years 2013 to 2017 was not assessed, and results should be interpreted cautiously. However, for all TBI Waiver services, Amerigroup and Sunflower reported at least 2 providers in all 105 counties in 2014, and in 2017, all services for Amerigroup decreased, with three services by more than half, UnitedHealthcare increased, and Sunflower stayed the same with the exception of Speech Therapy that reduced to 50 from 105. It is not clear if the changes in provider network reporting had an impact on reporting.

For the remaining 22 HCBS services, results should be interpreted cautiously due to the changes made in provider network reporting and not knowing, at this time, what impact it had on reporting. As reported by the MCOs, the following was noted when comparing 2013 to 2017:

- Six HCBS services, each year, have had at least two service providers available in all 105 Kansas counties from the three MCOs:
  - Personal Emergency Response (Installation)
  - Personal Emergency Response (Rental)
  - Personal Services
  - Home Delivered Meals (HDM)
  - Attendant Care Services (Direct)
  - Assistive Services

- Specialized Medical Care/Medical Respite services had at least two service providers available in all 105 Kansas counties from the three MCOs each year except 2014 from one MCO with 90 Kansas counties.
- Eleven HCBS services had a decrease in the number of counties with at least 2 providers by one or more MCO when comparing 2013 to 2017; however, 7 of the services (asterisked below) continued to have at least 2 providers in >100 Kansas counties:
  - Financial Management Services*
  - Long-term Community Care Attendant*
  - Wellness Monitoring*
  - Medication Reminder*
  - Nursing Evaluation Visit*
  - Assistive Technology*
  - Transitional Living Skills*
  - Home Telehealth
  - Comprehensive Support (Direct)
  - Sleep Cycle Support
  - Health Maintenance Monitoring

Table 40. Number of Counties with Access to Home and Community Based Services (HCBS) CY2013 and CY2017*

Provider Type	Two or More Service Providers					
	2013			2017		
	AGP	SHP	UHC	AGP	SHP	UHC
Behavior Therapy – TBI Waiver	105	105	1	100↓	105	54↑
Cognitive Therapy – TBI Waiver	105	105	1	101↓	105	22↑
Occupational Therapy – TBI Waiver	105	105	11	29↓	105	14↑
Physical Therapy – TBI Waiver	105	105	14	16↓	105	30↑
Speech Therapy – TBI Waiver	105	105	7	36↓	50↓	11↑
Personal Emergency Response (Installation)	105	105	105	105	105	105
Personal Emergency Response (Rental)	105	105	105	105	105	105
Personal Services	105	105	105	105	105	105
Home-Delivered Meals (HDM)	105	105	105	105	105	105
Attendant Care Services (Direct)	105	105	105	105	105	105
Specialized Medical Care/Medical Respite	105	105	105	105	105	105
Assistive Services	105	105	105	105	105	105
Home Modification	23	105	105	101↑	105	105
Intermittent Intensive Medical Care	84	78	105	101↑	95↑	105
Adult Day Care	74	47	87	83↑	49↑	44↓
Financial Management Services (FMS)	105	105	105	103↓	105	105
Long-Term Community Care Attendant	105	105	105	103↓	105	105
Wellness Monitoring	105	105	105	105	103↓	105
Medication Reminder	105	105	105	102↓	105	105
Nursing Evaluation Visit	105	105	105	102↓	105	105
Assistive Technology	105	105	105	101↓	105	105
Transitional Living Skills	105	105	105	101↓	105	105
Home Telehealth	105	105	105	89↓	105	105
Comprehensive Support (Direct)	105	105	105	43↓	105	105
Sleep Cycle Support	105	105	105	37↓	105	105
Health Maintenance Monitoring	70	105	105	54↓	96↓	105
Speech Therapy – Autism Waiver	3	13	2	^	12↓	2

*2018 data not available for Amerigroup, as Amerigroup's contract ended December 31, 2018, and the State limited the amount of data Amerigroup was required to submit.

^In 2017, Amerigroup reported "With the implementation of policy E2015-040, developmental speech therapy services are covered under the Medicaid State Plan and not under the Autism Waiver. Per guidance in that policy, providers of developmental speech-language pathology services are not independently enrolled."

↑↓Arrows indicate whether the number of counties with access to the service increased or decreased compared to CY2013.

- Two HCBS services had an increase in the number of counties with at least 2 providers, by one or more MCO, when comparing 2013 to 2017:
  - Intermittent Intensive Medical Care – From 2013, Amerigroup and Sunflower increased by 17 Kansas counties.
  - Home Modification – Amerigroup increased by 78 Kansas counties.
- Adult Day Care – Amerigroup and Sunflower had a slight increase in Kansas counties (9 and 2, respectively) and UnitedHealthcare had a decrease of 43 Kansas counties.
- Of the HCBS services, Speech Therapy – Autism Waiver continues to have the least number of counties with at least two providers available.

I/DD Provider Services

The State expanded I/DD reporting starting in January 2014, upon completion of the I/DD Pilot, to follow the requirements and format of the HCBS report. I/DD provider services are listed in Table 41, comparing 2014 to 2017 In 2013, Sunflower and UnitedHealthcare reported the number of contracted providers for each I/DD specialty and not the provider services by county, as Amerigroup did.

- Six of 14 I/DD services had 2 or more providers in all 105 Kansas counties from 2014–2016 by all three MCOs and in 2017, had two or more providers in ≥100 Kansas counties: Targeted Case Management, Residential Support, Sleep Cycle Support, Personal Assistant Services, Financial Management Services, and Respite Care Overnight.
- Amerigroup improved the number of counties with access for seven services from 2014 to 2017 and 7 services decreased in access. Sunflower improved 5 and 1 service decreased. UnitedHealthcare had a decrease in access for 5 services.

Table 41. Number of Counties with Access to at Least Two I/DD Providers, by MCO, CY2014 and CY2017*

Provider Type	2014			2017		
	AGP	SHP	UHC	AGP	SHP	UHC
Medical Alert Rental	5	54	105	105^↑	105↑	105^
Targeted Case Management	105	105	105	104↓	105	105
Sleep Cycle Support	105	105	105	103↓	105	105
Personal Assistant Services	105	105	105	103↓	105	105
Respite Care (Overnight)	105	105	105	103↓	105	105
Financial Management Services (FMS)	105	105	105	103↓	105	105
Assistive Services	6	90	105	102↑	105↑	105
Specialized Medical Care - LPN	19	93	105	102↑	104↑	105
Residential Support	105	105	105	103↓	105	100↓
Supportive Home Care	57	105	105	103↑	105	81↓
Day Support	105	105	93	103↓	105	59↓
Specialized Medical Care - RN	31	88	105	101↑	104↑	105
Wellness Monitoring	30	101	105	99↑	102↑	62↓
Supported Employment Services	35	105	32	37↑	98↓	24↓

*In 2013, SHP and UHC reported the number of contracted providers for each I/DD specialty and not the provider services by county. 2018 data not available for Amerigroup, as Amerigroup's contract ended December 31, 2018, and the State limited the amount of data Amerigroup was required to submit.

^Provider specialty not specific to I/DD.

↑↓Arrows indicate whether the number of counties with access to the service increased or decreased in 2017 compared to 2014.

- Supported Employment Services – Had the lowest number of Kansas counties with 2 or more providers in 2017.
- For the service Respite Care Overnight, in 2014, all three MCOs had at least 2 providers in all 105 counties and in 2017, that only decreased by 2 counties for one MCO.
- The largest improvement was for Amerigroup, increasing Assistive Services from 6 counties in 2014 to 102 counties in 2017.

Provider Open/Closed Panel Report
This measure is tracked through the quarterly Provider Network report the MCOs submit to the State. The report includes a data field for indicating whether the provider panel is open, closed, or accepting only existing patients. This is primarily populated for PCP types. Due to issues in MCO Provider Network reporting (see methodology for more details), in 2016, the State requested the MCOs update the Provider Network Report to include more thorough reporting of open/closed panels. KDHE provided clear guidelines as to how data should be reported and directed the MCOs to make corrections based on these guidelines. The corrections that have been made are beginning to provide more accurate Provider Network reports.

Provider After-Hours Access (24 hours per day/7 days per week)
This measure tracked after-hours access to a provider (24 hours per day/7 days per week). MCOs are required by the State to ensure 24/7 access is available to members. No tracking report templates, however, are required of the MCOs by the State for tracking this. This is due in part to differing methods and systems used by the MCOs for monitoring provider adherence to these standards; therefore, aggregate results for the evaluation period could not be assessed. Also, in 2014, one MCO changed its method for evaluating after hours coverage compliance.

Methods used to ensure 24/7 access availability to members included surveys (completed by MCO, web-based [primarily by self-report], or vendor), meeting with providers not in compliance, vendor calling a random sample of providers, and "secret shopper" activities. For the surveys KFMC reviewed 2013 through 2018, the average rate of compliance was 84.6%. However, results should be interpreted cautiously due to in 2017 and 2018 review of the MCO and vendor descriptions of the survey sampling, methodology, survey conclusions, and comparisons to prior year survey results raised questions, about the conclusions reached for the survey outcomes. Questions raised among the MCOs reported results included but are not limited to:

- After the survey was conducted, the vendor extrapolated the After-Hours Access survey data to remaining providers who shared the same phone number. The number of providers on which the *"fully compliant"* percentages were based was reported on a different denominator rather than the denominator described as the *"random sample."*
- It is unclear what is meant by "*eligible for survey,"* or *"successfully contacted*" as it would be all providers sampled would be eligible and should be able to be contacted. Further detail is needed to ensure providers were not excluded from the results instead of considered non-compliant.
- It is not clear how the rate of compliance was determined.
- It is unclear what the After-Hours sample size was and how it was selected from the random sample of providers. Further information is needed regarding the noted discrepancies.

Annual Provider Appointment Standards Access (In-office wait times; Emergent, urgent and routine appointments; Prenatal care – first, second, third trimester and high-risk)
This measure tracked provider appointment access standards for in-office wait times; emergent, urgent and routine appointments; and prenatal care for the first, second, and third trimester and high-risk. The MCOs are required by the State to ensure that in-office wait time requirements are met. No tracking report templates, however, (as per the 24/7 access performance measure above) are required of the MCOs by the State for tracking these measures.

Methods that have been used to ensure annual provider appointment access standards are met included surveys (completed by MCO, web-based, or vendor), follow-up provider education to monitor access appointments, and a "secret shopper" approach used by the vendor for calling a random sample

of providers where they do not identify themselves as representing the MCO. Follow-up is completed with providers that were identified as non-compliant.

Survey results to date have not included in-office wait times. For all three MCOs, from 2013 through 2016, no information specifically related to access to prenatal care visits was submitted for review. However, in 2017, one MCO began reporting appointment access for prenatal care by trimester for 1st through 3rd available appointment for new and established patients.

Due to variation in methodologies, descriptions of survey sampling, survey conclusions, and data discrepancies, questions were raised about the conclusions reached for the survey outcomes (see the 24/7 access performance measure above for details). Due to this, aggregate results for the evaluation period could not be assessed and the results detailed below should be interpreted cautiously. The MCOs have reported data in different formats; therefore, data from 2016 to 2018 were used. Additionally, one MCO expanded reporting in 2018.

The highlights of the results for data reported by the MCOs are described below and rates are not always reflective of all MCOs, rather may apply to only one MCO.

- Overall, from 2016 to 2018, for the appointment availability access standards reported by all three MCOs, most rates ranged from 74.9%–100%.
- Areas <50% compliant in 2016 and/or 2017 from any one MCO, but increased in 2018:
  - Emergent Care:
    - The rate increased to 100% in 2018 from 28.5% (2017) and 39.3% (2016). PCP: The rate increased to 99.1% in 2018 from 79.7% (2016).
  - Urgent Care:
    - Specialists: The rate increased to 100% in 2018 from 58.3% (2016) and 38.2% (2017)
    - BH: The rate increased to 83.7% in 2018 from 35.7% (2017) and 56.3% (2016)
    - Oncology: The rate increased to 45% in 2018 from 45% (2017).
    - Obstetricians: The rate increased to 52% in 2018 from 42% (2017).
- Urgent Care: PCP decreased to 63% in 2018 from 99% in 2016.
- Urgent Care areas <50% in 2018:
  - BH: 33% (new patients) and 38% (established patients)
  - Oncology: 39% for new patients.

2) Member Survey – CAHPS

Member Experience with the Appointment Availability in Medicaid and CHIP Populations: Measures Based on Questions in the Child and Adult CAHPS Surveys

The measures for this subcategory of *Access to Care* were assessed to examine the improvement in member experience with appointment availability among the child and adult populations.

The measures related to member experience with appointment availability among the child and adult populations were based on the adult and child CAHPS Surveys. The evaluation results of these measures are summarized below.

Evaluation Summary

The data for seven CAHPS survey questions related to member experience with appointment availability among child and adult populations were used for the evaluation of this subcategory. Out of these seven questions, three established whether the specific follow-up questions were applicable to the respondent or not. Thus, three follow-up questions provided the needed information for the evaluation of this subcategory. In addition to these three questions, one question was also included in the evaluation of this subcategory among the child and adult populations. The 2014–2018 data are presented in Table 42. The child measures were assessed in both GC and CCC populations.

The rates of all four measures for the child and adult populations were consistently high throughout the five-year period showing high member satisfaction with their experience with the appointment availability aspect of the access to care received by them during this evaluation period. As most of these measures were high throughout the period, statistically significant increasing trends were seen only for few measures. The measures showing statistically significant improvements in the trends over time and in the rates for the most recent year compared to the baseline are summarized in Figure 57.

Improved Trends	Improved Rates Compared to Baseline	NCQA ≥ 50th Quality Compass Percentile
•Statistically significant improvements in the trends over time for **two out of four measures** in the GC population, and for **one out of four measures** in the CCC population. •High rates throughout the five-year period for **all four measures** (>80% for three measures and >91% for one measures) in both GC and CCC populations. •No statistically significant trends; however, there were high rates throughout the five-year period for **four out of four measures** in the adult population (>80%).	•In 2018, the rates for **three measures** among both child populations were above 91%; and for **one measure** were above 85%. •In 2018, the rates for **all four measures** were above 82% among the adult population.	•The QC ranking ≥50th QC percentile throughout the five-year period for most of the years for **all four measures** among both the child (GC and CCC) and adult populations.

Figure 57. Improvement in the Performance Measures for the Member's Experience with Appointment Availability

The following measures showed statistically significant improvement in trends in the five-year period among the child and adult populations.

- Improved trends over the five-year period in the rates of member perception of provider treatment measures among the child populations:
  - Among the GC population – In the last 6 months, when you (your child) needed care right away, how often did you (your child) get care as soon as you (he or she) needed?
  - Among the GC population – How often was it easy to get the care, tests, or treatment you (your child) needed?
  - Among the CCC population – How often did you get an appointment (for your child) to see a specialist as soon as you needed?

Though, no statistically significant improvement was seen in the trends over the five-year period for some measures among child populations, and in all four measures among the adult population, the rates for these measures were consistently high throughout this period. The high rates maintained throughout these years indicated a high satisfaction of members with these aspects in this period.

- Measures with the high rates during 2014–2018 without showing improvement in the trends over time among the child populations:
  - Among the GC and CCC populations, rates were above 90% – In the last 6 months, how often did you get (when you made) an appointment for a check-up or routine care for your child at a doctor's office or clinic (how often did you get an appointment) as soon as your child needed?
  - Among the GC population, rates were above 93% – In the last 6 months, when your child needed care right away, how often did you (your child) get care as soon as he or she needed?
  - Among the CCC population, rates were above 91% – How often was it easy to get the care, tests, or treatment you (your child) needed?
  - Among the CCC population, rates were above 83% – How often did you get an appointment (for your child) to see a specialist as soon as you needed?
- Measures with high rates during 2014–2018 without showing improvement in the trends over time among the adult population:
  - Rates were above 86% – In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
  - Rates were above 82% – In the last 6 months, how often did you get (when you made) an appointment for a check-up or routine care at a doctor's office or clinic (how often did you get an appointment) as soon as you needed?
  - Rates were above 87% – How often was it easy to get the care, tests, or treatment you needed?
  - Rates were above 81% – How often did you get an appointment to see a specialist as soon as you needed?

Though, rates for all the measures seen in the most recent year among adult population were above 82%, further improvement could be achieved indicating an opportunity for improvement in the future.

The final evaluation of the measures related to the members' experience with appointment availability among child and adult populations based on the child and adult CAHPS survey questions showed that these measures contributed to high access to care among KanCare program beneficiaries. The evaluation findings also highlighted opportunities for improvement for this subcategory, especially among the adult population to further strengthen the overall access to care among beneficiaries.

Evaluation Results for the Member's Experience with the Appointment Availability (CAHPS Survey)

The *Member Experience with the Appointment Availability* aspect of the *Member Survey – Access to Care* subcategory was assessed by seven measures among child members (GC population – TXIX and TXXI), and CCC population – TXIX and TXXI) and the adult Medicaid population based on CAHPS Survey questions (Table 42).

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Table 42. Member Survey – CAHPS Access to Care Questions, CY2014–CY2018											
Question	Pop	Weighted % Positive Responses					Quality Compass ≥50th Percentile^				
		2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
Member Experience With the Appointment Availability – Child and Adult Populations											
In the last six months, did you (your child) have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?	Adult	45.2%	45.7%	44.0%	46.3%	45.2%					
	GC	35.1%	37.9%	35.7%	37.9%	39.4%					
	CCC	43.6%	47.4%	43.1%	45.2%	49.0%					
In the last 6 months, when you (your child) needed care right away, how often did you (your child) get care as soon as you (he or she) needed?	Adult	88.1%	87.2%	86.2%	88.4%	87.7%	↑	↑	↑	↑	↑
	GC	94.1%	93.2%	93.7%	94.7%	94.2%	↑	↑	↑	↑	↑
	CCC	95.0%	93.9%	95.1%	97.0%	95.2%	↑	↑	↑	↑	↑
In the last 6 months, did you make any appointments for a check-up or routine care (for your child) at a doctor's office or clinic?	Adult	75.8%	77.1%	76.3%	75.3%	76.9%					
	GC	70.8%	68.9%	69.5%	70.0%	69.6%					
	CCC	80.0%	78.7%	77.3%	78.4%	79.5%					
In the last 6 months, how often did you get (when you made) an appointment for a check-up or routine care (for your child) at a doctor's office or clinic (how often did you get an appointment) as soon as you (your child) needed?	Adult	82.9%	82.7%	82.5%	84.6%	82.6%	↑	↑	↑	↑	↑
	GC	90.6%	89.7%	90.0%	90.4%	91.3%	↑	↑	↑	↑	↑
	CCC	92.2%	92.4%	92.2%	93.3%	93.1%	↓	↑	↑	↑	↑
How often was it easy to get the care, tests, or treatment you (your child) needed?	Adult	87.6%	88.1%	87.1%	88.0%	87.1%	↑	↑	↑	↑	↑
	GC	93.4%	92.0%	92.1%	93.0%	93.7%	↑	↑	↑	↑	↑
	CCC	93.0%	91.9%	92.4%	93.6%	93.2%	↑	↑	↑	↑	↑
Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments (for your child) to see a specialist?	Adult	43.0%	46.5%	44.3%	46.8%	45.3%					
	GC	17.9%	19.4%	17.9%	19.5%	21.4%					
	CCC	38.4%	39.5%	39.8%	40.7%	43.2%					
How often did you get an appointment (for your child) to see a specialist as soon as you needed?	Adult	84.8%	81.7%	86.2%	82.9%	83.1%	↑	↑	↑	↑	↑
	GC	83.2%	84.6%	79.8%	87.6%	85.2%	↑	↑	↓	↑	↑
	CCC	85.3%	83.3%	86.0%	87.0%	86.2%	↑	↑	↑	↑	↑

^↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile

A five-year trend for these measures was examined from 2014 through 2018. The most recent rates for the child and adult populations were compared to the baseline rates. The Quality Compass rankings for these measures were also seen.

***In the last 6 months,* did you (your child) have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?**

The measure was tracked for the child (GC and CCC) and adult populations by assessing the percentages of *"Yes" responses* to the survey question.

No statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations. The rates for 2018 was significantly higher compared to the baseline rate for both GC and CCC populations ($p<.001$). The QC rankings were not provided by the NCQA.

No statistically significant trend was seen in the rates over the five-year period for the adult population. The comparison of 2018 and baseline rates for adults did not show a statistically significant difference. The QC rankings were not provided by the NCQA.

Among those who responded ***"Yes"*** to this question, the following question was further assessed:

- ***In the last 6 months,* when you needed care right away, how often did you (for your child) get care as soon as you (your child) needed?**
  A statistically significant increasing trend was seen in the rates over the five-year period for the CCC population (*p*=.01). Though, no statistically significant trend was seen in the rates over the five-year period for the GC population, the rates were considerably high throughout this period (above 93%). The comparison of 2018 and baseline rates for both GC and CCC populations did not show statistically significant differences. The QC rankings among both GC and CCC populations were ≥50th QC percentile throughout this period (Figure 58).

  Though, no statistically significant trend was seen in the rates over the five-year period for the adult population, the rates were considerably high throughout this period (above 86%). The comparison of 2018 and baseline rates for adults did not show a statistically significant difference. The QC rankings among the adult population were ≥50th QC percentile throughout this period.

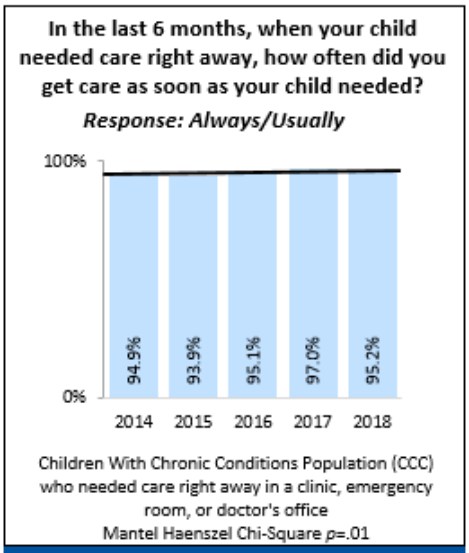

Figure 58. CAHPS CCC Question 4, CY2014–CY2018

***In the last 6 months,* did you make any appointments for a check-up or routine care (for your child) at a doctor's office or clinic?**
The measure was tracked for the child (GC and CCC) and adult populations by assessing the percentages of *"Yes" responses* to the survey question.

No statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations. The comparison of 2018 and baseline rates for both GC and CCC populations did not show statistically significant differences.

No statistically significant trend was seen in the rates over the five-year period for the adult population. The comparison of 2018 and baseline rates for adults did not show a statistically significant difference.

Among those who responded ***"Yes"*** to this question, the following question was further assessed:

- ***In the last 6 months,* not counting the times you needed care right away, how often did you get an appointment (for your child) for a check-up or routine care at a doctor's office or clinic as soon as you (your child) needed?**
  The measure was tracked for the child (GC and CCC) and adult populations by assessing the percentages of *"Always/Usually" responses* to the survey question.

  Though, no statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations, the rates were considerably high throughout this period (above 89%). The

comparison of 2018 and baseline rates for both GC and CCC populations did not show statistically significant differences. The QC rankings among the GC population were ≥50th QC percentile throughout this period and for most of the years for the CCC population.

Though, no statistically significant trend was seen in the rates over the five-year period for the adult population, the rates were considerably high throughout this period (above 82%). The comparison of 2018 and baseline rates for adults did not show a statistically significant difference. The QC rankings among the adult population were ≥50th QC percentile throughout this period.

In the last six months, how often was it easy to get the care, tests, or treatment you needed?
The measure was tracked for the child (GC and CCC) and adult populations by assessing the percentages of *"Always/Usually" responses* to the survey question.

A statistically significant increasing trend was seen in the rates over the five-year period for the GC population (p=.03). Though no statistically significant trend was seen in the rates over the five-year period for the CCC population, the rates were considerably high throughout this period (above 91%). The comparison of 2018 and baseline rates for both GC and CCC populations did not show statistically significant differences. The QC rankings among both GC and CCC populations were ≥50th QC percentile throughout this period.

No statistically significant trend was seen in the rates over the five-year period for the adult population. The comparison of 2018 and baseline rates for adults did not show statistically significant differences; however, the rates were considerably high throughout this period (above 87%). The QC rankings among the adult population were ≥50th QC percentile throughout this period.

In the last six months, did you make any appointments to see a specialist?
The measure was tracked for the child (GC and CCC) and adult populations by assessing the percentages of *"Yes" responses* to the survey question.

No statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations. The rate for 2018 was significantly higher compared to the baseline rate for both GC and CCC populations (p<.001). The QC rankings were not provided by the NCQA.

No statistically significant trend was seen in the rates over the five-year period for the adult population. The comparison of 2018 and baseline rates for adults did not show a statistically significant difference. The QC rankings were not provided by the NCQA.

Among those who responded ***"Yes"*** to this question, the following question was further assessed:

- **In the last six months, how often did you get an appointment (for your child) to see a specialist as soon as you needed?**
  The measure was tracked for the child (GC and CCC) and adult populations by assessing the percentages of *"Always/Usually" responses* to the survey question.

  A statistically significant increasing trend was seen in the rates over the five-year period for the GC population (p<.01). Though, no statistically significant trend was seen in the rates over the five-year period for the CCC population, the rates were considerably high throughout this period (above 83%). The comparison of 2018 and baseline rates for both GC and CCC populations did not show statistically significant differences. The QC rankings among the CCC population were ≥50th QC

percentile throughout this period. The QC rankings for this measure among the GC population were ≥50th QC percentile for most of the years in this period.

No statistically significant trend was seen in the rates over the five-year period for the adult population. The comparison of 2018 and baseline rates for adults did not show a statistically significant difference. The QC rankings among the adult population were ≥50th QC percentile throughout this period.

3) Member Survey – Mental Health

The MH Surveys conducted from 2011 through 2018 are described in the evaluation category "Quality of Care," subsection 8 "Member Survey – Quality of Care" performance measure "Member Perceptions of Mental Health Provider Treatment."

Member Perceptions of Access to MH Services: Measures Based on Questions in the MH Survey

Evaluation Summary

The 2011–2018 data for seven MH survey measures related to member perceptions of access to MH services among the Adult, Youth, and SED Waiver youth and young adult populations are presented in Table 43. Member perceptions of access to MH services are based on responses to MH surveys conducted from 2011 to 2018 of a random sample of KanCare members who received one or more MH services in the prior six-month period of each survey year. One question, **timely availability of medication**, was added to the survey in 2013; therefore, the evaluation period for this question is 2013 to 2018.

The General Youth and SED Waiver Youth (ages 12–17), youth responding; and SED Waiver Youth and Young Adults, family/member responding subgroups were assessed 2011 through 2017 and the Youth (ages 0–17), family responding, and Adult subgroups were assessed 2011 through 2018 (at the State's request).

The measures showing statistically significant improvements in the trends over time and in the rates for the most recent year compared to the baseline are summarized in Figure 59.

Improved Trends	Improved Rates Compared to Baseline
•Statistically significant improvement in the trends over time for **two out of seven measures** in the SED Waiver Youth (ages 12–17), youth responding, Youth (ages 0–17), family responding, and SED Waiver Youth and Young Adults, family/member responding, survey subgroups. •High rates (>90%) throughout the five-year and six-year period for **one out of seven measures** among the Adult and SED Waiver Youth and Young Adults, family/member responding, survey subgroups.	•Statistically significant higher rates in the most recent year compared to the baseline for **three out of seven measures** in the Adult, SED Waiver Youth (ages 12–17), youth responding, Youth (ages 0–17), family responding, and SED Waiver Youth and Young Adults, family/member responding, survey subgroups. •Maintained rates **for five out of seven measures** among all five survey subgroups were ≥75.2% in all five/six years.

Figure 59. Improved/Maintained Performance Measures for the Member Perceptions of Access to Care (MH Survey)

One measure, had high rates (>90%) for Adults and SED Waiver Youth and Young Adults, family/member responding, throughout the five-year and six-year

period. Five measures among all five survey subgroup populations were consistently maintained ranging from 75.2%–92.1% throughout the five-year and six-year period showing their contribution to the members perceptions of access to MH services by KanCare beneficiaries during this period.

The following measures showed a statistically significant improvement in the trends over the six-year and seven-year period and improved rates in 2018, compared to baseline (2012 and 2013):

- Adults – I was able to see a psychiatrist when I wanted to.
- Adults and SED Waiver Youth (ages 12–17), youth responding – I was able to get all the services I thought I needed.
- Youth (ages 0–17), family responding, and SED Waiver Youth and Young Adults, family/member responding – Medication available timely.

The following measure showed high rates (>90%) during the evaluation period – Medication available timely:

- Rates above 90.3% – Adults
- Rates above 90.9% – SED Waiver Youth and Young Adults, family/member responding

The following measures showing maintained rates during the evaluation period:

- Adults; General Youth (ages 12–17), youth responding; Youth (ages 0–17), family responding; SED Waiver Youth (ages 12–17), youth responding; and SED Waiver Youth and Young Adults, family/member responding – Services were available at times that were good for me (convenient for us/me).
- Adults – My mental health providers returned my calls in 24 hours.
- Adults – My mental health providers were able to see me as often as I felt it was necessary.
- Youth (ages 0–17), family responding; General Youth (ages 12–17), youth responding; and SED Waiver Youth and Young Adults, family/member responding – I was able to get all the services I thought I needed/My family got as much help as we needed for my child.
- Adults; Youth (ages 0–17), family responding; and SED Waiver Youth and Young Adults, family/member responding – During a crisis, I (my family) was able to get the services I (we) needed.

The following measure showed a statistically significant declined rate in 2018 compared to baseline (2011):

- Adults – I was able to get all the services I thought I needed.

Several measures related to the members' perception of access to MH services showed their contribution to the improved access to care for the beneficiaries. However, one measure within the SED Waiver Youth and Young Adults, family/member responding survey group and one measure with the Adult survey subgroup, showed an opportunity for improvement to strengthen access to care for the members receiving MH services.

Evaluation Results for the Member Perceptions of Access to Mental Health Services (MH Survey)

The performance measures, yearly rate, and statistical testing for trends overtime and in the most recent year (2017 or 2018) compared to baseline (2011 and 2012) are presented in Table 43 below.

Table 43. Mental Health Survey – Access-Related Questions

	Year	Rate (0% – 100%)	Numerator/ Denominator	95% Confidence Interval	Comparison of Most Current Year to Baseline and Pre-KanCare	Trend 5/6-Year*	Trend 7/8-Year*
I was able to see a psychiatrist when I wanted to.	**Adults (Age 18+)^**						
	2018	79.6%	228 / 287	74.5% – 83.8%			
	2017	81.3%	295 / 363	77.0% – 85.0%			
	2016	73.6%	195 / 265	67.9% – 78.5%			
	2015	83.4%	291 / 349	79.2% – 87.0%			
	2014	80.5%	598 / 744	77.5% – 83.2%			
	2013	82.3%	807 / 981	79.8% – 84.6%			
	2012	70.8%	187 / 264	65.1% – 76.0%	.02 +		
	2011	82.1%	225 / 274	77.1% – 86.2%			
I was able to get all the services I thought I needed.	**Adults (Age 18+)^**						
	2018	85.8%	276 / 322	81.5% – 89.2%			
	2017	83.9%	335 / 399	79.9% – 87.2%			
	2016	80.7%	235 / 290	75.8% – 84.9%			
	2015	84.9%	325 / 383	81.0% – 88.2%			
	2014	86.5%	704 / 814	84.0% – 88.7%			
	2013	86.0%	917/1,066	83.8% – 87.9%			
	2012	78.8%	219 / 278	73.6% – 83.2%	.02 +		
	2011	91.3%	274 / 300	87.6% – 94.1%	.03 -		
	General Youth (Ages 12–17), Youth Responding‡						
	2017	84.3%	187 / 222	78.9% – 88.5%			
	2016	83.1%	126 / 152	76.3% – 88.3%			
	2015	87.5%	126 / 144	81.0% – 92.1%			
	2014	83.8%	260 / 309	79.2% – 87.5%			
	2013	82.8%	427 / 518	79.1% – 86.0%			
	2012	85.0%	85 / 100	76.6% – 90.8%			
	2011	85.1%	114 / 134	78.0% – 90.2%			
	SED Waiver Youth (Ages 12–17), Youth Responding‡						
	2017	83.0%	160 / 193	77.0% – 87.7%		<.01 ↑	.03↑
	2016	79.3%	127 / 161	72.3% – 84.9%			
	2015	81.5%	123 / 151	74.6% – 86.9%			
	2014	74.8%	138 / 184	68.0% – 80.5%			
	2013	71.8%	165 / 229	65.7% – 77.2%	<.01↑		
	2012	76.3%	103 / 135	68.4% – 82.7%			
	2011	77.6%	97 / 125	69.5% – 84.1%			
My family got as much help as we needed for my child.	**Youth (Ages 0–17), Family Responding^**						
	2018	82.3%	327 / 398	78.2% – 85.7%			
	2017	83.5%	405 / 485	79.9% – 86.5%			
	2016	82.2%	264 / 320	77.6% – 86.0%			
	2015	86.3%	278 / 322	82.1% – 89.6%			
	2014	79.7%	609 / 766	76.7% – 82.4%			
	2013	83.2%	799 / 966	80.7% – 85.4%			
	2012	82.9%	213 / 257	77.8% – 87.0%			
	2011	84.2%	278 / 330	79.9% – 87.8%			
	SED Waiver Youth and Young Adults, Family/Member Responding‡						
	2017	79.3%	319 / 403	75.0% – 83.0%			
	2016	77.6%	253 / 325	72.7% – 81.8%			
	2015	78.9%	260 / 330	74.2% – 83.0%			
	2014	76.4%	318 / 413	72.0% – 80.2%			
	2013	75.2%	363 / 482	71.1% – 78.8%			
	2012	77.3%	248 / 321	72.4% – 81.6%			
	2011	77.4%	220 / 284	72.2% – 81.9%			

* 5-Year/7-Year trend is 2011 to 2017 and 6-Year/8-Year trend is 2011 to 2018.
‡ Adults (Age 18+) and Youth (Ages 0–17), Family Responding, subgroups were assessed 2011–2018.
‡ General Youth (Ages 12–17), Youth Responding; SED Waiver Youth (Ages 12–17), Youth Responding; and SED Waiver Youth and Young Adult, Family/Member Responding subgroups were assessed 2011–2017.

Table 43. Mental Health Survey – Access-Related Questions (Continued)

	Year	Rate (0% – 100%)	Numerator/ Denominator	95% Confidence Interval	Comparison of Most Current Year to Baseline and Pre-KanCare	Trend 5/6-Year*	Trend 7/8-Year*
My mental health providers were willing to see me as often as I felt it was necessary.	**Adults (Age 18+)^**						
	2018	87.0%	280 / 322	82.9% – 90.3%			
	2017	86.3%	341 / 395	82.6% – 89.4%			
	2016	84.0%	243 / 289	79.3% – 87.8%			
	2015	87.2%	332 / 381	83.4% – 90.2%			
	2014	87.9%	706 / 804	85.5% – 90.0%			
	2013	88.2%	927/1,051	86.2% – 90.1%			
	2012	85.3%	233 / 273	80.6% – 89.1%			
	2011	88.8%	262 / 295	84.7% – 92.0%			
Services were available at times that were good for me (convenient for us/me).	**Adults (Age 18+)^**						
	2018	90.8%	292 / 322	87.1% – 93.5%			
	2017	91.9%	367 / 399	88.8% – 94.3%			
	2016	87.4%	258 / 294	83.1% – 90.8%			
	2015	90.0%	343 / 381	86.6% – 92.7%			
	2014	89.8%	733 / 817	87.5% – 91.7%			
	2013	92.1%	985/1,071	90.4% – 93.6%			
	2012	87.7%	242 / 276	83.2% – 91.1%			
	2011	92.3%	277 / 300	88.7% – 94.9%			
	Youth (Ages 0–17), Family Responding^						
	2018	89.9%	364 / 405	86.5% – 92.5%			
	2017	87.4%	428 / 489	84.2% – 90.1%			
	2016	83.9%	276 / 328	79.6% – 87.5%			
	2015	90.9%	297 / 327	87.2% – 93.6%			
	2014	86.9%	682 / 783	84.4% – 89.1%			
	2013	88.7%	871 / 983	86.5% – 90.5%			
	2012	88.0%	235 / 267	83.5% – 91.4%			
	2011	85.9%	287 / 334	81.8% – 89.3%			
	General Youth (Ages 12–17), Youth Responding†						
	2017	87.5%	194 / 222	82.4% – 91.2%			
	2016	90.4%	141 / 156	84.6% – 94.2%			
	2015	88.5%	130 / 147	82.2% – 92.8%			
	2014	87.5%	271 / 308	83.3% – 90.7%			
	2013	88.7%	455 / 513	85.5% – 91.3%			
	2012	83.0%	83 / 100	74.4% – 89.2%			
	2011	89.5%	119 / 133	83.0% – 93.7%			
	SED Waiver Youth and Young Adults, Family/Member Responding†						
	2017	87.9%	357 / 407	84.3% – 90.7%			
	2016	84.1%	275 / 328	79.7% – 87.7%			
	2015	84.5%	283 / 336	80.2% – 88.0%			
	2014	85.2%	356 / 418	81.5% – 88.3%			
	2013	85.1%	415 / 487	81.6% – 88.0%			
	2012	88.6%	287 / 324	84.7% – 91.7%			
	2011	85.4%	243 / 285	80.8% – 89.0%			
	SED Waiver Youth (Ages 12-17), Youth Responding†						
	2017	88.8%	174 / 196	83.5% – 92.5%			
	2016	84.4%	139 / 164	78.0% – 89.2%			
	2015	85.7%	131 / 153	79.3% – 90.4%			
	2014	86.0%	167 / 194	80.3% – 90.2%			
	2013	82.6%	187 / 226	77.2% – 87.0%			
	2012	82.2%	111 / 135	74.8% – 87.8%			
	2011	83.7%	103 / 123	76.1% – 89.3%			

* 5-Year/7-Year trend is 2011 to 2017 and 6-Year/8-Year trend is 2011 to 2018.
^ Adults (Age 18+) and Youth (Ages 0–17), Family Responding, subgroups were assessed 2011–2018.
† General Youth (Ages 12–17), Youth Responding; SED Waiver Youth (Ages 12–17), Youth Responding; and SED Waiver Youth and Young Adult, Family/Member Responding subgroups were assessed 2011–2017.

Table 43. Mental Health Survey – Access-Related Questions (Continued)

	Year	Rate (0% – 100%)	Numerator/ Denominator	95% Confidence Interval	Comparison of Most Current Year to Baseline and Pre-KanCare	Trend 5/6-Year*	Trend 7/8-Year*
During a crisis, I was able to get the services I needed.	**Adults (Age 18+)^**						
	2018	85.9%	228 / 266	81.2% – 89.6%			
	2017	83.5%	277 / 332	79.1% – 87.1%			
	2016	80.7%	196 / 242	75.3% – 85.2%			
	2015	85.0%	265 / 312	80.6% – 88.5%			
	2014	86.0%	586 / 682	83.2% – 88.4%			
	2013	85.4%	742 / 870	82.9% – 87.6%			
	2012	79.2%	183 / 231	73.5% – 84.0%			
	2011	83.9%	209 / 249	78.8% – 88.0%			
During a crisis, my family was able to get the services we needed.	**Youth (Ages 0–17), Family Responding^**						
	2018	85.3%	256 / 302	80.9% – 88.9%			
	2017	86.3%	285 / 330	82.1% – 89.6%			
	2016	83.8%	209 / 248	78.7% – 87.9%			
	2015	84.6%	197 / 233	79.3% – 88.7%			
	2014	83.4%	457 / 548	80.1% – 86.3%			
	2013	86.2%	604 / 706	83.5% – 88.6%			
	2012	87.4%	173 / 198	82.0% – 91.4%			
	2011	89.5%	204 / 228	84.8% – 92.9%			
	SED Waiver Youth and Young Adults, Family/Member Responding†						
	2017	80.6%	270 / 334	76.0% – 84.5%			
	2016	78.0%	205 / 260	72.6% – 82.7%			
	2015	78.3%	213 / 272	73.0% – 82.8%			
	2014	81.5%	276 / 338	76.9% – 85.3%			
	2013	76.4%	299 / 390	71.9% – 80.3%			
	2012	79.1%	197 / 249	73.6% – 83.7%			
	2011	80.0%	173 / 216	74.2% – 84.8%			
My mental health providers returned my calls in 24 hours.	**Adults (Age 18+)^**						
	2018	86.4%	254 / 294	82.0% – 89.9%			
	2017	85.9%	303 / 353	81.8% – 89.2%			
	2016	79.6%	213 / 267	74.4% – 84.1%			
	2015	84.4%	292 / 346	80.2% – 87.9%			
	2014	83.3%	618 / 742	80.5% – 85.8%			
	2013	84.4%	840 / 995	82.0% – 86.5%			
	2012	80.8%	202 / 250	75.4% – 85.2%			
	2011	88.1%	251 / 285	83.8% – 91.4%			

* 5-Year/7-Year trend is 2011 to 2017 and 6-Year/8-Year trend is 2011 to 2018.

^ Adults (Age 18+) and Youth (Ages 0–17), Family Responding, subgroups were assessed 2011–2018.

† General Youth (Ages 12–17), Youth Responding; SED Waiver Youth (Ages 12–17), Youth Responding; and SED Waiver Youth and Young Adult, Family/Member Responding subgroups were assessed 2011–2017.

Table 43. Mental Health Survey – Access-Related Questions (Continued)

	Year	Rate (0% – 100%)	Numerator/ Denominator	95% Confidence Interval	Comparison of Most Current Year to Baseline and Pre-KanCare	Trend 5/6-Year*	Trend 7/8-Year*
Medication available timely‡	**Adults (Age 18+)^**						
	2018	92.1%	243 / 264	88.2% – 94.9%			
	2017	91.0%	310 / 341	87.5% – 93.6%			
	2016	92.9%	237 / 255	89.0% – 95.5%			
	2015	90.3%	296 / 328	86.5% – 93.1%			
	2014	92.7%	661 / 713	90.5% – 94.4%			
	2013	91.8%	827 / 903	89.8% – 93.4%			
	Question introduced in 2013						
	Youth (Ages 0–17), Family Responding^						
	2018	96.0%	218 / 227	92.5% – 98.0%		<.001 ↑	
	2017	95.6%	263 / 275	92.4% – 97.6%			
	2016	83.7%	171 / 204	78.0% – 88.2%			
	2015	88.0%	198 / 225	83.0% – 91.6%			
	2014	85.3%	408 / 478	81.8% – 88.2%			
	2013	86.1%	537 / 622	83.1% – 88.6%	<.001 +		
	Question introduced in 2013						
	SED Waiver Youth and Young Adults, Family/Member Responding†						
	2017	97.1%	333 / 343	94.7% – 98.5%		<.01↑	
	2016	94.5%	262 / 278	91.1% – 96.7%			
	2015	93.3%	275 / 294	89.8% – 95.7%			
	2014	94.8%	356 / 376	92.0% – 96.7%			
	2013	90.9%	379 / 416	87.8% – 93.3%	<.001↑		
	Question introduced in 2013						

* 5-Year/7-Year trend is 2011 to 2017 and 6-Year/8-Year trend is 2011 to 2018.
^ Adults (Age 18+) and Youth (Ages 0–17), Family Responding, subgroups were assessed 2011–2018.
† General Youth (Ages 12–17), Youth Responding; SED Waiver Youth (Ages 12–17), Youth Responding; and SED Waiver Youth and Young Adult, Family/Member Responding subgroups were assessed 2011–2017.
‡ Not asked in 2011 and 2012

Provider availability as often as member felt it was necessary

For Adult members, the rates were consistently maintained over the six-year period, ranging from 84.0% in 2016 to 88.2% in 2013.

Ability to get services during a crisis

For Adult members, the rates were consistently maintained over the six-year period, ranging from 80.7% in 2016 to 86.0% in 2014. Rates were consistently maintained over the six-year period for the following:

- Youth (ages 0–17), family respondents, ranging from 83.4% in 2014 to 86.3% in 2017.
- SED Waiver Youth and Young Adults, ranging from 76.4% in 2013 to 81.5% in 2014.

Services were available at times that were good for the member
For Adult members, the rates have been fairly high over the six-year period (87.4% [2016] to 92.1% [2013]. For the following subgroups, the rates were consistently maintained over the five-year and six-year period:

- Youth (ages 0–17), family responding, ranging from 83.9% in 2016 to 90.9% in 2015.
- General Youth (ages 12–17), youth responding, ranging from 87.5% in 2014 and 2017 to 90.4% in 2016).
- SED Waiver Youth and Young Adults, family/member responding, ranging from 84.1% in 2016 to 87.9% in 2017.
- SED Waiver Youth (ages 12–17), youth responding, ranging from 82.6% in 2013 to 88.8% in 2017.

Ability to see a psychiatrist when the member wanted
For Adult members, the rate in 2018 was 79.6%, which had a significant increase compared to baseline (2012) (70.8%; p=.02).

Ability to get all the services the members thought they needed
Adult members had a significantly higher percentage of positive responses in 2018 (85.8%) than baseline 2012 (78.8%; p=.02) and significantly lower than in 2011 (91.3%; p=.03). For Youth (ages 0–17), family responding, the rates were consistently maintained over the six-year period ranging from 79.7% in 2014 to 86.3% in 2015. For General Youth (ages 12–17), youth responding, the rates were consistently maintained over the five-year period ranging from 82.8% in 2013 to 87.5% in 2015. For SED Waiver Youth (ages 12–17), youth responding, the 2017 rate (83.0%) was the highest rate in the 7-year period and from 2011 to 2017 and 2013 to 2017, statistically significant increasing trends were seen in the percentages (p=.03; p<.01, respectively), and the 2017 rate (83.0%) was significantly higher compared to 2013 (71.8%, p<.01). For SED Waiver Youth and Young Adults, family/member responding, the rates were consistently maintained over the five-year period although they were lower, ranging from 75.2% in 2013 to 79.3% in 2017.

Timely availability of medication
From 2013 to 2018, the Adult population rates for medication availability have been above 90%. For Youth (ages 0–17), family responding, from 2013 to 2018, a statistically significant increasing trend was seen in the percentages (p<.001), and the 2018 rate (96.0%) was statistically significantly higher compared to 2013 (86.1%, p<.001). SED Waiver Youth and Young Adults, family/member positive responses have been over 90% during the five-year period, ranging from 90.9% in 2013 to 97.1% in 2017. Positive responses significantly increased in 2017 to 97.1% from 90.9% in 2013 (p<.001). Also, from 2013 to 2017, a statistically significant increasing trend was seen in the percentages (p<.01). Youth (ages 0–17), family responding and SED Waiver Youth and Young Adult, family/members positive responses were the highest they had been since 2013.

My MH provider returned my calls in 24 hours
For Adult members, the rates were consistently maintained over the six-year period (2013–2018), ranging from 79.6% in 2016 to 86.4% in 2018.

5) Member Survey – Substance Use Disorder

Evaluation Summary

Member perceptions of SUD treatment were assessed for improvement in Access to Care among members using SUD services (Figure 60). The measures for this subcategory of Access to Care were based on SUD Survey questions.

Maintained Rates in Appropriate Directions in Recent Years

- Rates for three out of five measures were consistently positive/high.

Figure 60. Improvemed/Maintained Performance Measures for Access to SUD Services (SUD Member Survey)

The results for survey questions related to Access to Care showed high performance in three out of five measures throughout the evaluation period (Table 43). Although remaining greater than 80%, there was a significant decrease in 2017 compared to 2014, regarding getting an appointment as soon as the member wanted (p<.05). Around 15% of members reporting being placed on a waiting list, with some members waiting longer than three weeks. Although members were highly satisfied with the time it took to see someone for urgent appointments, the percent that waited longer than 48 hours was 10% to 20%.

Evaluation Results for the Member Perceptions of Access to Substance Use Disorder Services (Substance Use Disorder)

The 2014–2017 data for five SUD measures related to member perceptions of access to SUD services are presented in Table 44. The survey was not completed in 2018.

Table 44. SUD Survey - Access-Related Questions, CY2014–CY2017

	CY2014	CY2015	CY2016	CY2017
Thinking back to your first appointment for your current treatment, did you get an appointment as soon as you wanted? *(Percent of "Yes" responses)*	92.1% (186/202)	87.7% (157 / 179)	84.4% (270 / 320)	84.0% (205 / 244)
Were you placed on a waiting list? (Percent of "Yes" responses)	12.2% (25 / 205)	15.6% (28 / 180)	21.2% (69 / 326)	15.2% (35 / 230)
If yes:				
If you were placed on a waiting list, how long was the wait? * *(Percent of "3 weeks or longer" responses)*	26.1% (6 / 23)	46.2% (12 / 26)	42.1% (24 / 57)	45.2% (14 / 31)
Is the distance you travel to your counselor a problem or not a problem? *(Percent of "Not a Problem" responses)*	89.1% (180 / 202)	88% (161 / 183)	87.9% (275 / 313)	85.0% (199 / 234)
In the last year, did you need to see your counselor right away for an urgent problem? *(Percent of "Yes" responses)*	28.5% (57 / 200)	25.7% (47 / 183)	28.4% (92 / 324)	29.2% (69 / 236)
If yes:				
How satisfied are you with the time it took you to see someone? *(Percent of "Very satisfied" and "Satisfied" responses)*	98.2% (56 / 57)	79.07% (34 / 43)	94.1% (79 / 84)	90.5% (57 / 63)
Were you seen within 24 hours, 24 to 48 hours, or did you have to wait longer than 48 hours? (Percent of ">48 hours" responses)	10.9% (6 / 55)	19.0% (8 / 42)	16.0% (12 / 75)	10.0% (6 / 60)

* Compare with caution due to low denominators.

The survey questions related to Access to Care showed high performance in three out of five measures throughout the evaluation period. Although remaining greater than 80%, there was a significant decrease in 2017 compared to 2014, regarding getting an appointment as soon as the member wanted (p<.05). Around 15% of members reporting being placed on a waiting list, with some members waiting

longer than three weeks. Although members were highly satisfied with the time it took to see someone for urgent appointments, the percent that waited longer than 48 hours was 10% to 19%.
A summary for Access to Care related questions for members receiving SUD services follows:

The following measures showed high rates for Access to Care over the evaluation period (2014–2017) with a reduction in 2017 compared to the baseline.

- *Getting an appointment as soon as the member wanted*. While rates remained above 80%, there was a significant decrease in 2017 compared to 2014 (p<.05). Around 12% to 20% were placed on waiting lists; some having to wait longer than three weeks.
- *Distance for member to travel to the counselor.* Greater than or equal to 85% of members surveyed reported the distance to the SUD counselor was not a problem. The decrease in 2017 was not significantly different from 2014.
- *Time it took to see a counselor for an urgent problem.* Members were greater than 90% satisfied with the time it took to see a counselor for an urgent problem in every year except 2015. However, 10% to 19% of members had to wait longer than 48 hours to see a counselor for an urgent appointment. The difference in 2017 was not significantly different from 2014.

The following measures showing positive responses (lower rates) for Access to Care over the evaluation period (2014–2017).

- Rates were below 29.2% – Members receiving SUD services – In the last year, did you need to see your counselor right away for an urgent problem? *(Percent of "Yes" responses)*
- Rates were below 19% – Members receiving SUD services – Were you seen within 24 hours, 24 to 48 hours, or did you have to wait longer than 48 hours? *(Percent of ">48 hours" responses)*
- Rates were below 21.2%– Members receiving SUD services – Were you placed on a waiting list? *(Percent of "Yes" responses)*

The following measure showed that positive responses decreased compared to the baseline for Access to Care over the evaluation period (2014–2017) and shows room for improvement:

- Rates were above 42.1% (2015–2017) – Members receiving SUD services – If you were placed on a waiting list, how long was the wait? *(Percent of "3 weeks or longer" responses)*

6) Provider Survey

Evaluation Summary

The Coordination of Care aspect of the Provider Survey subcategory was assessed with one measure. Providers were asked to rate their "***satisfaction with availability of specialists.***" Results are summarized in Table 45. Statistically significant improvements are noted in Figure 61.

The provider survey data available for this measure were available for varying time periods by MCO.
While each MCO survey included the same question related to quality, there were differences in provider population inclusion among the MCOs that impacted the ability to compare between the MCOs. Statistical significance testing was appropriate for certain time-periods for individual MCOs.

MCO: Improved Rates Compared to Baselines

- In 2018, Amerigroup providers had a significantly higher rate of satisfaction with the availability of specialists compared to 2014 (p<.05).
- Sunflower BH provider survey respondents had a significantly higher rate of satisfaction in 2017 compared to 2015.

Figure 61. Improvements in the Rate of Providers "Very" or "Somewhat" Satisfied with the MCO's Availability of Specialists for their Members (Provider Survey)

Amerigroup providers were significantly more satisfied with the availability of specialists in 2018 compared to 2014 (p<.05). Previously neutral respondents appeared to

shift to being satisfied, as there was a significant decrease in neutral responses in 2018 compared to 2014 (p<.05) and no significant difference in dissatisfaction.

The rate of Sunflower's BH (Cenpatico) provider respondents' satisfaction with availability of specialists was significantly higher (p<.05) in 2017 compared to 2015, although still under 50%. Sunflower's and UnitedHealthcare's General and BH providers' satisfaction with availability of specialists remained below 50% in the most recent measurement year.

Evaluation Results for the Provider Survey Measures (Provider Survey)

Amerigroup

In 2018, 59.8% of providers surveyed were very or somewhat satisfied with the availability of specialists through Amerigroup which was significantly higher than 45.9% in 2017, (p<.05). Previously neutral respondents appeared to shift to being more satisfied, as there was a significant decrease in neutral responses in 2018 compared to 2014 (p<.05), while there was no significant difference in the rate of dissatisfied respondents.

Sunflower

There were no statistically significant differences in General survey provider satisfaction/dissatisfaction/neutral responses with the availability of Sunflower specialists in 2017 compared to 2014. BH provider survey respondents had a significantly higher rate of satisfaction in 2017 compared to 2015; there were no significant differences in the rates of neutral and dissatisfied responses.

UnitedHealthcare

There were no statistically significant differences for the General provider survey satisfaction with availability of specialists (2017 compared to 2015) or BH provider satisfaction (2018 compared to 2014).

Table 45. Provider Satisfaction with Availability of Specialists, CY2014–CY2018

MCO Provider Survey Type	2014	2015	2016	2017	2018
	Very or Somewhat Satisfied				
Amerigroup*	45.9%	59.5%	59.4%	56.3%	59.8%
Sunflower *(General Provider)*	40.7%	52.9%	39.8%	41.9%	41%‡
Cenpatico *(Behavioral Health)*	†	27.4%	28.1%	48.5%	
UnitedHealthcare *(General Provider)*	^	45.2%	43.7%	40.5%	¶
Optum *(Behavioral Health)*	32.1%	38.6%	44.1%	41.0%	35.6%
	Neither Satisfied nor Dissatisfied				
Amerigroup*	37.0%	23.7%	18.8%	26.1%	23.9%
Sunflower *(General Provider)*	44.2%	30.9%	51.7%	48.5%	43.5%‡
Cenpatico *(Behavioral Health)*	†	65.3%	64.7%	51.5%	
UnitedHealthcare *(General Provider)*	^	32.9%	39.4%	37.8%	¶
Optum *(Behavioral Health)*	54.8%	55.4%	44.1%	49.4%	56.4%
	Very or Somewhat Dissatisfied				
Amerigroup*	17.1%	16.8%	21.9%	17.6%	16.3%
Sunflower *(General Provider)*	15.0%	16.2%	8.4%	9.6%	15.5%‡
Cenpatico *(Behavioral Health)*	†	7.3%	7.2%	0%	
UnitedHealthcare *(General Provider)*	^	21.9%	16.9%	21.6%	¶
Optum *(Behavioral Health)*	13.1%	5.9%	11.7%	9.6%	8.1%
	Total Responses				
Amerigroup*	257	333	160	272	209
Sunflower *(General Provider)*	226	259	261	167	161‡
Cenpatico *(Behavioral Health)*	†	124	167	33	
UnitedHealthcare *(General Provider)*	63	73	71	74	22
Optum *(Behavioral Health)*	84	101	145	156	149

*Amerigroup included Behavioral Health Providers in their General Survey
^UnitedHealthcare results for 2014 cannot be determined due to a typographical error in the survey instrument that included "Somewhat satisfied" twice and excluded "Somewhat dissatisfied."
†Question was not asked in Cenpatico survey in 2014.
‡ Cenpatico BH transitioned to Sunflower; 2018 provider survey included both General and BH providers. Compare with caution due to change in method.
¶ Denominator too small to report data.

7) Grievances – Access to Care

Evaluation Summary

The MCOs reported grievances by category through quarterly Grievance and Appeal reports (GAR), as well as in the quarterly STC report through 2016.

Due to MCO inconsistencies and grievance mis-categorizations, as well as the State's report improvements and definition clarifications, baseline to current comparisons are not possible. Generally, around 3% to 10% of grievances appear to be related to access (Figure 62).

Grievance Improvements

- KDHE has focused efforts on improvements in reporting templates, grievance category details, clarifications and training to MCO staff, addressing internal and EQRO reviews/recommendations to improve reporting consistency.

Figure 62. Improvemed/Maintained Performance Measures for Grievances (Access to Care Grievances)

Evaluation Results for Grievances – Access

KFMC's quarterly KanCare evaluation reports included detailed review of the grievance reports, primarily regarding inconsistencies between MCOs and between reports (GAR and STC), as well as MCO mis-categorization of grievances. The State spent considerable effort addressing inconsistencies between MCOs and between reports since 2013. Reporting requirements and templates have changed, and new grievance categories have been added. The State has clarified category definitions and provided additional training to the MCOs to increase consistency in reporting, primarily categorization of grievance type. Due to the various data discrepancies, comparisons are not possible. However, it generally appears around 3% to 10% of grievances are related to access.

8) Special Study – 2019 Kansas HCBS–CAHPS Survey – Access to Care

Evaluation Summary

A special study, 2019 Kansas HCBS-CAHPS Survey was conducted among HCBS waiver recipients across the state of Kansas. In this report, the preliminary data collected from 194 respondents of the survey were reviewed to summarize the findings for this subcategory. The assessment of the *Access to Care* aspect of the beneficiaries' experience receiving their home and community based long-term services and supports was based on two performance measures comprised of multiple questions and respective composite scores.

High percentages for the composite score for one measure and for few individual questions were seen for two performance measures (≥84%). Average/low percentages were seen for some questions (between 39%–71%).

Though, preliminary data showed positive results, definite conclusions could not be made at this point.

Preliminary Evaluation Results for the Special Study – 2019 Kansas HCBS-CAHPS Survey

The Special Study – 2019 Kansas HCBS-CAHPS Survey also focused on the *Access to Care* aspect of the beneficiaries' experience receiving their home and community based long-term services and supports. Preliminary data based on responses from 194 respondents were examined and reported below for this subcategory.

The preliminary data for the following performance measures based on survey questions were examined to assess the *Access to Care* aspect of the beneficiaries' experience receiving their home and community based long-term services and supports.

- **Transportation to medical appointments**
  For this measure, the percentages of the positive responses for three individual questions and a composite score based on these three questions were assessed (ride was available for medical appointments; ride was easy to get in and out of; and ride arrived on time to pick you up). The percentages represented the *"Always"* and *"Yes"* to these questions.

  High percentages were seen for the composite score and two questions (≥84%). An average percentage was seen for one question on whether the ride arrived on time to pick you up (71%). It will be important to see the percentage for this question from the final data as some doctor's offices cancel the appointment if the patient does not arrive within 15 minutes of the scheduled appointment time. If the final results from the survey are similar to the preliminary results, efforts will be needed to improve this coordination of care aspect.

- **Unmet needs and physical safety measures**
  For this measure, the percentages of the positive responses for six individual questions were assessed (no unmet need in dressing/bathing due to lack of help; no unmet need in meal preparation/eating due to lack of help; no unmet need in medication administration due to lack of help; no unmet need in toileting due to lack of help; no unmet need in with household tasks due to lack of help; and not getting hit or hurt by the staff).

  High percentages were seen for two questions (≥89%). An average/low percentage were seen for four questions 35%–68%). It will be important to see the percentage for these questions after completion of the survey. If the final results from the survey are similar to the preliminary results, efforts will be needed to improve this access to care aspect.

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Evaluation Category: Ombudsman Program

Goals, Performance Objectives, and Hypotheses for Ombudsman Program Subcategories:

- **Goal:**
  - Establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms as well.
- **Performance Objectives:**
  - Measurably improve health outcomes for members.
  - Support members successfully in their communities.
  - Promote wellness and healthy lifestyles.
  - Improve coordination and integration of PH care with BH care.
  - Lower the overall cost of health care.
- **Hypothesis:**
  - The state will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between PH, BH, MH, SUD, and LTSS.

1) Calls and Assistance

A primary task for the Ombudsman's Office has been to provide information to KanCare members and assist them in reaching MCO staff that can provide additional information and assistance in resolving questions and concerns.

Infrastructure and Capacity Improvement

Over the six-year period, the infrastructure and capacity of the Ombudsman office had been strengthened. In 2013, the Ombudsman office had two staff members (Ombudsman and a part-time assistant). In 2014, a full-time volunteer coordinator joined the office. The volunteer coordinator's responsibilities include recruitment of volunteers statewide to provide information and assistance to KanCare members, and referral, as needed, to the Ombudsman or other State agency staff. In 2015, eight volunteers joined the program. In 2017, a new volunteer position, Education and Resource Information Volunteer was created, which engages students from the St. Mary's College Health Information Management Program. The Education and Resource Information Volunteer recruited three students to provide assistance, including development of resources for beneficiaries. By the third quarter of 2018, the Ombudsman's Office had three full-time staff positions and had increased the number of volunteers to a total of ten in the two satellite offices. However, in the fourth quarter of 2018, the number of volunteers decreased from ten to six in the satellite offices; however, in subsequent months, the Ombudsman Office continued the volunteer recruitment process. The volunteer assistance has been a critical factor in helping meet the high demand for assistance needed from the Ombudsman office. The trainings were provided to the volunteers throughout this period to equip them with skills to perform their duties. Thus, during the six-year period, increased staffing and volunteer assistance efforts of the Ombudsman office strengthened the capacity of the ombudsman Program to fulfill its assigned responsibilities for the KanCare beneficiaries.

Another aspect of strengthened infrastructure of the Ombudsman office was the improved tracking system. The tracking system in 2013 only tracked voicemails, whereas changes made in 2014, made it possible to track emails and face-to-face contacts with members. The improved tracking system, when fully implemented, allowed the Ombudsman office to generate reports and efficiently track contacts by category of call and by category of caller. Thus, from 2014 onwards, the improved tracking system

enhanced the ability to assess quarterly trends in the number and types of contacts with the Ombudsman's office.

Types of questions and grievances submitted to the Ombudsman's office

The ombudsman office was available to KanCare members and potential members by phone, email, written communication, and in person. The Ombudsman's office tracked contacts by contact method, caller type, by specific issues and by location (main office or satellite office). The number of initial contacts received by the Ombudsman's office continued to increase from 2014 through 2018. As compared to 2014, the numbers of contacts doubled in 2018 (Table 46). Notes and email history from previous contacts were added in 2017, which has improved the level of assistance provided.

Table 46. Initial Contacts Received by Ombudsman's Office, CY2014–CY2018

Year	Number of Initial Contacts*
2014	2,092
2015	2,075
2016	3,186
2017	3,670
2018	4,485

* Aggregate number for all 4 Quarters
Source: Annual Report 2018. KanCare Ombudsman Office. https://www.kancare.ks.gov/docs/default-source/kancare-ombudsman/reports/2018/kancare-ombudsman-2018-annual-report.pdf?sfvrsn=9ad44c1b_4.

Since some contacts include more than one issue, the Ombudsman's Office tracks the number of certain issues addressed during contacts. The most frequent type of issues in each of the five years (2014–2018) were related to "Medicaid Eligibility Issues" including Medicaid General Issues/Questions, Medicaid Eligibility Questions, Medicaid Application Assistance, and Medicaid Information/Status Update.[9] For the types of issues for which data were available for each of the five years, a decline in frequency was seen over time for "Billing Issues," "Medical Services," and "Pharmacy."

The Ombudsman's Office also reported contact issues by waiver-related type. As shown in Table 47, the most frequent waiver-related inquires in each of the five years were related to the I/DD Waiver, PD Waiver, and FE Waiver[9].

Table 47. Waiver-Related Inquiries to Ombudsman's Office, CY2014–CY2018

Waiver	2014*		2015^		2016^		2017^		2018^	
	#	%	#	%	#	%	#	%	#	%
Intellectual/Development Disability	78	32.1%	117	25.4%	107	33.0%	200	35.7%	123	26.7%
Physical Disability	72	29.6%	166	36.1%	92	28.4%	154	27.5%	143	31.1%
Technology Assisted	23	9.5%	48	10.4%	27	8.3%	27	4.8%	18	3.9%
Frail Elderly	27	11.1%	61	13.3%	59	18.2%	128	22.8%	110	23.9%
Traumatic Brain Injury	29	11.9%	35	7.6%	25	7.7%	27	4.8%	32	7.0%
Serious Emotional Disturbance	9	3.7%	17	3.7%	8	2.5%	18	3.2%	26	5.7%
Autism	5	2.1%	16	3.5%	6	1.9%	7	1.2%	8	1.7%
Total	**243**	**100.0%**	**460**	**100.0%**	**324**	**100.0%**	**561**	**100.0%**	**460**	**100.0%**

* Aggregate numbers for Q3 & Q4.
^ Aggregate numbers for all 4 Quarters.
Source: Annual Report 2018. KanCare Ombudsman Office. https://www.kancare.ks.gov/docs/default-source/kancare-ombudsman/reports/2018/kancare-ombudsman-2018-annual-report.pdf?sfvrsn=9ad44c1b_4.

Inquiry response by Ombudsman's office and other involved entities

The KanCare Ombudsman's goal of responding to members/applicants is within two business days. The information was tracked on quarterly basis. In 2018, the Ombudsman Office reported that it responded to 86% of the 4,484 contacts made in 2018 within the two business days, whereas it responded to 72% of the 3,672 contacts made in 2017 within two business days. Thus, in 2018, an increase of 13.7 percentage points was seen compared to 2017.

In Q4 2018, the Ombudsman office began tracking data to show the length of time it takes to respond/resolve issues that need review and assistance from other state organizations. There were 232 referrals reported for Q4 2018, of which, 72% (166) were responded to within 0–2 days; 16% (36) in 3–7 days; 9% (22) in 8–30 days; and 3% (8) in 31 or more days.[9]

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Evaluation Category: Efficiency

Goals, Performance Objectives, and Hypotheses for Efficiency of Care Subcategories:

- **Goal:**
  - Establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms as well.
- **Performance Objectives:**
  - Measurably improve health outcomes for members.
  - Support members successfully in their communities.
  - Promote wellness and healthy lifestyles.
  - Improve coordination and integration of PH care with BH care.
  - Lower the overall cost of health care.
- **Hypothesis:**
  - The state will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between PH, BH, MH, SUD, and LTSS.

Performance measures related to each of the subcategories were evaluated to assess efficiency of the care received by KanCare program beneficiaries. The final evaluation results showed improvement in the efficiency of care received by KanCare program beneficiaries over the evaluation period (Figure 63).

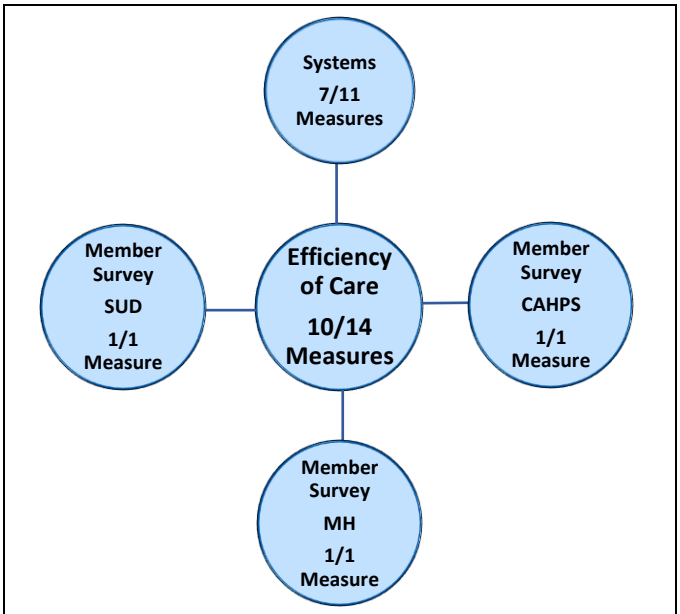

Figure 63. Improved/Maintained Measures for the Efficiency of Care Subcategories

The summaries and detailed results of the evaluation for each of the seven subcategories for the Efficiency of Care over a period of six years are described below:

1) Systems

The data for the three utilization measures related to Systems were available for 2012 through 2017 of the evaluation period. The three process timeliness measures consisted of eight metrics; five metrics had data available for comparison for 2013 through 2018, and the remaining three had comparable data available for 2014 through Q3 2018. These data were examined to assess improvement in this subcategory of the KanCare category *Efficiency*. Several performance measures had improved or maintained rates over in the most recent year compared to baseline and trending across years. The measures showing improved/ maintained rates for the most recent year compared to the baseline are summarized in Figure 64.

Evaluation Summary

One utilization measure had considerable improvement in the most recent year (2017) compared to the baseline (2014) for the subgroups TBI Waiver members and MH members. All three utilization measures were maintained over the evaluation period among the subgroups All KanCare Members, Total Waiver

Populations (TBI, FE, I/DD, and PD), and the four individual waivers (TBI, FE, I/DD, and PD). Four of the eight timeliness process measures consistently met State timeliness requirements throughout the evaluation period. While the remaining four metrics did not meet the 100% timeliness standards, they consistently had rates greater than 99%.

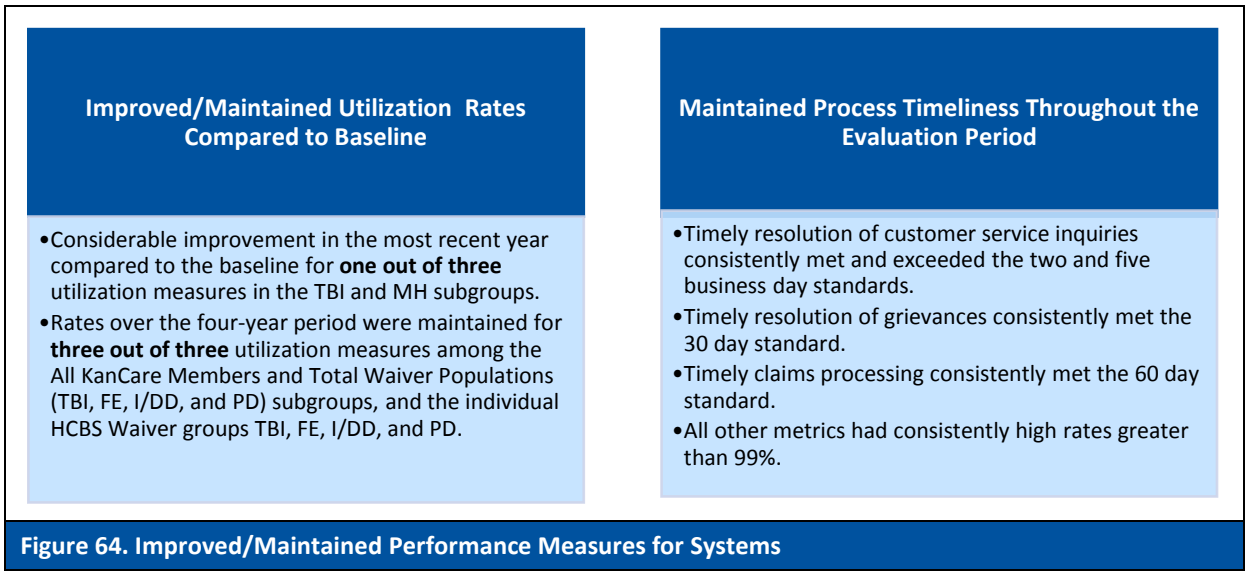

Figure 64. Improved/Maintained Performance Measures for Systems

The following measure showed considerable improvement in the most recent year (2017) compared to the baseline (2014):

- HCBS and MH ED Visits (including dual eligible members) – TBI and MH

The following measures maintained over the four-year period:

- HCBS and MH ED Visits (including dual-eligible members) – All KanCare Members, Total Waiver Populations (TBI, FE, I/DD, and PD), and FE and I/DD Waiver members;
- HCBS Inpatient Admissions – All KanCare Members, Total Waiver Populations (TBI, FE, I/DD, and PD), and the four individual waivers (TBI, FE, I/DD, and PD); and
- HCBS Readmissions within 30 days of Discharge – All KanCare Members, Total Waiver Populations (TBI, FE, I/DD, and PD), FE, I/DD, and PD Waiver members

The following measure showed a slight increase in rates in the most recent year (2017) compared to the baseline (2014) (the goal is to decrease the rate for this measure):

- HCBS and MH ED Visits (including dual eligible members) – PD Waiver members

The following measures showed consistently high rates over the evaluation period:

- Timely resolution of customer service inquiries (2013 through 2018)
- Timely resolution of grievances (2013 through 2018)
- Timely claims processing (2014 through Q3 2018)

Several utilization measures, HCBS and MH ED Visits, Inpatient Admissions, and Readmissions within 30 Days of Discharge among the subgroups All KanCare Members, Total Waiver Populations (TBI, FE, I/DD, and PD), and the four individual waivers (TBI, FE, I/DD, and PD), reflect potentially improved systems for KanCare members. However, the measure HCBS and MH ED Visits (including dual eligible members), within the subgroup PD Waiver members, showed opportunity for improvement.

All timeliness process metrics had consistently high rates, indicating system efficiencies. Although an opportunity for improvement is to further explore reasons the 100% timeliness metrics were not met to determine if there were any patterns indicating need for system improvements.

Evaluation Results for the Systems Performance Measures

Emergency Department (ED) Visits

This measure tracked emergency department visits for members who had a MH visit during the year. The measure was assessed for the subgroups All KanCare Members, Total Waiver Populations (TBI, FE, I/DD, and PD), as well as the four individual HCBS waiver groups (TBI, FE, I/DD, PD), and by MH. Due to changes in State reporting (State reporting changes were not applied to 2012 data) and unexplained decreases in rates seen in 2013, the data were assessed from 2014 (baseline) to 2017 for this final evaluation. All results, were drawn from the available descriptive data.

Table 48 and Table 49 detail HCBS and MH Emergency Department Visits (including/excluding dual-eligible members). Reported rates can differ a great deal depending on whether members with dual eligibility are excluded or included. Rates of ED visits per 1,000 member-months excluding dual-eligible members, in the baseline (2014) and for the most current year (2017), were higher for the Total Waiver Populations, MH, FE, I/DD, and PD. (Table 49). Dual-eligible members in 2017 composed approximately 10% of the overall KanCare population and approximately 70% of the HCBS population of TBI, FE, I/DD, and PD members. The percentage of dual members varied, too, by waiver type: FE–93% dual, PD–68% dual, I/DD–58% dual, and TBI–56% dual.

There are differences in the numbers and rates of ED visits for the TBI, FE, I/DD, PD, and MH members in 2014 through 2017 when including dual eligible members (Table 48) and excluding dual-eligible members (Table 49).

The summaries that follow are based on data that include members with dual eligibility (Table 48). ED visit rates for the Total Waiver Populations and each of the individual waiver populations except TBI were higher in 2017 compared to rates in the baseline (2014). All rates below are based on number of ED visits per 1,000 member-months during the calendar year.

- **All KanCare Population**: The member ED rates maintained over the four-year period, ranging from 68.51 (2017) to 73.77 (2015).
- **Total Waiver Populations (TBI, PD, I/DD, FE):** The rates maintained over the four-year period, ranging from 77.45 (2015) to 84.14 (2017).
- **TBI** – The member ED rate in 2017 (151.32) was considerably lower than the baseline rate (2014 – 194.09).
- **PD** – The member ED rate in 2017 (139.04) was slightly higher than the baseline rate (2014 – 130.95).
- **MH** – The member ED rate in 2017 (116.68) was considerably lower than the baseline rate (2014 – 128.65).
- **I/DD** – The member ED rate in 2017 was 48.99. The rates maintained over the four-year period, ranging from 46.72 (2014) to 49.47 (2016).
- **FE** – The member ED rates maintained over the four-year period, ranging from 65.25 (2015) to 75.26 (2017).

Table 48. HCBS and MH Emergency Department (ED) Visits, Including Dual-Eligible Members (Medicare and Medicaid), CY2012* – CY2017						
	2012*	2013*	2014	2015	2016	2017
All KanCare Members (provided for comparison)						
ED Visits	326,831	307,575	356,652	369,262	365,363	333,153
Members	463,285	467,632	481,950	490,441	498,611	490,325
Member-Months	4,592,675	4,655,420	4,918,690	5,005,417	5,160,959	4,863,127
Visits per 1,000 member months	71.16	66.07	72.51	73.77	70.79	68.51
Waiver Members						
Traumatic Brain Injury (TBI)						
ED Visits	1,452	1,202	1,294	1,110	930	810
Members	744	748	694	590	577	577
Member-Months	6,596	7,406	6,667	5,991	5,608	5,353
Visits per 1,000 member months	220.13	162.30	194.09	185.28	165.83	151.32
Frail Elderly (FE)						
ED Visits	6,199	3,944	4,229	3,996	3,988	4,276
Members	7,341	6,899	6,879	6,683	6,272	6,124
Member-Months	68,631	64,328	62,984	61,240	58,785	56,816
Visits per 1,000 member months	90.32	61.31	67.14	65.25	67.84	75.26
Intellectual/Developmental Disability (I/DD)						
ED Visits	5,601	4,219	4,893	5,005	5,269	5,266
Members	9,037	9,084	9,123	9,141	9,257	9,487
Member-Months	103,258	103,575	104,737	105,222	106,514	107,495
Visits per 1,000 member months	54.24	40.73	46.72	47.57	49.47	48.99
Physical Disability (PD)						
ED Visits	12,424	8,089	8,483	8,365	9,527	9,938
Members	6,984	6,340	6,166	6,368	6,905	6,874
Member-Months	75,087	68,468	64,782	66,098	71,236	71,474
Visits per 1,000 member months	165.46	118.14	130.95	126.55	133.74	139.04
Total Waiver Populations – TBI, FE, I/DD, PD						
ED Visits	25,676	17,454	18,899	18,476	19,714	20,290
Members	24,106	23,071	22,862	22,782	23,011	23,062
Member-Months	253,572	243,777	239,170	238,551	242,143	241,138
Visits per 1,000 member months	101.26	71.60	79.02	77.45	81.41	84.14
Mental Health (MH)						
ED Visits	113,755	108,505	136,232	150,521	151,725	147,586
Members	89,020	90,980	99,696	107,742	114,859	116,063
Member-Months	939,152	959,910	1,058,918	1,160,593	1,269,855	1,264,902
Visits per 1,000 member months	121.13	113.04	128.65	129.69	119.48	116.68

*Due to changes in State reporting (State reporting changes were not applied to 2012 data) and unexplained decreases in rates seen in 2013, the data were assessed from 2014 (baseline) to 2017.

Table 49. HCBS and MH Emergency Department (ED) Visits, Excluding Dual-Eligible Members (Medicare and Medicaid), CY2012* – CY2017						
	2012*	2013*	2014	2015	2016	2017
All KanCare Members – Excluding Dual-Eligible (provided for comparison)						
ED Visits	271,689	254,076	295,969	308,455	306,465	283,794
Members	405,448	411,120	425,636	435,122	445,132	440,215
Member-Months	4,026,589	4,100,783	4,361,384	4,463,500	4,633,272	4,361,233
Visits per 1,000 member months	67.47	61.96	67.86	69.11	66.14	65.07
Waiver Members – Excluding Dual-Eligible						
Traumatic Brain Injury (TBI)						
ED Visits	797	572	674	573	508	392
Members	303	299	274	231	233	256
Member-Months	2,727	3,021	2,594	2,364	2,207	2,230
Visits per 1,000 member months	292.26	189.34	259.83	242.39	230.18	175.78
Frail Elderly (FE)						
ED Visits	296	193	225	276	291	428
Members	263	249	304	318	373	406
Member-Months	2,515	2,270	2,773	3,115	3,577	4,083
Visits per 1,000 member months	117.69	85.02	81.14	88.60	81.35	104.82
Intellectual/Developmental Disability (I/DD)						
ED Visits	2,372	1,586	1,783	1,944	2,252	2,166
Members	4,255	3,271	3,404	3,527	3,720	4,021
Member-Months	46,812	36,255	38,139	39,892	42,092	44,364
Visits per 1,000 member months	50.67	43.75	46.75	48.73	53.50	48.82
Physical Disability (PD)						
ED Visits	4,419	2,648	2,907	3,175	3,776	4,253
Members	2,215	1,586	1,583	1,728	2,080	2,204
Member-Months	22,999	16,735	16,346	17,715	20,893	22,716
Visits per 1,000 member months	192.14	158.23	177.84	179.23	180.73	187.22
Total Waiver Populations – TBI, FE, I/DD, PD						
ED Visits	7,884	4,999	5,589	5,968	6,827	7,239
Members	7,036	5,405	5,565	5,804	6,406	6,887
Member-Months	75,053	58,281	59,852	63,086	68,769	73,393
Visits per 1,000 member months	105.05	85.77	93.38	94.60	99.27	98.63
Mental Health (MH)						
ED Visits	78,317	74,167	95,035	106,961	110,735	108,292
Members	64,107	66,171	73,903	81,149	90,159	92,379
Member-Months	672,690	692,990	780,539	871,960	996,107	996,423
Visits per 1,000 member months	116.42	107.02	121.76	122.67	111.17	108.68

*Due to changes in State reporting (State reporting changes were not applied to 2012 data) and unexplained decreases in rates seen in 2013, the data were assessed from 2014 (baseline) to 2017.

Inpatient Hospitalizations

This measure tracked inpatient hospitalizations. The measure was assessed for the subgroups All KanCare Members, Total Waiver Populations (TBI, FE, I/DD, and PD), as well as the four individual HCBS waiver groups TBI, FE, I/DD, and PD from baseline (2014) to 2017 (most currently reported available data reported by the State). Due to changes in State reporting (State reporting changes were not applied to 2012 data) and unexplained decreases in rates seen in 2013, the data were assessed from 2014 (baseline) to 2017 for this final evaluation. (Table 50).

Data reported below and in Table 48 for HCBS (TBI, FE, I/DD, and PD) and All KanCare Members are based on inpatient admissions per 1,000 member-months. All results were drawn from the available descriptive data.

Inpatient rates maintained over the four-year period for All KanCare Members, the Total Waiver Populations, and each HCBS waiver.

- **All KanCare Population** – The inpatient admission rate in 2017 was 15.23. The rates maintained over the four-year period, ranging from 14.61 (2016) to 15.81 (2014).
- **Total Waiver Populations (TBI, PD, I/DD, FE)** – The inpatient admission rates maintained over the four-year period, ranging from 36.30 (2015) to 37.65 (2017).
- **TBI** – The inpatient admission rates maintained over the four-year period, ranging from 45.58 (2017) to 50.46 (2016).
- **FE** – The inpatient admission rates maintained over the four-year period, ranging from 52.11 (2016) to 56.18 (2017).
- **I/DD** – The inpatient admission rates maintained over the four-year period, ranging from 13.25 (2014) to 14.84 (2016 and 2017).
- **PD** – The inpatient admission rate in 2017 was 56.62. The rates maintained over the four-year period, ranging from 54.86 (2015) to 56.88 (2014).

Table 50. HCBS Inpatient Admissions and Readmissions within 30 days of Discharge, CY2012* – CY2017

		Inpatient Admissions		Readmissions after Discharge	
Year	Members	Admits	Rate/1,000 Member-Months	Readmits	Rate/1,000 Member-Months
Total – All KanCare Members (provided for comparison)					
2012*	460,055	71,686	15.61	7,306	1.59
2013*	464,879	72,211	15.51	6,763	1.45
2014	478,871	77,755	15.81	7,436	1.51
2015	487,863	76,863	15.36	7,636	1.53
2016	496,328	75,401	14.61	7,950	1.54
2017	494,517	74,455	15.23	8,124	1.66
Waiver Members					
Traumatic Brain Injury (TBI)					
2012*	744	311	47.15	57	8.64
2013*	748	339	45.77	52	7.02
2014	694	309	46.35	46	6.90
2015	590	302	50.41	78	13.02
2016	577	283	50.46	56	9.99
2017	577	244	45.58	36	6.73
Frail Elderly (FE)					
2012*	7,341	3,433	50.02	500	7.29
2013*	6,899	3,312	51.49	465	7.23
2014	6,879	3,456	54.87	507	8.05
2015	6,683	3,198	52.22	505	8.25
2016	6,272	3,063	52.11	467	7.94
2017	6,124	3,192	56.18	540	9.50
Intellectual/Developmental Disability (I/DD)					
2012*	9,037	1,287	12.46	143	1.38
2013*	9,084	1,304	12.59	148	1.43
2014	9,123	1,388	13.25	183	1.75
2015	9,141	1,534	14.58	176	1.67
2016	9,257	1,581	14.84	217	2.04
2017	9,487	1,595	14.84	211	1.96
Physical Disability (PD)					
2012*	6,984	4,126	54.95	698	9.30
2013*	6,340	3,562	52.02	605	8.84
2014	6,166	3,685	56.88	699	10.79
2015	6,368	3,626	54.86	652	9.86
2016	6,905	3,929	55.15	795	11.16
2017	6,874	4,047	56.62	826	11.56
Total Waiver Populations (TBI, FE, I/DD, and PD)					
2012*	24,106	9,157	36.11	1,398	5.51
2013*	23,071	8,517	34.94	1,270	5.21
2014	22,862	8,838	36.95	1,435	6.00
2015	22,782	8,660	36.30	1,411	5.91
2016	23,011	8,856	36.56	1,535	6.34
2017	23,062	9,078	37.65	1,613	6.69

*Due to changes in State reporting (State reporting changes were not applied to 2012 data) and unexplained decreases in rates seen in 2013, the data were assessed from 2014 (baseline) to 2017.

Inpatient Readmissions within 30 Days of Inpatient Discharge

This measure tracked inpatient readmissions. The measure was assessed for the subgroups All KanCare Members, Total Waiver Populations (TBI, FE, I/DD, and PD), as well as the four individual HCBS waiver groups TBI, FE, I/DD, and PD. Due to changes in State reporting, (State reporting changes were not applied to 2012 data) and unexplained decreases in rates seen in 2013, the data were assessed from 2014 (baseline) to 2017 (most currently reported available data reported by the State) for this final evaluation. All results were drawn from the available descriptive data.

Readmission rates maintained over the four-year period for the subgroups All KanCare Members, Total Waiver Populations, FE, I/DD, and PD.

All rates below are based on total readmissions per 1,000 member-months each year.

- **All KanCare Population** – The readmission rates maintained over the four-year period, ranging from 1.51 (2014) to 1.66 (2017).
- **Total Waiver Populations (TBI, PD, I/DD, FE)** – The readmission rates maintained over the four-year period, ranging from 5.91 (2015) to 6.69 (2017).
- **TBI** – The readmission rate in 2015 (13.02) was considerably higher than the other three years (2014 – 6.90; 2016 – 9.99; 2017 – 6.73).
- **PD** – The readmission rates maintained over the four-year period, ranging from 9.86 (2015) to 11.56 (2017).
- **FE** – The readmission rates maintained over the four-year period, ranging from 7.94 (2016) to 9.50 (2017).
- **I/DD** – The readmission rate in 2017 was 1.96. The rates maintained over the four-year period, ranging from 1.67 (2015) to 2.04 (2016).

Timely Resolution of Customer Service Inquiries (2013 through 2018)

Quarterly tracking of timely resolution of customer service inquiries in the KanCare Evaluation were based on the MCOs' contractual requirements to resolve 95% of all inquiries within two business days; 98% within five business days; and 100% within 15 business days. The data sources for this measure were monthly call center customer service reports MCOs submitted to KDHE.

From 2013 through 2018, all of the MCOs consistently met and exceeded the timely resolution standards of 95% of all member and provider inquiries to be resolved within two business days and 98% within 5 business days. The MCOs did not meet the standard of 100% resolution within 15 business days; although aggregate rates were consistently above 99.60%. Exploration of the reasons 0.40% of inquiries were not resolved within 15 business days should occur to determine whether patterns exist, indicating a need for system improvement.

Timely resolution of grievances (2013 through 2018)

Grievances were reported and tracked on a quarterly basis by MCOs in the Grievance and Appeal (GAR) report. The report tracks the number of grievances received in the quarter, the number of grievances closed in the quarter, the number of grievances resolved within 30 calendar days, and the number of grievances resolved within 60 calendar days. Quarterly tracking and reporting of timely resolution of grievances in the KanCare Evaluation were based on the MCOs' contractual requirements to resolve 98% of all grievances within 30 calendar days and 100% of all grievances within 60 calendar days (via an extension request).

Except for 2016, the MCOs routinely met/exceeded the requirement for 98% grievance resolution within 30 days. From 2014 through 2018, the MCOs' did not meet the standard 100% resolution within 60 calendar days.

Timely claims processing (2014 through Q3 2018)
MCOs, including their vendors, are contractually required to process 100% of "clean" claims within 30 days; 99% of "non-clean" claims within 60 calendar days; and 100% of all claims within 90 calendar days, except those meeting specific exclusion criteria.

A "clean claim" is a claim that can be paid or denied with no additional intervention required and does not include the following: adjusted or corrected claims; claims that require documentation (i.e., consent forms, medical records) for processing; claims from out-of-network providers that require research and setup of that provider in the system; claims from providers where the updated rates, benefits, or policy changes were not provided by the State 30 days or more before the effective date; claims from providers under investigation for fraud or abuse; and/or claims under review for medical necessity. Claims received in the middle or end of a month may be processed in that month or the following month(s). Since a non-clean claim may take up to 60 days to process, a claim received in mid-September, for example, may be processed in September or may not be processed until early November and still meet contractual requirements.

The 2013 review of timeliness of claims payment was based on the P4P reports, using shorter timeframe requirements than 2014 through 2018; therefore, 2013 was not included in comparisons. The MCOs were not able to meet the clean claims payment standards of 100% within 30 days, or the standard of 100% of all claims processed within 90 days. While over 99% of claims were processed within the timeliness standards for clean and all claims, this is an area for improvement given the large volume of claims. The MCOs routinely met the standard of 99% of non-clean claims processed within 60 days.

System Design Innovations Implemented by KanCare/KDHE

- See the Interpretations, Policy Implications, and Interactions with Other State Initiatives Section for additional information regarding system design innovations.
- The Health Homes program for KanCare members with SMI provided care coordination services from August 2014 through June 2016, when the program was discontinued.
    - *Consumer and provider populations impacted*: members with SMI; over 51,600 members were eligible between July 1, 2014 and June 6, 2016.
    - From August 2014 to April 2016, MCOs reported processing an average of 21,664 claim lines per month for Health Home Core Services.
    - Health Promotion comprised 45% of all Core Services paid during the first 17 months of the SMI Health Homes Program, while Care Coordination services and Comprehensive Care Management services increased to 35% and 20% respectively. During the last six months of the program, a little over 1/3 of Health Home services were for Care Coordination, and 1/3 were for Health Promotion. Family Support Services, Referral to Community and Social Support Services and Comprehensive Transitional Care represented around 10% of the provided services.
    - MCOs reported that Health Home providers completed 12,773 Individual Health Action Plans (HAP) since August 2014, averaging 665 HAPs each month over 18 months.
    - Whether making the initial contact or maintaining ongoing interaction with the Health Home Member, direct communication was critical to ensuring the Member's success in the KanCare Health Home Program. From August 2014 to June 2016, MCOs reported 126,820 contacts were made to members with nearly 38% as direct face-to-face interaction.

  - Quality improvements during the two-year program included a reduction in acute general hospital utilization; reduced institutional care utilization; decreased inpatient readmissions; improved follow-up after hospitalization for mental illness within 7 days; and an increase in tobacco use assessment.
- CMH DSRIP - Expansion of PCMH and Neighborhoods
  - *Consumer and provider populations impacted:* Children and Youth with Medical Complexity (CYMC) and their siblings.
  - *Coverage by location/region:* Four practices in Northeast Kansas through 2017. In early 2018, the practice that received NCQA PCMH recognition was sold and is no longer a PCMH DSRIP participant. The three remaining practices continue to implement PCMH processes.
  - *Start dates and current stage of the initiative*: The project started January 1, 2015. One practice became PCMH-recognized by NCQA in 2016.The remaining three practices are in active stages of modifying their processes, per the PCMH model.
- Health Information Technology (HIT) and Health Information Exchange (HIE)
  - As mentioned in previous KanCare evaluation reports, the HITECH Act created provisions to promote the MU of health information technology. Through the Office of the National Coordinator for Health Information Technology Regional Extension Center program, KFMC provided support to more than 1,600 Eligible Professionals and 95 Eligible Hospitals across the state to achieve MU. The Regional Extension Center program was sunset on April 7, 2016.
  - KFMC, through funding by KDHE-DHCF, is providing technical assistance to Medicaid providers, including assisting them with health information technology (HIT) security risk assessments and meaningful use of an EHR between from February 2014 to current.
  - Increasing HIE capabilities is also a component of the HITECH Act. The presence of HIE is becoming more central in the work of healthcare providers in Kansas. As reported previously, there are two HIE organizations in Kansas that have been provided Certificates of Authority by KDHE to provide the sharing of health information in Kansas. The organizations, Kansas Health Information Network and the Lewis and Clark Information Exchange, have continued to expand their capabilities and to offer services to a wider audience.

Other System Innovations in Kansas

- Blue Cross/Blue Shield of Kansas (BCBSKS)
  BCBSKS has a Quality-Based Reimbursement Program that allows their contracting providers to earn additional revenue for performing defined activities.
  - *Consumer and provider populations impacted:* All specialty types contracted with BCBSKS and their patients.
  - *Coverage by location/region:* Kansas, excluding metro Kansas City
  - *Start dates and current stage of the initiative*: Since 2011, BCBSKS has incentivized a number of provider-based quality improvement initiatives such as Electronic Health Record (EHR) adoption, electronic prescribing, participation in a Health Information Exchange (HIE), and PCMH and an Accountable Care Organization (ACO). These incentives change each year and continued in 2018. More than 600 providers served more than 191,500 Kansans who were attributed to either a PCMH or an ACO during 2017. Both ACOs and PCMHs are created through special provider contracts and are focused on improving the overall quality of health care, creating better experiences for members and better controlling the total cost of care for a sustainable future.

- Blue Cross/Blue Shield of Kansas City (BlueKC)
  BlueKC's Medical Home Program focused on primary care aligns with the Blue Cross and Blue Shield Association's value-based programs allowing contracting providers to earn additional and alternative revenue for performing defined practice transformation activities
  - *Consumer and provider populations impacted:* All primary care providers contracted with BlueKC and their patients.
  - *Coverage by location/region:* Kansas City Metro
  - *Start dates and current stage of the initiative*: In 2010, Blue Cross and BlueKC launched its Medical Home program as a new, innovative solution to managing healthcare spend and providing high-quality healthcare to its members. Focusing on the PCP as the hub of a comprehensive, coordinated delivery system, the program strives to improve costs by coordinating care, and improving quality and patient experience by involving the patient as an active participant in the management of their health. Our local Blue KC Medical Home program is currently comprised of 854 physicians practicing at 181 different locations throughout the greater Kansas City metropolitan and surrounding area. These dedicated providers care for over 371,537 members. To become a Blue KC Medical Home provider, your practice must apply to the Blue KC Medical Home program and then undergo a Developmental Review, administered by Blue KC Medical Home staff. After the review, the practice may be placed in one of three performance tiers, i.e. the Developing, Established or Advanced tier. Consult the Medical Home Provider Manual for more information about the Blue KC Medical Home program application and review process, as well as the details of the program itself.
- The Comprehensive Primary Care Plus (CPC+) Project
  CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States.
  - *Consumer and provider populations impacted:* All primary care providers formally participating in the Kansas City Metro Region; there are also three payers providing alternative payments to participating practices: Medicare, BlueKC and United Healthcare.
  - *Coverage by location/region:* 47 Kansas-based practices in the Kansas City Metro area (99 total practices on both the Missouri and Kansas side of the border). For full listing, see the CPC+ Participant List.
  - *Start dates and current stage of the initiative*: The project started January 2017 and is currently in option year 2 of the project. There are two more optional years, for a total of five years of performance. CPC+ seeks to improve quality, access, and efficiency of primary care. Practices in both tracks will make changes in the way they deliver care, centered on key Comprehensive Primary Care Functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Planned Care and Population Health.
- Kansas Healthcare Collaborative – Practice Transformation Network (PTN)
  The Kansas Healthcare Collaborative (KHC), a quality organization founded by the Kansas Medical Society and the Kansas Hospital Association, is the lead organization in Kansas for the PTN. The PTN involves group practices, health care systems, and others joining forces to collectively share quality improvement expertise and best practices to reach new levels of coordination, continuity, and integration of care. KHC provides coaching and assistance to clinician practices preparing for clinical and operational practice transformation from a fee-for-service payment model to performance-based payment.

  - *Consumer and provider populations impacted:* Primary care practices, health care systems, and the consumers they serve.
  - *Coverage by location/region:* More than 1,400 Kansas clinicians are participating in this effort.
  - *Start date of the initiative*: The grant was awarded September 29, 2015, and the project is scheduled to end September 28, 2019.
- The UKHS –Kansas Clinical Improvement Collaborative (KCIC–ACO), previously the Kansas Heart and Stroke Collaborative (KHSC). The KCIC–ACO is working in partnership with rural Kansas providers to implement new treatment models that result in better patient outcomes and reduced healthcare costs, including:
  - Shared clinical guidelines for moving patients to the next level of care.
  - Care coordination/management and health coaching.
  - Telemedicine resources.
  - Electronic health information exchanges.
  - Establishing standards and procedures to increase efficiency and economics of scale.
  - Design and deploy payment models to support rural providers.
  - Create a forum for sharing best practices and regional care strategies.
    - *Consumer and provider populations impacted:* All consumers of participating providers. *Coverage by location/region:* The UKHS 2018 Annual Report indicates the collaborative has included greater than 50 hospitals, 1800 clinicians, and >49,000 patient interactions.
    - *Start date and current stage of the initiative*: The KHSC initiative started September 1, 2014 and extended through August 31, 2017.The KCIC-ACO was subsequently formed and continues into 2019.
- ACOs are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high-quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program. As of February 2019, there were 11 ACOs in Kansas; this is a decrease from 13 in January 2018.
- Kansas Association for the Medically Underserved – Health Center Controlled Network (HCCN) The HCCN is a group of safety net providers collaborating horizontally or vertically to improve access to care, enhance quality of care, and achieve cost efficiency through the redesign of practices to integrate services and optimize patient outcomes. Redesign includes a focus on health information technology systems, integration of electronic health record systems, Meaningful Use (MU) attestation, and quality improvement.
  - *Consumer and provider populations impacted:* Safety Net Clinics and their patients.
  - *Coverage by location/region:* Locations of participating safety net clinics include: Atchison, Garden City, Great Bend, Hays, Hoxie, Hutchinson, Junction City, Lawrence, Newton, Olathe, Salina, Wichita, and Winfield.
- Telehealth and Telemedicine: Telehealth is a broad scope of remote healthcare services, including long-distance clinical healthcare, patient and professional health-related education, and health administration activities. Telehealth refers to a broader scope of remote healthcare services, while telemedicine refers specifically to remote clinical services using interactive televideo, including use of digital stethoscopes, otoscope cameras, general exam cameras, and intra-oral scopes.
- The University of Kansas Center for Telemedicine & Telehealth (KUCTT) includes the following:
  - *Consumer and provider populations impacted:* Many hospitals and clinics across the state are equipped with video conferencing systems that allow providers to collaborate with KUCTT for

specialty clinical consults. The KUCTT has provided clinical telemedicine consults to patients across Kansas in more than 30 medical specialties.
  - *Coverage by location/region:* Throughout Kansas
  - *Start date and current stage of the initiative*: This is an ongoing service provided since 1991
- Project Extension for Community Healthcare Outcomes (ECHO)
  - *Consumer and provider populations impacted:* UKHS joined forces with CMH for the first local Project ECHO, focusing on treating epilepsy. Project ECHO has expanded beyond this initial joint project, with 97 of the 105 Kansas counties having at least one Project ECHO registered participant. It provides collaborative provider education, linking interdisciplinary specialty teams with multiple primary clinics and increases access for patients in rural and underserved communities. Topics have included airways, Epilepsy; Pediatric Psychopharmacology; Asthma; ADHD; Back-to-school; Pain Management; Opioid Addiction; Healthy Lifestyles Pediatric Obesity.
  - *Coverage by location/region:* There are four ECHO Hubs in Kansas and 97 of the 105 Kansas counties have at least one Project ECHO registered participant.
  - *Start date and current stage of the initiative*: This is an ongoing service provided since 2015
- Telehealth Rocks Schools
  - *Consumer and provider populations impacted:* Includes ECHO "tele-mentoring" to assist local medical, MH, and school providers in developing expertise in developmental and behavioral disorders to increase their capacity to identify and treat these disorders in local settings.
  - *Coverage by location/region:* Serving 11 counties and 19 school settings in southeast and south-central Kansas.
  - *Start date and current stage of the initiative*: This is an ongoing service provided since 2016

2) Member Surveys

Member Experience with the Health Plan's Customer Service in Medicaid and CHIP Populations: Measures Based on Questions in the Child and Adult CAHPS Surveys

The measure for this subcategory of *Efficiency of Care* was assessed to examine the improvement in the member experience with the health plan's customer service among the child and adult populations.

The measure was examined among the child and adult populations and was based on the child and adult CAHPS Surveys. The evaluation results are summarized below.

Evaluation Summary

The data for two CAHPS survey questions related to the member experience with the health plan's customer service among the child and adult populations were used for the evaluation of this subcategory. Out of these two questions, one established whether the specific follow-up question is applicable to the respondent or not. Thus, one follow-up question provided the needed information. The 2014–2018 data for this measure is presented in Table 51 below. The measure was assessed in both GC and CCC populations.

The rates of this measure for the child and adult populations were consistently high throughout the five-year period showing high member satisfaction with their experience with the health plan's customer service aspect of the efficiency of care received by KanCare beneficiaries during this evaluation period. The evaluation results for the trends over time and comparison of the most recent and baseline rates are summarized in Figure 65 below.

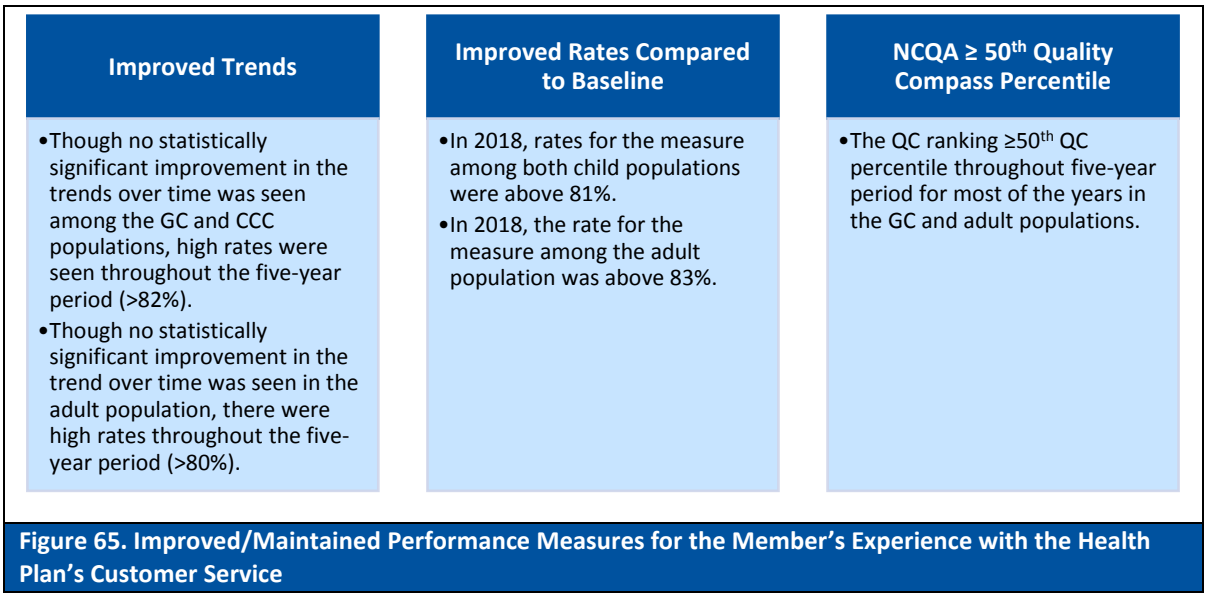

Figure 65. Improved/Maintained Performance Measures for the Member's Experience with the Health Plan's Customer Service

Though, no statistically significant improvement was seen in the trends the over the five-year period for the measure assessing the member experience with the health plan's customer service in both child (GC and CCC) and adult populations, the rates for the measure were consistently high throughout this period. The high rates maintained throughout this period indicated high satisfaction of the members with this aspect.

- The measure with high rates during 2014–2018 without showing improvement in trends over time among child populations:
  - Among the GC population, rates were above 83% – In the last 6 months, how often did your (child's) health plan's customer service give you the information or help you needed?
  - Among the CCC population, rates were above 82% – In the last 6 months, how often did your (child's) health plan's customer service give you the information or help you needed?
- The measure with high rates during 2014–2018 without showing improvement in trends over time among the adult population:
  - The rates were ≥ 80% – In the last 6 months, how often did your (child's) health plan's customer service give you the information or help you needed?

Though, rates for the measure in the most recent year among the child and adult populations were above 80%, further improvement could be achieved indicating an opportunity for improvement in the future.

The evaluation of the measure related to the members' experience with the health plan's customer service among child and adult populations based on the child and adult CAHPS survey questions showed that the measure contributed to the high efficiency of care provided to KanCare program beneficiaries. The evaluation findings also highlighted opportunities for improvement for this subcategory to further strengthen the overall efficiency of care among beneficiaries.

Evaluation Results for the Member Experience with the Health Plan's Customer Service: Based on the Child and Adult CAHPS Survey

The *Member Experience with the Health Plan's Customer Service* aspect of the *Member Survey – Efficiency* subcategory was assessed by one measure among child members (GC population – TXIX and TXXI), and CCC population – TXIX and TXXI) and the adult Medicaid population based on CAHPS Survey questions in Table 51 below.

Table 51. Member Survey – CAHPS Survey Efficiency Questions, CY2014–CY2018											
Question	Pop	% Positive Responses					Quality Compass ≥50th Percentile^				
		2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
Member Experience With the Health Plan's Customer Service – Child and Adult Populations											
In the last 6 months, did you get information or help from your (child's) health plan's customer service?	Adult	45.2%	33.2%	32.5%	31.4%	31.5%					
	GC	24.7%	27.3%	28.9%	26.6%	28.0%					
	CCC	28.3%	31.1%	30.2%	29.0%	31.5%					
In the last 6 months, how often did your (child's) health plan's customer service give you the information or help you needed?	Adult	80.0%	84.2%	83.8%	83.0%	83.3%	↓	↑	↑	↑	↑
	GC	86.7%	85.4%	84.5%	83.1%	83.6%	↑	↑	↑	↑	↓
	CCC	84.8%	84.4%	82.8%	82.7%	81.9%	↑	↑	↓	↓	↓
^↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile											

A five-year trend for this measure was examined from 2014 through 2018 (when appropriate a four-year trend was examined). The most recent rates for the child and adult populations were compared to the baseline rates. The QC rankings for this measure were also examined.

***In the last 6 months*, did you get information or help from your (child's) health plan's customer service?**
The measure was tracked for the child (GC and CCC) and adult populations by assessing the percentages of *"Yes" responses* to the survey question.

No statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations. The rates for 2018 were significantly higher compared to the baseline rates for both child populations (GC population: $p<.01$; CCC population: $p=.01$). The QC rankings for this measure were not provided by the NCQA.

No statistically significant trend was seen in the rates over the five-year period for the adult population. The comparison of 2018 and baseline rates for adults did not show a statistically significant difference. The QC rankings for this measure were not provided by the NCQA.

Among those who responded ***"Yes"*** to this question, the following question was further assessed:

- ***In the last 6 months,* how often did your (child's) health plan's customer service give you the information or help you needed?**
  The measure was tracked for the child (GC and CCC) and adult populations by assessing the percentages of *"Always/Usually" responses* to the survey question. The evaluation of this subcategory was based on this measure.

  Though, no statistically significant trend was seen in the rates over the five-year period for both GC and CCC populations, the rates were considerably high throughout this period (above 81%). The comparison of 2018 and baseline rates for both GC and CCC populations did not show statistically significant differences. The QC rankings among the GC population were ≥50th QC percentile for most of the years in this period. The QC rankings among the CCC population were below the 50th QC percentile in the recent years.

Though, no statistically significant trend was seen in the rates over the five-year period for the adult population, the rates were considerably high throughout this period (above 80%). The comparison of 2018 and baseline rates for adults did not show a statistically significant difference. The QC rankings among the adult population were ≥50th QC percentile for most of the years during this period.

Member Perception of Mental Health Provider Returning Calls: Measure Based on MH Survey Question

Evaluation Summary

The measure for this subcategory of *Efficiency of Care* was assessed to examine the improvement in the Adult members perception related to the provider returning their call in 24-hours. The MH Surveys conducted from 2011 through 2018 are described in the evaluation category "Quality of Care," subsection 8 "Member Survey – Quality of Care" performance measure "Member Perceptions of Mental Health Provider Treatment."

Six-year (2013–2018) and eight-year (2011–2018) trends for this measure were examined and none were noted. The most recent rate for the adult population was compared to the baseline rates in 2011 and 2012 and the data for this measure is presented in Table 52.

The rates for this measure were consistently maintained in the range of 79.6%–88.1% throughout the six-year evaluation period (2013–2018) and pre-KanCare (2011 and 2012) showing contribution to member perception for their provider returning their phone calls in 24-hours.

The measure related to the members perception for the provider returning their calls in 24-hours, showed their contribution to improved efficiency for the beneficiaries.

Evaluation Results for the Member's Perception of Mental Health Provider Returning Calls: MH Survey

The performance measure, yearly rate, and statistical testing for trends overtime and in the most recent year (2018) compared to baseline (2011 and 2012) are presented in Table 52.

Table 52. Mental Health Survey – Efficiency-Related Questions

	Year	Rate (0% – 100%)	Numerator/ Denominator	95% Confidence Interval	Comparison of Most Current Year to Baseline and Pre-KanCare	Trend 6-Year	Trend 8-Year
	Adults (Age 18+)*						
My mental health providers returned my calls in 24 hours.	2018	86.4%	254 / 294	82.0% – 89.9%			
	2017	85.9%	303 / 353	81.8% – 89.2%			
	2016	79.6%	213 / 267	74.4% – 84.1%			
	2015	84.4%	292 / 346	80.2% – 87.9%			
	2014	83.3%	618 / 742	80.5% – 85.8%			
	2013	84.4%	840 / 995	82.0% – 86.5%			
	2012	80.8%	202 / 250	75.4% – 85.2%			
	2011	88.1%	251 / 285	83.8% – 91.4%			

*The Adult (Age 18+) subgroup was assessed 2011–2018.

My mental health providers returned my calls in 24 hours
For Adult members, the rates were consistently maintained over the six-year period (2013–2018), ranging from 79.6% in 2016 to 86.4% in 2018.

Member Perception of Substance Use Disorder Counselor Communication: Measure based on SUD Survey

Evaluation Summary
The member's experience with the SUD Counselor's communication was assessed by one SUD Survey question. The SUD surveys were conducted by the MCOs on an annual basis from 2014 through 2017.

The question that follows is related to perception of efficiency for members receiving SUD services (Table 53).

The member's rating of the counselor on communicating clearly with the member consistently showed high rates throughout the four-year period indicating high satisfaction with SUD services provided to them through the KanCare program (Figure 66).

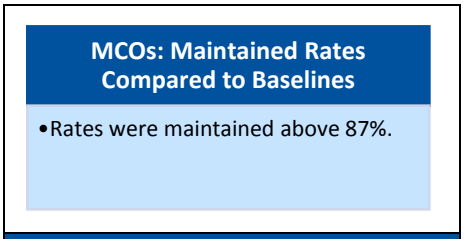

Figure 66. Improvemed/Maintained Performance Measures for Efficiency of SUD Services (SUD Member Survey)

Evaluation Results of Member Perception of Substance Use Disorder Counselor Communication: SUD Survey
How would you rate your counselor on communicating clearly with you?
In 2017, 87.3% of members surveyed rated the quality of service as very good or good. While the rates consistently remained high throughout the four-year period, the rate in 2017 was significantly lower ($p < .05$) than the rate in 2014.

Table 53. SUD Survey – Efficiency Related Question, CY2014–CY2017

	CY2014	CY2015	CY2016	CY2017
How well does your counselor communicate with you? *(Percent of "Very well" or "Well" responses)*	**93.9%**	**93.2%**	**92.1%**	**87.3%**

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Evaluation Category: Uncompensated Care Cost Pool

Evaluation Summary

UCC Pool payments increased from $20,568,567 in CY2012 to $41,026,795 in CY2013 and ranged from $40,698,530 to $40,983,780 in subsequent years.

Evaluation Results of Number of Medicaid Days for UCC Pool Hospitals Compared to UCC Pool Payments

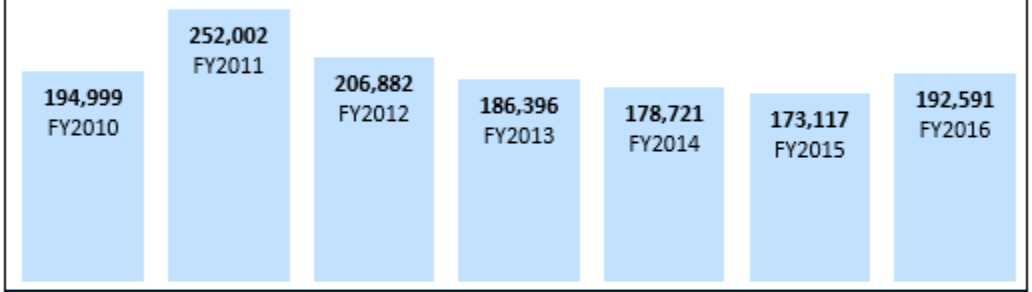
The UCC Pool permits payments from the State to hospitals based on the uncompensated cost of furnishing services to Medicaid and uninsured individuals. The UCC Pool funding is based on historical costs. For instance, the UCC Pool funding for CY2016 is based on costs of care during FY2014, and funding for CY2018 is based on costs of care during FY2016.

There were 194,999 Medicaid days for UCC Pool hospitals in CY2012. This number increased substantially to 252,002 Medicaid days in CY2013, in part because of the influx of beneficiaries at the start of KanCare. The number of Medicaid days subsequently decreased each year from 2014 through 2017 and increased in CY2018 (Table 54).

UCC Pool payments increased from $20,568,567 in CY2012 to $41,026,795 in CY2013. This increase was partially due to a change in Kansas Statute 65-6208 to increase HCAIP funding implemented at the start of the FY2013. UCC Pool payments ranged from $40,698,530 to $40,983,780 in subsequent years.

Table 54. UCC Payment History

Medicaid Inpatient Days by Fiscal Year



UCC Annual Payment Totals by Calendar Year

CY2012	CY2013	CY2014	CY2015	CY2016	CY2017	CY2018
$20,568,567	$41,026,795	$40,974,407	$40,929,060	$40,960,116	$40,698,530	$40,983,780

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Evaluation Category: Delivery System Reform Incentive Program (DSRIP)

Goals, Performance Objectives, and Hypotheses for DSRIP Subcategories:

- **Goal:**
  - To advance the goals of access to services and healthy living by specifically focusing on incentivizing projects that increase access to integrated delivery systems and projects that expand successful models for prevention and management of chronic and complex diseases.
- **Performance Objectives:**
  - Focus Area: Access to integrated delivery systems:
    a. Increase access to services, including primary care and preventive services.
    b. Increase the effective and efficient use of population health management through HIT.
    c. Increase integration of the health care delivery system, including medical, BH, and social services.
  - Focus Area: Prevention and management of chronic and complex diseases:
    a. Improve health literacy, including nutrition education and tobacco use prevention and control.
    b. Expand health and wellness programs and develop incentives for participation in these programs.
    c. Expand chronic and complex care management models.

The Kansas DSRIP program, launched in 2015, includes two major hospital systems, CMH and the UKHS. UKHS implemented two projects within the "prevention and management of chronic and complex diseases" focus area, while CMH implemented one project from each focus area. CMH projects include *the Beacon Program* and *Expansion of PCMH*. UKHS projects include STOP Sepsis and SPARCC.

Evaluation Summary

Each project contains Infrastructure Milestones (Category 1), Process Milestones (Category 2), Quality and Outcome Milestones (Category 3), and Population Focused Metrics (Category 4). Several improvements and accomplishments were noted in all Category Metrics and are summarized in Figure 67.

Infrastructure (Category 1)	Process (Category 2)	Quality (Categories 3 and 4)
•STOP Sepsis participation. •STOP Sepsis data submissions. •SPARCC participation. •Beacon registries and order sets. •Beacon's use of information. technology for Consultation. •Beacon and PCMH Recognitions. •PCMH On-line Message Board. •PCMH Community Engagement Resource Application. •PCMH Integrated Database Platform.	•STOP Sepsis Case Reviews. •Sepsis training modules. •SPARCC train-the-trainer modules via You Tube, Zoom and Telehealth. •PCMH Learning Collaboratives/Webinars. •PCMH Collaborative Service Agreements. •PCMH Competency Checklist. •PCMH Engagement. Compensation Scoring Model.	•Statistically significant improvements in two STOP Sepsis metrics. •Statistically significant improvement in two Beacon Program metrics. •Two Beacon rates greater than 80% for four years. •One STOP Sepsis rate greater than 80% for three years. •Four CMH Category 4 rates greater than 90%.

Figure 67. Improvements in DSRIP Metrics

Statistically significant improvements:

- STOP Sepsis hospital partners' (Critical Access Hospitals [CAHs] and non-CAHs) implementation of sepsis protocols.

- The proportion of patients progressing to septic shock, among partner facilities participating for at least 12 months in the STOP Sepsis project.
- Beacon patient/family experience with provider follow-up after labs, x-rays or other studies.
- Beacon patients with a Pediatric Emergency Information Form to use in the event care is needed by Emergency Medical System (EMS) or another healthcare organization.
- Results with high rates or larger improvements:
  - Annual Height, Weight, and Body Mass Documentation of patients in Medicaid ages 3-17, who had an outpatient visit, above 95% for the three most recent years (CMH Category 4).
  - Annual Counseling for Nutrition of Patients in Medicaid ages 3-17 who had an Outpatient Visit above 95% for the three most recent years (CMH Category 4).
  - Annual Counseling for Physical Activity of Patients in Medicaid ages 3-17 who had an Outpatient Visit above 95% for the three most recent years (CMH Category 4).
  - Lead Testing for Patients in Medicaid, age 2, that had a well-child visit with a CMH PCP, greater than or equal to 90% for the three most recent years (CMH Category 4).
  - CMH ED Visits for Patients with Asthma, per 1,000, decreased from 305 per 1,000 in 2015 to 122 per 1000 in 2018 (CMH Category 4); unable to test for statistical significance due to denominator not provided.
  - Annual Influenza Vaccination for Patients with Asthma rate greater than 90% for 2015, 2016 and 2018, and greater than 82% for 2017 (Beacon program).
  - Patients with a Documented Health and Services Care Plan in the Previous 13 months, greater than 85% for the most recent four years (Beacon program).
  - Increased ED identification of septic patients at any stage of continuum, greater than 80% for the three most recent years (STOP Sepsis program).

Infrastructure accomplishments:

- STOP Sepsis participation: 227 engaged community partners, including 65 NFs, 69 CAHs, and 48 Emergency Medicaid System (EMS) providers. Training was provided to 1,986 partner staff members throughout Kansas.
- STOP Sepsis data submissions: 57 community partners sharing sepsis data through Research Electronic Data Capture (REDCap).
- SPARCC participation: 105 participating community partners (hospitals, NFs, clinics etc.), all sent participants to a SPARCC training workshop.
- Beacon registries and order sets: Order sets are tied to Category 3 and 4 measures; 16 registries were developed, maintained and actively used for population health management.
- Beacon's use of HIT for Consultation services: telehealth locations are distributed throughout the state; not in northwest Kansas yet, potentially in 2019.
- PCMH Recognitions: The Beacon program achieved NCQA PCMH recognition in 2015 and re-recognition in early 2018. One practice participating in the PCMH DSRIP project achieved NCQA recognition in 2016.
- PCMH On-line Message Board: a CMH developed forum for the practices to communicate with each other during the Learning Collaboratives and throughout the project.
- PCMH Community Engagement Resource Application (CERA): CMH developed and maintained the on-line searchable tool, containing information for over 860 community organizations that address various social determinants of health; it was accessed 25,970 times in 2018.
- PCMH Integrated Database Platform: CMH developed this to provide patient data from multiple sources in one database, to assist practices with using health IT for population health management.

Process related accomplishments:

- STOP Sepsis Case Reviews: UKHS hosted 20 case reviews, as Learning Collaborative Arenas, with increasing partner participation (42 in 2018).
- Sepsis training modules: online modules accessible in YouTube videos.
- SPARCC train-the-trainer modules, including 13 videos, available via You Tube, Zoom and telehealth technologies. UKHS trained a total of 241 facilitators across six Kansas regions, including 163 registered nurses, physician assistants, and nurse practitioners and 49 other health professionals (social workers, dieticians, health educators, and BH specialists).
- PCMH Learning Collaboratives/Webinars: CMH provided over 30 Learning Collaborative opportunities, which included applicable educational webinars.
- PCMH Collaborative Service Agreements: Over the past two years, 94% of all specialist referrals for patients 0–20 years of age had an associated Collaborative Services Agreement (CSA).
- PCMH Competency Checklist: CMH developed this dynamic tool to assist in evaluating, documenting and planning full implementation of practice transformation.
- PCMH Engagement Compensation Scoring Model: CMH uses to evaluate and document each practice's level of participation and progress towards practice transformation. Provider compensation is based on level of involvement.

Lessons Learned and Areas for Improvement:

- During selection and planning of the project, more fully address the adequacy of the projected number of project participants and consider contingency plans for participant recruitment strategies, project interventions and project participant (providers and patients) withdrawals mid-project, to improve project success.
- Dedicate more time up front to the development of clear measures and plans for data collection and analysis to improve consistency and accuracy of reported results.
- Explain reasons for data changes over time, being as specific as possible (e.g., recalculating after allowance for claim lag, identifying an error in an Excel formula, etc.). After allowance for claims lag or other known data lags, past analysis and reported results should be set and saved, with no further recalculations allowed.

Evaluation Results of the DSRIP Program: based on DSRIP Hospital Reports

The University of Kansas Hospital System

STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis

UKHS is using the DSRIP initiative to spread their internal quality programs that address sepsis, seeking to reduce the disparity of care for sepsis patients in rural communities and improve early identification and treatment with a goal of reducing the need for hospitalization or minimizing the length of stay and intensity of hospital care. The STOP Sepsis program focuses on education of sepsis recognition and management at nursing homes, emergency departments, hospitals and EMS. As reported by the Centers for Disease Control and Prevention in their August 2016 Vital Signs focused on sepsis, "*Sepsis begins outside of the hospital for nearly 80% of patients*." This highlights the importance of focusing this DSRIP project on implementing protocols not only by hospitals, but also by NFs, long-term care facilities, and EMS providers.

Category 1: Infrastructure Milestones

UKHS met their Infrastructure milestones of engaging community partners to participate in the STOPS Sepsis initiative, to enter data into the UKHS provided database, and to obtain training. UKHS well exceeded their overall goal, with 227 engaged community partners, including 65 NFs, 69 CAHs, and 48

EMS providers. Of the initially targeted 185 communities, 143 were intended to be NFs; UKHS continues to recruit and add NFs each year of the project. UKHS noted, "Enlisting NFs to participate in a project that includes additional data tracking activities has been a challenge." UKHS developed and implemented in 2017 a new database tool for NFs for tracking and reporting sepsis data. The NF and hospital database were transferred to REDCap, a browser-based software solution which project partners have found more user-friendly than the previous database. This provided UKHS staff more efficient and expanded reporting capabilities from multiple types of partnering facilities. As of 2018, there were 57 facilities sharing sepsis data. UKHS previously planned for participating partners to conduct retrospective chart review to identify their baseline prior to beginning the Sepsis project; retrospective review was not completed and baselines are the first measurement period after beginning the project.

From 2015 to 2018, STOP Sepsis training was provided to 1,986 staff from hospitals, NFs, EMS, and other healthcare providers throughout Kansas. UKHS has also partnered with the technology company Redivus Health on a mobile app to assist providers in recognizing and diagnosing sepsis.

Category 2: Process Milestones, Focus on Process Changes and Improvements
Since UKHS provided Metric 2.1 information regarding registered facilities entering data into the provided database with Metric 1.2, they added measurement of participation in their Learning Collaborative Arenas (LCAs), involving collaborative multi-disciplinary multi-organization sepsis case reviews. Since November 2016, UKHS hosted 20 case reviews, with participation increasing over time. In 2018, there were 42 unique partner organizations represented at case reviews, a 16.7% increase from 36 participating partner organizations in 2017. In addition to partner organizations, 10 non-partner organizations were represented in 2018. NFs have not submitted any cases for review. UKHS is considering the barriers to NF participation and seeking additional opportunities to engage NFs in the case review process in 2019.

UKHS has developed a variety of sepsis online modules accessible in YouTube videos with hundreds of views tracked and reported. Information is also available on the STOP Sepsis website that also provides links to additional sepsis information resources. In the semiannual report, UKHS reported the Stop Sepsis YouTube channel includes *Introduction to Sepsis, Recognizing Sepsis, Treating Sepsis, Measuring Outcomes*, *and Sepsis and NF*s.

Category 3: Quality and Outcome Milestones
UKHS works with hospitals after completion of their formal STOP Sepsis training to help ensure compliance with the protocols. They continue to survey participating organizations regarding their use of sepsis protocols. As of December 31, 2018, 95.4% (69/73) of hospital partners (CAHs and non-CAHs) have implemented sepsis protocols, a statistically significant ($p < .001$) increase from 2016 (62.8%, 27/43) (Table 55).

There were some data discrepancies with several measures, including ED identification of septic patients in early stages; at septic shock stage; transfer of septic patients to a higher-level facility; and transfers to the hospital from a long-term care facility. Variations potentially occurred during the transition to REDCap and reporting should improve going forward. Through record review, UKHS noted improvement in ED identification of sepsis at any stage; however, identification of the specific stage continues to need substantial improvement to ensure patients receive time-critical diagnoses and immediate initiation of treatment. UKHS noted the national Surviving Sepsis Campaign (SSC) is addressing similar issues by replacing its three-hour bundle with a single "hour-1 bundle" with the explicit intention of beginning

resuscitation and management immediately. UKHS is incorporating the SSC's "hour-1 bundle" in its training and will work with participants in developing and refining internal processes for executing sepsis protocols at the point of care. Additionally, using REDCap, UKHS is evaluating compliance with protocols at the individual patient level; this enhances the opportunities for targeted coaching and improvement efforts.

For partner facilities participating for at least 12 months in the STOP Sepsis project, there was a 37.8% statistically significant decrease ($p < .05$) in the proportion of patients progressing to septic shock, from 31.7% in 2016 to 21.0% in 2018.

Table 55. DSRIP, University of Kansas Health System

	2013	2014	2015	2016	2017	2018
STOP Sepsis						
Category Three Metrics – Project Participants						
Improved in-hospital implementation of sepsis management bundles as defined by the Surviving Sepsis Campaign				62.8%	84.1%	94.5%
Increased ED identification of septic patients at any stage of continuum				80.6%	89.4%	89.2%*
Increased ED identification of septic patients with severe sepsis				40.1%	25.1%	34.8%*
Decrease in proportion of septic patients progressing to septic shock				31.7%	23.6%	21.0%
Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC)						
Category Three Metrics – Participants in Patient Education Groups						
Those with Heart Failure or Diabetes who Self-Report Daily Monitoring of Blood Glucose Levels from Week 1 to Week 4¶				NA‡	42.2%^ to 52.8%† to 53.3%‡	50.0% to 52.2% to NA
Quality of Life and Functional Health Status Average Scores from Week 1 to Week 4, Scale 0 to 100¶				71.1 to 77.2 to 77.2	75.0 to 80.0 to 80.8	74.5 to 78.9 to NA
Anxiety and Depression Assessment/ Screening Scores from Week 1 to Week 4 to Six Month Check, Scale 0 to 30 (lower score - less anxiety and less depression)¶				6.4 to 4.9 to 5.5	4.5 to 3.9 to 3.7	4.8 to 4.4 to NA
Daily Weight Monitoring reported from Week 1 to Week 4 to Six Month Follow-up¶				NA 44.8% to 61.5%	34.4% to 64.5% to NA	40.9% to 54.3% to NA

*Only includes 3 quarters of 2018 data due to claims lag.

^ Rate or score reported in Week 1 of Education Group.

† Rate or score reported in Week 4.

‡ Rate or score reported in 6 month follow-up to education sessions.

¶ Compare with caution due to small variation in number of respondents to repeat measurement.

Table 55. DSRIP, University of Kansas Health System (Continued)						
	2013	2014	2015	2016	2017	2018
Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC) (Continued)						
Category Four Metrics – KanCare Population						
Overall ED Utilization (KanCare, HEDIS); rate per 1000	65.7	64.2	66.3	59.5	62.4	
Inpatient Readmission Rate Following Hospitalization; rate per 1000	1.6	1.5	1.5	1.5	1.7	
Controlled High Blood Pressure (HEDIS)	47.3%	51.4%	48.2%	52.1%	53.6%	
Members indicating they Smoked or Used Tobacco (CAHPS)	37.7%	33.6%	32.2%	33.2%	31.6%	
Members who smoked advised to quit by healthcare provider (CAHPS)	75.7%	76.2%	79.5%	80.0%	78.7%	
Members who smoked whose healthcare provider discussed cessation medication (CAHPS)	48.3%	43.1%	46.1%	51.3%	52.2%	
Members who smoked whose healthcare provider discussed cessation strategies other than medication (CAHPS)	38.6%	37.5%	44.4%	48.4%	46.1%	

Category 4: Population Focused Improvements
There has been improvement in most Category 4 measures (Table 55), which are aggregated HEDIS or CAHPS results provided by the three KanCare MCOs for the overall KanCare population. These measures are further discussed in the HEDIS and CAHPS sections of this Final Report.

Partner and Trailblazer Valuations
At least 20% of the patients served through the project are affiliated with external community partners. UKHS' extended their outreach and capacity-building to rural and underserved areas of Kansas.

Evaluation Design Table Goals and Metrics
All additional goals and metrics for reporting and tracking progress over time have been incorporated into previous discussion of Category 1 through 4 metrics.

Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC)

The SPARCC program focuses on building heart failure (HF) patients' ability to care for themselves and be resilient in the face of their chronic condition. The program also includes caregivers, who benefit as well from the skills learned through the training. UKHS trains SPARCC facilitators to lead group sessions and track related results at Week 1, Week 4 and the 6-month follow-up.

Category 1: Infrastructure Milestones
UKHS identified 163 potential partner organizations and have engaged 105 participating community partners (hospitals, NFs, clinics etc.). To be considered participating, the organization must have sent participants to a SPARCC training workshop. UKHS estimated 3,375 people with heart failure in the 43 Kansas counties where SPARCC training was planned to be focused.

Category 2: Process Milestones focus on process changes and improvements
UKHS developed train-the-trainer modules, including 13 training videos accessible through a YouTube website and via telehealth technologies. As of December 2018, UKHS had trained a total of 241 facilitators across six Kansas regions, including 163 registered nurses, physician assistants, and nurse practitioners and 49 other health professionals (social workers, dieticians, health educators, and BH specialists). Three RNs had also been trained in motivational interviewing and social support services as health coaches.

As reported in 2018, 73 (30.3%) have provided at least one group education session. UKHS revised a previous metric (*Identify mechanisms by which to contact and disseminate information about the SPARCC*) to focus on the number of patients completing weeks one through four of the SPARCC education group compared to the number of facilitators having completed at least one four-week group session. The ratio has increased from 1.34 to 1 (43 patients/32 facilitators) in 2016 to a cumulative ratio of 3.90 to 1 (285 patients/73 facilitators) in 2018.

Since the original number of facilitators determined to be required for this project was 90 facilitators, it is important to acknowledge that UKHS has reached 81% of their original goal for engaged facilitators. It can be challenging for trained facilitators to devote the time needed to conduct trainings as often as may be desired. The UKHS strategy of training facilitators beyond the original goal has been effective, although it may dilute the percent of "engaged" facilitators.

The number of patients participating in the SPARCC program increased from 86 in 2016 (DY [Demonstration Year] 4) to a cumulative 285 in 2018 (DY6). Given that the booster session occurs six months later, a total of 238 have had enough time lapse for this session to be possible. Of that 238, 145 participated in the six-month follow-up.

UKHS is coordinating with the Kansas Clinical Improvement Collaborative to further recruit and engage patients. Trainings can now be facilitated via Zoom. UKHS continues to evaluate ongoing mentoring modalities. Turning Point, a wholly-owned subsidiary of UKHS, makes behavioral specialists available through Zoom and other telehealth technologies.

Category 3: Quality and Outcome Milestones
The quality measures are based on self-reporting from the participating patients with HF at week 1, week 4 and the six-month follow-up (Table 55). Approximately one-half to two-thirds of the patients participating in the SPARCC program are also diabetic, which supports reasons for incorporating the additional metric in 2017 regarding daily monitoring of blood glucose levels. UKHS reported increases in daily monitoring of blood glucose and weight, as well as improvements in Quality of Life/Functional Health Status and Anxiety/Depression Scores from week one to week four of participation in the SPARCC program. The level of improvement appears to be maintained through the six-month follow-up. However, conclusions are not possible due to small inconsistencies in the denominators between week 1, week 4 and the six-month follow-up, indicating the self-reporting wasn't completed by specifically the same people over time.

An additional quality measure is the rate of HF readmissions for patients in the program, as reported by the patient each week. Due to the amount of variation in the number of patients reporting each week and six-month session, the results are not included.

Category 4: Population Focused Improvements
There have been improvements in most Category 4 measures (Table 55), which are aggregated HEDIS and CAHPS results provided by the three KanCare MCOs for the overall KanCare population. These measures are further discussed in the HEDIS and CAHPS sections of this Final Report.

Partner and Trailblazer Valuations
At least 20% of the patients served through the project are affiliated with external community partners. UKHS' extended their facilitator trainings and patient group sessions to rural and underserved areas of Kansas.

Evaluation Design Table Goals and Metrics
All additional goals and metrics for reporting and tracking progress over time have been incorporated into previous discussion of Category 1 through 4 metrics.

Children's Mercy Hospital and Clinics

Improving Coordinated Care for Medically Complex Patients (Beacon Program)

The goal of the Beacon Program is to encourage quality care for CMC or CYMC and their siblings, across the delivery system. This is achieved through a referral process where the Beacon Program becomes the primary care provider/independent medical home for the patient if they live within 55 miles of Kansas City. For those living outside the Kansas City area, the Program accepts the patient as a community consult, using a regional care coordination model. For community consults, the child's community PCP remains the primary provider and the Beacon Team consults on the patient once a year to develop a comprehensive care plan. These consults are performed via telehealth and can be completed in the PCP's office, or another approved facility. Additionally, the Beacon Program remains available to the PCP throughout the year, 24 hours a day, for assistance with the child with medical complexity.

Category 1: Infrastructure Milestones
Beacon's multi-disciplinary team initially included physicians, nurse practitioners, nurses, care coordinators, social workers, a dietitian and an office coordinator. Later, a medical director, psychologist, and a pharmacist were added to the team to meet changing needs of the population served. The team used information learned from a gap analysis to ensure they met the NCQA PCMH requirements. They applied for PCMH recognition and achieved NCQA Level III recognition in December 2015. The Beacon Program was successful in obtaining PCMH re-recognition in early 2018.

CMH maintains the electronic clinic note, updating the Health and Service Evaluation (H&S) and all order sets as needed. Order sets are tied to Category 3 and 4 measures and include immunizations, well child checks, CBC and lead screening. Sixteen registries were developed, maintained and actively used for population health management. The Beacon team developed pre-visit planning reports and nursing preparation processes to ensure consistency and improve efficiencies. New providers have been trained on telehealth visits. Beacon continues to focus on enhancing their website to be more family focused; they sought family and patient input. In 2018, the Beacon Program reported their website analytics identified their educational videos as the most accessed. Their website provides a link to the Beacon program for providers and families to communicate.

The number of Kansas City Medical Home Beacon patients (CYMC and siblings) served annually, at some point, has grown from 56 in 2015 to 140 in 2018. The uptake for Community Consultative services has been slow, with none until the 18 in 2017 and 38 in 2018. In 2018, Beacon staff focused on building relationships with PCPs (existing and potential partners/referral sources) through in-person site visits and streamlining referral processes. The number of consults more than doubled in 2018, with 38

consults. The Beacon program currently has locations distributed throughout the state, except in northwest Kansas, where they anticipate exploring a location in 2019.

Category 2: Process Milestones focus on process changes and improvements
In addition to meeting metrics regarding PCMH recognition, the Beacon program developed a "Medical Neighborhood" action plan that focuses on use of collaborative service agreements. These have primarily been within Children's Mercy but efforts are ongoing to extend to additional medical services.

Category 3: Quality and Outcome Milestones
There are too few children in the specified age groups (ages 2, 6, 13, and 16-18) in the individual Immunization metrics and the Hemoglobin/Hematocrit Testing metric to allow valid annual comparisons of progress; data is not reported in this report. The rate for annual influenza vaccination for patients with asthma was almost always greater than 92% (Table 56). Every year, CMH reviewed the reasons the remaining patients had not received needed vaccinations. Most of the cases had valid reasons, including medical contraindications, different schedules due to catch-up vaccinations, and new patients' immunization records requested.

Patient/family reported positive experience with provider follow-up after labs, x-rays or other studies, increased significantly from 90% in 2017 to 100% in 2018 ($p < .05$). Additionally, one focus of the Beacon program is to ensure Beacon patients have a Pediatric Emergency Information Form to use in the event care is needed by EMS or another healthcare organization. There was a 73% improvement from 2015 to 2018 ($p < .001$). The percent of patients with a documented Health and Service Care Plan varied annually within 5 percentage points. Further CMH chart review identified reasons for not having a H&S Plan included unexpected provider medical leave, appointment no-shows or rescheduling, and appointment overdue (not currently scheduled).

Table 56. DSRIP, Children's Mercy Hospital and Clinics

	2015	2016	2017	2018
Improving Coordinated Care for Medically Complex Patients (Beacon Program)				
Category Three Metrics – Project Participants				
Annual Influenza Vaccination for Patients with Asthma	95.7%	92.7%	82.6%	92.3%
Patient/Family Experience Regarding Coordination of Care after Labs/X-rays or Other Studies.	NA*	83.3%	90.0%	100.0%
Patients with Pediatric Emergency Information Form for EMS and Receiving Health Organizations	52.6%	87.7%	91.6%	91.0%
Patients with a Documented Health and Services Care Plan in the Previous 13 months	89.5%	86.2%	91.6%	87.6%
Expansion of Patient Centered Medical Homes and Neighborhoods (PCMH)				
Category Three metrics – Patients in PCMH Participating Practices				
Annual Height, Weight, and Body Mass Documentation of patients in Ages 3-17	34.9%	75.2%	76.7%/ 59.8%^	43.7%
Annual Counseling for Nutrition of Patients Ages 3-17	46.9%	58.8%	72.3%/ 52.8%^	39.2%
Annual Counseling for Physical Activity of Patients Ages 3-17	44.0%	43.9%	47.51%/ 10.2%^	27.4%
HEDIS Combination 10 Immunization Rate for Children Age 2	48.4%	52.8%	48.8%/ 48.5%^	43.8%

*Had no survey respondents in 2015
^Second percentage is rate recalculation excluding one practice sold in 2018 and new provider did not continue) to allow for comparisons going forward.

Table 56. DSRIP, Children's Mercy Hospital and Clinics (Continued)				
	2015	2016	2017	2018
Expansion of Patient Centered Medical Homes and Neighborhoods (PCMH)				
Category Three metrics - Patients in PCMH Participating Practices (Continued)				
Lead Screening for Children Age 2	42.7%	71.1%	76.1%/ 76.4^	77.6%
Hemoglobin/Hematocrit Testing for Children Age Two	73.4%	82.1%	85.3%/ 86.3%	83.0%
Adolescent Well-Care Visit for Patients Ages12-21 years with two or more chronic conditions or one chronic condition at risk for a second in the measurement period	46.3%	52.4%	54.9%/ 46.7%^	48.8%
ED visits for Patients with Asthma per 1000	456.0	292.0	369.0/ 321.0^	309.0
Category Four Metrics - Children's Mercy Hospital and Clinics' Population				
CMH ED Visits for Patients with Asthma per 1,000	305.0	139.7	98.3	122.4
CMH Medicaid Inpatient Hospitalizations with Readmissions within 30 days per 1000	90.1	92.5	84.9	87.8
Annual Height, Weight, and Body Mass Documentation of patients in Medicaid ages 3-17, who had an outpatient visit	34.7%	100.0%	100.0%	99.9%
Annual Counseling for Nutrition of Patients in Medicaid ages 3-17 who had an Outpatient Visit	46.9%	99.3%	99.4%	99.3%
Annual Counseling for Physical Activity of Patients in Medicaid ages 3-17 who had an Outpatient Visit	44.0%	98.0%	98.1%	95.8%
Appropriate Testing for Children, ages 2-18, with Pharyngitis	51.6%	77.5%	79.8%	85.1%
Lead Testing for Patients in Medicaid, age 2, that had a well-child visit with a CMH PCP	42.7%	93.8%	95.7%	89.6%

^Second percentage is rate recalculation excluding one practice sold in 2018 and new provider did not continue) to allow for comparisons going forward.

Category 4: Population Focused Improvements

The Population Focused metrics are based on rates for the CMH patient population. There have been improvements in all Category 4 measures (Table 56), with most improvements sustained for a few years. Statistical testing between baseline and 2018 is not possible due to denominators not consistently being reported.

Partner and Trailblazer Valuations

In 2018, at least 20% of the patients served were affiliated with external community partners, through the Beacon Community Consultative program. Community partners include providers from rural and frontier Kansas counties. Community resource guides developed by the Beacon program and Children's Mercy Integrated Care Solutions provide resource information to 89 counties in Kansas, including those in rural areas of the state.

Evaluation Design Table Goals and Metrics

All additional goals and metrics for reporting and tracking progress over time have been incorporated into previous discussion of Category 1 through 4 metrics.

Expansion of Patient-Centered Medical Homes and Neighborhoods

CMH is promoting the PCMH model to transform the way pediatric primary care is organized and delivered in Kansas. Components of the PCMH DSRIP project include increasing access to effective and efficient and patient-centered primary care services and increasing the use of population health management through health information technology. CMH is partnering with selected clinics (initially four, currently three) that serve a high percentage or volume of Kansas Medicaid clients.

Category 1: Infrastructure Milestones

The project team members included CMH Practice Facilitation Specialists and four initial practices, including physicians, nurses, a PCMH facilitator, office/clinic managers, and medical records staff. CMH completed a PCMH gap analysis against NCQA PCMH recognition criteria. Work plans were developed with each practice to address the gap areas, including the establishment of Collaborative Service Agreements, improving transitions of care, and developing methods to identifying and tracking patients to coordinate care. The Practice Facilitation Specialists meet face-to-face with each practice at a minimum once per quarter and regularly communicates via email and conference calls between visits.

CMH provided over 30 Learning Collaborative opportunities, associated with applicable educational webinars. An online message board was developed and used as a forum for the practices to communicate with each other during the Learning Collaboratives and throughout the project. The CMH on-line searchable CERA, contains detailed information for over 860 community agencies and organizations that address various social determinants of health, including housing instability and quality, food instability, utility needs, interpersonal violence, transportation needs, family and social supports, education, employment, income, and health behaviors. This application was accessed 25,970 times in 2018 (an increase from 11,000 in 2017).

CMH also developed an integrated database platform, providing patient data from multiple sources in one database. This was developed to assist the practices with using health information technology for population health management.

Category 2: Process Milestones focus on process changes and improvements

CMH and the practices have actively used an electronic workplan to document accomplishments, goals and next steps. Supporting documentation including communications is also maintained in this system. CMH Engagement Compensation Scoring Models are completed to evaluate and document each practice's level of participation (e.g., in Learning Collaboratives, Webinars, meetings with Practice Facilitators) and progress towards practice transformation. Provider compensation is based on level of involvement. The three remaining practices continue to earn high engagement compensation.
Since the release of the new NCQA PCMH 2017 standards in late October 2017, CMH has worked diligently to assist the practices in reviewing and developing plans to implement the new components. CMH noted that much "*rework*" was required; they have developed a competency checklist "Kansas PCMH Project, Patient-Centered Medical Home Competency Report" to be used with practices to ensure they continue to develop and sustain all current core PCMH competencies. This is a dynamic tool/checklist is used by CMH and the practices to evaluate, document and plan further improvements needed to complete full practice transformation using the NCQA PCMH requirements.

One practice achieved NCQA PCMH recognition in 2016. In early 2018, this practice was sold and is no longer a participant in the PCMH DSRIP project. Two of the remaining three practices planned to submit for PCMH recognition in 2017 but were delayed due to issues with the NCQA system/process not providing timely reports/access for submission during the transition to the new standards. Since then,

the two practices have determined they will no longer be submitting applications for NCQA recognition, as they are preparing to retire or sell their businesses. Specific timelines are not known at this time and they continue to work with CMH, as does the third remaining practice. Other changes have been the implementation of new electronic medical records (EMRs) by two of the practices. CMH has provided technical assistance to these practices, including communications with the EMR vendors and practices regarding implementation of reporting capabilities.

The PCMH project facilitated development of a Medical Neighborhood, which is an expanded patient-centered care model where primary care and specialty providers, hospitals and other clinicians work together in partnership to provide complete and coordinated care. Use of related CSAs expanded in 2017 with the addition of the web-based Children's Mercy Hospital CSA. The individual practices have CSAs with two to six specialty providers each, including cardiology, an asthma specialist, an orthopedic surgeon, a pediatric dentist, and KU Medical Center, in addition to CMH. Over the past two years, 94% of all specialist referrals for patients 0–20 years of age had an associated CSA.

Category 3: Quality and Outcome Milestones

CMH noted data presents a challenge for practices to identify those patients/members who have Kansas Medicaid and there were some barriers to gaining routine access to claims to determine baseline and quarterly progress. The facilitators have also found gaps in coding and billing practices, which impacts measurement.

Six of the eight Category 3 measures improved annually from 2015 through 2017, with *Height/Weight/BMI screening, Counseling for Nutrition*, and *Lead Screening* having the largest increases (41.8 pp, 33.4pp, and 25.4pp respectively). Statistical significance testing was not completed as denominators were not consistently provided. With one practice leaving the project in 2017, CMH provided additional recalculated 2017 rates for the three remaining practices, to allow for comparisons between 2017 and 2018. However, in 2018, CMH noted several decreases in rates could be due to one of the remaining practices (planning to close) beginning to decrease their patient population and downsizing their practice. CMH noted, "Their focus changed from transformation to maintenance." A second practice lost a provider and had a provider with health issues. CMH continues to work with all remaining practices.

Category 4: Population Focused Improvements

The Population Focused metrics are based on rates for the Children's Mercy Hospital and Clinics' patient population. There have been improvements in all Category 4 measures (Table 56), with most improvements sustained for a few years. Statistical testing between baseline and 2018 is not possible due to denominators not consistently being reported.

Partner and Trailblazer Valuations

The three clinics are community partners external to CMH. The number of patients served by the clinics actively participating in this project has been greater than the required 20%. Also, two of the three clinics continue to serve rural and underserved populations and multiple examples of outreach and capacity building were provided.

Evaluation Design Table Goals and Metrics

All additional goals and metrics for reporting and tracking progress over time have been incorporated into previous discussion of Category 1 through 4 metrics.

Conclusions

As mentioned in the preceding sections, the final comprehensive evaluation of the KanCare Program was conducted for the period of 2013–2018 in accordance to the KanCare Evaluation Design approved in 2013.[6] The purpose of the evaluation was to measure the effectiveness and usefulness of the demonstration as a model to help shape healthcare delivery and policy in the state and at the national level.[6] This final evaluation incorporated the results that were obtained each year by monitoring the progress towards goals and other successes achieved by the KanCare program.[2]

As described in the Methodology section, the evaluation design specifications were structured into eight categories in alignment with the KanCare demonstration goals, performance objectives, and evaluation hypotheses, as well as STC evaluation domains of focus. These eight categories of the evaluation design were as follows:

- Quality of Care
- Coordination and Integration of Care
- Cost of Care
- Access to Care
- Ombudsman Program Assistance
- Efficiency
- Impact of the Uncompensated Care pool; and
- Impact of the Delivery System Reform Incentive Payment Pool.

The eight evaluation design categories were organized into the subcategories. Appropriate performance measures were assigned for each subcategory to examine the related evaluation hypotheses. These performance measures for each subcategory were evaluated in detail as described in the Results section to see the impact on their respective categories in alignment with the goals and objectives of the KanCare Program. Several measures in these subcategories showed improvement over time. In addition, the rates/percentages for several measures remained consistently high throughout the evaluation period indicating continuous positive impact on the effectiveness of the various categories of the KanCare program. **A total of 154 PMs were assessed to examine the multiple subcategories of the six evaluation categories. The evaluation results showed that out of 154 PMs, 113 measures were either improved or maintained over the evaluation period contributing to the impact of different aspects of the program in achieving its goals and objectives. In addition, two categories, the UCC Pool Program and DSRIP through its four projects also strengthened the KanCare program**. **The results seen by the assessment of some of the measures also indicated the aspects related to the categories of the KanCare program where further improvements can be made, thus indicating opportunities for improvement of the program.** This information will assist the KanCare Program to address these opportunities for improvement to further strengthen the effectiveness and impact of the care provided to the beneficiaries through the program.

The highlights of the results obtained by the assessment of the categories of KanCare Program are as follows:

Quality of Care

- Several performance measures related to the ten subcategories of the *Quality of Care* aspect of the KanCare Program showed positive results, including improvement over time and from the baseline,

as well as maintenance of high rates/percentages throughout the evaluation period. These results indicated improvement in the *quality of care* provided to the Kansas Medicaid beneficiaries through the KanCare program over the evaluation period.

- ***Physical Health Measures – Positive Results:*** Statistically significant improvements in the trends over time were seen for thirteen out of eighteen physical health HEDIS measures. Statistically significant higher rates in the most recent year compared to the baseline were seen for fourteen out of eighteen physical health HEDIS measures. In addition, high rates were seen for most of the measures in most recent years.
- ***Physical Health Measures – Opportunity for Improvement:*** Declining trends over time were seen for a couple of the physical health HEDIS measures along with consistent low rates for one of the measures (Engagement in the treatment for alcohol or other drug dependence (IET)), thus indicating areas of improvement in the future.
- ***SUD Services Measures* (NOMS Data) – *Positive Results*:** One of the five measures showed both a statistically significant improvement in the trend over time (2013–2018) and a statistically significant higher rate in the most recent year compared to the baseline (2012). In addition, high rates were seen for three other measures throughout the six-year period.
- ***SUD Services Measures – Opportunity for Improvement*:** One measure did not show any improvement in the trend over time, as well as the rates remained consistently low throughout the evaluation period (percent of members receiving SUD services attending self-help meetings). Although the measure for "percent of members receiving SUD services whose employment status was improved or maintained" showed both a statistically significant improvement in the trend over time and a statistically significant higher rate in the most recent year compared to the baseline, the rates remained low (<50%) throughout the six-year period.
- ***MH Service Measures (NOMS Data) – Positive Results*:** Statistically significant improvement in the trend over time were seen for two of the three measures for youth experiencing SED receiving mental health services. Statistically significant reduction in the trend over time was seen for inpatient mental health services utilization among KanCare members. Statistically significant higher rate in the most recent year compared to the baseline for one of the three measures for youth experiencing SED receiving mental health services. In addition, improved rates were maintained for three PMs throughout the evaluation period (high rates >80% for two PMs among youth with SED; low rates ≤0.3% for one measure among KanCare members).
- ***MH Service Measures (NOMS Data) – Opportunity for Improvement*:** Improvements could be made in the rates for all measures to further strengthen the quality of care provided to the adults with SPMI and youth with SED. Several measures showed declining trends, as well lower rates throughout the evaluation period showing opportunit for improvement in the provision of mental health services for the adults with SPMI and youth with SED.
- ***Healthy Life Expectancy Measures – Positive Results:*** The measures for this subcategory assessed *Health Literacy and Prevention/Treatment* aspects. Statistically significant improvements in the trends over time for the health literacy measures were seen in both of the child and adult populations (three out of nine measures in the GC population; four out of nine measures in the CCC population; and one out of seven measures in the adult Medicaid population). High rates throughout the five-year period for several health literacy measures were seen in both the child and adult populations. High rates (above 80%) for six health literacy measures for the most recent year were seen in the GC and CCC populations (with rates above 90% for five measures in the child populations), as well as in the adult population. Statistically significant improvements in the trends over time for some of the *prevention /treatment measures* were seen among adult members (in

appropriate directions). In addition, statistically significant improvement in the rates for two prevention/treatment measures in the most recent year compared to the baseline was seen in the adult population.

Among the PD, I/DD, and SMI populations, two metrics in the Comprehensive Diabetes Care measure remained consistently high during the evaluation period (HbA1c testing: >84% throughout the five years; medical attention for nephropathy: >87% in most recent years). In the prevention measure, adults' access to preventive ambulatory health services, the rates remained consistently high (>94%) for members in the PD, I/DD, and SMI populations.

- ***Healthy Life Expectancy Measures – Opportunity for Improvement:*** A couple of health literacy measures showed average/low rates during 2015–2018 among the child population indicating opportunity for improvement in the future. The prevention/treatment measures among adults consistently showed low rates. The rates for receiving influenza vaccine not only remained low throughout this period, but also did not show any improvement over time. Though, a declining trend (appropriate direction for improvement) was seen in the percentages of the members who were current smokers (smoked every day/some days); however, as shown by the percentages throughout the evaluation period, about one-third of the adult members were current smokers. In addition, the rates for two measures related to the health providers efforts for assisting these current smokers with the cessation treatment remained low throughout the five-year period. Thus, efforts needed to be focused on the prevention/treatment efforts among the KanCare beneficiaries.

  For the HEDIS measure, "diabetes monitoring for people with schizophrenia and diabetes," the rates remained below 66% throughout the evaluation period and there was no statistically significant difference in the most recent year compared to the baseline. Three out of four prevention measures (cervical and breast cancer screening and adolescent immunization) assessed for members among the PD, I/DD, and SMI populations showed consistently average/lower rates. Also for members in these populations, three metrics for the treatment/recovery measure (comprehensive diabetes care) had consistently average/low rates throughout the evaluation period.
- ***HCBS Waiver Services – Positive Results:*** The comparison of the 2017 rates with 2016 for the measure, "percent of waiver participants whose service plans addressed their assessed needs and capabilities as indicated in the assessment," showed higher rates for six of the seven waiver types with considerably higher differences in percentage points for three waiver types (PD, I/DD and TA). For both quality of care measures ("percent of HCBS Waiver participants whose service plans addressed their assessed needs and capabilities as indicated in the assessment" and "percent of HCBS Waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan"), four waiver types (PD, FE, TA and SED) had high percentages (>80%) in the most recent year. For members in the I/DD Waiver type, the percentage was high (>80%) in the most recent year for one measure ("percent of HCBS Waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan").
- ***HCBS Waiver Services – Opportunity for Improvement:*** Members in the Autism Waiver had the lowest rates (37%) among the seven waiver types for the following two measures:
  - Percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment.
  - Percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan.

- ***Long Term Care: Nursing Facilities Measures – Positive Results*:**
  - Statistically significant improvement (reduction) in the percentage of Medicaid NF claims denied by the MCO in the trend over the five-year period, as well as a reduction in the most recent year compared to the baseline.
  - Improved number of Person-Centered Care Homes as recognized by the PEAK program in the MCO network for the most recent year compared to the baseline.
- ***Long Term Care: Nursing Facilities Measures – Opportunity for Improvement*:** Statistically significant increase in the percentage of members discharged from a NF who had a hospital admission within 30 days for the most recent year compared to the baseline.
- ***Member Surveys: CAHPS Survey Measures – Positive Results:*** Statistically significant improvements in the trends over time were seen for several measures assessing member perception of the provider treatment among child and adult populations (five out of six measures in the GC population; four out of six measures in the CCC population; and one out of six measures in the adult Medicaid population). The high rates for several of these measures were seen throughout the five-year period in both the child and adult populations (above 80%). Rates for a couple of these measures were above 90% among both GC and CCC populations, as well as in the adult population in all five years.
- ***Member Surveys: CAHPS Survey Measures – Opportunity for Improvement:*** Average rates for the positive rating of all the health care received in last six months (between 73% and 75%) were seen throughout the five years among the adult population, thus showing an opportunity for improvement in the future.
- ***Member Surveys: MH Survey Measures – Positive Results:*** Statistically significant improvement in the trends over time were seen for two out of eight measures in the SED Waiver Youth (ages 12–17), youth responding survey subgroup. Statistically significant higher rates in the most recent year compared to the baseline were seen for two out of eight measures in the Adult and General Youth (ages 12–17), youth responding, survey subgroups. High rates (>90%) throughout the eight-year period were seen for three out of eight measures among all survey subgroups for one measure; the Youth (ages 0–17), family responding and SED Waiver Youth and Young Adult, family/member responding subgroups for the second measure; and Youth (0–17), family responding subgroup for the third measure. Consistently maintained rates for six out of eight measures among all survey subgroups for one measure; the Adult survey subgroup for three measures; and Adults, Youth (ages 0–17), family responding, and SED Waiver Youth and Young Adults, family/member responding, survey subgroups for six measures; and all were >80% in all seven/eight years.
- ***Member Surveys: MH Survey Measures – Opportunity for Improvement:*** Five measures that included the Adult and SED Waiver Youth and Young Adult survey subgroup populations showed opportunities for improvement related to better control of daily life, member choice of treatment goals, being able to deal with crisis, handling daily life, and doing what they want to do.
- ***Member Surveys: SUD Survey Measures – Positive Results:***
  Although there were no statistically significant improvements in 2017 compared to 2014, rates were above 80% for all three measures throughout the four years.
- ***Member Surveys: SUD Survey Measures – Opportunity for Improvement:***
  Although there were high ratings of counselors as very good/good over the evaluation period, there was a significant decrease in 2017 (88.2%) compared to 2014 (94.3%) ($p<.05$). Efforts are needed to to improve the rate and avoid its further decline.

- ***Provider Survey: Provider Perception of Member Quality of Care Measures – Positive Results:*** Two of the three MCOs had statistically significant improvements. Amerigroup had a statistically significant improvement ($p<.05$) in the rate of providers (general and BH providers in one survey) being very or somewhat satisfied with the MCO's commitment to high quality of care for their members, in 2018 compared to 2014. Sunflower had a statistically significant improvement ($p<.05$) in general provider satisfaction with the MCO's commitment to high quality care, in 2017 compared to 2014 (unable to compare to 2018).
- ***Provider Survey: Provider Perception of Member Quality of Care Measures – Opportunity for Improvement:*** Only around half, to less than half, of Sunflower's and UnitedHealthcare General providers were satisfied with the MCOs' commitment to high quality care from 2014 through 2017.
- ***Grievance Measures – Positive Results:*** The State has committed considerable effort to revising reporting templates/requirements and providing additional training to MCOs regarding grievance category definitions and categorization processes.
- ***Grievance Measures – Opportunity for Improvement:*** Ongoing attention to MCOs' accuracy and consistency in categorization of grievances, as well as reconciliation of data between reports is warranted.

Coordination (and Integration) of Care

- Several performance measures related to the seven subcategories of the *Coordination (and Integration) of Care* aspect of the KanCare Program showed positive results, including improvement over time and from the baseline, as well as maintenance of high rates/percentages throughout the evaluation period. These results indicated improvement in the *coordination and integration of care* provided to the Kansas Medicaid beneficiaries through the KanCare program over the evaluation period.
- ***Care Management for Members Receiving HCBS Services Measures – Positive Results:***
  - In the comparison of the 2017 rate with 2016 for the measure, "percent of participants who had assessments completed that included physical, behavioral, and functional components to determine their needs," six of the seven waiver types showed higher rates with considerably higher differences in percentage-points for four waiver types (I/DD, PD, TA, and Autism).
  - In the comparison of the 2017 rate with 2016 for the measure, "percent of participants with documented change in needs whose service plans were revised, as needed, to address the change," four of the seven waiver types showed higher rates with considerably higher differences in percentage-points for two waiver types (I/DD and TA).
  - For the HEDIS-like measure "adults' access to preventive/ambulatory health services" the percentage of participants receiving these services during the final evaluation period was high (>91%).
- ***Care Management for Members Receiving HCBS Services Measures – Opportunity for Improvement:***
  - Five of the seven waiver types, in the most recent year, had percentages that were average (I/DD, PD, FE, and TBI) or low (Autism; 22%) for "participants with documented change in needs whose service plans were revised, as needed, to address the change."
  - Two of the seven waiver types, in the most recent year, had percentages that were average (SED and Autism) for the measure "participants who had assessments completed that included physical, behavioral, and functional components to determine their needs."
  - In the HEDIS-like measure for annual dental visits, the rates remained low (<54%) during the evaluation period.

- ***Care Management Pilot Project for Members with Intellectual or Development Disability (I/DD) – Positive Results:*** Active involvement of the I/DD Pilot Advisory Committee and many opportunities for communication and learning among consumers, MCOs, I/DD providers and State Agencies increased shared understanding and built relationships. Collaborative determinations of services and the service delivery model lead to:
  - Continued TCM services;
  - Service delivery and related assessment/tiering remained a responsibility of the CDDOs, CSP, and TCMs;
  - Extended plans of care to allow sufficient time for MCOs to load authorizations and develop integrated service plans; and
  - No major service delivery interruptions for members receiving I/DD services while participating in the Pilot Project.

  Lessons learned during Pilot testing of the billing/claims system resulted in improvements, such as allowing providers to use of the KMAP system for front-end billing as well as allowing billing through the MCO web portals; changes to ensure compliance with whole unit billing while allowing for billing flexibility; and MCO development and posting of billing guides.
- ***Member Surveys: CAHPS Survey Measures – Positive Results:*** Statistically significant improvements in the trends over time for some of the measures assessing member perception of the care and treatment among the child populations were seen. High rates for these measures were seen among the child and adult populations throughout the evaluation period. The rates for seven measures in both GC and CCC populations were >81% (five measures above 91%) in all five years. Similarly, rates for all three measures in the adult population were >80 in all five years. Most of the measures assessing member perception of the care and treatment were consistently high throughout the five-year period among child and adult populations showing high member satisfaction with this aspect of the coordination of care during this evaluation period.
- ***Member Surveys: CAHPS Survey Measures – Opportunity for Improvement:*** A couple of measures related to the member perception of the care and treatment among child populations (the help provided from child's health plan, doctor's office, or clinic to coordinate child's care among these different providers or services; and the help provided from child's health plan, doctor's office, or clinic to get child's prescription medicines) showed average rates throughout the evaluation period indicating an opportunity for improvement in the future.
- ***Member Surveys: MH Survey Measures – Positive Results:*** Statistically significant improvement in the trends over time (2011 to 2017) and (2013 to 2017) were seen for one out of two measures in the SED Waiver Youth (ages 12–17), youth responding, survey subgroup. 2018 rates for one out of two measures were improved compared to the baseline rate among the SED Waiver Youth (ages 12–17), youth responding, and SED Waiver Youth and Young Adults, family/member responding, survey subgroups and were ≥79.3%.
- ***Member Surveys: MH Survey Measures – Opportunity for Improvement:*** One measure, within the Adult survey subgroup showed opportunities for improvement related to being encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).
- ***Member Surveys: SUD Survey Measures – Positive Results:*** Coordination of Care between SUD counselors through requests for "release of information" increased to greater than 80% from baseline.
- ***Member Surveys: SUD Survey Measures – Opportunity for Improvement:*** Only around two-thirds of survey respondents reported having a primary care provider or medical doctor. Of those with a

medical provider, almost one-third were not asked to sign a "release of information" for information sharing between the SUD counselor and Medical provider.

- ***Provider Survey: Provider Perception of Coordination of Care (Precertification/Authorization) Measures – Positive Results:***
  Amerigroup had a statistically significant improvement ($p<.05$) in the rate of providers (general and BH providers in one survey) being very or somewhat satisfied with the MCO's precertifications and/or authorizations in 2018 compared to 2014.
- ***Provider Survey: Provider Perception of Coordination of Care Measures – Opportunity for Improvement***
  Rates of General provider satisfaction with obtaining precertifications/authorizations for Sunflower and UnitedHealthcare were ≤50% across included measurement years.

Cost of Care

- ***Cost of Care – Positive Results:*** Both PMs showed improvement with service utilization for all nine services showed improvement in an appropriate direction (increased utilization for six services and decreased utilization for three services) and increase in the PMPM service expenditures for the most recent year for four out of the six populations compared to the baseline year.
- ***Cost of Care – Opportunity for Improvement:*** The PMPM service expenditures for the most recent year for two populations (pregnant women and other) decreased.

Access to Care

- Several performance measures related to the six subcategories of the *Access to Care* aspect of the KanCare Program showed positive results, including improvement over time and from the baseline, as well as maintenance of high rates/percentages throughout the evaluation period. These results indicated improvement in the *access to care* provided to the Kansas Medicaid beneficiaries through the KanCare program over the evaluation period.
- ***Provider Network – GeoAccess Measures – Positive Results:*** During the evaluation period, for the BH provider type, there was 100% access for all 105 Kansas counties; and the number of BH providers had a 28% average increase. For all county types, there did not appear to be a substantial change overtime for the average distance to the closest/choice BH provider.

  Corrections to the Provider Network and GeoAccess reports are beginning to provide more accurate counts for provider specialty availability (includes provider open/closed panels). Also, incorrectly included records and duplicate entries in Network Provider reporting, have decreased to 0.25% in 2018. Since 2013, there was a large increase in four provider types (number of providers/provider locations) and one provider type also had one of the largest increases in number of providers. Since 2012, access to provider specialties has improved for members who were residents of Non-Urban counties. Access to four provider types, in Non-Urban counties, improved with access availability by at least one MCO since 2013. The number of Non-Urban counties that had 0% access from any of the MCOs decreased from 16 provider types (2012 – pre-KanCare) to 2 provider types (2017).

  Fifteen of 29 provider types in Urban and Semi-Urban counties and 16 of 29 Non-Urban counties had a decrease in the percent not within access standards. All members who were residents of any of the 16 Urban/Semi-Urban counties had access to at least one provider in all provider types in 2012 (pre-Kancare) and since 2013 by at least one MCO. When comparing 2013 to 2017, two MCOs had at least two providers in all 105 Kansas counties for most of the HCBS services. Of the 14 I/DD

provider services, in 2017, most of them had 2 or more providers in ≥100 Kansas counties from all three MCOs. For provider after-hours access surveys completed 2013 through 2018, the average rate of compliance was 84.6%. For the appointment availability access standards reported by all three MCOs, most rates ranged from 74.9%–100% (2016 to 2018).

- ***Provider Network – GeoAccess Measures – Opportunity for Improvement:*** During the evaluation period, the provider type Optometry had one of the largest decreases (number of providers/provider locations). Ophthalmology and X-ray were among those with the greatest decrease in number of providers, and General Surgery and Occupational Therapy were among those with the greatest decrease in provider locations. Neonatology and Nephrology, have a higher number of Non-Urban counties with 0% access. For Non-Urban counties, the most counties without access are for the provider types Neonatology, Physical Medicine/Rehab, Plastic Reconstructive Surgery, Gastroenterology, Podiatry, and Pulmonary Disease; and for Urban and Semi-Urban counties, Plastic & Reconstructive Surgery, and Neonatology.

  In the GeoAccess report, there are some instances where it would be appropriate for the member population counts to be more reflective of the members accessing the service (e.g., OB/GYN – include only females and neonatology – infants). Unmapped provider types (not yet reported through GeoAccess mapping and reports) lack information on counties without/limited access, names of counties that have less than two providers/no providers available, and there is no indication whether members needing these services are residents of the counties where there are no providers or less than two providers.

  There appears to be a wide gap in reporting of availability of TBI-related services that indicated a potential discrepancy in reporting by the MCOs and/or differences in defining the criteria required for service providers for these specialized services. The HCBS service, Speech Therapy – Autism Waiver and the I/DD provider service, Supported Employment Services had the lowest number of Kansas counties with 2 or more providers.

  For Provider After-Hour Access and Annual Provider Appointment Standards Access, a standardized report template, methodology, and interview tool is needed. Survey questions for in-office wait times need to be included and reported, and consistency is needed in including survey questions for prenatal care 1st – 3rd trimester and high-risk. MCO and vendor descriptions of the survey sampling, methodology, survey conclusions, and comparisons to prior year survey results raised questions, about the conclusions reached for the survey outcomes.

  For the appointment availability access standards reported by the MCOs (rates may apply to only one MCO), Urgent Care – PCP decreased to 63%. Urgent Care areas <50% in 2018 included: Behavioral Health: 33% (new patients) and 38% (established patients) and Oncology: 39% (new patients).
- ***Member Surveys: CAHPS Survey Measures – Positive Results:*** Statistically significant improvements in the trends over time for some of the measures assessing member experience with the appointment availability were seen among the child populations. High rates throughout the five-year period for all four measures (>80% for three measures and >91% for one measures) were seen in both GC and CCC populations. Similarly, high rates throughout the five-year period for all four measures were seen in the adult population (>80%). In the most recent year, the rates for all four measures were above 85% (with three measures above 91%) among both child populations, and above 82% among the adult population.

- ***Member Surveys: CAHPS Survey Measures – Opportunity for Improvement:*** Though, rates for all the measures seen in the most recent year among the adult population were above 82%, further improvement could be achieved indicating an opportunity for improvement in the future.
- ***Member Surveys: MH Survey Measures – Positive Results:*** Statistically significant improvement in the trends over time were seen for two out of seven measures in the SED Waiver Youth (ages 12–17), youth responding; Youth (ages 0–17), family responding; and SED Waiver Youth and Young Adults, family/member responding, survey subgroups. High rates (>90%) throughout the five-year and six-year period were seen for one out of seven measures among the Adult and SED Waiver Youth and Young Adults, family/member responding, survey subgroups. Statistically significant higher rates in the most recent year compared to the baseline were seen for three out of seven measures in the Adult; SED Waiver Youth (ages 12–17), youth responding; Youth (ages 0–17), family responding; and SED Waiver Youth and Young Adults, family/member responding, survey subgroups. Five measures among all five survey subgroups were consistently maintained in the range of 75.2%–92.1% throughout the five-year and six-year period showing their contribution to the members perceptions of access to MH services by KanCare beneficiaries during this period.
- ***Member Surveys: MH Survey Measures – Opportunity for Improvement:*** One measure within the SED Waiver Youth and Young Adults, family/member responding survey subgroup, related to the family getting as much help as they needed for their child; and one measure within the Adult survey subgroup related to being able to see a psychiatrist when they want to, showed opportunity for improvement.
- ***Member Surveys: SUD Survey Measures – Positive Results:*** High performance in three out of five measures throughout the evaluation period; >80% for getting an appointment as soon as wanted; >85% satisfaction with travel distance to reach counselor; >90% satisfaction with time it took to see a counselor for an urgent appointment.
- ***Member Surveys: SUD Survey Measures – Opportunity for Improvement:*** Although satisfaction remained above 80% in 2017, there was a significant decrease compared to baseline in satisfaction with getting an appointment as soon as the member wanted. Up to one-fifth of members were placed on a waiting list with some having to wait three weeks or longer. Also, 10% to 19% had to wait longer than 48 hours to see a counselor for an urgent appointment.
- ***Provider Survey: Access to Specialist Measures – Positive Results:*** Amerigroup providers were significantly more satisfied with the availability of specialists in 2018 compared to 2014 ($p<.05$). Previously neutral respondents appeared to shift to being satisfied, as there was a significant decrease in neutral responses in 2018 compared to 2014 ($p<.05$) and no significant difference in dissatisfaction.
  The rate of Sunflower's BH (Cenpatico) provider respondents' satisfaction with availability of specialists was significantly higher ($p<.05$) in 2017 compared to 2015, although still under 50%.
- ***Provider Survey: Access to Specialist Measures – Opportunity for Improvement:*** Sunflower's and UnitedHealthcare's General and BH providers' satisfaction with availability of specialists remained below 50% in the most recent measurement year.
- ***Grievance Access Measures – Positive Results:*** The State has committed considerable effort to revising reporting templates/requirements and providing additional training to MCOs regarding grievance category definitions and categorization processes.
- ***Grievance Access Measures – Opportunity for Improvement:*** Ongoing attention to MCOs' accuracy and consistency in categorization of grievances, as well as reconciliation of data between reports is warranted.

Ombudsman Office Assistance

- The increased staffing and volunteer assistance efforts of the Ombudsman office and improved tracking system over the evaluation period has strengthened the capacity of the Ombudsman Program to fulfill its assigned responsibilities for KanCare beneficiaries.
- ***Calls and Assistance – Positive Results:*** By the end of 2018, the Ombudsman's Office had three full-time staff positions and ten trained volunteers in the two satellite offices. In addition, from 2014 onwards, the improved tracking system enhanced the ability to assess the quarterly trends in the number and types of contacts with the Ombudsman's office. The number of initial contacts received by the Ombudsman's office continued to increase throughout the evaluation period with the numbers of contacts doubled in 2018 compared to 2014. The percentage of contacts for whom response was made within two business days was increased in 2018 to 86%.
- ***Calls and Assistance – Opportunity for Improvement:*** Timeliness in response to the contacts made to the Ombudsman office can be improved further in the future. In addition, further strengthening of the tracking system could be done in the future for collecting information on the timely complete resolution of the inquiry by the Ombudsman office and other appropriate entities.

Efficiency

- Performance measures related to the two subcategories of the *Efficiency of Care* aspect of the KanCare Program showed positive results. These results indicated improvement in the *efficiency of care* provided to Kansas Medicaid beneficiaries through the KanCare program over the evaluation period.
- ***Systems Measures – Positive Results:*** HCBS and MH ED Visits (including dual eligible members) had considerable improvement in the most recent year (2017) compared to the baseline (2014) for the subgroups TBI Waiver members and MH members. All three utilization measures, ED Visits (including dual-eligibles), Inpatient Admissions, and Readmissions within 30 Days of Discharge among the groups, All KanCare Members, Total Waiver Populations (TBI, FE, I/DD, and PD), and the four individual waivers (TBI, FE, I/DD, and PD) reflect potentially improved systems for KanCare members.
- Throughout the six years, member and provider inquiries were consistently resolved within the timeliness standards of 95% within two business days and 98% within 5 business days. Grievance resolutions were routinely resolved at rates above the required 98% within 30 days. Processing of non-clean claims consistently met the standard of 99% within 60 days.
- ***Systems Measures – Opportunities for Improvement:*** HCBS and MH ED Visits (including dual eligible members), within the subgroup PD Waiver members, had a slight rate increase from 2017 compared to baseline (2014), showing opportunity for improvement (the goal is to decrease the rate for this measure). While the four timeliness metrics not meeting 100% requirements had rates over 99%, exploration of the reasons standards were not met is warranted to identify whether a system improvement is needed.
- ***Member Surveys: CAHPS Survey Measures – Positive Results:*** The evaluation of the measure related to the member experience with the health plan's customer service among child and adult populations showed that the measure contributed to the high efficiency of care provided to the KanCare program beneficiaries. High rates for this measure were seen throughout the five-year period in both the child and adult populations (>80%). In addition, the high rates were seen in the most recent year for the child populations (>81%), as well as in the adult population (83%).

- ***Member Surveys: CAHPS Survey Measures – Opportunity for Improvement:*** Though, rates for the measure in the most recent year among the child and adult populations were above 81%, further improvement could be achieved indicating an opportunity for improvement in the future.
- ***Member Surveys: MH Survey Measures – Positive Results:*** The rates for this measure were consistently maintained in the range of 79.6%–88.1% throughout the six-year evaluation period (2013–2018) and pre-KanCare (2011 and 2012) showing contribution to member perception for their provider returning their phone calls in 24-hours.
- ***Member Surveys: MH Survey Measures – Opportunity for Improvement:*** The rate in 2018 showed a decrease in performance compared to 2011 (baseline), although not statistically significant.
- ***Member Surveys: SUD Survey Measures – Positive Results:*** Overall, members highly rated (>87%) their counselor's clear communicationas very well or well through the four years evaluated.
- ***Member Surveys: SUD Survey Measures – Opportunity for Improvement:*** The members' ratings in 2017 for how well their SUD counselor clearly communicated was significantly lower ($p<.05$) than in 2014.

Uncompensated Care Cost Pool:

- ***Positive Results:*** UCC Pool payments increased from $20,568,567 in CY2012 to $41,026,795 in CY2013. This increase was partially due to a change in Kansas Statute 65-6208 to increase Health Care Access Improvement Program (HCAIP) funding implemented at the start of the FY2013. UCC Pool payments ranged from $40,698,530 to $40,983,780 in subsequent years.
- ***Opportunity for Improvement:*** None identified.

Delivery System Reform Incentive Program (DSRIP):

- ***Positive Results:*** Each project contains Infrastructure Milestones (Category 1), Process Milestones (Category 2), Quality and Outcome Milestones (Category 3), and Population Focused Metrics (Category 4). Several improvements and accomplishments were noted in all Category Metrics, including statistically significant improvement in the implementation of sepsis protocols among the STOP Sepsis partners and in the proportion of patients progressing to septic shock.

  Children's Mercy's Beacon program had significant improvement ($p<.05$) in patient/family experience with provider follow-up after labs, x-rays and other studies. The Beacon program was also able to increase the use of development and distribution of the Emergency Information Forms.
- ***Opportunity for Improvement:*** During selection and planning of the project, more fully address the adequacy of the projected number of project participants and consider contingency plans for participant recruitment strategies, project interventions and project participant (providers and patients) withdrawals mid-project, to improve project success. More time up front is needed in developing clear measures and plans for data collection and analysis to improve consistency and accuracy of reported results. Reasons for data changes over time should be explains, being as specific as possible (e.g., recalculating after allowance for claim lag, identifying an error in an Excel formula, etc.). After allowance for claims lag or other known data lags, past analysis and reported results should be set and saved, with no further recalculations allowed.

Recommendations

Physical Health – HEDIS Measures

1. MCOs should pay particular attention to improving results for HEDIS measures that have been identified by CMS as core quality measures, particularly where results were below the 25th Quality Compass percentile in 2017.

SUD Services – NOMS Data (Quality of Care)

1. MCOs should explore opportunities for improvement in the two measures with low rates (<50%), "members employed at time of discharge from SUD services" and "members receiving SUD services attending self-help programs."

Mental Health Services – NOMS Data (Quality of Care)

1. Future improvement efforts are needed for two measures that showed statistically significant declining trends over time and significantly lower rates in the most recent year compared to the baseline (adults with SPMI employed and adults with SPMI homeless at the beginning of the quarter housed by the end of the quarter).

Healthy Life Expectancy

1. MCOs should explore researched based strategies to improve the HEDIS rates for diabetes monitoring for people with schizophrenia and diabetes (SMD) since the rates remained below 66% during the evaluation period.
2. Based on consistent average/low rates for the prevention and treatment/recovery measures (cancer screening and adolescent immunizations) among the PD, I/DD, and SMI members, improvement efforts are needed.

HCBS Waiver Services (Quality of Care)

1. MCOs should focus on improvement efforts for members in the Autism Waiver due to the low rate (37%) for the following measures:
    - Percent of HCBS Waiver participants whose service plans addressed their assessed needs and capabilities as indicated in the assessment; and
    - Percent of HCBS Waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan.

Long Term Care: Nursing Facilities (Quality of Care)

1. Due to the statistically significant increase in the percentage of members discharged from a NF who had a hospital admission within 30 days (most recent year compared to the baseline) improvement efforts are needed to decrease the number of hospital admissions.

Care Management for Members Receiving HCBS Services (Care Coordination)

1. MCOs should focus on improvement efforts for members in the Autism Waiver due to the low rate (22%) for the measure "percent of HCBS Waiver participants percent of participants with documented change in needs whose service plans were revised, as needed, to address the change."
2. MCOs should explore opportunities for improvement in the HEDIS-like measure for the annual dental visits due to the rates remaining low (<54%).

Provider Network – GeoAccess (Access to Care)

1. MCOs should revise, where appropriate, their GeoAccess mapping and specific counts of access to be more to be more reflective of the members accessing the service (e.g., OB/GYN – include only females and neonatology – infants).
2. The State should consider requiring the MCOs to include in GeoAccess mapping of availability each currently unmapped HCBS provider service. At a minimum, a list of counties with limited access to specific HCBS services (reported, as of 2018, by counts and not by county names).
3. The State follow up with the MCOs to clarify the availability of the TBI-related HCBS service providers.
4. MCOs continue work to increase HCBS providers in Kansas counties where there are less than 2 or more providers with particular emphasis on Adult Daycare and Speech Therapy – Autism Waiver and TBI Waiver.
5. MCOs continue work to increase I/DD providers in Kansas counties that do not have at least two providers with particular emphasis on Supportive Employment Services, Wellness Monitoring, and Day Support.
6. MCOs should ensure their surveys have an adequate number of participants to achieve meaningful and generalizable results wherever possible.
7. MCOs should review and address in future reports KFMC's questions raised regarding vendors' processes and reports for Access related surveys.
8. In contacting practices, appointment availability should be based on the provider in the random sample and not based on availability from any of many providers in the practice.
9. MCOs should follow up with all providers identified as non-compliant in after-hours access and appointment availability, with priority attention to those who have been non-compliant in more than one year.
10. MCOs should include in their appointment availability surveys not only routine, urgent, and emergent appointment access, but also, where applicable, pregnancy-related appointments by trimester and high risk.
11. For after-hours access and appointment availability surveys, the State should consider creating a standardized report template and reporting tool and requiring the MCOs to have a more standardized methodology.

Member Surveys: MH Survey Measures (Quality of Care, Access to Care, and Care Coordination)

1. Explore methods to increase positive results in the following performance measures for the applicable survey subgroups:
    a. SED Waiver Youth and Young Adults:
        i. Better ability to handle daily life or control life; and do things they want to do. (Quality of Care)
        ii. The member/family feeling like they got as much help as they needed. (Access to Care)
    b. Adults:
        i. Being better able to deal with crisis (Quality of Care)
        ii. Feeling like they decided their treatment goals (Quality of Care)
        iii. Being able to see a psychiatrist when they want to (Access to Care)
        iv. Explore ways to increase members being encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.) and to ensure rates do not continue to decline over time. (Coordination of Care).

Member Surveys: CAHPS Survey Measures (Quality of Care, Access to Care, and Care Coordination)

1. MCOs should ensure their surveys have an adequate number of participants to achieve meaningful and generalizable results wherever possible.
2. MCOs should review and address in future reports KFMC's questions raised regarding vendors' processes and reports for Access related surveys.

Member Surveys: SUD Survey Measures (Quality of Care, Access to Care, and Care Coordination)

1. Though there were high quality scores for SUD counselors, MCOs should monitor future rates and assess the need for improvements, due to the significant decreases in 2017 quality and communication scores compared to 2014.
2. MCOs should explore and implement methods to help ensure members receiving SUD services know and access their primary care provider.
3. MCOs should work with SUD counselors to increase their obtaining "releases of information" to coordinate care with the primary care provider.
4. MCOs should review areas of need based on the locations or regions that had members waiting longer than 48 hours for an urgent appointment, or were put on a wait list for an initial appointment.

Provider Surveys: Provider Survey Measures (Quality of Care, Access to Care, and Care Coordination)

1. MCOs should explore methods to increase providers' satisfaction with the MCOs' commitment to high quality care for their members, and for obtaining precertifications/authorizations.
2. MCOs should ensure their surveys have an adequate number of participants to achieve meaningful and generalizable results wherever possible.

Grievances: Grievance Reporting Measures (Quality of Care and Access to Care)

1. Continue to review MCOs' accuracy and consistency in categorization of grievances, as well as reconciliation of data between reports.

Systems (Efficiency)

1. For all KanCare members, waiver populations (TBI, FE, I/DD, and PD), and members receiving MH services, continue to look for ways to reduce HCBS and MH emergency ED visits, HCBS inpatient admissions, and HCBS readmissions within 30 days of discharge.

DSRIP

1. During selection and planning of the project, more fully address the adequacy of the projected number of project participants and consider contingency plans for participant recruitment strategies, project interventions and project participant (providers and patients) withdrawals mid-project, to improve project success.
2. Dedicate more time up front to developing clear measures and plans for data collection and analysis to improve consistency and accuracy of reported results.
3. Document reasons for data changes over time, being as specific as possible (e.g., recalculating after allowance for claim lag, identifying an error in an Excel formula, etc.). After allowance for claims lag

or other known data lags, past analysis and reported results should be set and saved, with no further recalculations allowed.

Overall Recommendations

1. The current list of the performance measures should be reviewed to identify a set of standard, robust and comparable measures that have agreed-upon specifications/definitions and data collection methodologies/strategies, as well as established data collection systems. This will assist in implementing the program evaluation by conducting consistent and accurate monitoring of these measures in an ongoing manner. This will help in identifying the patterns and continuous assessment of the outcomes of the KanCare Program.
2. The measures from the current list should also be identified that are still developmental in nature and require further discussions for reaching a consensus on the valid specifications/definitions of their numertaors and denominators, identifying standard data collection methodologies/strategies, as well as creating/improving data collection/tracking systems. These measures could be used for the program evaluation at a later time once agreed-upon definitions and data collection methodologies are identified and a robust system to collect accurate data are available.
3. Some of the subcategories within multiple evaluation categories, such as Grievances, should be assessed by examining the measures that are more qualitative in nature. This will assist in classifying the issues raised by the providers and beneficiaries into groups that can be further examined using qualitative data analysis methods for identifying similar and dissimilar themes. This information will help the state and MCOs to work on the broader system changes to improve the care provided to the beneficiaries in addition to the resolution of day-to-day person-related issues. The trainings of the MCO staff for application of the qualitative data analysis methods will be needed to obtain the information on the qualitative themes from assessment of these PMs.

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Interpretations, Policy Implications, and Interactions with Other State Initiatives

The State Quality Strategy – as part of the comprehensive quality improvement strategy for the KanCare program – as well as the Quality Assurance and Performance Improvement (QAPI) plans of the KanCare MCOs, supported strong, high quality performance of the program. Kansas Medicaid long-range planning, including the KanCare 2.0 Quality Strategy, was guided by information collected from KanCare MCO and state reporting, quality monitoring, onsite reviews and other KanCare contract monitoring results; external quality review findings and reports; feedback from State and Federal agencies, the KanCare MCOs, Medicaid providers, Medicaid members, and public health advocates. This combined information assisted KDHE, KDADS and the MCOs to identify and recommend quality initiatives to monitor and improve services provided to the Kansas Medicaid population.

The State values a collaborative approach with KanCare MCOs, providers, policy makers, reviewers, and others to maximize the strength of the KanCare program and services. Kansas recognized that some of the performance measures for this program represent performance above the norm in existing programs, or first-of-their-kind measures designed to drive to stronger ultimate outcomes for members and have required additional effort by the KanCare MCOs. Since 2013, Kansas worked collaboratively with the MCOs, providing ongoing policy guidance and program direction in a good faith effort to ensure that all of the measures were clearly understood; that all measures were consistently and clearly defined for operationalizing; that the necessary data to evaluate the measures were identified and accessible; and that every concern or consideration from the MCOs was heard. While various necessary clarifications and resulting revisions in analytic and reporting methodologies impacted the ability to compare certain measure results over time for this evaluation, the measures and reporting have been strengthened, allowing for more accurate comparisons going forward. Generally, the nationally standardized measures (e.g., HEDIS and CAHPS) produced MCO results that could be aggregated to the KanCare program level and statistically compared for improvement in the most recent year compared to baseline, and for trends over time. Some efforts have been necessary to ensure all MCOs are sampling the appropriate populations and reporting stratified data according to Kansas specific requirements, as allowed by the standardized NCQA specifications.

To support the quality strategy, KDHE staff conducted regular meetings with MCO staff, relevant cross-agency program management staff, and EQRO staff to work on KanCare operational details and ensure that quality activities were occurring consistent with Section 1115(a) standard terms and conditions, the KanCare quality management strategy and KanCare contract requirements. All products were distributed to relevant cross-agency program and financial management staff. KDHE and KDADS established a senior leadership committee jointly responsible for comprehensive oversight and monitoring. Additionally, the KanCare Steering Committee included the senior leadership, as well as program and quality managers from both agencies, to initiate and review policies or program changes.

Throughout the past six years, the State engaged in extensive outreach and communication through multiple avenues, including routine and issue-specific meetings with a broad range of providers, associations, advocacy groups, consumers, and other interested stakeholders. Methods of bi-directional communication included in-person State Tour open forums; rapid response calls; routine conference calls seeking call-in questions. State leadership has ongoing

monthly meetings with associations (grouped by Physical Health; Behavioral Health; and NF/HCBS); quarterly, all groups come together for a whole group meeting. Additionally, the State developed and provides an extensive training program on Managed Care, including:

- Introduction to Medicaid Managed Care;
- The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate;
- Medicaid Overview;
- Introduction to Healthcare Codes & Claims;
- Grievance, Appeals, & State Fair Hearings;
- Eligibility;
- HCBS Eligibility;
- History of Kansas Managed Care;
- Medicaid Waivers.

The trainings are typically two times per year in Topeka and have been well received. The State provides training in other state locations upon request.

Furthermore, the State requires the MCOs to convene Member Advisory Committees, as well as to conduct regular joint MCO provider training. MCOs also conduct separate trainings by topic or provider type. The topics for training may arise from provider concerns and the MCO will visit the office if the provider is having issues. The MCOs also post webinars, bulletins and Frequently Asked Questions (FAQs).

Initiatives within Kansas Medicaid/KanCare included:

The KanCare program includes ***Value-Added Benefits*** from each MCO, at no cost to the State. Following are the top value-added services provided in 2018:

- Adult Dental Care;
- Member Incentive Program;
- Mail Order Over The Counter (OTC) benefit;
- CentAccount Debit Card;
- Comprehensive Medication Review;
- Additional Vision Services;
- Baby Blocks Program and Rewards; and
- Home Helper Catalog Supplies.

Examples of ***other value-added services*** have included:

- Pharmacy Consultation;
- Rewards for Preventive Visits, Completion of Programs, and HealthCare Follow-up;
- Pest Control;
- Additional Respite Care for DD Waiver population;
- Additional Respite Care for Autism Waiver;
- Weight Watcher Vouchers;
- Pediatric Obesity Classes
- Hypoallergenic Bedding;
- Safelink Phone Service;
- Disease and Healthy Living Coaching;

- Adult Briefs;
- Membership to Youth Organizations;
- Hospital Companion;
- Additional Podiatry Visits;
- Infant Care Book for Pregnant Women;
- Debit-Card Rewards for several types of screenings, follow-up, or completions of programs; and
- Mental Health First Aid Program.

MCO Performance Improvement Project (PIP) topics are prescribed or approved by the State. Topics have focused on areas of needed improvement as identified through performance reporting and have included:

- Pre-diabetes (joint MCO PIP)
- HPV vaccination (joint MCO PIP)
- Well-child visit rates in the third, fourth, fifth and sixth years of life.
- Initiation and engagement of alcohol and other drug dependence treatment.
- Follow-up after hospitalization for mental illness.
- Diabetes screening for people with schizophrenia or bipolar disorder.

Examples of Other MCO Programs/Initiatives:

- Community Health Workers
- Transitioning youth (youth in foster care aging out of system)
- Parent Management Training – Oregon Model
- Farmers Market vouchers
- Smoking cessation programs
- Disease management programs
- Prenatal and infant health programs
- Employment programs
- Foster Placement Stability pilot
- Corrections pilot
- Partnering with providers for medical and dental days
- Health Babies, Healthy Mom initiative

Examples of MCOs' Value Based Provider Incentive Programs:

- Behavioral Health Incentive Program – Program designed to improve outcomes, lower total cost of care and encourage Community Mental Health Center integration with primary care network through a Behavioral Health Incentive program.
- Primary Care Provider Incentive - Program designed to improve outcomes and reduce total cost of care by aligning incentive models with primary care providers; may include shared savings agreements for the provider to manage the whole person with targets for improving specific quality measures and targets for total cost of care for their assigned population.
- CMHC Incentive – Alternate payment method for Behavioral Health that was deployed with CMHC's in Kansas.
- Value-based models across the state in all major urban, rural and frontier communities, focused on Alternate Payment Models, Social Determinants of Health, Independence,

Behavioral Health Services, Long-Term Supports and Services, Physical and Behavioral Health Integration Strategies and Telehealth.

- Adult and Pediatric Quality-Based Pay for Performance (P4P) Program: targeted seven large health systems for participation in this program, which extended to more than 50,000 eligible adult and pediatric MCO members. Participating providers were rewarded through bonus reimbursement for achieving target quality results in five HEDIS measures.
- Timeliness of Prenatal Care Incentive Program: OB/GYNs and their support teams are financially incented upon successful completion of the Notice of Pregnancy during an office visit in the first trimester of pregnancy or within 42 days of enrollment.
- Pharmacy Incentive Program: For network pharmacy practices that become accredited by the Center for Pharmacy Practice Accreditation, the MCO reimburses an enhanced professional fee added to each claim paid to the pharmacy.

PCMH/Health Homes:

The DSRIP program has included a focus on PCMH through the two Children's Mercy Hospital projects. The PCMH project involved CMH facilitating the adoption of PCMH transformative processes in four practices, through individual technical assistance and Learning Collaboratives involving all four practices; one practice achieved NCQA PCMH recognition. A component of the CMH Beacon project has been to serve as the PCMH for children and youth with chronic conditions; CMH achieved NCQA PCMH recognition.

The KDHE Health Home initiative provided care coordination services for KanCare members with SMI and was effective July 2014 through June 2016 (services began August 2014). Quality improvements during the two-year program included a reduction in acute general hospital utilization; reduced institutional care utilization; decreased inpatient readmissions; improved follow-up after hospitalization for mental illness within 7 days; and an increase in tobacco use assessment.

A legislative proviso passed in 2018 directed KDHE to implement a health homes program. To avoid the confusion caused by the term health homes, a new name was selected for the program – OneCare Kansas. Authority to spend planning money was received from CMS and a OneCare Kansas Planning council has convened to help plan implementation of the new health homes program. While many details still need to be developed, the program will have the same model as the state's previous health homes program – the MCOs will serve as Lead Entities and community providers will serve as OneCare Partners, providing the six core services directly. The target population will be defined differently, and payment will be simpler. The program is scheduled to launch January 1, 2020.
Kansas is using lessons learned in its first health homes program (July 2014 through June 2016), including defining a narrower target population, requiring an application process for OneCare providers and having a single monthly rate with a bonus for completion of a Health Action Plan.

Health Information Technology: Electronic Health Records

KDHE implemented the Kansas Medicaid EHR Incentive Program (now called Promoting Interoperability Program) in early 2012 to encourage clinicians and eligible hospitals to adopt, implement, upgrade and demonstrate meaningful use of Certified Health Record Technology. The program name-change in 2018 represented an increased focus on interoperability and improving patient access to health information. Through this program, educational webinars and individual technical assistance are provided to clinicians.

The two PCMH related DSRIP projects have involved using EHR data for population health management, including development and use of patient registries.

Health Information Technology: Telehealth and Telemedicine

In 2013, KDHE allowed certain mental health services to be billed with a telemedicine modifier. In 2017, CMS created a new place of service code for telemedicine to be used by the physician or practitioner furnishing telemedicine services from a distant site. In 2018, billing codes were allowed for reporting synchronous (real-time) telemedicine services; procedures involve electronic communication using interactive telecommunications equipment that includes, at a minimum, audio and video. Telemedicine equipment must be compliant with the Health Information Privacy Protection Act (HIPAA).

Effective December 1, 2018, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) may function as both the originating site and distant site when furnishing services through telemedicine (Indian Health Centers were added in spring 2019). This will improve access to quality health care in rural and frontier areas of the State. The KKMAP seeks to improve access to care and patients' health outcomes by permitting synchronous two-way, real-time interactive communication between the patient at the originating site and the physician or practitioner at the distant site. Effective with dates of service on and after January 1, 2019, the Kansas Telemedicine Act was enacted in accordance with Senate Substitute for House Bill No. 2028.

Other Technological Improvements

A system upgrade to the Kansas Modular Medicaid System (KMMS) Provider Enrollment Wizard was completed on December 31, 2018. With the system upgrade, all KanCare MCO enrollments must now begin with KMAP and be entered through the Provider Enrollment Wizard.
In addition to supporting a common enrollment application, the upgraded Provider Enrollment Wizard will support a bidirectional exchange of provider data between the MCOs and KMAP (functionality not available yet).

Policies or Processes Developed in Response to KanCare Data or Identified Needs:

Smoking Cessation

More KanCare members smoke than the general population and improvements are needed in providers' recommendations to quit, discussing and offering smoking cessation assistance.

Effective with dates of service on and after January 1, 2014, smoking cessation products (e.g., medications, inhalers, patches, sprays, lozenges, gum) were covered by KMAP. In January 2017, a KMAP bulletin reminded providers of several covered smoking cessation products.

Effective with processing dates on or after May 15, 2017, and retroactive to dates of service on and after October 1, 2016, providers could bill for smoking cessation counseling for pregnant women when billed with certain other codes. The counseling time spent must be documented and be three minutes or longer. Effective with dates of service on and after July 1, 2018, cessation counseling became available as a Medicaid billable service to all Medicaid populations.

- Individual counseling for smoking and tobacco usage can be provided and billed by any provider who has education and/or counseling within their scope of practice and are billable by:
  - Physician
  - Mid-level practitioner (such as nurse practitioner, physician assistant)

  - Mental health provider
  - SUD provider
  - Clinic (such as FQHC, RHC, and local health department)
  - Hospital
  - Home Health Agency
  - Indian Health Services
- Group counseling for tobacco cessation can be provided by a clinic or physician's office billable by:
  - Physician
  - Mid-level practitioner (such as nurse practitioner, physician assistant)
  - Mental health provider
  - SUD provider
  - Clinic (such as FQHC, RHC, local health department, and CMHC)
  - Indian Health Services

Tobacco cessation counseling (individual and group) can also be provided by any provider who has education and/or counseling within their scope of practice, as long as the service is under the supervision of a physician or midlevel practitioner. This includes those individuals who have a Tobacco Treatment Specialist certificate from a program accredited by the Council for Tobacco Treatment Training Programs. The Tobacco Treatment Specialist has to be employed by a clinic or physician's office that is an enrolled KMAP provider to bill for the service.

Children and Youth in KanCare and Foster Care

Challenges were identified that impacted effective coordination of care for children and youth in Foster Care. One issue was with the distribution of KanCare membership cards upon entry into foster care due to the timing of transfers from emergency placements to foster homes. KDHE and the MCOs worked with the DCF to develop a solution. The MCOs agreed to distribute two KanCare membership cards (instead of the one previously distributed). One card is sent to DCF and one to the Foster Home. Furthermore, the process for completing a "release of information" to allow for sharing of information to the Foster Care contractor (DCF subcontractor not considered the provider) was developed Also, the MCOs developed and distributed a desk-aid for the DCF contractors containing contact information by question/issue type.

Lessons Learned and Recommendations

Lessons Learned from the Demonstration

The demonstration provided Kansas the opportunity to test and confirm the effectiveness of the extensive initial and ongoing bi-directional communication with MCOs, providers, consumers, associations, and advocacy groups, as well as the comprehensive approach to provider and stakeholder training.

A considerable amount of time and collaborative effort was needed among KDHE, KDADS, the MCOs, the EQRO and other consultants to streamline, strengthen and standardize measurement and reporting processes. While the State provided report templates, defined measurement specifications, discussed MCO follow-up questions and provided clarifications, differences in interpretation and application of the specifications were often discovered during review and comparison of reported data. Some data reports, such as categorization of grievances and geo-access/provider network reports have been

revised over time when identification of needed clarification or reporting improvements occur. The revisions have increased standardization and reporting accuracy.

Due to the complexity of the KanCare data, populations and measurement processes, discrepancies in measurement analysis and reporting between MCOs and/or between remeasurements impacted the ability to compare some results between years and to aggregate MCO data for overall review of KanCare as a program. Although discrepancies and data issues are less likely with standardized measures, such as HEDIS and CAHPS where NCQA certified vendors are used, issues can and did occur with applying State specific requirements for population inclusion, stratification and reporting. While NCQA allows for these types of State reporting requirements, the HEDIS certified auditors may not evaluate the MCOs' processes against additional State requirements.

The State and EQRO have concluded the number of required MCO reports and measurements was too much to fully synthesize and likely included measurements and reports not useful to the management and evaluation of the program. Furthermore, with the first KanCare evaluation design, measures were included that upon evaluation implementation were determined to not be available. The requested reports should be reviewed for applicability to management and oversight of the KanCare program. The KanCare 2.0 evaluation design will tie directly to the State Quality Strategy; measures should be prioritized and selected based on meaningfulness to the program oversight and management, opportunities for improvement, measurability, and data reliability/validity.

While designing KanCare 2.0 and the new MCO contracts, the State took into consideration lessons learned when developing, implementing and managing KanCare 1.0. Identification of needed/requested changes was also an outgrowth of active and continued stakeholder engagement.

Throughout the demonstration, the State heard concerns about MCO-provided care coordination that fell into the following categories:

- The member was unaware they had a care coordinator
- The member was not able to easily contact their care coordinator
- Care coordinators had high rates of turnover
- Care coordinators had too-large caseloads
- Care coordinators did not have the expertise necessary to serve some specific populations

To address these concerns, the new managed care contracts, effective January 1, 2019, include a requirement that the MCOs contract with local community agencies to provide CSC for the seven 1915(c) HCBS populations, as well as for the adult behavioral health population. CSC will be phased in beginning January 2020. MCOs will be expected to work closely with CSC agencies to share data, collect quality outcomes information, and ensure plans of service or person- centered care plans, as appropriate for each population, are being developed and monitored.

Additionally, the State learned more is needed in the area of MCO Provider Relations staff, particularly with increased direct provider contact. The new managed care contracts incorporated more specific key personnel requirements, including Provider Relations staff dedicated to specific provider types (e.g., physical health and behavioral health). Member and provider advocates/representatives are also required, as is an EPSDT Coordinator.

As Kansas moves from DY 6 into DY7, and providers become more experienced with managed care, the State is encouraging the MCOs to explore more value-based purchasing (VBP) arrangements with various providers to improve outcomes for specific populations. The State required MCOs to propose a variety of VBP options when bidding on the 2019 contract. Areas included:

- Alternative payment models
- Promotion of greater integration of physical and behavioral health
- Proposals specific to both the behavioral health population and those members receiving MLTSS
- Enhanced use of telehealth, including specific proposals for:
  - Telemedicine
  - Telemonitoring
  - Telementoring
- Addressing social determinants of health and independence

The State will bring together a project team to select from among the proposals submitted and work with the MCOs to implement those with the greatest promise for improved outcomes.

Recommendations for Other States Interested in Implementing a Similar Approach

1. Provide multiple opportunities for bi-directional communication with MCOs, providers, consumers, and related associations, to share and receive information, including:
   a. In-person meetings throughout the state;
   b. Webinars,
   c. Routine open-phone sessions to answer questions and gather information;
   d. Routine stakeholder meetings, by type and all together; and
   e. Ombudsman's office.
2. Offer multiple opportunities for training providers, consumers, stakeholders, MCO staff about the program, background/history, populations served, services provided, etc.
3. Require MCOs to conduct routine joint provider trainings.
4. Encourage collaboration between MCOs and with other entities, such as Drug Utilization Review Board, Foster Care Agencies, providers and other key entities.
5. Require MCOs to convene Member Advisory Committees.
6. Ensure Care Coordination has adequate local community presence.
7. Require MCOs to have more key personnel, particularly in areas of provider and member advocates, as well as coordinators for specific populations or issues (e.g., EPSDT Coordinator, Foster Care Coordinator, etc.).
8. Request the MCOs propose Value-Added services in their request for proposal (RFP) responses.
9. Require MCOs to include plans for Value-Based Purchasing in their RFP responses.
10. Require MCOs to implement processes as similarly as possible to increase understanding and decrease provider burden.
11. Ensure the information posted for members and providers, through manuals and the website are clear and easy to understand.
12. Make State expectations of the MCOs clear and well-known, such as for contract audits; can't communicate enough.
13. Build audit tool on the last one completed to ensure all previous concerns are addressed.
14. Readiness reviews for new MCOs are critical.
15. Limit requirements for routine reports to those that will be routinely used for management and oversight; link requested data more specifically to the State Quality Strategy.

16. Use regularly established measures in the demonstration evaluation design.
17. Develop a process for closing the loop on recommended/needed changes to help ensure identified issues are appropriately handled and do not repeat over time.
18. Establish a process for documenting and communicating changes to analytic methodologies, or policies and procedures that impact measurement results and the appropriateness of comparisons between subgroups and across measurement periods.
19. Devote sufficient time up front to defining measures, developing analytic plans, ensuring clarity and assessing MCOs' interpretation of analytic methodologies to help limit subsequent analytic and reporting revisions. Changes in methodology impact the ability to compare results over time, and thus impact the ability to make conclusions regarding the program.
20. Encourage collaboration between MCOs and with other State programs that also work to improve similar health concerns.

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11. Monthly MCO KanCare Key Management Activities Reports (KKMAR) submitted for Health Homes SMI SPA between August 2014 and June 2016. Data Source: Monthly MCO KanCare Key Management Activities Reports (KKMAR) submitted for Health Homes SMI SPA between August 2014 and June 2016.

Appendix A

2013-2018 Final KanCare Evaluation Report

January 2013–December 2018

KanCare Evaluation Design

Kansas Foundation for Medical Care, Inc
URAC ACCREDITED
Independent Review Organization: External
Expires 06/01/2021

Final Evaluation Design

Submitted by the Kansas Department of Health and Environment,
Division of Health Care Finance

August 24, 2013
Revised March 2015

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Background

KanCare is an integrated managed care Medicaid program that will serve the State of Kansas through a coordinated approach. In 2011, Governor Sam Brownback identified the need to fundamentally reform the Kansas Medicaid program to control costs and improve outcomes. KanCare will enable provision of efficient and effective health care services and will ensure coordination of care and integration of physical and behavioral health services with each other and with home and community based services (HCBS).

On December 27, 2012, the Centers for Medicare and Medicaid Services (CMS) approved the State of Kansas Medicaid section 1115 demonstration proposal, entitled KanCare. KanCare is operating concurrently with the state's section 1915(c) Home and Community-Based Services (HCBS) waivers and together provide the authority necessary for the state to require enrollment of almost all Medicaid beneficiaries (including the aged, people with disabilities, and some individuals who are dually eligible) across the state into a managed care delivery system to receive state plan and HCBS waiver services. This represents an expansion of the state's previous managed care program, which consisted of HealthWave (managed care organization) and HealthConnect Kansas (primary care case management), and provided services to children, pregnant women, and parents in the state's Medicaid and CHIP programs. KanCare also includes a safety net care pool to support certain hospitals that incur uncompensated care costs for Medicaid beneficiaries and the uninsured, and to provide incentives to hospitals for programs that result in delivery system reforms that enhance access to health care and improve the quality of care.

This five year demonstration will:

- Maintain Medicaid state plan eligibility;
- Maintain Medicaid state plan benefits;
- Allow the state to require eligible individuals to enroll in managed care organizations (MCOs) to receive covered benefits through such MCOs, including individuals on HCBS waivers, except:
  - American Indian/Alaska Natives will be presumptively enrolled in KanCare but will have the option of affirmatively opting-out of managed care.
- Provide benefits, including long-term services and supports (LTSS) and HCBS, via managed care; and
- Create a Safety Net Care Pool to support hospitals that provide uncompensated care to Medicaid beneficiaries and the uninsured.

Goals

The KanCare demonstration will assist the state in its goals to:

- **Provide integration and coordination of care** across the whole spectrum of health to include physical health, behavioral health (mental health and substance use disorders) and LTSS;
- **Improve the quality of care** Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes);
- **Control Medicaid costs** by emphasizing health, wellness, prevention and early detection, as well as integration and coordination of care; and
- **Establish long-lasting reforms** that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms as well.

Hypotheses

The evaluation will test the following KanCare hypotheses:

- By holding MCOs to outcomes and performance measures, and tying measures to meaningful financial incentives, the state will improve health care quality and reduce costs;

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- The KanCare model will reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired;
- The state will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health, and LTSS; and
- KanCare will provide integrated care coordination to individuals with developmental disabilities, which will improve access to health services and improve the health of those individuals.

Performance Objectives

Through the extensive public input and stakeholder consultation process, when designing the comprehensive Medicaid reform plan, the State has identified a number of KanCare performance objectives and outcome goals to be reached through the comprehensive managed care contracts.

These objectives include the following:

- Measurably improve health care outcomes for Members in the areas including:
  - Diabetes
  - Coronary Artery Disease
  - Prenatal Care
  - Behavioral Health;
- Improve coordination and integration of physical health care with behavioral health care;
- Support Members' desires to live successfully in their communities;
- Promote wellness and healthy lifestyles; and
- Lower the overall cost of health care.

Evaluation Plan

Evaluation is required to measure the effectiveness and usefulness of the demonstration as a model to help shape health care delivery and policy. The KanCare evaluation is to be completed by the Kansas Foundation for Medical Care, Inc. (KFMC), which will subcontract as needed for targeted review. Evaluation criteria are outlined in the comprehensive KanCare Program Medicaid State Quality Strategy and the Centers for Medicare & Medicaid Services Special Terms and Conditions document.

In an effort to achieve safe, effective, patient-centered, timely and equitable care the State will assess the quality strategy on at least an annual basis and revise the State Quality Strategy document accordingly. The State Quality Strategy – as part of the comprehensive quality improvement strategy for the KanCare program – as well as the Quality Assurance and Performance Improvement (QAPI) plans of the KanCare MCOs, are dynamic and responsive tools to support strong, high quality performance of the program. As such, the State Quality Strategy will be regularly reviewed and operational details will be continually evaluated, adjusted and put into use. Revisions in the State Quality Strategy will be reviewed to determine the need for restructuring the specific measurements in the evaluation design and documented and discussed in the evaluation reports.

Evaluation Timeline

- Present overview and obtain feedback from KanCare Advisory Council, March 12, 2013.
- Present overview/design specifications and obtain feedback from combined meeting of Consumer and Specialized Issues (CSI) workgroup and the Provider and Operations Issues (POI) workgroup, on March 27, 2013.
- Revise draft by April 19, 2013, based on feedback obtained from Advisory Council and workgroups. Revisions included:
  - Adding Substance Use Disorder Consumer Survey results;

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  - Clarifying the areas involving stratification by population categories and adding this stratification to the grievance reviews; and
  - Adding the populations with development disabilities and physical disabilities to the Healthy Life Expectancy composite measure.
- Draft Evaluation Design to CMS by April 26, 2013.
- CMS provided feedback regarding the Evaluation Design on June 25, 2013.
- Discussed CMS feedback and obtained further input from stakeholders in July.
- Final design completed by 8/24/2013.
- Quarterly and Annual evaluation progress reports will be submitted.
- Draft evaluation report to be submitted 120 days after expiration of the demonstration.
- Revision of the KanCare Evaluation Design in March 2015 due to program updates, changes in HEDIS measure specifications, and subsequent revisions of performance measures and updated monthly and quarterly reporting templates.

Evaluation Design Process

Data Sources

The evaluation will include assessment of quantitative or qualitative process and outcome measures using the following data sources:

- Administrative data (e.g., financial data; claims; encounters; nursing home Minimum Data Set [MDS]; Addiction and Prevention Services' Kansas Client Placement Criteria [KCPC] database; Mental Health Automated Information Management Systems [AIMS]; etc.).
- Medical and Case Records.
- Consumer and provider feedback (surveys, grievances, Ombudsman reports)

Additionally, the entities responsible for calculations vary among the measures, including the MCOs, KDHE and KDADS. For instance, there are Substance Use Disorder measures currently using the KCPC data noted above; KDADS manages this database and will be providing the measurement results. Previously, the Evaluation Design referred to "KDADS report." This has been clarified to indicate KDADS will be completing the calculation for the specific SUD measures. Given the length of this Demonstration, sources for the data and the entity responsible for calculation may change; the information provided in the measurement table reflects current data sources and entities responsible for calculation.

Given the comprehensiveness of the State Quality Strategy and required reporting and monitoring, a large portion of the evaluation will draw from existing reports. Measures were chosen for the evaluation design by focusing on the KanCare objectives, as well as the STCs. Additionally, the evaluation design includes existing measures reviewing a range of ages, populations and programs in order to provide a broad representation of KanCare. There will be several evaluation measures requiring additional analyses using encounter and financial data. Existing reports include the following:

- Quantitative, performance measure reports using administrative and medical/case record information, including the following:
  - Healthcare Effectiveness Data and Information Set (HEDIS®)
  - Mental Health measures, including Serious Emotional Disturbance (SED) Waiver reports and National Outcome Measures (NOMS)
  - Nursing Facility measures
  - Substance Use Disorder measures
  - HCBS Waiver reports (e.g., Intellectual/Developmental Disability [I/DD]; Physical Disability [PD]; Traumatic Brain Injury [TBI])
  - Case Record reviews
  - Access reports
  - Financial reports
- Qualitative reports using surveys, and other forms of self-reported data including:

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- Consumer Assessment of Health Plans Study (CAHPS®)
- Mental Health Statistical Improvement Program (MHSIP) consumer survey
- Substance Use Disorder (SUD) consumer survey
- Provider Survey
- KCPC database contains member self-reported data
- AIMS database includes some self-reported data
- Care Manager feedback and surveys
- Grievance reports

Analysis Plan

KFMC completed a review of initial background information, to assist in providing context for the evaluation findings. The background information involved determining demographics and characteristics of MCO enrollees: age, gender, marital status, race, language, %FPL, prevalence of chronic conditions, Type of Waiver, Nursing Facility (NF), Substance Use Disorder (SUD), Serious Mental Illness (SMI), Employment, and Residential Status. Initial review has occurred to determine potential demographic data to include in stratifications, based on apparent completeness of data. Following are potential types of stratifications and preliminary enrollee numbers per strata.

- Program types: Medicaid (323,869); CHIP (54,990)
- Race: Black (52,022); White (291,279); Asian (8,551); Native American (6,475); Other (19,532)
- Ethnicity: Hispanic (81,155); Non-Hispanic (296,704)
- Gender: Female (202,860); Male (174,992)
- County – to allow for stratification by Urban (203,331), Semi-urban (58,443), Densely Settled Rural (73,567), Rural (28,874), and Frontier (13,644)

The measurement table (Figure 1) below indicates the type of stratifications per measure. Many of the measures also are unique to a number of the other enrollee characteristics noted above. There are measures specific to SUD, SMI, HCBS Waivers, NF, chronic conditions, employment, residential status, sex and age. Further stratifications (e.g., by race, urban/rural etc.) may be warranted for further focused study.

To isolate the effects of the KanCare demonstration from other initiatives occurring in Kansas, KFMC is cataloguing the various related initiatives occurring in Kansas. KFMC is in regular contact with the various provider associations and state agencies to identify, at a minimum, initiatives with potential to affect a broad KanCare population. KFMC is collecting the following information about the other initiatives to help determine overlap with KanCare initiatives:

- Consumer and provider populations impacted
- Coverage by location/region
- Available performance measure data
- Start dates and current stage of the initiative

The evaluation will include baseline and cross-year comparisons. The first year of the KanCare demonstration, calendar year (CY) 2013, serves as a baseline year. Also, with many measures, pre-KanCare data is available, frequently multi-year data. Since the first Evaluation Design submission, some proposed comparisons have been changed to better reflect availability of comparable data. Further evaluation will occur regarding appropriateness of using pre-KanCare rates to compare to KanCare rates if the included populations are too different.

If no major overlapping initiatives are identified for a particular measure and statistical improvement is identified when compared to pre-KanCare or first year baseline rates, evaluation results will indicate the improvement is due to the effect of KanCare. Examples include assessing outcomes related to the MCOs'

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value-added services, such as determining correlations between use of smoking cessation value added services and consumer survey reported smoking measures.

When substantial overlapping initiatives are identified, KFMC will determine whether control comparisons are possible. Since KanCare is a statewide demonstration, control groups may not be available. Possibility for control group comparisons within KanCare include assessing performance measure results for members actively receiving care management services compared to results for members eligible for care management but who choose not to participate.

If there is overlap with other initiatives within the state, KFMC will determine whether the populations and areas impacted are distinct enough to warrant comparison between available performance measure results in the other initiatives, compared to the related KanCare initiative. One example is the various initiatives regarding health homes and person-centered medical home initiatives (PCMH). The KDHE Division of Health Care Finance is implementing a health home initiative, with health homes potentially being based in non-medical settings. If these settings and consumers served are distinctly different enough from the PCMH related initiatives in the state, it may be possible to compare rates of improvement, to help determine the effect of the health home initiative. Furthermore, outcomes could be compared for KanCare consumers receiving care management without assignment to a health home, versus consumers receiving care management with assignment to a health home.

The following table includes design specifications structured by previously noted KanCare Demonstration Goals, Objectives, and Hypotheses, as well as the following STC Evaluation Domains of Focus:

- Impact of KanCare for each population regarding:
  - Access to Care
  - Quality of Care
  - Efficiency
  - Coordination of Care
  - Cost of Care
- Impact of including Long Term Support Services (with sub-focus on HCBS) in the capitated managed care benefit.
- The Ombudsman program's assistance.
- Evaluation of the Intellectual Disabilities/Developmental Disabilities (ID/DD) Pilot Project, lessons learned.
- Impact of the uncompensated care pool and the delivery system reform incentive payment pool.

Additionally, the table provides the following elements:

- Type of measure
- National Quality Forum and CMS Core Measure cross-walk
- Population and stratifications;
- Data source;
- Type of comparisons; and
- Evaluation frequency.

Individual components of the evaluation will be reviewed as the data become available. While some of the measures are monitored by the State on a more frequent basis (particularly within the first demonstration year), the overall KanCare evaluation is typically based on annual review, with some measures including interim monitoring. The evaluation frequency of each measure is provided in the Measurement table, Figure 1. KFMC will develop a "quality control" database/dashboard, similar to one used for their CMS Medicare Quality Improvement Organization contract. Due to the large amount of measurement involved in the evaluation, the database will allow for routine updating of data as it becomes available, as well as for tracking and trending over time.

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KDHE proposed an amendment 8/19/2013 that delayed the implementation of the DSRIP Pool for one year, from DY 2 (2014) to DY 3 (2015), to allow the State and CMS to focus on other critical activities related to the KanCare demonstration. Consequently, receipt of CMS feedback on the DSRIP Protocols was delayed. On 2/05/2015, KDHE received notification from CMS of approval of the revised hospital DSRIP project proposals. Now that projects are approved, the State and KFMC (as the EQRO) will develop additional evaluation measures to assess overall and periodic progress of the hospital projects and trends over time.

External Evaluator

As previously noted, the Kansas Foundation for Medical Care, Inc. will serve as the external evaluator for the KanCare Demonstration. KFMC has 29 years of experience conducting case review for fee-for-service Medicaid. KFMC has also been the External Quality Review Organization (EQRO) for Kansas Medicaid since managed care was implemented in 1995. Through the EQRO contract, KFMC has conducted many focused studies, performance measurements and surveys, in addition to the various validation activities to review MCO reported data. The KFMC Vice President responsible for the KanCare Evaluation has 18 years EQRO experience. The EQRO manager, KFMC Director of Quality Review and Epidemiologist, has a Ph.D. in Public Health and comes to KFMC with experience evaluating a variety of large data sources. As the Medicare Quality Improvement Organization, KFMC works with data on a daily basis, evaluating quality improvement data at the provider, regional and statewide levels. KFMC will subcontract as needed for targeted (e.g., financial) analyses.

Costs

The budget for the external evaluation of the five year demonstration will average $137,659.00 per year.

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Figure 1: Measurement Table

Goals and Objectives	Evaluation Questions	Measurement	Type of Measure and Population	Measure Cross-Walk	Source of Data	Populations/ Stratifications	Comparisons for Purposes of Determining Effect of the Demonstration	Evaluation Frequency
Goal: **Improve the quality of care** Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes). **Related Objectives:** Measurably improve health care outcomes for members in areas including: diabetes; coronary artery disease; prenatal care; behavioral health. Improve coordination and integration of physical health care with behavioral health care. Support members successfully in their communities. Promote wellness and healthy lifestyles.	**Hypothesis:** By holding MCOs to outcomes and performance measures, and tying measures to meaningful financial incentives, the state will improve health care quality and reduce costs; **Hypotheses:** The state will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health, mental health, substance use disorder, and LTSS.	**Quality of Care**						
		(1) Physical Health						
		Comprehensive Diabetes Care. This measure is actually a composite HEDIS measure composed of 8 rates • HbA1C testing***** • Eye Exam***** • Medical Attention for Nephropathy***** • HbA1C <8.0***** • HbA1C<7.0 • HbA1C poor control >9.0 • Blood pressure <140/90***** • LDL-C Screening	*****P4P for 5 of the 8 metrics Quantitative Process and Outcomes Measures	NQF: 0057 0055 0062 0575 0059 0061	MCO HEDIS (CDC) reports	• Ages 18-75 • Medicaid • Also see measure #4: SMI; I/DD; PD	Pre-KanCare compared to KanCare and trending over time.	Annual
		Well-Child Visits in the First 15 Months of Life.	Quantitative Process Measures	NQF1392 CMS Core	MCO HEDIS (W15) reports	• Age through 15 months • Medicaid and CHIP combined populations	Pre-KanCare compared to KanCare and trending over time.	Annual
		Well-Child Visits in the First 7 Months of Life – 4 visits in first 7 months for births in January – May.	P4P Quantitative Process Measures	NQF1392 CMS Core	MCO reports; HEDIS-like measure	• Age through 7 months • Medicaid and CHIP combined populations	Annual comparison to 2013 baseline	Annual
		Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Quantitative Process measure	NQF1516 CMS Core	MCO HEDIS (W34) reports	• Ages 3-6 years • Medicaid and CHIP combined populations	Pre-KanCare compared to KanCare and trending over time.	Annual

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Figure 1: Measurement Table

Goals and Objectives	Evaluation Questions	Measurement	Type of Measure and Population	Measure Cross-Walk	Source of Data	Populations/ Stratifications	Comparisons for Purposes of Determining Effect of the Demonstration	Evaluation Frequency
		Adolescent Well Care Visits	Quantitative Process measure	CMS Core	MCO HEDIS (AWC) reports	• Ages 12 - 21 • Medicaid and CHIP combined populations	Annual comparison to 2013 baseline and trending over time.	Annual
		Adults' Access to Preventive/ Ambulatory Health Services	Quantitative process measure		MCO HEDIS (AAP) reports	• Ages 20-44; Ages 45-64; Age 65 and older; Total – ages 20 and older • Medicaid	Annual comparison to 2013 baseline for ages 65 and older. Pre-KanCare compared to KanCare (for ages <65).	Annual
		Preterm Birth. Each MCO has its own method validated by the EQRO.	P4P Quantitative Outcomes Measure		MCO	• Medicaid and CHIP combined populations	Annual comparison to 2013 baseline.	Annual
		Annual Monitoring for Patients on Persistent Medications	P4P Quantitative Process and Outcomes Measure	NQF2371	MCO HEDIS (MPM) report	• Medicaid • Age 18 and older	Annual comparison to 2013 baseline, trending over time.	Annual
		Medication Management for People with Asthma	Quantitative Process Measure	NQF1799 CMS Core	MCO HEDIS (MMA) report	• Ages 5 –11; Ages12-18; Ages 19-50; Ages 51-65; Total – Ages 5-65 • Medicaid and CHIP combined populations	Annual comparison to 2013/2014 baseline, trending over time.	Annual
		Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	Quantitative Process Measure	NQF 0108 CMS Core	MCO HEDIS (ADD) report	• Ages 6-12 • Medicaid and CHIP combined populations	Annual comparison to 2013/2014 baseline, trending over time.	Annual

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Figure 1: Measurement Table

Goals and Objectives	Evaluation Questions	Measurement	Type of Measure and Population	Measure Cross-Walk	Source of Data	Populations/ Stratifications	Comparisons for Purposes of Determining Effect of the Demonstration	Evaluation Frequency
		Follow-up after Hospitalization for Mental Illness, within seven days of discharge	P4P Quantitative Process and Outcomes Measure	NQF0576 CMS Core	MCO HEDIS (FUH) report	• Medicaid and CHIP combined populations	Annual comparison to 2013 baseline, trending over time.	Annual
		Prenatal Care	Quantitative Process Measure	NQF1517	MCO HEDIS (PPC) report	• Medicaid and CHIP combined populations	Pre-KanCare compared to KanCare and trending over time.	Annual
		Postpartum Care	Quantitative Process Measure	NQF1517	MCO HEDIS (PPC) report	• Medicaid and CHIP combined populations	Pre-KanCare compared to KanCare and trending over time.	Annual
		Chlamydia Screening in Women	Quantitative Process Measure	NQF0033	MCO HEDIS (CHL) report	• Medicaid and CHIP combined populations • Ages 16-20 • Ages 21-24 • Total - Ages 16-24	Annual comparison to 2013 baseline, trending over time	
		Controlling High Blood Pressure	Quantitative Process Measure	NQF0018	MCO HEDIS (CBP) report	• Medicaid • Age 18 and older	Annual comparison to 2013 baseline, trending over time	
		Initiation in AOD Dependence Treatment	Quantitative Process Measure	NQF0004	MCO HEDIS (IET) report	• Medicaid and CHIP combined populations • Ages 13-17 • Age 18 and older • Total – Age 13 and older	Annual comparison to 2013 baseline, trending over time	

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Figure 1: Measurement Table

Goals and Objectives	Evaluation Questions	Measurement	Type of Measure and Population	Measure Cross-Walk	Source of Data	Populations/ Stratifications	Comparisons for Purposes of Determining Effect of the Demonstration	Evaluation Frequency
		Engagement in AOD Dependence Treatment	Quantitative Process Measure	NQF0004	MCO HEDIS (IET) report	• Medicaid and CHIP combined populations • Ages 13-17 • Age 18 and older • Total – Age 13 and older	Annual comparison to 2013 baseline, trending over time	
		Weight Assessment for Children/Adolescents - BMI	Quantitative Process Measure	NQF0024	MCO HEDIS (WCC) report	• Medicaid and CHIP combined populations • Ages 3-11 • Ages 12-17 • Total – Ages 3-17	Annual comparison to 2013 baseline, trending over time	
		Counseling for Nutrition for Children/Adolescents	Quantitative Process Measure	NQF0024	MCO HEDIS (WCC) report	• Medicaid and CHIP combined populations • Ages 3-11 • Ages 12-17 • Total – Ages 3-17	Annual comparison to 2013 baseline, trending over time	
		Counseling for Physical Activity for Children/Adolescents	Quantitative Process Measure	NQF0024	MCO HEDIS (WCC) report	• Medicaid and CHIP combined populations • Ages 3-11 • Ages 12-17 • Total – Ages 3-17	Annual comparison to 2013 baseline, trending over time	

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Figure 1: Measurement Table

Goals and Objectives	Evaluation Questions	Measurement	Type of Measure and Population	Measure Cross-Walk	Source of Data	Populations/ Stratifications	Comparisons for Purposes of Determining Effect of the Demonstration	Evaluation Frequency
		Adult BMI Assessment	Quantitative Process Measure		MCO HEDIS (ABA) report	• Medicaid • Age 18 and older	Annual comparison to 2013/2014 baseline, trending over time	
		Annual Dental Visit	Quantitative Process Measure		MCO HEDIS (ADV) report	• Medicaid and CHIP combined populations • Ages 2-3 • Ages 4-6 • Ages 7-10 • Ages 11-14 • Ages 15-18 • Ages 19-21 • Total – Ages 2-21 years	Annual comparison to 2013 baseline, trending over time	
		Appropriate Treatment for Children with Upper Respiratory Infection	Quantitative Process Measure	NQF0069	MCO HEDIS (URI) report	• Medicaid and CHIP combined population • Ages 3 months to18 years	Annual comparison to 2013 baseline, trending over time	
		Appropriate Treatment for Children with Pharyngitis	Quantitative Process Measure	NQF0002	MCO HEDIS (CWP) report	• Medicaid & CHIP combined population • Ages 2-18	Annual comparison to 2013 baseline, trending over time	
		(2) Substance Use Disorder Services						
		The number and percent of members, receiving SUD services, whose living arrangements improved.	Qualitative outcome measure for population receiving SUD services		KCPC, containing member self-reported information. Measure calculated by KDADS.	SUD	Pre-KanCare compared to KanCare and trending over time.	Annual

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Figure 1: Measurement Table

Goals and Objectives	Evaluation Questions	Measurement	Type of Measure and Population	Measure Cross-Walk	Source of Data	Populations/ Stratifications	Comparisons for Purposes of Determining Effect of the Demonstration	Evaluation Frequency
		The number and percent of members, receiving SUD services, whose criminal justice involvement improved.	Quantitative outcome measure for population receiving SUD services		KCPC, containing member self-reported information. Measure calculated by KDADS.	SUD	Pre-KanCare compared to KanCare and trending over time.	Annual
		The number and percent of members, receiving SUD services, whose drug and/or alcohol use decreased.	Qualitative outcome measure for population receiving SUD services		KCPC, containing member self-reported information. Measure calculated by KDADS .	SUD	Pre-KanCare compared to KanCare and trending over time.	Annual
		The number and percent of members, receiving SUD services, whose attendance of self-help meetings increased.	Qualitative process measure for population receiving SUD services		KCPC, containing member self-reported information. Measure calculated by KDADS.	SUD	Pre-KanCare compared to KanCare and trending over time.	Annual
		The number and percent of members, receiving SUD services, whose employment status increased.	P4P Qualitative outcome measure for population receiving SUD services.		KCPC, containing member self-reported information. Measure calculated by KDADS.	SUD	Pre-KanCare compared to KanCare and trending over time.	Annual

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Figure 1: Measurement Table

Goals and Objectives	Evaluation Questions	Measurement	Type of Measure and Population	Measure Cross-Walk	Source of Data	Populations/ Stratifications	Comparisons for Purposes of Determining Effect of the Demonstration	Evaluation Frequency
		(3) Mental Health Services – National Outcome Measurement System (NOMS)						
		The number and percent of adults with SPMI who had increased access to services.	P4P Quantitative process measure for population with SPMI		KDADS calculations using AIMS and MMIS data.	SPMI	Pre-KanCare compared to KanCare and trending over time.	Annual
		The number and percent of youth experiencing SED who had increased access to services.	P4P Quantitative process measure for youth with SED		KDADS calculations using AIMS and MMIS data.	SED	Pre-KanCare compared to KanCare and trending over time.	Annual
		The number and percent of adults with SPMI who were homeless at the initiation of CSS services and experienced improvement in their housing status.	Qualitative Outcome Measure for adults with SPMI		KDADS calculations using MMIS and AIMS – (member self-reported housing status)	SPMI	Pre-KanCare compared to KanCare and trending over time.	Annual
		The number and percent of KanCare youth receiving MH services with improvement in their Child Behavior Checklist (CBCL) Competence T-scores.	Qualitative Outcome Measure for youth with SED		KDADS calculations using MMIS and AIMS – (includes member self-reported components of CBCL)	SED	Pre-KanCare compared to KanCare and trending over time.	Annual
		The number and percent of youth with an SED who experienced improvement in their residential status.	Quantitative Outcome Measure for youth with SED		KDADS calculations using MMIS and AIMS	SED	Pre-KanCare compared to KanCare and trending over time.	Annual

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Goals and Objectives	Evaluation Questions	Measurement	Type of Measure and Population	Measure Cross-Walk	Source of Data	Populations/ Stratifications	Comparisons for Purposes of Determining Effect of the Demonstration	Evaluation Frequency
		The number and percent of youth with an SED who maintained their residential status.	Quantitative Outcome Measure for youth with SED		KDADS calculations using MMIS and AIMS	SED	Pre-KanCare compared to KanCare and trending over time.	Annual
		The number and percent of KanCare members, diagnosed with SPMI whose employment status increased.	P4P Quantitative Outcome Measure for adults with SPMI		MCO	• Ages 18-65 • SPMI	Annual comparison to 2013 baseline, trending over time.	Annual
		The number and percent of members utilizing inpatient psychiatric services, including state psychiatric facilities and private inpatient mental health services.	P4P Quantitative Measure for KanCare population		Inpatient Screening Database	KanCare	Annual comparison to 2013 baseline, trending over time.	Annual
		(4) Healthy Life Expectancy						
		Health Literacy: <u>Adult members:</u> *In the last 6 months,* • Did you and a doctor or other health provider talk about specific things you could do to prevent illness? • How often did your personal doctor explain things in a way that was easy to understand? • How often did your personal doctor listen carefully to you? • Did you and a doctor or other health provider talk about starting or stopping a prescription medicine? If yes: *When you talked about starting*	Qualitative Measure for KanCare population		CAHPS survey data	• Medicaid • CHIP • Adult • Child – General population • Child – CCC population	Annual comparison to 2014 baseline, trending over time	Annual

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		or stopping a prescription medicine, ○ How much did a doctor or other health provider talk about the reasons you might want to take a medicine? ○ How much did a doctor or other health provider talk about the reasons you might <u>not</u> want to take a medicine? ○ Did a doctor or other health provider ask you what you thought was best for you? <u>Child members (General population and CCC population):</u> *In the last 6 months,* • Did you and your child's doctor or other health provider talk about specific things you could do to prevent illness in your child? • How often did you have your questions answered by your child's doctors or other health providers? • How often did your child's personal doctor explain things about your child's health in a way that was easy to understand? • How often did your child's personal doctor explain things in a way that was easy for <u>your child</u> to understand? • How often did your child's personal doctor listen carefully to you?						

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Goals and Objectives	Evaluation Questions	Measurement	Type of Measure and Population	Measure Cross-Walk	Source of Data	Populations/ Stratifications	Comparisons for Purposes of Determining Effect of the Demonstration	Evaluation Frequency
		• Did you and your child's doctor or other health provider talk about starting or stopping a prescription medicine for your child? If yes: *When you talked about your child starting or stopping a prescription medicine,* ○ How much did a doctor or other health provider talk about the reasons you might want your child to take a medicine? ○ How much did a doctor or other health provider talk about the reasons you might <u>not</u> want your child to take a medicine? ○ Did a doctor or other health provider ask you what you thought was best for your child?						
		Flu Shots for adults	P4P Qualitative Measure for KanCare population	NQF: 0039	CAHPS survey data HEDIS (FVA)	• Medicaid	Annual comparison to 2014 baseline, trending over time.	Annual
		Smoking Cessation • Do you now smoke cigarettes or use tobacco every day, some days, or not at all? *If every day or some days –* *In the last 6 months:* • How often were you advised to quit smoking or using tobacco by a doctor or other	P4P* Qualitative Measure for KanCare population	NQF: 0027**	CAHPS survey data HEDIS (MSC)**	• Medicaid	Annual comparison to 2014 baseline, trending over time.	Annual

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		health provider in your plan? (*P4P) • How often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication? (**NQF0027) • 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? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.						
		Diabetes Monitoring for People with Diabetes and Schizophrenia	Quantitative Process Measure for Medicaid population	NQF1934	MCO HEDIS (SMD) report	• Medicaid • Ages 18-64	Annual comparison to 2013 baseline, trending over time	Annual
		Healthy Life Expectancy for persons with Serious Mental Illness (SMI); for persons with Intellectual or Developmental Disabilities (I/DD); and for persons with Physical Disabilities (PD). • Prevention <u>Screenings, Vaccinations, Preventable Emergency Visits:</u> ○ Mammograms (BCS)*	P4P Qualitative and Quantitative Measures for population with SMI, I/DD and PD	NQF: 2372 0032 0057 0055 0062 0575 0059 0061	HEDIS data reported for SMI, I/DD, PD subpopulations	• SMI • I/DD • PD	Annual comparison to 2013/2014 baseline, trending over time.	Annual

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		○ Cervical Cancer Screening (CCS)* ○ Preventive Ambulatory Health Service (AAP)* • Treatment/Recovery • Diabetes Management – 5 measures: HbA1C testing; HbA1C <8.0; Medical attention for Nephropathy; Eye Exam; Blood Pressure < 140/90						
		(5) HCBS Waiver Services (see item 3 for additional SED Waiver measures)						
		The number and percent of KanCare members, receiving HCBS Physical Disability (PD) or Traumatic Brain Injury (TBI) waiver services that are eligible for the WORK program who have increased competitive employment.	P4P Quantitative Outcome Measure for members receiving TBI HCBS services		MCO's Case Management data collection	• Ages 18-65 • PD • TBI	Annual comparison to 2013 baseline	Annual
		Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment	HCBS Waiver Services Process Measure		Record Review	Waivers: • SED • I/DD • PD • TBI • TA • Autism • MFP • FE	Comparison between years, with baseline being pre-KanCare calendar year 2012.	Annual

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		Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan.	Medicaid Quality Strategy Measure for members receiving HCBS Waiver services		Record review	Waivers: • SED • I/DD • PD • TBI • TA • Autism • MFP • FE	Comparison between years, with baseline being pre-KanCare calendar year 2012.	Annual
		(6) Long Term Care: Nursing Facilities						
		Percentage of Medicaid Nursing Facility (NF) claims denied by the MCOs.	P4P (2013/2014) Quantitative Process Measure, regarding populations in Nursing Facilities		MCO report	NF	Comparison of pre-KanCare to KanCare and trending over time.	Annual
		The percentage of NF members who had a fall with a major injury.	P4P Quantitative Outcome Measure for members in NF.		KDADS report using nursing home MDS data	NF	Comparison of pre-KanCare to KanCare and trending over time.	Annual
		The percentage of members discharged from a NF who had a hospital admission within 30 days.	P4P Quantitative Measure for members discharged from an NF.		MCO report using claims data.	NF	Comparison of pre-KanCare to KanCare and trending over time.	Annual
		Number of Person Centered Care Homes as recognized by the PEAK program (Promoting Excellent Alternatives in Kansas) in the MCO network.	P4P Quantitative Process Measure regarding		KDADS report	NF	Comparison of pre-KanCare to KanCare and trending over time.	Annual

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Goals and Objectives	Evaluation Questions	Measurement	Type of Measure and Population	Measure Cross-Walk	Source of Data	Populations/ Stratifications	Comparisons for Purposes of Determining Effect of the Demonstration	Evaluation Frequency
			Nursing Facilities					
Goal: **Improve the quality of care** Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes); **Related Objectives:** Measurably improve health care outcomes for members in the following areas: diabetes; coronary artery disease; chronic obstructive pulmonary disease; prenatal care; behavioral health.	**Hypothesis:** The state will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health, mental health, substance use disorder, and LTSS. **STC Domains of Focus:** What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care, for each demonstration population or relevant population group (STC XV 103.a.i.)	**(7) Member Survey – Quality**						
		Member perceptions of provider treatment: • Rating of personal doctor. • Rating of health care. • Rating of health plan. • Rating of specialist seen most often. • Doctor spent enough time with the member. • Doctor respected member comments.	Qualitative measures for the Medicaid and CHIP populations.		MCO CAHPS Survey Results (Adult, Child, and Children with Chronic Conditions Module)	• Medicaid Adult Child – general Child- Chronic Condition • CHIP Child – general Child – Chronic Conditions	Comparison to pre-KanCare and KanCare	Annual
		Member perceptions of mental health provider treatment as measured by the following: • If I had other choices, I would still get services from my mental health providers. • My mental health providers helped me obtain information I needed so that I could take charge of managing my illness. • I, not my mental health providers, decided my treatment goals. • I felt comfortable asking questions about my treatment and medication. • My mental health providers spoke with me in a way I understood. • As a direct result of services I received, I am better able to control my life.	Qualitative Measures for members with SPMI or SED.		Mental Health Statistics Improvement Program (MHSIP) Survey Results (adult, youth, SED Waiver)	• Adult - MH • Youth – general MH • Youth – SED Waiver	Comparison to pre-KanCare and KanCare	Annual

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Goals and Objectives	Evaluation Questions	Measurement	Type of Measure and Population	Measure Cross-Walk	Source of Data	Populations/ Stratifications	Comparisons for Purposes of Determining Effect of the Demonstration	Evaluation Frequency
		• As a direct result of services I received, I am better able to deal with crisis. • As a direct result of services I received, I am better able to do things that I want to do.						
		<u>Member perceptions of SUD services as measured by the following:</u> • Overall, how would you rate the quality of service you have received from your counselor? • How would you rate your counselor on involving you in decisions about your care? • Since beginning treatment, in general are you feeling much better, better, about the same, or worse?	Qualitative Measures for members receiving SUD services		Substance Use Disorder Consumer Survey Results	SUD	Comparison to pre-KanCare and KanCare	Annual
		(8) Provider Survey						
		Provider perceptions of beneficiary quality of care • Please rate your satisfaction with the MCO's demonstration of their commitment to high quality of care for their members.	Qualitative Measures		Provider Survey	MCO Providers	Comparison between years beginning 2014.	Annual
		(9) Grievances						
		Compare/track number of grievances related to quality over time, by population type.	Quantitative measure		Grievance Reports	KanCare	Comparison of baseline to subsequent years.	Quarterly

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		(10) Other (Tentative) Studies (Specific studies to be determined.)						
		Impact of P4P on quality. For HEDIS measures that were less than the 50th percentile at baseline, what was the level of improvement in the P4P measures compared to the non-P4P measures?	Quantitative for Medicaid and CHIP populations.		MCO HEDIS reports	Medicaid and CHIP combined populations	Compare baseline to subsequent years.	DY 3-5
		Impact of targeted value-added services (e.g. smoking cessation programs for the MCOs that provide these services) on outcomes (e.g., number of members who smoke [per CAHPS]) and costs, if appropriate.	TBD		MCO value added reports and CAHPS data	TBD	Compare baseline to subsequent years.	DY 3-5
Goal: **Provide integration and coordination of care** across the whole spectrum of health to include physical health, behavioral health, mental health, substance use disorders and LTSS; **Related Objectives:** Improve coordination and integration of physical health care with behavioral health care. Support members successfully in their communities.	**Hypothesis:** The KanCare model will reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired; **STC Domain of Focus:** What is the impact of including LTSS in the capitated managed care benefit, with a sub-focus on the inclusion of HCBS in	**Coordination of Care (and Integration) – HCBS and LTSS**						
		(11) Care Management for Members Receiving HCBS Services						
		The number and percent of KanCare member waiver participants with documented change in needs whose service plans were revised, as needed, to address the change.	Quantitative Measure for HCBS members		Case Audits completed by the State or its contractor/ agent.	Members receiving HCBS services.	Comparison of baseline to subsequent years.	Annual
		The number and percent of KanCare member waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs.	Quantitative Measure for HCBS members.		Case Audits completed by the State or its contractor/ agent.	Members receiving HCBS services.	Comparison of baseline to subsequent years.	Annual

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Goals and Objectives	Evaluation Questions	Measurement	Type of Measure and Population	Measure Cross-Walk	Source of Data	Populations/ Stratifications	Comparisons for Purposes of Determining Effect of the Demonstration	Evaluation Frequency
	capitated managed care? (STC XV. 103.a.ii.)	Increased Preventive Care: Increase in the number of primary care visits	P4P Quantitative Measure for members using HCBS waiver services		HEDIS-like measure; HEDIS criteria (AAP) limited to members receiving HCBS waiver services	Members receiving HCBS waiver services	Comparison of baseline to subsequent years	Annual
		Decrease in Emergency Room visits	P4P Quantitative Measure for members using HCBS waiver services		HEDIS-like measure; HEDIS criteria (AMBA) limited to members receiving HCBS waiver services	Members receiving HCBS waiver services	Comparison of baseline to subsequent years	Annual
		Increase in annual dental visits	P4P Quantitative Measure for members using HCBS waiver services		HEDIS-like measure; HEDIS criteria (ADV) limited to members receiving HCBS waiver services	Members receiving HCBS waiver services, Ages 2-21	Comparison of baseline to subsequent years	Annual
		(12) Other (Tentative) Study (Specific study to be determined.)						
		Impact of in lieu of services on inpatient/institutional/facility utilization.	Quantitative analyses of utilization of services		Claims	• TBD	Comparison of baseline to subsequent years.	Year 5 study, looking back annually.
	Hypothesis: KanCare will provide integrated care coordination to individuals with developmental disabilities, which will improve access to health services and	**(13) Care Management for members with I/DD** (Also see I/DD related measures in items 4, 5, 13, and 19.)						
		Number of I/DD providers who, having requested it, report receiving helpful information and assistance from MCOs about how to enter their provider network.	Qualitative Measure for population in I/DD pilot project.		Survey/ Interviews	I/DD	To Be Determined (TBD)	End of Pilot

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	improve the health of those individuals. **STC Domain of Focus:** What did the state learn from the ID/DD Pilot Project that could assist the state in moving ID/DD HCBS services into managed care? (STC XV.103.a.iv.)	Number of DD providers submitting a credentialing application to an MCO, who completed the credentialing application to an MCO, who completed the credentialing process within 45 days.	Quantitative Process Measure for DD providers		MCO Reports	I/DD	(TBD)	End of Pilot
		Number of DD providers who, having requested it, report receiving helpful information and assistance from MCOs about how to submit claims for services provided.	Qualitative Measure for population in I/DD pilot project.		Survey/ Interviews	I/DD	(TBD)	End of Pilot
		Number of providers who, having participated in the DD pilot project, report understanding how to help the members they support understand the services available in the KanCare program and how to access those services.	Qualitative Measure for population in I/DD pilot project.		Survey/ Interviews	I/DD	(TBD)	End of Pilot
		Improved access to services including physical health, behavioral health, specialists, prevention. Targeted Case Managers participating in the pilot will be the focus of this measurement.	Qualitative Measure for population in I/DD pilot project.		Survey/ Interviews	I/DD	(TBD)	End of Pilot
		Wichita State University will facilitate the process for determining that members and guardians are aware of service options and how to access services in the KanCare structure. Focus will be members, family members, parents and guardians participating in the pilot. Areas covered will include: • What is KanCare	Qualitative Measure for population in I/DD pilot project.		Survey/ Interviews	I/DD	(TBD)	End of Pilot

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		• DD services • TCM role • Care coordinator role • Coordination of DD services and other Medicaid services. • Provider network navigation and selecting an MCO • How can services be accessed to meet new or changing needs.						
		MCOs have demonstrated an understanding of the Kansas DD service system. <u>MCOs demonstrate a knowledge and understanding of:</u> • The statutes and regulations that govern the IDD service delivery system. • The person-centered planning process and regulations related to the process. • The various types of providers and the roles they play in the IDD service system. • Tools/strategies used by CDDO/Stakeholder processes. • The tools used by CDDOs to implement various local processes (local quality assurance, funding committees, crisis determinations, public school system collaboration, etc.)	Qualitative Measure for population in I/DD pilot project.		Survey/ Interviews	I/DD	(TBD)	End of Pilot
	<u>Hypothesis:</u> The state will improve quality in Medicaid services by integrating and	**(14) Member Survey - CAHPS**						
		<u>Perception of care and treatment in Medicaid and CHIP populations:</u>	Qualitative Measure for Medicaid an		MCO Survey Report	• Medicaid Adult Child-general	Comparison of baseline to subsequent years.	Annual

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	coordinating services and eliminating the current silos between physical health, behavioral health, mental health, substance use disorder, and LTSS (in this case to be measured through patient perceptions of care). Other measures address this hypothesis through other data sources (e.g., administrative data, case record review etc.).	• In the last 6 months, did you get care from a doctor or other health provider besides your personal doctor? • In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers? • In the last 6 months, did you make any appointments to see a specialist? • In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed? • In the last 6 months, how often was it easy to get the care, tests, or treatment you needed? <u>Children with Chronic Conditions (CCC) Module</u> • In the last 6 months, did your child get care from a doctor or other health provider besides his or her personal doctor? • In the last 6 months, how often did your child's personal doctor seem informed and up-to-date about the care your child got from these doctors or other health providers? • In the last 6 months, did your child get care from more than one kind of health care provider or use more than one kind of health care service?	CHIP populations			Child-CCC • CHIP Child-general Child-CCC		

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		• In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services? • Does your child have any medical, behavioral, or other health conditions that have lasted more than 3 months? • Does your child's personal doctor understand how these medical, behavioral or other health conditions affect your child's day-to-day life? • Does your child's personal doctor understand how your child's medical, behavioral or other health conditions affect your family's day-to-day life? • In the last 6 months, did you make any appointments for your child to see a specialist? • In the last 6 months, how often was it easy to get appointments for your child with specialists? • In the last 6 months, how often was it easy to get the care, tests, or treatment you thought your child needed through his or her health plan? • In the last 6 months, did you get or refill any prescription medicines for your child? • In the last 6 months, was it easy to get prescription medicines for your child through his or her health plan?						

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		• Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines? • In the last 6 months, did you need your child's doctors or other health providers to contact a school or daycare center about your child's health or health care? • In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?						
		(15) Member Survey – MH						
		<u>Perception of care coordination for members receiving MH services:</u> • I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.). • My family got as much help as we needed for my child. (I was able to get all the services I thought I needed.)	Qualitative Measure for Adults and Youth with at least one MH service, and for Youth receiving SED Waiver services.		MHSIP Survey conducted by KFMC	• Adult – MH • General Youth – MH • Youth - SED Waiver	Comparison to pre-KanCare and - KanCare	Annual
		(16) Member Survey - SUD						
		<u>Perception of care by SUD population:</u> • Has your counselor requested a release of information for this other substance abuse counselor who you saw? • Has your counselor requested a release of information for and discussed your treatment with your medical doctor?	Qualitative Measure for population receiving SUD services.		MCO Survey	SUD	Comparison to pre-KanCare and KanCare	Annual

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		(17) Provider Survey						
		Provider perceptions regarding coordination of care: • Satisfaction with obtaining precertification and/or authorization for members.	Quality Measure for KanCare providers.		MCO Reports	KanCare providers (stratification to be determined)	Comparison between baseline CY2013 and subsequent years.	Annual
Goal: **Control Medicaid costs** by emphasizing health, wellness, prevention and early detection, as well as integration and coordination of care. **Related Objectives:** Promote wellness and healthy lifestyles. Lower the overall cost of health care.	**Hypothesis**: By holding MCOs to outcomes and performance measures, and tying measures to meaningful financial incentives, the state will improve health care quality and reduce costs. **STC Domains of Focus:** What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care, for each demonstration population or relevant population group (STC XV 103.a.i.)	**Cost of Care**						
		(18) Costs						
		Total dollars spent on HCBS budget compared to institutional costs	Quantitative Measure		Financial/ Claims/ Encounter Data	HCBS	Compare pre-KanCare to KanCare and trend over time	DY 2-5
		Per member per month (PMPM) costs • Compare pre-KanCare PMPM costs to KanCare PMPM costs by MEG.	Quantitative Measure		Financial/ Claims/	• ABD/SD Dual • ABD/SD Non Dual • Adults • Children • DD Waiver • LTC • Waiver	Compare pre-KanCare to KanCare and trend over time	DY 2-5
		• Compare pre-KanCare and KanCare costs for members in care management, comparing costs prior to enrollment in care management to costs after enrollment in care management.	Quantitative Measure		Financial/ Claims/ Encounter Data	Care Management	Compare baseline to subsequent years	DY2-5
Goal: **Establish long-lasting reforms** that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for	**Hypothesis:** The state will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health, mental	**Access to Care**						
		(19) Provider Network - GeoAccess						
		Percent of counties covered within access standards, by provider type (physicians, hospital, eye care, dental, ancillary [PT, OT, x-ray, lab], and pharmacy). • Urban/Semi-Urban	Quantitative Access Measure		MCO Geo-Access Reports	Provider Type	Comparisons will occur to pre-KanCare access and trending over time.	Annual

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Medicaid payment and delivery system reforms as well. **Related Objectives:** Measurably improve health outcomes for members. Support members successfully in their communities. Promote wellness and healthy lifestyles. Improve coordination and integration of physical health care with behavioral health care. Lower the overall cost of health care.	health, substance use disorder, and LTSS. **STC Domains of Focus:** (STC XV 103.a.i.) What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care, for each demonstration population or relevant population group? (STC XV.103.a.iii.) How did the Ombudsman's program assist the KanCare program and its beneficiaries? (STC XV.103.a.v.) How did the UC Pool impact care under Medicaid in the state? (STC XV.103.a.vi.) An assessment of the impact of DSRIP payments to participating providers including:	• Densely Settled Rural/Rural Frontier						
		Average distance to a behavioral health provider • Urban/Semi-Urban • Densely Settled Rural • Rural Frontier	Quantitative Access Measure		MCO Geo-Access Reports	BH Provider	Comparisons will occur to pre-KanCare access and trending over time	Annual
		Percent of counties covered within access standards for behavioral health • Urban/Semi-Urban • Densely Settled Rural • Rural Frontier	Quantitative Access Measure		MCO Geo-Access Reports	BH Provider	Comparisons will occur to pre-KanCare access and trending over time	Annual
		Home and Community Based Services (HCBS) Counties with Access to at least two providers, by provider type and services • Adult Day Care • Assistive Services • Assistive Technology • Attendant Care Services (Direct) • Behavior Therapy • Cognitive Therapy • Comprehensive Support (Direct) • Financial Management Services (FMS) • Health Maintenance Monitoring • Home Modification • Home Telehealth • Home-Delivered Meals (HDM) • Intermittent Intensive Medical Care	Quantitative Access Measure		MCO Geo-Access Reports	HCBS Provider Type	Comparisons will occur to pre-KanCare access and trending over time	Annual

KanCare Evaluation Design

March 2015

Figure 1: Measurement Table

Goals and Objectives	Evaluation Questions	Measurement	Type of Measure and Population	Measure Cross-Walk	Source of Data	Populations/ Stratifications	Comparisons for Purposes of Determining Effect of the Demonstration	Evaluation Frequency
		• Long-Term Community Care Attendant • Medication Reminder • Nursing Evaluation Visit • Occupational Therapy • Personal Emergency Response (Installation) • Personal Emergency Response (Rental) • Personal Services • Physical Therapy • Sleep Cycle Support • Specialized Medical Care/Medical Respite • Speech Therapy • Transitional Living Skills • Wellness Monitoring						
		• Provider After Hour Access (24 hrs. per day/7 days per week) • Annual Provider Appointment Standards Access (In-office wait times; emergent, urgent and routine appointments; prenatal care – first, second, third trimester and high risk) • Provider Open/Closed Panel Report	Process Access Measure for Medicaid and CHIP populations, as well as applicable stratified populations (e.g., MH, SUD, HCBS)		MCOs' Access Reports	Types of providers (e.g., PCP, Specialist, etc.)	Pre-KanCare compared to KanCare and trending over time.	Annual, beginning 2013
		(20) Member survey - CAHPS						
		• In the last 6 months, did you make any appointments (for your child) to see a specialist? • In the last 6 months, how often did you get an appointment (for	Qualitative Access Measure for Medicaid and CHIP populations		Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Title 19 • Adults • Children • Children with Chronic	Comparisons will occur to pre-KanCare access and trending over time.	Annual, beginning 2014

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March 2015

Figure 1: Measurement Table

Goals and Objectives	Evaluation Questions	Measurement	Type of Measure and Population	Measure Cross-Walk	Source of Data	Populations/ Stratifications	Comparisons for Purposes of Determining Effect of the Demonstration	Evaluation Frequency
		your child) to see a specialist as soon as you needed? • In the last 6 months, how often was it easy to get the care, tests, or treatment you (your child) needed? • In the last 6 months, did you make any appointments for a check-up or routine care (for your child) at a doctor's office or clinic? • In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for (your child) for a check-up or routine care at a doctor's office or clinic as soon as you thought you needed? • In the last 6 months did you (your child) have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office? • In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?			Survey Results (Adult, child, and Children with Chronic Conditions (CCC) Module) conducted by MCOs	Conditions (CCC) CHIP • Children • Children with Chronic Conditions (CCC)		
		(21) Member Survey - MH						
		• My mental health providers were willing to see me as often as I felt it was necessary. • My mental health providers returned my calls in 24 hours. • Services were available at times that were good for me.	Qualitative Measure for Adults and Youth with at least one MH service, and for Youth		MHSIP Survey Results (adult, youth, SED Waiver). MCOs required to provide	• Adult - MH • Youth – general MH • Youth -SED Waiver	Comparisons will occur to pre-KanCare and trending over time.	Annual

KanCare Evaluation Design

March 2015

Figure 1: Measurement Table

Goals and Objectives	Evaluation Questions	Measurement	Type of Measure and Population	Measure Cross-Walk	Source of Data	Populations/ Stratifications	Comparisons for Purposes of Determining Effect of the Demonstration	Evaluation Frequency
		• I was able to get all the services I thought I needed. • I was able to see a psychiatrist when I wanted to. • During a crisis, I was able to get the services I needed. • If you are on medication for emotional/behavioral health problems, were you able to get it timely?	receiving SED Waiver services		assistance to members as needed for completion of surveys; State to monitor.			
		(22) Member Survey - SUD						
		• Did you get an appointment as soon as you wanted? • For urgent problems, how satisfied are you with the time it took you to see someone? • For urgent problems, were you seen within 24 hours, 24 to 48 hours, or did you wait longer than 48 hours? • Is the distance you travel to your counselor a problem or not a problem? • Were you placed on a waiting list? • If you were placed on a waiting list, how long was the wait?	Qualitative Access Measure for population receiving SUD services		Substance Use Disorder Consumer Survey Results conducted by MCOs.	SUD	Comparisons will occur to pre-KanCare access and trending over time.	Annual, beginning 2013
		(23) Provider Survey						
		Provider perception of access to specialists: How satisfied are you with the availability of specialists?	Qualitative Access Measure for KanCare providers		Provider Survey	KanCare Providers	Annual comparisons	Annual

KanCare Evaluation Design

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Figure 1: Measurement Table

Goals and Objectives	Evaluation Questions	Measurement	Type of Measure and Population	Measure Cross-Walk	Source of Data	Populations/ Stratifications	Comparisons for Purposes of Determining Effect of the Demonstration	Evaluation Frequency
		(24) Grievances						
		Compare/track number of access related grievances over time, by population categories.	Qualitative and Quantitative Access Measure by population type		MCO Grievance Reports	KanCare	Quarterly comparisons	Quarterly
		Ombudsman Program						
		(25) Calls and Assistance						
		Evaluate for trends regarding types of questions and grievances submitted to Ombudsman's Office.	Qualitative Measure for overall KanCare population		Ombudsman report		Quarterly trending	Quarterly
		Track number and type of assistance provided by the Ombudsman's Office.	Quantitative Measure for overall KanCare population		Ombudsman report		Quarterly trending	Quarterly
		Efficiency						
		(26) Systems						
		Quantify system design innovations implemented by KanCare such as: Person Centered Medical Homes Electronic Health Record use Use of Telehealth Electronic Referral Systems	Qualitative and Quantitative Process Improvement		KDADS, KDHE and MCO reports	Overall KanCare	Pre-KanCare compared to KanCare	Annual
		• Emergency Department visits • Inpatient Hospitalizations • Inpatient Readmissions within 30 days of inpatient discharge	Quantitative Utilization Measures		Claims Encounters	KanCare Total MH I/DD PD TBI FE	Compare preKanCare to KanCare and trending over time.	DY 2-5

KanCare Evaluation Design

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Figure 1: Measurement Table

Goals and Objectives	Evaluation Questions	Measurement	Type of Measure and Population	Measure Cross-Walk	Source of Data	Populations/ Stratifications	Comparisons for Purposes of Determining Effect of the Demonstration	Evaluation Frequency
		• Timely resolution of grievances • Timely resolution of customer service inquiries • Timeliness of claims processing	Year 1 P4P Process Measures for overall KanCare population		MCO reports	Overall KanCare	Comparison of baseline to post-measurement over time.	Quarterly
		(27) Member Surveys						
		In the last 6 months, did you get the information or help from your (child's) health plan's customer service? If yes, how often did your (child's) health plan's customer service give you the information or help you needed?	Qualitative Measures for Medicaid and CHIP populations		MCO CAHPS report	Medicaid • Adult • Child-general • Child – CCC CHIP • Child- general • Child – CCC	Comparison of baseline CY2013 to annual measurement and trending over time.	Annual
		My mental health providers returned my calls in 24 hours.	Qualitative Measures for Adults and Youth with at least one MH service and for youth receiving SED Waiver Services		MHSIP survey conducted by KFMC.	Adult Youth – general Youth – SED Waiver	Comparison of baseline CY2013 to annual measurement and trending over time.	Annual
		How would you rate your counselor on communicating clearly with you?	Qualitative Measures for SUD population		SUD survey reported by MCOs	SUD	Pre-KanCare compared to Post-KanCare and trend over time.	Annual
				Uncompensated Care Pool				
		Number of Medicaid Days for UC Pool hospitals compared to UC Pool payments	Quantitative Measure		Claims data	Medicaid	Comparison/trending over time	Annual

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Figure 1: Measurement Table

Goals and Objectives	Evaluation Questions	Measurement	Type of Measure and Population	Measure Cross-Walk	Source of Data	Populations/ Stratifications	Comparisons for Purposes of Determining Effect of the Demonstration	Evaluation Frequency
		DSRIP						
		Delivery System Reform Incentive – KDHE proposed an amendment August 19, 2013, to delay the implementation of the DSRIP Pool for one year, from DY 2 (2014) to DY 3 (2015), to allow the State and CMS to focus on other critical activities related to the KanCare demonstration. CMS provided feedback in 2014, and the DSRIP hospitals revised their project proposals based the feedback. CMS approval of the revised DSRIP projects was received on 2/5/2015. Now that projects are approved, KDHE and KFMC (as the EQRO) will develop additional evaluation measures to assess overall progress of the hospital projects over time.						

Appendix B

2013-2018 Final KanCare Evaluation Report

January 2013–December 2018

List of Related Acronyms

Kansas Foundation for Medical Care, Inc
urac ACCREDITED Independent Review Organization: External Expires 06/01/2021

List of Related Acronyms	
Acronym	**Description**
AAP	Adults' Access to Preventive/Ambulatory Health Services
ABA	Adult BMI Assessment
ACO	Accountable Care Organization
ADD	Follow-up Care for Children Prescribed ADHD Medication
ADHD	Attention Deficit Hyperactivity Disorder
ADV	Annual Dental Visit
AGP	Amerigroup Kansas, Inc. (Amerigroup)
AHRQ	Agency for Health Care Research and Quality
AIMS	Automated Information Management Systems
AWC	Adolescent Well-Care Visits
BASIS	Basic Assessment and Services Information System
BCBSKS	Blue Cross/Blue Shield of Kansas
Beacon Program	Improving Coordinated Care for Medically Complex Patients
BH	Behavioral Health
BlueKC	Blue Cross/Blue Shield of Kansas City
BMI	Body Mass Index
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBCL	Child Behavior Checklist Competence T-Scores
CBP	Controlling High Blood Pressure
CCC	Children with Chronic Conditions (CAHPS survey population)
CDC	Comprehensive Diabetes Care
CDDO	Community Developmental Disability Organization
CERA	Community Engagement Resource Application
CHIP	Children's Health Insurance Program (Title XXI)
CHL	Chlamydia Screening in Women
CMC	Children with Medical Complexity
CMH	Children's Mercy Hospital and Clinics
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CPC+	Comprehensive Primary Care Plus
CSA	Collaborative Service Agreements
CSC	Community Service Coordination
CSP	Community Service Provider
CWP	Children with Pharyngitis
CY	Calendar Year
CYMC	Children and Youth with Medical Complexity

List of Related Acronyms	
Acronym	**Description**
DCF	Kansas Department for Children and Families
DSRIP	Delivery System Reform Incentive Program
DY	Demonstration Year
ECHO	Extension for Community Healthcare Outcomes
ED	Emergency Department
EDU	Emergency Department Utilization
HER	Electronic Health Record
EMR	Electronic Medical Record
EMS	Emergency Medical System
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review Organization
%FPL	Federal Poverty Line
FE	Frail Elderly (Waiver)
FQHC	Federally Qualified Health Centers
FUH	Follow-up After Hospitalization (for Mental Illness)
GAR	Grievance and Appeal Report
GC	General Child - CAHPS Survey Population
HbA1c	Hemoglobin A1c (Glycated hemoglobin)
HCAIP	Health Care Access Improvement Program Pool
HCBS	Home and Community-Based Services
HCCN	Health Center Controlled Network
HEDIS	Healthcare Effectiveness Data and Information Set
HF	Heart failure
HIE	Health Information Exchange
HIPAA	Health Information Portability and Accountability Act
HIT	Health information technology
HITECH	Health Information Technology for Economic and Clinical Health Act
H&S	Health and Service Evaluation
I/DD	Intellectual/Developmental Disability (Waiver)
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
KCIC	Kansas Clinical Improvement Collaborative
KCPC	Kansas Client Placement Criteria (tracking system)
KDADS	Kansas Department for Aging and Disability Services
KDHE	Kansas Department of Health and Environment
KDHE-DHCF	Kansas Department of Health and Environment, Division of Healthcare Finance
KFMC	Kansas Foundation for Medical Care, Inc. (the EQRO)
KHC	Kansas Healthcare Collaborative

List of Related Acronyms	
Acronym	**Description**
KHSC	Kansas Heart and Stroke Collaborative
KMAP	Kansas Medical Assistance Program
KUCTT	University of Kansas Center for Telemedicine & Telehealth
LPTH/BCCH	Large Public Teaching Hospital/Border City Children's Hospital Pool
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MDS	Minimum Data Set
MH	Mental Health
MMA	Medication Management for People with Asthma
MPM	Annual Monitoring for Patients on Persistent Medications
MHSIP	Mental Health Statistics Improvement Program
MU	Meaningful Use
NCQA	National Committee for Quality Assurance
NF	Nursing Facility
NOMS	National Outcome Measurement System
OB/GYN	Obstetrician/Gynecologist
OT	Occupational Therapy
P4P	Pay for Performance
PCMH	Patient Centered Medical Homes
PCP	Primary Care Provider/Physician
PD	Physically Disabled (Waiver)
PEAK	Promoting Excellent Alternatives in Kansas (Person-Centered Care Homes)
PH	Physical Health
PIP	Performance Improvement Projects
PM	Performance Measure
PMPM	Per member per month
PPC	Prenatal and Postpartum Care
PT	Physical Therapy
PTN	Patient Transformation Network
Q	Quarter
QAM	Quality Assurance Mentor
QC	Quality Compass
REDCap	Research Electronic Data Capture
RFP	Request for Proposal
RHC	Rural Health Clinics
SED	Serious Emotional Disturbance (Waiver)
SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia

List of Related Acronyms	
Acronym	**Description**
SMI	Serious Mental Illness
SPARCC	Supporting Personal Accountability and Resiliency for Chronic Conditions
SPMI	Severe and Persistent Mental Illness
SHP	Sunflower Health Plan of Kansas
SSC	Surviving Sepsis Campaign
SSI	Supplemental Security Income
STC	Special Terms and Conditions
STOP Sepsis	Standard Techniques, Operations, and Procedures Sepsis Awareness Program
SUD	Substance Use Disorder
TA	Technical Assistance (Waiver)
TBI	Traumatic Brain Injury (Waiver)
TCM	Targeted Case Management/Manager
TXIX	Title XIX/Medicaid
TXXI	Title XXI/CHIP, Children's Health Insurance Program
UCC	Uncompensated Care Cost Pool
UHC	UnitedHealthcare Community Plan of Kansas (UnitedHealthcare)
UKHS	The University of Kansas Hospital System
URI	Upper Respiratory Infection
VBP	Value-based Purchasing
VR	Vital Research
W15	Well-Child Visits in the First 15 Months of Life
W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
WWC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
WORK	Work Opportunities Reward Kansas program