Annual Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Year Ending 12.31.14

State of Kansas

Kansas Department of Health and Environment

Division of Health Care Finance

KanCare
Section 1115 Annual Report
Demonstration Year: 2 (1/1/2014-12/31/2014)

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I. Introduction

Pursuant to the KanCare Special Terms and Conditions issued by the Centers for Medicare and Medicaid Services, Number 11-W-00283/7, the State of Kansas, Department of Health and Environment, Division of Health Care Finance, submits this annual report related to Demonstration Year 2014. KanCare is a managed care Medicaid program which serves the State of Kansas through a coordinated approach. The State determined that contracting with multiple managed care organizations will result in the 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 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 August 6, 2012, the State of Kansas submitted a Medicaid Section 1115 demonstration proposal, entitled KanCare. That request was approved by the Centers for Medicare & Medicaid Services on December 27, 2012, effective from January 1, 2013, through December 31, 2017.

KanCare is operating concurrently with the state's section 1915(c) Home and Community-Based Services (HCBS) waivers, which together provide the authority necessary for the state to require enrollment of almost all Medicaid beneficiaries (including the aged, disabled, and some dual eligibles) across the state 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 provided services to children, pregnant women, and parents in the state's Medicaid program, as well as carved out managed care entities that separately covered mental health and substance use disorder services. 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 are 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.

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, 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 as well.

II. STC 78(a) – Summary of Quarterly Report Items

Items from the quarterly reports which are not included in others areas of this annual report, have not already been provided in cumulative annual form, and/or are subject to annualizing are summarized here:

A. Operational Developments/Issues

i. Systems and reporting issues, approval and contracting with new plans: No new plans have been contracted with for the KanCare program. Through a variety of accessible forums and input avenues, the State is kept advised of any systems or reporting issues on an ongoing basis and worked either internally, with our MMIS Fiscal Agent, with the operating state agency and/or with the MCOs and other contractors to address and resolve the issues. Examples of this include ongoing external work groups with consumer focus and provider focus; technical work groups with key provider associations to resolve outstanding issues; and claims projects to assess and correct systemic issues. Focused reviews of the MCOs as well as comprehensive annual reviews are discussed elsewhere in this report. Kansas conducted additional intensive provider experience improvement activities in early DY2014. Each quarter, the State reports then-current consumer issues, their resolution, and actions taken to prevent further occurrences. Summaries of those issues are included in the state's quarterly STC reports submitted to CMS and posted at www.kancare.ks.gov.

ii. Benefits: All pre-KanCare benefits continue, and the program includes value-added benefits from each of the three KanCare MCOs at no cost to the State. A summary of value added services used, per KanCare MCO and total, by members using the service, by total units and by total value for January-December, 2014:

KanCare Value-Added Services Totals:

Members YTD	244,689	Total Units YTD	280,266	Total Value YTD	$3,933,784

Each KanCare MCO:

Amerigroup	Total Members	Total Units	Total Value
Adult Dental Care	1,810	3,662	$421,759
Member Incentive Program	7,216	12,865	$279,055
Mail Order OTC	8,758	8,990	$148,449
Healthy Families Program	92	92	$75,000
Pest Control	265	266	$35,195
Smoking Cessation Program	154	275	$29,670
Hypoallergenic Bedding	119	118	$11,594
Weight Watcher Vouchers	152	194	$7,155
Additional Respite Care for Autism Waiver Population	33	698	$2,094
Member Transportation to Community Locations	1	1	$287
Entertainment Book Coupons	25	26	$14
2014 GRAND TOTALS	**22,704**	**31,269**	**$1,010,273**

Sunflower	Total Members	Total Units	Total Value
CentAccount debit card	48,711	49,468	$989,360
Dental visits for adults	6,695	19,324	$406,952
Smoking cessation program	579	579	$138,960
Start Smart	3,899	3,899	$109,757
Disease and Healthy Living Coaching	34,917	34,900	$91,091
Lodging for specialty and inpatient care	102	619	$50,139
SafeLink®/Connenctions Plus cell phones	345	345	$16,501
In-home caregiver support/ additional respite	43	3,984	$12,946
Community Programs for Healthy Children	443	443	$6,645
Meals for specialty and inpatient care	30	132	$3,300
Hospital companion	8	963	$3,130
2014 GRAND TOTALS	**89,529**	**114,656**	**$1,828,782**

United	Total Members	Total Units	Total Value
Additional Vision Services	8,747	10,662	$517,351
Adult Dental Services	1,916	2,039	$109,345
Join for Me - Pediatric Obesity Classes	158	35	$87,500
Annual Wellness Reminders	104,616	111,643	$70,335
Baby Blocks Program and Rewards	1,137	990	$58,806
Peer Bridgers Program	225	221	$52,920
Weight Watchers - Free Classes	599	347	$41,293
Membership to Youth Organizations	703	729	$36,450
Sesame Street - Food For Thought	1,002	988	$34,580
KAN Be Healthy Screening Age 3 to 19 - Debit Card Reward	1,186	1,557	$15,570
Infant Care Book for Pregnant Women	1,100	1,191	$15,483
Mental Health First Aid Program	136	147	$14,393
KAN Be Healthy Screening Age Birth to 30 months - Debit Card Reward	634	1,064	$10,640
Additional Podiatry Visits	85	58	$5,562
Asthma Bedding	88	95	$4,940
New Member Dental Exam - Debit Card Reward	383	460	$4,600
New Member Vision Exam - Debit Card Reward	296	376	$3,760
Coverage for Sports/School Physicals	434	51	$3,305
Adult Biometric Screening - Debit Card Reward	206	154	$2,310
Weight Watchers Reward - Reward for Completing Classes	105	35	$1,750
Join for Me - Reward for Completion of Program	35	35	$1,750
A is for Asthma	1,271	1,374	$687
Annual Vision Exam for Person with Diabetes - Debit Card Reward	95	29	$580
Follow-Up After Behavioral Health Hospitalization - Debit Card Reward	9	14	$350
Annual A1C Exam - Debit Card Reward	102	30	$300
Annual Monitoring for Persistent Medications - Debit Card Reward	53	17	$170
2014 GRAND TOTALS	**132,456**	**134,341**	**$1,094,729**

iii. Enrollment issues: For the calendar year 2014 there were 44 Native Americans who chose to not enroll in KanCare.

The table below represents the enrollment reason categories for calendar year 2014. All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories	2014 Totals
Newborn Assignment	25
KDHE - Administrative Change	316
WEB - Change Assignment	79
KanCare Default - Case Continuity	703
KanCare Default - Morbidity	1,475
KanCare Default - 90 Day Retro-reattach	589
KanCare Default - Previous Assignment	1,219
KanCare Default - Continuity of Plan	13,619
AOE – Choice	660
Choice - Enrollment in KanCare MCO via Medicaid Application	2,537
Change - Enrollment Form	1,439
Change - Choice	2,654
Change - Access to Care – Good Cause Reason	59
Change - Case Continuity – Good Cause Reason	0
Assignment Adjustment Due to Eligibility	32
Total	**25,406**

iv. Grievances and appeals:

The following grievance, appeal and state fair hearing data reports activity for all of 2014:

MCOs' Grievance Database
Members – CY14 Annual Report

MCO	Access of ofc	Avail-ability	QOC	Attitude/ Service of Staff	Bene-fits	Billing/ Fin Issues	Transp-Timely	Transp-Access	Pharm	DME	Med Proc/ Trtmt	Waiver HCBS Service	Mail/ Other
AMG	27	109	98	119	194	147	23	41	36	13	5	23	26
SUN	24	114	28	113	24	150	123	61	26	10	11	2	32
UHC	8	1	95	113	3	499	234	58	37	11	2	1	0

MCOs' Appeals Database
Members – CY14 Annual Report

MCO	PA Dental	PA DME	PA MRI, CT	PA Phar-macy	PA OP/IP Surg/ Proc	PA Comm Based Svcs	LTSS/ HCBS PCA/ LTC/ RTC/ TCM/ MH Hrs	HH/ Hospice Hrs	OT/ PT/ ST	Inpt Covg	Ster/ Epid Inj/ Sleep	PCP/ Spec-ialist	Bal Bill	Claim Denial	Lock-In
AMG	15	20	59	17	17	33	71	4	9	9	11	10	0	7	0
SUN	10	57	50	115	40	61	75	28	48	67	9	0	0	8	1
UHC	11	21	33	43	10	104	90	5	12	1	3	6	2	1	0

Members – CY14 Annual Report (continued)

MCO	PA WORK Hrs	PA Gen Tests	LTACH/ Air Ambul
AMG	15	0	13
SUN	38	3	14
UHC	85	0	6

Providers – CY14 Annual Report (appeals resolved)

MCO	MCO Auth	MCO Prov. Rela-tions	MCO Claim/ Billing	MCO Clin/ UM	MCO Phar	MCO Plan Admin/ Other	MCO QOC	MCO Cred/ Cont	Vision Auth	Vision Claim/ Billing	Dent Auth	Dent Claim/ Billing	Dent Plan Admin	Dent Clin/ UM	Cen-patico STRS Auth
AMG	55	5	25,369*	283	0	0	0	0	15	21	3	133	0	0	0
SUN	86	0	1,056	114	48	22	23	1	33	151	41	12	19	109	19
UHC	0	0	4,316	0	0	0	1	0	2	55	0	64	0	0	0

State of Kansas Office of Administrative Fair Hearings
Members - CY14 Annual Report

AMG-Red SUN-Green UHC-Purple	PA Dental Denied/ Not Covered	PA CT/ MRI/ X-ray Denied	PA Pharm Denied	PA DME Denied	PA Home Health Hours Denied	PA Comm Psych Support/ BH Svcs/ Assist Svc Funds Denied	PA PT/OT Inpt Rehab Denied	LTSS/ HCBS/ WORK PCA Hrs/ Wtg List Denied	PA Med Proc Denied	Waiver Elig Denied	Lock-In
Withdrawn	2		1		1		3	1 3 16			
Dismissed-Moot MCO reversed denial	1	1 3	5 3	1 3	2	3 1	3 1	1 4 12	4 2	1	
Dismissed-No Adverse Action			1								
Default Dismissal Plaintiff no-show	2	2		2	1	1	2	1 6 1	1		1
Dismissed-Untimely				2	1		2	3 1			
FH in process								3 4			
OAH upheld State/MCO decision	1	1	1 1 1	1	1	5	2	4 2	2	1 1	1
OAH reversed MCO decision			1 1					1			
FH dec pending	1	1	1	1				1 20	1 1		

State of Kansas Office of Administrative Fair Hearings
Providers - CY14 Annual Report

AMG-Red SUN-Green UHC-Purple	Claim Denied	Dental Denied	DME Denied	Radiology Denied	Pharm Denied	Waiver Elig Denied/ Pt Liab	Home Health/ Hospice Denied	PT/ST Denied	Inpt/ Rehab Covrg Denied	Med Proc Denied	LTSS PCA Hrs	Recoup-ment
Withdrawn	26 2 2			1			6 3	1	4 2	1	1	
Dismissed-Moot MCO reversed denial	241 2 4	1 2	9 2 5	2	3 10 4	4	21 5 6	1 1	7 10	3 5 6		
Dismissed-No internal appeal	19 6	5 11	1 1 1	1 4	3 3		3		4	5		
FH in process	2				1	2	3		3		1	
Dismissed-Untimely	2		1		1		11 6		1	3		
OAH upheld MCO decision	8									1		4
FH dec pending	29			3	1	2	1	2	4			

*Amerigroup treats and counts every provider initiated claim action request from all sources (verbal, written, email, web-submission, submitted by provider representative or other individual in any form) as an appeal for reporting purposes. Even though there may be commonality of cause across a number of provider contacts, the action itself is counted as a singular event regardless of the number of claims impacted or reported (claim appeals are not aggregated for common cause). Amerigroup's appeal workflow system accounts for each appeal intake as a distinct action.

B. Customer service reporting:

KanCare Customer Service Report - Member

MCO/Fiscal Agent January-December 2014	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:12	0.6%	163,183
Sunflower	0:20	2.2%	197,406
United	0:15	0.5%	166,849
HP – Fiscal Agent	0.00	0.1%	27,377

KanCare Customer Service Report - Provider

MCO/Fiscal Agent January-December 2014	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:16	0.6%	83,123
Sunflower	0:18	1.3%	114,188
United	5.67	0.4%	72,649
HP – Fiscal Agent	0.00	0.02%	8,514

C. Summary of critical incident reporting:

Critical Incidents	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
	AIR Totals	**AIR Totals**	**AIR Totals**	**AIR Totals**	**TOTALS**
Total # Received	389	333	315	285	**1322**
Total # Reviewed	208	174	167	118	**667**
Total # Pending Resolution	127	131	133	143	**534**
APS Substantiations*	95	94	93	74	**356**

** Note: the APS Substantiations exclude possible name matches when no date of birth is identified. One adult may be a victim/alleged victim of multiple types of allegations. The information provided is for adults on HCBS programs who were involved in reports assigned for investigation and had substantiations during the quarter noted. An investigation may include more than one allegation.*

D. Safety Net Care Pool: The Safety Net Care Pool (SNCP) is divided into two pools: the Health Care Access Improvement Program (HCAIP) Pool and the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool. The attached Safety Net Care Pool Reports identify pool payments to participating hospitals, including funding sources, applicable to DY2.

   Disproportionate Share Hospital payments continue, as does support for graduate medical education.

III. STC 78(b) – Total Annual Expenditures

Total annual expenditures for the demonstration population for Demonstration Year 2 (2014), with administrative costs reported separately, are set out in the attached document entitled "KanCare Budget Neutrality – Demonstration Year 2."

IV. STC 78(c) – Yearly Enrollment Reports

Yearly enrollment reports for demonstration enrollees for Demonstration Year 2 (2014), including all individuals enrolled in the demonstration, that include the member months, as required to evaluate compliance with the budget neutrality agreement, and the total number of unique enrollees within Demonstration year 2, are set out in the attached document entitled "KanCare Budget Neutrality – Demonstration Year 2."

V. STC 78(d) – Quality Strategy

Kansas has created a broad-based structure to ensure comprehensive, collaborative and integrated oversight and monitoring of the KanCare Medicaid managed care program. KDHE and KDADS have established iACT (the Interagency Collaboration Team) for comprehensive oversight and monitoring. In October, this group replaced the KanCare Interagency Monitoring Team (IMT) as the oversight management team, and iACT performs similar functions to that of IMT. iACT is a review and feedback body that will meet in frequent work sessions, focusing on the monitoring and implementation of the State's KanCare Quality Improvement Strategy (QIS), consistent with the managed care contract and approved terms and conditions of the KanCare 1115(a) Medicaid demonstration waiver. iACT includes representatives from KDHE and KDADS, and operates under the policy direction of the KanCare Steering Committee which includes leadership from both KDHE and KDADS.

These sources of information guide the ongoing review of and updates to the KanCare QIS: Results of KanCare managed care organization (MCO) and state reporting, quality monitoring/onsite reviews and other KanCare contract monitoring results; external quality review findings and reports; feedback from governmental agencies, the KanCare MCOs, Medicaid providers, Medicaid members/consumers, and public health advocates; and iACT's review of and feedback regarding the overall KanCare quality plan. This combined information assists iACT and the MCOs to identify and recommend quality initiatives and metrics of importance to the Kansas Medicaid population.

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, they will be regularly reviewed and operational details will be continually evaluated, adjusted and put into use.

The State values a collaborative approach that will allow all KanCare MCOs, providers, policy makers and monitors to maximize the strength of the KanCare program and services. Kansas recognizes that some of the performance measures for this program represent performance that is above the norm in existing programs, or first-of-their-kind measures designed to drive to stronger ultimate outcomes for members, and will require additional effort by the KanCare MCOs and network providers. Therefore, Kansas

continues to work collaboratively with the MCOs and provide ongoing policy guidance and program direction in a good faith effort to ensure that all of the measures are clearly understood; that all measures are consistently and clearly defined for operationalizing; that the necessary data to evaluate the measures are identified and accessible; and that every concern or consideration from the MCOs is heard. When that process is complete (and as it recurs over time), as determined by the State, final details are communicated and binding upon each MCO.

To support the quality strategy, KDHE staff conduct 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 are occurring consistent with Section 1115(a) standard terms and conditions, the KanCare quality management strategy and KanCare contact requirements. Included in this work have been reviews, revisions and updates to the QIS, including operational specifications of the performance measures (and pay for performance measures); reporting specifications and templates; LTSS oversight and plan of care review/approval protocols; and KanCare Key Management Activity reporting and follow up. All products are distributed to relevant cross-agency program and financial management staff, and are incorporated into updated QIS and other documents.

Kansas has provided quarterly updates to CMS about the activities related to quality monitoring, performance measure development, and about specific activities related to MLTSS services, quality measures, and related HCBS waiver amendment application development and submission.

Consistent with the STCs, the State received approval for revisions to the concurrently operating 1915(c) waivers (KS-0476, KS-0304, KS-4165, KS-4164, KS-0320 and KS-0224) to incorporate performance measures that are reflective of services delivered in a managed care delivery system, taking into account a holistic approach to care. The State sought technical assistance from CMS and a CMS vendor in the development of the new performance measures. The State revised the KanCare Comprehensive Quality Strategy to incorporate the new performance measures, and submitted the updated strategy document to CMS for review and approval in September, 2014.

VI. STC 78(e) – MFP Benchmarks

Kansas's Money Follows the Person (MFP), five year demonstration grant, serves four HCBS populations: the Frail Elderly (FE), the Physically Disabled (PD), the Traumatic Brain Injured (TBI), and the Intellectually/Developmentally Disabled (I/DD). During the first quarter of calendar year 2014, 33 individuals were transferred from institutions to their home and community, and during the second and third quarters, 48 and 67 individuals, respectively, transitioned. During the fourth quarter of calendar year 2014, 56 individuals were able to return to their homes and communities with assistance of the MFP Program and MCOs.

Summary of 2014 performance on annual transition benchmarks in the Kansas Money Follows the Person grant follows:

Calendar Year 2014	FE	DD/ICF	PD	TBI
Total Number of annual transition benchmarks achieved	53	18	137	6
Total Number of annual transition benchmarks (revised)	53	19	132	6
Percent Achieved	100.00%	94.74%	103.79%	100.00%

Calendar Year 2014	FE	DD/ICF	PD	TBI
Total Number of current MFP participants who are reinstitutionalized	9	1	16	0
Total Number of current MFP participants	48	19	127	7
Reinstitutionalized Percent	18.75%	5.26%	12.60%	0.00%
Post Transition Success Target	80.00%	80.00%	80.00%	80.00%
Percentage of MFP participants maintaining the same level of service after moving to HCBS (post transition success) **Percent Achieved**	81.25%	94.74%	87.40%	100.00%

VII. STC 78(f) – HCBS Waiver Waiting Lists

Pursuant to STC 47, the state must report on the status of individuals receiving HCBS Services, including progress regarding waiting lists.

Additional Funding to Address Waiting Lists

In the third quarter of 2013, Kansas added nearly $18.5 million for fiscal year 2014 to address the PD and IDD waiting lists. $8.2 million in all funds were added in fiscal year 2013. As a result, 250 individuals with IDD were added to the IDD waiver by the first quarter of 2014. Additional funds were allocated in early 2014, which resulted in the ability to increase the number of individuals on the HCBS-IDD program in the last two quarters of 2014. Additionally, Kansas eliminated the IDD "underserved" list by the end of July 2014. Additional funds are anticipated to be added to address the waiting lists for fiscal year 2015.

PD Waiting List Management

In 2014 KDADS conducted a comprehensive review of the PD Program's Waiting List. Multiple attempts were made to reach individuals on the HCBS-PD waiting list including offer letters, phone calls, and Notices of Action. Starting in July of 2014, KDADS began offering individuals on the waiting list services. A total of 729 individuals from the waiting list accepted services in 2014. There are currently 5,318 on

the HCBS PD Program as of December 31, 2014. The State continues to offer services to individuals on the PD waiting list until the State reaches the approved point in time number designated in the PD waiver.

Current Status of PD Waiver:

- 2,523 individuals on the HCBS PD Waiting List as of December 31, 2014
  - 2,567 individuals on the HCBS PD Waiting List were offered services in 2014
  - 729 individuals have accepted services in 2014

I/DD Unserved Waiting List Management

In the first two quarters of 2014, 104 individuals, waiting for HCBS-IDD services, were offered services. In the third quarter, the State offered services to an additional 107 individuals. In the fourth quarter an additional 60 individuals were offered services.

The current point-in-time limit for HCBS-IDD is 8,700. KDADS submitted a renewal for the IDD waiver, which includes a proposed increase in the point-in-time limit to 8,900. Based upon appropriations, KDADS will continue to offer services until waiver membership has reached 8,900 participants, once the increased point-in-time number for the HCBS-IDD Program is approved by CMS. CMS approval is expected to be effective April 1, 2015.

Additional reporting elements to address progress of individuals receiving HCBS services include:

A. Total number of people in nursing facilities, and public ICF/IDs

Program	CY 2012	CY 2013	CY 2014
Nursing Facilities	14,913	14,517	14,565
Public ICF/IDDs	350	344	337

B. Total Number of people on each of the 1915(c) waiting lists

- Intellectual/Developmental Disabilities waiver program: 3,073 as of January 12, 2015
- Physical Disabilities waiver program: 2,523 as of January 12, 2015

C. Number of people that have moved off the waiting list and the reason

- Intellectual/Developmental Disabilities waiver program: as of January 12, 2015

Reason moved off waiting list	Number of people
Placed on Services (Includes HCBS, MFP, and PACE)	243
Other	62

- Physical Disabilities waiver program: as of January 12, 2015

Reason moved off waiting list	Number of people
Placed on Services (Includes HCBS, MFP, and PACE)	461
Deceased	198
Other	792

D. Number of people that are new to the waiting list: 580 for I/DD waiver; 1,267 for PD waiver

E. Number of people on the waiting list, but receiving community-based services through the managed care delivery system: The IDD request for additional services list (RASL) is commonly referred to as the "underserved" list. Previously maintained by the CDDOs, Kansas began managing it in 2014 and worked with the MCOs to assess the 1740 individuals who were on the RASL as of December 2013. For those who had not responded to the letter verifying their need for additional services, Kansas conducted outreach activities and engaged the CDDOs in the efforts. The individuals on the RASL were assessed by the end of July 2014 and either granted additional services or denied and given appeals rights. KDADS reviewed the limited disputes related to the scope, duration and type of additional services as they arose.

VIII. STC 78(g) – Institutional Days and NF, ICF/IDD Admissions

Include those admitted from MCOs HCBS delivery system into each institutional setting and those who are not KanCare HCBS recipients admitted from the community into each institutional type specified in STC 47. (See also information at Section VII[A] above, regarding numbers served over years.)

One Quarter Lag 10/01/2013-09/30/2014	Nursing Facilities	Private ICF/IDDs
Days	4,846,900	91,965
Admissions	6,295	28

IX. STC 78(h) – Ombudsman Program

A summary of the KanCare Ombudsman program activities for demonstration year 2014 is attached.

X. STC 78(i) – I/DD Pilot Project

The I/DD Pilot Project concluded effective February 1, 2014, when HCBS I/DD waiver services become a part of the KanCare program.

XI. STC 78(j) – Managed Care Delivery System

A. Project Status, Accomplishments and Administrative Challenges: The initial focus of KanCare implementation was to ensure a successful transition for all populations, with a particular emphasis on populations new to managed care, including the introduction of elderly and people

with disabilities to managed care, and the addition of people with developmental disabilities as of February 1, 2014. The Health Homes program for people with serious mental illness was also successfully launched July 1, 2014. Kansas continues to diligently work toward adding certain chronic medical conditions to the Health Homes program.

Steps taken in 2014 included the following (about which significant detail has been provided in the quarterly STC reports to CMS):

- Regular reporting of key operational data
- Claims system monitoring
- Separate and joint critical issues logs
- Regular meetings involving KDHE, KDADS and all three MCOs
- Educational and listening tours
- KanCare Advisory Council and external workgroup meetings
- Provider experience survey

Despite some stakeholder concerns initially that the transition to KanCare might have a negative effect on enrollment, total Medicaid and CHIP KanCare membership increased nearly 4% during the first year, and enrollment continued to increase during year two.

Among remaining challenges from 2013, ensuring that providers are paid promptly and correctly continued to be marked for improvement. As previously reported, the State supported legislation, in collaboration with the Kansas Hospital Association, Kansas Medical Society and other provider groups, that calls for applying interest penalties on late payments from MCOs to providers. The State also launched a provider experience survey in late 2013 continuing into 2014, and then conducted against in late 2014, to assist the state in the development of focused interventions to resolve outstanding issues. In the interest of transparency, global system issues logs (the KanCare Claims Resolution Log) are available for public viewing on the KMAP (Kansas Medical Assistance Program) website. In addition, each MCO has their own issue log posted on their website for plan-specific system issues.

B. Utilization Data: Utilization data related to all three KanCare MCOs, separately addressing physical health services, behavioral health, nursing facility, and HCBS services, are collected, with data reported by demonstration quarter, and a lag time for claims data to be substantially complete and for data analysis to be conducted. These reports are one component of the state’s utilization analysis.

Attached is the KanCare Utilization Report for demonstration year 1 (calendar year 2013). A comparison between pre-KanCare measurements and DY 1 data demonstrates a positive trend in the reduced utilization and expense of facility services during the first year of KanCare. Both the inpatient and nursing facility encounters reduced in usage from pre-KanCare CY 2012 to CY

2013. Similarly, there was also a reduction for outpatient facility emergency room and non-emergency room services. Inpatient expenditure alone reduced 18%, with a utilization reduction of 22%. Nevertheless, inpatient care remains the most expensive finance category for the program.

There is a significant increase in the usage of primary care physicians (PCPs) and FQHC/RHCs, increasing in utilization 28% and 19% respectively. The reduction of inpatient and facility care coupled with the increase in primary physician care shows a trend away from expensive facility care towards outpatient physician care. This should also be an indication of a trend away from reactive acute and emergency care towards preventative whole-person care.

C. CAHPS Survey: In 2014, all KanCare MCOs conducted adult and child with chronic conditions (CCC) Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0H surveys. The survey timeframe is generally from mid-February through the end of May each year. All three MCOs are fully NCQA accredited, and the CAHPS survey is a required part of that accreditation. NCQA approves any supplemental CAHPS questions posed by each MCO. In the initial CAHPS survey, two of the MCOs did not to pull separate child Medicaid and CHIP samples per specifications outlined by CMS. Both have taken corrective action to ensure those standards are fully complied with in the next survey round.

The results of the surveys show some universal trends. All three plans received quality compass (QC) low scores on provider communication with members and access to specialists. However, most of the QC percentiles were mid-range for all three plans.

Amerigroup – Amerigroup's survey overall had quite positive responses for access, timeliness and quality of care. The composite and overall ratings results for the adult survey were quite favorable when compared to national 2013 QC percentiles. Amerigroup reached or exceeded the QC 90th percentile for two of the four composites: "Getting Care Quickly" (86.6% composite score) and "Getting Needed Care" (88.7% composite score). One composite ("How Well Doctors Communicate") and one overall rating ("Personal Doctor") were between the QC 90th and 75th percentile. One composite ("Customer Service") and two overall ratings ("Health Care" and "Specialist") were below the 75th percentile.

For the General Child population, Amerigroup reached or exceeded the QC 90th percentile for one composite: "Customer Service" (92% composite score) and one overall rating "Health Care" (89.7%). Three composite scores ("How Well Doctors Communicate", "Getting Care Quickly" and "Getting Needed Care") and three overall ratings ("Personal Doctor", "Specialist" and "Health Plan") were between the QC 90th and 75th percentile. No results were below the 75th percentile.

Finally, for the CCC population, there were two overall rating scores at or above the QC 90th percentile, "Health Care" (87.2% composite score) and "Access to Prescription Medicines" (95.3%). Four composite scores ("Getting Care Quickly", "Access to Specialized Services", "FCC: Personal Doctor Who Knows Child" and "FCC: Getting Needed Information") was between the QC 90th and 75th percentile. Three composite scores ("How Well Doctors Communicate", "Getting Needed Care" and "Coordination of Care for Children with Chronic Conditions") and two overall ratings ("Personal Doctor" and "Specialist") were below the 75th percentile.

Two areas were recommended for improvement. First, it was suggested that Amerigroup consider a healthcare provider intervention to improve Medicaid and CHIP member experience. Amerigroup's response is to facilitate member communication by including member tips on self-advocacy. Next, Amerigroup plans to integrate better listening skills into their 2015 provider training. And third, they will ask their member-driven Health Education Advisory Committee for ideas on promoting more effective communication between members and providers.

Secondly, Amerigroup should analyze the low scores for customer service assistance to the CCC population. This idea has been circulated internally within Amerigroup for employee training and improvement ideas.

Sunflower – Positive trends include high QC marks for getting care and appointments, customer service, doctor communication for the general population and specialized service access for the CCC population. Many of the questions related to access, timeliness and/or quality of care had high percentages of positive ratings, however those ratings did not always correspond to high QC rankings. Like the other three plans, Sunflower received low marks for effective communication and answering member questions. Sunflower had universally low marks for access to specialists. Finally, care coordination with specialists and schools/daycares was also marked low for the CCC population.

For the adult survey, Sunflower reached or exceeded the QC 90th percentile for three of the four composites: "Getting Care Quickly" (87.0% composite score), "Customer Service" (90.1% composite score) and "Getting Needed Care" (86.2% composite score). One overall rating ("Health Care") was between the QC 90th and 75th percentile. One overall rating of "Personal Doctor" was between the QC 75Th and 50th percentile. One composite ("How Well Doctors Communicate") and two overall ratings ("Health Plan" and "Specialist") were below the 50th percentile.

For the General Child population, Sunflower had three composite scores ("Customer Service", "Getting Care Quickly" and "Getting Needed Care") and two overall ratings ("Health Care" and "Health Plan") were between the QC 90th and 75th percentile. The composite measure "How

Well Doctors Communicate" and the overall ratings for "Personal Doctor and "Specialist" were between the 75th and 50th percentile.

Finally, for the CCC population, there was one composite rating score at or above the QC 90th percentile, "Access to Specialized Services" (82.1% composite score). "Access to Prescription Medicines" and "Health Care" were between the QC 90th and 75th percentile. Four composite scores ("Customer Service", "Getting Needed Care", "Coordination of Care for Children with Chronic Conditions" and "Getting Care Quickly") and three overall ratings ("Personal Doctor", "Health Plan" and "Specialist") were between the 75th and 50th percentile. "FCC: Personal Doctor Who Knows Child" and "How Well Doctors Communicate" only scored at or above the 25th percentile, while "FCC: Getting Needed Information" only ranked at the 10th percentile.

Several recommendations for improvement included: increase monitoring and assist the communication efforts between physicians and members, initiate a program with better care coordination for the CCC population, and improve access to specialists for all the Sunflower members.

UnitedHealthcare – Like Amerigroup and Sunflower, UnitedHealthcare also had issues with provider communication and access to specialists. Uniquely, UHC child members had difficulty obtaining assignment with PCPs. Customer service questions for the CCC population also indicate low satisfaction with the service provided. Positive trends included questions receiving high marks for access, timeliness and quality of care, however these marks did not always correspond to high QC marks.

For the adult survey, UHC was between the QC 90th and 75th percentile for two of the four composites: "Getting Needed Care" (83.5% composite score) and "How Well Doctors Communicate" (90.8% composite score). One overall rating ("Health Care") was also between the 90th and 75th percentile. The overall rating of "Specialist" and the composite of "Getting Care Quickly" were between the QC 75Th and 50th percentile. Two overall ratings ("Health Plan" and "Personal Doctor") were between the 50th and 25th percentile. The remaining composite score "Customer Service" scored less than the QC 10th percentile.

For the General Child population, UHC had three composite scores ("Customer Service", "How Well Doctors Communicate" and "Getting Needed Care") and one overall rating ("Health Care") were between the QC 90th and 75th percentile. The composite measure "Getting Care Quickly" and the overall ratings for "Health Plan", "Personal Doctor and "Specialist" were between the 75th and 50th percentile.

Finally, for the CCC population, there was one composite score above the 90th percentile ("Access to Specialized Services"). There were three composite rating score between the QC 90th and 75th percentile ("Customer Service", "Access to Prescription Medicines", and "FCC: Getting Needed Information"). Four composite scores ("Getting Needed Care", "How Well Doctors Communicate", "FCC: Personal Doctor Who Knows Child", and "Getting Care Quickly") and three overall ratings ("Personal Doctor", "Health Plan" and "Specialist") were between the 75th and 50th percentile. "Health Plan" and "Coordination of Care for Children with Chronic Conditions" only scored at or above the 25th percentile.

Several recommendations for improvement included: investigating provider and health care delivery issues that may be negatively impacting the experiences of children with chronic conditions, improve access to specialists, and improve customer service.

D. Annual Summary of Network Adequacy: The MCOs continue to recruit and add providers to their networks. All MCOs focused upon I/DD providers for the merger of I/DD services into KanCare. The number of contracting providers under each plan is as follows (for this table, providers were de-duplicated by NPI):

KanCare MCO	# of Unique Providers as of 3/31/14	# of Unique Providers as of 6/30/14	# of Unique Providers as of 9/30/14	# of Unique Providers as of 12/31/14
Amerigroup	15,667	13,455	13,682	13,997
Sunflower	15,931	16,314	17,728	18,056
UHC	19,872	19,911	19,747	19,476

Gaps in coverage are reported each month by the MCOs by way of Geo Access Reports. Where gaps exist, the plans report their strategy for closing those gaps. In addition to continuing to recruit pre-KanCare Medicaid providers and any newly identified providers, the plans are committed to working with providers in adjacent cities and counties to provide services to members. Required levels of network coverage for HCBS services are met with the exception of a few specialties in which there is a shortage of providers available. In these instances, the plans are working with and encouraging contracted providers to extend services to areas without providers.

Regarding MCO compliance with provider 24/7 availability, information as to each of the MCOs' processes, protocols and results on this issue follow:

Amerigroup – Amerigroup's contractual agreements with all its providers mandate that, in accordance with regulatory requirements, provider must ensure that members have access to 24 hour-per-day, 7 day-per-week urgent and emergency services. Amerigroup's provider

manual, incorporated by reference into provider contracts, also requires that PCPs arrange for coverage of services to assigned members 24 hours a day, 7 days a week in person or by an on-call physician.

In order to properly monitor that this access is available from both an appointment availability and after-hours access perspective, Amerigroup conducts an annual survey over a broad spectrum of providers (both primary care and specialists) surveying their availability to members. The survey provides the foundation for adjusting provider servicing activities to more fully achieve the best access available for members. Amerigroup measures compliance of two distinct components in overall member access 1) appointment availability and 2) after-hours access. For appointment availability, Amerigroup's efforts resulted in significant improvement from 69% (2013) to 89% (2014) compliance; averaged across all four surveyed groups (PCPs / Pediatrics / Behavioral Health / Specialists). Specialists continued to lag in compliance, at 75%, and will be an area of renewed focus for the 2015 provider servicing plan. All other provider types exceeded 90% compliance. After-hours compliance remained stable with total compliance at 86% across the two survey groups of PCPs and Pediatric providers. In 2015, the provider servicing plan includes requirements for the Network Relations Specialists to conduct on-site visits to educate and validate non-compliant practices. We will first conduct on-site visits with compliant practices and capture their "best practices" to share with non-compliant practices and other tips/ techniques/procedures that may assist. There will be particular emphasis on addressing specialist compliance for appointment availability, including increased contracting activity in areas where network sufficiency is contributing to appointment availability scarcity. Note also that, in accordance with federal regulations, Amerigroup does not require authorization for emergency services. Providers rendering emergency services are not required to be enrolled in the Amerigroup network to receive payment.

Sunflower – Sunflower's contractual agreements with all its providers mandate that, in accordance with regulatory requirements, provider must ensure that members have access to 24 hour-per-day, 7 day-per-week urgent and emergency services. Sunflower's Provider Manual states that PCPs and specialty physicians are required to maintain sufficient access to needed health care services on an ongoing basis and shall ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows. The selected method of 24-hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. Whenever possible, PCP, specialty physician, or covering medical professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number. Sunflower will monitor providers' offices through scheduled and unscheduled visits and audits conducted by Sunflower Provider Relations staff.

Additionally, Sunflower has contracted with NurseWise to provide after-hours services to members and providers. When the Sunflower toll-free number is called after hours, callers have the option of being directed to NurseWise for after hours, weekends and holiday coverage to members and providers. NurseWise reports daily the number of calls received and will escalate any quality of care issues. Sunflower conducts monthly/quarterly Joint Oversight Committee meetings with the vendor to ensure compliance with the contract standards. The oversight meetings are managed by the Sunflower's vendor manager. Members of the Sunflower leadership staff attend the oversight meetings and are responsible for reviewing the reports supplied by the vendor.

Results from Sunflower's monitoring of these issues include the following, as reported by Sunflower:

Accessibility of Primary Care Services

Sunflower State Health Plan (Sunflower) monitors primary care provider appointment accessibility against its standards, identifies opportunities for improvement and initiates actions as needed to improve results. Below are survey results used to verify providers meet contractual access standards. Sunflower also uses CAHPS data for this purposes, those are not included in this report.

Practitioner Office Survey - Conducted late 2013, scheduled to repeat in next 45 days

Sunflower conducted a web-based survey of appointment access, per the standards required by Sunflower's contract with the state of Kansas. Primary care and OB/GYN provider offices were identified by determining those office sites with a large number of members assigned to that practice, and emailed an electronic survey.

Appointment Type	Goal	N	D	No Response	Rate
Primary care: Routine, Non-Symptomatic	90% within 21 calendar days of request	150	246	86	70%
Primary care: Urgent, Symptomatic	90% within 48 hours of request	157	246	88	63.8%
Primary care: Emergent	90% within 24 hours of request	148	246	96	60.16%
OB: First Trimester	90% within 14 calendar days of request	40	52	9	76.9%
OB: Second Trimester	90% within 7 calendar days of request	31	52	11	56.6%

Appointment Type	Goal	N	D	No Response	Rate
OB: Third Trimester	90% within 3 calendar days of request	22	52	12	42.3%
OB: High Risk Pregnancy	90% within 3 calendar days of request	26	52	19	50%
Wait Time in Office	Patients seen in less than 45 min. of	170	246	68	69.1%

The results of the appointment access web survey did not meet Sunflower's goal of at least 90% in each area, with rates by appointment type falling between a high of 79.6% and a low of 42.3%. A significant contributor to the low compliance rates is believed to be the high number of questions in which no response was provided by the office. 2013 was the first year of operations for Sunflower; therefore this was the first time an appointment accessibility survey was conducted. Since Sunflower had not received access complaints, the intent of the web survey was to primarily to assess performance of state requirements, and a web-based survey was chosen as a means to reduce the burden on practitioner offices (versus Sunflower calling the office during business hours to conduct the survey). However, this method led to incomplete data since respondents were able to not respond to questions, even though all questions were applicable for every office (other than the OB questions not being applicable for primary care offices). Sunflower will re-evaluate the survey methodology for future surveys and make questions mandatory that apply for all providers if a web-based tool is used as the survey method.

Offices which did not pass all elements of the survey will be re-educated onsite during an office visit conducted by the practitioner's Provider Relations Representative and will be re-surveyed at a later time. Practitioners who fail the second survey will be required to submit a written corrective action plan.

After-hours Care

Access to after-hours care was assessed per the web-based survey noted above, and through calls placed directly to practitioner offices after business hours by Sunflower staff. Provider offices were then called after regular business hours by Sunflower staff to verify their responses regarding after-hours coverage and the results documented.

2013 - After- hours access monitoring

Year	Goal	N	D	No Response	Rate
2013 (web survey and phone verification)	90% have acceptable after-hours coverage	202	246	0	82.11%
2014 (phone verification)	90% have acceptable after-hours coverage	265	331	NA	80.06%

In 2013, 82.1% of offices responded positively to having a process for after-hours coverage, but not meeting Sunflower's goal of at least 90% of offices meeting the standard for adequate after-hours access. Follow-up calls were also made to verify the presence of adequate after-hours coverage.

In 2014, Sunflower changed its method for evaluating after hours coverage compliance. Instead of allowing providers to self-report their compliance and supplementing with phone verification, Sunflower completed all calls to the provider offices after hours and independently assessed provider performance against after-hours standards. In 2014, that translated into a 80.06% performance rate. This performance does not meet the goal, thus immediate corrective action is necessary for providers surveyed and a reminder of call standards is planned in 2015 as well consideration of additional monitoring.

United – UnitedHealthcare's contractual agreements with all its providers mandate that, in accordance with regulatory requirements, providers must ensure that members have access to 24 hour-per day, 7 day-per-week urgent and emergency services. United's Provider Administrative Guide, which is incorporated by reference into provider contracts, requires that both Primary Care Physicians and Specialists be available to members 24 hours a day, 7 days a week, or have arrangements for live telephone coverage by another UnitedHealthcare provider. To assess appointment access and availability, United employs a vendor to make calls on their behalf using a script in which the caller identifies themselves as representing the health plan, describes symptoms that represent either an urgent need or a routine need, and requests the next available appointment with the specific provider named on the list. The script scenarios include both child and adult symptoms/appointments. A random sample of calls is also done after hours to assess whether on-call service is available and how quickly care can be provided. The results of the 2014 information was recently provided to United and for the providers contacted in 2014, results reflected 70.8% compliance with the 24/7 requirement. Providers who were not in compliance will be contacted and educated regarding the requirements to provide 24/7 coverage.

E. Outcomes of Onsite Reviews – Both the State and the state's EQRO conducted comprehensive onsite reviews of MCO compliance with federal and state program requirements in 2013. Reports regarding the findings of those reviews were finalized in 2014 and presented to each of the MCOs, and related remedial actions have been underway by all MCOs, with varying timelines for full compliance depending upon the issue involved. Follow up reviews related to federal regulatory requirements were conducted by the EQRO in 2014, and another full onsite review will be conducted in 2015.

   Additionally as to targeted review activities in 2014: KDHE annual on-site visits to the managed care organizations were focused on the implementation of a new service, Health Homes for members with serious mental illness (SMI). On-site readiness reviews of the MCOs were conducted in May 2014 to determine capacity and systems preparedness for the July 2014 implementation. A readiness review tool was developed with questions to assess six major focus areas: Enrollment, Provider Networks, Service Delivery Systems, Payment Methodologies, Quality Monitoring and Evaluation, and Six Core Services. The recommendations to all MCOs following the reviews included resolution of rate issues prior to implementation, and continued building of networks for chronic conditions Health Homes. Overall, two of the three MCOs demonstrated system preparedness through written plans, policies and procedures. They also demonstrated network capacity. A highlight of the readiness reviews included piloting the program with a long-standing service provider.

   To remedy deficiencies with the third health plan, KDHE formally outlined all deficits in a letter. KDHE offered the plan an opportunity to further develop their system and implement Health Homes on the previously established timeframe. Based upon review of additional materials submitted by the plan, KDHE extended provisional approval with recommendation for continuation. In October 2014, KDHE notified the MCO of intent to conduct a focused review one month later to ensure that all documentation and planning provided to address areas of concern were fully functional post-implementation. The November 2014 on-site focused review revealed a great deal of advancement and an additional opportunity to refine areas for further improvement.

   A follow up six month onsite review of performance operationalizing for SMI Health Homes with all three MCOs is the planned next step for this focused review activity by the state.

F. Summary of PIPs: Two of the three KanCare MCOs – Amerigroup and United – initiated performance improvement projects (PIP) in July 2013. Sunflower's project planning process extended into late 2013; therefore, interventions were not initiated until January 1, 2014. The three MCOs are also working on finalizing the methodology for a collaborative PIP focused on diabetes prevention to be implemented in January 2015. Each PIP methodology was reviewed and revised to ensure that clear interventions, outcomes, tracking, and measurement methods were identified. Representatives of each MCO report PIP progress at regularly occurring KanCare

interagency meetings. Written quarterly updates have also been provided post-implementation of each PIP. Following is a brief summary of each MCO's PIP and current standing.

United selected follow-up after hospitalization for mental illness (FUH) for its PIP topic. The primary focus of this PIP is to improve rates of follow-up appointments within 7 days and 30 days of discharge after hospitalization for mental illness and ensuring members have medication available in hand at discharge. United estimated that 900 members would participate in the PIP, including 862 Title XIX and 38 Title XXI. United is working to answer the study question: "Does providing timely and appropriate aftercare appointments for members hospitalized for select mental health disorders increase member compliance with follow-up care?" United's interventions care coordinator assistance with discharge planning; contact with members by discharge specialists; assigning "high risk members" an FCA or peer support specialist to assist; and tracking provision of medication at time of discharge. Two additional interventions – a $25 gift card, and expansion of the Bridge on Discharge program – have been added in 2014 in efforts to improve rates for follow-up care. There has been considerable progress made over the past year with communication with providers, and improving access to information on admissions and discharges. But there has not yet been measurable improvement in targeted outcomes during the first year of the PIP due to delays and difficulties initially with communication and access to information.

Amerigroup selected well-child visits in the third, fourth, fifth, and sixth years of life for their PIP topic. Amerigroup estimated that 19,774 members were eligible in 2013 for the study, including 17,116 Title XIX and 2,658 Title XXI members. Amerigroup is working to answer the study question: "Does the implementation of targeted interventions improve well-child visit rates in the third, fourth, fifth, and sixth years of life?" Amerigroup's interventions include: member education; a rewards program of $25 paid to parents for compliance with well child visits for those aged 5 and 6; birthday postcards; reminder calls; community events; and provider outreach. Monthly data indicate a continually positive trend; however, the annual 2013 data compared unfavorably with pre-KanCare HEDIS data. The HEDIS rate for 2014 was 60.9%, which was below the 2013 HEDIS percentage (67.2%). New goals have been added for 2015 which will assist Amerigroup to meet the overall objective. An outbound call contact rate measure of 20% and Healthy Rewards participation rate of 10%. The children age 6 had the lowest rates of well-child visits, so Amerigroup is planning to target this age range for special enrollment and educational efforts. KDHE will continue to monitor this PIP on a monthly basis and assist Amerigroup with suggestions for improvement.

Sunflower selected initiation and engagement in alcohol and other drugs (AOD) treatment for its PIP topic. For the first year of this PIP (2013 data), Sunflower provided a semi-annual report. The population for this study will include all Sunflower members receiving and/or eligible to receive an AOD encounterable service. Sunflower is working to answer the study question: "Will

provision of care coordination to members diagnosed needing AOD treatment result in a statistically significant improvement in member initiation and engagement in AOD services?" Sunflower's primary intervention will be the offering of care coordination to the project population. The first report for this PIP focused upon the high risk populations of Urgent, Pregnant and Using, IV-Drug use and first time in treatment. The second half of 2014 will expand referrals to care coordination for all the substance use population identified in the Kansas Client Placement Criteria database. Sunflower will also work to promote partnerships between care coordinators and providers, schedule and promote meetings with providers and care coordinators to generate ideas on how to improve member engagement, and provide specific trainings to providers based on training needs identified during the meetings.

The collaborative PIP project, which all three KanCare MCOs are implementing together, will be the KanBeWell program, assisting members in preventing diabetes through healthier eating habits and being more active. Implementation of this program will begin January 2015. KanBeWell metrics will be contrasted to the marks of those members participating in the Diabetes Prevention Program. Abdominal girth, exercise, food intake and types of food eaten as some of the important items compared. Data points marking the progress of this PIP will be reported monthly to KDHE for monitoring during its initial stages.

G. Outcomes of Performance Measure Monitoring: Some of the key performance measure outcomes for which data is now available include the following:

2014 HEDIS Measures

HEDIS Code	Performance Measure	Performance Measure	Combined KanCare MCO Performance
AAP	Adults' Access to Preventive/ Ambulatory Health Services	Age 20-44	85.4
		Age 45-64	92.2
		Age 65 plus	89.5
		Total	88.4
IET	Initiation and Engagement of AOD Dependence Treatment	Age 13-17 Initiation	49.0
		Age 18+ Initiation	40.9
		Total Initiation	42.1
		Age 13-17 Engagement	32.5
		Age 18+ Engagement	12.2
		Total Engagement	15.2
CDC	Comprehensive Diabetes Care	HbA1c Testing	83.1
		HbA1c Poor Control >9.0% (lower % better)	54.4
		HbA1c Control <8.0%	39.0

		Eye Exam LDL-C Screening LDL-C <100 mg/dL Medical Attention for Nephropathy Blood Pressure Controlled <140/80 Blood Pressure Controlled <140/90	50.1 67.0 27.1 75.8 37.2 53.1
FUH	Follow-up After Hospitalization for Mental Illness	30-day Follow-up 7-day Follow-up	79.9 61.0
CHL	Chlamydia Screening in Women	Age 16-20 Age 21-24 Total	42.4 55.6 46.1
CBP	Controlling High Blood Pressure		47.3
WCC	Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI - Age 3-11 BMI - age 12-17 BMI - total	33.7 36.6 34.7
	Counseling for Nutrition	Age 3-11 Age 12-17 Total	47.4 46.0 46.9
	Counseling for Physical Activity	Age 3-11 Age 12-17 Total	39.6 53.1 44.0
ADV	Annual Dental Visit	Age 2-3 Age 4-6 Age 7-10 Age 11-14 Age 15-18 Age 19-21 Total	40.8 66.3 70.7 62.8 53.9 31.5 60.3
PPC	Prenatal and Postpartum Care	Timeliness of Prenatal Care Postpartum Care	71.4 58.5
AWC	Adolescent Well-Care Visits		42.3
MPM	Annual Monitoring for Patients on Persistent Medications		84.9
URI	Appropriate Treatment for Children with URI		71.9

CWP	Appropriate Testing for Children with Pharyngitis		51.6
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medication		73.0
W34	Well Child Visits ages 3 to 6		60.8
SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia		62.9

Dental Care

The KanCare program and the MCO partners have made a commitment to increasing dental health and wellness among the KanCare population. The MCOs know that the dental program is very important to our members and make great efforts to increase utilization. Efforts from coloring books for children to Health Home coordination of dental services inform members. Value added benefits (VABs) in 2014 for adult members are another way that MCOs show this commitment and are increasing access for members, outside of the official KanCare program. The MCOs served 25,025 members through VABs.

The dental services statistics from fiscal year 2013 show improvement over the benchmark period of FY12. The increase in members receiving dental care is particularly impressive in the areas indicated by preventative services:

	SFY 2013	**SFY 2012**
Total Eligible receiving dental treatment	108,474	94,382
Total eligible receiving preventative services	253,850	202,254

Pay for Performance Measures

The final results of the KanCare MCOs' performance for each of the 2013 pay for performance measures is detailed in the document attached to this report entitled "KanCare Pay for Performance Measures – Year One (Summary of 2013 Performance Outcomes)."

Additional performance results and analysis of performance results are included in the 2014 KanCare annual evaluation report developed by Kansas Foundation for Medical Care, attached to this report.

H. Summary of Plan Financial Performance: As of December 31, 2014, all three plans are in a sound and solvent financial standing. Although each health plan experienced net operating losses for demonstration year 2, each plan's parent entity contributed adequate capital to

ensure each health plan met or exceeded capital requirements as outlined in state of Kansas solvency statutes and requirements. As KanCare begins DY 3, filings with the Kansas Insurance Department, as well as analysis completed by KDHE, indicate that each MCO has significantly reduced their medical loss ratios. We anticipate this trend to endure as the MCOs continue their focus on improving the health outcomes of the Medicaid beneficiaries.

Statutory filings for the KanCare health plans can be found on the NAIC's "Company Search for Compliant and Financial Information" website: ***https://eapps.naic.org/cis/.***

I. Analysis of Service Reductions: The State reviews any requests for additional services, reduction in services, and terminations for HCBS-IDD services. MCOs could not request reductions in service prior to August 1, 2014. The MCOs notify the State of voluntary and involuntary terminations, including voluntary removal from services, transitions between two services, moving out of state, and death using the State's information system (KAMIS). These are being reviewed at the time of request and as part of quality assurance and program integrity reviews to ensure changes in services are consistent with the expectation of the special terms and conditions of the KanCare program. During the fourth quarter, there were 52 requests for termination, reduction or suspension, but final review and approval had not been granted. During 2015, the state will continue to review reductions and ensure consistency among the MCOs when determining changes in services.

POC Reduction Requests – HCBS/IDD – 8/1/14 to 1/20/15				
Status	**Amerigroup**	**Sunflower**	**United**	**Total**
Under Review	4	50	0	54
Approved				
Denied				
Returned for more information	0	1	0	1
Total	**4**	**51**	**0**	**55**

XII. Post Award Forum

The KanCare annual public forum, pursuant to STC 15, was conducted on December 19, 2014. A summary of the forum, including comments and issues raised at the forum, is attached.

XIII. Annual Evaluation Report & Revised Evaluation Design

The entity selected by KDHE to conduct KanCare Evaluation reviews and reports is the Kansas Foundation for Medical Care (KFMC). The draft KanCare evaluation design was submitted by Kansas to CMS on April 26, 2013. CMS conducted review and provided feedback to Kansas on June 25, 2013.

Kansas addressed that feedback, and the final design was completed and submitted by Kansas to CMS on August 23, 2013. On September 11, 2013, Kansas was informed that the Evaluation Design had been approved by CMS with no changes. Since then, KFMC has developed and submitted quarterly evaluation reports and the first annual evaluation report for all of 2013, as well as quarterly reports for each quarter of 2014.

KFMC's annual report for 2014 is attached. As with the previous evaluation design reports, the State will review the annual report, with specific attention to the related recommendations, and will continue to take responsive action designed to accomplish real-time enhancements to the state's oversight and monitoring of the KanCare program, and to improve outcomes for members utilizing KanCare services.

In addition, attached is the revised KanCare Final Evaluation Design, with revisions as of March, 2015. As the KanCare program has been operationalized, and performance measures (especially first of their kind pay-for-performance measures) have been fully prepared for implementation, as well as relevant program updates and changes in HEDIS measure specifications, some adjustments to the evaluation design have necessarily occurred. Those adjustments are reflected in the attached revised design. Unless specific feedback is received from CMS, which results in further adjustments, the attached revised version of the design will guide future analysis and reporting. If additional revisions become necessary due to program implementation, future revised versions will be submitted with quarterly or annual STC reporting.

XIV. Enclosures/Attachments

The following items are attached to and incorporated in this annual report:

Section of Report Where Attachment Noted	Description of Attachment
II(D)	KanCare Safety Net Care Pool Reports
III/IV	KanCare Expenditure & Budget Neutrality – DY2 2014
IX	KanCare Ombudsman Report – Calendar Year 2014
XI(B)	KanCare Utilization Report for 2013
XI(G)	KanCare 2013 Pay for Performance Results
XII	Summary of 2014 KanCare Public Forum
XIII	KFMC's KanCare Evaluation Report for DY2 2014
XIII	Revised KanCare Final Evaluation Design

XV. State Contacts(s)

Dr. Susan Mosier, Acting Secretary and Medicaid Director
Michael Randol, Division Director
Kansas Department of Health and Environment
Division of Health Care Finance
Landon State Office Building – 9th Floor
900 SW Jackson Street
Topeka, Kansas 66612
(785) 296-3512 (phone)
(785) 296-4813 (fax)
SMosier@kdheks.gov
MRandol@kdheks.gov

XVI. Date Submitted to CMS

March 31, 2015

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 2 - YE 2014

Health Care Access Improvement Pool

Paid dates 1/1/2014 through 12/31/2014

Hospital Name	YE 2014 Amt Paid	Provider Access Fund 2443	Federal Medicaid Fund 3414
Bob Wilson Memorial Hospital	184,583.26	79,666.14	104,917.12
Children's Mercy Hospital South	735,330.09	317,368.47	417,961.62
Coffey County Hospital	45,839.13	19,784.17	26,054.96
Coffeyville Regional Medical Center, Inc.	341,376.98	147,338.30	194,038.68
Cushing Memorial Hospital	425,173.33	183,504.81	241,668.52
Galichia Heart Hospital LLC	Added to Wesley		
Geary Community Hospital	529,544.42	228,551.37	300,993.05
Hays Medical Center, Inc.	1,253,512.23	541,015.88	712,496.35
Hutchinson Hospital Corporation	819,566.87	353,725.06	465,841.81
Kansas Medical Center LLC	300,367.36	129,638.55	170,728.81
Kansas Rehabilitation Hospital	6,357.45	2,743.88	3,613.57
Labette County Medical Center	291,330.63	125,738.30	165,592.33
Lawrence Memorial Hospital	1,141,681.50	492,749.74	648,931.76
Marillac Center INC	7,627.19	3,291.90	4,335.29
Memorial Hospital, Inc.	179,266.50	77,371.42	101,895.08
Menorah Medical Center	624,286.19	269,441.92	354,844.27
Mercy - Independence	240,801.35	103,929.86	136,871.49
Mercy Health Center - Ft. Scott	382,730.52	165,186.49	217,544.03
Mercy Hospital, Inc.	21,365.33	9,221.28	12,144.05
Mercy Reg Health Ctr	535,659.70	231,190.73	304,468.97
Miami County Medical Center	268,981.01	116,092.20	152,888.81
Morton County Health System	92,779.08	40,043.45	52,735.63
Mt. Carmel Medical Center	872,942.56	376,762.01	496,180.55
Newton Medical Center	769,725.14	332,213.37	437,511.77
Olathe Medical Center	1,203,432.69	519,401.55	684,031.14
Overland Park Regional Medical Ctr.	2,447,985.69	1,056,550.62	1,391,435.07
Prairie View Inc.	39,613.86	17,097.34	22,516.52
Pratt Regional Medical Center	207,917.18	89,737.05	118,180.13
Providence Medical Center	1,787,013.38	771,274.97	1,015,738.41
Ransom Memorial Hospital	345,115.18	148,951.71	196,163.47
Saint Luke's South Hospital, Inc.	371,010.19	160,128.00	210,882.19
Salina Regional Health Center	514,689.98	222,140.20	292,549.78
Salina Surgical Hospital	11,715.88	5,056.57	6,659.31
Shawnee Mission Medical Center, Inc.	2,464,468.07	1,063,664.42	1,400,803.65
South Central KS Reg Medical Ctr	184,292.21	79,540.52	104,751.69
Southwest Medical Center	451,872.12	195,028.01	256,844.11
SSH - Kansas City	86,568.20	37,362.84	49,205.36
St. Catherine Hospital	733,117.69	316,413.60	416,704.09
St. Francis Health Center	1,263,769.74	545,443.02	718,326.72
St. John Hospital	408,804.97	176,440.23	232,364.74

Stormont Vail Regional Health Center	3,495,197.20	1,508,527.11	1,986,670.09
Sumner Regional Medical Center	136,334.68	58,842.05	77,492.63
Surgical & Diag. Ctr. of Great Bend	602,951.88	260,234.03	342,717.85
Susan B. Allen Memorial Hospital	530,908.79	229,140.23	301,768.56
Via Christi Hospital St Teresa	415,130.18	179,170.19	235,959.99
Via Christi Regional Medical Center	6,908,217.33	2,981,586.60	3,926,630.73
Via Christi Rehabilitation Center	216,490.53	93,437.31	123,053.22
Wesley Medical Center	5,141,091.23	2,218,894.97	2,922,196.26
Western Plains Medical Complex	566,619.38	244,552.92	322,066.46
	40,605,156.05	**17,525,185.35**	**23,079,970.70**

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 2 - YE 2014

Large Public Teaching Hospital/ Border City Children's Hospital Uncompensated care pool

Paid dates 1/1/2014 through 12/31/2014

Provider Name	YE 2014 Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	9,964,136.00	4,300,521.10	5,663,614.90
University of Kansas Hospital	29,892,412.00	12,901,565.02*	16,990,846.98
Total	**39,856,548.00**	**17,202,086.12**	**22,654,461.88**

*IGT funds are received from the University of Kansas Hospital.

KanCare Budget Neutrality
Demonstration Year 2

DY 2
Start Date: 1/1/2014
End Date: 12/31/2014

	Assistance Total Expenditures	Total Member Months	Administration Total Expenditures
DY2Q1	630,974,052.27	1,046,660	44,343,611
DY2Q2	641,139,610.12	1,073,451	48,382,537
DY2Q3	637,198,222.10	1,071,962	45,646,365
DY2Q4	686,775,523.14	1,082,877	28,126,403
DY2 Total	2,596,087,407.63	4,274,950	166,498,916

UNIQUE ENROLLEES			
Pop 1: ABD/SD Dual	24,324	Pop 6: LTC	27,220
Pop 2: ABD/SD Non Dual	37,350	Pop 7: MN Dual	4,295
Pop 3: Adults	57,574	Pop 8: MN Non Dual	4,527
Pop 4: Children	276,661	Pop 9: Waiver	5,982
Pop 5: DD Waiver	9,190		
		Total:	447,123

OVERALL UNDUPLICATED BENEFICIARIES: 428,373

	Population 1: ABD/SD Dual	Population 2: ABD/SD Non Dual	Population 3: Adults	Population 4: Children	Population 5: DD Waiver	Population 6: LTC	Population 7: MN Dual	Population 8: MN Non Dual	Population 9: Waiver
DY2Q1									
Expenditures	10,122,495.83	96,875,068.18	66,071,509.73	136,798,353.63	101,332,051.29	179,589,602.73	4,491,431.63	6,614,747.23	33,024,783.05
Member-Months	55,977	91,351	116,654	666,014	27,107	67,448	4,428	4,309	13,372
PCP	(11,663.34)	(631,494.34)	(194,779.78)	(2,772,811.49)	(79,141.03)	(125,484.28)	(1,152.71)	(35,266.94)	(94,197.12)
DY2Q2									
Expenditures	10,245,140.18	96,606,678.92	71,899,595.99	140,548,916.79	102,597,921.36	179,884,342.08	4,242,050.34	6,761,024.99	32,348,056.17
Member-Months	56,921	92,543	124,410	683,847	27,408	66,507	4,396	4,238	13,181
PCP	(11,818.39)	(624,217.80)	(211,317.15)	(2,825,125.69)	(59,039.08)	(131,094.47)	(1,138.40)	(36,850.09)	(93,515.63)
DY2Q3									
Expenditures	10,135,154.62	95,198,027.00	71,241,749.22	140,563,644.96	103,548,988.66	178,345,935.61	4,318,165.32	6,795,729.87	31,023,861.64
Member-Months	56,602	91,241	125,560	684,108	27,121	66,120	4,416	4,107	12,687
PCP	(11,685.27)	(614,748.93)	(214,169.09)	(2,814,045.17)	(58,895.88)	(130,864.94)	(1,161.90)	(37,447.34)	(90,016.28)
DY2Q4									
Expenditures	14,338,376.92	92,580,848.83	70,888,564.14	149,733,908.98	114,936,316.38	207,958,215.63	1,962,247.47	4,604,328.97	33,143,248.23
Member-Months	56,078	91,703	129,716	688,945	27,036	67,563	4,909	4,294	12,633
PCP	(14,668.66)	(457,771.96)	(196,248.83)	(2,443,019.30)	(51,190.46)	(115,182.84)	(463.08)	(17,775.19)	(74,212.09)
DY2 Total									
Expenditures	44,791,331.89	378,932,389.90	279,284,904.23	556,789,822.71	422,167,011.24	745,275,469.52	15,009,978.67	24,648,491.50	129,188,007.97
Member-Months	225,578	366,838	496,340	2,722,914	108,672	267,638	18,149	16,948	51,873
DY 2 PMPM	198.56	1,032.97	562.69	204.48	3,884.78	2,784.64	827.04	1,454.36	2,490.47

Note:
1) Administration costs are allocated to the waiver based on the percentage of Waiver assistance expenditures to the total Medicaid assistance expenditures.
2) Reported expenditures are net of Risk Corridor payments.
3) The increase in expenditures for the 4th quarter is due to mid-year capitation payment adjustments that occurred in November 2014, as well as contractual obligations to the Managed Care Organizations.
4) Administrative expenses lower in Q4 due to several large invoices not paid in December. Additionally, school based administration payments were delayed.

KanCare Ombudsman Annual Report 2014

Kerrie J. Bacon, Kancare Ombudsman

Accessibility

The months with the highest call volume were February, March, July and October.

Contact by Month	
January	153
Feb	195
Mar	197
April	148
May	169
June	157
July	182
August	174
September	170
October	238
November	175
December	134
Average by month	**174**

MCO related

2014	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Amerigroup	67	73	77	56
Sunflower	96	91	134	102
United	51	46	45	52
None	331	264	270	337
Total	**545**	**477**	**526**	**547**

Outreach (recap)

- The Ombudsman webpage was completely revamped during first quarter and materials have been added or updated periodically as KanCare member resources. (i.e. Appeals process, Medical assistance information, Contact information page, etc.)
- The Ombudsman's brochure was updated and printed. Qtr 1
- The Ombudsman attended the I/DD listening tour sessions across Kansas (March 18, Salina; March 19, Wichita; March 20, Pittsburg; March 21, Topeka).
- Attended and/or presented report at the quarterly KanCare Advisory Council meeting in Topeka.
- Attended and presented report at the quarterly Consumer Specialized Issues (CSI) committee meetings.
- The Ombudsman's office sponsors the KanCare (I/DD) Friends and Family Advisory Council which met three times during first quarter and had several conference calls.
- Hosted bi-weekly Lunch-and-Learn conference calls for the Intellectual/Developmental Disability (I/DD) parents, guardians and other consumers and HCBS waiver members. ***The format is changing for 2015.*** It is going to be called KanCare Member Lunch and Learn Bi-Weekly Calls. The topics will be about KanCare and resources that may be of interest to people who are on Medicaid. We are hoping to appeal to the broader range of members including the long term care members.
- Provided a vendor booth for the ARC Transition Expo at Free State High School in Lawrence, KS, April 9, 2014.
- Provided testimony to the Bob Bethell KanCare Oversight Committee regarding Ombudsman activities each quarter.
- Attended the Employment First Summit and provided a vendor booth; April 30-May 1, 2014. Approximately 300 people in attendance from the Disability Community.
- Attended the Health Home Listening Session; Pittsburg, KS, June 5; 2014. Provided information about the Ombudsman's office.
- Attended Training on the Prevention of Elder Abuse, Neglect and Exploitation, Augusta, KS. June 4, 2014. Provided information about the Ombudsman's office.
- Gave presentation on KanCare Ombudsman to Money Follows the Person Steering Committee, Topeka, KS. June 10, 2014.
- Provided a vendor booth for the Conference on Poverty in Topeka, July 16-18, 2014
- Coordinated a dozen trainings with disability, agency, and community partnering organizations as part of orientation for the ombudsman volunteer coordinator training; used this as an opportunity for outreach for the Ombudsman office.
- Provided a vendor booth for the Conference on Poverty in Topeka, July 16-18, 2014.
- Coordinated a dozen trainings with disability, agency, and community partnering organizations as part of orientation for the ombudsman volunteer coordinator training; used

this as an opportunity for outreach for the Ombudsman office. Attended PRTF (Psychiatric Residential Treatment Facility) Stakeholder Meeting; 10/8/14

- Provided a Vendor Booth at Interhab Conference; 10/16/14
- Attended State Aging and Advisory Council Meeting; 10/17/14
- Spoke briefly about Ombudsman's office at Brain Injury Conference; 10/25/14
- Attended HCBS Public Listen Sessions 11/14/14
- Mailing to all Targeted Case Managers in Kansas (101 TCMs) a letter of introduction from the Ombudsman and a package of Ombudsman brochures.
- The Ombudsman's office sponsors the KanCare (I/DD) Friends and Family Advisory Council which meets several times during the year.

Data

The next several charts show the normal reporting information by quarter for 2014.

Contact Method	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Email	194	83	90	90
Face-to-Face Meeting	1	2	2	1
Letter	5	5	2	1
ONLINE	1	0	0	0
Other	1	0	0	0
Telephone	343	384	432	455
Total	**545**	**474**	**526**	**547**

Caller Type	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Consumer	384	347	412	437
MCO Employee	4	5	1	3
Other type	22	7	21	30
Provider	135	115	92	77
Total	**545**	**474**	**526**	**547**

The top two categories for the year are Billing and Appeals/Grievances. The number of Appeals/Grievances has almost doubled in the 3rd and 4th quarters vs. 1st and 2nd quarters.

Issues	Q1	Issues	Q2	Issues	Q3	Issues	Q4
HCBS Eligibility issues	55	Durable Medical Equipment	35	Appeals / Grievances	46	Medical Services	70
Billing	51	Billing	33	HCBS General Issues	45	HCBS General Issues	49
Pharmacy	38	Medical Services	31	Medical Services	41	Appeals / Grievances	46
Durable Medical Equipment	25	HCBS General Issues	25	Billing	40	Billing	42
Appeals, Grievances	22	Appeals / Grievances	22	Durable Medical Equipment	25	Nursing Facility Issues	24
HCBS Reduction in hours of service	22	Access to Providers	16	Pharmacy	20	Pharmacy	19
Access to Providers	16	Dental	15	HCBS Waiting List	19	Access to Providers (usually Medical)	15
Dental	16	Pharmacy	15	Care Coordinator Issues	18	Care Coordinator Issues	14
Guardianship Issues	16	HCBS Eligibility issues	14	Transportation	18	Transportation	13
Medicaid Service Issues	14	Nursing Facility Issues	12	Nursing Facility Issues	16	HCBS Eligibility issues	11
Questions for Conf Calls/sessions	13	Change MCO	11	HCBS Reduction in hours of service	15	Housing Issues	10
HCBS General Issues	11	HCBS Reduction in hours of service	11	Questions for Conference Calls/Sessions	15	Change MCO	9
Transportation	11	Care Coordinator Issues	9	Housing Issues	12	Dental	9
Care Coordinators	10	HCBS Waiting List	8	Change MCO	10	Durable Medical Equipment	8
Nursing Facility Issues	8	Housing Issues	8	HCBS Eligibility issues	10	HCBS Reduction in hours of service	8
Change MCO	6	Transportation	8	Dental	8	HCBS Waiting List	7
HCBS Waiting List issues	3	Questions for Conference Calls/Sessions	5	Access to Providers (usually Medical)	6	Guardianship	2
Housing issues	3	Guardianship	3	Guardianship	1	Questions for Conference Calls/Sessions	2
Medicaid Eligibility Issues	81	Medicaid Eligibility Issues	73	Medicaid Eligibility Issues	90	Medicaid Eligibility Issues	194
Other	49	Other	75	X-Other	103	X-Other	112
Unspecified	73	Unspecified	44	Z Thank you.	10	Z Thank you.	13
Thank you	2	Thank you.	1	Z Unspecified	33	Z Unspecified	27
Total	545	Total	474	Total	600	Total	704

This is the same issues category sorted in alphabetical order by quarter in order to compare categories by quarter.

Issues	Q1	Issues	Q2	Issues	Q3	Issues	Q4
Access to Providers	16	Access to Providers	16	Access to Providers (usually Medical)	6	Access to Providers (usually Medical)	15
Appeals, Grievances	22	Appeals / Grievances	22	Appeals / Grievances	46	Appeals / Grievances	46
Billing	51	Billing	33	Billing	40	Billing	42
Care Coordinators	10	Care Coordinator Issues	9	Care Coordinator Issues	18	Care Coordinator Issues	14
Change MCO	6	Change MCO	11	Change MCO	10	Change MCO	9
Dental	16	Dental	15	Dental	8	Dental	9
Durable Medical Equipment	25	Durable Medical Equipment	35	Durable Medical Equipment	25	Durable Medical Equipment	8
Guardianship Issues	16	Guardianship	3	Guardianship	1	Guardianship	2
HCBS Eligibility issues	55	HCBS Eligibility issues	14	HCBS Eligibility issues	10	HCBS Eligibility issues	11
HCBS General Issues	11	HCBS General Issues	25	HCBS General Issues	45	HCBS General Issues	49
HCBS Reduction in hours of service	22	HCBS Reduction in hours of service	11	HCBS Reduction in hours of service	15	HCBS Reduction in hours of service	8
HCBS Waiting List issues	3	HCBS Waiting List	8	HCBS Waiting List	19	HCBS Waiting List	7
Housing issues	3	Housing Issues	8	Housing Issues	12	Housing Issues	10
Medicaid Eligibility Issues	81	Medicaid Eligibility Issues	73	Medicaid Eligibility Issues	90	Medicaid Eligibility Issues	194
Medicaid Service Issues	14	Medical Services	31	Medical Services	41	Medical Services	70
Nursing Facility Issues	8	Nursing Facility Issues	12	Nursing Facility Issues	16	Nursing Facility Issues	24
Pharmacy	38	Pharmacy	15	Pharmacy	20	Pharmacy	19
Questions for Conf Calls/sessions	13	Questions for Conference Calls/Sessions	5	Questions for Conference Calls/Sessions	15	Questions for Conference Calls/Sessions	2
Transportation	11	Transportation	8	Transportation	18	Transportation	13
Other	49	Other	75	X-Other	103	X-Other	112
Unspecified	73	Unspecified	44	Z Unspecified	33	Z Unspecified	27
Thank you	2	Thank you.	1	Z Thank you.	10	Z Thank you.	13
Total	545	Total	474	Total	600	Total	704

The issue category charts by Managed Care Organization for the four quarters may help identify trends for these companies and potentially provide better customer service.

Amerigroup

Total calls to the Ombudsman's office by quarter have increased slightly each quarter. Durable medical equipment had a significant decrease in fourth quarter.

Issue Category - Amerigroup	Q1	Q2	Q3	Q4
Access to Providers (usually Medical)	5	6	3	6
Appeals / Grievances	2	4	3	4
Billing	9	8	11	7
Care Coordinator Issues	3	0	4	3
Change MCO	1	3	0	2
Dental	3	6	2	4
Durable Medical Equipment	11	13	9	4
Guardianship	0	0	0	0
HCBS Eligibility issues	3	3	2	3
HCBS General Issues	0	4	13	9
HCBS Reduction in hours of service	3	2	2	2
HCBS Waiting List	0	1	4	1
Housing Issues	0	2	0	2
Medicaid Eligibility Issues	7	3	9	13
Medical Services	2	3	5	15
Nursing Facility Issues	0	0	2	5
Pharmacy	5	5	3	2
Questions for Conference Calls/Sessions	0	0	0	0
Transportation	7	3	6	2
X-Other	6	11	7	11
Z Thank you.	0	0	1	1
Z Unspecified	1	3	2	0
(not identified)	1	0	0	2
Total	**69**	**80**	**88**	**98**

Sunflower

Total calls to the Ombudsman's office show lower call rate in first and second quarter and higher call rate in third and fourth quarter. Appeals and Grievances are higher in third and fourth quarter than first and second quarter. Durable medical equipment had a significant decrease in fourth quarter.

Issue Category - Sunflower	Q1	Q2	Q3	Q4
Access to Providers (usually Medical)	6	0	1	5
Appeals / Grievances	2	12	33	30
Billing	16	7	10	13

Care Coordinator Issues	5	6	13	8
Change MCO	3	5	6	5
Dental	3	5	0	2
Durable Medical Equipment	7	10	13	4
Guardianship	1	2	0	0
HCBS Eligibility issues	11	4	3	4
HCBS General Issues	6	5	13	10
HCBS Reduction in hours of service	5	4	7	3
HCBS Waiting List	0	3	2	0
Housing Issues	1	0	3	4
Medicaid Eligibility Issues	3	2	9	16
Medical Services	2	16	20	15
Nursing Facility Issues	0	0	1	1
Pharmacy	17	5	11	5
Questions for Conference Calls/Sessions	1	0	0	1
Transportation	0	2	5	4
X-Other	7	6	12	13
Z Thank you.	0	0	4	1
Z Unspecified	3	3	10	3
(not identified)	4	0	0	3
Total	**103**	**97**	**176**	**150**

United

Total calls to the Ombudsman's office show an increase in calls for fourth quarter. HCBS General Issues has grown from first quarter to fourth quarter. Durable medical equipment had a decrease in fourth quarter.

Issue Category - United	**Q1**	**Q2**	**Q3**	**Q4**
Access to Providers (usually Medical)	4	4	0	2
Appeals / Grievances	4	4	5	7
Billing	8	7	8	6
Care Coordinator Issues	1	2	0	3
Change MCO	1	2	3	1
Dental	3	0	2	0
Durable Medical Equipment	3	6	2	0
Guardianship	2	0	0	1
HCBS Eligibility issues	4	0	0	3
HCBS General Issues	2	3	8	13
HCBS Reduction in hours of service	4	3	3	1
HCBS Waiting List	0	1	1	1
Housing Issues	0	1	3	2
Medicaid Eligibility Issues	8	1	4	10
Medical Services	2	3	7	9

Nursing Facility Issues	0	0	0	2
Pharmacy	3	3	3	4
Questions for Conference Calls/Sessions	0	0	0	0
Transportation	1	2	1	3
X-Other	2	4	5	9
Z Thank you.	0	0	0	1
Z Unspecified	3	1	0	0
(not identified)	0	0	0	2
Total	**55**	**47**	**55**	**80**

CY 2013

Utilization Report

The Utilization Report consists of two Medicaid/CHIP data sets, one for CY 2012 and one for CY 2013--All data on this page has been extracted from the DSS. The CY 2012 data consists of Medicaid/CHIP Encounter and Fee-For-Service (FFS) data. The CY 2013 data consists of Medicaid/CHIP and Encounter data only, the CY 2013 data is KanCare encounter data only. To keep the CY 2012 and CY 2013 comparable, the CY 2012 FFS data does not include any population or service that is not included in KanCare. To see a listing of these populations and services, please look on the Utilization Methods tab. The Utilization Methods tab also contains the definitions pertaining to the Utilization Types of Services included in this report. For further explanation of the Utilization Report, please see the Important Notes section below the report.

*The Date range for this report is as follows: Dates of Service 1/1/2013 thru 12/31/2013 with a Paid Date >= 1/1/2013.

*The Utilization Report data was pulled from the DSS September 12, 2014.

Utilization Report		KanCare: CY 2013 Encounter only			Pre KanCare: CY 2012 Encounter and FFS			Comparing CY 2013 to CY 2012			
Type of Service	Units Reported	Total Expenditures	Count	Utilization Per/1000	Total Expenditures	Count	Utilization Per/1000	Total Expenditures	% Difference	Utilization Per/1000	% Difference
Behavioral Health	Claims	$ 205,434,674	1,941,776	5,049	$ 176,938,653	2,072,761	5,232	$ 28,496,021	16%	-184	-4%
Dental	Claims	$ 60,452,026	387,540	1,008	$ 54,608,622	353,978	894	$ 5,843,404	11%	114	13%
HCBS	Unit	$ 188,219,337	52,920,090	5,234,430	$ 202,135,122	58,156,325	5,180,772	$ (13,915,785)	-7%	53,658	1%
Inpatient	Days	$ 351,538,053	360,586	938	$ 430,759,659	478,443	1,208	$ (79,221,606)	-18%	-270	-22%
Nursing Facility	Days	$ 440,147,604	3,208,490	305,374	$ 428,310,299	3,656,123	339,389	$ 11,837,305	3%	-34,015	-10%
Outpatient ER	Claims	$ 68,345,308	292,879	761	$ 67,511,768	313,869	792	$ 833,540	1%	-31	-4%
Outpatient Non-ER	Claims	$ 98,896,537	657,034	1,708	$ 94,807,650	721,902	1,822	$ 4,088,887	4%	-114	-6%
Pharmacy	Prescriptions	$ 256,355,314	3,748,661	9,747	$ 255,827,890	3,967,141	10,015	$ 527,424	0%	-268	-3%
Transportation	Claims	$ 12,448,056	276,976	720	$ 14,132,378	248,294	627	$ (1,684,322)	-12%	93	15%
Vision	Claims	$ 15,912,161	154,818	403	$ 12,630,841	130,980	331	$ 3,281,320	26%	72	22%
Primary Care Physician	Claims	$ 160,864,705	1,867,783	4,856	$ 90,609,480	1,500,234	3,787	$ 70,255,225	78%	1,069	28%
FQHC/RHC	Claims	$ 38,702,400	398,727	1,037	$ 21,726,453	344,119	869	$ 16,975,947	78%	168	19%
Utilization Totals		$ 1,897,316,174			$ 1,849,998,813			$ 47,317,361			

Member Months 2013 Aggregate	
Plan	All Members
Amerigroup	1,486,698
United	1,468,406
Sunflower	1,660,200
All MCOs	4,615,304

Member Months 2013 HCBS & NF		
Plan	HCBS	Nursing Fac
Amerigroup	39,608	42,156
United	39,703	41,285
Sunflower	42,009	42,640
All MCOs	121,320	126,081

*Please see Utilization Methods tab for explanation on HCBS and Nursing Facility Member Months.

Member Months CY 12 Agg	
T19 & T21	4,753,664

Member Months CY 12 HCBS & NF	
HCBS	134,705
Nursing Facility	129,272

Utilization Report Per MCO		Amerigroup			United			Sunflower		
Type of Service	Units Reported	Total Expenditures	Count	Utilization Per/1000	Total Expenditures	Count	Utilization Per/1000	Total Expenditures	Count	Utilization Per/1000
Behavioral Health	Claims	$ 80,095,481	708,890	5,722	$ 59,873,992	597,058	4,879	$ 65,465,200	635,828	4,596
Dental	Claims	$ 20,678,177	129,269	1,043	$ 17,743,297	113,796	930	$ 22,030,552	144,475	1,044
HCBS	Unit	$ 73,164,562	14,409,749	4,365,709	$ 44,084,946	10,953,258	3,310,558	$ 70,969,830	27,557,083	7,871,765
Inpatient	Days	$ 113,204,696	127,103	1,026	$ 104,251,673	102,608	839	$ 134,081,684	130,875	946
Nursing Facility	Days	$ 147,740,725	847,581	241,270	$ 143,733,022	1,137,887	330,741	$ 148,673,857	1,223,022	344,190
Outpatient ER	Claims	$ 22,544,675	97,054	783	$ 22,022,600	88,218	721	$ 23,778,033	107,607	778
Outpatient Non-ER	Claims	$ 30,279,137	218,133	1,761	$ 32,279,264	187,888	1,535	$ 36,338,135	251,013	1,814
Pharmacy	Prescriptions	$ 87,646,901	1,260,278	10,172	$ 80,686,571	1,205,354	9,850	$ 88,021,842	1,283,029	9,274
Transportation	Claims	$ 1,950,332	19,422	157	$ 4,430,885	100,233	819	$ 6,066,840	157,321	1,137
Vision	Claims	$ 5,216,629	50,912	411	$ 5,755,910	52,765	431	$ 4,939,622	51,141	370
Primary Care Physician	Claims	$ 45,914,361	470,497	3,798	$ 51,939,497	606,702	4,958	$ 63,010,847	790,584	5,714
FQHC/RHC	Claims	$ 16,016,084	176,227	1,422	$ 8,753,612	81,335	665	$ 13,932,704	141,165	1,020
Utilization Totals		$ 644,451,759			$ 575,555,269			$ 677,309,145		

Important Notes pertaining to the Utilization Report:

*Data analyst staff collaborated with DHCF clinical nurses to develop the Data Extraction Method. This effort was designed to define standardized utilization reporting criteria between the MCOs and the State.

*The Encounter Expenditures taken from the DSS include claims with an MCO Paid Status and an MMIS Paid or Denied Status.

*The HCBS CY 2012 FFS data does not contain Developmentally Disabled Waiver Services.

*Utilization per 1000 formula is Units Reported/Member Months *12000 - this illustrates the services used per 1000 beneficiaries over a 12 month period.

*The Utilization totals on this page will not match the Encounter Expenditures Total on the Summary page because Utilization is only looking at select Types of Service and the Summary Page is All Types of Services.

KanCare Pay for Performance Measures – Year One

(Summary of 2013 Performance Outcomes)

Subject	P4P Metric	Amerigroup – Final 2013 P4P Calculation			Sunflower – Final 2013 P4P Calculation			United – Final 2013 P4P Calculation		
Monthly		**Total # Met**	**Total Standards**	**Payout (of .5% of capitalization)**	**Total # Met**	**Total Standards**	**Payout (of .5% of capitation)**	**Total # Met**	**Total Standards**	**Payout (of .5% of capitation)**
Claims Processing	- 100% of clean claims are processed within 20 days - 99% of all non-clean claims are processed within 45 days - 100% of all claims are processed within 60 days	0	*out of 12*	0.000	0	*out of 12*	0.000	0	*out of 12*	0.000
Encounters	Contractor meets all of the performance standards within 60 days from implementation date.	6	*out of 12*	0.250	6	*out of 12*	0.250	6	*out of 12*	0.250
Credentialing	- 90% providers completed in 20 days - 100% providers completed in 30 days	11	*out of 12*	0.458	1	*out of 12*	0.042	11	*out of 12*	0.458
Customer Service	- 98% of all inquiries are resolved within 2 business days from receipt date - 100% of all inquiries are resolved within 8 business days from receipt date	12	*out of 12*	0.500	12	*out of 12*	0.500	12	*out of 12*	0.500
Quarterly										
Grievances	- 98% of grievances are resolved within 20 days - 100% of grievances are resolved within 40 days	3	*out of 4*	0.375	4	*out of 4*	0.500	4	*out of 4*	0.500
Appeals	Contractor sends an acknowledgement letter within 3 business days of receipt of the appeal request	3	*out of 4*	0.375	3	*out of 4*	0.375	3	*out of 4*	0.375
			Total	**1.958**		**Total**	**1.667**		**Total**	**2.083** out of 3%

Summary of KanCare Annual Post Award Forum Held 12.19.14

The KanCare Special Terms and Conditions, at item #15, provide that annually "the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. … The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in STC77, associated with the quarter in which the forum was held. The state must also include the summary of its annual report as required in STC78."

Consistent with this provision, Kansas held its 2014 KanCare Public Forum, providing updates and opportunity for input, on Friday, December 19, 2014, from 1:30-2:30 pm at the Memorial Hall Auditorium, 120 SW 10th Ave., Topeka, Kansas. The forum was published as a "Latest News – Upcoming Events" on the face page banner of the www.KanCare.ks.gov website, starting on November 20, 2014. A screenshot of that face page banner is included in the PowerPoint document utilized at the forum (set out below). A screen shot of the notice linked from the KanCare website face page banner is as follows:

KanCare Update + Q&A

Public Forum

Please join us for a progress update and Q&A regarding the KanCare Program....

Date: Friday, Dec. 19, 2014
Time: 1:30-2:30 pm
Place: Memorial Hall
Auditorium – 2nd Floor
120 SW 10th Ave.
Topeka, KS

KDHE and KDADS will provide a progress update and answer your questions regarding the KanCare Program. Please join us!

At the public forum, 22 KanCare program stakeholders attended and participated, as well as Acting Secretary Susan Mosier, MD, and additional staff from the Kansas Department of Health and

Environment; and Secretary Kari Bruffett, and additional staff from the Kansas Department of Aging and Disability Services. A summary of the information presented by state staff is included in the following PowerPoint document:

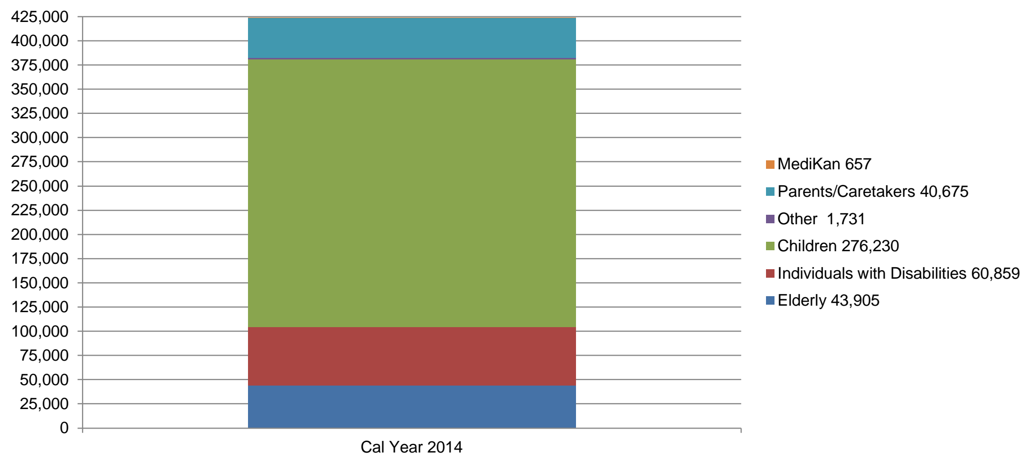
2014 KanCare Public Forum
Updates & Opportunity for Input

Friday, December 19, 2014

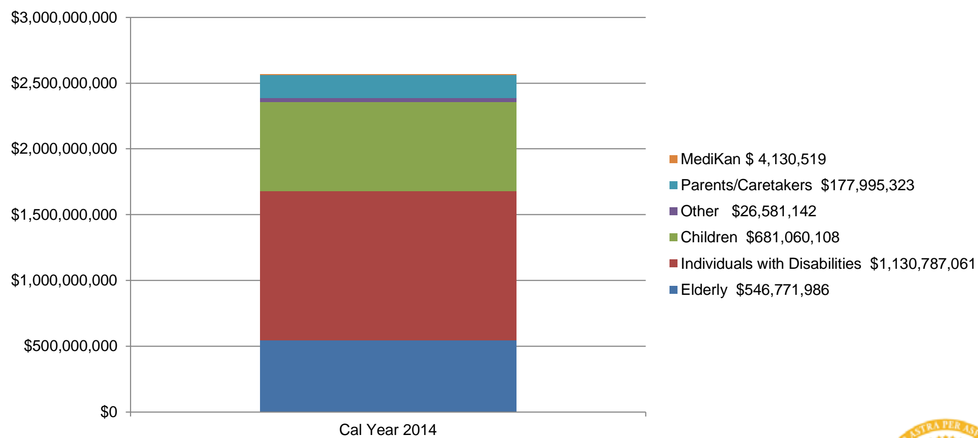
Agenda for Today

- Review Some KanCare Updates
  - Medicaid Members & Expenditures
  - KanCare Member Issues And Updates
  - KanCare Expenditures
  - Provider Network
  - Value Added Benefits
  - Customer Service
  - Health Homes
- Receive Questions, Suggestions And Other Feedback
  - Note Cards
  - Follow Up – Today And After

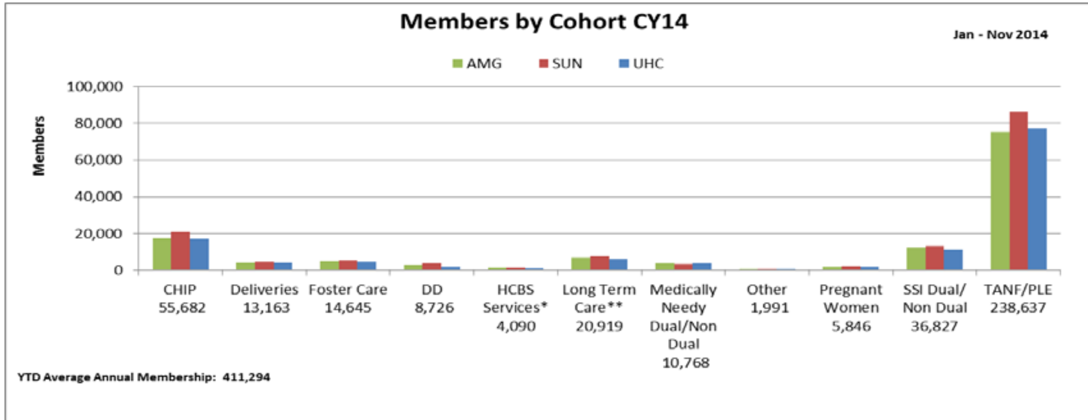
Medicaid Members - General



Medicaid Expenditures

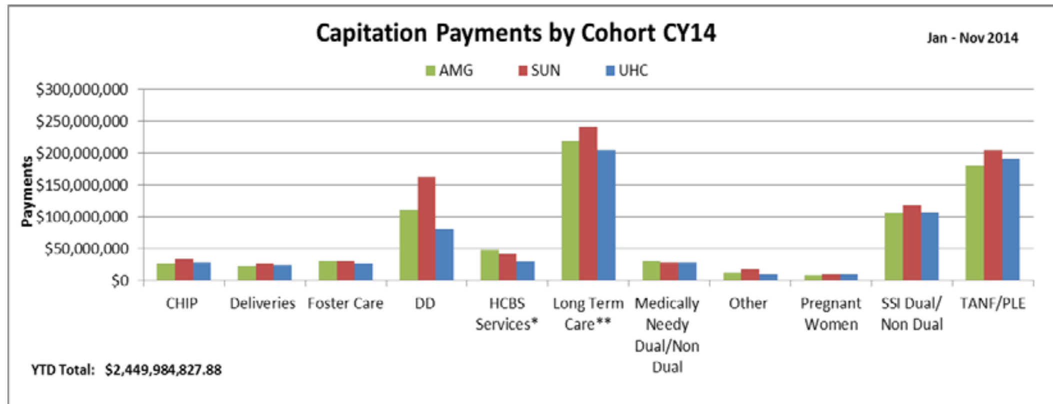


Members & Expenditures



*HCBS Services includes Autism, Severe Emotional Disturbance, Technology Assistance, and Traumatic Brain Injury
**Long Term Care includes Nursing Facilities; Money Follows the Person – Frail Elderly and Physical Disability Services; and the Physical Disability and Frail Elderly Waivers

Members & Expenditures



*HCBS Services includes Autism, Severe Emotional Disturbance, Technology Assistance, and Traumatic Brain Injury
**Long Term Care includes Nursing Facilities; Money Follows the Person – Frail Elderly and Physical Disability Services; and the Physical Disability and Frail Elderly Waivers

Member Issues - KDADS

- Physical Disability Waiver – Waiting List
- Intellectual/Developmental Disability Waiver – Transition
- Mental Health – Updates
- Utilization of Hospital Services by HCBS Waiver Members
  - Reduction in Emergency Department services for HCBS members
  - Decrease in use of inpatient services for HCBS members

Provider Networks

KanCare MCO	# of Unique Providers as of 9/30/14
Amerigroup	13,682
Sunflower	17,728
United	19,747

KanCare MCO	# of IDD Unique Providers HCBS / TCM	
	as of 5/20/14	as of 10/31/14
Amerigroup	74%/ 89%	76%/ 92%
Sunflower	81%/ 93%	82%/ 94%
United	73%/ 79%	73%/ 83%

Value Added Benefits

Amerigroup	Members YTD	Total Units YTD	Total Value YTD
Adult Dental Care	1,463	3,023	$347,842
Member Incentive Program	4,539	9,510	$222,580
Mail Order OTC	6,518	7,434	$122,694
Healthy Families Program	73	79	$62,500
Pest Control	205	232	$29,920
Smoking Cessation Program	122	223	$23,958
Hypoallergenic Bedding	104	111	$10,921
Weight Watcher Vouchers	117	169	$6,233
Member Transportation to Community Locations	100	1	$287
Entertainment Book Coupons	25	26	$14
2014 YTD GRAND TOTAL	18,359	24,333	$826,950

Value Added Benefits

Sunflower	Members YTD	Total Units YTD	Total Value YTD
CentAccount debit card	42,591	43,232	$864,640
Dental visits for adults	5,729	16,589	$319,723
Smoking cessation program	465	465	$111,600
Start Smart (mothers/children)	3,341	3,341	$94,049
Disease and Healthy Living Coaching	27,705	27,688	$72,268
Lodging for specialty and inpatient care	92	603	$48,843
SafeLink®/ Connections Plus cell phones	265	265	$12,675
In-home caregiver support/ additional respite	34	3,132	$10,181
Community Programs for Healthy Children:	410	410	$6,150
Meals for specialty and inpatient care	24	119	$2,975
Hospital companion	6	699	$2,272
2014 YTD GRAND TOTAL	74,419	96,544	$1,545,374

Value Added Benefits

United	Members YTD	Total Units YTD	Total Value YTD
Additional Vision Services	7,222	9,208	$449,600
Join for Me - Pediatric Obesity Classes*	35	35	$87,500
Adult Dental Services	1,475	1,528	$82,062
Annual Wellness Reminders	89,380	97,299	$61,298
Baby Blocks Program and Rewards	1,089	831	$49,361
Peer Bridgers Program	177	210	$47,628
Sesame Street - Food For Thought	982	988	$34,580
Weight Watchers - Free Classes	604	289	$34,391
Membership to Youth Organizations	566	681	$34,050
Infant Care Book for Pregnant Women	923	1,014	$13,182
Mental Health First Aid Program	114	133	$12,594
KAN Be Healthy Screening Age 3 to 19 - Debit Card Reward	957	957	$9,570
KAN Be Healthy Screening Age Birth to 30 months - Debit Card Reward	442	742	$7,420
Additional Podiatry Visits	69	47	$4,560
Asthma Bedding	104	81	$4,212
New Member Dental Exam - Debit Card Reward	277	354	$3,540
Coverage for Sports/School Physicals	128	45	$2,916
New Member Vision Exam - Debit Card Reward	207	255	$2,550
Join for Me - Reward for Completion of Program	209	35	$1,750
Weight Watchers Reward - Reward for Completing Classes	184	30	$1,500
Adult Biometric Screening - Debit Card Reward	86	94	$1,410
A is for Asthma	1,030	1,144	$572
Annual Vision Exam for Person with Diabetes - Debit Card Reward	89	15	$300
Annual A1C Exam - Debit Card Reward	17	15	$150
Follow-Up After Behavioral Health Hospitalization - Debit Card Reward	54	5	$125
Annual Monitoring for Persistent Medications - Debit Card Reward	11	12	$120
2014 YTD GRAND TOTAL	114,472	116,047	$946,942

Customer Service

MEMBER SERVICES MCO/Fiscal Agent Jan.-Sept. 2014	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:17	1.69%	132,616
Sunflower	0:19	2.45%	149,379
United	0:14	1.46%	124,272
HP – Fiscal Agent	0:00	.06%	5,103

PROVIDER SERVICES MCO/Fiscal Agent Jan.-Sept. 2014	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:19	1.19%	63,609
Sunflower	0:18	1.20%	88,329
United	0:11	.41%	56,037
HP – Fiscal Agent	0:00	.02%	6,599

Health Homes

- Health Homes for members with Serious Mental Illness – implemented July 1, 2014
- As of December, 2014
  - 34,151 members enrolled
  - Approximately 90 contracted Health Partners

Health Homes

- Seeing many early implementation success stories from members using Health Home service
- Sharing information and updates in many ways, including monthly Health Homes Herald Newsletter
- Example of success story

Q&A / Input / Suggestions / Next Steps

- Note Cards
  - Write out your question/suggestion
  - Include your name and phone # or email address for feedback
- Next Steps
  - Address what can here today
  - Follow up on individual questions/suggestions as needed
  - Summary of today's forum and your input/follow up will be included in the next KanCare quarterly report

More Information on: www.KanCare.ks.gov

A summary of the questions from participants, with responsive information provided, is as follows:

#	Public Forum Participant Question	Summary of Response
1	The waiver renewal calls for PD waiver consumers to move to the FE waiver when they turn 65. Is the FE waiver reimbursement going to be raised to the level of the PD wavier so Direct Support workers will not be taking a 40 cent an hour pay cut?	This proposal has generated a number of public comments, and we know a required transition at age 65 is a concern for some. The State will take those comments into account prior to submitting the waiver renewal Dec. 31. (Note: Subsequently, at the conclusion of the comment period, the State removed that provision.)
2	Will the final proposal of the TBI waiver be shared with providers/members prior to submission? Is the intent of the TBI waiver understood by the current administration, and are the values and cost savings noted? Per charts, HCBS is less costly – we need to keep members home rather than in facilities.	The waiver renewal application will be posted on the KDADS website when it is submitted, with a summary of changes based on public input. The State does value the TBI and other HCBS waivers, which help people remain in their homes and communities.
3	Have you made any progress on the FLSA home setting rule? Please share what you're going to do.	Kansas has proposed policy changes that will further clarify and assist self-directed consumers in their role as employer. The State is also closely following related litigation on this issue. No restrictions on services related to the Final Rule were proposed as part of the waiver renewals (for example, no new restrictions on work week).
4	When do you think case managers will stabilize? (i.e. decrease turnover) Is there a plan to improve notification when a case manager changes?	Clarified that the questions were indeed focused on the care coordinators who are employees of the MCO's. Provided these answers: Given the relative newness of the KanCare program, the state expected there would be some turnover of care coordination staff, and has monitored that issue consistently from the beginning of the program. Care coordination staffing has stabilized over time, and during 2014 the care coordinator positions vacated have ranged between 1 and 2.5 per month across the three MCOs. The state will continue to monitor this issue. The MCO's have notification plans in place when care coordinators change. If there are particular concerns with an MCO please let state staff know.
5	After adding the next group for chronic conditions into Health Homes, do you have plans to add other types of groups into the Health Home program, such as making I/DD a condition for enrollment into a Health Home?	Yes, following the implementation of the Chronic Conditions Health Home (Asthma and Diabetes), the plan would be to add additional groups to Health Homes. (The question came from an I/DD provider.) Specifically, if you have ideas relating to how the I/DD population could be included in Health Homes, we would welcome them.
6	KanCare contractors are still far behind on their payments to service providers. What can be done to facilitate these payments?	This is an issue that we continue to monitor closely, and review MCO performance regularly. Some additional improvement activities include: • Developing regulations to implement the inclusion of MCO payments to providers as part of Kansas' Prompt Pay Act (via HB2552 in the 2014 legislative session).

- Returning an enhanced performance in timeliness of claim payment as one of the Pay for Performance measures for 2015.
- Reviewing regular reporting from and conducting monthly meetings with MCO leadership and staff which includes review of claim payment issues and any related provider concerns.

#	Question	Response
7	Customer Service: Are there any statistics on call resolutions? Is there a breakdown between providers calling MCOs and how successful their questions were resolved? And is there a breakdown of consumers calling the MCOs and how successful their questions were answered?	Yes – a snapshot of customer service inquiries resolution is included in the KanCare Evaluation report that is attached to each of the state's KanCare Special Terms and Conditions reports (available at the KanCare website). From the latest report, this summary:

Table 1 - Timeliness of Resolution of Customer Service Inquiries

	CY2013				CY2014		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Number of Inquiries Received	261,286	181,427	157,547	146,374	141,964	133,570	**143,028**
Number of Inquiries Resolved Within 2 Business Days	260,859	180,903	157,185	146,299	141,907	133,539	**142,705**
Number of Inquiries Not Resolved Within 2 Business Days	298	524	362	75	57	27	**323**
Percent of Inquiries Resolved Within 2 Business Days	99.84%	99.71%	99.77%	99.95%	99.96%	99.98%	**99.77%**
Number of Inquiries Resolved Within 5 Business Days	261,286	181,427	157,458	146,349	141,951	133,570	**143,001**
Number of Inquiries Not Resolved Within 5 Business Days	0	0	89	25	13	0	**27**
Percent of Inquiries Resolved Within 5 Business Days	100%	100%	99.94%	99.98%	99.99%	100%	**99.98%**
Number of Inquiries Resolved Within 15 Business Days	261,286	181,427	157,547	146,374	141,964	133,570	**143,028**
Number of Inquiries Not Resolved Within 15 Business Days	0	0	0	0	0	0	**0**
Percent of Inquiries Resolved Within 15 Business Days	100%	100%	100%	100%	100%	100%	**100%**

Of the 143,028 customer service inquiries in the third quarter of calendar year 2014 (the most recent reporting period), 89,682 (62.7%) were from members, and 53,346 (37.3%) were from providers. For member inquiries, "resolved" means that the issue about which the member called was answered or addressed to conclusion. For provider inquiries, "resolved" can mean that the caller was referred to the correct MCO staff to get the inquiry answered or addressed to conclusion.

2014 KanCare Evaluation Annual Report

Year 2, CY2014, January - December 2014

KFMC Contract Number: 11231

Program(s) Reviewed: KanCare Demonstration

Submission Date: March 25, 2015

Review Team: Janice Panichello, Ph.D., MPA, Director of Quality Review and Epidemiologist
Lynne Valdivia, BSN, RN, MSW, CCEP, Vice President Quality Improvement and Review

Prepared for:

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2014 KanCare Evaluation Annual Report
Year 2, January-December 2014
March 25, 2015

Background

KanCare is an integrated managed care Medicaid program that is to serve 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 home and community based services (HCBS).

On 12/27/2012, the Centers for Medicare and Medicaid Services (CMS) approved the State of Kansas Medicaid section 1115 demonstration proposal, entitled KanCare. 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 individuals who are dually eligible) across Kansas into a managed care delivery system. This represents an expansion of the State's previous managed care program, which consisted of HealthWave (managed care organization), HealthConnect Kansas (primary care case management), Value Options-Kansas (VO) (substance abuse treatment), and provided services to children, pregnant women, and parents in the State's Children's Health Insurance Program (CHIP) and Medicaid 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 are presumptively enrolled in KanCare but 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;
- 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, and 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 being 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 CMS 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 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.

The KanCare Evaluation Design, approved by CMS on 9/11/2013, includes over 100 performance measures focused on seven major categories:

- Quality of Care
- Coordination of Care (and Integration)
- Cost of Care
- Access to Care
- Ombudsman Program
- Efficiency
- Uncompensated Care Cost Pool
- Delivery System Reform Incentive Program (DSRIP)

These eight categories have 27 subcategories (see Table 1). Over the five-year KanCare demonstration, performance measures will be evaluated on either a quarterly basis or an annual basis.

Due to revisions in reporting requirements, program updates, and changes in HEDIS measure specifications, a few measures were deleted, and several measures in the 2013 KanCare Evaluation Design were added or were slightly revised.

Data for the performance measures are provided by the Kansas Department of Health and Environment Division of Health Care Finance (KDHE-DHCF) and the Kansas Department for Aging and Disability Services (KDADS). Data sources include state tracking systems and databases, as well as reports from the MCOs providing KanCare/Medicaid services. In calendar year (CY) 2013 and CY2014, the three managed care organizations are Amerigroup Kansas, Inc. (Amerigroup or AGP),

Sunflower State Health Plan (Sunflower or SSHP), and UnitedHealthcare Community Plan of Kansas (UnitedHealthcare or UHC). In CY2012, the MCOs providing Medicaid services were Coventry Health Care of Kansas, UniCare, Kansas Health Solutions, and Value Options of Kansas.

Table 1: 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) Home and Community Based Services (HCBS) Waiver Services
(6) Long Term Care: Nursing Facilities
(7) Member Surveys - Quality
(8) Provider Survey
(9) Grievances
(10) Other (Tentative) Studies (specific studies to be determined)
Coordination of Care (and Integration)
(11) Care Management for Members Receiving HCBS Services
(12) Other (Tentative) Study (specific study to be determined)
(13) Care Management for Members with I/DD
(14) Member Survey - CAHPS
(15) Member Survey - Mental Health (MH)
(16) Member Survey - Substance Use Disorder (SUD)
(17) Provider Survey
Cost of Care
(18) Costs
Access to Care
(19) Provider Network - GeoAccess
(20) Member Survey - CAHPS
(21) Member Survey - MH
(22) Member Survey - SUD
(23) Provider Survey
(24) Grievances
Ombudsman Program
(25) Calls and Assistance
Efficiency
(26) Systems
(27) Member Surveys
Uncompensated Care Pool
Delivery System Reform Incentive (DSRIP)

Wherever appropriate, and where data are available, performance measures will be analyzed by one or more of the following stratified populations:

- Program - Title XIX (Medicaid) and Title XXI (CHIP)
- Age groups - particularly where stratified in Healthcare Effectiveness Data and Information Set (HEDIS) measures, waivers, and survey populations
- Waiver services
  - Intellectually/Developmentally Disabled (I/DD)
  - Physically Disabled (PD)
  - Traumatic Brain Injury (TBI)
  - Technical Assistance (TA)
  - Serious Emotional Disturbance (SED)
  - Frail Elderly (FE)
  - Money Follows the Person (MFP), and
  - 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

ANNUAL EVALUATION CALENDAR YEAR (CY) 2014

In the first year of KanCare, baseline data and data criteria were established and defined. For some of the performance measures, baseline data are available pre-KanCare. Where pre-KanCare data are not available, baseline data are based on CY2013 data or, for measures that require more than one year of data, CY2013/CY2014.

This second annual KanCare Evaluation includes analysis of performance for several measures that have pre-KanCare data, CY2013 data, and CY2014 available as of March 1, 2015. Data for CY2014 for many of the performance measures are not yet available. A major reason is that data for the entire year cannot be determined accurately until claims for the year, including fourth quarter CY2014 claims, are more complete (submitted to the MCOs and processed). Several measures are based on standardized HEDIS data analysis, and HEDIS data for 2014 will not be available until July 2015. Some of the HEDIS measures are multi-year measures; for these measures, baseline data for 2013 and 2014 will be analyzed in the KanCare Annual Evaluation for 2015. For measures where pre-KanCare data are available but no CY2014 data are available, this annual report will provide a summary of the data sources, baseline data sources, populations, and timelines for data availability for comparison in future annual reports.

In addition to the measures reviewed annually, there are several measures reviewed quarterly that are briefly summarized in this report. These quarterly measures are analyzed and summarized in detail in the KanCare Evaluation Quarterly Reports, beginning in Quarter 4 (Q4), CY2013, that are available for public review on the KanCare website.

QUALITY OF CARE

Goals, Related 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).

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.*

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 physical health, behavioral health, mental health, substance use disorder, and LTSS.*

(1) Physical Health

The Physical Health performance measures include 18 HEDIS measures:
- Comprehensive Diabetes Care (CDC),
- 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),
- Adolescent Well-Care Visits (AWC),
- Adults' Access to Preventive/Ambulatory Health Services (AAP),
- Annual Monitoring for Patients on Persistent Medications (MPM),
- Medication Management for People with Asthma (MMA),
- Follow-Up Care for Children Prescribed ADHD Medication (ADD),
- Follow-Up after Hospitalization for Mental Illness (FUH);,
- Prenatal and Postpartum Care (PPC),
- Chlamydia Screening in Women (CHL),
- Controlling High Blood Pressure (CBP),
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET),

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC),
- Adult BMI Assessment (ABA),
- Annual Dental Visit (ADV),
- Appropriate Treatment for Children with Upper Respiratory Infection (URI), and
- Appropriate Treatment for Children with Pharyngitis).

Other Physical Health measures include Well-Child Visits (four or more) within the first seven months of life (HEDIS-like measure) and Preterm Birth.

The baseline data for the HEDIS and HEDIS-like measures are HEDIS 2014 (CY2013) administrative and hybrid data from claims and medical record review. Administrative HEDIS data include all KanCare members from each MCO who met HEDIS eligibility criteria for each measure. Since these measures include all eligible members, the numerators and denominators for the three MCOs were combined to assess the aggregate baseline percentages. Hybrid HEDIS data are based on samples of eligible members and include both administrative data and medical record review. As the hybrid HEDIS data are based on samples from each MCO, the aggregate data for hybrid measures were weighted to adjust for any differences in population and sample sizes. Amerigroup and Sunflower did not sample Title XIX and Title XXI separately for hybrid HEDIS measures, while UnitedHealthcare had separate samples not only for Title XIX and Title XXI, but also for members in longer term care. Before aggregating the data for the three MCOs, KFMC first calculated a weighted percentage for UnitedHealthcare's three sample groups. The aggregated percentages were compared to National Committee for Quality Assurance (NCQA) Quality Compass (QC) percentiles for HEDIS 2014 (CY2013).

HEDIS results, including comparison to QC national percentiles are summarized in Table 2. Four HEDIS measures that have multi-year eligibility criteria are also listed in Table 2.

Pre-KanCare data available for some of the HEDIS measures below (CDC, W15, W34, AAP, and PPC) are based on HEDIS data for CY2012 from MCOs (Coventry and UniCare) that provided services to Kansas Medicaid members in 2012. The pre-KanCare and KanCare populations, however, are not directly comparable, as the KanCare populations include members receiving waiver services.

Table 2: Physical Health HEDIS 2014 Measures for Calendar Year 2013

Measure	Type		2014 HEDIS Aggregated Results (CY2013 Percentages)	Quality Compass 50th Percentile Comparison		
	Hybrid	Admin.	%	Above	Below	N/A
Comprehensive Diabetes Care						
HbA1c Testing (P4P)	X		83.1%		X	
Eye Exam (P4P)	X		50.1%		X	
Medical Attention for Nephropathy (P4P)	X		75.8%		X	
HbA1c Control (<8.0%) (P4P)	X		39.0%		X	
HbA1c Control (<7.0%)	X		26.5%		X	
HbA1c Poor Control (>9.0%) (lower % is goal)	X		54.4%		X	
Blood Pressure Control (<140/90) (P4P)	X		53.1%		X	
LDL-C Screening	X		67.0%		X	
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life						
	X		60.8%		X	
Adolescent Well Care Visits						
		X	42.3%		X	
Adults' Access to Preventive/Ambulatory Health Services (P4P)						
Ages 20-44	X		85.4%	X		
Ages 45-64	X		92.2%	X		
Ages 65 and older	X		89.5%	X		
Ages 20 and older	X		88.4%	X		
Annual Monitoring for Patients on Persistent Medications						
		X	84.9%		X	
Follow-up after Hospitalization for Mental Illness, within seven days of discharge						
		X	61.0%	X		
Prenatal Care						
	X		71.4%		X	
Postpartum Care						
	X		58.5%		X	
Chlamydia Screening in Women						
Ages 16-20			42.4%		X	
Ages 21-24		X	55.6%		X	
Total – Ages 16-24			46.1%		X	
Controlling High Blood Pressure						
	X		47.3%		X	
Initiation in Treatment for Alcohol or other Drug Dependence						
Ages 13-17			49.0%	X		
Ages 18 and older		X	40.9%	X		
Total – Ages 13 and older			42.1%	X		

Table 2: Physical Health HEDIS 2014 Measures for Calendar Year 2013 (Continued)						
Measure	Type		2014 HEDIS Aggregated Results (CY2013 Percentages)	Quality Compass 50th Percentile Comparison		
	Hybrid	Admin.	%	Above	Below	N/A
Engagement in Treatment for Alcohol or other Drug Dependence						
Ages 13-17		X	32.5%	X		
Ages 18 and older			12.2%	X		
Total – Ages 13 and older			15.2%	X		
Weight Assessment/BMI for Children and Adolescents						
Ages 3-11	X		33.7%		X	
Ages 12-17			36.6%		X	
Total – Ages 3-17			34.7%		X	
Counseling for Nutrition for Children and Adolescents						
Ages 3-11	X		47.4%		X	
Ages 12-17			46.0%		X	
Total – Sges 3-17			46.9%		X	
Counseling for Physical Activity for Children and Adolescents						
Ages 3-11	X		39.6%		X	
Ages 12-17			53.1%		X	
Total – Ages 3-17			44.0%		X	
Annual Dental Visit						
Ages 2-3		X	40.8%	X		
Ages 4-6			66.3%	X		
Ages 7-10			70.7%	X		
Ages 11-14			62.8%	X		
Ages 15-18			53.9%	X		
Ages 19-21			31.5%	X		
Total - Ages 2-21			60.3%	X		
Appropriate Treatment for Children with Upper Respiratory Infection						
		X	71.9%		X	
Appropriate Testing for Children with Pharyngitis						
		X	51.6%		X	
Multi-Year HEDIS Measures to be Reported beginning with HEDIS 2015						
Well-Child Visits in the First 15 Months of Life						
Medication Management for People with Asthma						
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication						
Adult BMI						

HEDIS measures

- **Comprehensive Diabetes Care**
  This measure is a composite HEDIS measure composed of eight metrics. Five of these metrics are pay-for-performance (P4P) measures. In CY2013, the three MCOs reported hybrid data for each of these eight measures. All eight of the aggregated percentages were below the QC 50th percentile; four of these eight measures were below the QC 25th percentile (noted below). However, all eight of these percentages were higher than the pre-KanCare aggregated rates for CY2012.
  - Population: Ages 18-75; Medicaid
  - Analysis: Pre-KanCare compared to KanCare and trending over time
  - **HbA1c Testing** (P4P) **-** The KanCare aggregate percentage based on weighted hybrid data for CY2013 was 83.1% (compared to the CY2012 pre-KanCare aggregate percentage of 76.5%). One MCO, AGP, was just above the QC 50th percentile.
  - **Eye Exam** (P4P) - The KanCare aggregate percentage based on weighted hybrid data for 2013 was 50.1% (CY2012 - 41.7%). One MCO, UHC, was above the QC 50th percentile.
  - **Medical Attention for Nephropathy** (P4P) - The KanCare aggregate percentage based on weighted hybrid data for 2013 was 75.8% (CY2012 - 66.3%).
  - **HbA1c Control (<8.0%)** (P4P) - The KanCare aggregate percentage based on weighted hybrid data for 2013 was 39.0% (CY2012 - 16.0%).
  - **HbA1c Control (<7.0%)** - Only one of the MCOs reported hybrid data for this metric. The 26.5% result was below the 25th QC percentile, but above the CY2012 pre-KanCare percentage of 13.3%.
  - **HbA1c Poor Control (>9.0%)** - The KanCare aggregate percentage based on weighted hybrid data for 2013 was 54.4% (CY2012 - 83.4%). (Lower rates for this measure are the goal.) The CY2013 rate was below the QC 25th percentile.
  - **Blood Pressure Control (<140/90)** (P4P) - The KanCare aggregate percentage based on weighted hybrid data for CY2013 was 53.1%. This percentage was below the QC 25th percentile, but above the CY2012 pre-KanCare percentage of 12.8%.
  - **LDL-C Screening** - The KanCare aggregate percentage based on weighted hybrid data for CY2013 was 67.0% (CY2012 - 54.1%). This percentage was below the QC 25th percentile.
- **Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life**
  - Population: Ages 3-6; Medicaid and CHIP combined populations
  - Analysis: Pre-KanCare compared to KanCare and trending over time
    The KanCare aggregate percentage based on administrative data for CY2013 was 60.8%. This percentage was below the QC 25th percentile. The CY2012 pre-KanCare aggregate percentage was higher at 65.4%.
- **Adolescent Well Care Visits**
  - Population: Ages 12-21; Medicaid and CHIP combined populations
  - Analysis: Annual comparison to CY 2013 baseline, and trending over time

The KanCare aggregate percentage based on administrative data for CY2013 was 42.3%. This percentage was below the QC 50th percentile (and above the 25th QC percentile).

- **Adults' Access to Preventive/Ambulatory Health Services**
  In each of the age ranges, the aggregate HEDIS results for CY2013 were above the QC 50th percentile, and for ages 45-64, were at the QC 90th percentile. Pre-KanCare data was available for ages 20-44 and ages 45-64; for ages 20-44, the pre-KanCare percentage was slightly higher, and for ages 45-64 the pre-KanCare percentage was lower.
  - Population: Ages 20-44; 45-65; 65 and older; Total (P4P); Medicaid
  - Analysis: Annual comparison to CY2013 baseline, trending over time
  - **Ages 20-44 -** The KanCare aggregate percentage based on administrative data for CY2013 was 85.4%. One MCO, SSHP, was above the 75th percentile. In CY2012, the aggregate pre-KanCare percentage was slightly higher at 86.1%.
  - **Ages 45-64 -** The KanCare aggregate percentage based on administrative data for CY2013 was 92.2%, which was above the QC 90th percentile. In CY2012, the aggregate pre-KanCare percentage was lower at 87.8%.
  - **Ages 65 and older -** The KanCare aggregate percentage based on administrative data for CY2013 was 89.5%. (Pre-KanCare data was not reported by the MCOs for CY2012 for those ages 65 and older.)
  - **Total – Ages 20 and older -** The KanCare aggregate percentage based on administrative data for CY2013 was 88.4%, which was above the 75th percentile. For CY2012, no pre-KanCare data for Kansas MCOs were available.
- **Annual Monitoring for Patients on Persistent Medications** (P4P)
  - Population: Medicaid, Age 18 and older
  - Analysis: Annual comparison to CY2013 baseline, trending over time
    The KanCare aggregate percentage based on administrative data for CY2013 was 84.9%. This percentage was below the QC 50th percentile (and above the 25th QC percentile).
- **Follow-up after Hospitalization for Mental Illness, within seven days of discharge** (P4P)
  - Population: Medicaid and CHIP combined populations
  - Analysis: Annual comparison to CY2013 baseline, trending over time.
    The KanCare aggregate percentage based on administrative data for CY2013 was 61.0%. This percentage was above the QC 75th percentile. One MCO, SSHP, was above the QC 90th percentile.
- **Prenatal Care**
  - Population: Medicaid and CHIP combined populations
  - Analysis: Pre-KanCare compared to KanCare and trending over time.
    The KanCare aggregate rate based on weighted hybrid data for CY2013 was 71.4%. This percentage was below the QC 50th percentile (and above the 25th QC percentile). The CY2012 hybrid percentage available from one of the pre-KanCare MCOs was lower at 57.9%.
- **Postpartum Care**
  - Population: Medicaid and CHIP combined populations
  - Analysis: Pre-KanCare compared to KanCare and trending over time.

The KanCare aggregate percentage based on weighted hybrid data for CY2013 was 58.5%. This percentage was below the QC 50th percentile (and above the 25th QC percentile). The CY2012 hybrid percentage available from one of the pre-KanCare MCOs was lower at 54.8%.

- **Chlamydia Screening in Women**
  The CY2013 aggregate total percentage of women ages 16-24 in KanCare who were screened for chlamydia, and percentages for both age strata, were below the QC 25th percentile (administrative HEDIS data).
  - Population: Medicaid and CHIP combined populations
  - Analysis: Annual comparison to CY2013 baseline and trending over time.
  - **Ages 16-20** - 42.4%.
  - **Ages 21-24** - 55.6%.
  - **Total – Ages 16-24** - 46.1%.
- **Controlling High Blood Pressure**
  - Population: Medicaid
  - Analysis: Annual comparison to CY2013 baseline, trending over time
    The KanCare aggregate percentage based on weighted hybrid data for CY2013 was 47.3%. This percentage was below the QC 25th percentile.
- **Initiation in Treatment for Alcohol or other Drug Dependence**
  The CY2013 aggregate HEDIS results for the total eligible KanCare population and for both age strata were above the QC 50th percentile. For those ages 13-17, the aggregate HEDIS results were above the QC 75th percentile.
  - Population: Medicaid and CHIP combined populations
  - Analysis: Annual comparison to CY2013 baseline, trending over time.
  - **Ages 13-17** - The KanCare aggregate percentage based on administrative data for CY2013 was 49.0% (above the QC 75th percentile).
  - **Age 18 and older** - The KanCare aggregate percentage based on administrative data for CY2013 was 40.9%. One MCO, UHC, was above the QC 75th percentile.
  - **Total – Age 13 and older** - The KanCare aggregate percentage based on administrative data for 2013 was 42.1%. One MCO, UHC, was above the QC 75th percentile.
- **Engagement in Treatment for Alcohol or other Drug Dependence**
  The CY2013 aggregate HEDIS results for the total population were above the QC 75th percentile. For those ages 13-17, the aggregate HEDIS results were above the QC 90th percentile, while the aggregate HEDIS results for those ages 18 and older were above the 50th percentile. It should be noted, however, that the national HEDIS percentages for engagement in treatment are not very high; although the total results for the KanCare population in CY2013 were above the QC 75th percentile, only 12.2% of eligible members ages 13 and older met the criteria for engagement in treatment. As per initiation in treatment above, those ages 13-17 had much higher rates of engagement in treatment than those ages 18 and above.
  - Population: Medicaid and CHIP combined populations
  - Analysis: Annual comparison to CY2013 baseline and trending over time
  - **Ages 13-17** - The KanCare aggregate percentage based on administrative data for CY2013 was 32.5% (above the QC 90th percentile).

- **Age 18 and older** - The KanCare aggregate percentage based on administrative data for CY2013 was only 12.2%, but the percentage was above the QC 50th percentile.
- **Total – Ages 13 and older** - The KanCare aggregate percentage based on administrative data for CY2013 was 15.2%. This percentage was above the QC 75th percentile.

- **Weight Assessment/BMI for Children and Adolescents**
  CY2013 aggregate weighted hybrid HEDIS results for each age strata (ages 3-11; ages 12-17: and ages 3-17) were all below the QC 25th percentile.
  - Population: Medicaid and CHIP combined populations
  - Analysis: Annual comparison to CY2013 baseline and trending over time
  - **Ages 3-11** - 33.7%.
  - **Ages 12-17** - 36.6%.
  - **Total – Ages 3-17** - 34.7%.
- **Counseling for Nutrition for Children and Adolescents**
  The CY2013 aggregate weighted hybrid HEDIS results for those in KanCare ages 3-11 and for the total eligible population (ages 3-17) were below the QC 25th percentile. For those ages 12-17, the aggregate HEDIS results were above the QC 25th percentile (and below the 50th percentile).
  - Population: Medicaid and CHIP combined populations
  - Analysis: Annual comparison to CY2013 baseline and trending over time
  - **Ages 3-11** - 47.4%.
  - **Ages 12-17** - 46.0%.
  - **Total – Ages 3-17** - 46.9%.
- **Counseling for Physical Activity for Children and Adolescents**
  The CY2013 aggregate weighted hybrid HEDIS results for each age strata (ages 3-11; ages 12-17: and ages 3-17) were below the QC 50th percentile (and above the QC 25th percentile. The results for one MCO, UHC, however, were above the QC 50th percentile for each age range; SSHP also had percentages above the QC 50th percentile for the 12-17 age range.
  - Population: Medicaid and CHIP combined populations
  - Analysis: Annual comparison to CY2013 baseline and trending over time
  - **Ages 3-11** - 39.6%.
  - **Ages 12-17** - 53.1%.
  - **Total – Ages 3-17** - 44.0%.
- **Annual Dental Visit**
  The CY2013 aggregate (administrative) HEDIS results (listed below) for KanCare for each age range except ages 19-21 were above the QC 50th percentile. The QC percentile for those ages 19-21 were below the QC 50th percentile (and above the QC 25th percentile).
  - Population: 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)
  - Analysis: Annual comparison to CY2013 baseline and trending over time
  - **Ages 2-3** – 40.8%.
  - **Ages 4-6** - 66.3%.
  - **Ages 7-10** - 70.7%.
  - **Ages 11-14** - 62.8%.

  - **Ages 15-18** - 53.9%.
  - **Ages 19-21** - 31.5%.
  - **Total - Ages 2-21** - 60.3%.
- **Appropriate Treatment for Children with Upper Respiratory Infection (URI)**
  - Population: Medicaid and CHIP combined populations
  - Analysis: Annual comparison to CY2013 baseline and trending over time.
    The KanCare aggregate percentage based on administrative data for CY2013 was 71.9%. This percentage was below the QC 10th percentile.
- **Appropriate Testing for Children with Pharyngitis**
  - Population: Medicaid and CHIP combined populations
  - Analysis: Annual comparison to 2013 baseline and trending over time
    The KanCare aggregate percentage based on administrative data for CY2013 was 51.6%. This percentage was below the QC 25th percentile.

Multi-year HEDIS measures

The eligibility criteria for the following HEDIS measures extend beyond one year. Data for CY2013 and CY2014 will be reported in HEDIS 2015 and will serve as baselines for assessing changes in subsequent years. Comparison analyses will be completed in the CY2015 annual KanCare evaluation report.

- **Well-Child Visits in the First 15 Months of Life**
  - Population: Age through 15 months; Medicaid and CHIP combined populations
  - Analysis: Pre-KanCare compared to KanCare and trending over time
- **Medication Management for People with Asthma**
  - Population: Ages 5-11, 12-18, 19-50, 51-65; Medicaid and CHIP combined populations
  - Analysis: Annual comparison to 2013/2014 baseline and trending over time
- **Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication**
  - Population: Ages 6-12; Medicaid and CHIP combined populations
  - Analysis: Annual comparison to 2013/2014 baseline and trending over time
- **Adult BMI**
  - Population: Medicaid and CHIP combined populations
  - Analysis: Annual comparison to 2013/2014 baseline, trending over time

Additional P4P Physical Health Measures

- **Well-Child Visits, four visits within the first seven months of life** (P4P)
  For this P4P measure, the MCOs are reporting the percentage of children who have four or more well-child visits within the first seven months (post-discharge after birth). This measure is HEDIS-like, in that the HEDIS criteria and software for the Well-Child Visits within the first 15 months of Life (W15) was adapted to include well-child visits only within the first seven month.
  - Population: Medicaid and CHIP combined populations
  - Analysis: Annual comparison to 2013 baseline, trending over time
    This measure is being validated in March/April 2015 by the EQRO. Comparison analyses will be completed in the third annual KanCare evaluation report.

- **Preterm Birth** (P4P)
  - Population: Medicaid and CHIP combined populations
  - Analysis: Annual comparison to 2013 baseline, trending over time
    Preterm birth rates in 2013 to Medicaid and CHIP members are the baseline data. Each MCO uses unique systems for tracking preterm births. This measure is being validated in March/April 2015 by the EQRO. Comparison analyses will be completed in the CY2015 annual KanCare evaluation report.

(2) Substance Use Disorder (SUD) Services

The following performance measures are based on National Outcome Measurement System (NOMS) measures for members who are receiving SUD services, including improvement in living arrangements; reduction in number of arrests; reduction in drug and alcohol use; attendance at self-help meetings; and employment status. Each of these measures will be tracked annually and for trends over time, comparing pre-KanCare (CY2012) with each year of the KanCare demonstration project.

In the following SUD measures, members may be included in more than one quarter of data (or may be counted more than once in a quarter), as they may be discharged from SUD treatment in one month, but re-enter treatment later in the quarter or year. The denominators in the tables below represent the number of times members were discharged from SUD treatment during the quarter. The actual number of individual members who received SUD services in CY2014 is not reported.

Recommendation: Where possible, the State should report the total number of unduplicated members discharged from SUD services during the year, as well as the number of members who were discharged from SUD services more than once during the year. Reporting these counts would give a clearer picture of the scope and impact of the SUD services provided.

For the SUD performance measures below, CY2014 fourth quarter results were compared with CY2012 and CY2013 to assess general trends over time.

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

The denominator for this performance measure is the number of KanCare members who were discharged from SUD services during the measurement period, and whose living arrangement details were collected by KDADS in the Kansas Client Placement Criteria (KCPC) state tracking system (see Table 3). The numerator is the number of members with stable living situations at time of discharge from SUD services.

Analysis: Data for this measure are tracked and reported quarterly by KDADS. The percentages of members in stable living conditions at time of discharge from SUD services were consistently high throughout CY2012 through CY2014. In Q4 CY2014 99.3% were in stable living situations at time of discharge, up from 98.9% in Q4 CY2013.

Table 3: Number and percent of members receiving SUD services who were in stable living situations at discharge - CY2012, CY2013, and CY2014												
	Pre-KanCare				KanCare							
	CY2012				CY2013				CY2014			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of KanCare members in stable living situations at discharge	190	234	178	195	262	251	183	177	172	237	197	148
Denominator: Number of KanCare-members discharged from SUD services during the reporting period	190	238	180	197	264	254	184	179	174	238	198	149
Percent of KanCare members in stable living situations at discharge from SUD services	**100%**	**98.3%**	**98.9%**	**99.0%**	**99.2%**	**98.8%**	**99.5%**	**98.9%**	**98.9%**	**99.6%**	**99.5%**	**99.3%**

The number and percent of members receiving SUD services whose criminal justice involvement improved

The denominator for this measure is the number of members who were discharged from SUD services during the measurement period and whose criminal justice involvements were collected in the KCPC system at both admission and discharge from SUD services (see Table 4). The numerator is the number of episodes of care in which members reported no arrests in the prior 30 days at both admission and discharge, or that reported fewer arrests at discharge than at admission to SUD services.

Table 4: Number and percent of members receiving SUD services whose criminal justice involvement decreased - CY2012, CY2013, and CY2014												
	Pre-KanCare				KanCare							
	CY2012				CY2013				CY2014			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of members without arrests	190	235	177	195	261	253	183	178	173	234	196	148
Denominator: Number of members discharged from SUD services during reporting period	190	238	180	197	264	254	184	179	174	238	198	149
Percent of members without arrests during reporting period	**100%**	**98.7%**	**98.3%**	**99.0%**	**98.9%**	**99.6%**	**99.5%**	**99.4%**	**99.4%**	**98.3%**	**99.0%**	**99.3%**

Analysis: Data for this measure are tracked and reported quarterly by KDADS. Quarterly rates of those without arrests were over 98% for each quarter of CY2012 through CY2014. In CY2014, quarterly rates were 99.0% or higher for Q1, Q2, and Q4.

The number and percent of members, receiving SUD services, whose drug and/or alcohol use decreased

The denominator for this measure is the number of members who were discharged from SUD services during the measurement period, and whose substance use was collected in KCPC at both admission and discharge (see Table 5). The numerator is the number of members who reported at discharge no use of alcohol and other drugs for the prior 30 days.

Table 5: Number and percent of members receiving SUD services with decreased drug and/or alcohol use - CY2012, CY2013, and CY2014												
	Pre-KanCare				KanCare							
	CY2012				CY2013				CY2014			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of members discharged from SUD services who were abstinent from alcohol and other drugs	185	221	172	187	244	242	173	170	170	229	185	141
Denominator: Number of KanCare members discharged from SUD services during reporting period	189	238	180	196	263	254	184	179	174	238	198	149
Percent of members abstinent from alcohol and other drugs at time of discharge from SUD services	**97.9%**	**92.9%**	**95.6%**	**95.4%**	**92.8%**	**95.3%**	**94.0%**	**95.0%**	**97.7%**	**96.2%**	**93.4%**	**94.6%**

Analysis: The quarterly percentages of decreased use of alcohol and other drugs were above 90% in each quarter of CY2012 through CY2014. In CY2014 the percentages were higher in Q1 (97.7%) and Q2 (96.2%) than in Q3 (93.4%) and Q4 (94.6%).

The number and percent of members, receiving SUD services, whose attendance of self-help meetings increased

The denominator for this measure is the number of members who were discharged from SUD services during the measurement period, and whose attendance at self-help programs was collected in KCPC at both admission and discharge from SUD treatment services (see Table 6). The numerator is the number of members who reported attendance at self-help programs prior to discharge from SUD services.

Table 6: Number and percent of members receiving SUD services attending self-help programs - CY2012, CY2013, and CY2014												
	Pre-KanCare				KanCare							
	CY2012				CY2013				CY2014			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of KanCare members attending self-help programs	117	136	108	121	123	98	82	70	81	123	71	63
Denominator: Number of KanCare members discharged from SUD services during reporting period	190	238	180	197	264	254	184	179	174	238	198	149
Percent of KanCare members attending self-help programs	**61.6%**	**57.1%**	**60.0%**	**61.4%**	**46.6%**	**38.6%**	**44.6%**	**39.1%**	**46.6%**	**51.7%**	**35.9%**	**42.3%**

Analysis: The CY2013 KanCare Evaluation Annual Report analysis of this measure noted a statistically significant decrease ($p<0.001$) when comparing reported increases in self-help meeting attendance in Q4 CY2012 with reports of attendance in Q4 CY2013. In Q4 CY2012, 61.4% of members receiving SUD services reported increased attendance, while in Q4 CY2013 only 39.1% of members reported increased attendance. This trend appears to be continuing in CY2014. While attendance increased to 46.6% in Q1 2014 and again increased in Q2 to 51.7%, reported attendance dropped in Q3 to 35.9%, followed by an increase to 42.3% in Q4 2014. Reported attendance is much lower in CY2013 and CY2014 than in pre-KanCare CY2012.

Recommendations:

- MCOs should work with SUD treatment providers to identify barriers to meeting attendance and to identify any regional differences in attendance rates.
- KFMC again this year recommends that the SUD survey be considered as a potential tool to gain information on reasons for poor attendance.
- A major focus of the Sunflower AOD performance improvement project (PIP) is to increase partnerships between providers and care coordinators and generate ideas to increase engagement in treatment. These partnerships can be opportunities for additional feedback from members and providers on barriers and to generate ideas for improving attendance.

The number and percent of members receiving SUD services whose employment status was improved or maintained (P4P)

The denominator for this measure is the number of members, ages 18 and older at admission to SUD services, who were discharged from SUD services during the measurement period, and whose employment status was collected in the KCPC database at both admission and discharge (see Table 7). The numerator is the number of members who reported for the 30 days prior to discharge from SUD services that they maintained employment at both admission and discharge, or that reported that they were employed at discharge.

Table 7: Number and percent of members discharged from SUD services during the quarter who were employed - CY2012, CY2013, and CY2014

	Pre-KanCare				KanCare							
	CY2012				CY2013				CY2014			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of KanCare members employed (full-time or part-time)	62	74	54	49	78	78	61	63	54	117	75	56
Denominator: Number of KanCare members discharged from SUD services during reporting period	190	238	180	197	264	254	184	179	174	238	198	149
Percent of members employed (full-time or part-time) who were discharged from SUD services during the quarter	**32.6%**	**31.1%**	**30.0%**	**24.9%**	**29.5%**	**30.7%**	**33.2%**	**35.2%**	**31.0%**	**49.8%**	**37.9%**	**37.6%**

Analysis: In CY2014, this measure was revised to focus on reporting the percentages of KanCare members discharged from SUD services during each quarter who were employed full-time or part-time.

(3) Mental Health Services

The following performance measures are based on NOMS for members who are receiving mental health services, including adults with SPMI and youth experiencing SED. Measures focus on increased access to services for SPMI adults and SED youth (P4P); improvement in housing status for homeless adults; improvement or maintenance of residential status for youth; gain or maintenance of employment status for SPMI adults (P4P); improvement in Child Behavior Checklist (CBCL) Competence scores; and reduction in inpatient psychiatric services (P4P). Each of these measures

will be tracked annually and for trends over time, comparing pre-KanCare (CY2012) with each year of the KanCare demonstration project.

In the following measures, members may be included in more than one quarter of data, as housing and employment status may change throughout the year. Members may also have more than one inpatient admission during the year (or within a quarter).

The number and percent of adults with SPMI who had increased access to services (P4P)
The denominator for this measure is the number of KanCare adults with SPMI at the beginning of each quarterly measurement period (see Table 8). The numerator is the number of KanCare adults with SPMI with increased access to services by the end of the quarterly measurement period.

Table 8: Number and percent of KanCare adults with SPMI who had increased access to services - CY2012, CY2013, and CY2014

	Pre-KanCare				KanCare							
	CY2012				CY2013				CY2014			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of KanCare adults with SPMI with increased access to services	7,949	7,991	8,104	8,161	5,761	5,763	5,763	5,694	5,641	5,578	5,300	5,241
Denominator: Number of KanCare adults with SPMI	121,927	124,211	124,153	124,334	125,624	126,952	126,952	125,790	128,786	130,485	134,870	133,815
Percent of SPMI adults who had increased access to services	6.5%	6.4%	6.5%	6.6%	4.6%	4.5%	4.5%	4.5%	4.4%	4.3%	3.9%	3.9%
Adult access rate per 10,000	**651.9**	**643.3**	**652.7**	**656.4**	**458.6**	**454.0**	**454.0**	**452.7**	**438.0**	**427.5**	**393.0**	**391.7**

Analysis: The number of KanCare adults with SPMI has increased each year from CY2012 to CY2014. The number and percent of these adults with increased access to services have decreased each quarter and each year.

The number and percent of youth experiencing SED who had increased access to services (P4P)
The denominator for this measure is the number of KanCare youth experiencing SED at the beginning of each measurement period (see Table 9). The numerator is the number of KanCare youth experiencing SED with increased access to services by the end of the measurement period.

Analysis: The number of KanCare youth with SED has increased each quarter and each year from CY2012 to CY2014. The number and percent of these youth with increased access to services have decreased each quarter and each year.

Table 9: Number and percent of KanCare youth experiencing SED who had increased access to services - CY2012, CY2013, and CY2014												
	Pre-KanCare				KanCare							
	CY2012				CY2013				CY2014			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of SED youth with increased access to services by the end of the measurement period	14,496	14,860	15,053	15,340	12,012	11,934	11,997	11,994	12,032	11,956	10,721	10,634
Denominator: Number of KanCare SED youth	264,905	266,709	268,968	270,570	272,938	272,594	275,031	276,739	279,314	285,985	287,499	283,969
Percent of SED youth with increased access to services	5.5%	5.6%	5.6%	5.7%	4.4%	4.4%	4.4%	4.3%	4.3%	4.2%	3.7%	3.7%
Youth access rate per 10,000	**547.2**	**557.2**	**559.7**	**567.0**	**440.1**	**437.8**	**436.2**	**438.2**	**430.8**	**418.1**	**372.9**	**374.5**

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 denominator for this measure is the number of KanCare homeless adults with SPMI at the beginning of each measurement period (see Table 10). The numerator is the number of KanCare adults with SPMI with improvement in their housing status by the end of the measurement period.

Table 10: Number and percent of members with SPMI who were homeless at the beginning of the reporting period that were housed at the end of the reporting period - CY2012, CY2013, and CY2014												
	Pre-KanCare				KanCare							
	CY2012				CY2013				CY2014			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of KanCare adults with SPMI who were homeless at the beginning of reporting period that were housed at the end of the reporting period	52	63	78	81	54	60	65	53	32	30	46	30
Denominator: Number of KanCare adults with SPMI who were homeless at the beginning of the reporting period	126	140	164	169	101	100	103	96	64	64	84	69
Percentage of adults with SPMI who were homeless at the beginning of the reporting period who were housed by the end of the reporting period	**41.3%**	**45.0%**	**47.6%**	**47.9%**	**53.5%**	**60.0%**	**63.1%**	**55.2%**	**50.0%**	**46.9%**	**54.8%**	**43.5%**

Analysis: In CY2012, housing status improved for 41.3% of homeless members in Q1, increasing to 47.9% by Q4. In CY2013, housing status improved even more, with quarterly rates ranging from 53.5% (Q1) to a high of 63.1% in Q3. The total number of homeless adults with SPMI dropped from 169 in Q4 CY2012 to only 96 in Q4 CY2013. In CY2014, the percentages of homeless SPMI who were housed by the end of each quarter decreased, dropping to 43.5% in Q4 of CY2014. The number of homeless members with SPMI, however, has continued to drop in CY 2014. While there were 96 homeless SPMI members at the beginning of Q4 of CY2013, there were 69 at the beginning of Q4 of CY2014.

The number and percent of KanCare youth receiving MH services with improvement in their Child Behavior Checklist (CBCL Competence T-scores)

The denominator is the number of youth with prior competence scores within clinical range. The numerator is the number of youth with improvement in their most recent competence score (see Table 11).

Table 11: Number and percent of KanCare SED/CBS youth with improvement in their Child Behavior Checklist (CBCL) Scores - CY2012, CY2013, and CY2014

	Pre-KanCare		KanCare			
	CY2012		CY2013		CY2014	
	S1	S2	S1	S2*	S1	S2
Numerator: Number of KanCare SED/CBS youth with increased total competence score	1313	1170	1466		912	785
Denominator: Number of KanCare SED/CBS youth with prior competence score less than 40	2,490	2,207	2,796		1,705	1,513
Percent of KanCare SED/CBS youth with improvement in their most recent CBCL competence score	**52.7%**	**53.0%**	**52.4%**		**53.5%**	**51.7%**

* The source of the data for these measures is the Automated Information Management System (AIMS).
Multiple CMHCs are still in the process of submitting the entirety of 2013 data

Analysis: The numbers of SED/CBS youth with prior competence scores less than 40 have decreased each year from CY2012 to CY2014. The percentage with improvement in their most recent CBCL score has been relatively comparable in each of these testing periods.

The number and percent of youth with an SED who experienced improvement in their residential status

The denominator for this measure is the number of KanCare SED youth with unstable living arrangements at the beginning of each quarterly measurement period (see Table 12). The numerator for this measure is the number of KanCare SED youth with improved housing status at the end of the quarterly measurement period.

Table 12: Number and percent of SED youth who experienced improvement in their residential status - CY2012, CY2013, and CY2014

	Pre-KanCare				KanCare							
	CY2012				CY2013				CY2014			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of KanCare SED youth with improved housing status at end of measurement period	204	218	196	213	205	137	180	184	151	138	138	140
Denominator: Number of KanCare SED youth with unstable living arrangements at beginning of measurement period	246	264	241	266	244	193	220	219	187	168	169	173
Percent of SED youth with improved housing status	**82.9%**	**82.6%**	**81.3%**	**80.1%**	**84.0%**	**71.0%**	**81.8%**	**84.0%**	**80.7%**	**82.1%**	**81.7%**	**80.9%**

Analysis: In CY2012, percentages of improved housing status dropped each quarter, from 82.9% in Q1 to 80.1% in Q4. In CY2013, rates improved in Q1 to 84%, dropped to 71% in Q2, but were up to 84% by Q4. In CY2014, rates were comparable to CY2012 but lower than CY2013. The numbers of SED youth at the beginning of each measurement period in CY2014, however, were lower than those in each quarter of CY2012 and CY2013.

The number and percent of youth with an SED who maintained their residential status

The denominator for this measure is the number of KanCare SED youth with stable living arrangements at the beginning of the measurement period. The numerator is the number of KanCare SED youth who maintained a stable living arrangement at the end of the measurement period (see Table 13).

Table 13: Number and percent of SED youth who maintained their residential status - CY2012, CY2013, and CY2014

	Pre-KanCare				KanCare							
	CY2012				CY2013				CY2014			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of KanCare SED youth who maintained a stable living arrangement at end of measurement period	4,622	5,628	5,475	5,410	4,763	4,558	4,423	4,473	3,352	2,923	3,820	3,075
Denominator: Number of KanCare SED youth with stable living arrangements at beginning of measurement period	5,646	5,669	5,511	5,445	4,798	4,703	4,451	4,496	3,376	2,940	3,863	3,084
Percent of SED youth that maintained residential status	**81.9%**	**99.3%**	**99.3%**	**99.4%**	**99.3%**	**96.9%**	**99.4%**	**99.5%**	**99.3%**	**99.4%**	**98.9%**	**99.7%**

Analysis: Rates of maintaining stable living arrangements for SED youth were consistently and strongly high in CY2012 through CY2014. At the end of Q4 CY2012, 99.4% of SED youth had maintained a stable living arrangement, and this rate remained steady throughout CY2014. In Q4 CY2014, 99.7% of SED youth were maintaining stable living arrangements.

The number and percent of KanCare members, diagnosed with SPMI, who were competitively employed (P4P)

The denominator for this measure is the number of KanCare adults with SPMI in the workforce at the start of each quarter, and the numerator is the number of adults with SPMI who are competitively employed at the end of the quarter (see Table 14).

Analysis: The percentage of KanCare members with SPMI who were competitively employed improved each quarter of CY2014, increasing from 15.2% in Q1 to 16.5% in Q4, and increasing from 12.2% in Q4 of CY2013.

Table 14: Number and percent of KanCare adults diagnosed with an SPMI who were competitively employed during reporting period - CY2012, CY2013, and CY2014

	Pre-KanCare				KanCare							
	CY2012				CY2013				CY2014			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of KanCare SPMI adults competitively employed	552	505	499	368	400	379	360	390	635	570	538	564
Denominator: Number of KanCare SPMI adults in the workforce	4,362	3,961	3,604	2,455	3,295	2,963	2,940	3,201	4,182	3,646	3,426	3,421
Percent of SPMI adults in the workforce competitively employed	**12.7%**	**12.7%**	**13.8%**	**15.0%**	**12.1%**	**12.8%**	**12.2%**	**12.2%**	**15.2%**	**15.6%**	**15.7%**	**16.5%**

The number and percent of members utilizing inpatient mental health services (P4P)
The denominator for this measure is the number of KanCare eligible members at the end of each quarter. The numerator is the number of KanCare members admitted to an inpatient mental health facility during each quarter (see Table 15).

Rates are reported per 10,000.

Table 15: Number and percent of members utilizing inpatient mental health services - CY2012, CY2013, and CY2014

	Pre-KanCare				KanCare							
	CY2012				CY2013				CY2014			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of KanCare members with an inpatient mental health admission during the reporting period	1522	1445	1612	1661	1270	1292	1337	1293	1,285	1,362	1,290	1,288
Number of KanCare eligible members	386,832	390,920	393,121	394,904	421,964	401,627	402,949	400,384	412,212	420,146	423,275	418,808
Percent of members utilizing inpatient mental health services	0.4%	0.4%	0.4%	0.4%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
Rate per 10,000	39.35	36.96	41.01	42.06	30.10	32.17	33.18	32.29	31.17	32.42	30.48	30.75

Analysis: There was a statistically significant decrease in inpatient admissions when comparing the rate in Q4 CY2012 (42.06 per 10,000) with the rate in Q4 CY2013 (32.29 per 10,000), $p<0.001$. In CY2014, the rate per 10,000 continued to decrease. By Q4 CY2014, this rate dropped to 30.75 per 10,000.

(4) Healthy Life Expectancy

Health Literacy
Survey questions for this performance measure are based on questions in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

In 2014, although all three MCOs conducted separate surveys of sample populations of adults, general child population (GC), and children with chronic conditions (CCC), two of the MCOs (Amerigroup and UnitedHealthcare) did not sample the Title XIX/Medicaid and Title XXI (CHIP) populations separately. In 2015, all three MCOs will administer the CAHPS survey to separate sample populations of Title XIX and Title XXI children

using the child survey with CCC module. In the KanCare Evaluation Annual Report, the aggregated weighted results from the adult, GC, and CCC populations are reported. The CAHPS survey data available for CY2012 includes adult and GC survey data (CCC survey data were not available). Survey results in CY2014 are compared to pre-KanCare CY2012 where data was available (and where questions were worded the same in both surveys).

Except for child survey questions without a corresponding adult survey question, the child revision of the survey question is in parentheses if similar to the adult survey question. The analysis below is based on the percentage of positive responses as reported in the CAHPS surveys. Results for CY2014 are compared to the QC national percentiles where data were available.

Table 16 shows response rates for questions related to physical health. (See Table 20 for questions related to quality of care; Table 22 for questions related to coordination of care, Table 26 for questions related to access to care, and Table 28 for an efficiency-related question.)

In the last 6 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)?**
  Results for the highest weighted percentages for the adult and child surveys were slightly higher in CY2014 than pre-KanCare CY2012, ranging from 70.7% (GC) to 71.6% (adults) in CY2014 and from 68.9% (child) to 70.0% (adults) in CY2012.
- **How often did you have your questions answered by your child's doctors or other health providers?**
  Responses were high and comparable for both child sample populations in CY2014 (GC – 89.6%; CCC – 90.9%). (Not included in CAHPS for CY2012)
- **How often did your (child's) personal doctor explain things (about your child's health) in a way that was easy to understand?**
  Over 90% of the responses on the adult and child surveys in CY2014 were positive, ranging from 91.9% (adult) to 95.5% (GC). The weighted aggregate percentages for adults were above the QC 75th percentile and above the QC 50th percentile for both GC and CCC surveys. The CY2014 percentages were also slightly above the pre-KanCare results.
- **How often did your child's personal doctor explain things in a way that was easy for your child to understand?**
  Results for positive responses to this question were above 90% (and comparable) in CY2014 and CY2012 for the child surveys.
- **How often did your (child's) personal doctor listen carefully to you?**
  Positive response percentages were higher for the child surveys (GC – 95.7%; CCC – 94.4%) than for the adult survey population (89.7%). The weighted child survey positive responses were above the QC 50th percentile, and the weighted adult survey positive responses were below the QC 50th percentile. (GC results for AGP and SSHP Title XXI were above the QC 75th percentile.) The CY2014 positive result percentages were above the CY2012 results.

Table 16: Healthy Life Expectancy - CAHPS Survey

Question	Population	Highest Weighted %	QC 50th Percentile			Pre-KanCare Highest %
			Above	Below	N/A	
Q8. **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)?** (GC and CCC Q8)	Adult	71.6%			X	70.0%
	GC	70.7%			X	68.9%
	CCC	73.3%			X	
Q9. **In the last six months, how often did you have your questions answered by your child's doctors or other health providers?**	GC	89.6%			X	
	CCC	90.9%			X	
Q17. **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?** (GC and CCC Q32)	Adult	91.9%	X			89.7%
	GC	95.5%	X			94.3%
	CCC	95.3%	X			
Q36. **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?**	GC	91.1%			X	92.5%
	CCC	92.4%			X	
Q18. **In the last six months, how often did your (child's) personal doctor listen carefully to you?** (GC and CCC Q33)	Adult	89.7%		X		85.2%
	GC	95.7%	X			94.3%
	CCC	94.4%	X			
Q9. **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)?** (GC and CCC Q10)	Adult	53.5%			X	50.8%
	GC	31.9%			X	37.3%
	CCC	51.3%			X	
Q10. **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?** (GC and CCC Q11)	Adult	49.3%	X			53.3%
	GC	59.5%	X			60.8%
	CCC	65.5%	X			
Q11. **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 not want (your child) to take a medicine?** (GC and CCC Q12)	Adult	27.9%		X		36.7%
	GC	28.3%	X			34.5%
	CCC	35.2%		X		
Q12. **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)?** (GC and CCC Q13)	Adult	75.9%		X		73.7%
	GC	77.7%	X			79.6%
	CCC	83.5%	X			
Q38. **Have you had either a flu shot or flu spray in the nose since July 1, 2013?**	Adult	47.5%			X	
Q39. **Do you now smoke cigarettes or use tobacco every day, some days, or not at all?**	Adult	37.7%			X	37.2%
Q40. **In the last six 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%			X	65.5%
Q41. **In the last six 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.**	Adult	48.3%			X	41.5%
Q42. **In the last six 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.**	Adult	38.6%			X	24.5%

- **Did you and a (your child's) doctor or other health provider talk about starting or stopping a prescription medicine (for your child)?**
  Over half of the adult survey (CY2014 – 53.5%; CY2012 – 50.8%) and CCC survey respondents (51.3%) indicated they had talked with a provider about starting or stopping a medication in the previous six months, while for the GC survey, there were 31.9% in CY2014 compared to 37.3% in CY2012.
  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?**
    Results were lower for adults in CY2014 (49.3%) compared to CY2012 (53.3%). Results were higher for CCC survey respondents (65.5%) compared to GC surveys in CY2014 (59.5%) and CY2012 (60.8%). The adult and child survey results were above the QC 50th percentile for CY2014.
  - **How much did a doctor or other health provider talk about the reasons you might not want (your child) to take a medicine?**
    Fewer members reported that their providers talked with them about reasons they might not want (their child) to take a medicine than reasons they might want (their child) to take a medicine. The results for adults in CY2014 (27.9%) were higher in CY2012 (36.7%) and were below the QC 50th percentile. The results for the GC population (28.3%) were above the QC 50th percentile, but lower than in CY2012 (34.5%). The CCC population results (35.2%) were higher than the GC population, but below the QC 50th percentile.
  - **Did a doctor or other health provider ask you what you thought was best for you (your child)?**
    Results for the adult survey in CY2014 (75.9%) were higher than in CY2012 (73.7%), but lower than the CY2014 child surveys (GC – 77.7%; CCC – 83.5%). The CY2014 adult survey results were less than the QC 50th percentile, while results for both child surveys were above the QC 50th percentile.

Flu shots for adults (P4P)

- **Have you had either a flu shot or flu spray in the nose since July 1, 2013?**
  The flu shot question is a new CAHPS question in 2014. Of those in the adult survey sample, 48.8% indicated they did receive a flu shot or flu spray in the second six months of CY2013. Results from this year's adult survey are the baseline results for P4P comparisons in subsequent years.

Smoking Cessation

Survey questions for this performance measure are based on questions included in the CAHPS adult survey.

- **Do you now smoke cigarettes or use tobacco: every day, some days, or not at all?**
  In CY2014, 37.7% of the KanCare adults surveyed indicated they smoked every day or some days, compared with 37.2% in CY2012.

Members who responded "every day" or "some days" were asked the following questions:

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?** (P4P)
  In CY2014, 75.7% of the KanCare adults surveyed responded positively, which was an increase from CY2012 (65.5%). This year's results are the baseline for P4P in subsequent years.
- **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.**
  In CY2014, 48.3% of the KanCare adults surveyed responded positively, which was an increase from CY2012 (41.5%).
- **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.**
  In CY2014, 38.6% of the KanCare adults surveyed responded positively, which was an increase from CY2012 (24.5%).

Diabetes Monitoring for People with Diabetes and Schizophrenia

- Population: Members diagnosed with diabetes and schizophrenia
- Analysis: Annual comparison to CY2013 baseline and trending over time
  The CY2013 aggregate percentage, 62.9% was at the QC 25th percentile.

Healthy Life Expectancy for persons with SMI, for persons with I/DD, and for persons with PD

The following measures are described as "HEDIS-like" in that HEDIS criteria will be used for each performance measures, but the HEDIS programming will be adapted to include only those populations that meet eligibility criteria and are also I/DD, PD, or SMI.

Prevention

- **Breast Cancer Screening** (P4P)
  The breast cancer screening HEDIS measure has eligibility criteria that are multi-year. The MCOs will use HEDIS criteria for the subpopulation of SMI, I/DD, and PD. The EQRO will be validating this measure in CY2015, and analysis of this measure will be included in the CY2015 KanCare Evaluation Annual Report.
- **Cervical Cancer Screening** (P4P)
  The EQRO is validating this measure in March CY2015, and analysis of this measure will be included in the CY2015 KanCare Evaluation Annual Report.
- **Preventive Ambulatory Health Service** (P4P)
  The EQRO is validating this measure in March CY2015, and analysis of this measure will be included in the CY2015 KanCare Evaluation Annual Report.

Treatment/Recovery

- **Comprehensive Diabetes Care** (P4P)
  In CY2015, the five P4P HEDIS diabetes measures that are P4P for the general KanCare adult population will be P4P measures for KanCare members who have an SMI or are receiving I/DD or PD waiver services. The EQRO will be validating this measure in CY2015, and analysis of this measure will be included in the CY2015 KanCare Evaluation Annual Report.

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

The populations for the following performance measures are members who are receiving HCBS services (includes I/DD, PD, FE, TBI, TA, SED, Autism, and MFP)

- **The number and percent of KanCare members receiving PD or TBI waiver services who are eligible for the WORK program who have increased competitive employment** (P4P)
  The EQRO is validating this measure in CY2015. Data for this measure for CY2013 and CY2014 will be reported in the CY2015 KanCare Evaluation Annual Report.

Data related to the following HCBS performance measures – consistent with CMS-approved HCBS waiver applications – are undergoing review completion, and results will be included in the evaluation process when available. Analysis of this data will be included in the CY2015 KanCare Evaluation Annual Report.

- **Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment**
- **Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan**

(6) Long Term Care: Nursing Facilities

Percentage of Medicaid Nursing Facility (NF) claims denied by the MCO (P4P CY2014)

The denominator for this measure is the number of nursing facility claims, and the numerator is the number of these claims that were denied in the calendar year (see Table 17).

Table 17: Nursing Facility Claims Denials - CY2012, CY2013, and CY2014			
	CY2012	CY2013	CY2014
Total number of nursing facility claims	555,652	337,767	361,584
Number of nursing facility claims denied	63,976	45,472	34,414
Percent of nursing facility claims denied	**11.51%**	**13.46%**	**9.52%**

The percentage of NF claims that were denied increased from 11.51% in CY2012 (pre-KanCare) to 13.46% in CY2013, but decreased to 9.52% in CY2014. This measure was a P4P measure for CY2014. Claims denials will continue to be monitored by the State in the reports submitted quarterly by each MCO.

Percentage of NF members who had a fall with a major injury (P4P)
The denominator for this measure is the number of NF members in KanCare, and the numerator is the number of these members that had falls that resulted in a major injury during the year (see Table 18).

Table 18: Nursing Facility Major Injury Falls - CY2012, CY2013, and CY2014			
	CY2012	CY2013	CY2014
Nursing Facility Medicaid Members	46,794	46,114	46,137
Number of Nursing Facility Major Injury Falls	288	246	231
Percentage of Nursing Facility Medicaid Members with Major Injury Falls	**0.62%**	**0.53%**	**0.50%**

The percentage of NF Medicaid members who had falls with major injuries decreased from 0.62% in CY2012 (pre-KanCare) to 0.53% in CY2013, and decreased again in CY2014 to 0.50%. There were 42 fewer falls in CY2013 than in CY2012, and 57 fewer falls in CY2014 than in CY2012. This measure is a P4P measure that will be validated in CY2015. As many of the nursing facilities have members from more than one MCO, MCOs have been encouraged by the State 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 (Promoting Excellent Alternatives in Kansas) in the MCO network (P4P - CY2014)
PEAK program data is used to identify Person Centered Care Home designated nursing facilities, along with MCO provider files to verify inclusion in the network. According to KDADS staff, PEAK program data is reported on a fiscal year basis, based on the State fiscal year, which begins July 1. In FY2014, there were 8 nursing facilities recognized as PEAK, six Level 5 homes, and two that are Level 4. KDADS staff continue to work with other homes at Levels 1 through 3 that are working toward becoming Level 4 and Level 5 homes.

Percentage of members discharged from a NF who had a hospital admission within 30 days (P4P)
The denominator for this measure is the number KanCare members discharged from a NF. The numerator is the number of these members who had hospital admissions within 30 days of being discharged from the NF (see Table 19).

Table 19: Hospital Admissions after Nursing Facility Discharge - CY2012, CY2013, and CY2014			
	CY2012	CY2013	CY2014
Number of Nursing Facility Discharges	2,130	2,052	2,214
Number of Hospital Admissions after Nursing Facility Discharge	153	87	85
Percentage of Hospital Admissions after Nursing Facility Discharge	**7.18%**	**4.24%**	**3.84%**

The percentage of NF Medicaid members who were readmitted to a hospital after being discharged from an NF decreased from 7.18% in CY2012 (pre-KanCare) to 4.24% in CY2013, and decreased again in CY2014 to 3.84%. This measure is a P4P measure that will be validated in CY2015.

(7) Member Survey – Quality

CAHPS Survey

CAHPS questions related to quality of care include the following questions focused on patient perceptions of provider treatment. Four of the questions are "rating" questions where survey respondents were asked to rate their (or their child's) personal doctor, health care, health plan, and the specialist seen most frequently. Rating was 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 below follow the NCQA standard of combining results for selections of "9" or "10," and then weighted by MCO population for aggregating the results. Results for the ratings questions and two additional questions are provided in Table 20.

- **Rating of personal doctor**
  Ratings of members' personal doctors were similar in CY2014 and CY2012. 64.4% of adults surveyed in CY2014 rated their doctors as 9 or 10 (compared to 66.7% in CY2012. The adult results were above the QC 50th percentile. Child survey results had higher positive percentages (GC – 73.4%; CCC – 71.8%), though these results were below the QC 50th percentile.
- **Rating of health care**
  Rating of members' perceptions of health care resulted in all survey populations (adult, GC, and CCC) being above the QC 50th percentile. Ratings were comparable in CY2014 with CY2012. In CY2014 52.8% of adult survey respondents rated their health care as 9 or 10; as did 68.6% of GC and 65.2% of CCC survey respondents.
- **Rating of health plan**
  Adult survey results in CY2014 (54.7%) were comparable to those in CY2012 (52.8%) and were below the QC 50th percentile. General child survey results improved in CY2014 (71.0%) compared to CY2012 (65.9%) and were above the QC 50th percentile. The CCC results for positive rating (63.3%) were below the QC 50th percentile.
- **Rating of specialist seen most often**
  Highest ratings of specialists were higher in CY2014 but below the QC 50th percentile for all three survey sample populations (adults – 64.8%; GC - 69.6%; CCC – 68.5%).
- **Doctor respected member's comments.**
  Over 90% of survey respondents in CY2014 indicated their personal doctor showed respect for what they had to say. Adult results in CY2014 (91.9%) were higher than CY2012 (83.7%), and results for the general child survey (96.7%) were also higher than CY2012 (91.8%); the adult results were above the QC 50th percentile, and the GC population results were above the QC 75th percentile. The CCC survey population had 94.4% positive response, which was below the QC 50th percentile.

- **Doctor spent enough time with the member.**
Results in CY2014 were comparable to those of CY2012 for adults (89.0% - CY2014; 90.8% - CY2012) and for the general child survey populations (90.4% - CY2014; 91.6% - CY2012); the adult results were above the QC 75th percentile, and the GC population results were above the QC 50th percentile. The CCC results of 90.6% positive were below the QC 50th percentile.

Table 20: Member Survey - Quality of Care Questions						
Question	Population	Highest Weighted Percentage*	QC 50th Percentile			Pre-KanCare Highest Percentage*
			Above	Below	N/A	
Using any number from 0 to 10, where 0 is the worst score possible and 10 is the best score possible... **(Applies to questions 23, 13, 35 and 27 below)**						
Q23. **What number would you use to rate your (your child's) personal doctor?** (GC and CCC Q41)	Adult	64.4%	X			66.7%
	GC	73.4%		X		74.6%
	CCC	71.8%		X		
Q13. **What number would you use to rate all your (your child's) health care in the last 6 months?** (GC and CCC Q14)	Adult	52.8%	X			54.7%
	GC	68.6%	X			62.7%
	CCC	65.2%	X			
Q35. **What number would you use to rate your (your child's) health plan?** (GC and CCC Q54)	Adult	54.6%		X		55.3%
	GC	71.0%	X			65.9%
	CCC	63.3%		X		
Q27. **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?** (GC and CCC Q48)	Adult	64.8%		X		64.0%
	GC	69.6%		X		67.4%
	CCC	68.5%		X		
* Highest Percentage in each population is a combination of the 9 and 10 results.						
Question	Population	Highest Weighted Percentage	QC 50th Percentile			Pre-KanCare Highest Percentage
			Above	Below	N/A	
Q19. **In the last 6 months, how often did your (your child's) personal doctor show respect for what you had to say?** (GC and CCC Q34)	Adult	91.9%	X			83.7%
	GC	96.7%	X			91.8%
	CCC	94.4%		X		
Q20. **In the last 6 months, how often did your (your child's) personal doctor spend enough time with you (your child)?** (GC and CCC Q37)	Adult	89.0%	X			90.8%
	GC	90.4%	X			91.6%
	CCC	90.6%		X		

Mental Health Survey

Patient perceptions of mental health provider treatment are based on responses to mental health surveys conducted in CY2014 of a random sample of KanCare members who had received one or more mental health services in the prior six month period while a member. The Mental Health Statistics Improvement Program (MHSIP) Youth Services Survey, Youth Services Survey for Families, and Adult Consumer Survey tools, as modified by KFMC over the past five years, were used for this project.

Survey results were reported by Adult, General Youth, and by SED Youth and Young Adults receiving mental health services through the SED Waiver. Results were also stratified by whether the member completed the survey or whether a family member completed the survey for a child (age <18).

In CY2014, 839 General Adult surveys were completed; 803 General Youth surveys; 406 SED Youth surveys; and 20 SED young adult surveys. In CY2012 the survey was mailed to 5,238 members. In CY2014, the survey was mailed to16,390 members to better assess the mental health services being provided by three MCOs compared to the one Pre-Paid Ambulatory Health Plan (Kansas Health Solutions) in CY2012.

Response rates to CY2014 survey questions were compared to results from CY2013. Questions were the same in each year, with the exception of a question added in CY2013 on whether medication was available timely. After comparing these results, KFMC compared responses from CY2012 and CY2011 (which included the same questions as CY2014) to better identify trends over time.

Table 21 shows response rates for questions related to quality of care. (See Table 23 for questions related to coordination of care, Table 27 for questions related to access to care, and Table 29 for an efficiency-related question.)

For most of the questions, responses were generally positive and did not change significantly from pre-KanCare (CY2011 and CY2012) to KanCare (CY2013 and CY2014). The survey population in CY2014 and CY2013, however, was three times the size of populations surveyed in CY2011 and CY2012. The larger population adds greater strength to the confidence in the rates reported in CY2014 and CY2013.

The quality-related questions in Table 21 focus on the following:

- **If given other options, the member would still get services from the mental health provider providing recent care.**
  This question was asked of adults (non-SED, ages 18 and older). From CY2013 to CY2014 there was a slight, though non-significant, increase in positive response from 88.3% to 89.5%. From CY2012 to CY2013, there was a statistically significant increase in this rate ($p < 0.05$), increasing from 84.4% to 88.3%. The percentage in CY2011 was the same as CY2013; however, the survey population size in CY2013 was three times that of the survey population in CY2011, which adds strength to the confidence in the results.
- **Comfort in asking questions about treatment, medication, and/or children's problems**
  Responses were consistently high in the three populations (adults, youth/age 0-17, and in the SED youth and young adults), with rates ranging from 88.0% (SED youth and young adult, family responding) to 90.7% (adults). Rates in CY2014 were comparable to the rates in the previous three years for each of these populations.
- **Understandable communication from provider with member**
  Rates were consistently high in all of the populations surveyed. Rates in CY2014 ranged from 93.6% (general adults) to 98.2% (SED youth and young adults).

Table 21: Mental Health Survey - Quality-Related Questions

Question	Year	%	N/D	95% Confidence	p-value (compare 2014 to 2013)
If I had other choices, I would still get services from my mental health providers.	General Adult (Age 18+)				
	2014	**89.5%**	720 / 805	87.3% - 91.6%	0.45
	2013	**88.3%**	913 / 1034	86.4% - 90.3%	
	2012	*84.4%*	*232 / 275*	*79.5% - 88.5%*	
	2011	*88.3%*	*263 / 298*	*84.6% - 91.9%*	
I felt comfortable asking questions about my treatment and medication.	General Adult (Age 18+)				
	2014	**90.7%**	733 / 808	88.7% - 92.7%	0.75
	2013	**91.1%**	959 / 1052	89.4% - 92.8%	
	2012	*87.5%*	*244 / 279*	*83.0% - 91.1%*	
	2011	*93.6%*	*278 / 297*	*90.8% - 96.4%*	
I have people I am comfortable talking with about my child's problems.	General Youth (Age <18), Family Responding				
	2014	**90.4%**	687 / 760	88.3% - 92.5%	0.39
	2013	**91.6%**	875 / 955	89.9% - 93.4%	
	2012	*93.1%*	*244 / 262*	*89.4% - 95.9%*	
	2011	*92.6%*	*301 / 325*	*89.8% - 95.5%*	
	SED Waiver Youth and Young Adult (0-21), Family/Member Responding				
	2014	**88.0%**	367 / 417	84.9% - 91.1%	0.62
	2013	**89.1%**	424 / 476	86.3% - 91.9%	
	2012	*87.5%*	*281 / 321*	*83.9% - 91.2%*	
	2011	*89.4%*	*254 / 284*	*85.9% - 93.0%*	
I, not my mental health providers, decided my treatment goals.	General Adult (Age 18+)				
	2014	**84.1%**	656 / 780	81.5% - 86.6%	0.22
	2013	**81.8%**	809 / 989	79.4% - 84.2%	
	2012	*77.0%*	*198 / 257*	*71.4% - 82.0%*	
	2011	*83.8%*	*237 / 283*	*79.5% - 88.0%*	
I helped to choose my treatment goals.	General Youth (Age 12-17), Youth Responding				
	2014	**84.1%**	255 / 303	80.0% - 88.2%	0.06
	2013	**88.8%**	409 / 460	86.0% - 91.7%	
	2012	*81.6%*	*80 / 98*	*72.5% - 88.7%*	
	2011	*86.8%*	*112 / 129*	*81.0% - 92.7%*	
	SED Waiver Youth (Age 12-17), Youth Responding				
	2014	**86.9%**	168 / 194	82.2% - 91.7%	0.18
	2013	**82.2%**	186 / 226	77.2% - 87.2%	
	2012	*81.3%*	*109 / 134*	*73.7% - 87.6%*	
	2011	*83.5%*	*101 / 121*	*76.9% - 90.1%*	
I helped to choose my child's treatment goals.	General Youth (Age <18), Family Responding				
	2014	**92.2%**	692 / 750	90.3% - 94.1%	0.22
	2013	**90.5%**	846 / 935	88.6% - 92.4%	
	2012	*91.6%*	*229 / 250*	*87.5% - 94.7%*	
	2011	*90.7%*	*294 / 324*	*87.6% - 93.9%*	
	SED Waiver Youth and Young Adult (0-21), Family/Member Responding				
	2014	**95.8%**	395 / 413	93.8% - 97.7%	0.09
	2013	**93.1%**	450 / 483	90.8% - 95.4%	
	2012	*96.2%*	*303 / 315*	*94.1% - 98.3%*	
	2011	*94.0%*	*264 / 281*	*91.2% - 96.7%*	
As a direct result of services I received, I am better able to do things that I want to do.	General Adult (Age 18+)				
	2014	**74.3%**	582 / 783	71.3% - 77.4%	0.09
	2013	**77.7%**	787 / 1012	75.2% - 80.3%	
	2012	*70.1%*	*185 / 264*	*64.2% - 75.5%*	
	2011	*82.4%*	*238 / 289*	*78.0% - 86.8%*	
As a result of the services my child and/or family received, my child is better able to do things he or she wants to do.	General Youth (Age <18), Family Responding				
	2014	**80.7%**	606 / 750	77.9% - 83.6%	0.06
	2013	**84.3%**	785 / 932	81.9% - 86.6%	
	2012	*85.0%*	*215 / 253*	*80.0% - 89.2%*	
	2011	*84.1%*	*264 / 314*	*80.0% - 88.1%*	
	SED Waiver Youth and Young Adult (0-21), Family/Member Responding				
	2014	**71.2%**	289 / 406	66.7% - 75.6%	0.43
	2013	**73.5%**	349 / 475	69.6% - 77.5%	
	2012	*72.2%*	*229 / 317*	*67.3% - 77.2%*	
	2011	*76.4%*	*210 / 275*	*71.3% - 81.4%*	

Table 21: Mental Health Survey - Quality-Related Questions (Continued)

Question	Year	%	N/D	95% Confidence	p-value (compare 2014 to 2013)
My mental health providers spoke with me in a way I understood.	General Adult (Age 18+)				
	2014	**93.6%**	765 / 817	92.0% - 95.3%	0.54
	2013	**94.3%**	1002 / 1063	92.9% - 95.7%	
	2012	*91.5%*	*257/ 281*	*87.6% - 94.5%*	
	2011	*93.4%*	*282 / 302*	*90.6% - 96.2%*	
	General Youth (Age 12-17), Youth Responding				
	2014	**95.5%**	290 / 304	93.2% - 97.8%	0.56
	2013	**96.3%**	450 / 467	94.6% - 98.0%	
	2012	*98.0%*	*97 / 99*	*92.9% - 99.8%*	
	2011	*97.0%*	*131 / 135*	*94.2% - 99.9%*	
	SED Waiver Youth (Age 12-17), Youth Responding				
	2014	**96.9%**	183 / 189	94.4% - 99.4%	0.14
	2013	**93.8%**	217 / 231	90.7% - 96.9%	
	2012	*92.0%*	*126 / 137*	*86.1% - 95.9%*	
	2011	*92.1%*	*116 / 126*	*87.3% - 96.8%*	
My child's mental health providers spoke with me in a way I understood.	General Youth (Age <18), Family Responding				
	2014	**97.5%**	767 / 786	96.4% - 98.6%	0.81
	2013	**97.3%**	953 / 979	96.3% - 98.3%	
	2012	*97.8%*	*262 / 268*	*95.2% - 99.2%*	
	2011	*96.8%*	*327 / 338*	*94.9% - 98.6%*	
	SED Waiver Youth and Young Adult (0-21), Family/Member Responding				
	2014	**98.2%**	415 / 422	96.9% - 99.5%	0.42
	2013	**97.4%**	476 / 488	96.0% - 98.8%	
	2012	*97.8%*	*314 / 321*	*96.2% - 99.4%*	
	2011	*97.2%*	*278 / 286*	*95.3% - 99.1%*	
My mental health providers helped me obtain information I needed so that I could take charge of managing my illness.	General Adult (Age 18+)				
	2014	**86.8%**	675 / 778	84.4% - 89.2%	0.62
	2013	**87.6%**	893 / 1020	85.5% - 89.6%	
	2012	*81.6%*	*213 / 261*	*76.4% - 86.1%*	
	2011	*89.3%*	*258 / 289*	*85.7% - 92.8%*	
As a direct result of services I received, I am better able to control my life.	General Adult (Age 18+)				
	2014	**84.9%**	669 / 788	82.4% - 87.4%	0.28
	2013	**83.0%**	850 / 1024	80.7% - 85.3%	
	2012	*76.4%*	*204 / 267*	*70.9% - 81.4%*	
	2011	*86.5%*	*250 / 289*	*82.6% - 90.4%*	
As a result of services I received, I am better at handling daily life.	General Youth (Age 12-17), Youth Responding				
	2014	**86.0%**	260 / 302	82.1% - 89.9%	0.30
	2013	**88.6%**	413 / 466	85.7% - 91.5%	
	2012	*88.8%*	*87 / 98*	*80.8% - 94.3%*	
	2011	*83.1%*	*108 / 130*	*76.6% - 89.5%*	
	SED Waiver Youth (Age 12-17), Youth Responding				
	2014	**84.1%**	157 / 187	78.8% - 89.3%	0.24
	2013	**79.6%**	179 / 225	74.3% - 84.8%	
	2012	*82.4%*	*112/ 136*	*76.0% - 88.8%*	
	2011	*90.1%*	*109 / 121*	*84.8% - 95.4%*	
As a result of services my child and/or family received, my child is better at handling daily life.	General Youth (Age <18), Family Responding				
	2014	**79.6%**	607 / 763	76.7% - 82.5%	0.20
	2013	**82.1%**	775 / 945	79.6% - 84.5%	
	2012	*81.0%*	*205 / 253*	*75.6% - 85.7%*	
	2011	*79.4%*	*258 / 325*	*75.0% - 83.8%*	
	SED Waiver Youth and Young Adult (0-21), Family/Member Responding				
	2014	**72.0%**	294 / 408	67.6% - 76.4%	0.42
	2013	**74.4%**	355 / 477	70.5% - 78.3%	
	2012	*75.6%*	*241 / 319*	*70.8% - 80.3%*	
	2011	*79.4%*	*227 / 286*	*74.7% - 84.1%*	
As a direct result of services I received, I am better able to deal with crisis.	General Adult (Age 18+)				
	2014	**78.7%**	602 / 765	75.8% - 81.6%	0.84
	2013	**79.1%**	780 / 986	76.6% - 81.6%	
	2012	*71.4%*	*182 / 255*	*65.4% - 76.8%*	
	2011	*80.4%*	*221 / 275*	*75.7% - 85.1%*	

- **Member choice of treatment goals**
  In CY2014, positive responses increased, though not significantly, in all populations except for general youth, ages 12-17, youth responding, where positive responses dropped from 88.8% in CY2013 to 84.1% in CY2014. Rates in CY2013 were highest in SED youth and young adult, family responding (95.8%) and lowest in the general adults and general youth (84.1%). The 81.8% rate in the general adult population, however, was an increase from the 81.8% rate in CY2013.
- **Better able to do things the member wants to do, as a direct result of services provided.**
  Rates for general adult, general youth (family responding), and SED waiver youth/young adult (family responding) decreased, though not significantly, from CY2013 to CY2014.
- **Assistance in obtaining information to assist members in managing their health**
  In CY2013 there was a statistically significant increase in the percentage of positive responses compared to CY2012 (81.6%) to CY2013 (87.6%), $p<0.01$, in the general adult population. In CY2014, this positive trend continued, with 86.8% positive responses from adults.
- **Better control of daily life due to services provided**
  Rates were fairly consistent within populations from CY2011 through CY2014. In CY2014, general youth (age 12-17), youth responding, had the highest satisfaction rate (86.0%); and SED waiver youth/young adult (family responding) had the lowest rate (72.0%).
- **Better ability to deal with crisis, as a direct result of services provided**
  There was a statistically significant increase in the CY2013 rate (79.1%) compared to the CY2012 rate (71.4%), $p<0.01$, for the general adult population. The rate in CY2014 was comparable to CY2013 at 78.7%.

<u>**SUD Consumer Survey**</u>

In 2011 and 2012, Value Options-Kansas (VO) conducted member satisfaction survey members who accessed substance use disorder treatment services. The survey consisted of 30 questions that were administered in 2012 by mail and through face-to-face interviews at provider locations. The VO survey was administered to 629 individuals, including Medicaid members and others receiving SUD services. In 2014 this survey was administered by the three MCOs to 238 KanCare members through face-to-face interviews, mail, and follow-up phone calls. The demographics differed somewhat in that 43.9% of the 2014 survey respondent were male compared to 61.6% for the 2012 VO survey; the average age for the 2014 survey was 33.7 compared to 31.8 for the VO survey. A summary report was completed by the MCOs in January 2015.

The 2012 results are reported for the SUD survey questions in this report; however, due to the difference in numbers of survey respondents and the additional non-Medicaid members surveyed in 2012, comparisons cannot be directly made with 2014 survey results.

The survey will be administered again in 2015. Recommendations made to the MCOs by the State and KFMC included: increasing the number of survey participants; revise the survey instrument to more clearly indicate questions that should be skipped; provide additional detail on whether the survey participants reflect the demographics of the members accessing SUD services; and to expand the number of provider sites where the survey is administered.

- **Overall, how would you rate the quality of service you have received from your counselor?**
  In 2014, 94.3% of 212 members surveyed rated the quality of service as very good or good. (2012 - 95.3%)
- **How would you rate your counselor on involving you in decisions about your care?**
  In 2014, 92.0% of 213 members rated counselor involvement of members in decisions about their care as very good or good. (2012 – 93.5%; 2011 – 96.7%)
- **Since beginning treatment, in general are you feeling much better, better, about the same, or worse?**
  In 2014, 87.1% of 209 members responded they were feeling much better or better since beginning treatment. (2012 – 98.8%)

(8) Provider Survey

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 to be worded identically on each of the MCOs' surveys to allow comparison and ability to aggregate the results to better assess the overall program and trends over time. The preferred neutral response option was to be "Neither Satisfied nor Dissatisfied." Amerigroup and UnitedHealthcare indicated this would be problematic for printing purposes and requested permission to use the response option "Neither."

Two of the MCOs, Sunflower and UnitedHealthcare, administer separate surveys to their behavioral health (BH) providers. The MCOs were asked to include these three questions on their BH surveys as well. UnitedHealthcare did include the three questions with wording for questions and response options as directed. Sunflower's BH survey included a question about preauthorization with differing wording for the question and response options and no questions for quality or availability of specialists. (Response options were "Very Good," "Good," "Average," "Poor," and "Very Poor.")

In their 2014 provider survey, UnitedHealthcare included the three questions, but had typographical errors in the response options that resulted in two options for "Somewhat Satisfied" and no option for "Somewhat Dissatisfied." Due to this error, the provider survey results in this annual report are not able to be aggregated and are reported separately. The separate UnitedHealthcare BH survey did word the questions and response options correctly; as a result, BH survey results are reported for each of the three provider survey questions.

The surveys also differed in the numbers of survey responses. For the three questions reviewed in this report, Amerigroup had 257 to 283 provider responses; Sunflower had

226 to 251 provider responses (plus 52 BH providers for the preauthorization question); and UnitedHealthcare had only 66 responses (before excluding the responses with typographic errors) plus 84 BH providers.

In this section, results are reported for Quality. The provider survey results for the timeliness-related question are in Section 17, and results for the access-related question are in Section 23.

This is the first year that the provider survey quality question was included on the three MCOs' provider surveys.

Providers were asked, "**Please rate your satisfaction with (MCO name's) demonstration of their commitment to high quality of care for their members."** Table 22 provides the available survey results by individual MCO.

Table 22: Provider Satisfaction with MCO's Commitment to High Quality of Care for their Members

	Amerigroup		Sunflower		UnitedHealthcare		UnitedHealthcare BH survey	
	#	%	#	%	#	%	#	%
Very Satisfied	51	18.0%	23	9.2%	4	6.1%	6	7.1%
Somewhat Satisfied	93	32.9%	71	28.3%	*	*	40	47.6%
Neither Satisfied nor Dissatisfied**	86	30.4%	113	45.0%	*	*	31	36.9%
Somewhat Dissatisfied	35	12.4%	24	9.6%	*	*	3	3.6%
Very Dissatisfied	18	6.4%	20	8.0%	9	13.6%	4	4.8%
Total Responses*	283		251		66		84	

* Cannot be determined due to typographical errors in survey instrument
** Amerigroup and UnitedHealthcare provider survey response options are "Neither."

- **Amerigroup**
  - 50.9% (144) of 283 providers surveyed were "very satisfied" (18.0%) or "somewhat satisfied" (32.9%).
  - 18.8% (53) of the providers were "very dissatisfied" (6.4%) or "somewhat dissatisfied" (12.4%).
- **Sunflower**
  - 37.5% (94) of 251 providers surveyed "very satisfied" (9.2%) or "somewhat satisfied" (28.3%).
  - 17.6% (44) of the providers were "very dissatisfied" (8.0%) or "somewhat dissatisfied" 9.6%)
- **UnitedHealthcare**
  - Of the 66 providers surveyed, 4 (6.1%) were "very satisfied," and 9 (13.6%) were "very dissatisfied."
  - 54.7% (46) of 84 BH providers surveyed were "very satisfied" (7.1%) or "somewhat satisfied" (47.6%).
  - 8.4% (7) of the BH providers were "very dissatisfied" (4.8%) or "somewhat dissatisfied" (3.6%).

Recommendations:

- UnitedHealthcare has confirmed that they will ensure that the CY2015 general provider survey will include the correct response options.
- The Sunflower BH survey should include the correct wording for each of the three questions and responses required by the State.
- Amerigroup and UnitedHealthcare should investigate printing options that will allow them to include the response option "Neither Satisfied nor Dissatisfied" instead of "Neither" to provide greater clarity.

(9) Grievances – Reported Quarterly

- **Compare/track number of grievances related to quality over time, by population type.**
  Grievances are analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review.

(10) Other (Tentative) Studies (Specific studies to be determined)

The focus and topics for "other studies" will be determined based on review of the various program outcomes, planned preventive health projects, and value-added benefits provided by the MCOs. Potential examples of studies include:

- 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?
- 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.

Coordination of Care (and Integration)

Goals, Related Objectives, and Hypotheses for Coordination of Care subcategories:

> *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 healthcare with behavioral healthcare.*
> - *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.*

(11) Care Management for Members Receiving HCBS Services

The population for the following performance measures is members who are receiving HCBS services (includes I/DD, PD, FE, TBI, TA, SED, Autism, and MFP)

- **Increased preventive care – Increase in the number of primary care visits** (P4P)
  - Population: HCBS
  - Analysis: Annual comparison to baseline, trending over time
  - The EQRO is validating this measure in March CY2015, and analysis of this measure will be included in the CY2015 KanCare Evaluation Annual Report.
- **Decrease in number of Emergency Department Visits** (P4P)
  - Population: HCBS
  - Analysis: Annual comparison to 2013 baseline, trending over time
  - The EQRO is validating this measure in March CY2015, and analysis of this measure will be included in the CY2015 KanCare Evaluation Annual Report.
- **Increase in Annual Dental Visits** (P4P)
  - Population: HCBS
  - Analysis: Annual comparison to 2013 baseline, trending over time
  - The EQRO is validating this measure in March CY2015, and analysis of this measure will be included in the CY2015 KanCare Evaluation Annual Report.

Data related to the following HCBS performance measures – consistent with CMS-approved HCBS waiver applications – are undergoing review completion, and results will be included in the evaluation process when available. Analysis of this data will be included in the CY2015 KanCare Evaluation Annual Report.

- **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.**
- **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.**

(12) Other (Tentative) Study (Specific study to be determined)

This measure will be reported when a specific study and study criteria are determined and defined, and will be based on areas of special focus on care coordination and integration of care. An example of a potential study includes analysis of the impact of "in lieu of" services on inpatient/institutional/facility utilization.

(13) Care Management for members with I/DD

> *Hypothesis: 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.*

The following measures refer to the I/DD pilot project conducted in CY2013 through January 2014.

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**

- **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**

In 2013, Wichita State University (WSU) facilitated the development of consumer-friendly information and educational sessions to ensure members, guardians, friends, and family were aware of service options and how to access services in the KanCare structure. Working with KDADS and the I/DD Friends and Family Advisory Council, WSU created a consumer brochure to supplement the KanCare/IDD Consumer letter sent in October 2013 that explained what KanCare is, existing I/DD services, roles of the care coordinator and targeted case manager, and how to contact the MCOs. WSU facilitated and evaluated educational tours held in May, July, September, and December of 2013, and worked with KDADS to provide information to members, guardians, friends, and family about the roles of targeted case managers and care coordinators, navigating MCOs, and how to access services to meet new or changing needs. This education continued through the WSU-facilitated Consumer Lunch and Learn calls, held weekly in December 2013 through the first quarter of 2014.

Number of I/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

No data related to completing the credentialing application process within 45 days for this Attachment L DD Pilot Project measure were provided in time for the development of this report.

MCOs have demonstrated an understanding of the Kansas DD service system. MCOs demonstrate a knowledge and understanding of:

- **The statutes and regulations that govern the I/DD 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 I/DD 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.)**

KDADS provided technical assistance and training to MCOs on the Kansas I/DD service system, including a Targeted Case Manager and Care Coordinator Summit to educate care coordinators. In the readiness reviews, the MCOs provided information about comprehensive training for care coordinators who were in the process of being hired for I/DD integration into KanCare. No data related to MCOs demonstrating an understanding of each of the above topics from this Attachment L DD Pilot Project were provided in time for the development of this report.

I/DD pilot project provider surveys were to be the data source for the following three performance measures. No provider survey data related to these Attachment L DD Pilot Project measures were provided in time for the development of this report.

- **The number of I/DD providers who, having requested it, report receiving helpful information and assistance from MCOs about how to enter their provider network.**
- **Number of I/DD providers who, having requested it, report receiving helpful information and assistance from MCOs about how to submit claims for services provided.**
- **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.**

The data source for the following performance measure was to be a survey of targeted case managers. No targeted case manager survey data related to these Attachment L DD Pilot Project measures were provided in time for the development of this report.

- **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.**

(14) Member Survey – CAHPS
Additional detail on the CAHPS survey In CY2014 can be found in Section 4 of this report in the Health Literacy section.

CAHPS questions related to coordination of care (see Table 23) include the following questions focused on perception of care and treatment in the Medicaid and CHIP populations:

- **In the last 6 months, how often was it easy (for your child) to get the care, tests, or treatment you (your child) needed?**
  Results were very positive in CY2014, with percentages ranging from 87.6% for adults (compared to 84.7% in CY2012); 93.4% GC population (compared to 90.5% in CY2012); and 93.0% CCC population. These results were all above the QC 75[h] percentile.

- **In the last 6 months, did you (your child) get care from a doctor or other health provider besides your (child's) personal doctor?**
  The 2014 survey results indicated that 62.0% of the adults, 39.5% of the general child (GC) population, and 80.5% of the children with chronic conditions (CCC) received care from a provider other than their personal doctor. In 2012, results were comparable for adults (57.6%) and the GC population (37.5%).
  - **In the last 6 months, 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?**
    Those who responded positively to receiving care from a provider other than their personal doctor were asked this question focusing on whether their

personal doctor seemed informed and up-to-date on the care provided by other health providers.
  - 83.0% of adults and 81.9% of the GC sample population responded positively. These results were higher than the CY2012 results (adults - 72.9%; GC – 78.7%); the adult results were above the QC 75th percentile, and the GC population results were above the QC 50th percentile.
  - For the CCC population, 58.3% indicated their child's personal doctor seemed informed of the health care by other providers. This result was below the QC 50th percentile.

- **In the last 6 months, did you make any appointments (for your child) to see a specialist?**
  In CY2014, 43.0% of adults (compared to 35.9% in CY2012); 17.9% of GC survey population (compared to 19.8% in CY2012); and 38.4% of the CCC survey population reported having one or more appointments with a specialist in the previous 6 months.
  - **In the last 6 months, how often did you get an appointment (for your child) to see a specialist as soon as you needed?**
    In CY2014, 84.8% of adults, 83.2% of the GC population, and 85.3% of the CCC population indicated they were able to see a specialist as soon as they needed. These positive responses were higher than in CY2012 (adults – 75.9%; GC – 79.0%). The adult results were above the QC 75th percentile, and the GC and CCC were above the QC 50th percentile.

CAHPS questions related to coordination of care include the following questions focused on perception of care and treatment from the Children with Chronic Conditions (CCC) Module. (QC percentiles are only available for the CCC population for the following measures, and pre-KanCare results for CY2012 were not available.)

- **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?**
  Fewer GC population children received these additional services (22.3%) compared to the CCC population (46.2%).
  - **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?**
    Of those receiving these additional services, 56.7% of the GC surveyed population and 57.9% of the CCC population received help from their child's help plan, doctor's office, or clinic in coordinating their care with these additional providers. For the CCC population, the aggregated results were below the QC 50th percentile.

- **Does your child have any medical, behavioral, or other health conditions that have lasted more than 3 months?**
  This question is used to help identify children who have chronic conditions surveyed in the GC population sample. 24.5% of the GC sample population and 77.2% of the CCC surveyed population responded positively to this question.

- **Does your child's personal doctor understand how these medical behavioral or other health conditions affect your child's day-to-day life?**
  Of those who indicated their child has a medical, behavioral, or other health condition that has lasted more than 3 months, 92.9% of the GC population and 92.3% of the CCC population surveyed responded positively. For the CCC population, the aggregated results, though above 92%, were below the QC 50th percentile.
- **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?**
  Of those who indicated their child has a medical, behavioral, or other health condition that has lasted more than 3 months, 92.5% of the GC population and 90.3% of the CCC population surveyed responded positively. For the CCC population, the aggregated results were above the QC 50th percentile.

- **In the last 6 months, did you get or refill any prescription medicines for your child?**
  In CY2014, 24.5% of the GC population surveyed and 77.2% of the CCC population surveyed indicated they had gotten or refilled a prescription medicine for their child.
  - **In the last 6 months, was it easy to get prescription medicines for your child through his or her health plan?**
    Of those who indicated they had gotten or refilled a prescription for their child in the last 6 months, 95.2% of the GC population and 94.7% of the CCC population indicated it was easy to get prescriptions for their child through their health plan.
  - **Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?**
    Of those who indicated they had gotten or refilled a prescription for their child in the last 6 months, 56.7% of the GC population and 57.6% of the CCC population indicated they received help from their health plan, doctor's office, or clinic to get the child's prescription. For the CCC population, these results were below the QC 50th percentile.

- **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?**
  Of those children enrolled in school or daycare, 10.4% of GC and 16.6% of CCC survey respondents indicated they needed their child's doctors or other health providers to contact a school or daycare center about their child's health.
  - **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?**
    Of those who needed help in contacting a school or daycare, 91.1% of the GC population and 96.5% of the CCC population indicated they received the help they needed. For the CCC population, results were above the QC 50th percentile.

Table 23: Member Survey - CAHPS Coordination of Care Questions						
Question	Population	Highest Weighted Percentage	QC 50th Percentile			Pre-KanCare Highest Percentage
			Above	Below	N/A	
In the last 6 months…						
Q21. **Did you (your child) get care from a doctor or other health provider besides your (his or her) personal doctor?** (GC and CCC Q39)	Adult	62.0%			X	57.6%
	GC	39.5%			X	37.5%
	CCC	80.5%			X	
Q22. **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 and CCC Q40)	Adult	83.0%	X			72.9%
	GC	81.9%	X			78.7%
	CCC	58.3%		X		
Q24. **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?** (GC and CCC Q45)	Adult	43.0%			X	35.9%
	GC	17.9%			X	19.8%
	CCC	38.4%			X	
Q25. **How often did you get an appointment (for your child) to see a specialist as soon as you needed?** (GC and CCC Q46)	Adult	84.8%	X			75.9%
	GC	83.2%	X			79.0%
	CCC	85.3%	X			
Q14. **How often was it easy to get the care, tests, or treatment you (your child) needed?** (GC and CCC Q15)	Adult	87.6%	X			84.7%
	GC	93.4%	X			90.5%
	CCC	93.0%	X			
Q28. **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%			X	
	CCC	46.2%			X	
Q29. **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%			X	
	CCC	57.9%		X		
Q42. **Does your child have any medical, behavioral, or other health conditions that have lasted more than 3 months?**	GC	24.5%			X	
	CCC	77.2%			X	
Q43. **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%			X	
	CCC	92.3%		X		
Q44. 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%			X	
	CCC	90.3%	X			
Q55. **In the last 6 months, did you get or refill any prescription medicines for your child?**	GC	50.8%			X	
	CCC	86.5%			X	
Q56. **How often was it easy to get prescription medicines for your child through his or her health plan?**	GC	95.2%			X	
	CCC	94.7%			X	
Q57. **Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?**	GC	56.7%			X	
	CCC	57.6%		X		
Q17. **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%			X	
	CCC	16.6%			X	
Q18. **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%			X	
	CCC	96.5%	X			

(15) Member Survey – Mental Health

The Mental Health Surveys conducted in CY2014 and CY2013 are described above in Section 7. The questions in Table 24 are related to the perception of care coordination for members receiving mental health services.

Table 24: Mental Health Survey - Questions related to Coordination of Care

Question	Year	%	N/D	95% Confidence	p-value (compare 2014 to 2013)
I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	General Adult (Age 18+)				
	2014	**82.3%**	590 / 717	79.5% - 85.1%	0.57
	2013	**83.4%**	801 / 961	81.0% - 85.7%	
	2012	*76.7%*	*191 / 249*	*71.0% - 81.8%*	
	2011	*82.3%*	*214 / 260*	*77.7% - 87.0%*	
I was able to get all the services I thought I needed.	General Adult (Age 18+)				
	2014	**86.5%**	705 / 814	84.2% - 88.9%	0.74
	2013	**86.0%**	916 / 1065	83.9% - 88.1%	
	2012	*78.8%*	*219 / 278*	*73.5% - 83.4%*	
	2011	*91.3%*	*274 / 300*	*88.2% - 94.5%*	
	General Youth (Age 12-17), Youth Responding				
	2014	**83.8%**	259 / 309	79.7% - 87.9%	0.73
	2013	**82.8%**	388 / 468	79.4% - 86.2%	
	2012	*85.0%*	*85 / 100*	*76.5% - 91.4%*	
	2011	*85.1%*	*114 / 134*	*79.0% - 91.1%*	
	SED Waiver Youth (Age 12-17), Youth Responding				
	2014	**74.8%**	138 / 184	68.5% - 81.0%	0.50
	2013	**71.8%**	167 / 233	66.0% - 77.6%	
	2012	*76.3%*	*103 / 135*	*68.2% - 83.2%*	
	2011	*77.6%*	*97 / 125*	*70.3% - 84.9%*	
My family got as much help as we needed for my child.	General Youth (Age <18), Family Responding				
	2014	**79.7%**	610 / 766	76.8% - 82.5%	0.06
	2013	**83.2%**	804 / 966	80.9% - 85.6%	
	2012	*82.9%*	*213 / 257*	*77.7% - 87.3%*	
	2011	*84.2%*	*278 / 330*	*80.3% - 88.2%*	
	SED Waiver Youth and Young Adult (0-21), Family Responding				
	2014	**76.4%**	316 / 414	72.3% - 80.5%	0.68
	2013	**75.2%**	363 / 483	71.3% - 79.0%	
	2012	*77.3%*	*248 / 321*	*72.7% - 81.8%*	
	2011	*77.5%*	*220 / 284*	*72.6% - 82.3%*	

- **Encouragement to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).**
    - From CY2011 to CY2012, rates in the general adult survey dropped from 82.3% to 76.7%. From CY2012 to CY2013, rates increased to 83.4%, and were comparable in CY2014 at 82.3%.
- **Perception that the members were able to access all of the services that they thought they needed.**
    - Rates were fairly consistent with no statistically significant changes from CY2013 to CY2014.
    - The highest perceived satisfaction was in the general adult population (86.5%), and the lowest continue to be from SED Waiver youth (ages 12-17), youth responding (74.8%).

(16) Member Survey – SUD

Section 7 above provides background on the SUD survey conducted by the three MCOs in 2014. Questions related to perceptions of care coordination include the following:

- **Has your counselor requested a release of information for this other substance abuse counselor who you saw?**
  - 70 (35.7%) of 196 surveyed indicated they received services from another substance abuse counselor in addition to the counselor currently providing services.
  - Of these 70, 12 responded that they did not know whether their counselor requested a release of information from the other counselor.
  - Of the remaining 58, 35 (60.3%) indicated their counselor did request a release of information from the other counselor.
- **Has your counselor requested a release of information for and discussed your treatment with your medical doctor?**
  - 15 (7.5%) of 201 survey respondents indicated they did not know if they have a primary care provider (PCP).
  - Of the remaining 196, 137 (69.9%) indicated they do have a primary care provider, and 59 indicated they do not have a primary care provider.
  - Of the 137 who responded that they do have a primary care provider, 49 indicated they did not know if their counselor requested a release of information and eight skipped this question.
  - Of the remaining 80, 42 (52.5%) indicated their counselor requested a release of information for and discussed the member’s treatment with their primary care provider.

(17) Provider Survey

Background information and comments on the 2014 Provider Survey are described in Section 8 above. In this section, results are reported for satisfaction with the preauthorization process (Table 25). The provider survey results for the quality-related question are in Section 8, and results for the access-related question are in Section 23.

Providers were asked, “**Please rate your satisfaction with obtaining precertification and/or authorization for (MCO’s) members**.” Table 25 provides the available survey results by individual MCO.

- **Amerigroup**
  - 53.3% of 272 providers surveyed were “very satisfied” (19.1%) or “somewhat satisfied” (34.2%). These results are higher than results in CY2013: 40.7% of 167 providers were “very satisfied” (9.6%) or “somewhat satisfied” (31.1%).
  - 22.8% of the providers were “very dissatisfied” (7.4%) or “somewhat dissatisfied” (15.4%). In CY2013, 42.6% were “very dissatisfied” (19.8%) or “somewhat dissatisfied” (22.8%).

Table 25: Provider Satisfaction with Obtaining Precertification and/or Authorization for Members										
	Amerigroup		Sunflower		Sunflower BH Survey+		UnitedHealthcare		UnitedHealthcare BH survey	
	#	%	#	%	#	%	#	%	#	%
Very Satisfied	52	19.1%	17	7.1%	15	28.8%	4	6.1%	7	8.3%
Somewhat Satisfied	93	34.2%	75	31.1%	18	34.6%	*	*	37	44.0%
Neither Satisfied nor Dissatisfied**	65	23.9%	79	32.8%	14	26.9%	*	*	29	34.5%
Somewhat Dissatisfied	42	15.4%	41	17.0%	4	7.7%	*	*	7	8.3%
Very Dissatisfied	20	7.4%	29	12.0%	1	1.9%	15	22.7%	4	4.8%
Total Responses*	272		241		52		66		84	

*Cannot be determined due to typographical errors in survey instrument
+Response options for the Sunflower BH survey were: "Very Good," "Good," "Average," "Poor," and "Very Poor."
** Amerigroup and UnitedHealthcare provider survey response options are "Neither."

- **Sunflower**
  No comparison can be made with CY2013 results since Sunflower's 2013 survey questions were asked of providers only in comparison to other MCOs.
  - 38.2% of the 241 providers surveyed were "very satisfied" (7.1%) or "somewhat satisfied" (31.1%).
  - 29.0% of the providers were "very dissatisfied" (12.0%) or "somewhat dissatisfied" (17.0%).
  - Sunflower's BH providers were asked, "How would you rate the authorization process (sending in a form) for your Cenpatico clients?"
    - 63.4% of the 52 BH providers surveyed (28.8%) replied "very good" (28.8%) or "good" (34.6%).
    - 9.6% of the BH providers (1.9%) replied "very poor" (1.9%) or "poor" (7.7%).
- **UnitedHealthcare**
  - Of the 66 providers surveyed, 4 (6.1%) were "very satisfied," and 15 (22.7%) were "very dissatisfied."
  - 52.3% of the 84 BH providers surveyed were (8.3%) were "very satisfied" (8.3%) or "somewhat satisfied" (44.0%).
  - 13.1% of the BH providers were "very dissatisfied" (4.8%) or "somewhat dissatisfied" (8.3%).

Cost of Care

Goals, Related Objectives, and Hypotheses for Costs subcategory:

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 typing measures to meaningful financial incentives, the state will improve health care quality and reduce costs.

(18) Costs

The data for the following measures continue to be analyzed and will be included in future reporting.

- **Total dollars spent on HCBS budget compared to institutional costs**
  - Population: Members receiving HCBS
  - Analysis: Pre-KanCare compared to KanCare and trending over time beginning in DY2
- **Per member per month (PMPM) costs - Compare pre-KanCare PMPM costs to post-KanCare PMPM costs by MEG.**
  - Population: ABD/SD Dual, ABD/SD Non-Dual, Adults, Children, NF, I/DD, PD, and FE Waivers
  - Analysis: Pre-KanCare compared to KanCare and trending over time
- **Compare pre-KanCare and post-KanCare costs for members in care management, comparing costs prior to enrollment in care management to costs after enrollment in care management.**
  - Population: Members in Care Management
  - Analysis: Compare baseline to subsequent years

ACCESS TO CARE

Goals, Related 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.

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.*

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.

(19) Provider Network – GeoAccess

Percent of counties covered within access standards, by provider type (physicians, hospital, eye care, dental, ancillary [physical therapy, occupational therapy, x-ray, and lab], and pharmacy).

KFMC reviewed the GeoAccess reports, maps, and other data to identify the percent of counties where specific provider types are not available from at least one MCO. KFMC also reviewed GeoAccess maps showing provider access by provider type for CY2014, CY2013, and CY2012 (see Table 26).

Table 26	Non-Urban Counties with no providers in any of 3 MCOs in 2014			Non-Urban Counties with no providers in any of 3 MCOs in 2013			Non-Urban Counties with no providers in any of 3 MCOs in 2012		
Provider type	Number of counties with no providers	Percent of 89 non-urban counties	Percent of all 105 counties	Number of counties with no providers	Percent of 89 non-urban counties	Percent of all 105 counties	Number of counties with no providers	Percent of 89 non-urban counties	Percent of all 105 counties
Availability in 2014 same as 2012 (Pre-KanCare)									
Physicians									
Primary Care Provider	0	0%	0%	0	0%	0%	0	0%	0%
General Surgery	0	0%	0%	0	0%	0%	0	0%	0%
Hematology/Oncology	0	0%	0%	0	0%	0%	0	0%	0%
Internal Medicine	0	0%	0%	0	0%	0%	0	0%	0%
Ophthalmology	0	0%	0%	0	0%	0%	0	0%	0%
Orthopedics	0	0%	0%	**2**	**2.2%**	**1.9%**	0	0%	0%
Pulmonary Disease	0	0%	0%	**3**	**3.4%**	**2.9%**	0	0%	0%
Hospitals	0	0%	0%	0	0%	0%	0	0%	0%
Retail Pharmacy	0	0%	0%	0	0%	0%	0	0%	0%
Ancillary Services									
Physical Therapy	0	0%	0%	0	0%	0%	0	0%	0%
X-ray	0	0%	0%	0	0%	0%	0	0%	0%
Lab	0	0%	0%	0	0%	0%	0	0%	0%
Increased Availability in 2014 Compared to 2012 (Pre-KanCare)									
Physicians									
Dermatology	0	0%	0%	**3**	**3.4%**	**2.9%**	**4**	**4.5%**	**3.8%**
Neonatology	**13**	**14.6%**	**12.4%**	**36**	**40.4%**	**34.3%**	**28**	**31.5%**	**26.7%**
Nephrology	**1**	**1.1%**	**1.0%**	**3**	**3.4%**	**2.9%**	**3**	**3.4%**	**2.9%**
Neurology	**1**	**1.1%**	**1.0%**	0	0%	0%	**20**	**22.5%**	**19.0%**
Neurosurgery	**11**	**12.4%**	**10.5%**	**20**	**22.5%**	**19.0%**	**36**	**40.4%**	**34.3%**
OB/GYN	0	0%	0%	0	0%	0%	**6**	**6.7%**	**5.7%**
Otolaryngology	0	0%	0%	0	0%	0%	**3**	**3.4%**	**2.9%**
Physical Medicine/Rehab	**1**	**1.1%**	**1.0%**	**3**	**3.4%**	**2.9%**	**12**	**13.5%**	**11.4%**
Plastic & Reconstructive Surgery	**15**	**16.9%**	**14.3%**	**21**	**23.6%**	**20.0%**	**33**	**37.1%**	**31.4%**
Podiatry	0	0%	0%	**1**	**1.1%**	**1.0%**	**23**	**25.8%**	**21.9%**
Psychiatrist	0	0%	0%	0	0%	0%	**5**	**5.6%**	**4.8%**
Urology	**1**	**1.1%**	**1.0%**	**3**	**3.4%**	**2.9%**	**3**	**3.4%**	**2.9%**
Eye Care - Optometry	0	0%	0%	**4**	**4.5%**	**3.8%**	**7**	**7.9%**	**6.7%**
Ancillary Services									
Occupational Therapy	0	0%	0%	0	0%	0%	**12**	**13.5%**	**11.4%**
Dental Primary Care	0	0%	0%	**6**	**6.7%**	**5.7%**	**2**	**2.2%**	**1.9%**
Decreased Availability in 2014 Compared to 2012 (Pre-KanCare)									
Physicians									
Allergy	**8**	**9.0%**	**7.6%**	**9**	**10.1%**	**8.6%**	0	0%	0%
Cardiology	**1**	**1.1%**	**1.0%**	0	0%	0%	0	0%	0%
Gastroenterology	**28**	**31.5%**	**26.7%**	**27**	**30.3%**	**25.7%**	**12**	**13.5%**	**11.4%**

Of the 105 counties in Kansas, 16 are “Urban” or “Semi-Urban,” 21 are “Densely-Settled Rural,” and 68 are “Rural” or “Frontier.”

Urban/Semi-Urban

In CY2014, CY2013, and CY2012, KanCare 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 CY2014, 69.4% (275,982) of the KanCare members were residents of Urban or Semi-Urban Counties.

Densely-Settled Rural/Rural/Frontier

In CY2014, 30.6% of KanCare members were residents of Densely-Settled Rural, Rural, or Frontier counties. KanCare members who were residents of any of the 21 Densely-Settled Rural, 32 Rural, and 36 Frontier counties had access to at least one of the following provider types through at least one MCO: Primary Care Provider (PCP); Dermatology, General Surgery; Hematology/Oncology; Internal Medicine; OB/GYN; Ophthalmology, Orthopedics, Otolaryngology; Podiatry, Psychiatrist, and Pulmonary Disease. Residents of the non-urban counties also had access to Hospitals; Dental Primary Care; Optometry; Retail Pharmacy; and all of the Ancillary Services (Physical Therapy, Occupational Therapy, X-ray, and Lab).

Added to the list since CY2013 are Dermatology (three additional counties in CY2014), Orthopedics (two additional counties in CY2014), Podiatry (one additional county in CY2014), Pulmonary Disease (three additional counties in CY2014), Dental Primary Care (six additional counties in CY2014), and Optometry (four additional counties in CY2014).

In CY2014, KanCare members who lived in some of the Densely-Settled Rural, Rural, or Frontier counties did not have access to certain provider types from any of the MCOs. These 11 provider types (and numbers of counties without access) included: Allergy (8 counties with no providers), Cardiology (1), Gastroenterology (28), Neonatology (13), Nephrology (1), Neurology (1), Neurosurgery (11), Physical Medicine/Rehab (1), Plastic and Reconstructive Surgery (15), and Urology (1).

The provider types that had the biggest improvements in reductions in numbers of counties without access were:

- Neonatology – In CY2013, 36 counties did not have access. In CY2014, only 13 counties did not have access.
- Neurosurgery – In CY2013, 20 counties did not have access. In CY2014, 11 counties did not have access.
- Plastic & Reconstructive Surgery – In CY2013, 21 counties did not have access. In CY2014, 15 counties did not have access.

The county with the least amount of access to providers was Cheyenne, which did not have access to 9 provider types listed above. Of the other 27 counties with no access to one or more provider types: 6 had no access to 4 provider types; 8 had no access to 3 provider types; 9 had no access to 2 provider types; and 5 had no access to 1 provider type. Not factored into this analysis are the numbers of counties with no access to one or more providers that are adjacent on all sides to counties with no access to these same provider types.

Average distance to a behavioral health provider

Average distance to one, two, three, four, and five BH providers by county type and by MCO in CY2014 are described below.

Urban/Semi-Urban

- Amerigroup– The average distance to a choice of five providers was 1.9 miles; to four providers was 1.8 miles; to three providers was 1.7 miles; to two providers was 1.5 miles; and to one provider was 1.2 miles.
- Sunflower – The average distance to a choice of five providers was 1.9 miles; to four providers was 1.8 miles; to three providers was 1.6 miles; to two providers was 1.5 miles; and to one provider was 1.2 miles.
- United– The average distance to a choice of five providers was 2.0 miles; to four providers was 1.9 miles; to three providers was 1.9 miles; to two providers was 1.7 miles; and to one provider was 1.5 miles.

Densely-Settled Rural

- Amerigroup – The average distance to a choice of five providers was reported as 4.7 miles; to four providers was 4.6 miles; to three providers was 3.9 miles; to two providers was 3.3 miles; and to one provider was 2.5 miles.
- Sunflower – The average distance to a choice of five providers was 5.4 miles; to four providers was 5.0 miles; to three providers was 4.9 miles; to two providers was 4.6 miles; and to one provider was 3.5 miles.
- United – The average distance to a choice of five providers was 4.3 miles; to four providers was 4.2 miles; to three providers was 4.1 miles; to two providers was 4.0 miles; and to one provider was 3.4 miles.

Rural/Frontier

- Amerigroup – The average distance to a choice of five providers was reported as 18.6 miles; to four providers was 15.0 miles; to three providers was 12.8 miles; to two providers was 10.3 miles; and to one provider was 7.3 miles.
- Sunflower – The average distance to a choice of five providers was 17.3 miles; to four providers was 16.8 miles; to three providers was 14.3 miles; to two providers was 12.9 miles; and to one provider was 10.7 miles.
- United – The average distance to a choice of five providers was 11.4 miles; to four providers was 11.3 miles; to three providers was 10.8 miles; to two providers was 10.4 miles; and to one provider was 9.5 miles.

Recommendation update from KanCare Evaluation Annual Report for CY2013: Amerigroup GeoAccess reports were corrected to ensure accurate reporting for average distance and access standards.

Percent of counties covered within access standards for behavioral health

Behavioral health providers were available to members of all three MCOs within the State access standards for each county type.

Urban/Semi-Urban

The access standard for Urban and Semi-Urban counties is a distance of 30 miles. This access standard was met in CY2013 for 100% of the 16 Urban and Semi-Urban counties in Kansas, as reported by the three MCOs. Based on the GeoAccess map reports, the access standard was also met in CY2013 and CY2012.

Densely-Settled Rural
The access standard for Densely-Settled Rural counties is a distance of 45 miles. This access standard was met in CY2014 for 100% of the 21 Densely-Settled Rural counties in Kansas, as reported by the three MCOs. Based on the GeoAccess map reports, the access standard was also met in CY2013 and CY2012.

Rural/Frontier
The access standard for Rural and Frontier counties is a distance of 60 miles. This access standard was met in CY2014 for 100% of the 32 Rural counties and the 36 Frontier counties in Kansas, as reported by Amerigroup, Sunflower, and United. Based on the GeoAccess map reports, the access standard was also met in CY2013 and CY2012.

Home and Community Based Services (HCBS) - Counties with access to at least two providers by provider type and services.
Table 27 provides information reported by the three MCOs indicating the number of counties that have at least two service providers, and the number of counties that have at least one service provider, for each HCBS provider type. The baseline for this measure is CY2013 since no comparable pre-KanCare reports of HCBS provider type by county were identified for review.

As indicated in Table 27, 16 of the 27 HCBS services are available from at least two service providers in all 105 counties for members of all three MCOs.

Of the remaining 11 Home and Community Based Services:
- **Adult Day Care**
    - Amerigroup - Services are available from at least two providers in 82 counties, an increase of 8 additional counties in CY2014. At least one service provider is available in 103 of the 105 counties (same as CY2013).
    - Sunflower - Services are available from at least two providers in only 50 counties, an increase of 3 counties in CY2014. At least one service provider is available in 76 counties, an increase of 3 counties in CY2014.
    - UnitedHealthcare - Services are available from at least two providers in 87 counties, an increase of 13 counties in CY2014. UHC continues to have at least one service provider in all 105 counties.
- **Intermittent Intensive Medical Care**
    - In CY2013 and CY2014, Amerigroup reported that 84 counties had at least two service providers, and 104 counties had at least one service provider.
    - Sunflower reported that in CY2014 at least two service providers are available in 91 counties, an increase of 13 compared to CY2013. Sunflower reported in CY2014 and CY2013 that all 105 counties had at least one service provider.
    - UnitedHealthcare reported that there were at least two service providers available in CY2013 and CY2014 in all 105 counties.
- **Speech Therapy (Autism Waiver)**
    - Amerigroup – In CY2014, Amerigroup reported that in 79 counties there were two or more providers available for specialized speech therapy for those on the

Autism Waiver. In CY2013, Amerigroup reported services from at least two providers were only available in three counties.
  - Sunflower - In CY2014, Sunflower reported that in 15 counties there were two or more providers available for specialized speech therapy for those on the Autism Waiver, and that at least one service provider was available in 28 counties. In CY2013, Sunflower reported services from at least two providers were available in 13 counties, and at least one service provider in 27 counties.
  - UnitedHealthcare – In CY2014 and CY2013, UHC reported that these specialized services were only available from two or more providers in two counties.
- **Speech Therapy – TBI Waiver**
  - In CY2013 and CY2014, Amerigroup and Sunflower reported that at least two providers were available in all 105 counties for this specialized speech therapy for those with TBI.
  - UnitedHealthcare reported that at least two providers were available in 5 counties (a decrease of two from CY2013), and that at least one provider was available in 21 counties in CY2014 and CY2013.
- **Behavior Therapy – TBI Waiver**
  - Amerigroup and Sunflower reported that at least two providers were available in all 105 counties for this specialized behavior therapy for those with TBI.
  - UnitedHealthcare reported that at least two providers were available in 12 counties (an increase of 11 compared to CY2013), and that at least one provider was available in 41 counties in CY2014 (compared to 4 counties in CY2013).
- **Cognitive Therapy – TBI Waiver**
  - In CY2014 and CY2013, Amerigroup and Sunflower reported that at least two providers were available in all 105 counties for this specialized cognitive therapy for those with TBI.
  - UnitedHealthcare reported that at least two providers were available in 12 counties (an increase of 11 compared to CY2013), and that at least one provider was available in 41 counties in CY2014 (compared to 4 counties in CY2013).
- **Occupational Therapy – TBI Waiver**
  - In CY2014 and CY2013, Amerigroup and Sunflower reported that at least two providers were available in all 105 counties for this specialized occupational therapy for those with TBI.
  - UnitedHealthcare reported that in CY2014 and CY2013 at least two providers were available in 11 counties. In CY2014, UnitedHealthcare reported that at least one provider was available in 26 counties in CY2014, a decrease of 6 compared to CY2013.
- **Physical Therapy – TBI Waiver**
  - Amerigroup and Sunflower reported that at least two providers were available in all 105 counties in CY2014 and CY2013 for this specialized physical therapy for those with TBI.
  - UnitedHealthcare reported that at least two providers were available in 24 counties in CY2014, compared to 14 in CY2013, and that at least one provider was available in 53 counties in CY2014, an increase of 17 compared to CY2013.

Table 27: Home and Community Based Services (HCBS) - Counties with access to at least 2 providers, by provider type and services

	Amerigroup		Sunflower		UnitedHealthcare	
Provider type	**2 or more**	**at least 1**	**2 or more**	**at least 1**	**2 or more**	**at least 1**
Adult day care	**82**	**103**	**50**	**76**	**74**	105
Intermittent intensive medical care	**84**	**104**	**91**	105	105	105
Speech therapy - Autism Waiver	**79**	**79**	**15**	**28**	**2**	**2**
Speech therapy - TBI waiver	105	105	105	105	**5**	**21**
Behavior therapy - TBI waiver	105	105	105	105	**12**	**41**
Cognitive therapy - TBI waiver	105	105	105	105	**12**	**41**
Occupational therapy - TBI waiver	105	105	105	105	**11**	**26**
Physical therapy - TBI waiver	105	105	105	105	**24**	**53**
Home modification	**23**	105	105	105	105	105
Health maintenance monitoring	**70**	**103**	**91**	105	105	105
Specialized medical care/medical respite	105	105	**90**	105	105	105
Assistive services	105	105	105	105	105	105
Assistive technology	105	105	105	105	105	105
Attendant care services (Direct)	105	105	105	105	105	105
Comprehensive support (Direct)	105	105	105	105	105	105
Financial management services (FMS)	105	105	105	105	105	105
Home telehealth	105	105	105	105	105	105
Home-delivered meals (HDM)	105	105	105	105	105	105
Long-term community care attendant	105	105	105	105	105	105
Medication reminder	105	105	105	105	105	105
Nursing evaluation visit	105	105	105	105	105	105
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
Sleep cycle support	105	105	105	105	105	105
Transitional living skills	105	105	105	105	105	105
Wellness monitoring	105	105	105	105	105	105

- **Health Maintenance Monitoring**
  - Amerigroup – In CY2013 and CY2014, Amerigroup reported that at least two service providers were available in 70 counties, and 103 counties had at least one service provider.
  - Sunflower – In CY2014, Sunflower reported that two or more providers were available in 91 counties (a decrease of 14 compared to CY2013) and that at least one provider was available in 105 counties (same as CY2013).
  - UnitedHealthcare – In CY2013 and CY2014, UHC reported that at least two service providers were available in all 105 counties. Z
- **Home Modification**
  - In CY2013 and CY2014, Amerigroup reported that only 23 counties had at least two service providers, and 105 counties had at least one service provider.
  - In CY2014 and CY2013, Sunflower and UnitedHealthcare reported that at least two service providers were available in all 105 counties.

- **Specialized medical care/medical respite**
    - In CY2013 and CY2014, Amerigroup and UnitedHealthcare reported that at least two service providers were available in all 105 counties.
    - In CY2014, Sunflower reported that at least two service providers were available in 90 counties, a decrease of 15 compared to CY2013. In both CY2013 and CY2014, Sunflower reported that at least one provider was available in all 105 counties.

As discussed in last year's KanCare Evaluation Annual Report, there is a wide gap in reporting of availability of the TBI-related services that indicates potential discrepancies in reporting by the MCOs and/or differences in defining the criteria required for service providers for these specialized services.

There is no indication in the report again this year as to which counties do not have at least two services available. The provider network adequacy reports indicate specific providers, but do not separately provide a list of counties with no providers (or less than two providers).

Population – The HCBS reports 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 are in need of services that are not commonly needed or available.

Recommendations:

- KFMC again recommends this year that reporting be revised to require MCOs to report the specific counties where there are no providers contracted for specific services and specific counties where only one provider is contracted for specific services.
- KFMC again recommends that the State follow up with the MCOs to clarify the availability of the TBI-related HCBS service providers.
- For those counties with no providers, it would be important to know the number of members needing these services that reside in that county and their average distance to a provider. It is possible members needing these services are able to obtain them in a nearby county (or through arrangement by the MCO in a neighboring state). It is also possible, particularly in low-population Frontier counties, for there to be no members in need of a particular service.

Provider Open/Closed Panel Report

The MCOs submit monthly Network Adequacy reports that include a data field for indicating whether the provider panel is open, closed, or accepting only existing patients. This is primarily populated for primary care provider types.

Last year KFMC recommended that, due to a high frequency of duplicate entries (including exact duplicates, address variations for the same address, P.O. Box address and street address in a small town, etc.), the MCOs should review this report and remove duplicate entries. Some entries indicated the provider is not accepting patients, while others for the same provider at the same address gave either no indication or conflicting information. State program managers routinely de-duplicate the entries to better identify available providers on this report that has tens of thousands of entries.

KFMC again this year selected a sample of several hundred physician records in each MCO's most recent Network Adequacy report.

- Amerigroup continued to have many exact duplicate entries. In one group of 89 physicians reviewed, 19 were exact duplicate entries. In another group of 576 physicians 65 were exact duplicates.
- The samples selected for UnitedHealthcare and Sunflower had no exact duplicates, but there were a number of addresses for the same building but different suite numbers or had addresses that differed by one number. (Sunflower's 2013 provider survey validation report completed by KFMC noted that 99 of 1,500 surveys mailed were returned for "bad address," and that follow-up calls found 74 wrong numbers, 20 disconnected numbers, and 14 with changes in phone numbers.)
- In all of the MCOs' recent 2015 reports there were a number of physicians whose termination dates were in 2013. Two of the MCOs had over 2,000 entries listed as terminated in 2013.
- It was also noted that in Sunflower's network adequacy report, all cardiologists appeared to be listed as well as cardiovascular surgeons (at the same address). This should be corrected, as these are separate specialties, and cardiologists are generally not cardiovascular surgeons.

Other questions raised in reviewing the provider network adequacy reports:

- The numbers of records in the report ranged from 43,980 (Sunflower) to 63,060 (UnitedHealthcare) to 72,502 (Amerigroup).
- Sunflower's report did not include a "Credentialed" field. The "credentialed" options in UnitedHealthcare's report are "yes" (57,509) and "blank" (5,551). Amerigroup's "credentialed" options are "yes" (69,281) and "no" (3,221).
- The reports from all three MCOs included providers "terminated" in 2013: Amerigroup 2,214; Sunflower 204; and UnitedHealthcare 2,332.

Recommendations:

- The MCOs should continue to update the Network Adequacy report to include complete de-duplicated data and current status as to whether the practice is open or closed for accepting new patients, and up-to-date physical addresses of each provider.
- Amerigroup should review their provider database to remove duplicate entries.
- Report entries identified as "terminated" in 2013 should be reviewed to determine if these providers remain "terminated" in 2015.

- Sunflower should remove duplicate entries for cardiologists who are incorrectly listed as cardiovascular surgeons.
- Sunflower should add a "credentialed" field to their report, if required by the State. Response options for this field (for all MCOs) should include, at a minimum "yes" and "no."

Provider After-Hour Access (24 hours per day/7 days per week)

The MCOs are required by the State to ensure that the 24/7 requirement is met. 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.

- Amerigroup conducts an annual survey of providers. Their first annual survey in 2013 found that 87% of the providers surveyed were in compliance with after-hours requirements. Amerigroup staff meet with providers not in compliance, and then follow up with "secret shopper" type activities to confirm that changes have been put in place.
- Sunflower assessed after hours care through a web-based survey and through calls to provider offices after regular business hours. In 2013, their after-hours monitoring was primarily through self-report by providers. In 2014 Sunflower directly called providers after-hours and found a performance rate of 80.06% (below the goal of 90%). Sunflower is planning to remind providers of call standards in 2015 and continue to monitor progress.
- UnitedHealthcare contracts with a vendor (Dial America) that calls a random sample of providers after hours to ensure on-call service is available.

Amerigroup and UnitedHealthcare also included a supplemental question in their CAHPS surveys in CY2014 addressing after-hours appointment access.

- Amerigroup asked in their adult survey, "**In the last six months, if you called your doctor's office after office hours for an urgent need, how many minutes did you usually have to wait between making a call to the office and speaking to the doctor or doctor's representative?"**
    - 21.8% indicated they called after hours for an urgent need.
    - 71.3% of those who called said their wait to speak to a doctor or the doctor's representative was less than 20 minutes; 14.9% said they waited more than 20 minutes; and 13.8% said their wait exceeded 60 minutes.
- United asked in their adult survey, **"In the last 6 months, did you call a doctor's office of clinic after hours to get help for yourself?"** A similar question was included in the child survey. A follow-up question was also added for both adult and child surveys of those who responded positively: **"In the last 6 months, when you called a doctor's office or clinic after hours, how often did you get the help you wanted?"**
    - 11.3% of adults, 7.6% of general child survey respondents and 10.4% of children with chronic conditions survey respondents indicated they called after hours to get help.

- Of those who indicated they called their provider after hours:
  - Adults – 66% said they always or usually got the help they wanted, and 19.1% said they never got the help they wanted.
  - GC survey – 81.2% said they always or usually get the help they wanted, and 12.5% said they never got the help they wanted.
  - CCC survey – 82.2% said they always or usually get the help they wanted, and 8.9% said they never got the help they wanted.

Annual Provider Appointment Standards Access (In-office wait times; Emergent, urgent and routine appointments; Prenatal care – first second, 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 above) are required of the MCOs by the State for tracking these measures.

- Sunflower reported to the State that in late 2013 they conducted a web-based survey of appointment access for various appointment types (including routine, urgent, high risk pregnancy, trimester of pregnancy) and for wait times in office. The survey results showed that access rates varied from 42.3% to 79.6%, compared to the 90% goal.
- The MCOs use surveys, "secret shopper" calls, and follow-up provider education to monitor access to appointments.
- Calls from members with concerns about access prompt follow-up contact by provider representatives through the grievance processes.
- UnitedHealthcare's vendor (Dial America) also contacts providers, identifies themselves as representing United, describes symptoms that represent either an urgent or routine need, and ask when the next available appointment would be. Dial America contacts a random sample of 10% of the callers, using a "secret shopper" approach where they do not identify themselves as representing United. United then follows up with providers who are identified as not being in compliance.

Sunflower included a supplemental question in the CAHPS surveys in CY2014 related to appointment access: "In the last 6 months, how many days did you usually have to wait between making an appointment (for your child) for urgent care and actually seeing a provider?"

- Response options were: "Within 3 business days" and "Greater than 3 business days."
- Adults – 79.7% within 3 business days; GC Title XIX population – 90.3%; GC Title XXI population – 91.8%; CCC Title XIX population – 88.7%; CCC Title XXI population – 90.8%.
- Of concern is the response options of only "within or greater than 3 business days." The State standard for provision of urgent office visits is "within 48 hours." (A delay of 3 business days for a child with an ear infection or strep throat on a Friday night would mean the appointment would be on Wednesday afternoon.)

Recommendations for the 24/7 and Appointment Access Requirements:

- If no common reporting system or template can reasonably be developed for tracking these measures in CY2014, KFMC recommends that the State review the methods and systems used by each MCO to track provider adherence to these standards, and require routine reporting by each MCO that provides evidence that these access standards are consistently met.
- KFMC recommends that provider after-hour access be confirmed through after-hours phone calls to the providers.
- MCOs should report compliance rates and appointment availability for calls to provider offices from "secret shoppers" separately from callers who first identify that they are representatives of an MCO.
- Including access to care supplemental questions in the CAHPS survey is helpful in identifying member experience in accessing appointments. Wording of responses is important, however, in actually assessing whether the member had access within the goal response time. If Sunflower again includes the supplemental question, "In the last 6 months, how many days did you usually have to wait between making an appointment (for your child) for urgent care and actually seeing a provider?" in their CAHPS survey, response options should be revised from "Within 3 business days" and "Greater than 3 business days" to "Within 48 hours" and "Greater than 48 hours" to better reflect State standards for provision of "urgent" services to members.

(20) Member survey – CAHPS

Additional detail on the CAHPS survey In CY2014 can be found in Section 4 of this report in the Health Literacy section. CAHPS questions related to access of care include the questions in Table 28.

- **In the last 6 months, did you make any appointments (for your child) to see a specialist?**
  In CY2014, 43.0% of adults (compared to 35.9% in CY2012); 17.9% of GC survey population (compared to 19.8% in CY2012); and 38.4% of the CCC survey population reported having one or more appointments with a specialist in the previous 6 months.
  - **In the last 6 months, how often did you get an appointment (for your child) to see a specialist as soon as you needed?**
    In CY2014, 84.8% of adults, 83.2% of the GC population, and 85.3% of the CCC population indicated they were able to see a specialist as soon as they needed. These positive responses were higher than in CY2012 (adults – 75.9%; GC – 79.0%). The adult results were above the QC 75th percentile, and the GC and CCC were above the QC 50th percentile.
- **In the last 6 months, how often was it easy (for your child) to get the care, tests, or treatment you (your child) needed?**
  Results were very positive in CY2014, with percentages ranging from 87.6% for adults (compared to 84.7% in CY2012); 93.4% GC population (compared to 90.5% in CY2012); and 93.0% CCC population. These results were all above the QC 75th percentile.

Table 28: Member Survey - CAHPS Access to Care Questions						
Question	Population	Highest Weighted Percentage	QC 50th Percentile			Pre-KanCare Highest Percentage
			Above	Below	N/A	
Q24. 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? (GC and CCC Q45)	Adult	43.0%			X	35.9%
	GC	17.9%			X	19.8%
	CCC	38.4%			X	
Q25. In the last 6 months, how often did you get an appointment (for your child) to see a specialist as soon as you needed? (GC and CCC Q46)	Adult	84.8%	X			75.9%
	GC	83.2%	X			79.0%
	CCC	85.3%	X			
Q14. In the last 6 months, how often was it easy to get the care, tests, or treatment you (your child) needed? (GC and CCC Q15)	Adult	87.6%	X			84.7%
	GC	93.4%	X			90.5%
	CCC	93.0%	X			
Q5. 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? (GC and CCC Q5)	Adult	75.8%			X	73.5%
	GC	70.8%			X	77.8%
	CCC	80.0%			X	
Q6. 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? (GC and CCC Q6)	Adult	82.9%	X			81.3%
	GC	90.6%	X			89.9%
	CCC	92.2%		X		
Q3. 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? (GC and CCC Q3)	Adult	45.2%			X	44.3%
	GC	35.2%			X	32.1%
	CCC	43.6%			X	
Q4. 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 and CCC Q4)	Adult	88.1%	X			80.0%
	GC	94.1%	X			85.6%
	CCC	95.0%	X			

- **In the last 6 months, did you make any appointments for a <u>check-up or routine care</u> (for your child) at a doctor's office or clinic?**
  In CY2014, 75.8% of the adults made appointments for a check-up or routine care within the previous 6 months, comparable to CY2012 (73.5%). The percentage of the GC population that scheduled a check-up or routine care was lower in CY2014 (70.8%) compared to CY2012 (77.8%). For the CCC population surveyed in CY2014, the percentage was 80.0%
  - **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 <u>check-up or routine care</u> at a doctor's office or clinic as soon as you thought you needed?**
    Of those who did schedule an appointment, 82.9% of adults (CY2012 – 81.3%); 90.6% of the GC population (CY2012 – 89.9%); and 92.2% of the CCC population indicated they were able to get an appointment as soon as they needed it. The adult results were above the QC 75th percentile; the GC results were above the QC 50th percentile; and the CCC results were below the QC 50th percentile (and above the 25th percentile).

- **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 CY2014, 45.2% of adults (CY2012 – 44.3%); 35.2% of the GC (CY2012 – 32.1%); and 43.6% of the CCC populations surveyed indicated they needed care right away in a clinic, emergency room, or doctor's office during the previous 6 months.
  - **In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?** The results in CY2014 for adults (88.1%) were higher than the CY2012 results (80.0%) and above the QC 90th percentile. Results for the GC population (94.1%) were also higher than the CY2012 results (85.6%), and were above the QC 75th percentile. The CCC population results (95.0%) were above the QC 50th percentile.

(21) Member survey – Mental Health
The Mental Health Surveys conducted in CY2014 and CY2013 are described above in Section 7.

Questions related to member perceptions of access to mental health services are listed in Table 29 and results are described below:

- **Provider availability as often as member felt it was necessary**
  - Results in CY2014 (87.9%) from the general adult survey were comparable to CY2013 (88.2%). Annual rates for this measure in the general adult population have been consistent, with rates ranging from 85.4% (CY2012) to 88.8% (CY2011).
- **Provider return of calls within 24 hours**
  - Response results in CY2014 (83.3% positive) were comparable to CY2013 (84.4%) in the general adult survey population.
- **Services were available at times that were good for the member**
  - Responses in CY2014 were comparable to those in CY2013, with no statistically significant changes. Positive response rates ranged from 85.2% (SED Waiver youth and young adults) to 89.8% (general adult survey).
- **Ability to get all the services the members thought they needed**
  - In CY2013 (compared to CY2012), there was a statistically significant increase in the positive response rate in the general adult population from CY2012 (78.8%) to CY2013 (86.0%), $p<0.01$. The positive response rate in CY2014 was comparable to CY2013, increasing slightly to 86.5%.
  - In CY2014, positive response rates ranged from 74.8% for SED Waiver youth (ages 12-17), youth responding, to 86.5% for general adult survey.
- **Ability to see a psychiatrist when the member wanted to**
  - In CY2013 there was a statistically significant increase in the positive response rate (82.3%) for general adults compared to CY2012 (70.8%), $p <0.001$. The rate in CY2014 decreased only slightly to 80.5%.
- **Ability to get services during a crisis**
  - There were no statistically significant changes in positive response results in CY2014 compared to CY2013. The percentage of positive responses from the general adult population increased slightly from 85.4% to 86.0%; for the general

youth, family responding, there was a decrease from 86.2% to 83.4%; and for the SED Waiver youth and young adults, family responding, an increase in positive responses from 76.4% in CY2013 to 81.5% in CY2014.

Table 29: Mental Health Survey - Access-Related Questions

Question	Year	%	N/D	95% Confidence	p-value (compare 2014 to 2013)
My mental health providers were willing to see me as often as I felt it was necessary.	**General Adult (Age 18+)**				
	2014	**87.9%**	707 / 804	85.7% - 90.2%	0.84
	2013	**88.2%**	928 / 1051	86.3% - 90.2%	
	2012	*85.4%*	*233 / 273*	*80.6% - 89.3%*	
	2011	*88.8%*	*233 / 273*	*80.6% - 89.3%*	
My mental health providers returned my calls in 24 hours.	**General Adult (Age 18+)**				
	2014	**83.3%**	619 / 743	80.7% - 86.0%	0.55
	2013	**84.4%**	840 / 996	82.1% - 86.6%	
	2012	*80.8%*	*202 / 250*	*75.4% - 85.5%*	
	2011	*88.1%*	*251 / 285*	*84.3% - 91.8%*	
Services were available at times that were good for me.	**General Adult (Age 18+)**				
	2014	**89.8%**	734 / 817	87.7% - 91.9%	0.08
	2013	**92.1%**	986 / 1070	90.5% - 93.8%	
	2012	*87.7%*	*242/276*	*83.2% - 91.3%*	
	2011	*92.3%*	*277/300*	*89.3% - 95.3%*	
	General Youth (Age <18), Family Responding				
	2014	**86.9%**	680 / 783	84.5% - 89.3%	0.26
	2013	**88.7%**	871 / 983	86.7% - 90.6%	
	2012	*88.0%*	*235 / 267*	*83.5% - 91.7%*	
	2011	*85.9%*	*287 / 334*	*82.2% - 89.7%*	
	General Youth (Age 12-17), Youth Responding				
	2014	**87.5%**	270 / 308	83.8% - 91.2%	0.60
	2013	**88.7%**	411 / 464	85.8% - 91.6%	
	2012	*83.0%*	*83 / 100*	*74.2% - 89.8%*	
	2011	*89.5%*	*119 / 133*	*84.3% - 94.7%*	
	SED Waiver Youth and Young Adult (0-21), Family Responding				
	2014	**85.2%**	357 / 418	81.8% - 88.6%	0.95
	2013	**85.1%**	415 / 487	81.9% - 88.3%	
	2012	*88.6%*	*287 / 324*	*85.1% - 92.0%*	
	2011	*85.3%*	*243 / 285*	*81.2% - 89.4%*	
	SED Waiver Youth (Age 12-17), Youth Responding				
	2014	**86.0%**	167 / 194	81.1% - 90.9%	0.35
	2013	**82.6%**	190 / 230	77.7% - 87.5%	
	2012	*82.2%*	*111 / 135*	*74.7% - 88.3%*	
	2011	*83.7%*	*103 / 123*	*77.2% - 90.3%*	
I was able to see a psychiatrist when I wanted to.	**General Adult (Age 18+)**				
	2014	**80.5%**	599 / 745	77.6% - 83.3%	0.33
	2013	**82.3%**	808 / 982	79.9% - 84.7%	
	2012	*70.8%*	*187 / 264*	*65.0% - 76.2%*	
	2011	*82.1%*	*225 / 274*	*77.6% - 86.7%*	

Table 29: Mental Health Survey - Access-Related Questions (Continued)					
Question	**Year**	**%**	**N/D**	**95% Confidence**	**p-value (compare 2014 to 2013)**
I was able to get all the services I thought I needed.	**General Adult (Age 18+)**				
	2014	**86.5%**	705 / 814	84.2% - 88.9%	0.74
	2013	**86.0%**	916 / 1065	83.9% - 88.1%	
	2012	*78.8%*	*219 / 278*	*73.5% - 83.4%*	
	2011	*91.3%*	*274 / 300*	*88.2% - 94.5%*	
	General Youth (Age 12-17), Youth Responding				
	2014	**83.8%**	259 / 309	79.7% - 87.9%	0.73
	2013	**82.8%**	388 / 468	79.4% - 86.2%	
	2012	*85.0%*	*85 / 100*	*76.5% - 91.4%*	
	2011	*85.1%*	*114 / 134*	*79.0% - 91.1%*	
	SED Waiver Youth (Age 12-17), Youth Responding				
	2014	**74.8%**	138 / 184	68.5% - 81.0%	0.50
	2013	**71.8%**	167 / 233	66.0% - 77.6%	
	2012	*76.3%*	*103 / 135*	*68.2% - 83.2%*	
	2011	*77.6%*	*97 / 125*	*70.3% - 84.9%*	
My family got as much help as we needed for my child.	**General Youth (Age <18), Family Responding**				
	2014	**79.7%**	610 / 766	76.8% - 82.5%	0.06
	2013	**83.2%**	804 / 966	80.9% - 85.6%	
	2012	*82.9%*	*213 / 257*	*77.7% - 87.3%*	
	2011	*84.2%*	*278 / 330*	*80.3% - 88.2%*	
	SED Waiver Youth and Young Adult (0-21), Family Responding				
	2014	**76.4%**	316 / 414	72.3% - 80.5%	0.68
	2013	**75.2%**	363 / 483	71.3% - 79.0%	
	2012	*77.3%*	*248 / 321*	*72.7% - 81.8%*	
	2011	*77.5%*	*220 / 284*	*72.6% - 82.3%*	
During a crisis, I was able to get the services I needed.	**General Adult (Age 18+)**				
	2014	**86.0%**	587 / 682	83.4% - 88.6%	0.72
	2013	**85.4%**	744 / 872	83.0% - 87.7%	
	2012	*79.2%*	*183 / 231*	*73.4% - 84.3%*	
	2011	*88.1%*	*251 / 285*	*84.3% - 91.8%*	
During a crisis, my family was able to get the services we needed.	**General Youth (Age <18), Family Responding**				
	2014	**83.4%**	456 / 547	80.3% - 86.5%	0.17
	2013	**86.2%**	607 / 704	83.7% - 88.8%	
	2012	*87.4%*	*173 / 198*	*81.9% - 91.7%*	
	2011	*89.5%*	*204 / 228*	*85.5% - 93.5%*	
	SED Waiver Youth and Young Adult (0-21), Family Responding				
	2014	**81.5%**	275 / 338	77.3% - 85.6%	0.10
	2013	**76.4%**	298 / 390	72.2% - 80.6%	
	2012	*79.1%*	*197 / 249*	*74.1% - 84.2%*	
	2011	*80.1%*	*173 / 216*	*74.8% - 85.4%*	
Medication available timely*	**General Adult (Age 18+)**				
	2014	**92.7%**	660 / 712	90.8% - 94.6%	0.52
	2013	**91.8%**	833 / 907	90.0% - 93.6%	
	General Youth (Age <18)				
	2014	**85.3%**	407 / 477	82.1% - 88.5%	0.72
	2013	**86.1%**	530 / 616	83.3% - 88.8%	
	SED Waiver Youth and Young Adult (0-21), Family Responding				
	2014	**94.8%**	358 / 377	92.6% - 97.1%	**0.03**
	2013	**90.9%**	380 / 418	88.2% - 93.7%	**+**
	(*Not asked in 2012 and 2011)				

- **Timely availability of medication**
  - There was a statistically significant increase in positive responses from SED Waiver youth and young adults (family responding), increasing from 90.9% in CY2013 to 94.8% in CY2014, p=0.03.
  - Positive response rates in CY2014 for the general adult survey population increased slightly from 91.8% in CY2013 to 92.7% in CY2014, and decreased slightly in the general youth survey population from 86.1% in CY2013 to 85.3% in CY2014.

(22) Member Survey – SUD

Section 7 above provides background on the SUD survey conducted by the three MCOs in 2014. Questions related to perceptions of access to care for members receiving SUD services include the following:

- **Did you get an appointment as soon as you wanted?**
  For their first appointment for their current treatment, 186 (92.1%) of 202 members who responded indicated they got an appointment as soon as they wanted. (2012 – 89.6%)
- **For urgent problems, how satisfied are you with the time it took you to see someone?**
  - 57 (28.5%) of 200 survey respondents indicated that in the past year they had needed to see their counselor right away for an urgent problem. (2012 – 26%)
  - Of these 57, 56 (98.2%) indicated they were very satisfied or satisfied with the time it took to get to see someone. (2012 – 98.0%)
- **For urgent problems, were you seen within 24 hours, 24 to 48 hours, or did you wait longer than 48 hours?**
  55 of the 57 who indicated they had an urgent problem for which they needed to see a counselor.
  - 32 (58.2%) of the 55 were seen within 24 hours.
  - 17 (30.9%) of the 55 were seen within 24 to 48 hours.
  - 6 (10.9%) of the 55 were seen more than 48 hours later.
- **Is the distance you travel to your counselor a problem or not a problem?**
  Of 202 survey respondents, 180 (89.1%) indicated that the distance to travel to their counselor was not a problem. (2012 – 90.5%)
- **Were you placed on a waiting list?**
  Of 205 survey respondents, 25 (12.2%) indicated they were put on a waiting list. (2012 – 11.7%)
- **If you were placed on a waiting list, how long was the wait?**
  23 of the 25 members that indicated they were put on a waiting list responded:
  - For 8 of the 23, the wait was 2 to 7 days.
  - For 9 of the 23, the wait was 10 to 14 days.
  - For 3 of the 23, the wait was 3 to 4 weeks.
  - For 2 of the 23, the wait was 2.5 to 3 months, and 1 member responded "months."

  Due to the small sample size, it cannot be determined whether it is common or unusual for members to be on waiting lists for over two months. Additional follow-up is recommended to determine the numbers and locations of members on waiting

lists for SUD counseling for over two months to better identify areas where additional services should be provided.

(23) Provider Survey
Background information and comments on the Provider Survey are described in Section 8 above. In this section, results are reported for satisfaction with the preauthorization process (see Table 30). The provider survey results for the quality-related question are in Section 8, and results for the preauthorization-related question are in Section 17.

Providers were asked, "**Please rate your satisfaction with availability of specialists**." Table 30 provides the available survey results by individual MCO.

Table 30: Provider Satisfaction with Availability of Specialists

	Amerigroup		Sunflower		UnitedHealthcare		UnitedHealthcare BH survey	
	#	%	#	%	#	%	#	%
Very Satisfied	44	**17.1%**	18	**8.0%**	6	**9.5%**	3	**3.6%**
Somewhat Satisfied	74	**28.8%**	74	**32.7%**	*	*	24	**28.6%**
Neither Satisfied nor Dissatisfied**	95	**37.0%**	100	**44.2%**	*	*	46	**54.8%**
Somewhat Dissatisfied	28	**10.9%**	24	**10.6%**	*	*	7	**8.3%**
Very Dissatisfied	16	**6.2%**	10	**4.4%**	5	**7.9%**	4	**4.8%**
Total Responses*	257		226		63		84	

* Cannot be determined due to typographical errors in survey instrument
** Amerigroup and UnitedHealthcare provider survey response options are "Neither."

- **Amerigroup**
  - 45.9% of 257 providers surveyed (17.1%) were "very satisfied" (17.1%) or "somewhat satisfied" (28.8%).
  - 17.1% of the providers were "very dissatisfied" (6.2%) or "somewhat dissatisfied" (10.9%).
- **Sunflower**
  - 40.7% of the 226 providers surveyed were "very satisfied" (8.0%) or "somewhat satisfied" (32.7%).
  - 15.0% of the providers were "very dissatisfied" (4.4%) or "somewhat dissatisfied" (10.6%).
- **UnitedHealthcare**
  - Of the 36 providers surveyed, 6 (9.5%) were "very satisfied," and 5 (7.9%) were "very dissatisfied."
  - 32.2% of the 84 BH providers surveyed (3.6%) were "very satisfied" (3.6%) or "somewhat satisfied" (28.6%).
  - 13.1% of the BH providers were "very dissatisfied" (4.8%) or "somewhat dissatisfied" (8.3%).

EFFICIENCY

(24) Grievances – Reported Quarterly

- **Compare/track number of access-related grievances over time, by population type.**
  Grievances are analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review.

(25) Calls and Assistance – Reported Quarterly

- **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.**
  The types of assistance and numbers of contacts provided to KanCare members by the Ombudsman's Office are analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review.

(26) Systems

Baseline data for 2013, stratified by SUD, I/DD, PD, TBI, Frail Elderly (FE), and Mental Health (MH) for the following measures will be compared to CY2014 data when data are available for both years. Reporting of Emergency Department Visits, Inpatient Hospitalizations, and Readmissions within 30 days of Inpatient Discharge are currently in development by KDHE staff for the KanCare population and by waiver and will be analyzed for CY2013 and CY2014 in the CY2015 KanCare Evaluation Annual Report. HEDIS data reported for CY2013 for ED visits are reported below for the KanCare population based on HEDIS data submitted to KDHE by the three MCOs.

- **Emergency Department (ED) Visits**
  - Population: KanCare (all members), and stratified by I/DD, PD, TBI, MH, and FE
  - Analysis: Comparison of baseline CY2013 to annual measurement and trending over time.
    The aggregate number of visits per 1,000 member months for 2013, as reported for HEDIS 2014 by the three MCOs is 65.17 visits per 1,000 member months. This is just above the QC 50th percentile for CY2013. There were 288,712 ED visits (using HEDIS criteria) for 4,430,392 combined member months in CY2013.
- **Inpatient Hospitalizations**
  - Population: KanCare (all members), and stratified by I/DD, PD, TBI, MH, and FE
  - Analysis: Comparison of baseline CY2013 to annual measurement and trending over time.
    This measure is in development by KDHE staff and will be reported for CY2013 and CY2014 for the KanCare population and by waiver in the CY2015 KanCare Annual Evaluation Report.

- **Inpatient Readmissions within 30 days of inpatient discharge**
  - Population: KanCare (all members), and stratified by I/DD, PD, TBI, MH, FE, and MH.
  - Analysis: Comparison of baseline CY2013 to annual measurement and trending over time.

    This measure is in development by KDHE staff and will be reported for CY2013 and CY2014 for the KanCare population and by waiver in the CY2015 KanCare Annual Evaluation Report.
- **Quantify system design innovations implemented by KanCare such as: Person-Centered Medical Homes, Electronic Health Record use, Use of Telehealth, and Electronic Referral Systems**
  System design innovations for improved health care provision throughout Kansas have been analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review. For CY2015, these systems design innovations will be reported in the KanCare Evaluation Annual Report.
- **Timely resolution of grievances – Reported Quarterly**
  Timely resolution of grievances is analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review.
- **Compare/track number of access-related grievances over time, by population type – Reported Quarterly**
  Comparisons and tracking of access-related grievances over time and by population are reported in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review.
- **Timeliness of claims processing – Reported Quarterly**
  Timeliness of processing clean claims, non-clean claims, and all claims is reported and analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review. Included in this measure are the numbers of claims received each month, the number of claims processed within contractually required timeframes, and analysis of trends over time for turn-around times for processing clean claims.

(27) Member Surveys

CAHPS Survey

Additional detail on the CAHPS survey In CY2014 can be found in Section 4 of this report in the Health Literacy section.

CAHPS questions related to efficiency include the following questions listed in Table 31:

Table 31: Member Survey - CAHPS						
Question	Population	Highest Weighted Percentage	QC 50th Percentile			Pre-KanCare Highest Percentage
			Above	Below	N/A	
Q30. **In the last 6 months, did you get information or help from your (child's) health plan's customer service?** (GC and CCC Q49)	Adult	**33.1%**			X	**33.8%**
	GC	**24.7%**			X	**37.9%**
	CCC	**28.3%**			X	
Q31. **In the last 6 months, how often did your (child's) health plan's customer service give you the information or help you needed?** (GC and CCC Q50)	Adult	**80.0%**		X		**77.1%**
	GC	**86.7%**	X			**80.1%**
	CCC	**84.8%**	X			

- **In the last 6 months, did you get information or help from your (child's) health plan's customer service?**
  In CY2014, 33.1% of adults indicated they requested help or information from their MCO's customer service (33.8% in CY2012). For the GC population, only 24.7% of those surveyed contacted customer service in CY2014, compared to 37.9% in CY2012. Contacts from the CCC population in CY2014 (28.3%) were comparable to the GC population.
  - **In the last 6 months, how often did your (child's) health plan's customer service give you the information or help you needed?**
    Of those who contacted their health plan's customer service in CY2014, 80.0% of adults; 86.7% of the GC population; and 84.8% of the CCC population indicated they received the information or help they needed. These percentages are increases compared to CY2012 (adults - 77.1%; GC – 80.1%). The adult percentage in CY2014 was below the QC 50th percentile; the GC results were above the QC 75th percentile; and CCC percentages were above the QC 50th percentile.

Mental Health Survey

The Mental Health Surveys conducted in CY2014 and CY2013 are described above in Section 7. The question related to efficiency of mental health services was: "**My mental health providers returned my calls in 24 hours**.*"* As shown in Table 32, over 83% of the adults surveyed in CY2014 indicated providers returned their calls within 24 hours, comparable to the CY2013 84.4% positive response.

Table 32: Mental Health Survey - Efficiency-Related Questions					
Question	Year	%	N/D	95% Confidence	p-value (compare 2014 to 2013)
My mental health providers returned my calls in 24 hours.	General Adult (Age 18+)				
	2014	**83.3%**	619 / 743	80.7% - 86.0%	0.55
	2013	**84.4%**	840 / 996	82.1% - 86.6%	
	2012	*80.8%*	*202 / 250*	*75.4% - 85.5%*	
	2011	*88.1%*	*251 / 285*	*84.3% - 91.8%*	

SUD Survey

Section 7 above provides background on the SUD survey conducted by the three MCOs in 2014. The question that follows is related to perception of efficiency for members receiving SUD services.

- **How would you rate your counselor on communicating clearly with you?** Of the 214 surveyed, 201 (93.9%) members rated their counselor as very good (70.1%) or good (23.8%) in communicating clearly with them.

Uncompensated Care Cost (UCC) Pool

Number of Medicaid Days for Uncompensated Care Cost 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 CY2013 is based on costs of care during FY2011, and funding for CY2014 is based on costs of care during FY2012.

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 to 206,882 in CY2014. 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 the Kansas Statute implemented at the start of the Kansas Fiscal Year 2013. The UCC Pool payments decreased slightly in CY2014 to $40,974,407.

Delivery System Reform Incentive Program (DSRIP)

KDHE proposed an amendment 8/19/2013, 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 subsequently 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.

CONCLUSIONS

In this second KanCare Evaluation Annual Report, KFMC has found that performance outcomes continue to be generally positive.

Comparison data varied based on the type of measure and availability of data.

- Many measures reviewed in this report include comparisons with pre-KanCare outcomes, including: SUD Services (Section 2); SUD Survey (Sections 7, 16, 22, and 27); five MH NOMS (Section 3); MH Survey (Sections 7, 14, 21, and 27); NF (Section 6); CAHPS Survey (Sections 4, 7, 14, 20, and 27); Provider Network Access (Section 19); and UCC Pool.
- For some measures, baseline data first became available in CY2014, including: HEDIS measures for CY2013 (Sections 1, 4, and 26); Flu Shots for Adults (new CAHPS question in CY2014); Provider Surveys (Sections 8, 17, and 23). Validation of several P4P measures is being finalized and will be reported in the CY2015 KanCare Evaluation Annual Report (Sections 1, 4, 5, and 11). Measures with data being finalized, and will be available for pre-KanCare comparison in the CY2015 KanCare Evaluation Annual Report, include HCBS service plan reviews (Sections 5 and 11), three MH NOMS (Section 3), Costs (Section 18), and Inpatient Admissions, Readmissions, and waiver-related ED visits (Section 26). Baseline data for multi-year HEDIS measures will be available in CY2015 (Sections 1 and 4).
- Measures reported in KanCare Quarterly Evaluation reports, beginning in Q4 CY2013, are referenced in this report (Sections 9, 24, 25, and 26) and are available for public review on the KanCare website.

Quality of Care

Physical Health

The baseline data submitted by the MCOs for 18 HEDIS measures, including results by age group, demonstrate areas of strength (where results were above the QC 50th percentile, and some higher than the 75th percentile) and areas where additional efforts should be focused (where results were below the QC 50th percentile or lower). Some of these lower scoring measures had higher results than pre-KanCare that will continue to be monitored for annual progress.

HEDIS measures in CY2013 with weighted aggregated results above the QC 50th percentile included:

- Adults' Access to Preventive/Ambulatory Health Services - all age ranges; ages 45-64 was above the QC 90th percentile, and the total (ages 20 and older) was above the QC 75th percentile;
- Follow-up (within 7 days) after Hospitalization for Mental Illness (P4P) – above the QC 75th percentile;
- Initiation and Engagement in Treatment for Alcohol or other Drug Dependence - Initiation for those ages 13-17 was above the QC 75th percentile, and for Engagement was above the QC 90th percentile; and
- Annual Dental Visit - all age groups except ages 19-21.

HEDIS measures in CY2013 with weighted aggregated results below the QC 50th percentile included:

- Comprehensive Diabetes Care (P4P for five of the eight measures) – below the QC 25th percentile for four of the eight measures (Blood Pressure Control [<140/90] [P4P]; LCL-C Screening; HbA1c Poor Control [>9.0%]; and HbA1c Control [<7.0%]);
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (below the QC 25th percentile);
- Adolescent Well Care Visits;
- Annual Monitoring for Patients on Persistent Medications;
- Prenatal and Postpartum Care;
- Chlamydia Screening in Women – below the QC 25th percentile;
- Controlling High Blood pressure – below the QC 25th percentile;
- Weight Assessment for Children and Adolescents (BMI) – below the QC 25th percentile;
- Counseling for Nutrition for Children and Adolescents – below the QC 25th percentile for ages 3-11;
- Counseling for Physical Activity for Children and Adolescents;
- Appropriate Treatment for Children with Upper Respiratory Infection – below the QC 10th percentile; and
- Appropriate Testing for Children with Pharyngitis (below the QC 25th percentile).

SUD Services

- Employment status (P4P) improved in CY2014. Overall and individual MCO P4P targets were met for CY2014.
- Attendance of self-help programs continues to be much lower in CY2014 than in CY2012. The percentage of involvement in these programs did increase in the first half of CY2014, but then dropped to below CY2012 percentages in the second half of the year.
- Three of the five measures (stable living at time of discharge from SUD services, decreased arrests, and decreased use of alcohol and/or other drugs) have had consistently high success rates pre-KanCare (CY2012) and in KanCare (CY2013-CY2014).

Mental Health Services

- The percentage of SPMI adults who were competitively employed improved each quarter of CY2014, increasing from 15.2% in Q1 to 16.5% in Q4. The overall and individual MCO P4P targets for two of the MCOs were met in CY2014.
- The rate of inpatient admissions was higher in the first two quarters of CY2014 than in CY2013, but was lower in Q3 and Q4. The overall and individual P4P targets for one of the three MCOs (UnitedHealthcare) were met for CY2014.
- The percentages of homeless adults with SPMI decreased during each quarter of CY2014 compared to CY2013. Compared to CY2012, quarterly percentages were higher in CY2014 for the first three quarters; the Q4 CY2014 percentage, however, was 4.4% lower than in Q4 CY2012.

- The percentages of SPMI adults and SED youth with increased access to services have decreased each year from CY2012 to CY2014.
- The percentage of SED youth who maintained a stable living arrangement remained high in CY2014. The percentage of youth who experience improvement in their residential status was somewhat lower than CY2013, but the numbers of SED youth at the beginning of each measurement period in CY2014 were lower than those in CY2012 and CY2013.
- Overall and individual P4P targets were not met for increased access to services for SPMI adults and SED youth. Comparison data for CY2012 and CY2013 were not available for this report.

Healthy Life Expectancy
<u>CAHPS Survey</u>

- Only 70.7% - 73.3% of members surveyed reported their health provider talked with them about specific things they could do to prevent illness. This was an improvement, however, compared to CY2012 survey results (68.9% - 70.0%).
- The CY2014 survey results for having questions answered by providers (89.6% - 90.9%), for explaining things in ways easy for the adult/parent to understand (91.9% - 95.5%), for explaining things in ways easy for the child to understand (91.1% - 92.4%), and for providers listening carefully (89.7%-95.7%) were higher than in CY2012.
- Of those who talked with their health provider about starting or stopping a medicine in CY2014 (Adults – 53.5%; GC – 31.9%; and CCC – 51.3%):
    - 59.5% of the GC and 60.8% of CCC survey respondents indicated the provider talked with them about reasons they might want their child to take a medicine. These results were above the QC 50th percentile and comparable to CY2012. Positive responses from adults in CY2014 (49.3%), though above the QC 50th percentile, were lower than in CY2012 (53.3%).
    - Fewer members reported their providers talked with them about reasons <u>not</u> to take a medicine. GC population (28.3%) results were above the QC 50th percentile but lower than in CY2012 (34.5%). The CCC survey results were higher than the GC population (35.2%) but below the QC 50th percentile. Adult survey results (27.9%) were lower than in CY2012 (36.7%) and below the QC 50th percentile.
    - Over 75% of the survey respondents indicate their provider asked what the member thought was best for them or their child. The GC (77.7%) and CCC (83.5%) results were above the QC 50th percentile, while the adult results (75.9%) were below the QC 50th percentile.
- Flu shot or flu spray for adults – In this baseline year, 48.8% of adults surveyed indicated they received a flu shot or flu spray in the second six months of CY2013.
- Smoking
    - 37.7% of adult members surveyed in CY2014 indicated they smoke cigarettes or use tobacco every day or some days (compared to 37.2% in CY2012).
    - 75.7% of those surveyed indicated their provider advised them to quit smoking or using tobacco, an increase from CY2012 (65.5%). This year's results are baseline for P4P in subsequent years.

- 48.3% (compared to 41.5% in CY2012) indicated their provider recommended medication to assist with quitting smoking or using tobacco.
- 38.6% (compared to 24.5% in CY2012) indicated their provider discussed or provided other methods or strategies other than medication to assist with quitting smoking or using tobacco.

HEDIS – The CY2013 baseline for "Diabetes Monitoring for people with Diabetes and Schizophrenia" at 62.9% was at the QC 25th percentile. Four additional P4P HEDIS measures reported for members who are SMI or are receiving PD or I/DD waiver services are being validated and will be reported in the CY2015 report.

Long Term Care: Nursing Facilities (NF)

- The percentage of NF claims denied increased from 11.51% in CY2012 to 13.46% in CY2013, and then decreased to 9.52% in CY2014.
- Falls with major injuries decreased from 0.62% in CY2012 to 0.53% in CY2013, and decreased further in CY2014 to 0.50% in CY2014.
- The percentage of NF Medicaid members readmitted to a hospital after being discharged from a NF decreased from 7.18% in CY2012 to 4.24% in CY2013, and decreased again in CY2014 to 3.84%.

Member Survey – CAHPS

On a scale of 0 to 10, with 10 being best possible and 0 being worst possible:

- 64.4% of adults, 73.4% of the GC, and 71.8% of the CCC populations surveyed rated their personal doctor as 9 or 10 (highest levels). The adult results were above the QC 50th percentile, and results for both child surveys were below the QC 50th percentile. Ratings of personal doctors in CY2014 were comparable to CY2012.
- 52.8% of adults (compared to 54.7% in CY2012), 68.6% of the GC population (compared to 62.7% in CY2012), and 65.2% of the CCC population rated their health care as 9 or 10. All results in CY2014 were above the QC 50th percentile.
- 54.6% of adults (compared to 55.3% in CY2012), 71.0% of the GC population (compared to 65.9% in CY2012), and 63.3% of the CCC population rated their health plan as 9 or 10. The adult and CCC results were below the QC 50th percentile, and results for the GC population were above the QC 50th percentile.
- 64.8% of adults (compared to 64.0% in CY2012), 69.6% of the GC population (compared to 67.4% in CY2012), and 68.5% of the CCC population rated the specialist they saw most often as 9 or 10. All results were below the QC 50th percentile.
- All three surveys had positive responses (above 90%) in CY2014 as to whether their personal doctor showed respect for what they had to say. The adult responses (91.9% compared to 83.7% in CY2012) and GC survey responses (96.7% compared to 91.8% in CY2012) were above the QC 50th percentile, while the CCC survey responses (94.4%) were below the QC 50th percentile.
- Positive responses were also high in CY2014 and CY2012 for whether their personal doctors spent enough time with the members. The adult responses (89.0% compared to 90.8% in CY2012) and GC survey responses (90.4%

compared to 91.6% in CY2012) were above the QC 50th percentile, while the CCC survey responses (90.6%) were below the QC 50th percentile.

Member Survey – Mental Health

- Responses were generally very positive in CY2014.
- There was a slight, though non-significant, increase in positive response from 88.3% to 89.5% as to whether the member, if given other options, would still get services from the mental health provider providing recent care.
- For member choice of treatment goals, positive responses increased in all populations except for general youth, ages 12-17, (youth responding) where positive responses dropped from 88.8% in CY2013 to 84.1% in CY2014.
- In CY2013 there were statistically significant increases compared to CY2012 in the percentages of positive responses by adults for ability to better deal with a crisis and in obtaining information for managing their health. The CY2014 percentages maintained comparably high positive response percentages.

Member Survey – SUD

The SUD surveys in CY2014 and CY2012 were convenience samples of members contacted in person, by mail, and by phone. The CY2014 survey included 238 members, compared to 629 (including non-Medicaid receiving assistance through Value Options) in CY2012.

Results were generally very positive. In 2014, 94.3% of those surveyed rated the quality of services as very good or good (compared to 95.3% in 2012); 92.0% rated counselor involvement of members in decision making as very good or good (compared to 93.5% in 2012; and 87.1% responded they were feeling much better or better since beginning treatment (compared to 98.8% in 2012).

Provider Survey

Results could not be aggregated in this year's report due to typographical errors in the UnitedHealthcare provider survey. Survey responses were provided from 283 Amerigroup, 251 Sunflower, and 150 UnitedHealthcare providers. For the question on "provider satisfaction with MCO's commitment to high quality of care for its members," responses for "very satisfied" ranged from 6.1% to 18.0%, and for "very dissatisfied" ranged from 4.8% to 13.6%.

Coordination of Care (and Integration)

Member Survey – CAHPS

- In CY2014, 62.0% of adults, 39.5% of the GC population, and 80.5% of the CCC population indicated they received care from a provider other than their personal doctor. When asked if their personal doctor seemed informed and up-to-date about the care they received from these other providers, 83.0% of adults (compared to 72.9% in CY2012), 81.9% of GC (compared to 78.7% in CY2012), and 58.3% of the CCC members surveyed responded positively. The adult results were above the GC 75th percentile, the GC results were above the QC 50th percentile, and the CCC results were below the QC 50th percentile.

- Of the 22.3% of GC and 46.2% of CCC surveyed that used more than one kind of health care service, 56.7% of GC and 57.9% of the CCC members received help from the child's health plan, doctor's office, or clinic to coordinate care. For the CCC population, this was below the QC 50th percentile.
- Of children with a medical, behavioral, or other health condition that lasted more than three months, 92.5% of GC and 90.3% CCC parents indicated their personal doctor understands how this affects their family's day-to-day life (above the QC 50th percentile for CCC); 92.9% of GC and 92.3% of CCC responded that their personal doctors understand how this affect their child's day-to-day life (below the QC 50th percentile for CCC).
- Of the 24.5% of GC and 77.2% of CCC that received or refilled a prescription in the previous six months, 95.2% of the GC and 94.7% of the CCC indicated it was easy to get prescriptions through their MCO. Of those who requested help from their MCO or doctor's office to get their prescriptions, 56.7% of GC and 57.6% of CCC received help (below the QC 50th percentile for CCC).
- Of the children enrolled in school or daycare, 10.4% of GC and 16.6% of CCC surveyed indicated they needed help from their health provider to contact the school daycare. Of these 91.1% of GC and 96.5% of CCC said they received the help they needed (above the QC 50th percentile for CCC).

Member Survey – MH
For care coordination questions on use of consumer-run programs and ability to access services the members thought were needed, positive responses had increased from CY2012 to CY2013. These percentages remained steady in CY2014.

Member Survey - SUD
Fifteen (7.5%) of 201 survey respondents did not know if they have a PCP. Of the remaining 196, 137 (69.9%) said they have a PCP and 59 said they do not.

Provider Survey
For the survey question on "provider satisfaction with obtaining precertification and/or authorization for (MCO's) members," responses for "very satisfied" ranged from 6.1% to 28.8%%, and for "very dissatisfied" ranged from 1.9% to 12.0%.

Access to Care
Provider Network – GeoAccess
Access Standards

- All provider and ancillary services were available in the 16 Urban and Semi-Urban counties in CY2014.
- Services provided in all Kansas counties in CY2014 within State-specified access standards included the following: PCP, Dermatology, General Surgery, Hematology/Oncology, Internal Medicine, OB/GYN, Ophthalmology, Orthopedics, Otolaryngology, Podiatry, Psychiatry, Pulmonary Disease, Hospitals, Dental Primary Care, Optometry, Occupational Therapy, Physical Therapy, X-ray, Lab, and Retail Pharmacy.
- Services that were offered in more counties in CY2014 than in CY2012 (pre-KanCare) included: Dermatology, Neonatology, Nephrology, Neurology,

Neurosurgery, OB/GYN, Otolaryngology, Physical Medicine/Rehab, Plastic & Reconstructive Surgery, Podiatry, Psychiatry, Urology, Optometry, Dental Primary Care, and Occupational Therapy.
- Services that were offered in more counties in CY2014 than in CY2013 included: Allergy, Dermatology, Neonatology, Nephrology, Neurosurgery, Orthopedics, Physical Medicine/Rehab; Plastic & Reconstructive Surgery, Podiatry, Pulmonary Disease, Urology, Dental Primary Care, and Optometry.
- Services that were offered in fewer counties in CY2014 than in CY2012 included Allergy, Cardiology, and Gastroenterology.
- Services offered in one less county in CY2014 than in CY2013 included Neurology, Cardiology, and Gastroenterology.
- Of the 28 counties without access to one or more provider type, Cheyenne did not have access to nine provider types, while the remaining 27 did not have access to one to four types. Not factored in this analysis were the numbers of counties with no access to one or more providers in all adjacent counties.

Behavioral Health - Behavioral health services were provided in all counties within the access standards required by the State.

HCBS – Counties with access to at least two providers by provider type and services
Of the 27 HCBS services, 16 are available from at least two providers in all 105 Kansas counties from all three MCOs. Of the remaining 11 HCBS services (with noted changes compared to CY2013):
- **Adult day care** – Services are available from at least two providers in 82 counties through Amerigroup (8 more than in CY2013), with at least one service provider in 103 counties. Services are available from at least two providers in 74 counties through UnitedHealthcare (13 fewer than in CY2013), with at least one service provider in all counties. Through Sunflower, services are available from at least two providers in 50 counties (3 more than in CY2013), with at least one service provider in available in only 76 counties (3 more than in CY2013).
- **Intermittent intensive medical care** – At least two service providers are available through UnitedHealthcare in all counties. In Amerigroup, 84 counties have at least two service providers, and 104 counties have at least one service provider. Through Sunflower, 91 counties have at least two service providers (13 more than in CY2013), and all counties have at least one service provider.
- **Speech therapy – Autism waiver** – Again this year there was a wide gap in the availability of this specialized service as reported by MCOs. Services are available from at least one or two providers in 79 counties through Amerigroup (76 more than in CY2013). Through Sunflower network, there are at least two providers in 15 counties (2 more than in CY2013), and at least one service provider in 28 counties (1 more than in CY2013). Services through UnitedHealthcare are only available from at least one or two providers in 2 counties.
- **TBI waiver therapies: Speech, Behavior, Cognitive, Occupational, and Physical** – Again this year there was a wide gap in the availability of these specialized services as reported by MCOs. Amerigroup and Sunflower, as in CY2013, report that at least two service providers for each of these services are

available in all counties (same as CY2013). UnitedHealthcare reports, as in CY2013, far fewer available providers for these TBI waivers: Speech Therapy -at least two providers in 5 counties (2 fewer than CY2013), 21 in at least one county; Behavior Therapy -at least two providers in 12 counties (11 more than in CY2013), 41 in at least one county (37 more than in CY2013); Cognitive Therapy -at least two providers in 12 counties (11 more than in CY2013), 41 in at least one county (37 more than in CY2013); Occupational Therapy -at least two providers in 11 counties, 26 in at least one county (6 more than in CY2013); and Physical Therapy -at least two providers in 24 counties (10 more than in CY2013), 53 in at least one county (17 more than in CY2013).
- **Home modification** – At least two service providers are available through Sunflower and UnitedHealthcare in all counties. In Amerigroup, only 23 counties have at least two service providers, and all counties have at least one service provider.
- **Health maintenance monitoring** – At least two service providers are available through UnitedHealthcare in all counties. In Amerigroup, only 70 counties have at least two service providers, and 103 counties have at least one service provider. Through Sunflower, two service providers are available in 91 counties (14 fewer than CY2013), and all counties have at least one service provider.
- **Specialized medical care/medical respite** – At least two service providers are available through Amerigroup and UnitedHealthcare in all counties. Through Sunflower, two service providers are available in 90 counties (15 fewer than in CY2013), and all counties have at least one service provider.

As in CY2013, there is no indication in the HCBS report as to which counties do not have at least two services available. The report also again does not indicate whether members needing services are residents of the counties where there are no providers or where there are less than two providers. In a "Frontier" county, in particular, it is possible that there are no members in the county that are in need of one of the more specialized HCBS services.

Open/Closed Panels

The numbers of exact duplicate entries in the network adequacy reports, particularly for the Sunflower and UnitedHealthcare, have been greatly reduced this year. Amerigroup's report still, however, has many duplicate entries. The reports from all three MCOs include entries for providers terminated in 2013 (ranging from 204 to 2,332). The credentialing fields differ also by MCO; while Amerigroup offers "yes/no" response options, UnitedHealthcare's response options are "yes" or "blank," and Sunflower doesn't have a "credentialed" field in their report.

Provider After-Hours Access and Provider Appointment Standards Access

Various methods were used by the MCOs, including web surveys and calls during and after office hours. In 2014, each of the MCOs included a supplemental question in their CAHPS survey related to appointment access.

Member Survey – CAHPS

- Of the 43.0% of adults (compared to 35.9% in CY2012), 17.9% of GC (compared to 19.8% in CY2012), and 38.4% of CCC survey populations who had one or more appointments with a specialist in the previous six months, 84.8% of adults, 83.2% of GC, and 85.3% of CCC were able to see a specialist as soon as needed. The adult results were above the QC 75th percentile, and the GC and CCC survey results were above the QC 50th percentile.
- Results were very positive (above the QC 75th percentile) for ease of getting care, tests, and treatment.
- Of the 75.8% of adults, 70.8% of GC, and 80.0% of CCC survey populations who scheduled a check-up or routine office visit in the prior 6 months: 82.9% of adults (above the QC 75th percentile), 90.6% of the GC survey population (above the QC 50th percentile), and 92.2% of the CCC survey population (below the QC 50th percentile) reported they got an appointment as soon as they thought it was needed.
- Of the 45.2% of adults, 35.2% of GC, and 43.6% of CCC survey populations who had an illness, injury, or condition in the prior 6 months that needed care right away in a clinic, emergency room or doctor's office: 88.1% of adults (above the QC 90h percentile), 94.1% of the GC survey population (above the QC 75th percentile), and 95.0% of the CCC survey population (above the QC 50th percentile) reported they received care as they thought it was needed.

Member Survey – MH

- Responses for each of the seven access-related questions were again consistently positive in CY2014.
- There was a statistically significant increase in positive responses from SED Waiver youth and young adults (family responding) for timely availability of medication, increasing from 90.9% in CY2013 to 94.8% in CY2014 ($p=0.03$).

Member Survey – SUD

- Members surveyed in CY2014 had consistently positive responses to questions related to appointment availability (including urgent appointments) and distance to travel to see a counselor.
- Of 205 surveyed, 25 (12.2%) were placed on a waiting list for an appointment. While most members (74%) reported their wait was two weeks or less, a few members reported being on a waiting list for 2.5 to 3 months. Due to the small sample size, it cannot be determined whether waits this long are common or unusual.

Provider Survey

For the survey question on "provider satisfaction with availability of specialists," responses for "very satisfied" ranged from 3.6% to 17.1%%, and for "very dissatisfied" ranged from 4.4% to 7.9%.

Efficiency

Emergency Department Visits

The aggregate HEDIS result for the number of ED visits in CY2013 was 65.17 visits per 1,000 member months. This is just above the QC 50th percentile. Additional results by waiver are in development.

Member Survey – CAHPS

Of the 24.7% of GC, 28.3% of CCC, and 33.1% adult members surveyed who requested help from their MCO's customer service in CY2014, 80.0% of adults (compared to 77.1% in CY2012), 86.7% of GC (compared to 80.1% in CY2012), and 84.8% of CCC members indicated they were provided the information or help they needed. The adult results were below the QC 50th percentile, the GC survey results were above the QC 75th percentile, and the CCC results were above the 50th percentile.

Member Survey – MH

Over 83.3% of adult members in CY2014 indicated their mental health provider returned their calls within 24 hours. This is comparable to CY2013 (84.4%), which was an increase compared to CY2012 (80.8%).

Member Survey SUD

In 2014, 93.9% of members surveyed rated their counselor as very good (70.1%) or good (23.8%) in communicating clearly with them.

Uncompensated Care Cost Pool

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 to 206,882 in CY2014. 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 the Kansas Statute implemented at the start of the Kansas Fiscal Year 2013. The UCC Pool payments decreased slightly in CY2014 to $40,974,407.

Recommendations

HEDIS and CAHPS Surveys

- MCOs should pay particular attention to improving results, not only for P4P measures, but also for HEDIS measures where results are below the QC 50th percentile, particularly those below the QC 25th percentile.
- MCOs should encourage providers to offer medication or other alternatives to members who smoke or use tobacco products.

SUD Services

- Where possible, the State should report the total number of unduplicated members discharged from SUD services during the year, as well as the number of members who were discharged from SUD services more than once during the year.

Reporting these counts would give a clearer picture of the scope and impact of the SUD services provided.

- MCOs should work with SUD treatment providers to identify barriers to self-help program meeting attendance and identify any regional differences in attendance rates.
- KFMC again recommends that the SUD survey be considered as a potential tool to gain information on reasons for continued poor attendance at self-help program meetings.
- A major focus of the Sunflower AOD performance improvement project (PIP) is to increase partnerships between providers and care coordinators and generate ideas to increase engagement in treatment. These partnerships can be opportunities for additional feedback from members and providers on barriers and to generate ideas for improving attendance.

SUD Survey

- MCOs should increase the number of survey respondents in 2015.
- MCOs should encourage SUD providers to help members who don't know if they have a primary care provider (PCP) to identify that provider or to assist them in obtaining a PCP.
- Additional follow-up is recommended to determine the numbers and locations of members who are on waiting lists for SUD counseling for over two months to better identify areas where additional services should be provided.

Mental Health Services

- MCOs should place a high priority in CY2015 on significantly increasing access to services to SPMI adults and SED youth.

Provider Survey

- UnitedHealthcare has confirmed that they will ensure that the CY2015 provider survey will include the correct wording for response options.
- The Sunflower BH survey should include the correct wording for each of the three questions and response options required by the State.
- Amerigroup and UnitedHealthcare should investigate printing options that will allow them to include the response option "Neither Satisfied nor Dissatisfied" instead of "Neither" to provide greater clarity.

Care Coordination

- Efforts should be made to improve care coordination, particularly for children with chronic conditions, including communication of PCPs with other healthcare providers; assistance from the MCO in coordinating care; and assistance in acquiring prescriptions.

Access to Care

- Additional analysis should be completed to assess provider access needs for members who do not have access within their county, particularly where there is no access within adjacent counties.

- Provider Network Reports should be reviewed to eliminate exact duplicate entries and to assess whether provider entries listed as “terminated” in 2013 remain terminated in 2015. If the “credentialed” field is required by the State, it should be added to the Sunflower report; response options for this field should, at a minimum, include “yes” and “no.”
- If no common reporting system or template can reasonably be developed for tracking these measures in CY2014, KFMC recommends that the State review the methods and systems used by each MCO to track provider adherence to these standards, and require routine reporting by each MCO that provides evidence that these access standards are consistently met.
- KFMC recommends that provider after-hour access be confirmed through after-hours phone calls to the providers.
- Reporting compliance rates and appointment availability based on calls to provider offices from “secret shoppers” separately from callers who first identify that they are representatives of an MCO is recommended.
- Including access to care supplemental questions in the CAHPS survey is helpful in identifying member experience in accessing appointments. Wording of responses is important, however, in actually assessing whether the member had access within the goal response time. If Sunflower again includes the supplemental question, “In the last 6 months, how many days did you usually have to wait between making an appointment (for your child) for urgent care and actually seeing a provider?” in their CAHPS survey, response options should be revised from “Within 3 business days” and “Greater than 3 business days” to “Within 48 hours” or “Greater than 48 hours” to meet State standards for provision of “urgent” services by providers.

Appendix A

2014 KanCare Evaluation Annual Report

Year 2, CY2014, January – December 2014

List of Related Acronyms

kfmc Kansas Foundation for Medical Care, Inc.

List of Related Acronyms	
Acronym	**Description**
AGP	Amerigroup Kansas, Inc.
Amerigroup	Amerigroup Kansas, Inc.
AOD	Alcohol and Other Drugs
CCC	Children with Chronic Conditions (CAHPS survey)
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBCL	Child Behavior Checklist
CHIP	Children's Health Insurance Program (Title XXI)
CMS	Centers for Medicare & Medicaid Services
CSS	Community Support Services
CY	Calendar Year
DSRIP	Delivery System Reform Incentive Program
EQRO	External Quality Review Organization
FE	Frail Elderly
GC	CAHPS General Child Sample Population
HbA1c	Glycated Hemoglobin
HCBS	Home and Community-Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
I/DD	Intellectually/Developmentally Disabled
KCPC	Kansas Client Placement Criteria
KDADS	Kansas Department for Aging and Disability Services
KDHE-DHCF	Kansas Department of Health and Environment, Division of Health Care Finance
KFMC	Kansas Foundation for Medical Care, Inc. (the EQRO)
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MFP	Money Follows the Person
MH	Mental Health
MHSIP	Mental Health Statistics Improvement Program
NCQA	National Committee for Quality Assurance
NF	Nursing Facility
NOMS	National Outcome Measurement System
PCP	Primary Care Provider
PD	Physically Disabled

List of Related Acronyms	
Acronym	**Description**
PEAK	Promoting Excellent Alternatives in Kansas
P4P	Pay for Performance
PIP	Performance Improvement Project
Q	Quarter
QC	Quality Compass
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SPMI	Serious and Persistent Mental Illness
SSHP	Sunflower State Health Plan of Kansas
SUD	Substance Use Disorder
Sunflower	Sunflower State Health Plan of Kansas
TA	Technical Assistance
TBI	Traumatic Brain Injury
Title XIX	Medicaid
Title XXI	CHIP, Children's Health Insurance Program
UC	Uncompensated Care
UHC	UnitedHealthcare Community Plan of Kansas
UnitedHealthcare	UnitedHealthcare Community Plan of Kansas
VO	Value Options-Kansas
WORK	Working Healthy Medicaid program
WSU	Wichita State University

Final Evaluation Design

Submitted by the Kansas Department of Health and Environment,
Division of Health Care Finance

August 24, 2013
Revised March 2015

KanCare Evaluation Design

March 2015

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;
- 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;
  - 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:
  - 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.

<u>To isolate the effects of the KanCare demonstration from other initiatives</u> 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' 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.

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.

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
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
		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

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
		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
		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

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
		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	
		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	

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
		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	
		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	

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
		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
		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

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 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
		(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

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 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 or stopping a prescription medicine,* o How much did a doctor or other health provider talk about the reasons you might want to take a medicine?	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

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
		o How much did a doctor or other health provider talk about the reasons you might not want to take a medicine? o Did a doctor or other health provider ask you what you thought was best for you? Child members (General population and CCC population): *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 your child 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,* o How much did a doctor or other health provider talk about the reasons you might want your child to take a						

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
		medicine? o How much did a doctor or other health provider talk about the reasons you might not want your child to take a medicine? o 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 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:	P4P* Qualitative Measure for KanCare population	NQF: 0027**	CAHPS survey data HEDIS (MSC)**	• Medicaid	Annual comparison to 2014 baseline, trending over time.	Annual

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
		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 Screenings, Vaccinations, Preventable Emergency Visits: o Mammograms (BCS)* o Cervical Cancer Screening (CCS)* o 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	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
		(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

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
		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
		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

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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
		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 Nursing Facilities		KDADS report	NF	Comparison of pre-KanCare to KanCare and trending over time.	Annual
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

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
		• 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 as measured by the following: • 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
		(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

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
		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 capitated managed care? (STC XV. 103.a.ii.)	**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
		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

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
		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 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.)	**(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
		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

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
		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 • 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.	Qualitative Measure for population in I/DD pilot project.		Survey/ Interviews	I/DD	(TBD)	End of Pilot
		MCOs have demonstrated an understanding of the Kansas DD service system. MCOs demonstrate a knowledge and understanding of: • 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.	Qualitative Measure for population in I/DD pilot project.		Survey/ Interviews	I/DD	(TBD)	End of Pilot

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 tools used by CDDOs to implement various local processes (local quality assurance, funding committees, crisis determinations, public school system collaboration, etc.)						
	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 (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.).	**(14) Member Survey - CAHPS**						
		Perception of care and treatment in Medicaid and CHIP populations: • 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? Children with Chronic Conditions (CCC) Module • 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?	Qualitative Measure for Medicaid an CHIP populations		MCO Survey Report	• Medicaid Adult Child-general Child-CCC • CHIP Child-general Child-CCC	Comparison of baseline to subsequent years.	Annual

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
		• 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? • 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?						

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
		• 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						
		Perception of care coordination for members receiving MH services: • 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						
		Perception of care by SUD population: • 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
		(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

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: **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 Medicaid payment and delivery system reforms as well. **Related Objectives:** Measurably improve health outcomes for members. Support members successfully in their communities.	**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:** (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	**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 • Densely Settled Rural/Rural Frontier	Quantitative Access Measure		MCO Geo-Access Reports	Provider Type	Comparisons will occur to pre-KanCare access and trending over time.	Annual
		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	Quantitative Access Measure		MCO Geo-Access Reports	BH Provider	Comparisons will occur to pre-KanCare access	Annual

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
Promote wellness and healthy lifestyles. Improve coordination and integration of physical health care with behavioral health care. Lower the overall cost of health care.	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:	• Urban/Semi-Urban • Densely Settled Rural • Rural Frontier					and trending over time	
		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 • 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	Quantitative Access Measure		MCO Geo-Access Reports	HCBS Provider Type	Comparisons will occur to pre-KanCare access and trending over time	Annual

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
		• 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 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?	Qualitative Access Measure for Medicaid and CHIP populations		Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Results (Adult, child, and Children with Chronic Conditions (CCC) Module) conducted by MCOs	Title 19 • Adults • Children • Children with Chronic Conditions (CCC) CHIP • Children • Children with Chronic Conditions (CCC)	Comparisons will occur to pre-KanCare access and trending over time.	Annual, beginning 2014

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
		• In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?						
		(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. • 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?	Qualitative Measure for Adults and Youth with at least one MH service, and for Youth receiving SED Waiver services		MHSIP Survey Results (adult, youth, SED Waiver). MCOs required to provide assistance to members as needed for completion of surveys; State to monitor.	• Adult - MH • Youth – general MH • Youth -SED Waiver	Comparisons will occur to pre-KanCare and trending over time.	Annual
		(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

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
		(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
		(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

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
		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.						