

May 29, 2020

Sheri Jurad
EQR Audit Manager/Supervisor
Kansas Department of Health & Environment
Division of Health Care Finance
900 SW Jackson St., Room 900
Topeka, KS 66612

RE: KanCare Program Annual External Quality Review Technical Report for Aetna Better Health of Kansas, Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas, 2019–2020 Reporting Cycle

Dear Ms. Jurad:

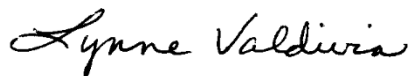
Enclosed is KFMC's report for the KanCare Annual External Quality Review Technical Report for the 2019–2020 reporting cycle for Aetna Better Health of Kansas, Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas. KDHE ended MCO services with Amerigroup Kansas, Inc. in December of 2018, however, this report includes their final PMV report. All other reports for Amerigroup were included in last year's "KanCare Program Annual External Quality Review Technical Report 2018-2019 Reporting Cycle."

This report includes summaries of reports for the following activities: Information Systems Capabilities Assessment (ISCA) and Performance Measure Validation (PMV), Performance Improvement Project (PIP) Validation, CAHPS 5.0H Survey Validation, HCBS CAHPS Survey, Mental Health Consumer Perception Survey, Provider Survey Validation, Regulatory Compliance Review, and Quality Assurance Performance Improvement (QAPI) Assessment.

The format of the Annual Technical Report is based on requirements delineated in *42 CFR 438.364 External quality review results*. The Annual Technical Report summarizes reports (based on the CMS EQR protocols) submitted to the State throughout this reporting cycle.

Please feel free to contact me, lvaldivia@kfmc.org, if you have any questions regarding this report.

Sincerely,



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

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Enclosures



KanCare Program Annual External Quality Review Technical Report 2019–2020 Reporting Cycle

Contract Number: 46100

Submission Date: May 29, 2020

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Prepared for:



KanCare Program Annual External Quality Review Technical Report

2019 - 2020 Reporting Cycle

Contract #46100

Aetna Better Health of Kansas

Sunflower State Health Plan

UnitedHealthcare Community Plan of Kansas



ACCREDITED
Independent Review
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No tables or figures



KanCare Program Annual External Quality Review Technical Report Aetna Better Health of Kansas, Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas 2019–2020 Reporting Cycle Submission Date: May 29, 2020

Overview

The Kansas Foundation for Medical Care (KFMC), under contract with the Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF), serves as the External Quality Review Organization (EQRO) for KanCare, the Medicaid Section 1115 demonstration program that operates concurrently with the State’s Section 1915(c) Home and Community-Based Services (HCBS) waivers. The goals of KanCare are to provide efficient and effective health care services and ensure coordination of care and integration of physical and behavioral health services for children, pregnant women, and parents in the State’s Medicaid and Children’s Health Insurance Program (CHIP) programs. The Aetna Better Health of Kansas (Aetna or ABH) KanCare managed care organization (MCO) contract was effective January 1, 2019. Sunflower Health Plan (Sunflower or SHP) and UnitedHealthcare Community Plan of Kansas (UnitedHealthcare or UHC) have provided KanCare managed care services since January 2013. The Amerigroup Kansas, Inc. (Amerigroup or AGP) KanCare contract ended December 31, 2018. This report includes Amerigroup’s final Performance Measure Validation report, since measures for 2018 were calculated in 2019. All other reports for Amerigroup were included in last year’s “KanCare Program Annual External Quality Review Technical Report 2018-2019 Reporting Cycle.”

As the EQRO, KFMC evaluated services provided in 2018/2019 by the MCOs, basing the evaluation on protocols developed by the Centers for Medicare & Medicaid Services (CMS). This report includes summaries of reports (submitted to the State in April 2019 through May 2020) evaluating the following activities for each MCO:

- Information Systems Capabilities Assessment (ISCA)
- Performance Measure Validation (PMV)
- Review of Compliance with Medicaid and CHIP Managed Care Regulations (Compliance Review)
- Quality Assessment and Performance Improvement (QAPI)
- Performance Improvement Project (PIP) Validation
- Consumer Assessment of Health Care Providers and Systems (CAHPS^{®1}) Survey Validation
- Provider Survey Validation

KFMC also conducted the Home and Community Based Services (HCBS) CAHPS Survey and the Mental Health (MH) Consumer Perception Survey to evaluate the KanCare program, reflecting combined MCO performance.

¹ CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

KFMC completes individual reports for the External Quality Review (EQR) activities noted above throughout the year to provide the State and MCOs more timely feedback on program progress. In this Annual Technical Report, summaries are provided for each of the above activities, including objectives; technical methods of data collection; descriptions of data obtained; strengths and opportunities for improvement regarding quality, timeliness, and access to health care services; recommendations for quality improvement; and assessments of the degree to which the previous year's EQRO recommendations have been addressed. (See Appendix A for a list of the reports for the activities conducted in accordance with the Code of Federal Regulations §438.358. The full reports and appendices of each report provide extensive details by MCO, program, and metrics.) Recommendations and conclusions in the summaries that follow focus on those related directly to improving health care quality; additional technical, methodology, and general recommendations to the MCOs are included in the individual reports submitted to the State.

KFMC used and referenced the following CMS EQR Protocol worksheets and narratives in the completion of these activities:

- EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations
- EQR Protocol 2: Validation of Performance Measures Reported by the MCO
- EQR Protocol 3: Validating Performance Improvement Projects (PIPs)
- EQR Protocol 5: Validation and Implementation of Surveys

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Summary of Individual EQR Components

1. ISCA and PMV

Background/Objectives

Healthcare Effectiveness Data and Information Set (HEDIS^{®2}) is one of the most widely used sources of healthcare performance measures in the United States. The program is maintained by the National Committee for Quality Assurance (NCQA). NCQA develops and publishes specifications for data collection and result calculation to promote a high degree of standardization of HEDIS measures. Reporting entities (e.g., KanCare MCOs) are required to register with NCQA and undergo an annual NCQA HEDIS Compliance Audit^{™3}. To ensure audit consistency, only NCQA-licensed organizations using NCQA-Certified HEDIS Auditors may conduct a HEDIS Compliance Audit. The audit conveys sufficient integrity to HEDIS data, such that it can be released to the public to provide consumers and purchasers with a means of comparing healthcare organization performance.

The State required Amerigroup, Sunflower and UnitedHealthcare to report HEDIS 2019 measure data (reflecting calendar year 2018 performance) through the NCQA data submission portal. Amerigroup provided KanCare managed care services through December 31, 2018. Because 2019 was Aetna's first year as a Kansas MCO (effective January 1, 2019), their first performance measure compliance audit will occur with HEDIS 2020.

Aetna, Sunflower and UnitedHealthcare were required to undergo a biennial ISCA in 2019 which assessed their data collection, processing and reporting systems. Portions of the ISCA were also used in KFMC's assessment of compliance, validation of performance measures and validation of performance improvement projects (EQR Protocols 1, 2 and 3). Baseline ISCA's were conducted with Sunflower and UnitedHealthcare in 2013 with biennial updates through 2019. The September 2019 ISCA was Aetna's initial assessment.

The objectives of the PMV/ISCA process for Sunflower and UnitedHealthcare were to:

- Evaluate the policies, procedures, documentation and methods the MCO used to calculate the measures.
- Determine the extent to which reported rates were accurate, reliable, free of bias, and in accordance with standards for data collection and analysis.
- Verify measure specifications were consistent with the State's requirements.
- Ensure re-measurement rates were produced with methods and source data that parallel the baseline rates.
- Evaluate the capabilities of the MCO's systems to produce encounter data accurately and completely.
- Verify system structure supports performance measure reporting and quality improvement initiatives.
- Confirm these systems enable effective management of the healthcare delivered to its population.
- Ensure system data are secure and sufficient data back up and restore processes are in place.

² HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a registered trademark of the National Committee for Quality Assurance (NCQA).

The performance measure validation objectives for Amerigroup were to:

- Determine the extent to which reported rates were accurate, reliable, free of bias, and in accordance with standards for data collection and analysis.
- Verify measure specifications were consistent with the State’s requirements.

The objectives of the ISCA process with Aetna were to assess the potential impact of their information systems on their ability to:

- Conduct quality assessment and improvement initiatives.
- Calculate valid performance measures.
- Collect and submit complete and accurate encounter data to the State.
- Oversee and manage the delivery of health care to Aetna’s enrollees.
- Ensure system data are secure and sufficient processes are in place to back up and restore the data.

Technical Methods of Data Collection and Analysis/Description of Data Obtained Common Among the MCOs

KFMC contracted with MetaStar, Inc. (MetaStar), an organization licensed by NCQA to conduct HEDIS Compliance Audits, to conduct a combined performance measure validation and ISCA of Sunflower and UnitedHealthcare and to perform the ISCA for Aetna—the three KanCare MCOs for the State of Kansas during 2019. KFMC worked closely with MetaStar and the MCOs throughout the validation process. MetaStar performed validation of the calendar year (CY) 2018 HEDIS performance measures for Sunflower and UnitedHealthcare according to the 2012 Centers for Medicare & Medicaid Services (CMS) protocol, “*External Quality Review (EQR) Protocol 2: Validation of Performance Measures Reported by the MCO,*” (the Protocol). The 2012 protocol was used because the MCOs’ HEDIS measurement was completed and MetaStar’s validation activities had begun prior to publication of the revised protocols in October 2019. KFMC performed the final CY 2018 performance measure validation for Amerigroup.

Information System Capabilities Assessment Methods

CMS provides a worksheet (ISCA Tool) which can be used for ISCA data collection. KFMC incorporated new questions from the CMS’ 2019 proposed ISCA revisions into the 2012 ISCA Tool used for MetaStar’s assessment. The revisions to the ISCA Tool reflected changes in the IT environment since 2012 including the emergence of cloud platforms and a greater focus on data privacy and security.

MetaStar followed CMS’ recommended process for the ISCA review for Aetna, Sunflower and UnitedHealthcare:

- A copy of the ISCA Tool was provided to the MCOs, and they provided responses and supporting documentation.
- A preliminary review of responses and document submissions was conducted to ensure all sections were completed and all attachments were provided.
- An on-site interview was held with representatives of each MCO to validate items previously submitted, view demonstrations of various systems and obtain additional documentation.
- Findings from the interviews and submitted documentation were compiled and analyzed. MetaStar’s lead auditor completed a detailed review of the ISCA Tool and documentation, noting issues or items requiring further information or follow-up. Additional follow-up was conducted by telephone and email.

Performance Measure Validation Methods

Data reviewed included:

- Policies and procedures related to calculation of performance measures.
- HEDIS Roadmaps (a NCQA HEDIS® Compliance Audit™ data collection tool), Information Data Submission System (IDSS) files, HEDIS compliance audit reports, audited rates and support documents.
- Records of MCO validation efforts, including run, error and issues logs, file layouts and system flow diagrams.
- Member-level data showing numerator and denominator inclusion status.

Findings from interviews, provided documentation, system demonstrations and data output files, primary source verification, observations of data processing, and review of data reports were compiled and analyzed. Additional follow-up was conducted by telephone and email.

As part of the PMV process and with approval from the State, two measures, the Timeliness of Prenatal Care indicator of Prenatal and Postpartum Care (PPC) and the HbA1c Control (<8%) indicator of Comprehensive Diabetes Care (CDC), were reabstracted for SHP and UHC by MetaStar. KFMC provided a randomly selected list of cases to Sunflower and UnitedHealthcare, and the MCOs provided the medical records for the reabstraction. MetaStar performed the Sunflower and UnitedHealthcare reabstractions prior to the on-site interviews.

To further validate data completeness and comparability of rates between 2017 and 2018 for Amerigroup, Sunflower and UnitedHealthcare measures, KFMC conducted the following verifications:

- Rates were compared to rates calculated by KFMC by applying HEDIS criteria for the Childhood Immunization Status (CIS) and Immunizations for Adolescents (IMA) measures to records from the Medicaid Management Information System (MMIS) enrollment and eligibility tables (obtained directly from the KanCare fiscal agent).
- Monthly enrollment counts from the MMIS tables, stratified by age and gender, were compared to corresponding counts the MCOs reported for Mental Health Utilization (MPT).

Draft reports were provided to the State and to each MCO for feedback regarding any errors or omissions.

Performance Measure Evaluation Methods

HEDIS data for measurement years 2013–2018 were available for Amerigroup, Sunflower and UnitedHealthcare. KFMC analyzed data for most HEDIS measures and the present report contains 2014–2018 results for CMS 2019 Adult and Child Core Set measures. The Adult Core Set includes two measures, Flu Vaccinations for Adults Ages 18–64 (FVA) and Medical Assistance with Smoking and Tobacco Use Cessation (MSC), derived from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®⁴) survey questions. This section highlights measures displaying greatest improvements or declines and Tables B1 and B2 of Appendix B display detail outcomes from Adult and Child Core Sets, respectively.

⁴ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HEDIS measures may be classified by the methods of data collections:

- Administrative Method – Measures are calculated from administrative data sources, including member and enrollment records, claims and encounters, and immunization registries.
- Hybrid Method – A sample of records meeting administrative measure criteria are sampled for medical record review.
- CAHPS Survey – Rates are calculated from CAHPS survey responses.

For some measures for which either administrative or hybrid rates may be submitted to NCQA, the State required the hybrid methodology but allowed the MCOs to choose either method for the others.

Numerator and denominator specifications for the HEDIS measures can be found in the *HEDIS 2019, Volume 2: Technical Specifications for Health Plans* and *Volume 3: Specifications for Survey Measures*.

Statewide KanCare program rates (labeled “KanCare” within this report) were calculated according to the types of data submitted by each MCO:

- Administrative – KanCare rates were created by dividing the sum of the numerators for each reporting MCO by the sum of denominators for those MCOs.
- Hybrid – KanCare rates for hybrid measures are averages weighted by the administrative denominators (from which the hybrid sample is drawn).
- Mixed Hybrid and Administrative – Where the MCOs did not report rates using the same method, KanCare rates are also averages weighted by the administrative denominators. Several 2019 Amerigroup administrative rates for measures previously reported as hybrid were excluded from the KanCare averages because their inclusion would have caused significant decreases in rates that would not reflect changes in performance. For statistical testing of mixed KanCare rates, the administrative rates are treated as rates with denominator 411.
- CAHPS Survey – KanCare rates for CAHPS survey measures are averages weighted by the counts of members meeting survey eligibility criteria.

KFMC compared rates to national percentiles for all Medicaid and CHIP health plans made available through NCQA’s Quality Compass⁵ (QC). MCO and KanCare rates were ranked using the QC percentiles. The ranks are denoted, in order of worst to best performance: <5th QC, <10th QC, <25th QC, <33.33rd QC, <50th QC, ≥50th QC, >66.67th QC, >75th QC, >90th QC, and >95th QC. Note that, as QC percentiles are based on national rankings, some measures with high scores in Kansas may have very low QC rankings due to high scores nationwide. For example, a rate of 87 for one metric may be within the <10th QC percentile, while the same rate for another metric may be within the >90th QC.

Next, changes in MCO and KanCare rates and QC rankings across years 2014 to 2018 were assessed. For each measure, annual changes between rates and the prior year’s rates were tested for statistical significance using Fisher’s exact or Pearson chi square. Within this report, a “significant change” means the differences in rates was statistically significant with probability (p) less than 0.05. Note, statistical tests on administrative rates with very large denominators may report very small changes as statistically significant.

Slopes of 2014–2018 trend lines were calculated (using the ordinary least-squares method). The slopes provide the “average rate of change” across the five years in percentage points per year (pp/yr). The

⁵ Quality Compass[®] is a registered trademark of the National Committee for Quality Assurance.

slopes were tested to see if they were statistically significantly different from horizontal (i.e., not significantly different from 0 pp/yr) using Mantel-Haenszel chi square ($p < .05$ considered significant).

Tables are provided in Appendix B that include rates, QC rankings, and indicators for statistically significant changes in rates:

- Table B1 provides KanCare and MCO results for CMS 2019 Adult Core Set performance measures (31 HEDIS measures and 2 measures derived from CAHPS).
- Table B2 provides KanCare and MCO results for CMS 2019 Child Core Set performance measures (38 HEDIS measures).

KFMC's determination of key strengths and opportunities was based on multiple factors, including rates and QC rankings for the current year, changes in rates and QC rankings from prior years, and trends from 2014 to 2018. Generally, the following were considered when determining key strengths: percentages above 90% or above the 75th percentile, significant improvement in hybrid rates, increases of more than one QC rank, and 5-year average rates of change over 3 pp/yr. Rates below the 25th percentile, percentages below 50%, significant worsening in hybrid rates, decreases of multiple QC ranks, and average rates decreasing more than 1 pp/yr were generally considered when determining opportunities for improvement.

Conclusions Drawn from the Data Common Among the MCOs

ISCA and Performance Measure Validation

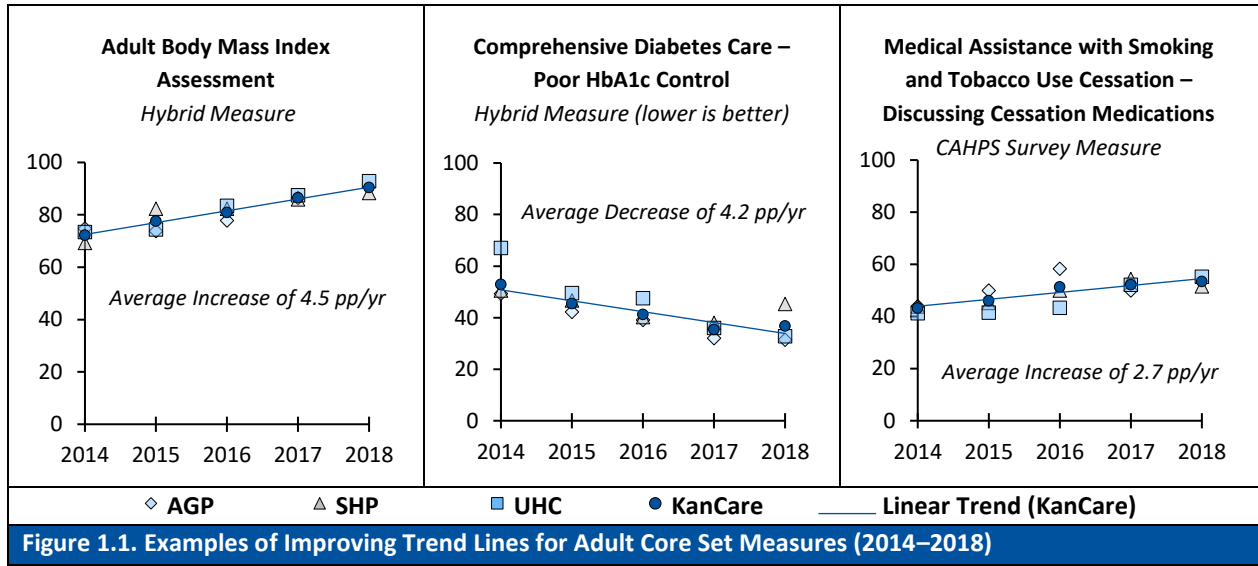
MCO information systems are configured to capture complete and accurate data. Each source system utilizes comprehensive edits to ensure fields are populated with valid and reasonable characters. In addition, comprehensive methods exist to ensure data accuracy throughout the data integration process in the areas of claims, encounters, eligibility and enrollment, provider, vendor and ancillary systems. The MCOs use software certified by NCQA to calculate rates for the HEDIS measures.

No concerns with data completeness or comparability of Amerigroup's, Sunflower's and UnitedHealthcare's 2017 rates to 2018 rates were found from KFMC's analysis performed on the IMA, CIS and MPT measures. No issues were found from the reabstraction of the two hybrid measures.

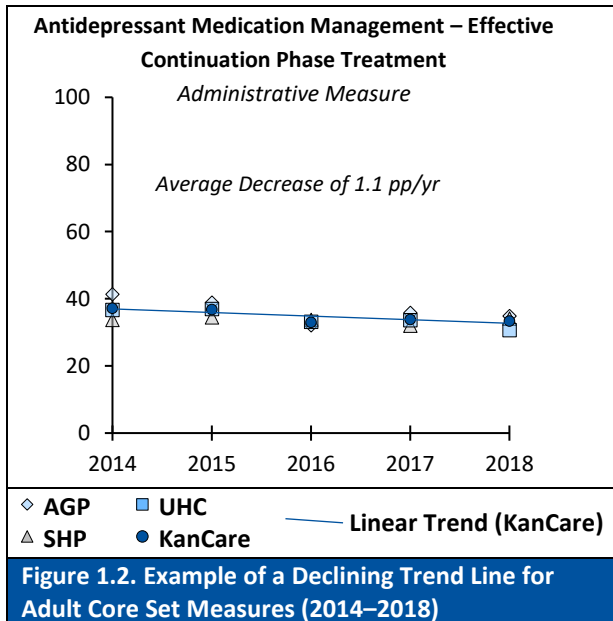
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Adult Core Set Performance Measure Evaluation

KanCare’s 2018 rates for Adult Core Set measures (33 measures) showed 5 measures ranked above the 75th percentile, 2 measures showed statistically significant improvement from 2017, and 10 measures showed statistically significant trending for improvement since 2014. Three Adult Core Set measures with strong average rates of change from 2014 to 2018 are displayed within Figure 1.1. Please note that a declining rate for the *Comprehensive Diabetes Care – Poor HbA1c Control* measure indicates better performance.

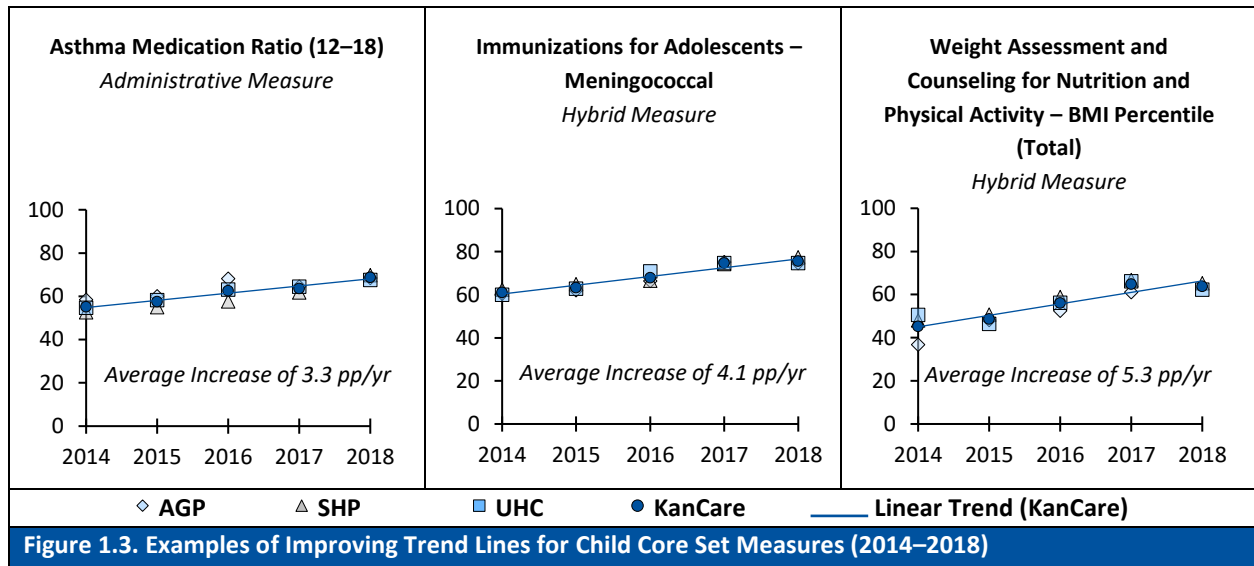


KanCare rates for Adult Core Set measures (33 measures) showed a total of 8 measures ranked below the 25th percentile. While no measures were significantly worse in 2018 than in 2017, 3 measures had 5-year average rates of change indicating significant declining performance (an example is shown in Figure 1.2).

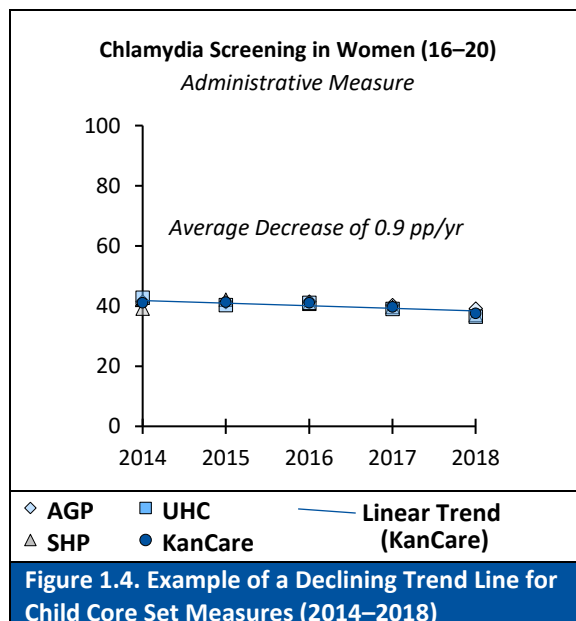


Child Core Set Performance Measures

KanCare overall 2018 performance for Child Core Set measures (38 measures) showed a total of 4 measures ranked above the 75th percentile, 6 measures showed statistically significant improvement from 2017, 17 measures showed statistically significant trending for improvement since 2014, and 2 measures showed statistically significant trending for improvement since 2015. Three noteworthy Child Core Set measures illustrating statistically significant improvement since 2014, are displayed within Figure 1.3.



KanCare overall 2018 performance for Child Core Set measures (38 measures) showed a total of 11 measures ranked below the 25th percentile, 5 measures showed statistically significant declining performance from 2017, and 2 measures showed statistically significant declining performance since 2014. No Child Core Set measures demonstrated a worsening trend with slopes decreasing more than 1.0 pp/yr. An example of a worsening trend is shown in Figure 1.4 below (0.9 pp/yr decrease).



Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services Common Among the MCOs

Technical

- The MCOs utilize robust and automated processes to extract, transfer and load data from source systems to their certified measure software.
- NCQA-certified vendors and compliance auditors are used by the MCOs to audit their processes and to calculate HEDIS rates.
- MCOs' staff are fully engaged in the HEDIS reporting process and conduct their own reviews of performance on an ongoing basis. They leverage their local team members with national plan expertise to ensure performance measure reporting requirements are met.

Performance Measures

Adult Core Set Measures

- **Adult BMI Assessment:** The 2018 KanCare rate (above 90%) was significantly higher than in 2017. Additionally, KanCare rates increased each year from 2014; the average increase was 4.5 pp/yr over the 5-year period.
- **Asthma Medication Ratio (Ages 19–50):** KanCare rates improved with an average increase of 2.4 pp/yr from 2014 to 2018. Sunflower's average increase was 3.5 pp/yr.
- **Comprehensive Diabetes Care – Poor HbA1c Control:** KanCare rates decreased (improved) from 2014 to 2018, averaging 4.2 pp/year. Amerigroup and UnitedHealthcare rates increased each year from 2014 to 2018, and Sunflower rates increased each year from 2014 to 2017 (average decreases for 2014–2018 were 4.6 pp/yr for AGP, 1.9 pp/yr for SHP, and 8.2 pp/yr for UHC).
- **Follow-Up After Hospitalization for Mental Illness:** 2018 KanCare and MCO rates were above the 75th percentile for both indicators:
 - **7 Days (Ages 18–64),** with Sunflower's rate ranked >90th QC.
 - **30 Days (Ages 18–64)**
- **Follow-Up After Emergency Department Visit for Mental Illness:** 2018 KanCare and MCO rates were above the 75th percentile for both indicators:
 - **7 Days (Ages 18–64),** with KanCare, Amerigroup, and UnitedHealthcare rates ranked >90th QC.
 - **30 Days (Ages 18–64),** with KanCare, Amerigroup, and Sunflower ranked >90th QC.
- **Flu Vaccinations for Adults Ages 18–64:** 2018 KanCare, Sunflower, and UnitedHealthcare rates ranked >90th QC. KanCare ranked >90th QC since 2016; the rate increased at an average of 2.1 pp/yr.
- **Annual Monitoring for Patients on Persistent Medications (Total):** The 2018 and 2017 KanCare rates were both above 90%. Sunflower and UnitedHealthcare's rates have also been above 90%.
- **Medical Assistance with Smoking and Tobacco Use Cessation – Discussing Cessation Medications:** Although the KanCare rate was 53% in 2018, rates increased each year from 2014 to 2018, averaging 2.7 pp/yr. 2014–2018 average increases were 2.5 pp/yr for Sunflower and 3.8 pp/yr for UnitedHealthcare.

Child Core Set Measures

- **Annual Dental Visit (Total):** KanCare rates increased each year since 2014, averaging 1.5 pp/yr, and have been above the 75th percentile since 2015. All 2018 MCO rates are above the 75th percentile.
- **Asthma Medication Ratio (Ages 12–18):** KanCare rates increased each year from 2014 to 2018, averaging 3.3 pp/yr (4.1 pp/yr for SHP, 3.2 pp/yr for UHC, 2.5 pp/yr for AGP).
- **Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total):** KanCare and MCO rates have been above the 75th percentile since 2015. Sunflower's 2018 rate ranked >90th QC.

- **Follow-Up After Hospitalization for Mental Illness:** 2018 KanCare and MCO rates were above the 75th percentile for both indicators:
 - **7 Days (Ages 6–7)** rate for UnitedHealthcare ranked >90th QC.
 - **30 Days (Ages 6–17)** rate for UnitedHealthcare ranked >90th QC.
- **Immunizations for Adolescents – Meningococcal:** Improvement in rates from 2014 to 2018 is an area of strength. The KanCare rate increased each year at an average of 4.1 pp/yr. From 2014 to 2018, the average rate of improvement for Amerigroup was 4.2 pp/yr, for Sunflower was 3.9 pp/yr, and for UnitedHealthcare was 4.1 pp/yr. However, the KanCare rate has ranked <25th QC for each of the 5 years, which indicates the rates are increasing nationally and additional improvement is possible. With two exceptions, the MCO rankings have also remained at <25th QC.
- **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI percentile (Total):** Like the Meningococcal rates, the State has followed a national trend of improvement. With each MCO increasing rates nearly every year, the average increase in the KanCare rate was 5.3 pp/yr. However, with two exceptions, the rates have been less than the 25th percentile since 2014. The five-year average increase for Amerigroup was 7.7 pp/yr, for Sunflower was 5.0 pp/yr, and was 4.3 pp/yr for UnitedHealthcare.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services Common Among the MCOs

Performance Measures

Adult Core Set Measures

- **Antidepressant Medication Management – Effective Continuation Phase Treatment:** The 2018 KanCare rate ranked <25th QC, as did UnitedHealthcare’s rate. From 2014 to 2018, the average decrease for KanCare was 1.1 pp/yr.
- **Breast Cancer Screening:** The 2018 KanCare rate ranked <25th QC, as did the rates for Sunflower and UnitedHealthcare. Amerigroup ranked <10th QC.
- **Chlamydia Screening in Women (Ages 21–24):** Since 2015, all KanCare and MCO rates were below the 25th percentile. Rates have remained below 60% since 2014.
- **Initiation and Engagement of Alcohol or Other Drug Abuse or Dependence Treatment – Initiation of AOD Treatment:** The 2017 and 2018 KanCare and MCO rates were below the 25th percentile for three of four indicators.
 - **Opioid abuse or dependence (18+ Years)** rates for SHP and UHC rates ranked <10th QC for 2018.
 - **Other drug abuse or dependence (18+ Years)** for UnitedHealthcare ranked <10th QC for 2018.
 - **Total (18+ Years)** for UnitedHealthcare ranked <5th QC in 2018.
- **Initiation and Engagement of Alcohol or Other Drug Abuse or Dependence Treatment – Engagement of AOD Treatment – Opioid abuse or dependence (18+ Years):** The 2017 and 2018 KanCare, SHP, and UHC rates ranked <25th QC.
- **Prenatal and Postpartum Care – Postpartum Care:** The 2018 KanCare rate ranked <25th QC.
- **Medical Assistance with Smoking and Tobacco Use Cessation (Non-Composite):** About one in three of each MCO’s adult respondents were current smokers or tobacco users. Among these, only half of them received a recommendation to use medication for cessation (53%); health providers of less than half discussed or provided cessation methods and strategies other than medication (46%). The QC rankings for these percentages also indicated they could be further improved. The KanCare percentages did not change significantly over the five-year period; however, UnitedHealthcare’s 2018 positive responses and QC rankings were the highest of the five-year period.

Child Core Set Measures

- **Use of Multiple Concurrent Antipsychotics in Children and Adolescents:** Although the KanCare rates decreased (improved) each year since 2014, the rates continue to be below the national 25th percentile for all three indicators: Ages 6–11, Ages 12–17, and Total. Amerigroup ranked < 10th QC for indicators Ages 12–17 (for the past 4 years) and Total (for the past 3 years).
- **Children and Adolescents' Access To PCP (12–24 Months):** While the KanCare and MCO rates are above 90%, they have decreased each year since 2015, and each 2018 rate was ranked <25th QC.
- **Chlamydia Screening in Women (Ages 16–20):** The 2018 rankings for KanCare and each MCO's rates were <10th QC. Rates are trending downward. The 2014–2018 average declines for the rates were 0.9 pp/yr for KanCare and 1.4 pp/yr for UnitedHealthcare.
- **Childhood Immunization Status:** The rates for nine of eleven indicators were ranked below the 50th percentile for 2018. The rate for Haemophilus Influenzae B (HiB) ranked <25th QC for 2018; Measles-Mumps-Rubella (MMR) and Varicella Zoster Virus (VZV) both ranked <33.33rd QC for 2018.
- **Immunizations for Adolescents – Meningococcal:** The KanCare ranking was <25th QC for 2014 to 2018.
- **Prenatal and Postpartum Care – Timeliness of Prenatal Care:** The KanCare rate for this measure has remained below the 25th percentile since 2014.
- **Well-Child Visits in the First 15 Months of Life — 6 or More Visits:** The KanCare rate for this measure decreased to below the 25th percentile, driven by a statistically significant decrease in UnitedHealthcare's rate.
- **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI percentile (Total):** The KanCare rates ranked <25th QC each year from 2014 to 2018.

Recommendations for Quality Improvement Common Among the MCOs

Performance Recommendations

1. All MCOs should continue and expand their care coordination efforts and enhance service access for adult and child behavioral health services, due to low performance in Adult Antidepressant Medication Management, Adult Initiation and Engagement of Treatment for Alcohol or Other Drug Abuse and Use of Multiple Concurrent Antipsychotics in Children and Adolescents.
2. All MCOs should improve service utilization, access and care coordination for adolescent and adult women, particularly in the areas of Breast Cancer Screening, Chlamydia Screening, and Prenatal and Postpartum Care (Postpartum Care had the lowest rate).
3. All MCOs should encourage providers to improve and expand communication between providers and members to encourage utilization of key child and adolescent preventive services with an emphasis on their importance for healthy development. MCOs should prioritize addressing low performance in Well-Child Visits, Weight Assessment and Counseling for Nutrition and Physical Activity, Childhood Immunization Status, and Immunizations for Adolescents (HPV has the lowest rate of three antigens).
4. While rates for Children and Adolescents' Access to PCP remain greater than 85% in all age groups, monitor and assess potential need for intervention due to measure year 2018 decreases. All MCO's rates ranked <25th QC for children 12–24 months old.
5. MCOs should continue to increase efforts and options to reduce smoking and tobacco use and to promote cessation. Consider coordinated efforts between MCOs to encourage providers to routinely give smoking and tobacco use cessation advice and to discuss medications and other methods to assist members with cessation.
6. MCOs should continue to increase efforts to ensure members receive a flu shot annually. Influenza has the lowest rate of the antigens for Childhood Immunization Status.
7. When implementing these recommendations, MCOs should frequently assess their impact and determine if more targeted interventions are needed. Consider analyzing data to determine variation in rates by certain demographics.

AETNA (ISCA ONLY)

Technical Methods of Data Collection and Analysis

The 2019 ISCA served as Aetna's baseline assessment. They were required to complete all questions on the ISCA Tool. In addition to methods noted above in the section Common Among MCOs, an on-site interview was held with representatives of Aetna to validate items previously submitted and to view demonstrations of various systems.

Conclusions Drawn from the Data

Since the plan was new for 2019, it was well supported by Aetna's corporate team in many of the shared service areas such as claims processing, enrollment processing, supplemental data configuration, vendor data acquisition and loading, as well as data pre-production and data integration preparation. Aetna's corporate team employs automation for many of its activities which instills confidence in data completeness and accuracy.

Aetna contracts with Inovalon, an NCQA-certified measure vendor, and will use its NCQA-certified software for both measure production and hybrid sample generation in future reporting years. Because of collaboration between the local and corporate teams and the experience within those teams, there is confidence that the HEDIS performance measures that will be generated will be complete and accurate.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

Technical

In addition to items included above in the section Common Among MCOs (excluding HEDIS rate results),

- Aetna was responsive to pre-onsite requests for documentation and information and allocated many staff members to participate in the onsite discussions and interview sessions, demonstrating its commitment to the ISCA review.
- Aetna's national team provides support to the local team and will be involved as Aetna prepares to report HEDIS 2020 measures.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

- Since this was the first ISCA review for Aetna, there were some gaps in understanding between what was being requested and what was provided for the Auditor's review. Aetna can use this experience in order to be better prepared for subsequent ISCA reviews.
- Aetna should continue to evaluate baseline performance measures and utilize regional and national quality improvement team knowledge and resources as it grows its own unique program.
- Aetna should continue to explore supplemental data sources beyond the immunization registry, such as lab results files, electronic medical records (EMR) feeds, or other sources that may augment HEDIS rates.

- Due to some timeliness issues with SkyGen’s encounter data file submissions, which were identified through Aetna’s vendor monitoring procedures, the MCO required a corrective action plan (CAP) for the vendor. Aetna should continue close oversight of this vendor to ensure the CAP has been followed, and that timeliness of encounter submissions does not become an issue again.
- As Aetna prepares to produce measure rates for 2019 performance, the MCO should ensure that all dual eligible members are included in the rates submitted for reporting.

Degree to which the Previous Year’s EQRO Recommendations Have Been Addressed

Since Aetna began serving as a KanCare MCO in 2019, no previous ISCA has been performed.

Recommendations for Quality Improvement Common Among the MCOs

This section is not applicable as this was Aetna’s baseline ISCA review and no PMV was performed.

SUNFLOWER

Technical Methods of Data Collection and Analysis

To avoid duplication of documentation available from Sunflower’s HEDIS Compliance Audit, sections not addressed in the HEDIS Roadmap or that were unique to the revised Tool were highlighted for responses.

Conclusions Drawn from the Data

As described above in the section Common Among MCOs, no issues were found from the reabstraction of the selected hybrid measures. The results instill confidence that the MCO’s information systems were configured appropriately and that performance measures were calculated correctly.

Sunflower’s overall 2018 performance for Adult Core Set measures (33 measures) showed a total of 5 measures ranked above the 75th percentile, 6 measures showed statistically significant improvement from 2017, and 7 measures showed statistically significant trending for improvement since 2014.

Performance for Child Core Set measures (38 measures) showed a total of 6 measures ranked above the 75th percentile, 5 measures showed statistically significant improvement from 2017, 17 measures showed improvement based on average rates of change (in pp/yr).

Sunflower’s overall 2018 performance for Adult Core Set measures showed a total of 10 measures ranked below the 25th percentile, 1 measure showed a statistically significant decline in performance from 2017, and no measures had a decline in performance based on average rates of change.

For Child Core Set measures, 8 rates ranked below the 25th percentile in 2018, 1 measure statistically significantly declined from 2017, and 2 measures were significantly declining based on average rates of change.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

The strengths below are in addition to the “Common Among MCOs” strengths.

Technical

- Sunflower, being a subsidiary of Centene, benefits from the Centene corporate structure, which offers exceptional tools and resources for monitoring data (accuracy and completeness).
- Visual tools in *Amisys* enable real-time analysis of claims inventory and status, with drill down capabilities.
- Enrollment files are staged and scrubbed to allow for efficient loading to *Amisys*.
- Sunflower’s staff are fully engaged in the HEDIS reporting process and conduct their own review of performance on an ongoing basis and develop their own initiatives.

Performance Measures

Adult Core Set Measures

- **Antidepressant Medication Management – Effective Acute Phase Treatment:** The rate increased significantly from 2017 to 2018.
- **Chlamydia Screening in Women (Age 21–24):** This rate significantly increased from 2017 to 2018 but remained ranked <25th QC.
- **Follow-Up After Hospitalization for Mental Illness – 30 day:** The 2018 ranking was >90th QC.
- **Initiation and Engagement of Alcohol or Other Drug Abuse or Dependence Treatment – Initiation of AOD Treatment:** Increases from 2017 to 2018 were significant two indicators:
 - **Alcohol abuse or dependence (18+ Years)** rates increased from 37.1% to 42.2%.
 - **Total (18+ Years)** rates increased from 33.6% to 37.0%.

Child Core Set Measures

- **Follow Up Care for Children Prescribed ADHD Medication – Initiation Phase:** Rates were above the 75th percentile from 2014 to 2018.
- **Asthma Medication Ratio (Ages 5–11):** The 2018 rate ranked >75th QC and improved at an average rate of 2.8 pp/yr since 2014.
- **Immunizations for Adolescents – Human Papillomavirus (HPV):** The rate increase from 2017 to 2018 (31.1% to 38.4%) was significant.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

The opportunities for improvement below are in addition to those “Common Among MCOs.”

Technical

- Sunflower should work with its corporate team to ensure HEDIS Roadmap sections and attachments for supplemental data are complete and specific to the section questions.
- Sunflower should explore capabilities in their case management system, *TruCare*, to upload paper versions of health risk assessments (HRAs) until they can auto-upload from tablets/laptops.
- Sunflower did not retain hard copies of health risk assessments that had been entered into *TruCare*. Sunflower should implement mechanisms to scan or store the hard copy assessment forms for audit purposes.

- Because no acknowledgement of receipt is received from vendors related to the MCO’s provision of enrollment files, Sunflower should consider working with the vendors to obtain verification that the files were received.

Performance Measures

Adult Core Set Measures

- **Cervical Cancer Screening:** The ranking was <25th QC for 2018.
- **Comprehensive Diabetes Care – Poor HbA1c Control:** The rate increased (worsened) significantly from 2017 to 2018.
- **Medical Assistance with Smoking and Tobacco Use Cessation – Advising Smokers to Quit:** The 2018 rate was below the 25th percentile.
- **Adherence to Antipsychotic Medications for Individuals With Schizophrenia:** The rate ranked <25th QC for 2018.

Child Core Set Measures

- **Use of Multiple Concurrent Antipsychotics in Children and Adolescents:** Sunflower’s rates for all indicators were below the 25th percentile.
- **Prenatal and Postpartum Care – Timeliness of Prenatal Care:** Sunflower’s rate ranked below the 25th percentile.
- **Well-Child Visits in the first 15 Months of Life – 6 or more visits:** Sunflower’s rate was below the 25th percentile.
- **Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents – BMI percentile:** Sunflower’s rate was below the 25th percentile.

Degree to which the Previous Year’s EQRO Recommendations Have Been Addressed

There were no recommendations for Sunflower in the previous year’s report. Through collaboration between KFMC and Sunflower, all recommendations during the validation process were incorporated prior to KFMC’s PMV report submission.

Recommendations for Quality Improvement

The recommendations below are in addition to the “Common Among the MCOs” recommendations.

Performance Recommendations

- Sunflower should address low rates for Comprehensive Diabetes Care – Poor HbA1c Control and Adherence to Antipsychotic Medications for Individuals with Schizophrenia.

Technical Recommendations

- Relative to TruCare, Sunflower should first explore capabilities to upload paper versions of health risk assessments (HRAs), then develop capabilities to utilize mobile devices for assessment collection and entry.
- Sunflower should work with external corporate teams and vendors to ensure complete Roadmap sections and supplemental attachments (corporate) and verification of enrollment file receipt (vendors).

UNITEDHEALTHCARE

Technical Methods of Data Collection and Analysis

To avoid duplication of documentation available from UnitedHealthcare’s HEDIS Compliance Audit, sections not addressed in the HEDIS Roadmap or that were unique to the revised Tool were highlighted for responses.

Conclusions Drawn from the Data

As described above in the section Common Among MCOs, no issues were found from the reabstraction of the selected hybrid measures. The results instill confidence that the MCO’s information systems were configured appropriately and that performance measures were calculated correctly.

UnitedHealthcare’s overall 2018 performance for Adult Core Set measures (33 measures) had 7 rates above the 75th percentile and 7 measures had average rates of change indicating improving performance since 2014.

For Child Core Set measures (38 measures), 6 rates were above the 75th percentile, 2 measures significantly improved from 2017, and 15 had average rates of change indicating improving performance.

UnitedHealthcare’s Adult Core Set measures had 8 rates for 2018 below the 25th percentile, 1 significant decline from 2017 (no statistically significant improvements), and 3 with average rates of change indicating declining performance.

For Child Core Set measures, 10 rates were below the 25th percentile in 2018, 4 measures significantly decreased from 2017, and 5 had average rates of change indicating declining performance.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

The strengths below are in addition to the “Common Among MCOs” strengths.

Technical

- UnitedHealthcare is proactive in its approach to data reporting, leveraging its local team members with national plan expertise to ensure performance measure reporting requirements are met. Local MCO staff were thoroughly engaged in all aspects of measure performance review and reporting.
- UnitedHealthcare utilizes robust quality control procedures for its data extraction, transfer, and load processes instilling confidence that the data used for measure production are complete and accurate.

Performance Measures

Adult Core Set Measures

- **Adult BMI Assessment:** The 2018 rate was greater than 90%.
- **Medical Assistance with Smoking and Tobacco Use Cessation – Advising Smokers to Quit:** 2018 ranking increased to >75th QC.
- **Annual Monitoring for Patients on Persistent Medications (Total):** The 2018 rate was greater than 90% (>66.67th QC).

Child Core Set Measures

- **Follow Up Care for Children Prescribed ADHD Medication:** Rankings were high over 5 years.
 - **Initiation Phase** rates were above the 75th percentile from 2014 to 2018.
 - **Continuation & Maintenance Phase** rates were above the 75th percentile from 2015 to 2018.
- **Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics:** UnitedHealthcare’s rates have been above the 75th percentile since 2015.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

The opportunities for improvement below are in addition to those “Common Among MCOs.”

Technical

- For future ISCA documentation submission, UnitedHealthcare should review the content of questions and responses thoroughly prior to submission, including the table that lists systems and applications with upgrade and retirement dates, and provide more accurate and detailed responses.

Performance Measures

Adult Core Set Measures

- **Antidepressant Medication Management – Effective Acute Phase Treatment:** The 2018 rate was ranked <25th QC.

Child Core Measures

- **Childhood Immunization Status:** Rates were below the 25th percentile for four indicators:
 - **Diphtheria-Tetanus-Acellular Pertussis (DTaP)**
 - **Haemophilus Influenzae B (HiB)**
 - **Measles-Mumps-Rubella (MMR)**
 - **Varicella Zoster Virus (VZV)**
- **Immunizations for Adolescents – Meningococcal:** Rates were below the 25th percentile.
- **Well-Child Visits in the first 15 Months of life (6 or more visits):** UnitedHealthcare’s rate showed a significant decrease from 2017 and ranked <25th QC.
- **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Total:** UnitedHealthcare’s rate ranked below the 25th percentile.

Degree to which the Previous Year’s EQRO Recommendations Have Been Addressed

UnitedHealthcare took action as a result of the recommendations from the prior year. See Appendix D for details.

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Recommendations for Quality Improvement

The recommendations below are in addition to the “Common Among the MCOs” recommendations.

Performance Recommendations

There are no additional recommendations for UnitedHealthcare not contained in the “Common Among the MCOs” recommendations.

Technical Recommendations

- Due to a change in methodology, the measurement year 2018 Timeliness of Prenatal Care indicator of the Prenatal and Postpartum Care (PPC) measure should not be trended with prior years’ rates and a break in trending should be reported with the data.
- Continue rigorous monitoring of the vendors data, particularly March Vision and SkyGen vendors that UnitedHealthcare identified as not consistently meeting performance expectations.
- UnitedHealthcare should review and enhance information systems capabilities and better prepare for and respond to future on-site ISCA activities.

AMERIGROUP (PMV ONLY)

Technical Methods of Data Collection and Analysis

For 2018 P4P, the State indicated the Amerigroup rates calculated by certified HEDIS software and submitted to NCQA could be considered accurate, reliable, free of bias, and in accordance with standards for data collection and analysis. An NCQA HEDIS Compliance Audit had been conducted by a certified auditor, Attest, Inc. The HEDIS rates were determined by Attest to be “reportable.”

Conclusions Drawn from the Data

In addition to the conclusions described above in the section Common Among MCOs,

- The rates, numerators, and denominators reviewed were determined to be accurate, calculated according to State specifications and NCQA standards, free of bias and valid for use in the P4P incentive program.
- The HEDIS rates were determined by Attest, their NCQA-auditor, to be “reportable” and no areas of concern were noted in the NCQA-certified auditor’s report.
- In the re-abstracted cases for HbA1c Control and Timeliness of Prenatal Care, KFMC found no bias in the designation of positive numerator events as per HEDIS specifications.

For Adult Core Set measures (25 measures), 7 rates were above the 75th percentile in 2018, 3 measures statistically significantly improved from 2017, and 4 measures had average rates of change indicating improving performance.

For Child Core Set measures (37 measures), 6 rates were above the 75th percentile in 2018, 7 measures statistically significantly improved from 2017, and 17 measures had average rates of change indicating improving performance.

For Adult Core Set measures, 7 rates were below the 25th percentile in 2018, 1 measure statistically significantly declined from 2017, and 2 measures had average rates of change indicating declining performance.

For Core Set measures, 12 rates were below the 25th percentile in 2018, 1 measure statistically significantly declined from 2017, and 1 measure had an average rate of change indicating declining performance.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

The strengths below are in addition to the “Common Among MCOs” strengths.

Technical

Because the State’s contract with Amerigroup was not renewed, a determination of strengths in processes was not made.

Performance Measures

Adult Core Set Measures

- **Comprehensive Diabetes Care – HbA1c Testing:** The 2018 rate was 90% (>66.67th QC) and had an average increase of 1.2 pp/yr since 2014.
- **Comprehensive Diabetes Care – Poor HbA1c Control:** Amerigroup’s rate was >75th percentile.
- **Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 days (18+ Years):** The rate increased significantly from 2017 to 2018 (12.8% to 18.5%).
- **Initiation and Engagement of Alcohol or Other Drug Abuse or Dependence Treatment – Engagement of AOD – Other drug abuse or dependence (18+ Years):** The increase from 2017 to 2018 (from 3.4% to 10.0%) was significant.
- **Annual Monitoring for Patients on Persistent Medications (Total):** The 2018 rate was statistically significantly higher from 2017 and was greater than 90% (>75th QC).

Child Core Set Measures

- **Asthma Medication Ratio (5–11):** The 2018 rate ranked >75th QC (up from <50th QC in 2017), with a significant increase in rate from 2017.
- **Childhood Immunization Status:** Rates increased from 2017 to 2018 for all eleven indicators, including:
 - **Hepatitis A** ranking improved from ≥50th QC to >75th QC.
 - **Inactivated Poliovirus Vaccine (IPV)** ranking improved from <25th QC to ≥50th QC and the 2018 rate was greater than 90% and statistically significantly higher than 2017.
 - **Pneumococcal Conjugate** ranking improved from <5th QC to ≥50th QC.
 - **Combination 10 (all 10 antigens)** ranking improved from <25th QC to ≥50th QC. The average increase from 2014 to 2018 was 3.3 pp/yr.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

Because the State’s contract with Amerigroup was not renewed, a determination of opportunities for improvement in processes was not made.

Performance Measures

Adult Core Set Measures

- **Adherence to Antipsychotic Medications for Individuals With Schizophrenia:** The rate ranked <25th QC since 2016.

Child Core Set Measures

- **Follow Up Care for Children Prescribed ADHD Medication – Continuation & Maintenance Phase:**
The 2018 rate was below the 25th percentile.
- **Immunizations for Adolescents – Human Papillomavirus (HPV):** The 2018 rate ranked <25th QC.

Degree to which the Previous Year’s EQRO Recommendations Have Been Addressed

Through collaboration between KFMC and Amerigroup, all recommendations made during the previous year’s validation process were incorporated prior to the PMV report submission.

Recommendations for Quality Improvement

Because the State’s contract with Amerigroup was not renewed, no recommendations were made.

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2. Performance Improvement Projects (PIPs) Validation

Background/Objectives

The purpose of a PIP is to assess and improve processes and, thereby, outcomes of care. MCOs are required to conduct PIPs in both clinical and non-clinical areas. The objectives of KFMC's review are to determine if the design of the improvement project is methodologically sound, to validate the annual PIP results, and to evaluate the overall validity and reliability of the methods and findings.

The MCOs continued the following PIPs in 2019:

- “Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications” (SSD). (Sunflower – Year 2)
- “Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications” (SSD). (UnitedHealthcare – Year 3)
- “Increasing compliance with Human Papillomavirus (HPV) vaccination administration in adolescents.” (MCO collaborative PIP: Aetna [Year 1], Sunflower and UnitedHealthcare [Year 4])

Each of the MCOs' selected PIPs were in a clinical area. Their interventions were targeted to providers and members enrolled in Medicaid (Title XIX) and the Children's Health Insurance Program (Title XXI).

Technical Methods of Data Collection and Analysis/Description of Data Obtained Common Among the MCOs

In 2019, quarterly interagency meetings were held including staff from KDHE, the Kansas Department of Aging and Disability Services (KDADS), KFMC, and each of the MCOs. Separate time periods were scheduled to meet with each MCO, which included time for a discussion of their PIP interventions and progress. Starting in June, monthly meetings were held to exclusively discuss the PIPs during months the interagency contract meetings were not scheduled. The MCOs were developing several new PIPs in 2019. KFMC provided feedback to the State and MCOs on initial and revised PIP methodology, interventions, data analysis, and annual progress.

KFMC conducted the PIP validations in accordance with the 2012 Validating PIPs Protocol worksheet and narrative provided by CMS; a revised Protocol was released by CMS in October 2019. Both Protocols outline 10 steps for the validation and provides for each step one or more questions for consideration. KFMC began transitioning to the revised October 2019 Protocol with the PIP validations in this annual EQR technical report. Evaluation of the annual PIP progress includes review of the MCOs' annual reports submitted for the current and prior years (where applicable), along with their originally submitted methodology worksheets.

The overall validity and reliability of the PIP is based on whether the MCO adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis, assessed for statistical significance of any differences, and provided an interpretation of the PIP results. For the assessment, KFMC devised a scoring system that uses an assigned numerical rating from the evaluation of PIP Activities to determine a level of overall confidence. Scores from 95% to 100% indicate a High Confidence, scores from 90% to <95% indicate Confidence, and scores from 80% to <90% indicate Low Confidence. Scores below 80% indicate results where there is Little Confidence in the PIP. Due to a revised MCO PIP documentation worksheet and KFMC's revised PIP validation worksheet, both implemented during transition to the revised October 2019 Protocol, the scoring system was modified for the collaborative MCO PIP. However, thresholds for the levels of overall confidence remained the same for each PIP validation.

SUNFLOWER

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Background/Objectives

Sunflower’s PIP topic is based on the HEDIS^{®6} SSD measure, “Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications.” This evaluation reflects annual diabetes screenings from 2016 through 2018 and the first seven months of 2019 (January to July). Sunflower’s baseline rate was HEDIS reported SSD data for 2016. In the evaluation, comparisons were made with Sunflower’s HEDIS SSD annual rates and the national QC percentiles reported by NCQA. Sunflower’s 2019 annual report will be the last submission for this PIP. In January 2020 they transitioned to a new PIP, “Diabetes Monitoring for People with Diabetes and Schizophrenia” (SMD).

Sunflower implemented five multifaceted interventions for the PIP population to increase the percentage of members who received a glucose test or Hemoglobin A1c (HbA1c) screening during the measurement year. Four interventions were initiated between February and June 2017 and the fifth intervention was launched in September 2019. The interventions included the following:

- Multiple staff trainings to increase knowledge and awareness,
- Referrals to case management teams for member education and support,
- Member education mailers,
- Pay-for-performance initiative with Community Mental Health Centers, and
- Providing diabetes screening compliance status to primary care physicians.

Technical Methods of Data Collection and Analysis/Description of Data Obtained

The HEDIS^{®1} technical specifications clearly identify the population for the SSD measure. Although the PIP population includes all members 18–64 years of age with schizophrenia or bipolar disorder, no specific information was provided indicating Sunflower considered input from enrollees with special health needs, specific to diabetes screening. Sunflower’s PIP design followed the HEDIS Technical Specifications that outline the use of encounters, claims, pharmacy claims, and laboratory data in the calculation of the SSD measure.

Sunflower’s 2018 annual progress report, submitted October 31, 2019, and their first annual progress report (2017), submitted in 2018, were the source documents for this evaluation. In the report, Sunflower provided analyses results for the SSD HEDIS measure and for each of their intervention strategies. Results of their PIP analyses were both described and presented in tables and graphs.

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⁶ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

Conclusions Drawn from the Data

Total PIP Population, SSD Rates

Sunflower’s diabetes screening baseline rate in 2016 was 76.10% (see Table 2.1). The 2017 SSD remeasurement rate of 80.66% exceeded their 5% improvement goal (79.91%) and was significantly higher ($p=.002$) than the rate in 2016. However, their 2018 SSD rate had a 1% relative decrease compared to 2017. The lack of improvement in the SSD measure between 2017 and 2018 may be in part attributed to HEDIS technical specification changes for 2018 (eight modifications). In QC there are two possible trending scenarios based on the significance of the specification changes, “Trend with Caution” or “Break in Trending.” The SSD measure for 2018 was identified with “Trend with Caution.”

Table 2.1. Total Population Diabetes Screening Rates, 2016 to 2018

Year	Screening Rate	N/D*
2018 ^	79.85%	1,248 / 1,563
2017	80.66% ↑	1,305 / 1,618
2016 †	76.10%	1,261 / 1,657

↑ Indicates percentage was statistically significantly higher than in 2016. ($p < .05$ considered significant)
* N/D = Numerator/Denominator
^ NCQA identified "Trend with Caution" due to specification changes from prior year.
† Baseline Year

Age, SSD Rates

The diabetes screening rates were stratified by six age groups between ages 18 to 64 (see Table 2.2). Over half of the 2018 PIP population (53% of 1,563) was 21 to 40 years of age; members in the 31 to 40 age group had the lowest SSD rate (77.05%) and represented 28% of the PIP population. Members age 51 to 64 years had the highest SSD rates from 2016 through 2018, with the rates ranging from 83.56% to 88.89%. However, these older members only represented about 22% of the PIP population across the measurement years. The percentage point difference between the highest and lowest SSD rates among the six age groups was smaller in 2018 (8.3) compared to 2017 (16.3). Sunflower identified this was mostly due to the 18 to 20 year old members who had a 10.5 percentage point increase in the SSD rate from 2017 (68.87%) to 2018 (79.38%).

Table 2.2. Diabetes Screening Rates by Age, 2016 to 2018

Year	18-20		21-30		31-40		41-50		51-60		61-64	
	Rate	N/D*	Rate	N/D*	Rate	N/D*	Rate	N/D*	Rate	N/D*	Rate	N/D*
2018	79.38%	77 / 97	79.39%	312 / 393	77.05%	339 / 440	78.69%	229 / 291	85.35%	233 / 273	84.06%	58 / 69
2017	68.87%	73 / 106	78.29%	339 / 433	81.84%	347 / 424	82.70%	239 / 289	83.56%	244 / 292	85.14%	63 / 74
2016	69.30%	79 / 114	70.32%	282 / 401	76.96%	354 / 460	73.55%	228 / 310	84.79%	262 / 309	88.89%	56 / 63

* N/D = Numerator/Denominator
^ Baseline Year

Additional Conclusions

- The Supplemental Security Income (SSI) population has represented the largest percentage of the PIP population (>60%) and had had SSD rates below 80% in both 2018 (78.62%) and 2017 (79.66%).
- In the regional analysis for 2018, the Urban region (Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte counties) represented over half of the PIP population and had the lowest diabetes screening rate (76.21%).
- In comparison with national QC percentiles, Sunflower’s SSD rates for 2013 through 2016 were below the annual HEDIS 25th percentile. Sunflower’s 2017 and 2018 SSD remeasurements were both greater than the 33.33rd percentile but less than the 50th percentile.

Sunflower’s PIP evaluation score for the 2018 annual progress report was 92.9% (91/98), which indicates that KFMC has confidence in the overall validity and reliability of their PIP methods and findings.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

- Multifaceted member interventions have been implemented to target members in the PIP population who were not screened for diabetes.
- The annual progress report assessed the results of the PIP outcome measure and each intervention.
- Sunflower completed a stratification of the SSD rates for members in the Urban region by demographics and interventions. This analysis was suggested as an opportunity for improvement in the 2017 annual evaluation report.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

The following opportunities for improvement were noted:

- Compare data between annual progress reports for consistency and discuss reasons for changes (between reports) in data for the same measurement time period.
- The NCQA appropriate designation regarding measure trending concerns (Trend with Caution or Break in Trending) should be included when PIP measures are impacted due to changes in the HEDIS technical specifications.
- With future PIPs, combine members in Medicaid (Title XIX) and CHIP (Title XXI) when the numbers for CHIP are very small.

Degree to which the Previous Year’s EQRO Recommendations Have Been Addressed

Sunflower addressed two of the four previous year’s recommendations that were noted. Please see Appendix D for more details.

Recommendations for Quality Improvement

1. Provide an explanation in the 2019 annual report for why the SSD measure denominator has been much larger than the population identified for the spring mailers, which has been reported as sent to the entire PIP population.
2. In the 2019 annual report, include the definition of a successful contact for a mailer (“*delivered to an address and not returned*”) to reflect the current measurement.
3. Revise the time period in the numerator for the spring and August mailer intervention from “measurement year” to “90 days after member mailer sent” to reflect the current measurement.
4. Specify in the 2019 annual report the number of attendees for each staff training, content of the trainings, and who the audiences were.
5. While activities for this PIP ended in 2019, Sunflower initiated a new intervention in September 2019 with primary care physicians to provide them the diabetes screening compliance status of their assigned/attributed members. This intervention was added as part of Sunflower’s transition to their new SMD PIP. However, Sunflower should continue monitoring the SSD rate to determine whether changes are needed to sustain improvements achieved during the PIP.

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UNITEDHEALTHCARE

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication

Background/Objectives

UnitedHealthcare's PIP topic is based on the SSD HEDIS® measure, "Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications." This evaluation reflects annual diabetes screenings from 2016 through 2018 and an interim measurement from January 1, 2019 to November 7, 2019. UnitedHealthcare's baseline rate was HEDIS reported SSD data for 2016. In the evaluation, comparisons were made with the HEDIS SSD annual rates and the national QC percentiles reported by NCQA. The activity for this PIP ends June 30, 2020, and UnitedHealthcare's 2020 annual report will be the last submission for this PIP. They are transitioning to a new PIP, "Diabetes Monitoring for People with Diabetes and Schizophrenia" (SMD).

UnitedHealthcare implemented four member-targeted and four provider-targeted interventions to increase the percentage of members in the PIP population who received a glucose test or HbA1c test during the measurement year:

- Waiver Management Outreach,
- Written Communications to Members,
- Whole Person Care,
- Visiting Nurse Outreach (only active in 2017),
- Behavioral Health Integration (ended in December 2018),
- Clinical Practice Consultant Outreach,
- Written Communication to Providers, and
- Provider Education.

Technical Methods of Data Collection and Analysis/Description of Data Obtained

The enrollees to whom the study question and indicator applied were clearly identified by the technical specification for the SSD measure. The HEDIS denominator criteria for the SSD indicator were used to define and identify the PIP population: members ages 18–64 with two or more behavioral health visits within the measurement year (MY) having diagnoses of schizophrenia or bipolar disorder who received an antipsychotic medication and did not have a previous diagnosis of diabetes or prescription for insulin or oral hypoglycemics or antihyperglycemics.

UnitedHealthcare's PIP design followed the HEDIS®¹ technical specifications that outline the use of encounters, claims, pharmacy claims, and laboratory data in the calculation of the SSD measure. The HEDIS production process was monitored by the MCO and audited by an NCQA-certified auditor so that valid and reliable data would be collected by qualified staff for the entire PIP population.

The source documents for KFMC's evaluation were the annual report submitted by UnitedHealthcare on January 17, 2020, and their PIP methodology worksheet originally submitted January 12, 2017, and updated with the annual progress report. In their annual report, comparisons of the HEDIS SSD rates were both described and provided in tables with statistical testing results between measurement years.

Conclusions Drawn from the Data

UnitedHealthcare completed comparisons and statistical testing between measurement years for their two primary indicators (annual HEDIS SSD rates and November Interim HEDIS SSD rates). The total annual HEDIS SSD rate improved four percentage points from baseline (76.03%) to 2018 (80.03%) and

the improvement was statistically significant ($p=.02$); see Table 2.3. The SSD rates for the stratified Long-Term Care (LTC) population were greater than 84% in 2016, 2017, and 2018.

Table 2.3. Study Indicator 1 – Annual HEDIS® SSD Rates				
	Total	Medicaid + CHIP	LTC	Statistical Test & Significance
Baseline Measure January 1, 2016 – December 31, 2016	76.03% (866/1,139)	74.28% (722/972)	86.23% (144/167)	
Remeasurement 1 (R1) Period January 1, 2017 – December 31, 2017	80.05% (1,003/1,253)	79.30% (858/1,082)	84.80% (145/171)	Total – statistically significant increase from baseline, $\chi^2=5.63$, $p=.02$ Medicaid + CHIP – statistically significant increase from baseline; $\chi^2=7.26$, $p=.01$
Remeasurement 2 (R2) Period January 1, 2018 – December 31, 2018	80.03% (978/1,222)	78.80% (829/1,052)	87.65% (149/170)	Total – statistically significant increase from baseline, $\chi^2=5.52$, $p=.02$ Medicaid + CHIP – statistically significant increase from baseline; $\chi^2=5.77$, $p=.02$

The November rates allow the MCO to review preliminary HEDIS SSD rates while planning the next calendar year’s PIP activities, rather than delaying until the following summer for the final rates. In comparing the Interim baseline measurements to the Interim 2019 reported rates for the total population and CHIP population combined, increases were 6.1 and 7.1 percentage points, respectively. Statistical comparisons of the November SSD rates (see Table 2.4.) also revealed some statistically significant differences from the second and third remeasurements compared to baseline.

Table 2.4. Study Indicator 2 – November Interim HEDIS® SSD Rates				
	Total	Medicaid + CHIP	LTC	Statistical Test & Significance
Baseline Measure January 1, 2016 – November 22, 2016	72.17% (796/1,103)	70.29% (660/939)	82.93% (136/164)	
Remeasurement 1 (R1) Period January 1, 2017 – November 7, 2017	75.37% (857/1,137)	74.26% (724/975)	82.10% (133/162)	
Remeasurement 2 (R2) Period January 1, 2018 – November 7, 2018	75.56% (906/1,199)	74.47% (773/1,038)	82.61% (133/161)	Medicaid + CHIP – statistically significant increase from baseline, $\chi^2=4.32$, $p=.04$
Remeasurement 3 (R3) Period January 1, 2019 – November 7, 2019	78.25% (975/1,246)	77.36% (803/1,038)	82.69% (172/208)	Total – statistically significant increase from baseline, $\chi^2=11.67$, $p<.001$ Medicaid + CHIP – statistically significant increase from baseline, $\chi^2=12.82$, $p<.001$

Additional conclusions include the following:

- Two annual remeasurements from baseline were available for this reporting period. Sustained improvement has been demonstrated in the annual SSD rate for the total PIP population from 2016 (76.03%) to 2017 (80.05%), and in 2018 (80.03%). The improvement from baseline to 2018 is statistically significant ($p=.02$).
- The annual baseline SSD rate for this PIP was 76.03%, which was below the QC 25th percentile. Both the 2017 and 2018 SSD remeasurements were greater than the 33.33rd percentile but less than the 50th percentile.
- The Whole Person Care (coordination of services from multiple provider services from multiple provider types) appears to be the most promising, with rates around 85% for members successfully enrolled in the program compared to an average of 76% for eligible members not successfully enrolled in the program.
- The Written Communications to Members and Providers intervention appears to be the least impactful, with screening rates less than 45% after mailings.

UnitedHealthcare’s PIP evaluation score for the 2019 annual progress report was 90.0% (90/100), which indicates that KFMC has confidence in the overall validity and reliability of their PIP methods and findings.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

- UnitedHealthcare’s evaluation was not restricted to highlighting improvements but also acknowledged barriers and addressed opportunities and plans for improvements.
- A variety of interventions were developed to target all members in the study population who were not screened for diabetes.
- Four interventions (Waiver Management Outreach, Whole Person Care, Clinical Practice Consultant Outreach, and Behavioral Health Integration [discontinued 12/31/2018]) also target members in need of services as indicated by other HEDIS measures, which helps produce an “economy of scale” and promotes person-centered care.
- The total annual HEDIS SSD rate improved four percentage points from the 2016 baseline measurement (76.03%) to 2018 (80.03%) and the improvement was statistically significant ($p=.02$).

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

The following opportunities for improvement were noted:

- Develop methods to directly obtain input from members with special health needs and/or their advocacy groups.
- Continue to further develop qualitative analysis of member, provider, care manager, and clinical practice consultant feedback.
- Continue to improve interventions and evaluation of their effectiveness.

Degree to which the Previous Year’s EQRO Recommendations Have Been Addressed

UnitedHealthcare fully addressed five of the six previous year’s recommendations that were noted. Please see Appendix D for more details.

Recommendations for Quality Improvement

1. Fully update the definition for PIP eligibility with any changes in the HEDIS technical specifications. Clarify whether the additional diagnosis of schizoaffective disorder was included when determining members eligible for the interventions.
2. Report the number of times the provider portal (if possible, more specifically the Gap-in-Care reports through the provider portal), is accessed in total and by tax identification number during the measurement year.
3. If a similar intervention is used in future PIPs, the paired member, prescriber and primary care provider mailings should occur earlier in the year to allow enough time to fully evaluate their effectiveness. Consider ways to improve this intervention to increase effectiveness.
4. In the 2019 final report for the SSD PIP, an overall summary and assessment of this PIP should be provided, including the following:
 - Key outcome results (including statistical evidence of any observed improvement that might reasonably have resulted from the interventions);
 - Drivers for the success;
 - Foreseen sustainability of the outcomes;
 - Aspects of the PIP that will be incorporated into standard practice within the MCO; and
 - Lessons learned applicable to their new SMD PIP.

COLLABORATIVE PIP

Increasing Compliance with Human Papillomavirus Vaccination Administration in Adolescents

Background/Objectives

The MCOs selected the HEDIS® Human Papillomavirus (HPV) vaccination metric for their PIP to improve the immunization rate for eligible adolescent females and males enrolled in the KanCare program. Their goal is to improve the rate by 5% each year as compared to the previous year's HEDIS HPV performance. In 2015 the HEDIS measure captured data only for female members. In 2016, the metric was added to the Immunizations for Adolescents (IMA) HEDIS measure. The HEDIS 2017 (measurement year [MY] 2016) technical specifications retired the female-only HPV measure and expanded the measure to include HPV vaccinations for both males and females.

Sunflower Health Plan and UnitedHealthcare Community Plan of Kansas have been conducting this PIP since it was initiated; 2019 was the first year of operation for Aetna Better Health of Kansas as an MCO in Kansas. Therefore, the analysis results, comparing multiple measurement years, were only applicable to two of the three MCOs.

The annual validated HEDIS HPV vaccination rates are used to determine overall success of the PIP and its interventions, while measurement of each intervention outcome helps determine whether improvement is the result of the planned quality improvement effort. The MCOs have used a multifaceted intervention approach to target members in the PIP population and providers. Since initiation of this PIP, three of the ten interventions have been discontinued. The remaining interventions include the following:

- Telephone Outreach to Parents/Guardians,
- Unable to Contact by Telephone Written Communication/Mailer,
- Mailing HPV-Specific Information Materials to Non-Compliant Members,
- HPV Professional Conference and/or Webinar Offerings,
- Gap in Care Reports to Providers,
- Provision of Provider Profiles that Include Detailed Reports of their Overall Performance, and
- HPV Information Packet for Psychiatric Residential Treatment Facilities and Adolescent Center for Treatment Staff to Use (developed after surveying the facilities to identify needs).

Technical Methods of Data Collection and Analysis/Description of Data Obtained

The PIP population was clearly defined by the MCOs based on the HEDIS technical specifications for the HPV vaccine measure. The specifications require continuous enrollment for the 12 months prior to the member's 13th birthday, preventing Aetna from calculating the year-to-date (YTD) baseline HPV vaccination measurements reported for January 1, 2019 to October 31, 2019. For Aetna's first performance year (2019), KDHE requested member enrollment for this PIP be modified by combining enrollment files for Aetna and Amerigroup (whose state contract ended in 2018). The combined files allowed Aetna to identify members with continuous enrollment for the 12 months prior to their 13th birthday.

The MCOs' 2019 annual progress report, submitted January 31, 2020, was the source document for KFMC's evaluation. Each MCO provided information regarding their data warehouse and process for handling the data. Sources of data included: claims, encounters, medical records, laboratory results, and immunizations identified through the Kansas immunization registry (KSWebIZ). The MCOs' PIP outcome measures, HEDIS HPV vaccine rates, have been deemed reportable by a NCQA-certified auditor and reported to NCQA.

For the PIP outcome measures, the MCOs presented most of the analysis results accurately and clearly in multiple tables and in the description of their results. However, they did not include with their findings an interpretation of the increases and decreases in the 2017 and 2018 administrative and hybrid HPV vaccine rates. Also, they did not address if they have identified any key drivers of success for this PIP. In the EQR evaluation, KFMC compared HEDIS annual rates to the national QC percentiles reported by NCQA.

Conclusions Drawn from the Data

A comparison of the female and male HPV vaccine rates is provided in Table 2.5. While the total female HPV vaccine rates in 2018 were still higher than the male rates, the percentage point increases from 2017 were greater for males than females in both the administrative and hybrid rates. Most notable, was a 3.92 percentage point increase in the hybrid male rate and a 2.81 percentage point increase in the female hybrid rate.

Although not reported by the MCOs, Sunflower’s hybrid male HPV vaccine rate had a statistically significant improvement ($p=.02$) from 2017 (26.34%) to 2018 (36.89%); and UnitedHealthcare’s administrative male HPV vaccine rate also had a significant improvement ($p=.01$) from 2017 (28.42%) in 2018 (32.16%).

Sunflower’s and UnitedHealthcare’s administrative and hybrid adolescent (female and male combined) HPV vaccine rates are displayed in Table 2.6. The MCOs reported their combined total administrative HPV vaccine rate had a statistically significant increase ($p=.04$) from 2017 (31.53%) to 2018 (33.08%). Sunflower’s hybrid adolescent HPV vaccine rate increased 7.30

percentage points from 2017 (31.14%) to 2018 (38.44%). UnitedHealthcare’s 2018 administrative adolescent HPV vaccine rate (33.33%) had a 2.88 percentage point increase compared to 2017 (30.45%).

Sex	Sunflower		UnitedHealthcare		Total	
	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
2018 Data						
Female	35.17%	40.00%	34.51%	39.38%	34.85%	39.68%
Male	30.67%	36.89%↑	32.16%↑	27.03%	31.36%	32.23%
2017 Data*						
Female	34.95%	36.90%	32.76%	36.84%	33.90%	36.87%
Male	30.37%	26.34%	28.42%	30.32%	29.42%	28.31%
2016 Data						
Female	22.19%	21.74%	19.71%	19.37%	21.08%	20.60%
Male	16.68%	16.75%	16.23%	17.73%	16.48%	17.25%
* Effective with HEDIS measurement year 2017, the number of recommended HPV vaccinations was reduced from three to two doses. Quality Compass identified a “Break in Trending” for 2017.						
↑ Indicates statistically significant increase from the MCO’s prior year’s rate. ($p < .05$)						

	2016		2017*		2018	
	N/D^	Rate	N/D^	Rate	N/D^	Rate
Sunflower						
Admin	849 / 4,413	19.24%	1,307 / 4,017	32.54%	1,316 / 4,006	32.85%
Hybrid	80 / 416	19.23%	128 / 411	31.14%	158 / 411	38.44%↑
UnitedHealthcare						
Admin	654 / 3,658	17.88%	1,147 / 3,767	30.45%	1,190 / 3,570	33.33%↑
Hybrid	76 / 411	18.49%	141 / 411	34.31%	139 / 411	33.82%
Total						
Admin	1,503 / 8,071	18.62%	2,454 / 7,784	31.53%	2,506 / 7,576	33.08%↑
Hybrid	156 / 827	18.86%	269 / 822	32.73%	297 / 822	36.13%
* Effective with HEDIS measurement year 2017, the number of recommended HPV vaccinations was reduced from three to two doses. Quality Compass identified a “Break in Trending” for 2017.						
^ N/D = Numerator/Denominator						
↑ Indicates statistically significant increase from the prior year’s rate. ($p < .05$)						

While not reported by the MCOs, the improvement in Sunflower’s hybrid rate was statistically significant ($p=.03$), as was the improvement in UnitedHealthcare’s administrative rate ($p<.01$).

Sunflower’s 2018 adolescent HPV vaccine rate (38.44%) was greater than the national QC 50th percentile but less than the 66.67th percentile. UnitedHealthcare’s 2018 adolescent HPV vaccine rate (33.82%) was greater than the 33.33rd percentile but less than the 50th percentile.

The MCOs included the following three improvements as part of their overall conclusions.

- *“Sunflower/United combined vaccination rates for members on the Serious Emotional Disturbance (SED) waiver increased from 2017 (22.67%) to 2018 (26.84%).*
- *Sunflower/United combined vaccination rates for members on the I/DD waiver increased from 2017 (17.19%) to 2018 (34.09%).*
- *Sunflower members who were successfully contacted by Sunflower in 2018 had a higher 90-day vaccine response rate (23.23%) than those who were not contacted (18.09%).”* This was a comparison of rates for members Sunflower successfully contacted by phone (targeted treatment group) and those they were unable to contact (control group).

Over the past year, the MCOs have continued to improve/modify and add member and provider interventions, as well as associated measures. In 2018, the “Phone outreach” member intervention was revised to target specific urban and non-urban counties; it is the first intervention to have a control group comparison (successful outreach [target group]; not contacted by telephone [control group]). In 2019, the MCOs reported a statistically significant difference ($p<.0001$) between the target group (27.2%) and the control group (12.3%).

Due to a revised MCO PIP documentation worksheet and KFMC’s revised PIP validation worksheet, both implemented for the collaborative HPV annual report, the scoring system was modified. As an assessment guide, KFMC assigns a numerical rating to each validation component (Yes = 1, Partially Yes = 0.25, 0.50 or 0.75 [depending on the degree met], and No = 0). The score for the 2019 annual HPV PIP progress report was 84.7%, which indicates that KFMC has a low confidence in the overall validity and reliability of their PIP methods and findings.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

- There are a variety of member and provider interventions.
- The intervention with targeted phone outreach to specific Urban and Non-Urban counties with a control group for comparison, which was the first intervention to have a control group.
- The MCOs have improved interventions, conducting Plan-Do-Study-Act cycles.
- The 2019 report included additional analyses/measurement of the MCOs’ interventions.
- Sunflower’s hybrid male HPV vaccine rate had a statistically significant improvement ($p=.02$) from 2017 to 2018 and UnitedHealthcare’s administrative male HPV vaccine rate also had a significant improvement ($p=.01$) from 2017 in 2018.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

- Continue to improve specificity when describing intervention processes and technical specifications, including who and how many are eligible for the intervention and defining data collection beginning/ending dates for implementation of intervention event and measurement periods.

- The provider interventions (i.e., Gap in Care and Provider Profile reports) do not appear to specifically focus on HPV vaccinations and have limited evaluation measures.
- Level of interpretation could be improved regarding the findings and potential impacts from intervention changes and differences among MCOs in how interventions are implemented (e.g., call script, frequency of intervention).

Degree to which the Previous Year’s EQRO Recommendations Have Been Addressed

The MCOs fully addressed six of the ten previous year’s recommendations that were noted. Please see Appendix D for more details.

Recommendations for Quality Improvement

1. The MCOs should include, with their findings, the interpretations and lessons learned regarding comparisons among measurement years and among MCOs.
2. Provide more detailed information regarding criteria used and rationale for determining who receives an intervention when 100% are not included.
3. Evaluate the impact on the measurement of members receiving a dose of the HPV vaccine within 90 days after successful telephone outreach when they are calling parents/guardians six months prior to the member’s birthday. Depending on the impact study, the MCOs may determine they want to review outcomes within 90 days after the successful call and again to review completion of the vaccination series by the 13th birthday for those with successful calls six months prior.
4. Evaluate the different elements of the “unable to reach” letter process, such as wording of the letter, and requiring the parent/guardian to call the MCO. Currently, the only outcome measure is the *“number of members who received a dose of the HPV Vaccine within 90 days of the Phone response call to the “Did Not Contact” letter.”* Consider also evaluating the number of members with a letter sent that received a vaccination after receipt of the letter, without having called the MCO; this would help evaluate the effectiveness of the letter, or whether requiring a response phone call is impacting a low follow-up vaccination rate.
5. Provide specific information regarding the method used for determining which providers are sent (mail, fax, secure email) or hand-delivered a Gap in Care report and when the information is sent.
6. Since the MCOs routinely use the Gap in Care reports (in-person, mail, and portal) as an intervention for their PIPs, it is recommended they work to identify a method for measuring whether the Gap in Care reports are being accessed through their portals.
7. Since the Provider Profile reports appear to focus on a wide range of preventive measures and other performance, consider ways to focus on the HPV vaccination rates in the Provider Profile reports, for PIP purposes.

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3. CAHPS Survey Validation

Background/Objectives

CAHPS^{®7} is a nationally standardized survey tool sponsored by the Agency for Healthcare Research and Quality and co-developed with NCQA. The overall objective of the CAHPS survey is to capture accurate and complete information about consumer-reported experiences with health care. The Healthcare Effectiveness Data and Information Set (HEDIS) measures and the CMS Child and Adult Core Sets of Health Care Quality Measures for Medicaid and CHIP (Core Sets) include CAHPS Health Plan Survey measures. The State contractually required managed care organizations (MCOs) providing Kansas Medicaid (TXIX) and CHIP (TXXI) services through the KanCare program to survey representative samples of adult, general child (GC), and Children with Chronic Conditions (CCC) populations. The State required each MCO to separately sample and report results for children receiving TXIX and TXXI services.

CAHPS surveys are also required for NCQA accreditation of the MCOs. CAHPS data from hundreds of health plans nationwide are submitted to NCQA, who then annually produces the Quality Compass that allows states and health plans to compare annual survey composite scores, ratings, and responses to many individual survey questions. The State also reports CAHPS data to CMS in an annual Children's Health Insurance Program Reauthorization Act (CHIPRA) report.

The 2019 CAHPS surveys were conducted by the Sunflower Health Plan, Inc (SHP) and the UnitedHealthcare Community Plan of Kansas (UHC) using the CAHPS 5.0H Adult Questionnaire (Medicaid) and CAHPS 5.0H Child Questionnaire (with CCC measure).⁸

Technical Methods of Data Collection and Analysis/Description of Data Obtained Common Among the MCOs

For the 2019 survey, both Sunflower and UnitedHealthcare contracted with NCQA-certified CAHPS survey vendors to assist with scoring methodology, fielding the survey, and presenting the calculated results—Sunflower contracted with Morpace and UnitedHealthcare contracted with DSS Research. As NCQA-certified vendors, DSS Research and Morpace are required to adhere to NCQA survey specifications. Both MCOs chose the mixed-mode mail/telephone protocol for administering the 2019 CAHPS surveys. Morpace also included an online option for Sunflower's members to complete the survey through an Internet link provided in the surveys the members received by mail. Surveys for both MCOs were fielded from February 2019 through May 2019.

The CAHPS tool and survey process have undergone extensive testing for reliability and validity. Detailed technical specifications are provided by NCQA for conducting the survey and processing results. Both MCOs complied with the following NCQA requirements:

- Eligibility for each group required continuous enrollment in the MCO from July 1 to December 31, 2018, with no more than one gap of up to 45 days; enrollment on December 31, 2018 and when surveyed. Members eligible for each survey were:
 - **Adults** – Age 18 years and older as of December 31, 2018;
 - **GC Populations** – Age 17 years and younger as of December 31, 2018;

⁷ CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

⁸ Aetna Better Health of Kansas (ABH), a KanCare MCO as of January 1, 2019, had no members meeting the survey's requirement of being enrolled in the MCO for at least five of the last six months of calendar year 2018. Amerigroup Kansas, Inc. (AGP), a KanCare MCO from 2013 through 2018, would not have had members meeting the requirement "enrolled at the time of the survey."

- **CCC Populations** – A subset of the GC population identified as “CCC” using HEDIS criteria based on health criteria and specific survey answers; and
- Minimum sample sizes set by NCQA assuming an average 45% response rate for Medicaid product lines and targeting 411 responses were:
 - **Adult Sample** – 1,350 adult sample;
 - **GC Sample** – 1,650 GC children;
 - **CCC Supplemental Sample** – 1,840 children more likely to have a chronic condition, based on claims and encounter data, drawn from child records not selected for the GC sample. The sample size can be lower than 1,840 if fewer than 1,840 children are available for selection.

The MCOs provided the State and KFMC copies of the vendor reports and cross-tabular tables that included response, non-response, and ineligible response counts for each of the CAHPS survey questions by population.

KFMC used and referenced the CMS Validating Surveys protocol worksheet and narrative to evaluate the technical methods and results from the MCO CAHPS reports. KFMC’s analyses in the CAHPS validation reports provide the State with annual comparisons of member satisfaction with services provided by each MCO, by MCO subpopulations, and in aggregate that help identify areas of strength and those where additional focus may be warranted.

KFMC uploaded response counts into tables populated with response counts from prior years’ surveys. Annual changes from the prior year were statistically tested (using Fisher’s exact) for each survey question (by MCO and by population) for years 2015 to 2019. KFMC also calculated aggregated annual percentages (weighted by population) for all survey questions and tested for statistically significant differences between consecutive years (using chi square). A statistical test (Mantel-Haenszel chi square) for trends over five years (2015–2019) was conducted to determine if the slope of the trend line on a graph was statistically significantly different from horizontal.

For questions identified as being related to quality, timeliness, and access to health care, KFMC compared results with (QC) national percentiles for health maintenance organizations for the year the survey was conducted. (Vendor reports included the prior year’s QC percentiles, as vendor reports were provided to MCOs in early summer before the current year’s QC percentiles were available.)

KFMC’s evaluation is based on multiple factors, including rates for the current year, rates in previous years, number of responses, and QC percentiles. Generally, “very high” refers to scores above 90% or the 75th percentile and “very low” refers to scores below the 25th percentile. A “significant change” means the differences in rates was statistically significant with probability p less than 0.05.

Conclusions Drawn from the Data Common Among the MCOs

With few exceptions, 2019 KanCare- and MCO-level survey results continued to demonstrate positive assessments by members of quality, timeliness, and access to healthcare. Rates were, for the most part, at or above the 50th QC percentile, with many of the ratings, composite scores, and question percentages on the child surveys above the 75th QC percentile.

Tables and appendices in the full report include annual results for each survey question and composite questions related to access, timeliness, and quality of care by MCO and subgroup for 2015–2019, annual statistical comparisons by question, and annual Quality Compass rankings for composites, ratings, and questions.

In this summary report, Table 3.1 displays Health Plan, Health Care, Personal Doctor, and Specialist Seen Most Often ratings and QC rankings by MCO population (adult, GC TXIX, GC TXXI, CCC TXIX, and CCC TXXI), and KanCare aggregate results. The ratings are the percentage responding 8, 9, or 10 out of 10.

Table 3.1. Rating by MCO and by Program in 2019 (Rating 8+9+10)										
Population	Program	MCO	Health Plan		Health Care		Personal Doctor		Specialist	
			%	QC	%	QC	%	QC	%	QC
Adult		SHP	77.5%	<50 th	76.1%	≥50 th	83.6%	≥50 th	84.0%	≥50 th
		UHC	80.0%	≥50 th	↑81.7%	>90 th	84.8%	>75 th	86.3%	>75 th
	KanCare Adult		78.8%	≥50 th	↑79.0%	>75 th	84.3%	>66.67 th	85.2%	>66.67 th
General Child	Title XIX	SHP	89.0%	>66.67 th	89.9%	>66.67 th	88.2%	<25 th	↓87.1%	<50 th
		UHC	87.0%	<50 th	84.3%	<25 th	90.5%	≥50 th	87%*	NA*
	Title XXI (CHIP)	SHP	90.6%	>75 th	91.1%	>75 th	90.9%	≥50 th	91.1%	>75 th
		UHC	90.3%	>75 th	90.5%	>75 th	89.3%	<33.33 rd	91%*	NA*
KanCare GC		88.4%	>66.67 th	87.7%	<50 th	89.5%	<50 th	87.8%	≥50 th	
Children with Chronic Conditions	Title XIX	SHP	83.7%	<50 th	87.4%	≥50 th	88.9%	<50 th	88.8%	≥50 th
		UHC	85.2%	≥50 th	85.2%	<25 th	88.2%	<50 th	86.9%	<50 th
	Title XXI (CHIP)	SHP	87.8%	>75 th	89.0%	>75 th	88.6%	<50 th	90.0%	>75 th
		UHC	91.2%	>90 th	89.8%	>75 th	91.0%	>66.67 th	90.5%	>75 th
KanCare CCC		85.2%	≥50 th	86.8%	<50 th	88.7%	<50 th	88.2%	≥50 th	

Note: The percentages are for those who responded with either an 8, 9, or 10 on a scale of 0 to 10, where 0 is the worst possible and 10 is the best possible.
* Indicates the number of responses was less than 100; NCQA assigns "NA" rather than QC percentile ranking.
↑↓ Indicates a statistically significant increase or decrease compared to the prior year; *p*<.05. Rankings above the 90th QC percentile are also highlighted in green.

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Scores and QC rankings for composites (Getting Care Quickly, Getting Needed Care, How Well Doctors Communicate, Shared Decision Making, Customer Service, Coordination of Care, and Health Promotion and Education) for each survey by MCO and by program for 2019 are reported in Table 3.2.

Composite	MCO	Adult		General Child				Children with Chronic Conditions			
				Title XIX		Title XXI		Title XIX		Title XXI	
		Score	QC	Score	QC	Score	QC	Score	QC	Score	QC
Getting Care Quickly	SHP	87.8	>90 th	↑95.6	>95 th	92.4	>66.67 th	95.6	>75 th	95.4	>75 th
	UHC	86.9	>90 th	91.9	>66.67 th	92.5	>75 th	95.2	>75 th	94.9	>75 th
KanCare		87.3	>90th	93.5	>75th			95.4	>75th		
Getting Needed Care	SHP	84.2	≥50 th	90.4	>90 th	89.6	>75 th	91.8	>95 th	91.4	>90 th
	UHC	↑88.4	>95 th	↓85.4	≥50 th	90.2	>90 th	90.4	>75 th	90.8	>75 th
KanCare		86.3	>75th	88.2	>75th			91.1	>75th		
How Well Doctors Communicate	SHP	93.2	>66.67 th	96.3	>75 th	96.3	>75 th	96.2	>75 th	95.7	>75 th
	UHC	92.4	≥50 th	93.3	<50 th	↑96.3	>75 th	95.4	≥50 th	↑98.0	>95 th
KanCare		92.8	≥50th	95.0	≥50th			96.0	>75th		
Shared Decision Making	SHP	80.1	≥50 th	81.9	>66.67 th	82.2	>75 th	87.3	>66.67 th	85.9	≥50 th
	UHC	78.6	<33.33 rd	81.7	>66.67 th	81.1	≥50 th	87.1	≥50 th	87.4	>66.67 th
KanCare		79.4	<50th	81.8	>66.67th			87.1	≥50th		
Customer Service	SHP	91.3	>75 th	90.3	>75 th	91.5	>75 th	90.4	>75 th	89.9	≥50 th
	UHC	92.2	>75 th	90*	NA*	↑91.4	>75 th	89.1	<50 th	93*	NA*
KanCare		91.7	>75th	90.4	>75th			90.0	≥50th		
Coordination of Care	SHP	87.6	>75 th	85.6	≥50 th	82.1	<33.33 rd	83.0	<50 th	82.8	<50 th
	UHC	78.0	<25 th	79.8	<25 th	↑89.3	>75 th	78.2	<10 th	85.7	>75 th
KanCare		82.7	<50th	83.2	<50th			81.1	<25th		
Health Promotion and Education	SHP	72.8	<50 th	69.4	<25 th	69.5	<25 th	75.1	<25 th	75.9	<33.33 rd
	UHC	72.3	<50 th	76.5	>90 th	70.3	<33.33 rd	74.3	<10 th	77.4	<50 th
KanCare		72.5	<50th	72.5	≥50th			75.0	<25th		

↑↓ Indicates a statistically significant increase or decrease compared to the prior year; $p < .05$. Rankings above the 90th QC percentile are also highlighted in green.

* Indicates the number of responses was less than 100; NCQA assigns "NA" rather than Quality Compass (QC) percentile ranking.

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Table 3.3 provides scores and QC rankings for composites specific to the CCC surveys: Access to Prescription Medicines, Access to Specialized Services, Coordination of Care for Children with Chronic Conditions, Family-Centered Care: Getting Needed Information, and Family-Centered Care: Personal Doctor Who Knows the Child.

Table 3.3. CCC Composite Scores by MCO and Program – 2019					
Composite		Title XIX		Title XXI	
		Score	QC	Score	QC
Access to Prescription Medicine	SHP	92.7	>66.67 th	94.5	>75 th
	UHC	91.9	≥50 th	95.3	>90 th
KanCare		92.7		>66.67 th	
Access to Specialized Services	SHP	↑84.4	>90 th	79.9	>66.67 th
	UHC	81.1	>75 th	88*	NA*
KanCare		82.9		>90 th	
Coordination of Care for Children with Chronic Conditions	SHP	77.6	≥50 th	79.9	>95 th
	UHC	76.1	<50 th	↑77.8	≥50 th
KanCare		77.2		<50 th	
Family-Centered Care: Getting Needed Information	SHP	93.1	≥50 th	94.0	>75 th
	UHC	92.4	≥50 th	94.4	>75 th
KanCare		93.0		≥50 th	
Family-Centered Care: Personal Doctor Who Knows Child	SHP	90.2	<33.33 rd	↑90.3	<33.33 rd
	UHC	↓88.1	<10 th	91.0	<50 th
KanCare		↓89.4		<25 th	
* Indicates the number of responses was less than 100; NCOA assigns "NA" rather than QC percentile ranking. ↑↓ Indicates a statistically significant increase or decrease compared to the prior year; p<.05. Rankings above the 90 th QC percentile are highlighted in green.					

Tables 3.4 and 3.5 provide results of non-composite CAHPS survey questions related to access, timeliness, and quality of care for the adult and child populations, respectively. Quality Compass are provided where available.

Table 3.4. Adult Non-Composite Measures Related to Access, Timeliness, and/or Quality of Care by MCO and Program – 2019						
Measure	KanCare		SHP		UHC	
	Percent	QC	Percent	QC	Percent	QC
Flu Vaccination for Adults 18–64 (FVA)	31.8%	≥50 th	54.3%	>90 th	52.4%	>90 th
Medical Assistance with Smoking and Tobacco Use Cessation (MSC)						
– Total % Current Smokers (lower is better)	31.8%	≥50 th	30.8%	≥50 th	32.7%	≥50 th
– Advising Smokers to Quit	76.1%	<50 th	71.5%	<25 th	80.5%	<25 th
– Discussing Cessation Medications	53.4%	<50 th	51.5%	<50 th	55.2%	<50 th
– Discussing Cessation Strategies	46.1%	<50 th	44.3%	<33.33 rd	47.8%	<33.33 rd
Mental or Emotional Health Ratings	32.0%		↓31.3%		32.6%	
Having a Personal Doctor	↑89.1%		↑89.2%		↑89.0%	
Looked for Information on the Internet	↓17.4%		17.2%		17.5%	
Found Needed Information on the Internet	71.8%	>75 th	*		*	
↑↓ Indicates a statistically significant increase or decrease compared to the prior year; p<.05. Rankings above the 90 th QC percentile are highlighted in green. * Indicates the number of responses was less than 100.						

Table 3.5. Child Non-Composite Measures Related to Access, Timeliness, and/or Quality of Care by MCO and Program – 2019					
Measure	MCO	General Child		Children with Chronic Conditions	
		Title XIX	Title XXI	Title XIX	Title XXI
Mental or Emotional Health Ratings	SHP	66.7%	80.6%	38.0%	51.6%
	UHC	65.5%	↓78.5%	31.9%	57.1%
KanCare		↓68.2%		↓38.0%	
Having a Personal Doctor	SHP	89.8%	86.8%	95.1%	94.5%
	UHC	88.1%	87.6%	94.3%	↑95.4%
KanCare		↑88.7%		↑94.7%	

↑↓ Indicates a statistically significant increase or decrease compared to the prior year; *p*<.05.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services Common Among the MCOs

Outcomes

Composites and ratings with high or scores or Quality Compass rankings in 2019 or improving trends

- **Rating of All Health Care:** For KanCare adults (79%, >75th QC), an improvement in the rating and its QC ranking was seen compared to 2018. The improvement was driven by a statistically significant increase for the UHC adults score (now ranked >90th QC).
- **Rating of Personal Doctor:** Very high rating was seen for the KanCare GC population (90%), but in comparison to other MCOs nationwide, the score ranked <50th QC. For KanCare CCC population, an improvement in the QC ranking was seen.
- **Rating of Specialist Seen Most Often:** For KanCare adult and CCC populations, an improvement in the QC ranking was seen compared to 2018. The ratings were very high for TXXI GC and TXXI CCC populations of both MCOs (90% or greater).
- **Getting Care Quickly:** For the KanCare and both MCO adult populations, the ranking was very high (>90th QC) and an improvement was seen compared to 2018. Very high scores were seen for both KanCare GC and CCC populations (94 or greater, >75th QC; MCO scores ranged 92–96).
- **Getting Needed Care:** KanCare CCC had a very high score (91), as did CCC populations of both MCOs (90–92). For KanCare adult and CCC populations, an improvement in the QC rankings was seen compared to 2018. The percentages for *easily getting needed care, tests or treatment* were very high for GC and CCC populations of both MCOs (>90%).
- **How well Doctors Communicate:** KanCare adult and child populations had very high scores (adult: 93; GC: 95; and CCC: 96) maintained over the five years. Scores for the adult and child populations of both MCOs ranged from 92 to 98. For the KanCare CCC population, an improvement in the QC ranking was also seen.
- **Customer Service:** Very high scores were seen for KanCare adult and child populations (Adult: 92; GC: 90; and CCC: 90), along with an improvement in QC rankings.
- **Access to Prescription Medicines (CCC composite):** The KanCare CCC score was very high (93, >66.67th QC). The high scores were maintained over the five years. 2019 scores for MCOs ranged from 92 to 95.
- **Access to Specialized Services (CCC composite):** The KanCare CCC score had a very high ranking (>90th QC), which improved considerably compared to 2018.
- **Family-Centered Care: Getting Needed information (CCC Composite):** The KanCare CCC score was very high (93), but in comparison to other MCOs nationwide, the score ranked ≥50th QC. The high scores were maintained over the five years. TXIX and TXXI CCC scores for both MCOs ranged from 93 to 94.

Non-composite measures with high or scores or Quality Compass rankings in 2019 or improving trends

- **Have a Personal Doctor (Non-Composite Rate):** KanCare CCC had a very high rate (95%) along with an improvement in QC ranking. The rates for KanCare adult and GC populations were higher than 2018, however, they could be further improved (adult and GC: 89%).
- **Medical Assistance with Smoking and Tobacco Use Cessation – Discussing Cessation Medications:** KanCare rates increased each year from 2015 to 2019, averaging 2.7 percentage points per year (based on the slope of the trend line). Sunflower and UnitedHealthcare rates also increased each year. Since 2019 Discussing Cessation Medications rates for KanCare adults is only 46%, there is still potential for improvement.
- **Flu Vaccinations for Adults 18–64 (Non-Composite):** QC rankings were >90th QC for three consecutive years and the average increase from 2015 to 2019 was 2.1 percentage points per year. The 2019 KanCare rate, 53%, indicates a continued opportunity for improvement.

Technical

Strengths identified related to survey administration and reporting

- Separate survey sample populations by program (adult, GC TXIX, GC TXXI, CCC TXIX, and CCC TXXI) allowed comparability and analysis of annual changes over the last five years.
- KanCare-level (aggregated) results allow overall comparison annually and by survey populations (adult, GC, and CCC). Comparison to the Quality Compass percentile benchmarks provides comparison of outcomes to rates nationally.
- Each MCO included supplemental questions to assess member satisfaction in areas of particular interest to them. Most questions were asked in two or more years, allowing comparison of progress over time.
- Both MCOs' survey processes included two reminder post cards and, for non-responders, second mailings of the survey questionnaires and telephone outreach.
- Results for CAHPS surveys for the MCOs from 2015 to 2019 are in one combined report that includes aggregated results (weighted by population) and annual results and statistical comparisons over five years for more effective comparison by MCO and overall results by subgroup.
- Surveys were administered by NCQA-certified vendors.
- Surveys conducted in 2019 met NCQA requirements for MCO accreditation.
- The survey process is clearly defined by NCQA and, when followed, provides comparative information across health plans.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services Common Among the MCOs

Outcomes

Measures with low rates or Quality Compass rankings in 2019 or declining trends

- **Rating of Health Plan:** The 2019 rating of the health plan and its ranking for the KanCare adult population were not very high (79%; ≥50th QC) and did not show improvement throughout the five-year period.
- **Health Promotion and Education:** The scores and rankings indicate a need for improvement in all populations. The 2019 KanCare adult and child composite scores and rankings for health promotion and education were not very high (Adult: 73, <50th QC; GC: 73, ≥50th QC; CCC: 75, <25th QC). The rankings for the KanCare CCC populations were very low during this period (<5th QC to <25th QC). More positively, this year's KanCare scores ranked at their highest levels over 2015 to 2019, and the scores for the UHC TXIX GC population have increased each year.
- **Coordination of Care:** The 2019 scores for coordination of care for KanCare adult and child populations indicated that they could be further improved (Adult: 83, <50th QC; GC: 83, <50th QC; CCC: 81, <25th QC).

In addition, the QC rankings for the adult and CCC KanCare populations declined compared to 2018 and their scores did not show improvement during five-year period. These results indicated an area for improvement. The MCO-level scores of coordination of care indicated the opportunity of the improvement applied to both MCOs' adult and child populations.

- **Shared Decision Making:** The 2019 scores for shared decision making and their QC rankings for KanCare adult and child populations indicated a need for further improvement (Adult: 79, <50th QC; GC: 82, >66.67th QC; CCC: 87, ≥50th QC); also, for all three KanCare populations, the 2019 QC rankings for the composite scores declined compared to 2018. In addition, the scores for adult and child KanCare populations did not show improvement during the five-year period. These results indicated an opportunity of improvement. The MCO-level scores for shared decision making indicated an opportunity of improvement for both MCOs' adult and child populations.
- **Coordination of Care for Children with Chronic Conditions (CCC Composite):** The scores and QC ranking continue to indicate an opportunity or improvement across all CCC populations. Some progress was made in 2019—the 2019 SHP TXXI CCC score was 80, which ranked >95th QC (only one other score from 2015 to 2019 reached 80). Although the KanCare performance was better in 2019 than in the other four years, it is still only ranked <50th QC.
- **Family-Centered Care: Personal Doctor Who Knows Child (CCC Composite):** The 2019 QC ranking for the KanCare CCC composite score for *family centered care: personal doctor who knows child* was quite low (<25th QC). The score and QC ranking were lower than in 2018. Except for two scores in 2017, the MCOs' rankings for the CCC populations ranged from 10th QC to ≥50th QC during 2015 through 2019—indicated an opportunity for improvement for both MCOs.
- **Mental or Emotional Health Ratings (Non-Composite):** This continues to be an area for improvement. Only 32% of KanCare adult respondents rated their overall mental or emotional health as *excellent* or *very good* (the lowest percentage in the 2015–2019 period). Statistically significant declining trends over a five-year period were seen in the ratings by KanCare GC and CCC populations. The percent of respondents who rated their child's overall mental or emotional health as *excellent* or *very good*, 68% for KanCare GC respondents and 38% for KanCare CCC, were also the lowest percentages in the 5-year period, significantly lower than percentages in 2018.
- **Medical Assistance With Smoking and Tobacco Use Cessation (Non-Composite):** There are opportunities for improvement for both MCOs. About one in three of each MCO's adult respondents were current smokers or tobacco users. Among these, only 76% received cessation advice from their health provider; only half of them received a recommendation to use medication for cessation (53%); and health providers of less than half discussed or provided cessation methods and strategies other than medication (46%). The QC rankings for these percentages also indicated they could be further improved. The KanCare percentages did not change significantly over the five-year period, however, UHC's 2019 positive responses and QC rankings were the highest of the five-year period for UHC.
- **Flu Vaccinations for Adults 18–64 (Non-Composite):** The adult vaccination rates were low for both MCOs from 2015 to 2019, ranging from 44% to 53%. Only 53% of the members, ages 18–64 years, of the KanCare adult population reported having a flu vaccination since July 1, 2018—indicating an opportunity for improvement for Sunflower and UnitedHealthcare. Flu vaccination rates are low nationally, and Kansas is doing comparably well. KanCare's rankings for 2017 to 2019 were >90th QC.
- **Coordination of Care for Children with Chronic Conditions – Multiple Providers or Services:** In 2019, 53% of responding KanCare parents and guardians indicated their child got care from more than one kind of healthcare provider or used more than one kind of healthcare service (Q28), and 59% of respondents who indicated multiple provider or services reported they got help from the child's health plan, doctor's office, or clinic to coordinate child's care among different providers or services (Q29). In other words, 22% of the CCC population had received care from multiple providers but did not receive help with coordination of care.

Technical

Opportunities identified related to survey administration and reporting

- Neither of the MCOs' vendor reports included sample frame counts.
- Child survey vendor reports of both MCOs did not indicate clearly how many of the CCC completed surveys were from the supplemental sample.
- The vendor reports for both MCOs did not describe in detail the steps of the sampling methodology for all surveys, including size of the sampling frames, exclusion/inclusion criteria used in sampling process, oversampling process (if applied), and supplemental sampling (if conducted).

Degree to which the Previous Year's EQRO Recommendations Have Been Addressed Common Among the MCOs

EQRO and MCO updates on the seven recommendations common to all MCOs made in the prior year's review are shown in Appendix D. Six of the seven recommendations were restated for this year's review.

Recommendations for Quality Improvement Common Among the MCOs

1. For the child surveys, each MCO should continue complying with NCQA CCC survey protocols to ensure adequate numbers of complete surveys in each subgroup to obtain generalizable results that meet NCQA requirements.
2. All MCOs should continue and expand their care coordination efforts, particularly for children with chronic conditions, to promote improvement of MCO and provider assistance in coordinating the child's care among different providers and services. Consider obtaining feedback from members (e.g., through supplemental CAHPS questions, patient and family advisory committees, focus groups) to better understand their expectations regarding CCC coordination of care, the type of assistance, if any, they want, and how the MCO and providers can improve.
3. MCOs should encourage providers to improve and expand communications between providers and members regarding illness prevention. Both MCOs should consider methods to evaluate the effectiveness of provider communications, trainings and education to help determine whether changes to the improvement efforts are needed prior to 2020.
4. MCOs should increase efforts to promote Shared Decision Making between providers and the members.
5. MCOs should further review their processes for encouraging providers to assess and respond to members' mental health and emotional health issues, and for encouraging members to access mental health or substance use disorder services.
6. MCOs should continue to increase efforts and options to reduce smoking and tobacco use and to promote cessation. Consider coordinated efforts between MCOs to encourage providers to routinely give smoking and tobacco use cessation advice and to discuss medications and other methods to assist members with cessation.
7. MCOs should continue to increase efforts to ensure members receive a flu shot annually. Consider obtaining feedback from members and providers (e.g., additional survey questions, focus groups, patient and family advisory councils, provider advisory groups) regarding barriers to annual flu vaccinations. Assess whether more targeted interventions are needed; consider analyzing data to determine variation in rates by certain demographics.

SUNFLOWER

Conclusions Drawn from the Data

- Sunflower’s sample sizes for the adult survey, the child surveys, and the CCC supplemental samples met NCQA sample requirements.
Adult Surveys – The sample of 1,755 adults from 37,822 eligible members included an oversample of 405; 436 surveys were completed.
Child Surveys
 - **TXIX** – The sample of 4,702 children from 65,083 eligible TXIX members included 2,310 randomly selected child members and a 2,392 CCC supplemental sample pulled after the child survey sample was drawn. The Title XIX survey responses consisted of 553 GC and 531 CCC completed surveys.
 - **TXXI** – The sample of 4,094 children from 12,409 eligible TXXI members consisted of 2,145 randomly selected child members and a 1,949 CCC supplemental sample pulled after the child survey sample was drawn. The TXXI survey responses consisted of 632 GC and 471 CCC completed surveys.
- Sunflower added nine supplemental questions to the adult survey and seven supplemental questions to the child surveys.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

Outcomes

Measures with high rates or Quality Compass rankings in 2019 or improving trends for Sunflower

- **Rating of Health Plan:** Sunflower’s ratings for GC TXXI (91%) and CCC TXXI were >75th QC.
- **Rating of All Health Care:** Ratings for GC TXXI (91%) and CCC TXXI were also >75th QC.
- **Rating of Specialist Seen Most Often:** Sunflower’s GC TXXI rating (91%) retained ranking >75th QC, and the CCC TXXI (90%) ranking increased to >75th QC.
- **Getting Care Quickly:** Sunflower’s adult score ranked >90th QC. The GC TXIX score (96, >95th QC) improved statistically significantly from 2018. The scores for GC TXXI (92) and CCC TXXI (95, >75th QC) retained their ranks, and the CCC TIX score (96, >75th QC) increased in rank.
- **Getting Needed Care:** Scores for all four child populations were at least 90 and above the 75th percentile (GC TXIX: 90, >90th QC; GC TXXI: 90, >75th QC; CCC TXIX: 92, >95th QC; CCC TXXI: 91, >90th QC). All four scores were greater than in 2018.
- **Coordination of Care:** The adult score ranked >75th QC.
- **How Well Doctors Communicate:** All scores were high and the child scores (each 96) were greater than the 75th percentile. The adult score was 93.
- **Shared Decision Making:** The GC TXXI score increased in rank to >75th QC.
- **Customer Service:** Improvement was seen for all populations. All are now at least 90 and four rankings are >75th QC.
- CCC composites:
 - **Access to Prescription Medicines:** Sunflower’s composite scores were both high (CCC TXIX: 93; CCC TXXI: 95, >75th QC).
 - **Access to Specialized Services:** The SHP CCC TXIX composite scores ranked high (>90th QC).
 - **Coordination of Care for Children with Chronic Conditions:** The SHP CCC TXXI composite score ranked >95th QC.
 - **Family Centered Care: Getting Needed Information:** Both Sunflower composite scores were high (93 and 94) and CCC TXXI ranked >75th QC.
- **Flu Vaccinations for Adults 18–64:** Sunflower’s rate ranked >90th QC.

Technical

Strengths identified related to survey administration and reporting

- Sunflower’s vendor (Morpace) included an internet response option in addition to mail and phone response options.
- Sunflower’s sample sizes for adult, GC TXIX, GC TXXI, CCC TXIX, and CCC TXXI surveys all met NCQA CAHPS criteria. The number of completed surveys allowed generalizability for all Sunflower survey subpopulations.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

Outcomes

Measures with low rates or Quality Compass rankings in 2019 or declining trends for Sunflower

Sunflower composites and ratings with subgroup scores below the 25th percentile in 2019 included:

- **Rating of Personal Doctor:** Sunflower’s composite score for GC TXIX dropped to <25th QC.
- **Health Promotion and Education:** Three populations’ rankings dropped to <25th QC: GC TXIX, GC TXXI, and CCC TIX.

Technical

- SHP’s vendor report did not include the timeline for survey implementation.

Degree to which the Previous Year’s EQRO Recommendations Have Been Addressed

There were no recommendations in 2018 specific to Sunflower not already noted in the recommendations section Common Among the MCOs.

Recommendations for Quality Improvement

There are no Sunflower-specific recommendations beyond those common among the MCOs.

UNITEDHEALTHCARE

Conclusions Drawn from the Data

- UnitedHealthcare’s sample sizes for the adult survey, the child surveys, and the CCC supplemental samples met NCQA sample requirements.
Adult survey – UnitedHealthcare’s sampled 1,620 adults (including an oversample of 270), with 424 completed surveys. UnitedHealthcare’s vendor report did not mention the sample frame size.
Child surveys
 - **TXIX** – The sample size of 4,886 eligible members included 2,310 randomly selected TXIX child members and a 2,174 CCC supplemental sample pulled after the child survey sample was drawn. The Title XIX survey responses consisted of 373 GC surveys and 425 CCC completed surveys.
 - **TXXI** – The sample size of 4,198 eligible members consisted of 2,310 randomly selected TXXI child members and a 2,184 CCC supplemental sample pulled after the child survey sample was drawn. The TXXI survey responses consisted of 527 GC surveys and 348 CCC completed surveys.
- UnitedHealthcare’s vendor report did not state the sample frame sizes.
- Ten supplemental questions were added to both the adult survey and child surveys.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

Measures with high rates or Quality Compass rankings in 2019 or improving trends for UnitedHealthcare

UnitedHealthcare composites and ratings with subgroup scores above the 75th QC in 2019 included:

- **Rating of Health Plan:** The GC TXXI rating (90) and ranked >75th QC. The CCC TXXI rating (91) ranked >90th QC.
- **Rating of All Health Care:** UnitedHealthcare’s adult rating ranked >90th QC. The GC TXXI rating (91) and CCC TXXI rating (90) both ranked >75th QC.
- **Rating of Personal Doctor:** The adult rating ranked >75th QC.
- **Rating of Specialists Seen Most Often:** The scores for adults (85) and CCC TXXI (91) ranked >75th QC.
- **Getting Care Quickly:** The score for adults ranked >90th QC, and three child composite scores were high (GC TXXI: 92; CCC TXIX: 95; CCC TXXCI: 95) and ranked >75th QC
- **Getting Needed Care:** The adult composite score increased statistically significantly from 2018, and its ranking increased to > 95th QC. The GC TXXI score (90) ranked >90th QC, and the CCC TXIX score (90) and CCC TXXI score (91) both ranked >75th QC.
- **Coordination of Care:** TXXI GC and TXXI CCC ranked >75th QC. The TXXI GC score increased significantly from 2018.
- **Health Promotion and Education:** The TXIX GC score ranked >90th QC.
- **How Well Doctors Communicate:** The composite score for CCC TXXI (98) ranked >95th, and the score for GC TXXI (96) ranked >75th.
- **Customer Service:** Two rankings increased to >75th QC: the adult score (92) and the GC TXXI score (91), which was statistically significantly greater than the prior year. The TXXI CCC score increased significantly.
- CCC composites:
 - **Access to Prescription Medicines:** The score for UHC’s CCC TXXI (95) was ranked >90th QC and the CCC TXIX score (92) was high.
 - **Access to Specialized Services:** UHC’s CCC TXIX score ranked >75th QC.
 - **Family Centered Care: Getting Needed Information:** Both of UHC’s composite scores were high. The CCC TXXI score was 94 and ranked >75th QC. The CCC TXIX score was 92.
 - **Coordination of Care for Children with Chronic Conditions:** UHC TXXI increased significantly.
- **Medical Assistance With Smoking and Tobacco Use Cessation – Advising Smokers to Quit:** Ranked >75th QC.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

Outcomes

Measures with low rates or Quality Compass rankings in 2019 or declining trends for UnitedHealthcare

- **Rating of All Healthcare:** Ratings for both GC TXIX and CCC TXIX ranked <25th QC. For GC TXIX, the ranking has dropped each year since 2016.
- **Coordination of Care:** The composite scores the adult and GC TXIX populations both ranked < 25th QC. The CCC TXIX score ranked <10th QC.
- **Health Promotion and Education:** The UnitedHealthcare CCC TXIX score ranked <10th QC.
- **Family Centered Care: Personal Doctor Who Knows Child (CCC Composite):** UnitedHealthcare’s CCC TXIX score dropped three percentage points, which was statistically significant. The 2019 score ranked <10th QC.

Technical

Strengths identified related to survey administration and reporting

UnitedHealthcare's TXIX GC and TXXI CCC survey populations received low numbers of complete surveys (TXIX GC: 373; TXXI CCC: 348) and had more rates that could not be compared to the national percentiles than the other child populations. Although more surveys were distributed in 2019 than in 2018, the number of surveys completed by mail and by phone both decreased.

Degree to which the Previous Year's EQRO Recommendations Have Been Addressed

There were no recommendations in 2018 specific to UnitedHealthcare that were not noted in the recommendations section Common Among the MCOs.

Recommendations for Quality Improvement

There are no UnitedHealthcare-specific recommendations beyond those common among the MCOs.

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4. 2019 KanCare Consumer Assessment of Healthcare Providers and Systems Home and Community-Based Services (HCBS CAHPS) Survey

Background/Objectives

KFMC subcontracted with Vital Research, LLC (Vital) to conduct the first CAHPS Home and Community-Based Services (HCBS) Survey⁹ on behalf of the Kansas Department for Aging and Disability Services (KDADS). Vital is a national research consulting firm bringing multi-state experience conducting the HCBS and related surveys, with data collection in over 20 states and 300,000 face-to-face interviews.

The HCBS CAHPS survey was developed by CMS for state Medicaid programs' ongoing quality improvement efforts. It is designed for surveying a wide range of adults with various physical, cognitive, developmental, mental, and intellectual disabilities. State Medicaid programs may choose to use the survey to learn about beneficiaries' experience receiving their home and community-based long-term services and supports. For KanCare, the 2019 survey was conducted across four HCBS Waiver programs: Frail Elderly (FE), Intellectual or Developmentally Disabled (I/DD), Physical Disability (PD), and Traumatic Brain Injury (TBI).

The survey objective was to:

- Gain member and guardian feedback about the services and supports members across the four waiver programs receive so that Kansas can better understand how well they are serving their clients' needs.

Technical Methods of Data Collection and Analysis

Survey Instrument:

In addition to the primary survey instrument, KDADS opted to include the Supplemental Employment Module. This module contains 21 questions about the member's employment status, whether he/she has a job coach, their experience with this job coach, etc. KDADS and KFMC also identified three supplemental questions, from the CAHPS Health Plan survey, to address members' access to medical care. Lastly, KDADS opted to tailor the case manager section of the survey to specifically address (1) the services that the I/DD population receives from their Targeted Case Managers (TCMs) and (2) the services that all four surveyed populations (I/DD, FE, PD, and TBI) receive from their MCO Care Coordinators.

The Kansas survey included the following parts:

- Screening questions
- Identification questions
- Core set of 69 questions
- "About You" section
- Post-interview set of questions for the interviewer
- Three supplemental access questions (from the CAHPS Health Plan Survey) to address members' access to medical care
- Supplemental Employment Module
- Repeat of the case manager section to ask about the care from TCMs and MCO Care Coordinators separately

⁹ CAHPS Home and Community Based Services Survey. Medicaid. Centers for Medicare & Medicaid Services. <https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/cahps-home-and-community-based-services-survey/index.html>

Survey Population:

The study population for the survey was comprised of members who received services and supports from the I/DD, FE, TBI, and PD waiver programs. The members from all four waiver groups were eligible for participation in the survey. The goal for the survey was to assess aggregate results across all waiver groups by conducting face-to-face interviews from a total of 400 members as required by the HCBS CAHPS guidelines. KDADS pulled contact information for all members who receive services and supports from the I/DD, FE, TBI, and PD waiver programs. Upon receipt of eligible members, Vital created a randomized sample of 1,200 members. The number of members on the sample list was three times the number of targeted interviews to compensate for unsuccessful outreach attempts, such as members with invalid contact information and members declining to participate.

In late January 2019, Vital printed and mailed pre-notification letters, approved by KDADS and KFMC, along with a Survey Details handout to 1,200 members in the sample. These materials notified members and guardians of the project, how they were selected to participate to provide feedback about their services and supports, and that they may expect a phone call from an interviewer at Vital. Consent procedures were outlined in these letters, as well. Vital implemented additional outreach strategies to engage stakeholders, including a project-specific website and a tollfree phone hotline. Out of the 1,200 sampled members, 147 had invalid contact information, 18 were deceased, and 17 did not receive services, for a total of 1,018 members (84.8%) eligible to contact. Field Interviewers reached out to a total of 845 of the 1,018 eligible members across the FE, I/DD, PD, and TBI waiver groups, of whom 402 were interviewed (47.6% overall response rate). After the target number of 400 interviews was reached, no additional members were contacted. Any members who agreed to participate in the survey were interviewed. The overall response rate for the survey was 47.6%.

Survey Analysis:

Descriptive statistics were calculated for every HCBS CAHPS item, in aggregate at the KanCare level, including the Supplemental Employment and Supplemental Access Modules.

Description of Data Obtained

Vital recruited, trained, and employed Field Interviewers throughout the state of Kansas (primarily in the South and East) to conduct in-person interviews for the project. The survey instrument was programmed in Computer Assisted Personal Interviewing (CAPI) survey software, enabling skip patterns and open text boxes that followed the HCBS CAHPS survey protocol. Vital research mailed prenotification letters and survey details (e.g., Frequently Asked Questions [FAQs]) to randomly selected members, as well as to any known legal guardians. Members and legal guardians had access to toll-free numbers and the project website for further information. Field Interviewers utilized CAHPS-based calling scripts to contact members after Vital mailed prenotification letters. Scripts included informed consent and proxy guidelines. Almost 50% of sampled members/proxies agreed to participate in an interview for a total of 402 in-person interviews.

Conclusions Drawn from the Data

Survey results showed several areas of strength, as well as indicated some opportunities for improvement. In general, most respondents across the four HCBS Waiver programs expressed a high level of satisfaction with the services they received and the staff who helped them. The results related to the HCBS CAHPS survey domains are summarized in this annual technical report.

The results related to the HCBS CAHPS survey domains summarized in this annual technical report (Tables 4.1 to 4.9) include:

- Getting needed services from personal assistance/behavioral health staff
- Treatment by and communication with personal assistance/behavioral health staff
- Homemaker services
- Getting services from TCMs and MCO care coordinators
- Members' personal safety
- Choosing services and availability of transportation services
- Community inclusion and empowerment
- Rating of help provided by personal assistance/behavioral health staff, TCMs and MCO care coordinators
- Access to medical care (supplemental questions)
- Employment (supplemental module)

Items in which 80% or more of respondents selected the survey response(s) that correspond with the most desired outcome are considered areas of strength. Items with less than 80% of respondents selecting the most desired outcome are considered opportunities for improvement. In the summary Tables 4.1 to 4.9, the percentages marked in black indicate areas of strength and the percentages marked in red indicate where there are opportunities for improvement.

[Getting Needed Services from Personal assistance/Behavioral Health Staff:](#)

Kansas HCBS Waiver program members who received services from personal assistance/behavioral health staff were asked about the reliability and helpfulness of services, as well as whether their needs were met. As seen in Table 4.1, areas of strength regarding the helpfulness and reliability of personal assistance/behavioral health staff included staff always working as long as they were supposed to (86%), letting members know if they could not make it that day (86%), and always making sure members had sufficient privacy for activities such as dressing, showering, or bathing (89%). One opportunity for improvement was the timeliness of personal assistance/behavioral health staff always coming to work on time (79%). When it came to meeting members' needs around daily activities, personal assistance/behavioral health staff were strong in all areas. Between 86%-97% of respondents indicated that members always received help when needed in getting dressed, taking a shower, or bathing, in getting something to eat when hungry, and in taking their medicine. Ninety-three percent of members who needed help with toileting also received all the help they needed.

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Table 4.1. Getting Needed Services from Personal Assistance/Behavioral Health Staff*		
Survey Topic	Frequency (Denominator)	Percent
Reliability and helpfulness of the personal assistance/behavioral health staff providing assistance to the members at their homes (in last three months)†		
Personal assistance/behavioral health staff <i>always</i> came to work on time. (Q13)	276 (351)†	78.6%^
Personal assistance/behavioral health staff <i>always</i> worked as long as they were supposed to. (Q14)	308 (358)†	86.0%
Someone let members know if personal assistance/behavioral health staff could not come the day they were scheduled. (Q15)	273 (319)†	85.6%
Personal assistance/behavioral health staff <i>always</i> made sure that members had enough privacy for dressing, showering, or bathing (members who needed help to and get dressed, take a shower, or bathe). (Q19)	203 (229)†	88.6%
Members' needs met (in last three months)‡		
Members who needed help to get dressed, take a shower, or bathe <i>always</i> got dressed, took a shower, or bathed when needed to. (Q17)	202 (231)†	87.4%
Members who needed help with meals were <i>always</i> able to get something to eat when hungry. (Q21)	299 (308)†	97.1%
Members who needed help taking their medicine <i>always</i> took medicine when supposed to. (Q24)	235 (272)†	86.4%
Members who needed help with toileting got all the help with toileting when they needed it. (Q27)	137 (147) †	93.2%
Note: *Personal assistance/behavioral health staff includes staff providing personal assistance or behavioral health specialist services. ^ Percentages marked in purple to show opportunity for improvement. † Denominator is based on members eligible for responding to the question (Q13, Q14 and Q15: Respondents receiving personal assistance services or behavioral health services; Q17 and Q19: respondents receiving personal assistance services or behavioral health services who needed help from the staff to get dressed, take a shower, or bathe; Q21: respondents receiving personal assistance services or behavioral health services who needed help with meal preparation or eating; Q24: Respondents receiving personal assistance services or behavioral health services who needed help from the staff to take medicine; Q27: Respondents receiving personal assistance services or behavioral health services who needed help from the staff with toileting). ‡ Analyses excluded "Don't Know," "Refused," "Unclear Response" or "Missing" answers.		

Treatment by and Communication with Personal Assistance/Behavioral Health Staff:

Respondents were also asked about the treatment by and communication with personal assistance/behavioral health staff. As seen in Table 4.2, areas of strength included staff always treating members with courtesy and respect (83%), never being difficult to understand because of an accent or the way they spoke English (84%), always explaining things in a way that is easy to understand (80%), knowing what kinds of help members needed with everyday activities like getting ready in the morning, getting groceries, or going to places in the community (94%), and encouraging members to do things for themselves, if they could (93%). Areas in which personal assistance/behavioral health staff could improve were in always treating members the way they want to be treated (79%) and always listening carefully to members (73%)

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Table 4.2. How Well Personal Assistance/Behavioral Health Staff Communicate and Treat Members*		
Survey Topic	Frequency (Denominator)	Percent
Treatment by the personal assistance/behavioral health staff (in last three months)†		
Personal assistance/behavioral health staff always treated members with courtesy and respect. (Q28)	301 (365)†	82.5%
Personal assistance/behavioral health staff always treated members the way they wanted to be treated. (Q30)	287 (365)†	78.6%^
Communication with the personal assistance/behavioral health staff (in last three months)‡		
Explanations provided by personal assistance/behavioral health staff were never hard to understand because of an accent or the way they spoke English. (Q29)	299 (355)†	84.2%
Personal assistance/behavioral health staff always explained things in a way that was easy to understand. (Q31)	286 (358)†	79.9%
Personal assistance/behavioral health staff always listened carefully to members. (Q32)	261 (360)†	72.5%^
Personal assistance/behavioral health staff knew what kind of help members needed with everyday activities, like getting ready in the morning, getting groceries, or going to places in the community. (Q33)	340 (363)†	93.7%
Personal assistance/behavioral health staff encouraged members to do things for themselves, if they could. (Q34)	329 (353)†	93.2%
Note: *Personal assistance/behavioral health staff includes staff providing personal assistance or behavioral health specialist services. ^ Percentages marked in purple to show opportunity for improvement. † Denominator is based on members eligible for responding to the question (respondents receiving personal assistance services or behavioral health services). ‡ Analyses excluded “Don’t Know,” “Refused,” “Unclear Response” or “Missing” answers.		

Homemaker Services:

Out of 337 members who received homemaker services, regardless of whether such services were provided by personal assistance staff or a different homemaker service provider, 89% said that household tasks, like cleaning and laundry, always got done when needed, showing this was a strong area of service provided.

Getting Needed Services from Targeted Case Managers and MCO Care Coordinators:

Overall, TCMs who worked with the I/DD Waiver population were perceived to have strengths in all areas measured. Most of the survey respondents among the I/DD population knew who their TCM was (97%). As seen in Table 4.3, areas of strengths encompassed members being able to contact their TCM when needed (96%) and the TCM working with the members when needing help getting or fixing equipment (97%) and making other changes to their service (92%). Similarly, also seen in Table 4.3, areas of strength for MCO Care Coordinators who worked with all waiver groups also included being able to be contacted by members when needed (92%) and working with members when they needed help with getting other changes to their service (86%). Slightly more than two-thirds (71%) of all respondents indicated they knew their MCO Care Coordinator, indicating an opportunity for improvement. Another opportunity for MCO Care Coordinators to improve was in working with members when they needed help with getting or fixing equipment (79%).

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Table 4.3. Getting Needed Services from Targeted Case Managers* and MCO Care Coordinators**		
Survey Topic	Frequency (Denominator)	Percent
Reliability and helpfulness of Targeted Case Managers (in last three months)		
Members could contact their Targeted Case Manager when needed. (Q49)	153 (159)†	96.2%
The Targeted Case Manager worked with member when member asked for help with getting or fixing equipment. (Q51)	32 (33)†	97.0%
The Targeted Case Manager worked with member when member asked for help with getting other changes to their service. (Q53)	55 (60)†	91.7%
Reliability and helpfulness of MCO Care Coordinators (in last three months)‡		
Members could contact their MCO Care Coordinator when needed. (Q49B)	236 (257)†	91.8%
The MCO Care Coordinator worked with member when member asked for help with getting or fixing equipment. (Q51B)	42 (53)†	79.2%^
The MCO Care Coordinator worked with member when member asked for help with getting other changes to their service. (Q53B)	67 (78)†	85.9%
Note: *For I/DD population only; Targeted Case Manager (TCM) is the person who helps make sure members have the services they needed. **For all Waivers (FE, TBI, PD, I/DD); MCO Care Coordinator is an employee of SHP, UHC, or ABH, who assists members with coordination of their health care needs ^ Percentages marked in purple to show opportunity for improvement. † Denominator is based on members eligible for responding to the question (Q49: Respondents among I/DD population who knew their TCM; Q51: Respondents among I/DD population who knew their TCM and asked for help from their TCM for getting or fixing equipment; Q53: Respondents among I/DD population who knew their TCM and asked for help from their TCM in getting any changes to their services or help with getting places or finding a job; Q49B: Respondents who knew their MCO Care Coordinator; Q51B: Respondents who knew their MCO Care Coordinator and asked their MCO Care Coordinator for help with getting or fixing equipment; Q53B: Respondents who knew their MCO Care Coordinator and asked their MCO Care Coordinator for help in getting any changes to their services, or for help with getting places or finding a job). ‡ Analyses excluded “Don’t Know,” “Refused,” “Unclear Response” or “Missing” answers.		

Members’ Personal Safety:

Around 93% of respondents said there was a person who they could talk to if someone hurt or did something to them that they did not like. Similarly, 94% of respondents said members did *not* have any staff yell, swear, or curse at them. A higher percent (96%) of respondents said that money or things were *not* taken from members without permission. And, nearly all respondents (99%) indicated that staff did *not* hit or hurt members. While these reported percentages are high, these are opportunities for improvement given the serious nature of personal safety violations. See Table 4.4 for more detail.

Table 4.4. Personal Safety		
Survey Topic	Frequency (Denominator)	Percent
Personal safety of members (in last three months)‡		
There was a person who members could talk to if someone hurt them or did something to them they did not like. (Q64)	361 (387)†	93.3%^
Members did not have their money or thing taken by staff without permission. (Q65)	373 (388)†	96.1%^
Members did not have any staff that yelled, swore, or cursed at them. (Q68)	364 (389)†	93.6%^
Members did not have any staff that hit or hurt them. (Q71) Members did not have any staff that hit or hurt them. (Q71)	389 (393)†	99.0%^
Note: ^These percentages are high, however they indicate an area of improvement due to the serious nature of the personal safety violations. † Denominator is based on members eligible for responding to the question (all respondents receiving HCBS services and support). ‡ Analyses excluded “Don’t Know,” “Refused,” “Unclear Response,” or “Missing” answers.		

Choosing Services and Availability of Transportation Services:

Regarding members’ ability to choose services, an area of strength included the survey result showing that the personal assistance/behavior health staff knew what was in the members’ plan, including the things that were important to members (90%). For more detail see Table 4.5. The survey results summarized in the table also show an opportunity for improvement when it comes to members’ ability to choose services, as only about 53% of the respondents indicated their service plan included all of the things that were

important to them. Table 4.5 also shows the areas of strength and opportunities for improvement with regard to the availability and reliability of transportation services. Areas of strength included members always having a way to get to medical appointments (91%) and being able to get in and out of their rides if using a van or some other transportation service that was not their own vehicle (91%). One opportunity for improvement was in the timeliness of vans or other transportation services always arriving on time (74%).

Table 4.5. Choosing Services and Availability of Transportation Services		
Survey Topic	Frequency (Denominator)	Percent
Ability to choose services (in last three months)		
Members' service plan included <i>all</i> of the things that were important to them. (Q56)	180 (340)†	52.9%^
Personal assistance/behavioral health staff* knew what was on members' service plan, including the things that were important to members. (Q57)	265 (295)†	89.8%
Availability and reliability of transportation services (in last three months)‡		
Members <i>always</i> had a way to get to medical appointments. (Q59)	360 (397)†	90.7%
Members were able to get in and out of their ride if using a van or some other transportation service that was not their own vehicle. (Q61)	204 (224)†	91.1%
Vans or other transportation services that were not members' own vehicle <i>always</i> arrived on time. (Q62)	161 (218)†	73.9%^
Note: * Personal assistance/behavioral health staff includes staff providing personal assistance or behavioral health specialist services. ^ Percentages marked in purple to show opportunity for improvement. † Denominator is based on members eligible for responding to the question (Q56 and Q59: All respondents receiving HCBS services and support; Q57: Respondents who received personal assistance/behavioral health specialist services; Q61 and Q62: Respondents using a van or some other transportation service). ‡ Analyses excluded "Don't Know," "Refused," "Unclear Response," or "Missing" answers.		

Community Inclusion and Empowerment:

Regarding member empowerment, areas of strength include members deciding what they do with their time each day (91%) and members deciding when they do things each day (91%). Survey results summarized in Table 4.6. Several opportunities for improvement were noted regarding members' relationship to the community and their ability to engage when they want to engage. For example, improvements can be made in the areas of members usually/always (79%) and always (57%) getting together with family members who lived nearby, usually/always (77%) and always (53%) getting together with friends who lived nearby and being able to usually/always (60%) and always (42%) do things in the community they like. The percentage of members who needed more help to do things in their community but did not receive it was 31%, indicating a need for addressing the issue.

Table 4.6. Community Inclusion and Empowerment		
Survey Topic	Frequency (Denominator)	Percent
Members' relationship to the community (in last three months)‡		
Members, when they wanted to, could <i>always</i> get together with family members who lived nearby. (Q75)	175 (307)†	57.0%^
Members, when they wanted to, could always get together with friends who lived nearby. (Q77)	137 (259)†	52.9%^
Members, when they wanted to, were <i>always</i> able to do things in the community that they liked. (Q78)	162 (386)†	42.0%^
Members <i>did not</i> need additional help from personal assistance/behavioral health staff* to do things in their community. (Q79)	238 (346)†	68.8%^
Members took part in deciding <i>what</i> to do with their time each day. (Q80)	361 (398)†	90.7%
Members took part in deciding <i>when</i> to do things each day. (Q81)	360 (394)†	91.4%
Note: * Personal assistance/behavioral health staff includes staff providing personal assistance or behavioral health specialist services. ^ Percentages marked in purple to show opportunity for improvement. † Denominator is based on members eligible for responding to the question (Q75: Respondents who have family members living nearby; Q77: Respondents who have friends who live nearby; Q78, Q80 and Q81: all respondents receiving HCBS services and support; Q79: Respondents who received services from personal assistance or behavioral health specialist staff). ‡ Analyses excluded "Don't Know," "Refused," "Unclear Response," or "Missing" answers.		

Rating of Help Provided by Personal Assistance/Behavioral Health Staff, Targeted Case Managers and MCO Care Coordinators:

If members utilized the services of personal assistance/behavioral health staff, TCMs, or MCO Care Coordinators, respondents were asked to rate the help received and whether or not they would recommend these staff members to their family and friends if their services were needed. As seen in Table 4.7, respondents gave high positive ratings for all three areas. The majority of the respondents rated the help they received from their personal assistance/behavioral health staff as excellent or very good (87%). About 88% of the respondents among the I/DD population rated the help they received from their TCM as excellent or very good. Similarly, most of the respondents rated the help they received from their MCO Care Coordinator as excellent or very good (88%). The opportunities for improvement were seen in all three areas with regard to members definitely recommending their staff to family and friends if they need help.

Table 4.7. Ratings of the Help Members Receive from Personal Assistance/Behavioral Health Staff*, Targeted Case Managers**, and MCO Care Coordinators***		
Survey Topic	Frequency (Denominator)	Percent
Overall ratings of help received by personal assistance/behavioral staff, Targeted Case Managers, and MCO Care Coordinators (in last three months)†		
Member rated the help received from personal assistance/behavioral health staff as excellent/very good . (Q35)	312(358)†	87.2%
Members would definitely recommend the personal assistance/behavioral health staff who helped them to family and friends if they needed help with everyday activities. (Q36)	244 (349)†	69.9%^
Member rated the help received from Targeted Case Managers as excellent/very good (I/DD population only). (Q54)	135 (154)†	87.7%
Members would definitely recommend the Targeted Case Managers who helped them to family and friends if they needed help with everyday activities. (Q55)	110 (153)†	71.9%^
Member rated the help received from MCO Care Coordinators as excellent/very good . (Q54B)	220 (251)†	87.6%
Members would definitely recommend the MCO Care Coordinators who helped them to family and friends if they needed help with everyday activities. (Q55B)	177 (247)†	71.7%^
Note: *Personal assistance/behavioral health staff includes staff providing personal assistance or behavioral health specialist services. **Targeted Case Manager (TCM) is the person who helps make sure members have the services they needed. ***MCO Care Coordinator is an employee of SHP, UHC, or ABH, who assists members with coordination of their health care needs. ^ Percentages marked in purple to show opportunity for improvement. † Denominator is based on members eligible for responding to the question (Q35 and Q36: Respondents receiving personal assistance services or behavioral health services; Q54 and Q55: Respondents among I/DD population who knew their TCM; Q54B and Q55B: Respondents who knew their MCO Care Coordinator). ‡ Analyses excluded “Don’t Know,” “Refused,” “Unclear Response,” or “Missing” answers.		

Access to Medical Care (Supplemental Questions):

In all areas, access to medical care could be improved (see Table 4.8). When asked about access to medical care, 72% of members who needed care, tests, or treatment in the last six months always found it easy to find a doctor or other provider in the network to get the care, tests, or treatment needed. Similarly, a slightly higher percent (74%) of respondents who needed care, tests, or treatment in last six months indicated members never had to wait too long to get an appointment for the care, tests, or treatment needed. When calling the doctor’s office after hours, only 39% of members needed to wait less than 20 minutes between making the call and speaking to the doctor or doctor’s representative.

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Table 4.8. Access to Medical Care (Supplemental Questions)		
Survey Topic	Frequency (Denominator)	Percent
Members' access to medical care (in last six months)		
Member <i>always</i> found it easy to find a doctor or other provider in the network to get the care, tests, or treatment needed.† (SA1)	250 (348)†	71.8%^
Members <i>never</i> had to wait too long to get an appointment for the care, tests, or treatment needed.† (SA2)	264 (359)†	73.5%^
Member waited less than 20 minutes between making a call and speaking to the doctor/doctor's representative if they called their doctor after office hours for an urgent need.* (SA3)	26 (66)†	39.4%^
Note: ^ Percentages marked in purple to show opportunity for improvement. † Denominator is based on members eligible for responding to the question (QSA1 and QSA2: All respondents receiving HCBS services and support who needed care, tests or treatment in last six months; QSA3: All respondents receiving HCBS services and support). ‡ Analyses excluded "Did not need to get care, tests, or treatment," and "Missing" answers. *Analysis excluded "Did not call the doctor's office after office hours" and "Missing" answers.		

Employment (Supplemental Module):

A supplemental module with questions about employment was included in the Kansas HCBS CAHPS survey. Results for the key points of the supplemental module are summarized in Table 4.9. The survey results indicated that in the last three months, 20% of members had a paid job, whereas 80% did not work for pay at a job. For members who did not work for pay at a job, about 35% expressed interest in wanting a paid job. Among those who did not currently have a paid job but wanted one, only 19% asked for the help in getting a job for pay. Among those who did not ask for help in getting a job for pay, less than half (46%) knew they could get help to find a job for pay.

Table 4.9. Employment (Supplemental Module)		
Survey Topic	Frequency (Denominator)	Percent
Current employment status among members (in last three months)		
Members who were currently working for pay at a job. (EM1)	80(400)†	20.0%
Members who did not work for pay at a job. (EM1)	320(400)†	80.0%
Survey findings among members who did not currently work for pay at a job		
Members who did not have a paid job indicated they want to work for pay. (EM2)	108(310)†	34.8%
Members asked for help in getting a job for pay (among members who are currently not working for pay but want to work for pay). (EM5)	20(107)†	18.7%^
Members who know they could get help to find a job for pay (among members who are currently not working for pay but want to work for pay and did not ask for help). (EM6)	39(85)†	45.9%^
Note: ^ Percentages marked in purple to show opportunity for improvement. † Denominator is based on members eligible for responding to the question (EM1: All respondents receiving HCBS services and support; EM2: respondents who reported they did not work for pay at a job; EM5: respondents who reported they did not work for pay at a job and want to work for pay at a job; EM6: respondents who reported they did not work and want to work for pay at a job and did not ask for help in getting a job). ‡ Analyses excluded "Don't Know," "Refused," "Unclear Response" or "Missing" answers.		

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

- The following strengths were **at or above 90.0%**:
 - Domain: Getting needed services from personal assistance/behavioral health staff:
 - Members who needed help with meals were always able to get something to eat when hungry (97.1%).
 - Members who needed help with toileting got all the help with toileting when they needed it (93.2%).
 - Domain: Treatment by and communication with personal assistance/behavioral health staff:
 - Personal assistance/behavioral health staff knew what kind of help members needed with everyday activities, like getting ready in the morning, getting groceries, or going to places in the community (93.7%).

- Personal assistance/behavioral health staff encouraged members to do things for themselves, if they could (93.2%).
- Domain: Getting services from TCM and MCO care coordinators:
 - For I/DD population only – members knew who their TCM was (97%).
 - For I/DD population only – members could contact their TCM when needed (96.2%).
 - For I/DD population only – TCM worked with member when member asked for help with getting or fixing equipment (97.0%).
 - For I/DD population only – TCM worked with member when member asked for help with getting other changes to their service (91.7%).
 - For all waivers – members could contact their MCO Care Coordinator when needed (91.8%).
- Domain: Choosing services and availability of transportation services:
 - Members always had a way to get to medical appointments (90.7%)
 - Members were able to get in and out of their ride if using a van or some other transportation service that was not their own vehicle (91.1%)
- Domain: Community inclusion and empowerment:
 - Members took part in deciding what to do with their time each day (90.7%)
 - Members took part in deciding when to do things each day (91.4%)

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

- The following opportunities for improvement included items **below 80%**:
 - Domain: Getting needed services from personal assistance/behavioral health staff:
 - Personal assistance/behavioral health staff always came to work on time (78.6%)
 - Domain: Treatment by and communication with personal assistance/behavioral health staff:
 - Personal assistance/behavioral health staff always treated members the way they wanted to be treated (78.6%)
 - Personal assistance/behavioral health staff always listened carefully to members (72.5%)
 - Domain: Getting services from TCM and MCO care coordinators:
 - For all waivers – Slightly more than two-thirds (71%) of all respondents indicated they knew their MCO Care Coordinator.
 - For all waivers – The MCO Care Coordinator worked with member when member asked for help with getting or fixing equipment (79.2%)
 - Domain: Choosing services and availability of transportation services:
 - Members' service plan included all of the things that were important to them (52.9%)
 - Vans or other transportation services that were not members' own vehicle always arrived on time (73.9%)
 - Community inclusion and empowerment:
 - Members, when they wanted to, could always get together with family members who lived nearby (57.0%)
 - Members, when they wanted to, could always get together with friends who lived nearby (52.9%)
 - Members, when they wanted to, were always able to do things in the community that they liked (42.0%)
 - Members did not need additional help from personal assistance/behavioral health staff* to do things in their community (68.8%)
 - Domain: Rating of help provided by personal assistance/behavioral health staff, TCMs and MCO care coordinators:
 - Members would definitely recommend the personal assistance/behavioral health staff who helped them to family and friends if they needed help with everyday activities (69.9%)

- Members would definitely recommend the TCMs who helped them to family and friends if they needed help with everyday activities (71.9%)
- Members would definitely recommend the MCO Care Coordinators who helped them to family and friends if they needed help with everyday activities (71.7%)
- Domain: Access to medical care (Supplemental Questions):
 - Member always found it easy to find a doctor or other provider in the network to get the care, tests, or treatment needed (71.8%)
 - Members never had to wait too long to get an appointment for the care, tests, or treatment needed (73.5%)
 - Member waited less than 20 minutes between making a call and speaking to the doctor/doctor's representative if they called their doctor after office hours for an urgent need (39.4%)
- Domain: Employment (Supplemental Module):
 - Members asked for help in getting a job for pay (among members who are currently not working for pay but want to work for pay) (18.7%)
 - Members who know they could get help to find a job for pay (among members who are currently not working for pay but want to work for pay and did not ask for help) (45.9%).
- Domain: Members' personal safety – although rates are high, the seriousness of any safety concerns is cause for improvement:
 - There was a person who members could talk to if someone hurt them or did something to them they did not like (93.3%)
 - Members did not have their money or thing taken by staff without permission (96.1%)
 - Members did not have any staff that yelled, swore, or cursed at them (93.6%)
 - Members did not have any staff that hit or hurt them (99.0%)

Degree to which the Previous Year's EQRO Recommendations Have Been Addressed

The first year for the KanCare HCBS CAHPS survey being conducted was in 2019.

Recommendations for Quality Improvement

1. Personal assistance/behavioral health staff may benefit from training that specifically addresses arriving to work on time, always treating the members the way they want to be treated, and always listening carefully to members, as those areas received the lowest satisfaction. Improvements in these areas may also further increase overall ratings of staff performance.
2. Review the transportation logistics for any potential improvements in service delivery.
3. Consider additional staff training around abuse, neglect, and exploitation and finding sensitive and safe ways to engage members in examining and communicating concerns related to their safety, well-being, and any risks, while including TCMs and MCO Care Coordinators in these discussions.
4. Consider various avenues in which to provide more assistance with accessing community-based activities for members.
5. Seek ways to coordinate care to mitigate long wait times and potential consequences of delayed access to medical care.
6. Consider following-up in subsequent surveys to ascertain the reasons behind the difficulty in finding a doctor or other provider in the network and developing strategies to ensure easy access to needed health care.
7. Consider providing additional outreach to raise awareness among HCBS Waiver recipients about the availability of help in their job search endeavors.

5. 2019 Mental Health Consumer Perception Survey

Background/Objectives

KFMC has administered the Kansas Medicaid Mental Health Consumer Perception Survey (mental health [MH] survey) to Kansas Medicaid beneficiaries receiving services since 2010. In 2019, KFMC subcontracted with Vital Research, LLC (Vital) to administer the survey; KFMC was involved throughout the process and worked with Vital on the analysis and written report.

The survey objectives were to:

- Determine strengths and weaknesses in consumer perception of access to care, quality, appropriateness, and effectiveness of MH services;
- Describe consumer perception of their participation in planning their treatment;
- Describe the health care access, quality, and outcomes for KanCare adult and youth members who have received mental health services; and
- Compare 2019 survey results to prior years (2011 to 2018).

Technical Methods of Data Collection and Analysis/Description of Data Obtained

The Mental Health Statistics Improvement Program (MHSIP) survey is a nationally standardized survey, having been tested and determined to be valid and reliable. The MSHIP survey tools (Youth Services Survey for Families and Adult Consumer Survey) were adapted for use in the KanCare survey. The survey tools were originally designed to be distributed at the point of service; however, Kansas has administered it by mail since 2010. Kansas MHSIP survey results may not be directly comparable to results from MHSIP surveys conducted in other states.

Members eligible to receive the survey were adults (ages 18 or older) and youth (ages 17 or younger) who were enrolled in KanCare on the date of sample selection and who had received one or more mental health services through one of the three MCOs between December 1, 2018, and May 1, 2019. KFMC identified 17,589 Adult members and 26,412 Youth members who met the criteria.

The enrollment and demographic data (such as member name, age, phone number, and mailing address) for determining survey sample frames were obtained from the August 2019 Medicaid Enrollment file. On September 6, 2019, KFMC sent finder files to the MCOs to obtain addresses for the adults and youth identified as having at least one qualifying mental health service during the survey period.

The minimum number of survey responses required to obtain a 95% confidence level with a 5% margin of error was calculated for the Adult (395) and Youth (379) populations. The sampling was stratified by MCO in 2013 and 2014 but has not been since 2015. As no significant difference was observed by MCO, KFMC and the State concluded that a random sample of the combined MCOs would provide an adequate overall representation.

The number of surveys to be mailed was calculated by dividing the minimum number of responses required by the expected raw response rate, which was estimated using prior years' rates. Surveys were mailed to 8,010 KanCare members, representing 4,135 Youth members and 3,875 Adult members (824 for ages 45 or older; 1,903 for ages 25–44; and 1,148 for ages 18–24).

The survey methodology employed a mail-only distribution process consisting of a three-wave mail protocol, with one questionnaire mailing and two reminder postcards. The tasks and timeframes employed were based on the standard NCQA protocol for administering surveys. Survey packets were mailed on October 4, 2019. Reminder postcards were mailed to non-respondents on October 18, and November 1, 2019. Surveys were re-mailed as requested by members from October 5 through November 15, 2019. The Adult mental health survey questionnaire was mailed to the adult members, and the Youth survey questionnaire was mailed to the parents/guardians of Youth members.

Of the 8,010 members mailed the survey, 818 complete and valid surveys were received (Adult: 435; Youth: 383), meeting the minimum required number of survey responses (Adult: 395; Youth: 379). The 2019 overall response rate for the Adult population was calculated to be 12.0%, and the overall response rate for the Youth population was 10.0%. Both were higher than in 2018 (9.9% and 9.4%, respectively).

To judge the impact of non-response bias on the survey results, demographic information from the Kansas MMIS was tabulated and analyzed for the sample frames and survey response groups of each survey subgroup. In general, the KanCare response group was fairly similar to the KanCare sampling frame when examining various demographic items, however there was potential response bias in the following areas:

Adult:

- Males were slightly overrepresented in the response group compared to their respective sampling frame quantity.
- American Indian/Alaskan Native identified group members were overrepresented in comparison to their respective sampling frame quantity.

Youth, Family Responding:

- American Indian/Alaskan Native, Hispanic or Latino, and White identified group members were overrepresented in comparison to their respective sampling frame distribution. The Other race category (e.g., Asian, Native Hawaiian/Other Pacific Islander, and Other) was underrepresented. There was no statistically significant difference in representation of the Black or African American identified group members compared to their respective sampling frame.
- There were significant differences between the sampling frame and response group among members residing in semi-urban (overrepresented), and densely-settled rural (underrepresented) counties.

Analysis included tests for statistically significant differences between 2019 and each prior year, nine-year linear trends from initial survey year 2011, and seven-year linear trends from the start of the KanCare program in 2013. Analysis was conducted at the individual question level and for the following service domain categories:

- General Satisfaction
- Service Access
- Participation in Treatment Planning
- Service Quality and Appropriateness (Adult only)
- Cultural Sensitivity (Youth only)
- Outcomes
- Improved Functioning
- Social Connectedness
- Crisis Management

Conclusions Drawn from the Data

For most of the questions, responses were generally positive and did not change significantly from pre-KanCare (2011 and 2012) to KanCare (2013 to 2019).

Among Adults, the General Satisfaction, Service Access, Participation in Treatment Planning, Service Quality and Appropriateness, and Crisis Management domains all had composite domain scores above 80%. General Satisfaction was highest for Adults (92.6%). The composite scores for Outcomes, Improved Functioning, and Social Connectedness were at or below 80%.

Among Youth, the General Satisfaction, Service Access, Participation in Treatment Planning, Cultural Sensitivity, Social Connectedness, and Crisis Management domains all had composite domain scores above 80%. The Cultural Sensitivity domain had the highest positive responses to survey questions for Youth (97.2%). The composite scores for Outcomes and Improved Functioning were at or below 80%.

Of the 818 surveys returned, there were a combined 1,266 comments across both Adult and Youth surveys. Fifty-eight percent were positive, 32.7% provided opportunities for improvement, and 9.2% were neutral.

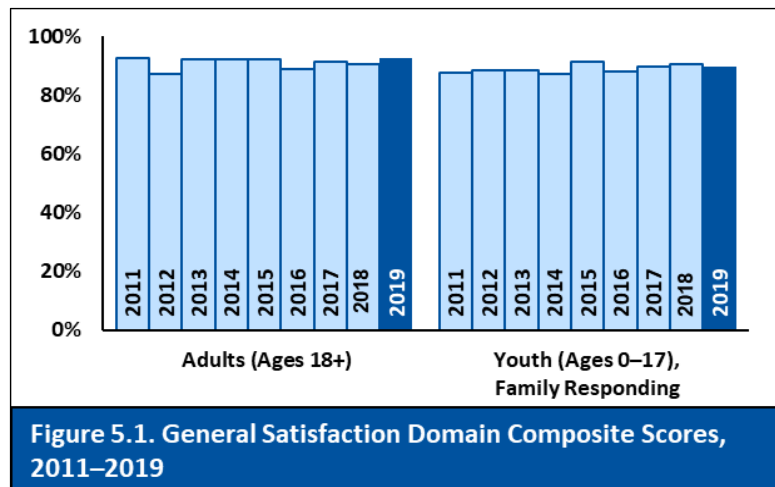
General Satisfaction Domain

Survey Domain Responses Over Time

Since 2011, General Satisfaction continues to be high for Adults and Youth (see Figure 5.1). The domain score for Adults in 2019 was 92.6% and 89.8% for Youth.

Survey Question Responses Over Time

In 2019, Adults and Youth had positive responses above 80 percent to each survey question comprising the General Satisfaction domain.



Adults

- The highest positive response in 2019 was 94.3% for Q1, *I like the services that I received*. Across the nine years, all but two years had responses above 90% on this item.
- Q2, *If I had other choices, I would still get services from my mental health providers*, had a percentage of 90.1% in 2019. The percentages in the prior eight years were lower than 90%, although, most years were already 85% or greater.
- Q3, *I would recommend my mental health providers to a friend or family member*, has had positive responses around 90% for most of the nine years, with a percentage of 89.8% in 2019.

Youth (Ages 0-17), Family Responding

- The highest positive response in 2019 was 91.5% for Q1, *Overall, I am satisfied with the services my child received*.
- The lowest positive response in 2019 was 83.1% for Q11, *My family got as much help as we needed for my child*, and responses to this item tended to be lower than other General Satisfaction domain items over time.
- The following questions have consistently had high positive responses:
 - Q4, *The staff helping my child stuck with us no matter what*. (89.4%)
 - Q5, *I felt my child had someone to talk to when he/she was troubled*. (90.9%)

- Q7, *The services my child and/or family received were right for us.* (88.6%)
- Q10, *My family got the help we wanted for my child.* (87.3%)

Service Access Domain

Survey Domain Responses Over Time

Since 2011, for Adults and Youth, positive responses continue to be high (see Figure 5.2). The Adult domain score for 2019 was 87.9%. For Youth, the domain score in 2019 was 86.8%.

Survey Question Responses Over Time

Adults

- The highest positive response in 2019 was 92.0% for Q7, *Services were available at all times that were good for me.*
- The lowest positive response in 2019 was 80.3% for Q9, *I was able to see a psychiatrist when I needed to.*
- Q4, *The location of services was convenient* had a positive response percentage of 89.8% in 2019.
- Q5, *My mental health providers were willing to see me as often as I felt it was necessary,* had a positive response percentage of 88.0% in 2019.
- Q6, *My mental health providers returned my calls in 24 hours,* had a positive response percentage of 88.2% in 2019 and was significantly higher than three of the past eight years (percentages from 2011 to 2018 ranged from 79.6% to 88.1%).
- Q8, *I was able to get all the services I thought I needed,* had a higher percentage of positive responses in 2019 (86.2%) than in the past four years.

Youth (Ages 0-17), Family Responding

For Youth, there are two questions in the Service Access domain regarding convenience of service location (Q8) and times of service availability (Q9), both with positive responses above 85%.

Participation in Treatment Planning Domain

Survey Domain Responses Over Time

- As in previous years, Adults had a lower positive response percentage in 2019 (81.2%) than the Youth subgroup (94.9%) (see Figure 5.3). Since 2011, Youth positive responses have continued to be high, and service domain composite scores have remained above 90% over the last nine years; furthermore, there was a significant positive trend from 2011 to 2019 ($p=.02$) and 2013 to 2019 ($p=.03$) (see Table 5.1).

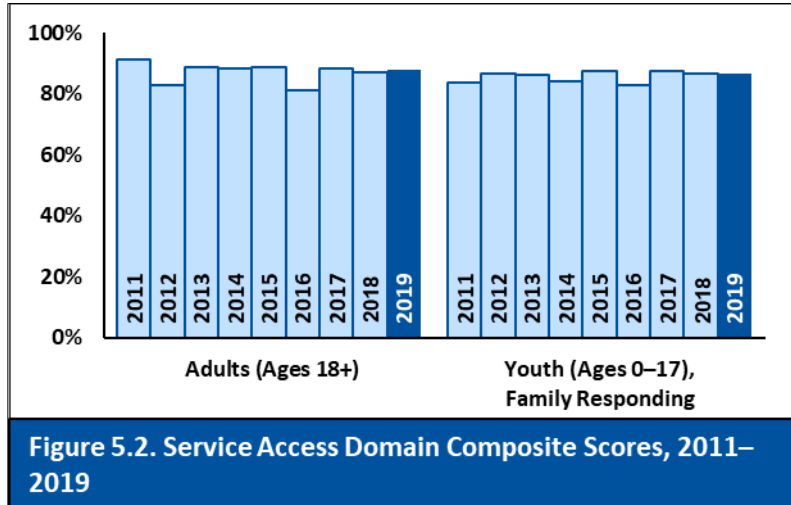


Figure 5.2. Service Access Domain Composite Scores, 2011–2019

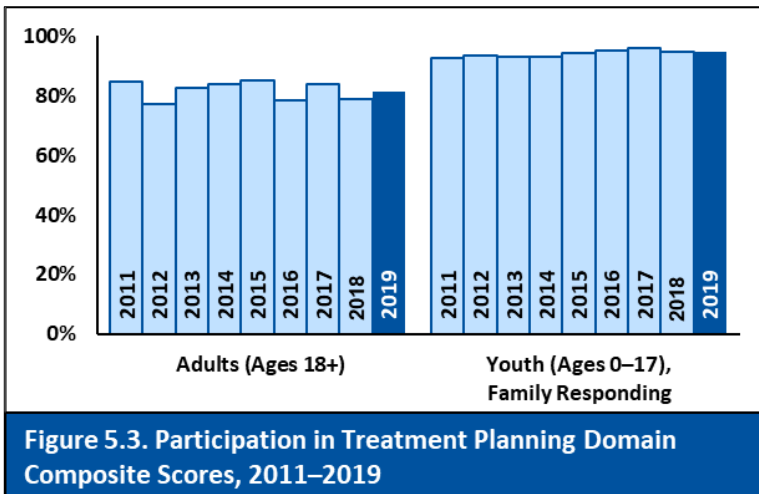


Figure 5.3. Participation in Treatment Planning Domain Composite Scores, 2011–2019

Survey Question Responses Over Time

Adults

- Q11, *I felt comfortable asking questions about my treatment and medication*, has had positive response scores close to 90% or above for seven of the nine years.
- Q17, *I, not my mental health providers, decided my treatment goals*, had a similar (80.5%) response to 2018. Positive response rates have ranged from 77.0% (2011) to 85.1% (2015).

Youth (Ages 0-17), Family Responding

- The highest positive response in 2019 was 94.7% for Q6, *I participated in my child’s treatment*, and rates were greater than 94% over the nine years.
- The lowest positive response was also a high score (90.5%) in 2019 for Q3, *I helped to choose my child’s treatment goals*; rates have ranged from 90.5% to 92.9% over the past nine years.
- For Q2, *I helped to choose my child’s services*, the percentage of positive responses in 2019 was 93.3% and has been 89% or above over the past nine years and there were significant positive trends from 2011 to 2019 ($p < .001$) and from 2013 to 2019 ($p < .001$).

Table 5.1. Participation in Treatment Planning Domain Survey Question – Youth, Family Responding, Composite Scores, Attribute Questions, and Comparison of 2011–2019 Rates										
Youth (Ages 0–17), Family Responding										Trend [†]
	Year	0%	100%	Rate*	N/D	95% CI		p-value [^]	7-Year	9-Year
Participation in Treatment Planning	2019			94.9%	357 / 375	92.2%	– 96.8%		.03 ↑	.02 ↑
	2018			94.6%	380 / 402	91.8%	– 96.4%	.82		
	2017			96.0%	461 / 480	93.8%	– 97.4%	.46		
	2016			95.0%	306 / 322	92.0%	– 96.9%	.97		
	2015			94.1%	305 / 324	91.0%	– 96.3%	.65		
	2014			93.0%	716 / 772	91.0%	– 94.6%	.21		
	2013			93.2%	896 / 966	91.5%	– 94.7%	.25		
	2012			93.5%	244 / 261	89.8%	– 96.0%	.44		
	2011			92.5%	307 / 332	89.1%	– 94.9%	.18		
Q2 I helped to choose my child’s services.	2019			93.3%	350 / 374	90.3%	– 95.5%		<.001 ↑	<.001 ↑
	2018			94.5%	376 / 398	91.8%	– 96.4%	.49		
	2017			94.2%	447 / 474	91.7%	– 96.0%	.58		
	2016			92.8%	293 / 316	89.3%	– 95.2%	.78		
	2015			89.9%	287 / 319	86.1%	– 92.8%	.11		
	2014			89.4%	678 / 761	87.0%	– 91.4%	.04 +		
	2013			90.6%	859 / 955	88.6%	– 92.3%	.11		
	2012			90.5%	228 / 252	86.2%	– 93.6%	.20		
	2011			89.2%	288 / 323	85.3%	– 92.1%	.05		

* Rate is weighted by MCO and, so, may differ slightly from numerator divided by denominator (N/D). The modified-Wald (Agresti–Coull) method was used for the 95% confidence intervals (CI).
[^] The "p-value" is the level of significance (p) of a chi-square test to determine if the 2019 percentage of positive responses is statistically significantly higher (+) or lower (-) than in each of the eight previous years ($p < .05$ considered significant).
[†] Columns "7-Year" and "9-Year" contain the levels of significance of Mantel–Haenszel chi-square tests for linearly increasing (↑) or decreasing (↓) 7-Year and 9-Year trends, respectively, ($p < .05$ considered significant).

Service Quality and Appropriateness Domain (Adult-only)

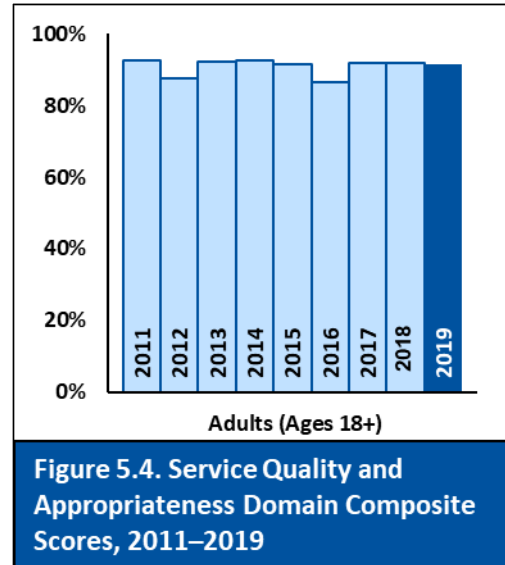
Survey Domain Responses Over Time

Since 2011, Adult members have had high domain composite scores above 85% related to service quality and appropriateness (see Figure 5.4). The 2019 domain score (91.4%) is similar to 2018 (91.9%).

Survey Question Responses Over Time

Of the nine questions in this domain, only one question had a rate below 80% in 2019, while the others ranged from 81.3% to 96.4%.

- Two questions had greater than 94% positive response in 2019 and were about 90% or greater over the nine years:
 - Q13, *I was given information about my rights*, had a 95% positive response in 2019.
 - Q16, *My mental health providers respected my wishes about who is and who is not to be given information about my treatment*, had a 96.4% positive response in 2019.
- The lowest positive response was for Q20, *I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line etc.* at 76.5%. Q20 also had significant negative trends in positive response percentages from 2011 to 2019 ($p=.02$) and from 2013 to 2019 ($p<.01$). (see Table 5.2)
- Q10, *My mental health providers believe that I can grow, change and recover*, had a 86.7% positive response in 2019.
- Q12, *I felt free to complain*, was 84.0% in 2019, which is a decrease from 2018 (86.7%) and significantly lower than 2017 (89.4%).
- Q14, *My mental health providers encouraged me to take responsibility for how I live my life*, was 90.3% in 2019.
- Q15, *My mental health providers told me what side-effects to watch out for*, was 81.3% in 2019.
- Q18, *My mental health providers were sensitive to my cultural background*, had a 90.7% positive response in 2019. While there were significant negative seven-year and nine-year trends, rates remain high.
- Q19, *My mental health providers helped me obtain the information I needed so that I could take charge of managing my illness*, remains fairly constant at 85.7%.



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Table 5.2. Service Quality and Appropriateness Domain Survey Question – Adults, Attribute Questions, and Comparison of 2011–2019									
	Year	Adults (Ages 18+)					Trend [†]		
		0%	100%	Rate*	N/D	95% CI	p-value [^]	7-Year	9-Year
Q20 I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	2019			76.5%	284 / 371	71.9% – 80.6%		<.01 ↓	.02 ↓
	2018			79.1%	227 / 287	74.0% – 83.5%	.43		
	2017			80.7%	274 / 340	76.2% – 84.6%	.17		
	2016			78.7%	207 / 264	73.3% – 83.2%	.52		
	2015			80.4%	278 / 346	75.9% – 84.3%	.21		
	2014			82.3%	589 / 716	79.4% – 84.9%	.02 -		
	2013			83.4%	802 / 962	80.9% – 85.6%	<.01 -		
	2012			76.7%	191 / 249	71.1% – 81.5%	.96		
	2011			82.3%	214 / 260	77.2% – 86.5%	.08		

* Rate is weighted by MCO and, so, may differ slightly from numerator divided by denominator (N/D). The modified-Wald (Agresti–Coull) method was used for the 95% confidence intervals (CI).
[^] The "p-value" is the level of significance (p) of a chi-square test to determine if the 2019 percentage of positive responses is statistically significantly higher (+) or lower (-) than in each of the eight previous years (p<.05 considered significant).
[†] Columns "7-Year" and "9-Year" contain the levels of significance of Mantel–Haenszel chi-square tests for linearly increasing (↑) or decreasing (↓) 7-Year and 9-Year trends, respectively, (p<.05 considered significant).

Cultural Sensitivity Domain (Youth-only)

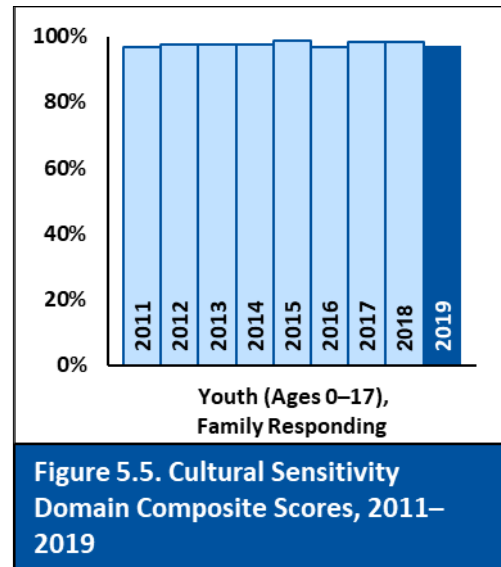
Survey Domain Responses Over Time

Since 2011, domain scores have remained fairly constant and continue to be very high at 97.2% in 2019 (see Figure 5.5).

Survey Question Responses Over Time

Youth (Ages 0–17), Family Responding

- Q12, *My child’s mental health providers treated me with respect*, positive response percentage was 96.2%, with percentages above 95% for the past nine years.
- Q13, *My child’s mental health providers respected my family’s religious/spiritual beliefs*, remains high (97.8%), with scores greater than 97.5% over the past nine years.
- Q14, *My child’s mental health providers spoke with me in a way that I understood*, has remained consistently high with a positive response percentage of 98.3% in 2019.
- Q15, *My child’s mental health providers were sensitive to my cultural/ethnic background*, has remained consistently high at 97.6% in 2019.



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Outcomes Domain¹⁰

Survey Domain Responses Over Time

Since 2011, positive responses have varied for Adults (69.5% [2016] to 85.0% [2011]) (see Figure 5.6). There has been a significant negative trend in Outcomes from 2011 to 2019 ($p < .01$), with 2019 at 73.9% (see Table 5.3). Youth service domain composite scores have remained fairly constant over the last nine years, with domain composite scores ranging from 78.2% (2016) to 82.5% (2013). The score for this domain in 2019 was 79.5%.

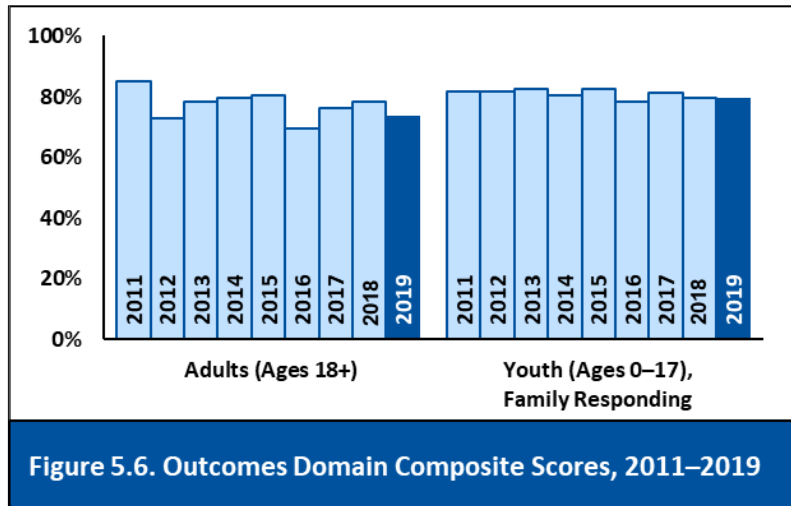


Figure 5.6. Outcomes Domain Composite Scores, 2011–2019

Survey Question Responses Over Time

In 2019, Adult members reported the lowest positive responses related to doing better in social situations, doing better in school and/or work, and symptoms not bothering them as much, with rates below 70%. Within the Adult subgroup, there were significant decreases in positive percentage rates for several questions compared to prior years. As in previous years, Youth, family responding, reported the lowest positive response related to being able to cope when things go wrong.

Adults

- The highest positive response in 2019 was 80.6% for Q25, *I deal more effectively with daily problems*.
- The lowest positive response in 2019 was 64.3% for Q32, *My symptoms are not bothering me as much*.
- Q26, *I am better able to control my life*, was 80.0% in 2019 and there was a significant negative trend from 2013 ($p = .04$).
- Q27, *I am better able to deal with crisis*, had a positive response rate of 72.1% in 2019 and significant negative seven and nine-year trends.
- Q28, *I am getting along better with my family* has been consistently above 77% over the nine years, with 2019 at 79.5%.
- Q29, *I do better in social situations*, had a positive response rate of 68.5% in 2019 and a significant negative nine-year trend.
- Q30, *I do better in school and/or work*, has been below 75% since 2011, with 2019 at 67.9%.
- Q31, *My housing situation has improved*, had a significantly lower percentage of positive responses in 2019 (74.2%) compared to 2018 (83.1%; $p < .01$).

¹⁰ The survey questions comprising the Outcomes and Improved Functioning domains are all the same with the exception of the omission of Q24 in the Improved Functioning domain. As a result, the summaries for Youth Outcomes and Improved functioning are similar.

Table 5.3. Outcomes Domain Trending Survey Questions – Adults										
Adults (Ages 18+)										
	Year	0%	100%	Rate*	N/D	95% CI	p-value [^]	Trend [†]	7-Year	9-Year
Outcomes	2019			73.9%	295 / 400	69.4% – 78.0%			.03 ↓	<.01 ↓
	2018			78.5%	239 / 305	73.5% – 82.7%	.16			
	2017			76.2%	271 / 356	71.5% – 80.3%	.47			
	2016			69.5%	191 / 274	63.8% – 74.6%	.21			
	2015			80.4%	274 / 341	75.8% – 84.3%	.04 -			
	2014			79.6%	587 / 737	76.6% – 82.4%	.03 -			
	2013			78.5%	751 / 958	75.8% – 81.0%	.06			
	2012			72.7%	181 / 249	66.8% – 77.9%	.74			
	2011			85.0%	232 / 273	80.2% – 88.8%	<.001-			
Q26 I am better able to control my life.	2019			80.0%	333 / 417	75.9% – 83.6%			.04 ↓	.08
	2018			82.0%	263 / 321	77.4% – 85.8%	.50			
	2017			82.0%	316 / 385	77.9% – 85.6%	.47			
	2016			74.8%	213 / 284	69.4% – 79.5%	.10			
	2015			83.8%	309 / 369	79.7% – 87.2%	.17			
	2014			84.9%	669 / 788	82.2% – 87.2%	.03 -			
	2013			83.0%	851/1,025	80.6% – 85.2%	.18			
	2012			76.4%	204 / 267	70.9% – 81.1%	.26			
	2011			86.5%	250 / 289	82.1% – 90.0%	.03 -			
Q27 I am better able to deal with crisis.	2019			72.1%	288 / 399	67.5% – 76.3%			<.01 ↓	.04 ↓
	2018			78.6%	242 / 308	73.7% – 82.9%	.05			
	2017			77.2%	285 / 369	72.7% – 81.2%	.10			
	2016			69.2%	192 / 277	63.6% – 74.4%	.42			
	2015			79.3%	279 / 352	74.8% – 83.3%	.02 -			
	2014			78.7%	602 / 765	75.7% – 81.5%	.01 -			
	2013			79.1%	780 / 987	76.4% – 81.5%	<.01 -			
	2012			71.4%	182 / 255	65.5% – 76.6%	.84			
	2011			80.4%	221 / 275	75.2% – 84.6%	.01 -			
Q29 I do better in social situations.	2019			68.5%	282 / 409	63.8% – 72.8%			.14	.04 ↓
	2018			70.9%	220 / 310	65.6% – 75.7%	.50			
	2017			70.6%	259 / 367	65.7% – 75.0%	.53			
	2016			65.6%	187 / 283	59.9% – 70.9%	.43			
	2015			71.2%	249 / 350	66.2% – 75.7%	.43			
	2014			71.9%	549 / 763	68.6% – 75.0%	.22			
	2013			72.0%	706 / 982	69.1% – 74.7%	.19			
	2012			67.7%	174 / 257	61.8% – 73.1%	.83			
	2011			77.9%	219 / 281	72.7% – 82.4%	<.01 -			

* Rate is weighted by MCO and, so, may differ slightly from numerator divided by denominator (N/D). The modified-Wald (Agresti–Coull) method was used for the 95% confidence intervals (CI).
[^] The "p-value" is the level of significance (p) of a chi-square test to determine if the 2019 percentage of positive responses is statistically significantly higher (+) or lower (-) than in each of the eight previous years (p<.05 considered significant).
[†] Columns "7-Year" and "9-Year" contain the levels of significance of Mantel–Haenszel chi-square tests for linearly increasing (↑) or decreasing (↓) 7-Year and 9-Year trends, respectively, (p<.05 considered significant).

Youth (Ages 0-17), Family Responding

- The highest positive response in 2019 was 84.2% for Q19, *My child is better at handling daily life*. The 2019 rate was the highest percentage seen in the eight previous years, which ranged from 77.8% (2016) to 82.9% (2017).
- The lowest positive response in 2019 was 75.5% for Q23, *My child is better able to cope when things go wrong*, and it has had comparatively lower positive response in each of the seven previous years.

- Q20, *My child gets along better with family members*, has ranged from 78.5% to 82.4% over the nine years, with 2019 at 79.7%.
- Q21, *My child gets along better with friends and other people*, had a lower percentage of positive responses in 2019 (78.6%) than in seven of eight prior years (79.9% [2016] to 84.7% [2012]) and a significant negative nine-year trend (see Table 5.4).
- Q22, *My child is doing better in school and/or work*, had a lower percentage of positive response in 2019 (77.6%) than in each of the eight previous years and had significant seven and nine-year negative trends. Rates prior to 2019 ranged from 80.8% (2018) to 85.7% (2013).
- Q23, *My child is better able to cope when things go wrong*, positive response was 75.5% in 2019.
- Q24, *I am satisfied with our family life right now*, was 76.3% in 2019 and has remained fairly constant over time; prior positive ratings have ranged from 76.5% (2011) to 80.6% (2012).
- Q25, *My child is better able to do things he or she wants to do*, was 80.8% in 2019 and has remained fairly constant over time; prior positive ratings have ranged from 80.0% (2018) to 85.0% (2012).

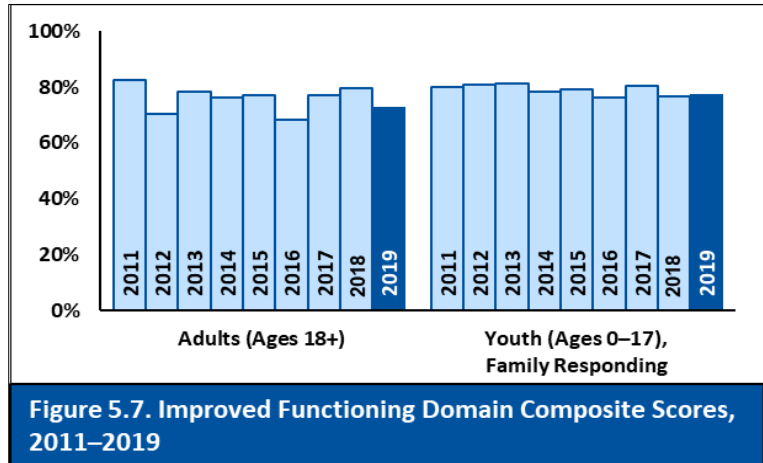
		Youth (Ages 0–17), Family Responding						Trend [†]	
	Year	0%	100%	Rate*	N/D	95% CI	p-value [^]	7-Year	9-Year
Outcomes	2019			79.5%	284 / 359	75.0% – 83.4%		.17	.16
	2018			79.6%	313 / 394	75.3% – 83.3%	.99		
	2017			81.3%	384 / 472	77.5% – 84.6%	.52		
	2016			78.2%	247 / 317	73.3% – 82.4%	.66		
	2015			82.4%	262 / 318	77.8% – 86.2%	.35		
	2014			80.5%	608 / 758	77.5% – 83.2%	.70		
	2013			82.5%	773 / 946	79.9% – 84.8%	.22		
	2012			81.9%	208 / 254	76.7% – 86.2%	.47		
	2011			81.7%	263 / 322	77.1% – 85.5%	.48		
21. My child gets along better with friends and other people.	2019			78.6%	287 / 364	74.1% – 82.5%		.09	<.01 ↓
	2018			80.3%	317 / 394	76.1% – 84.0%	.55		
	2017			81.0%	380 / 469	77.2% – 84.3%	.40		
	2016			79.9%	253 / 318	75.1% – 83.9%	.68		
	2015			82.0%	265 / 323	77.4% – 85.8%	.27		
	2014			78.3%	589 / 753	75.2% – 81.1%	.90		
	2013			84.1%	789 / 941	81.6% – 86.3%	.02 -		
	2012			84.7%	216 / 255	79.7% – 88.6%	.06		
	2011			84.5%	272 / 322	80.1% – 88.0%	.05		
22. My child is doing better in school and/or work.	2019			77.6%	275 / 356	72.9% – 81.6%		<.01 ↓	.02 ↓
	2018			80.8%	317 / 393	76.6% – 84.4%	.28		
	2017			83.4%	372 / 446	79.7% – 86.6%	.04 -		
	2016			81.4%	254 / 313	76.7% – 85.4%	.22		
	2015			81.9%	257 / 314	77.3% – 85.8%	.16		
	2014			81.6%	609 / 750	78.6% – 84.2%	.12		
	2013			85.7%	793 / 930	83.3% – 87.8%	<.001-		
	2012			82.6%	213 / 258	77.4% – 86.7%	.13		
	2011			82.3%	265 / 322	77.7% – 86.1%	.13		

* Rate is weighted by MCO and, so, may differ slightly from numerator divided by denominator (N/D). The modified-Wald (Agresti–Coull) method was used for the 95% confidence intervals (CI).
[^] The "p-value" is the level of significance (p) of a chi-square test to determine if the 2019 percentage of positive responses is statistically significantly higher (+) or lower (-) than in each of the eight previous years (p<.05 considered significant).
[†] Columns "7-Year" and "9-Year" contain the levels of significance of Mantel–Haenszel chi-square tests for linearly increasing (↑) or decreasing (↓) 7-Year and 9-Year trends, respectively, (p<.05 considered significant).

Improved Functioning Domain¹¹

Survey Domain Responses Over Time

Since 2011, positive responses have varied for both Adults (68.3% [2016] to 82.5% [2011]) and Youth (76.1% [2016] to 81.3% [2013]) (see Figure 5.7). The 2019 domain score for Adults was 73.0% and the score for Youth was 77.5%.



Survey Question Responses Over Time

Adults

- The highest positive response in 2019 was 81.9% for Q33, *I do things that are more meaningful to me*, and there were no statistically significant differences.
- The lowest positive response was 64.3% for Q32, *My symptoms are not bothering me as much*. The 2019 rate was lower than in six of eight prior years and every year was less than 75%.
- Three questions (Q34, Q35, and Q36) had the following significant decreases:
 - Q34, *I am better able to take care of my needs*, has significantly trended downward since 2011 ($p=.02$) as shown in Table 5.5. The 2019 positive response rating was 77.7%.
 - Q35, *I am better able to handle things when they go wrong*, was 69.8% in 2019 and this was significantly less than 2011 (76.7%; $p=.04$).
 - Q36, *I am better able to do things that I want to do*, significantly decreased from 80.6% in 2018 to 72.5% in 2019.

Youth (Ages 0-17), Family Responding

For Youth, the six questions in the Improved Functioning domain are all in the [Outcomes domain](#). Q24 is the only question in the Youth Outcomes domain that is not in the Youth Improved Functioning domain.

Table 5.5. Improved Functioning Domain Survey Question – Adult

	Adults (Ages 18+)							Trend [†]		
	Year	0%	100%	Rate*	N/D	95% CI		p-value [^]	7-Year	9-Year
34. I am better able to take care of my needs.	2019			77.7%	322 / 414	73.4%	– 81.4%		.06	.02 ↓
	2018			81.4%	257 / 316	76.7%	– 85.3%	.22		
	2017			81.0%	300 / 370	76.7%	– 84.7%	.25		
	2016			72.9%	205 / 279	67.4%	– 77.8%	.15		
	2015			79.6%	297 / 373	75.2%	– 83.4%	.50		
	2014			81.1%	628 / 774	78.2%	– 83.7%	.16		
	2013			82.3%	826/1,004	79.8%	– 84.5%	.04 -		
	2012			77.2%	200 / 259	71.7%	– 81.9%	.89		
	2011			86.6%	245 / 283	82.1%	– 90.1%	<.01 -		

* Rate is weighted by MCO and, so, may differ slightly from numerator divided by denominator (N/D). The modified-Wald (Agresti–Coull) method was used for the 95% confidence intervals (CI).

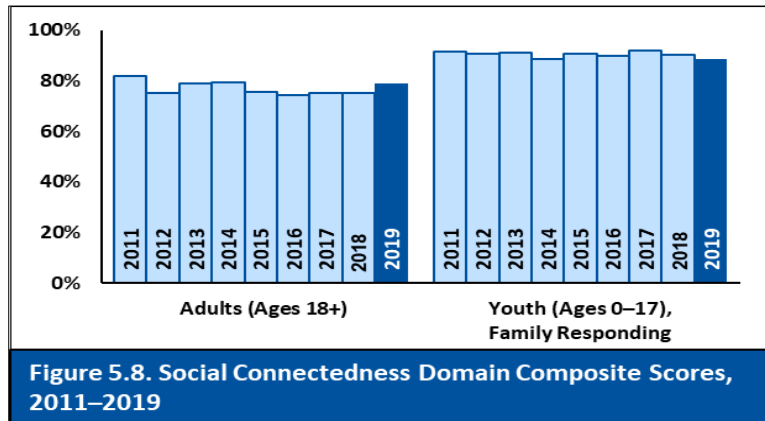
[^] The "p-value" is the level of significance (p) of a chi-square test to determine if the 2019 percentage of positive responses is statistically significantly higher (+) or lower (-) than in each of the eight previous years ($p<.05$ considered significant).

[†] Columns "7-Year" and "9-Year" contain the levels of significance of Mantel–Haenszel chi-square tests for linearly increasing (↑) or decreasing (↓) 7-Year and 9-Year trends, respectively, ($p<.05$ considered significant).

¹¹ See previous section for similarities between the Youth Outcomes and Improved Functioning domains.

Social Connectedness Domain
Survey Domain Responses Over Time

Since 2011, Social Connectedness domain composite scores have consistently been lower for Adult members than Youth members (see Figure 5.8), but both group scores have been fairly constant. The Adult domain in 2019 was 78.9%. The Youth domain score in 2019 was 88.6%.



Survey Question Responses Over Time
Adults

- The highest positive response in 2019 was 85.4% for Q38, *I have people with whom I can do enjoyable things*. Rates across the previous eight years ranged from 79.4% (2012) to 84.3% (2013).
- Q39, *I feel I belong in my community*, had the lowest positive response in 2019 (69.7%).
- Q37, *I am happy with the friendships I have*, had a positive response in 2019 of 82.2%. The rates in the previous three years ranged from 76.8% to 79.3%.
- Q40, *In a crisis, I would have the support I need from family or friends*, had a positive response in 2019 of 81.6%, which was fairly consistent with previous years.

Youth (Ages 0-17), Family Responding

- The highest positive response in 2019 was 91.3% for Q26, *I know people who will listen and understand me when I need to talk*. Rates have consistently been around or above 90% over the last nine years.
- The lowest positive response in 2019 was 85.9% for Q28, *In a crisis, I would have the support I need from family and/or friends*. While all rates in the past nine years have been close to 86% or above, 2019 was the lowest rate.
- Q27, *I have people I am comfortable talking with about my child’s problems*, had a lower rate (88.3%) in 2019, with the past eight years being above 90%.
- Q29, *I have people with whom I can do enjoyable things*, was close to 90% in 2019 (89.5%). While there has been a significant nine-year trending decrease ($p=.03$), all nine years have had percentages close to 90% or above (see Table 5.6).

Table 5.6. Social Connectedness Trending Survey Question – Youth

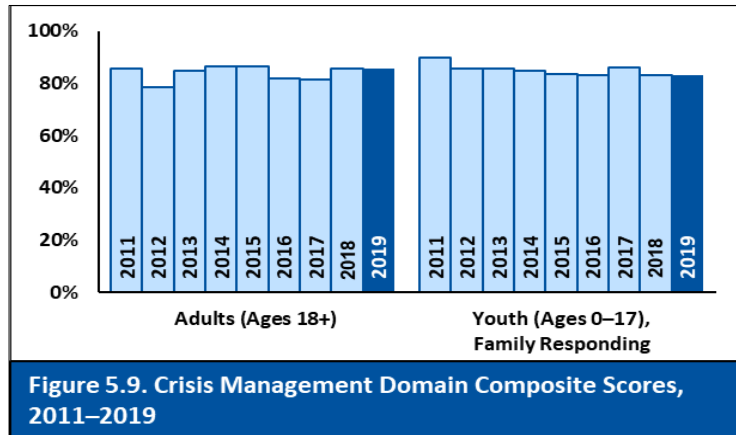
		Youth (Ages 0–17), Family Responding Trend†					Trend†			
		Year	0%	100%	Rate*	N/D	95% CI	p-value^	7-Year	9-Year
As a result of the services my child and/or family received:										
29.	I have people with whom I can do enjoyable things.	2019			89.5%	334 / 373	86.0% – 92.3%		.45	.03 ↓
		2018			90.3%	366 / 405	87.0% – 92.9%	.71		
		2017			93.1%	439 / 471	90.5% – 95.1%	.06		
		2016			94.2%	299 / 317	91.0% – 96.3%	.03 -		
		2015			90.2%	287 / 318	86.4% – 93.0%	.77		
		2014			91.2%	691 / 757	89.0% – 93.1%	.36		
		2013			91.9%	869 / 945	90.0% – 93.5%	.17		
		2012			93.4%	242 / 259	89.7% – 95.9%	.09		
		2011			95.7%	309 / 323	92.8% – 97.5%	<.01 -		

* Rate is weighted by MCO and, so, may differ slightly from numerator divided by denominator (N/D). The modified-Wald (Agresti–Coull) method was used for the 95% confidence intervals (CI).
 ^ The "p-value" is the level of significance (p) of a chi-square test to determine if the 2019 percentage of positive responses is statistically significantly higher (+) or lower (-) than in each of the eight previous years (p<.05 considered significant).
 † Columns "7-Year" and "9-Year" contain the levels of significance of Mantel–Haenszel chi-square tests for linearly increasing (↑) or decreasing (↓) 7-Year and 9-Year trends, respectively, (p<.05 considered significant).

Crisis Management Domain

Survey Domain Responses Over Time

Since 2011, Crisis Management domain composite scores for Adults and Youth have fluctuated; however, they have generally been above 80%. The domain score for Adults in 2019 was 85.5%. For Youth, there was a significant decrease in the positive response in 2019 (83.3%) compared to 2011 (89.7%; $p=.04$) (see Figure 5.9).



Survey Question Responses Over Time

Adults

- The highest positive response in 2019 was 85.9% for Q22, *During a crisis, I was able to get the services I needed*, which was the same in 2018 (85.9%). All but one of the past nine years had percentages greater than 80%.
- Q23, *The crisis services I received helped*, had a positive response in 2019 of 84.5%. There was a significant trending decrease in positive response percentages from 2013 to 2019 ($p=.03$) (see Table 5.7); however, percentages have ranged from 82.4% to 88.6% over the past nine years.
- The lowest positive response in 2019 was 81.8% for Q24, *The crisis services were available as soon as I needed*, although there were no significant differences compared to prior years.

Youth (Ages 0-17), Family Responding

- The highest positive response in 2019 was 85.6% for Q17, *The crisis services we received helped*.
- The lowest positive response in 2019 was 81.4% for Q18, *The crisis services were available as soon as we needed*. There was a significant negative nine-year trend ($p=.04$) (see Table 5.7).
- For Q16, *During a crisis, my family was able to get the services we needed*, the 2019 percentage rate of 83.2% was significantly lower than 2011 (89.5%; $p=.04$).

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Table 5.7. Crisis Management Domain Trending Survey Question – Adult And Youth											
		Adults (Ages 18+)							Trend [†]		
	Year	0%	100%	Rate [*]	N/D	95% CI		p-value [^]	7-Year	9-Year	
23.				84.5%	258 / 305	79.9%	– 88.1%		.03 ↓	.07	
		2018			85.3%	212 / 249	80.3%	– 89.2%			.79
		2017			82.9%	256 / 309	78.3%	– 86.7%			.61
		2016			82.4%	187 / 226	76.9%	– 86.8%			.53
		2015			87.1%	249 / 286	82.7%	– 90.6%			.35
		2014			88.6%	556 / 628	85.8%	– 90.8%			.08
		2013			86.9%	704 / 812	84.4%	– 89.0%			.29
		2012			83.0%	181 / 218	77.5%	– 87.5%			.66
		2011			88.3%	196 / 222	83.3%	– 91.9%			.21
		Youth (Ages 0–17), Family Responding							Trend [†]		
18.				81.4%	205 / 252	76.0%	– 85.7%		.10	.04 ↓	
		2018			81.1%	237 / 293	76.2%	– 85.2%			.94
		2017			84.7%	267 / 315	80.2%	– 88.2%			.30
		2016			79.8%	181 / 225	74.0%	– 84.5%			.66
		2015			81.2%	182 / 224	75.6%	– 85.8%			.96
		2014			82.8%	417 / 504	79.3%	– 85.9%			.62
		2013			85.6%	565 / 665	82.7%	– 88.1%			.12
		2012			83.0%	151 / 182	76.8%	– 87.8%			.67
		2011			86.9%	193 / 222	81.8%	– 90.8%			.10

* Rate is weighted by MCO and, so, may differ slightly from numerator divided by denominator (N/D). The modified-Wald (Agresti–Coul) method was used for the 95% confidence intervals (CI).
[^] The "p-value" is the level of significance (p) of a chi-square test to determine if the 2019 percentage of positive responses is statistically significantly higher (+) or lower (-) than in each of the eight previous years (p<.05 considered significant).
[†] Columns "7-Year" and "9-Year" contain the levels of significance of Mantel–Haenszel chi-square tests for linearly increasing (↑) or decreasing (↓) 7-Year and 9-Year trends, respectively, (p<.05 considered significant).

Non-Domain Results

- **Employment:**
 In response to the question *Are you doing what you want to do for paid work?:*
 - 21.3% responded they have a paid job doing what they want to do;
 - 11.2% responded they have a paid job, but it is not what they want to do;
 - 34.9% responded they want a paid job, but do not have one; and
 - 32.7% responded they do not have a paid job and do not want one.
- **Provider communication:**
 In response to the question *My mental health providers spoke with me in a way I understood,* 94.0% of adult members had a positive response in 2019.
- **Timely medication availability:**
 In response to the question *If you are on medication for emotional/behavioral problems, were you able to get it timely?,* 94.7% of the adult members responded positively, and 92.6% of Youth survey respondents indicated a positive response. For Adult members, all years were above 90%. Youth ratings for this item have continued to be above 90% starting with the 2017 survey, and the question displays a significant positive trend over the past seven years (p<.001).
- **Open-Ended Survey Comments Summary:**
 - Of the 818 surveys returned, there were a combined 1,266 comments across both Adult and Youth surveys. Fifty-eight percent were positive comments; 32.7% comments indicated an opportunity for improvement; and 9.2% were categorized as neutral.

- The three most frequent positive thematic areas among Adults were around Medications (n = 51 comments), Service Quality and Appropriateness (n = 89 comments), and Provider (n = 108 comments). Similar to Adults, the most frequent Youth positive themes included Service Quality and Appropriateness (n = 84) and Provider (n = 70). Youth also had more frequent positive comments regarding Outcomes and Improved Functioning (n = 40).
- The three most frequent themes related to opportunities for improvement among Adults were Service Access (n = 26 comments), Service Quality and Appropriateness (n = 24 comments), and Provider (n = 41 comments). Similarly, Youth respondents had more frequent negative comments regarding Service Quality and Appropriateness (n = 23) and Provider (n = 40). Youth also had more frequent negative comments regarding Provider Operations (n = 33).
- The themes with the fewest mentions for Adults were Care Coordination, Education, Social Connectedness and Participation in Treatment Planning. The fewest mentions for Youth were Crisis Management, Transportation and Social Connectedness.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

- The following 2019 domain scores were at or above 90%:
 - General Satisfaction – Adult members (92.6%);
 - Service Quality and Appropriateness – Adult members (91.4%);
 - Cultural Sensitivity – Youth (97.2%); and
 - Participation in Treatment Planning – Youth (94.9%).
- The following 2019 responses to Adult survey domain questions were at or above 90%:
 - General Satisfaction
 - I like the services that I received (94.3%)
 - If I had other choices, I would still get services from my mental health providers (90.1%)
 - Service Access
 - Services were available at times that were good for me (92.0%)
 - Participation in Treatment Planning
 - I felt comfortable asking questions about my treatment and medication (93.0%)
 - Service Quality and Appropriateness
 - I was given information about my rights (95.0%)
 - My mental health providers encouraged me to take responsibility for how I live my life (90.3%)
 - My mental health providers respected my wishes about who is and who is not to be given information about my treatment (96.4%)
 - My mental health providers were sensitive to my cultural background (90.7%)
- The following 2019 responses to Youth survey domain questions were at or above 90%:
 - General Satisfaction
 - Overall, I am satisfied with the services my child received (91.5%)
 - I felt my child had someone to talk to when he/she was troubled (90.9%)
 - Service Access
 - The location of services was convenient for us (90.0%)
 - Participation in Treatment Planning
 - I helped to choose my child's services (93.3%)
 - I helped to choose my child's treatment goals (90.5%)
 - I participated in my child's treatment (94.7%)
 - Cultural Sensitivity
 - My child's mental health providers:
 - Treated me with respect (96.2%)
 - Respected my family's religious/spiritual beliefs (97.8%)

- Spoke with me in a way that I understood (98.3%)
- Were sensitive to my cultural/ethnic background (97.6%)
- Social Connectedness
 - I know people who will listen and understand me when I need to talk (91.3%)
- One domain provided evidence of significant positive trends: Participation in Treatment Planning for Youth. This domain displayed significant positive trends for both seven- and nine-year periods.
 - Within Participation in Treatment Planning, there has been a consistent positive trend of the item, *I helped to choose my child's services*.
- 2019 non-domain questions:
 - Adults felt their mental health providers spoke to them in a way they understood (94.0%); as part of the Cultural Sensitivity domain, the Youth positive response was 98.3%.
 - Adult members and Youth expressed high positive responses related to getting their medication timely (94.7% and 92.6%, respectively). For Adult members, all years were above 90%. Youth ratings for this item have continued to be above 90% starting with the 2017 survey, and the question displays a significant positive trend over the past seven years ($p < .001$).

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

- The following 2019 domain scores were below 80%:
 - Outcomes – Adult members (73.9%), Youth (79.5%);
 - Improved Functioning – Adult members (73.0%), Youth (77.5%); and
 - Social Connectedness – Adult members (78.9%).
- The following 2019 responses to **Adult** survey domain questions were below 80%:
 - Service Quality and Appropriateness
 - I was encouraged to use consumer-run programs. (76.5%)
 - Outcomes
 - I am better able to deal with crisis. (72.1%)
 - I am getting along better with my family. (79.5%)
 - I do better in social situations. (68.5%)
 - I do better in school and/or work. (67.9%)
 - My housing situation has improved. (74.2%)
 - Improved Functioning
 - My symptoms are not bothering me as much. (64.3%)
 - I am better able to take care of my needs. (77.7%)
 - I am better able to handle things when they go wrong. (69.8%)
 - I am better able to do the things I want to do. (72.5%)
 - Social Connectedness
 - I feel I belong in my community. (69.7%)
 - Other Opportunities for Improvement related to Quality, Timeliness or Access
 - I was able to see a psychiatrist when I needed to (80.3%)I, not my mental health providers, decided my treatment goals. (80.5%)
- The following 2019 responses to **Youth** survey domain questions were below 80%:
 - Outcomes
 - I am satisfied with our family life now. (76.3%)
 - Outcomes & Improved Functioning
 - My child gets along better with family members. (79.7%)
 - My child gets along better with friends and other people. (78.6%)
 - My child is doing better in school and/or work. (77.6%)

- My child is better able to cope when things go wrong. (75.5%)
- The following domains and items show evidence of **significant negative trends**:
 - Encouragement to use consumer-run programs (Service Quality and Appropriateness, Adult)
 - Outcomes domain across Adult respondents
 - Feeling in control of life.
 - Dealing with crisis effectively.
 - Doing better in social situations.
 - Better able to take care of needs. (Improved Functioning, Adult)
 - Helpfulness of crisis management services. (Crisis Management, Adult)
 - Mental health providers sensitive to cultural background. (Service Quality and Appropriateness, Adult); although the positive response in 2019 was 90.7%.
 - Child gets along better with peers and others. (Outcomes and Improved Functioning, Youth)
 - Child doing better in school and/or work. (Outcomes and Improved Functioning, Youth)
 - Peers with which to engage in enjoyable activities. (Social Connectedness, Youth)
 - Crisis services availability. (Crisis Management, Youth)

Degree to which the Previous Year's EQRO Recommendations Have Been Addressed

Please see Appendix D for more details.

Recommendations for Quality Improvement

1. For Adult members, explore methods to increase positive results and mitigate trends among the following:
 - a. Involvement in peer- or consumer-led programming (Service Quality and Appropriateness).
 - b. Increasing effectiveness of crisis services (Crisis Management and Outcomes).
 - c. Coordinate services to provide housing stability (Outcomes).
 - d. Enhancing feelings of control; independence; social and community connections; and doing better in school and/or work (Outcomes, Improved Functioning, and Social Connectedness).
 - e. Reducing symptoms (Outcomes and Improved Functioning).
 - f. Ability to see a psychiatrist when wanted, in conjunction with other MCO Access Monitoring (Service Access).
 - g. Members feeling like they decided their treatment goals (Participation in Treatment Planning).
 - h. Explore methods to help members obtain employment when wanted.
2. For Youth members, explore methods to increase positive results and mitigate trends among the following:
 - a. Interpersonal relationships at home, with peers, and others (Outcomes, Improved Functioning, and Social Connectedness).
 - b. Doing better in school and/or work (Outcomes and Improved Functioning).
 - c. Coping strategies (Outcomes and Improved Functioning).
 - d. Satisfaction with family life right now (Outcomes).
 - e. Availability of crisis services (Crisis Management).
 - f. For both Adults and Youth, continue expanding availability of providers and services, including psychiatrists, crisis services, and options for services at different times of day and on weekends.

Technical Recommendations

For future survey administration, explore alternative data sources to determine if better quality contact data exist for the survey populations.

6. Provider Survey Validation

Background/Objectives

As the EQRO for the State of Kansas, KFMC completed a validation of the Provider Satisfaction Surveys conducted by Aetna, Sunflower, and UnitedHealthcare, the Kansas MCOs. The objective of KFMC's review was to validate the methodological soundness of the completed surveys.

Technical Methods of Data Collection and Analysis Common Among the MCOs

To validate the methodological soundness of the completed Provider Satisfaction Surveys, KFMC used and/or referenced the Validating Surveys Protocol worksheet and narrative provided by the Centers for Medicare & Medicaid Services (CMS), revised September 2012. This version of the protocol was used since the MCOs had begun their surveys prior to the revised protocols being published in October 2019. The protocol is comprised of seven validating activities listed below:

1. Review survey purpose(s) and objective(s) and intended use.
2. Assess the reliability and validity of the survey instrument.
3. Assess the sampling plan.
4. Assess the adequacy of the response rate.
5. Assess survey implementation.
6. Review survey data analysis and findings/conclusions.
7. Document evaluation of survey.

Description of Data Obtained Common Among the MCOs

Each MCO submitted survey documents, including the survey reports prepared by the survey vendors describing survey methodology and results, and a brief summary of key survey findings. Sunflower also provided their vendor's Survey Quality Management Program document. Aetna and Sunflower provided responses to the questions asked by KFMC to clarify certain items needed for the validation, whereas UnitedHealthcare provided frequency tables in response to KFMC's request.

All three MCOs contracted with vendors to conduct a Provider Satisfaction Survey to collect data to assess how well the plan is meeting its providers' expectations and needs, and to identify strengths and opportunities for improvement. All three MCOs used a dual-mode methodology, including mail and internet modalities. Sunflower and Aetna also used a phone follow-up component. Aetna and Sunflower surveys applied probability sampling methodologies to draw the survey samples. Aetna applied simple random sampling methodology to draw a sample of 1,500 PCPs and achieved a total of 108 completed surveys. Sunflower applied stratified random sampling methodology to draw a sample of 2,000 providers (PCPs, specialists and behavioral health clinicians) and achieved a total of 348 completed surveys. The UnitedHealthcare survey report noted 32 surveys were completed without providing information on what type of sampling methodology was applied and size of the sample drawn. The response rates for the mail/Internet survey component and the phone survey component for the Aetna survey were 3.0% and 12.5%, respectively. The response rates for the mail/Internet survey component and the phone survey component for the Sunflower survey were 6.3% and 28.4%, respectively. The response rate for the UnitedHealthcare survey was 2%.

Conclusions Drawn from the Data Common Among the MCOs

- The 2019 Provider Satisfaction Surveys conducted by the three MCOs were limited in providing results that could be generalizable to their KanCare provider population. The reasons include

representativeness of their samples to their provider network due to differences in their sample and study population compositions, low response rates and low numbers of completed surveys providing data for analysis.

- The ability of the MCOs' survey findings to provide conclusions specifically for Behavioral Health (BH) and HCBS providers was not possible for various reasons, including the provider types not being included in the survey or not obtaining an adequate number of completed surveys for these provider types.
- The ability of the MCOs' survey findings to provide conclusions specifically for KanCare providers was limited due to inadequate/no information on the survey study and sample compositions with regard to KanCare providers, low response rate and low number of completed surveys.
- Analysis of the survey questions for two MCOs (Aetna and Sunflower) were problematic due to the nature of the wording of the questions. In both surveys, the majority of the questions were relative questions including instructions to the providers to rate the MCO's plan in specific service areas when compared to their experience with other health plans they work with. Unless the provider's satisfaction with the other appropriate health plans for each of the measures in the survey was known, responses to such relative questions could not be adequately assessed. Also, differences in providers' understanding and application of the instructions could impact the responses. As such, there cannot be true assessment of the MCOs' actual performance or the provider satisfaction for those questions. The survey report of the third MCO (UnitedHealthcare) did not provide the survey instrument to assess the similarities and dissimilarities of its survey questions with those of the other two MCOs.
- The information from the MCO survey findings could not be compared to each other due to the following reasons:
 - Differences in sample compositions of the three MCOs.
 - Unavailability of or incomplete survey methodology information for three MCOs.
 - Issues with the generalizability of the MCO survey findings to their network providers, as well as to their KanCare providers due to the low numbers of completed surveys.
 - Differences in the language of the survey questions among the MCOs.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services Common Among the MCOs

- The surveys for two MCOs (Aetna and Sunflower) were conducted by SPH Analytics, a NCQA Certified CAHPS Survey Vendor. SPH Analytics has experience with like organizations.
- SPH Analytics conducted a pilot test of the survey used for Aetna and Sunflower with eight health plans and performed analytic procedures including reliability, factor, and regression analyses to assess reliability and validity of the survey instrument.
- Question categories seem to have been organized appropriately as indicated by the survey instruments for two MCOs (Aetna and Sunflower) and summary document of the third MCO (UnitedHealthcare).
- The use of a probability sampling method by two MCOs (Aetna and Sunflower) helps avoid the risk of biased results and helps in achieving the survey purpose/objective. Information on sampling methodology was not available for the third MCO (UnitedHealthcare).
- Multi-mode survey methodology including one-wave mail questionnaire with internet option and follow-up telephone calls to non-respondents applied by two MCOs (Aetna and Sunflower) assists in improving response rates and the number of complete surveys.

- An appropriate method of response rate calculation was applied by two MCOs (Aetna and Sunflower) to assess the response rate of both survey components (mail/internet survey and phone follow-up components). Information on response rate calculation was not available for the third MCO (UnitedHealthcare).
- Detailed and varied analyses using appropriate statistical procedures with graphical presentation of the results were done for the surveys of two MCOs (Aetna and Sunflower). A considerable number of metrics were examined for the survey of the third MCO (UnitedHealthcare).
- Benchmarking to 2018 SPH Analytics Medicaid and 2018 Aggregate Books of Business for objective analysis relative to similar findings applied for the surveys of two MCOs (Aetna and Sunflower).

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services Common Among the MCOs

- The information on application of reliability and validity testing of the survey instrument performed for the MCOs' specific survey target populations was not included in the survey reports of the three MCOs.
- A majority of the survey questions for two MCOs (Aetna and Sunflower) were relative questions. The responses to such relative questions could not be adequately assessed, creating an issue for the true assessment of MCOs' actual performance or the providers' satisfaction. The third MCO (UnitedHealthcare) did not include their survey instrument in the report.
- The survey sample of two MCOs (Aetna and Sunflower) were not in alignment with their provider network compositions, thus limiting the samples' representation of the study populations (provider network). Information on the sampling methodology of the third MCO (UnitedHealthcare) was not provided in its survey report.
- It was not feasible to fully assess the adequacy of sample sizes of three MCOs as information on all crucial aspects of sample size calculation was not provided in their survey reports.
- The response rates and number of complete surveys achieved by the three MCOs were low. The number of complete surveys provided by specialists and BH clinicians for two MCOs were very low (Sunflower and UnitedHealthcare). One MCO did not include BH clinicians in the survey sample.
- The survey samples of three MCOs did not include HCBS providers.
- Corrective steps were not applied by the MCOs to improve the response rate and number of completed surveys.
- Due to inadequate representations of the overall study populations and segments of the study populations (e.g., specialists, BH clinicians, HCBS) by survey samples, low response rates, low number of surveys completed by the survey respondents with even lower individual question responses, the survey findings of three MCOs were not generalizable to their overall provider network and to different segments of the network.
- The information on the number of KanCare providers in their KanCare provider network was not provided by three MCOs. The information on the number of KanCare providers in the survey samples was not provided by two MCOs (Sunflower and UnitedHealthcare)

Recommendations for Quality Improvement Common Among the MCOs

1. Describe the procedures applied to ensure the validity and reliability of the survey instrument in the survey report.
2. All MCOs should include questions with same language in the survey instrument to provide comparative results to assess how well the plans are meeting their providers' expectations and needs, and to identify common and unique strengths and opportunities for improvement across the MCOs.
3. Ensure the study population, sampling frame and selected survey sample are in alignment with the intended purpose of the survey.
4. Ensure generalizability of the survey findings to the intended study population by applying robust probability sampling method, alignment of the sampling frame and selected sample with the composition of the study population, sufficient sample size, and achieving an adequate response rate and number of completed surveys.
5. Ensure an adequate number of completed surveys to achieve a valid number of respondents for the individual questions of the survey.
6. Ensure inclusion of an adequate number of KanCare providers by provider type (including BH clinicians and HCBS providers) in the survey sample to achieve an adequate number of complete surveys to generalize the results to these segments of the MCO's provider network.
7. Use a multi-mode survey methodology including a two-wave mail survey accompanied with an internet option component and a phone follow-up component. Further strengthen the survey methodology by ensuring frequent reminder notices/follow-up, appropriate timings for fielding the survey, data collection over an adequate duration, and updated/correct contact information for tracking and contacting the providers.
8. Apply corrective actions during survey administration if there is a slow rate of return, such as contacting non-respondents, sending reminders to complete the survey, increasing the duration of the data collection. Evaluate the reasons for low response rates to mitigate the identified issues.
9. Ensure data analysis results are appropriately interpreted by documenting statistical testing performed per question and composite and clearly indicate when a finding is not statistically significant versus when response rates are too low. Limitations should be considered in the interpretation of the survey findings.
10. Include detailed description of the contents of the survey design and administration in the survey report and accompanying documents:
 - The sampling methodology description should include a clearly defined intended study population and its size; a clearly defined appropriate sampling frame and its size; and clearly described parameters (margin of error, confidence level, response rate) used in the sample size calculation.
 - The survey administration tasks should be described in detail.
 - The survey quality procedures applied for different steps of survey implementation should be included in the survey report with reference to the SPH Quality Management Plan (QMP), which should be provided along with the survey report.
 - Any changes made to the study design during the implementation of the survey along with the reasons for making these changes should be described.
 - The survey report should reference all accompanying documents, particularly those including detailed methodologic descriptions.

AETNA

Aetna of Kansas started their KanCare Managed Care contract with the State of Kansas, on January 1, 2019, and conducted the survey for the first time in 2019. Their survey was conducted from November 2019 through December 2019 by the vendor, SPH Analytics, an NCQA Certified CAHPS Survey Vendor.

Conclusions Drawn from the Data

- Aetna’s survey sample was composed of primary care providers (PCPs) only, whereas the identified study population was comprised of the Aetna Kansas provider network representing a mixture of PCPs, specialists, and BH clinicians. This limits the representativeness of the sample to the Aetna provider network’s PCPs only. In addition, the response rates for its survey components were low, as well as the number of completed surveys achieved was also small. All these issues limited the generalizability of the survey findings to Aetna’s network providers. Thus, it could be concluded that the *overall satisfaction rate with Aetna Better Health of Kansas Plan* was 30.3% among Aetna of Kansas network PCPs (the identified survey sample composition). However, a strong caution had to be applied to make this conclusion due to the low response rate and the low number of completed surveys.
- The survey data comparison with the benchmarks of the 2018 SPH Analytics Medicaid Book of Business and 2018 Aggregate Books of Business might be problematic as the benchmarks were comprised of plans representing respondents in primary care, specialty, and behavioral health.
- Forty-seven of the instrument’s sixty-four questions were relative questions including the following instructions: *Please rate Aetna Better Health of Kansas in the following service areas when compared to your experience with other health plans you work with.* Thus, due to the relative nature of questions, there cannot be a true assessment of Aetna’s actual performance or provider satisfaction for those questions.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

Following are the Aetna survey strengths in addition those described for all MCOs:

- Overall, the methods used for data analysis as described in the survey report appeared appropriate.
- The report described detailed technical methods; extensive analyses, with statistical testing limitations; graphical presentation of the results; and statistical significance testing to determine whether the 2019 data exceeded or were below 2018 SPH Analytics Medicaid and 2018 Aggregate Books of Business benchmarks.
- Given the implicit purposes of the survey, the selection of composites and summary rates seemed appropriate. Reported summary rates represented the most favorable response percentage(s).
- Aetna of Kansas developed the Executive Summary, including interpretation of the key results. They addressed the low satisfaction scores, noting multiple improvements implemented in 2019 and continuing in 2020. Improvements included efforts such as increasing dedicated provider relations staff located in or near their service areas; tracking issues submitted by providers and staff follow-up; and increasing communications.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

Following are the opportunities for improvement for the Aetna survey in addition to those described for all MCOs:

- The sampling methodology described in the survey report indicated the study population was Aetna Kansas providers, representing a mixture of PCPs, specialists, and BH clinicians. However, the

information provided by Aetna indicated the decision was made to draw a random sample of PCPs only. The reason for this decision was not provided. The survey report provided data results indicating specialist and BH clinicians were included, although the number of responses was low; there was no explanation as to whether these providers were PCPs. As per available information, it was not clear whether the study population and sampling frame was comprised of overall Aetna Kansas providers network or only the PCPs of the Aetna Kansas network. This clarification is crucial to assess the generalizability of the survey results to the study population.

- The purpose/objective of the survey was directed towards meeting the needs and expectations of Aetna Kansas providers; limiting the survey sample to only network PCPs limits the ability to meet the intended purpose of the survey.
- The response rates (3% for mail/Internet survey and 12.5% for phone survey) and total number of completed surveys obtained through both survey components (108 complete surveys) were considerably low.
- It was not feasible to assess whether survey implementation conformed to the survey implementation plan as any details regarding the initial survey implementation plan, changes made to the initial plan or reasons for making the changes were not provided. One example is the change from a two-wave mail survey methodology to a one-wave mail methodology.
- The procedures to maintain confidentiality were not documented in the Survey Report.
- The interpretation of results for comparison of survey data with the 2018 SPH Analytics Medicaid Book of Business and 2018 Aggregate Books of Business benchmarks did not clarify the reasons that these comparisons were valid despite the differences in their population compositions.
- As the survey sample was comprised of Aetna Kansas network PCPs who were KanCare providers, survey findings related to the assessment of *Access, Quality, and/or Timeliness* could only be applied to the network PCPs and not the entire study population, which included PCPs, specialists and behavioral health clinicians. A strong caution should be applied in using the survey findings

Degree to which the Previous Year's EQRO Recommendations Have Been Addressed

Aetna of Kansas conducted the Provider Satisfaction Survey for the first time in 2019, so there were no prior recommendations.

Recommendations for Quality Improvement

The recommendations below are in addition to the “Common Among the MCOs” recommendations.

- Revise the survey tool to remove the phrasing that makes the provider answer relative to the other health plans they work with.
- Consider using stratified random sampling to draw a sample in alignment with the Aetna provider network composition.
- Determine the reason for such a large number of ineligible surveys and take steps to address identified issues.
- Interpretation of the study results should reflect the study population represented by the sample and respondents.
- Develop and report timelines for implementing each step in the action plans Aetna develops in response to provider survey responses.

SUNFLOWER

The survey was conducted from August 2019 through October 2019 by the vendor SPH Analytics.

Conclusions Drawn from the Data

- Given the Sunflower survey sample composition, overall survey findings such as 64% *overall satisfaction rate with the Sunflower Health Plan* could be generalized to its overall provider network of PCPs, specialists and BH providers. However, caution should be applied with regard to generalizing the results to specialists and BH providers. While there was a larger stratified sample for specialists that reached the planned target, the response rate was low, resulting in a lower number of responses per question (32 to 72 responses). Results for BH providers are not valid. The BH stratified sample did not reach the stated target and was small (161 clinicians); the number of surveys completed by BH clinicians was very low (only 12 completed surveys) with even a lower number of responses per question (2 to 9 responses).
- The HCBS and NF provider categories were not included as categories for drawing the stratified sample. Sunflower noted the HCBS and NF providers were included in the three stratification categories (PCPs, SPs, and BH providers); it was unclear what categories they were assigned to. One table in the survey report indicated the number of HCBS and NF provider responses per question ranged from 16 to 60.
- Thirty-four of the instrument's forty-five questions were relative questions including the following instructions: *Please rate Sunflower Health Plan in the following service areas when compared to your experience with other health plans you work with.* Thus, due to the relative nature of the questions, there cannot be a true assessment of Sunflower's actual performance or provider satisfaction for those questions.
- The insufficient information on the similarities or differences between the 2019 Sunflower survey and prior Sunflower surveys, and the 2018 SPH Analytics Medicaid and Aggregate Books of Business, limited the ability to comment on the appropriateness of the comparison results.
- The information regarding the number of KanCare providers in the study population and in the sample was not provided. The lack of availability of this crucial information limited the ability to assess the generalizability of the survey results to the KanCare provider population.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

Following are the Sunflower survey strengths in addition to those described for all MCOs:

- Overall, the methods used for data analysis as described in the survey report appeared appropriate.
- The report described detailed technical methods; extensive analyses, with statistical testing limitations; graphical presentation of the results; and statistical significance testing to determine whether the 2019 data exceeded or were below 2018 SPH Analytics Medicaid and 2018 Aggregate Books of Business benchmarks.
- Given the implicit purposes of the survey, the selection of composites and summary rates seemed appropriate. Reported summary rates represented the most favorable response percentage(s).
- The stratified random sampling method was used to draw the survey sample of Sunflower providers; including PCPs, specialists, and BH providers helps to avoid the risk of biased results. The choice of the sampling method assists in ensuring generalizability of the results to the network's provider population.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

Following are the opportunities for improvement in addition to those described for all MCOs:

- The survey report did not discuss data limitations such as indicating which questions/attributes cannot be tested or are rejected.
- The number of providers in the study population and survey sample from each of the business lines or combinations of business lines was not provided. This information was crucial to assess the generalizability of the survey results to the Sunflowers KanCare population.

Degree to which the Previous Year’s EQRO Recommendations Have Been Addressed

There were no previous recommendations, as the MCO Provider Satisfaction Surveys were not included in the EQRO contract last year.

Recommendations Quality Improvement

The recommendations below are in addition to the “Common Among the MCOs” recommendations.

- Revise the survey tool to remove the phrasing that makes the provider answer relative to the other health plans they work with.
- The selected stratified sample should further be strengthened by sampling a higher number of specialists, and more importantly ensuring an adequate number of BH providers, thus helping to further the representativeness of the sample to all types of the providers in the study population (Sunflower network providers).
- Determine the reason for such a large number of ineligible surveys and take steps to address identified issues.
- Interpretation of the study results should reflect the study population represented by the sample and respondents.

UNITEDHEALTHCARE

The survey was conducted from September 9 to October 31, 2019. UnitedHealthcare partnered with Escalent to conduct this survey.

Conclusions Drawn from the Data

UnitedHealthcare’s survey report did not provide information on the overall crucial aspects of the study population and survey methodology, including data analysis procedures and quality control procedures applied to maintain the validity and quality of the survey administration. It is not feasible to draw conclusions from the survey results. Due to the very low response rate, very low total number of completed surveys and even lower number of responses to the individual questions, it was concluded the survey results were severely limited regarding their representativeness to the UnitedHealthcare network providers and more specifically to UnitedHealthcare KanCare providers. The following aspects of the survey data supported this conclusion:

- The findings of the report cannot be supported by the data. Only four out of 48 metrics (based on survey questions met the minimum threshold of 30 responses (one question has 31 responses and other three questions have 30 responses). For the remaining questions, less than 30 responses were available, indicating an inability to generate valid results.

- The four questions that have met the minimum threshold of 30 responses still did not have enough provider responses to represent UnitedHealthcare Kansas providers. With the low response rate (2% of a sample with no information on sample size), low total number of completed surveys (32), and even lower question responses, the findings cannot be generalized to the UnitedHealthcare provider network or the UnitedHealthcare KanCare provider network.
- The data reported on the UnitedHealthcare Results “scorecards” included percentages for 48 metrics (based on survey questions) without mentioning respective numerators and denominators; all but four had less than 30 respondents (UnitedHealthcare Data). The tables presenting these data did not include footnotes related to limitations due to insufficient sample size. The percentages are misleading some, as questions had only a fraction of the already few respondents answering, which makes the reported results invalid.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

Following are the UnitedHealthcare survey strengths in addition those described for all MCOs:

- Question categories seem to have been organized appropriately (UnitedHealthcare Summary).

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

Following are the areas of improvement for the UnitedHealthcare survey in addition those described for all MCOs:

- Due to unavailability of the information on crucial aspects of the survey methodology, it was not feasible to assess the appropriateness of the survey methodology.
- The dual mode survey methodology only included mail and internet component without telephone follow-up of the non-respondents.
- Tables showing national and state percentages for the 48 metrics did not provide numerators and denominators; they only included an overall “ $n = 32$ ” (total valid respondents). The percentages are misleading, as some questions had only a fraction of the already few respondents answering, which makes the reported results invalid. For example, reported findings (50% to 100%) for the questions regarding timeliness and usefulness of information were invalid, as only 2 of 32 providers responded according to the UnitedHealthcare Data report.
- The graphs and tables were not accompanied by narrative text or footnotes to assist in comparison and interpretation of the survey results, including any statistical tests or whether the percentages were based on an adequate number of respondents.

Degree to which the Previous Year’s EQRO Recommendations Have Been Addressed

There were no previous recommendations, as the MCO Provider Satisfaction Surveys were not included in the EQRO contract last year.

Recommendations for Quality Improvement

The recommendations below are in addition to the “Common Among the MCOs” recommendations.

- Consider using stratified random sampling method to draw a sample in alignment with the UnitedHealthcare KanCare provider network composition.
- Use a multi-mode survey methodology including a two-wave mail survey accompanied with an internet option component and a phone follow-up component.
- Ensure the analytic result for each question is based on a valid denominator. Findings based on inadequate numerators and denominators are not valid and can provide inaccurate interpretations.

7. Review of Compliance with Medicaid and CHIP Managed Care Regulations

Background/Objectives

The Medicaid and CHIP Managed Care Regulations¹² require performance of independent, external reviews of the quality and timeliness of, and access to care and services provided to Medicaid beneficiaries by MCOs. A full review is required every three years. KFMC, under contract with KDHE-DHCF, as the EQRO, completed a full assessment in 2016 and follow-up reviews in 2017 and 2018 of the MCOs' compliance with federal regulations.

In the 2017 follow-up review, KFMC began reviewing MCOs' compliance with the CMS regulatory changes that were updated May 6, 2016. MCOs have been encouraged to ensure they are in compliance with the regulations as each becomes effective. For those that went into effect immediately, KFMC determined most had no substantive changes for the MCOs, were not applicable to the MCOs, were requirements for the State, or were only applicable with a new MCO contract. In October 2017, the State determined the relevant regulations for KFMC's 2018 review.

For the 2018 review year, KFMC completed a partial review to evaluate the degree to which 2017 recommendations were addressed by SHP, and which 2016 outstanding recommendations and 2017 recommendations were addressed by UHC. In July 2018, the State approved for KFMC to submit the 2018 Follow-up Results table in lieu of a full report to close out the MCO's follow-up review.

Due to the Amerigroup contract with the State of Kansas ending December 31, 2018, Amerigroup's final compliance review was addressed in last year's EQR Annual Technical report dated April 26, 2019. For 2019, KFMC is conducting a full review of Aetna Better Health of Kansas, the contracted KanCare MCO effective January 1, 2019. Since Sunflower Health Plan and UnitedHealthcare have been reviewed for six years, their regulatory compliance assessment is being conducted over the three years, with one-third of regulations evaluated each year. All new regulations from the updated Medicaid Managed Care regulations are included in the first year of review. Documentation review began the summer of 2019, with on-site reviews to the three MCOs beginning in the fall of 2019. KFMC's 2019 regulatory compliance reviews will be individually reported in 2020 and included in the spring 2021 annual EQR Technical report.

Technical Methods of Data Collection and Analysis Common Among the MCOs

The Medicaid Managed Care Regulatory Provisions were grouped into the categories, below.

- Subpart C – Enrollee Rights and Protections
- Subpart D – Quality Assessment and Performance Improvement (QAPI)
- Subpart F – Grievance System

KFMC used a modified version of the EQR Protocol documentation and reporting tool template developed by CMS to compile the results of these monitoring activities. During the review, KFMC interacted with the MCOs to seek further clarification and obtain additional documentation, as needed.

Description of Data Obtained Common Among the MCOs

Following the 2016 full review, the State identified from KFMC's report which recommendations they would require the MCOs to implement and in which year they were to occur (2017 or 2018). For the

¹² Managed Care, 42 C.F.R. §438 (2016) <https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8>.

2018 follow-up review, KFMC requested documentation from the MCOs evidencing they implemented the changes, as directed by the State, to bring the regulatory requirements into full compliance. In their submissions of documentation, MCOs included a cover sheet detailing the changes made to bring areas into compliance and the applicable documentation to review.

Conclusions Drawn from the Data Common Among the MCOs

The MCOs continued to work to address issues identified in the 2016 review and 2017 follow-up review that were found to be less than fully met. The MCOs continue to look for new ideas to improve areas of work, and continue to have improvement opportunities.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services Common Among the MCOs

- The MCOs' efforts to bring areas that were found to be less than fully met into compliance will help ensure members get better access, quality, and timeliness of health care services.
- Both MCOs are forward-looking, innovative, and have a proactive approach to improvement.
- Throughout the process leading up to and during the follow-up review, both MCOs were organized and responsive.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services Common Among the MCOs

Actions for improvement were identified for both MCOs within the following regulatory areas:

- Availability of Services – Delivery Network (§438.206[b][1][iv–v]):
 - Improvements are needed in Network Adequacy and GeoAccess reporting (e.g., incorporate Network Adequacy improvements into GeoAccess reporting; county level information being included; and reporting requirements of identifying whether the provider services [psychiatry availability and SED Waiver] are for adults, pediatric, or both).
 - Continue to work to bring providers in-network that serve members in other MCO networks.
- Provider Selection (§438.214[b][2]):
 - For credentialing/recredentialing, verify the current uniform State credentialing and recredentialing application “*Kansas Organizational Provider Credentialing/Re-credentialing Application*” is being used.

Recommendations for Quality Improvement Common Among the MCOs

1. §438.206(b)(1)(iv) Availability of Services – Delivery Network (Providers not accepting new patients and Network Adequacy):
 - Continue to review and ensure consistency in provider classification, and continue to monitor network adequacy reports for errors.
 - Incorporate Network Adequacy Report corrections into the GeoAccess Report to ensure mapping of access correctly reflects network adequacy.
2. §438.206(b)(1)(v) Availability of Services – Delivery Network (Geographic location of providers and Medicaid enrollees):
 - Continue to make efforts to identify providers who are serving KanCare members in other MCO networks, contact those providers to reach agreements to bring them in-network to provide services to members, and, if an agreement cannot be reached, ensure timely access of members to providers in other MCO networks through a single case agreement.

SUNFLOWER

Conclusions Drawn from the Data

SHP addressed the majority of 2017 recommendations. They continue to work to address the remaining 17 issues found to be less than fully met and to look for new ideas to improve areas of work.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

- SHP’s efforts to bring areas found to be less than fully met into compliance will help ensure members get better access, quality, and/or timeliness of health care services.
- SHP is forward-looking, innovative, and has a proactive approach to improvement.
- Throughout the process leading up to and during the follow-up review, SHP was organized and responsive.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

- Availability of Services – Delivery Network (§438.206[b][1][iv-v]):
 - Review how providers are classified, ensure physician extenders are reported correctly.
 - Continue to recruit providers in counties that do not currently meet access standards.
 - Improvements are needed in the SHP Provider Manual.
- Furnishing of Services – Timely Access: SHP should submit the Provider Manual with the identified language change that SHP expects PCPs to be available 24/7, and a recorded message afterhours is not acceptable. (§438.206[c][1][iii])
- Coordination and Continuity of Care – Primary Care and Coordination of Services for all MCO Enrollees: Implement improvement efforts to increase awareness with providers of the need to develop processes to ensure effective follow-up. (§438.208[b][1])
- Provider Selection (§438.214[b][1-2]):
 - Credentialing and Recredentialing Requirements: Ensure written notification of credentialing/recredentialing determinations are sent to all providers. (§438.214[b][2])
 - State Requirements: All HCBS provider credentialing/recredentialing applications need to include the HCBS Supplemental Form.
- Sub-contractual Relationships and Delegation – Specific Conditions (§438.230[b][3]):
 - Improvements made in Delegated Vendor Oversight (DVO) Meeting Minutes need to be verified.
 - Improvements are needed in scorecards.
 - Additional information is needed on how data are calculated.

Degree to which the Previous Year’s EQRO Recommendations Have Been Addressed

Sunflower responded to and submitted documentation for the 2018 follow-up review. See Appendix D for details.

Recommendations for Quality Improvement

The recommendations below are in addition to the “Common Among the MCOs” recommendations. KFMC identified three regulations with opportunities for improvement involving six recommendations. Additionally, there are four regulatory areas the EQRO will review in 2019. See Appendix C for more details.

UNITEDHEALTHCARE

Conclusions Drawn from the Data

UHC addressed the majority of 2016 (outstanding) and 2017 recommendations. They continue to work to address the remaining eight issues found to be less than fully met and to look for new ideas to improve areas of work.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

- UHC’s efforts to bring areas found to be less than fully met into compliance will help ensure members get better access, quality, and/or timeliness of health care services.
- UHC is forward-looking, innovative, and has a proactive approach to improvement.
- Throughout the process leading up to and during the follow-up review, UHC was organized and responsive.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

Quality, Timeliness, and/or Access to Health Care Services

- Availability of Services – Delivery Network (§438.206[b][1][iv–v]):
 - Recruitment of specialists should be targeted in counties that do not meet access standards.
- Coordination and Continuity of Care (§438.208[b][1]):
 - Review of UHC internal audit results is needed.
 - Verification of assistance being provided to members with referrals and coordination of care is needed.
 - Verification of improved file documentation by the provider is needed.
- Provider Selection (§438.214[b][1–2] and [e]):
 - Verification is needed of appropriate quality checks and process monitoring taking place when:
 - Requesting disclosure of alternate provider and facility names and when checking all names against the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) Exclusions Database during the credentialing/recredentialing process.
 - In checking all names of owners, controlling interests, and managing employees noted on Disclosure of Ownership (DOO) forms against the OIG LEIE Exclusions Database.
 - For credentialing/recredentialing:
 - Verification files include all the applicable information, checks, and current forms.
 - Additional documentation review is needed.
- Resolution and Notification: Grievances and Appeals – Content of Notice of Appeal Resolution: For appeal case review, verification is needed that acknowledgement and disposition (resolution) letters include the “*Member Grievance and Appeals Process*” document (when appropriate). (§438.408[e][2][i–iii])

Technical

- Provider Selection: For State requirement 2.2.4.1.5. (§438.214[e]) related to conflict free case management, the revised “*Home & Community Based Service Provider Verification & Credentialing Policy*” is needed.

Degree to which the Previous Year's EQRO Recommendations Have Been Addressed

UnitedHealthcare responded to and submitted documentation for the 2018 follow-up review. See Appendix D for details.

Recommendations for Quality Improvement

The recommendations below are in addition to the "Common Among the MCOs" recommendations. KFMC identified three regulations with opportunities for improvement involving three recommendations. Additionally, there are six regulatory areas the EQRO will review in 2019. See appendix C for more details.

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8. Quality Assessment and Performance Improvement (QAPI) Assessment

Background/Objectives

Quality Assessment (QA) and Performance Improvement (PI) are mutually-reinforcing aspects of a quality management system. The QAPI approach is continuous, systematic, comprehensive, and data-driven. Implementing this approach allows organizations to improve on identified challenges as well as plan for future opportunities.¹³ The State’s Quality Management Strategy (QMS) aligns with QAPI program requirements outlined in the KanCare 2.0 contract, which requires MCO QAPI programs to:

- *Collect complete and accurate data to support robust analysis and reporting of data.*
- *Develop capacity to analyze data, make information actionable, and implement interventions to demonstrate improved results.*
- *Deploy rapid-cycle QI.*
- *Develop strong provider peer review mechanisms to evaluate the quality, appropriateness, and cost effectiveness of care delivered.*
- *Drive collaboration and innovation internally, across business units and externally with members, caregivers, participating providers, stakeholders, and community-based entities.¹⁴*

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

Technical Methods of Data Collection and Analysis Common Among the MCOs

KFMC evaluated MCO compliance with Section 5.9 of their KanCare 2.0 contract, *Quality Assessment and Performance Improvement*. Section 5.9 includes the following 12 sub-sections:

- 5.9.1 General Requirements
- 5.9.2 State and Federal Monitoring
- 5.9.3 Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles
- 5.9.4 Performance Measures
- 5.9.5 Performance Improvement Projects
- 5.9.6 Peer Review
- 5.9.7 National Committee for Quality Assurance Accreditation
- 5.9.8 Healthcare Effectiveness Data and Information Set and Consumer Assessment of Healthcare Providers & Systems
- 5.9.9 Adverse Incident Reporting and Management System
- 5.9.10 Member Satisfaction Surveys
- 5.9.11 Provider Satisfaction Surveys
- 5.9.12 Clinical and Medical Records

Description of Data Obtained Common Among the MCOs

MCO information was obtained from KFMC’s 2019 assessment of compliance with Medicaid managed care regulations and additional documentation requests. Documentation included the following:

- 2019 QAPI Program Description (including objectives, policies, committees, report samples);

¹³ QAPI Description and Background. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/gapidefinition>. Updated September 20, 2016. Accessed May 19, 2020.

¹⁴ KanCare 2.0 Quality Management Strategy. https://www.kancare.ks.gov/docs/default-source/policies-and-reports/quality-measurement/kancare-2-0---quality-mgmt-strategy_final-cms-submission.pdf?sfvrsn=25484d1b_4. Published July 2, 2018. Accessed May 19, 2020.

- 2019 QAPI Work Plan;
- MCOs' QAPI interview responses from KFMC's review of compliance with Medicaid Managed Care and CHIP; and
- 2018 Annual QAPI program Evaluation (applicable to Sunflower and UnitedHealthcare only).

Conclusions Drawn from the Data Common Among the MCOs

Of the 102 total requirements from Section 5.9 (QAPI) of the KanCare 2.0 contract, KFMC identified 3 requirements that were partially met across all three MCOs:

- Identifying members enrolled in an LTSS waiver but not receiving any waiver services (Section 5.9.1, General Requirements);
- Telehealth and e-visits (Section 5.9.3, Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles); and
- Retention of records (Section 5.9.12, Clinical and Medical Records).

KFMC identified two requirements that were not met by Aetna and UnitedHealthcare, and partially met by Sunflower:

- Education on the peer review process (Section 5.9.6, Peer Review) and
- Sampling methodology for HCBS and behavioral health providers (Section 5.9.11, Provider Satisfaction Surveys).

Based upon provided documentation and the QAPI interviews during KFMC's onsite review, it is clear the MCOs are committed to meeting all requirements. However, providing additional detail in the QAPI Program Description, and/or including references to associated documents, would improve QAPI documentation for each MCO. Aetna, Sunflower, and UnitedHealthcare recently completed the Annual Evaluation for their 2019 QAPI program, which will be included in KFMC's 2020 QAPI review.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services Common Among the MCOs

- Working across departments to maximize quality assessment and coordinate quality improvement.
- Using data collection, analysis, and reporting to drive improvement initiatives.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services Common Among the MCOs

Section 5.9.1 General Requirements

5.9.1(G): Develop and implement mechanisms to identify Members who are enrolled in LTSS Waivers but who are not receiving any Waiver services.

- While documentation included some discussion of monitoring services, a description of the process to identify members enrolled in LTSS waivers but not receiving any waiver services was not provided.

Section 5.9.3 Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles

5.9.3(A)(7): Pursue innovative approaches, including the use of telehealth, e-visits and alternative payment arrangements, to expand access to quality care and services.

- Although documentation described aspects of this requirement, telehealth and e-visits were not addressed.

Section 5.9.6 Peer Review

5.9.6(A)(9): Education to Members, the Member Advocate(s), QM and other CONTRACTOR(S)' staff, about the Peer Review process, so that Members and the CONTRACTOR(S)' staff can make referrals to the Peer Review committee of situations or problems relating to Participating Providers.

- Detail of how members, member advocates, QM, and other MCO staff are educated on the peer review process was not provided.

Section 5.9.11 Provider Satisfaction Surveys

5.9.11(D): Conduct a sampling methodology that includes a statistically significant sample for both the HCBS and Behavioral Health Provider populations.

- The QAPI related documents did not address the sampling methodology for inclusion of behavioral health and HCBS providers in the provider survey.

Section 5.9.12 Clinical and Medical Records

5.9.12(C): Records Retention requirements.

- The Provider Manual contained an incorrect timeframe for record retention after litigation (Sunflower).
- There was discussion of retention of records in the Program Description. However, information was not provided regarding the retention time periods or how this will be implemented and monitored (Aetna and UnitedHealthcare).

Degree to which the Previous Year's EQRO Recommendations Have Been Addressed Common Among the MCOs

Because this is the first year for KFMC's MCO QAPI review, there are no prior recommendations.

Recommendations for Quality Improvement Common Among the MCOs

1. 5.9.1(G) Mechanisms to identify LTSS Members not receiving any services:
 - Include a description of the process to identify members enrolled in LTSS waivers but not receiving any waiver services.
2. 5.9.3(A)(7) Pursuing innovative approaches to expand access to quality care and services (telehealth, e-visits and alternative payment arrangements):
 - Describe how the MCO is expanding access to quality care using telehealth and e-visits.
3. 5.9.6(A)(9) Education of peer review process:
 - Explain how QM, and other MCO staff are educated on the peer review process. Provide information regarding how members and member advocates are educated on the MCO's process for reviewing their reported quality of care concerns, including potential Peer Review and identifying what "Peer Review" means.
4. 5.9.11(D) Provider Satisfaction Survey sampling methodology:
 - Address achieving statistically valid samples for HCBS and BH provider populations.
5. 5.9.12(C) Medical Records Retention:
 - Update the timeframe for retention of records after litigation (not less than 10 years) in the Provider Manual (Sunflower).
 - Provide details regarding the retention time periods and how this will be implemented and monitored (Aetna and UnitedHealthcare).

AETNA

Conclusions Drawn from the Data

Of the 102 total requirements from Section 5.9 (QAPI) of the KanCare 2.0 contract, KFMC identified four requirements Aetna partially met, in addition to the three partially met and two not met requirements previously noted as common to all MCOs:

- Comparing waiver services received with services outlined in the treatment plan (Section 5.9.1, General Requirements);
- Dissemination of subcontractor and provider quality improvement information (Section 5.9.1, General Requirements);
- Processes to ensure complete and accurate data files and reports (Section 5.9.3, Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles); and
- Processes for maintaining staff with capacity to provide and describe Kansas specific data (Section 5.9.3, Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles).

KFMC also identified a general opportunity related to the QAPI Program Description. Providing additional detail in Aetna’s QAPI Program Description, and/or including references to associated documents, would improve Aetna’s QAPI documentation. Aetna has recently completed the Annual Evaluation for their 2019 QAPI program which will be included in KFMC’s 2020 QAPI review.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

During the first year of implementation, Aetna appears to have a good foundation for success in quality assessment and performance improvement. KFMC identified the following assets regarding Aetna’s QAPI program:

- Tracking utilization data to identify opportunities for improvement; one example is tracking emergency department utilization to better understand emergency department use for non-emergent needs.
- Development of the Care Unify population health platform to facilitate real-time quality assessment and improvement.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

General Program Description Requirements

Program Description

- Sections in the Program Description did not provide references to associated supplemental documents also submitted as part of the QAPI.

Section 5.9.1 General Requirements

5.9.1(F) [Partially Met]: Develop and implement mechanisms to compare services and supports received with those set forth in the Member’s treatment/service plan for individuals enrolled in LTSS Waivers.

- Although the Program Description cited the exact requirement and there was discussion of the treatment/service plan in the *ISC Program Description*, detail was not provided regarding how Aetna monitors to ensure services and supports received are those identified in the member’s treatment/service plan.

5.9.1(N)(9) [Partially Met]: Regularly, and as requested, disseminate Subcontractor and Provider quality improvement information including performance measures, dashboard indicators and Member Outcomes to the State and key stakeholders, including Members and family members.

- The Program Description cited the exact requirement; however, it did not provide information regarding how this would be accomplished. For example, this type of performance information was not included in the plan for communications described in the 2019 QAPI Work Plan.

Section 5.9.3 Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles

5.9.3(C)(1) [Partially Met]: Collect complete and accurate data on Members and Providers regarding service processes and Outcomes furnished through robust collection, analysis and reporting of data.

- Aetna policy 8000.70 Quality Management Oversight restated this requirement. However, there was no detail of how Aetna ensures data files and submitted reports are complete and accurate.

5.9.3(C)(2) [Partially Met]: Maintain staff with the capacity and capability to provide and describe Kansas specific data at every level of collection, analysis, and reporting by the Plan, as well as, Participating Providers and vendors.

- Although Aetna policy 8000.70 Quality Management Oversight restated this requirement, descriptive language regarding how this is accomplished was not included.

Degree to which the Previous Year’s EQRO Recommendations Have Been Addressed

Because this is the first year KFMC reviewed the MCOs’ QAPI programs and Aetna was a new MCO in 2019, there are no prior recommendations.

Recommendations for Quality Improvement

The recommendations below are in addition to the “Common Among the MCOs” recommendations.

1. QAPI General Recommendation:
 - Within each section of the Program Description, include references to all associated supplemental documents.
2. 5.9.1(F); Mechanisms to compare services and supports for LTSS Members:
 - Describe how Aetna monitors to ensure services and supports received are those identified in the member’s treatment/service plan.
3. 5.9.1(N)(9) Dissemination of subcontractor and provider quality improvement information:
 - Include a description of how Aetna is meeting this requirement such as inclusion in the communication portion of the QAPI Work Plan.
4. 5.9.3(C)(1) Complete and accurate data collection on members and providers:
 - Detail how Aetna ensures completeness and accuracy of data files and submitted reports.
5. 5.9.3(C)(2) Maintaining staff with capacity to describe Kansas specific data, including data collection, analysis, and reporting:
 - Describe how qualified staff are recruited, trained, and maintained

SUNFLOWER

Conclusions Drawn from the Data

Of the 102 total requirements from Section 5.9 (QAPI) of the KanCare 2.0 contract, KFMC identified two requirements Sunflower partially met, in addition to five partially met requirements previously noted as common to all MCOs.

- Peer review committee decisions (Section 5.9.6, Peer Review);
- Incorporation of results of the NCI and NCI-AD surveys (Section 5.9.10, Member Satisfaction Surveys); and
- Providing additional detail in Sunflower's QAPI Program Description, and/or including references to associated documents, would improve Sunflower's QAPI documentation. Sunflower has recently completed the Annual Evaluation for their 2019 QAPI program which will be included in KFMC's 2020 QAPI review.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

As an established MCO in Kansas, Sunflower's experience is evident with its focus on improving quality and access to care. KFMC identified the following assets regarding Sunflower's QAPI program:

- Developing diverse community partnerships to reduce health disparities.
- Using data collection, analysis, and reporting to drive improvement initiatives and drill down on opportunities.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

Section 5.9.6 Peer Review

5.9.6(A)(6): Appointment of a Peer Review committee, as a subcommittee to the quality management/quality improvement committee, to review Participating Provider performance when appropriate. The Chief Medical Officer (CMO) or a physician designee shall chair the Peer Review committee and all decisions made by the Peer Review Committee shall not be over-turned by the Credentialing Committee or other Committee without the knowledge or consensus approval of the Peer Review Committee.

- The description does not indicate whether decisions made by the Peer Review Committee are not over-turned by the Credentialing Committee or other Committee without their knowledge or consensus approval.

Section 5.9.10 Member Satisfaction Surveys

5.9.10(F): The State participates in the National Core Indicators (NCI) and NCI-Adults with Disabilities (AD) consumer satisfaction surveys for the elderly and adults with disabilities. The Contractors shall ensure that a representative sample of MLTSS and Behavioral Health Members are included in this survey process. The CONTRACTOR(S) shall incorporate results of the NCI and NCI-AD surveys in its QAPI program and into those of its delegates and Subcontractors.

- Evidence of incorporating NCI and NCI-AD results was not found in the QAPI documentation provided.

Degree to which the Previous Year's EQRO Recommendations Have Been Addressed

Because this is the first year KFMC reviewed Sunflower's QAPI program, there are no prior recommendations.

Recommendations for Quality Improvement

The recommendations below are in addition to the "Common Among the MCOs" recommendations.

1. 5.9.6(A)(6) Peer Review Committee:
 - Provide policy documentation that decisions made by the Peer Review Committee are not over-turned by the Credentialing Committee or other Committee without their knowledge or consensus approval. Ensure a process is in place for documentation of the Peer Review Committee's knowledge or consensus approval in the event their decision is over-turned.
2. 5.9.10(F) The CONTRACTOR(S) shall incorporate results of the NCI and NCI-AD surveys in its QAPI program and into those of its delegates and subcontractors:
 - Within QAPI documentation, reference how NCI and NCI-AD results are incorporated into the QAPI program and describe how they are included in the QAPI programs of any applicable delegates or subcontractors.

UNITEDHEALTHCARE

Conclusions Drawn from the Data

Of the 102 total requirements from Section 5.9 (QAPI) of the KanCare 2.0 contract, KFMC identified five requirements UnitedHealthcare partially met in addition to three partially met and two not met requirements previously noted as common among MCOs:

- Staff training and development (Section 5.9.3, Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles);
- Promoting member employment (Section 5.9.3, Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles);
- Processes to ensure complete and accurate data files and reports (Section 5.9.3, Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles);
- Timing for incident reporting (Section 5.9.9, Adverse Incident Reporting and Management System); and
- Evaluation of provider satisfaction survey results (Section 5.9.11, Provider Satisfaction Surveys).

KFMC identified one requirement that was not met by UnitedHealthcare:

- Addressing restraints and seclusions (Section 5.9.9, Adverse Incident Reporting and Management System).

Additionally, KFMC identified one opportunity related to the QAPI Program Description. Providing additional detail in UnitedHealthcare's QAPI Program Description, and/or including references to associated documents, would improve UnitedHealthcare's QAPI documentation. UnitedHealthcare has recently completed the Annual Evaluation for their 2019 QAPI program which will be included in KFMC's 2020 QAPI review.

Strengths Regarding Quality, Timeliness, and/or Access to Health Care Services

UnitedHealthcare’s experience is evident with its focus on improving quality and access to care. KFMC identified the following assets regarding UnitedHealthcare’s QAPI program:

- Using data collection, data analysis, and local report development to drive improvement initiatives.
- Having an additional detailed Utilization Management Program Evaluation.

Opportunities for Improvement Regarding Quality, Timeliness, and/or Access to Health Care Services

General Program Description Requirements

Program Description

- Sections in the Program Description did not provide references to associated supplemental documents that would further describe the QAPI program.

Section 5.9.3 Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles

5.9.3(A)(2) [Partially Met]: Empower staff excellence through hiring those who are Medicaid experienced and knowledgeable and investing in their development through relevant ongoing training, education, and mentorship.

- Information regarding training and development for staff was not documented.

5.9.3(B)(1) [Partially Met]: Develop performance measurement and performance improvement strategies to maximize health Outcomes and the quality of life for all Members to achieve the highest level of dignity, independence, and choice through the delivery of holistic, person-centered, and coordinated care and the promotion of employment and independent living supports.

- While this requirement was mostly addressed, promotion of member employment was not described in the QAPI materials provided.

5.9.3(C)(1) [Partially Met]: Collect complete and accurate data on Members and Providers regarding service processes and Outcomes furnished through robust collection, analysis and reporting of data.

- Although the Program Description outlined inter-rater reliability testing of review staff and physicians, there was no detail of how UnitedHealthcare ensures data files and submitted reports (other than audited HEDIS findings) are complete and accurate.

Section 5.9.9 Adverse Incident Reporting and Management System

5.9.9(C) [Partially Met]: Report all Adverse Incidents within 24-hours of becoming aware of the incident or event.

- While reporting of adverse incidents was described, the reporting requirement of “within 24-hours” was not included.

5.9.9(D)(2) [Not Met]: Investigate and follow up on any Behavioral Health Adverse Incidents reported in compliance with Behavioral Health guidelines. CONTRACTOR(S) shall only permit use of restraints and seclusions for members on the IDD and SED Waivers. Any use of physical or chemical restraint, isolation or seclusion in either Waiver is considered an adverse incident and must be reported via the AIR system within twenty-four (24) hours.

- UnitedHealthcare does not address restraints or seclusions in their QAPI documentation.

Section 5.9.11 Provider Satisfaction Surveys

5.9.11(A) [Partially Met]: Comply with the requirements in the QMS regarding Provider satisfaction survey(s).

- While some description regarding provider satisfaction surveys was provided, the following State QMS requirement for provider survey evaluation was not included: Each evaluation must provide a work plan that includes a timeline, barrier analysis, and intervention(s) to address results.

Degree to which the Previous Year’s EQRO Recommendations Have Been Addressed

Because this is the first year KFMC reviewed UnitedHealthcare’s QAPI program, there are no prior recommendations.

Recommendations for Quality Improvement

The recommendations below are in addition to the “Common Among the MCOs” recommendations.

1. QAPI General Recommendation:
 - Include references to all associated supplemental documents within each section of the Program Description.
2. 5.9.3(A)(2): Staff training and development:
 - Expand on the descriptions of staff training and development.
3. 5.9.3(B)(1): Promotion of member employment:
 - Describe how member employment is promoted.
4. 5.9.3(C)(1) Complete and accurate data collection on members and providers:
 - Detail how UnitedHealthcare ensures completeness and accuracy of data files and submitted reports (other than HEDIS audited findings).
5. 5.9.9(C) Adverse incident reporting within 24-hours:
 - Include the “within 24-hours” reporting requirement in documentation regarding reporting of adverse incidents.
6. 5.9.9(D)(2) Behavioral health adverse incidents:
 - Describe how UnitedHealthcare addresses the use of restraints and seclusions for members and reporting incidents within 24-hours.
7. 5.9.11(A) QMS requirements:
 - Address QMS requirements for providers surveys, including providing a work plan to the State that contains a timeline, barrier analysis, and intervention(s) to address results.

End of written report

Appendix A

KanCare Program Annual External Quality Review Technical Report 2019–2020 Reporting Cycle

List of KFMC EQR Technical Reports



Below is a list of reports on the required and optional EQRO activities described in 42 CFR 438.358 that have been submitted by KFMC to the State during the 2019 –2020 reporting cycle.

ISCA and PMV

KFMC contracted with MetaStar, Inc. (an organization licensed by NCQA to conduct HEDIS Compliance Audits) to conduct the ISCA of Aetna, as well as the PMV and ISCA of Sunflower and UnitedHealthcare. KFMC conducted the PMV of Amerigroup.

ISCA: The ISCA evaluation was conducted in accordance with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) Protocols 1, 2, and 3 (Compliance, Performance Measurement, and Performance Improvement), and applicable to Protocols 4 and 6 (Validation of Encounter Data and Calculation of Measures). The CMS ISCA tool in Appendix V of the CMS Protocol is used to facilitate this assessment.

PMV: Performance measures reported by each MCO were validated according to the 2012 CMS EQR Protocol 2, Validation of Performance Measures Reported by the MCO. Specifications for these measures can be found in the *HEDIS 2019 Volume 2, Technical Specifications for Health Plans*. All HEDIS measures were validated.

- Aetna (ISCA Only) *2019 ISCA of Aetna; December 19, 2019; The ISCA objectives are to assess the potential impact of Aetna’s IS capabilities. This report is an initial Aetna ISCA conducted in September 2019.*

- Sunflower *2019 ISCA and 2019 Validation of Sunflower Performance Measures for CY2018 HEDIS; December 18, 2019; This report contains measures with specifications derived from HEDIS.*

- UnitedHealthcare *2019 ISCA and 2019 Validation of UnitedHealthcare Performance Measures for CY2018 HEDIS; December 20, 2019; This report contains measures with specifications derived from HEDIS.*

- Amerigroup *2019 Validation of Amerigroup. Performance Measures for CY2018 HEDIS; October 22, 2019; This report contains measures with specifications derived from the Healthcare Effectiveness Data and Information Set (HEDIS).*

PIP

- Sunflower *2018 PIP Annual Evaluation of Sunflower, “Increasing the Rate of Diabetic Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications”; February 26, 2020; Year 2 annual evaluation*

- UnitedHealthcare *2019 PIP Annual Evaluation of UnitedHealthcare, “Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medication”; May 4, 2020; Year 3 annual PIP evaluation*

- Collaborative HPV *2019 Human Papillomavirus (HPV) Collaborative PIP Annual Evaluation; May 6, 2020; Year 4 PIP annual evaluation for Sunflower and UnitedHealthcare, and year 1 for Aetna*

CAHPS Survey Validation

KFMC completed a validation of the 2019 CAHPS surveys conducted by Sunflower and UnitedHealthcare, two of the three MCOs providing Kansas Medicaid and Children’s Health Insurance Program (CHIP) services through the KanCare program. The third MCO, Aetna, started its contract on January 1, 2019, and did not conduct the 2019 CAHPS surveys as its members did not fulfill the survey eligibility requirement of being enrolled in the MCO for at least five of the last six months of calendar year 2018.

- Sunflower *2019 CAHPS Health Plan 5.0H Survey Validation – Sunflower Health Plan and UnitedHealthcare Community Plan of Kansas; May 27, 2020; KFMC’s validation of the 2019 CAHPS surveys conducted by each MCO from February through May 2019, includes separate survey results by MCO and subpopulation for Adults, Title XIX/Medicaid, Title XXI/CHIP, Children with Chronic Conditions (CCC) Title XIX, and CCC Title XXI.*
UnitedHealthcare

HCBS CAHPS Survey

KFMC contracted with Vital Research, LLC to conduct the Home and Community-Based Services Consumer Assessment of Healthcare Providers and Systems (HCBS CAHPS) Survey across four HCBS Waiver programs: Frail Elderly (FE), Intellectual or Developmentally Disabled (I/DD), Physical Disability (PD), and Traumatic Brain Injury (TBI). KFMC was involved throughout the process and worked with Vital on the analysis and written report. Vital Research conducted in-person interviews from January 31, 2019 to June 18, 2019. Descriptive statistics were calculated for every HCBS CAHPS item, in aggregate at the KanCare level, including the Supplemental Employment and Supplemental Access Modules.

- Medicaid HCBS *2019 HCBS CAHPS Survey – Medicaid HCBS Population; May 25, 2020.*

Mental Health Survey

KFMC contracted with Vital Research, LLC (Vital) to administer the survey consistent with the CMS EQR Protocol, Validation and Implementation of Survey. KFMC was involved throughout the process and worked with Vital on the analysis and written report. The Mental Health Statistics Improvement Program (MHSIP) survey tools (Youth Services Survey for Families [YSS-F] and Adult Consumer Survey) were adapted for use in the project. The MHSIP survey is a nationally standardized survey. The mental health survey was administered from October 4, 2019, to November 21, 2019. Analysis was conducted based on standard MHSIP survey analysis procedures.

- Aetna *2019 Kansas Medicaid Mental Health Consumer Perception Survey;*
Sunflower *March 16, 2020*
UnitedHealthcare

Provider Survey Validation

KFMC completed a validation of the Provider Satisfaction Survey conducted by the three MCOs. The objective of KFMC’s review was to validate the methodological soundness of the completed survey. KFMC used and/or referenced the CMS EQR Protocol, Validating Surveys including the worksheet and narrative provided by CMS.

- Aetna *2019 Provider Survey Validaton; May 4, 2020; The survey was conducted from November 2019 through December 2019 by the vendor, SPH Analytics, a NCQA Certified Survey Vendor.*

- Sunflower *2019 Provider Survey Validaton; May 25, 2020; The survey was conducted from August 2019 through October 2019 by the vendor SPH Analytics, a NCQA Certified Survey Vendor.*

- UnitedHealthcare *2019 Provider Survey Validaton; May 7, 2020; The survey was conducted from September 9 - October 31, 2019. UnitedHealthcare partnered with Escalent to conduct this survey.*

Review of Compliance with Medicaid and CHIP Managed Care Regulations

In 2016, KFMC conducted a full review to determine each MCO's compliance with managed care regulations related to quality, timeliness, and access to care and services provided to Medicaid (KanCare) beneficiaries. For the 2018 review year, KFMC completed a partial review to evaluate the degree to which 2016 outstanding recommendations and 2017 recommendations were addressed by UHC.

- Sunflower *2018 Review of Compliance with Medicaid and CHIP Managed Care Regulations of Sunflower; December 18, 2018*

- UnitedHealthcare *2018 Review of Compliance with Medicaid and CHIP Managed Care Regulations of UnitedHealthcare; December 18, 2018*

QAPI

KFMC evaluated the 2019 MCO QAPI programs. The objectives were to review the completeness of the QAPI design, examining strengths, opportunities for improvement, and providing recommendations for improvement. KFMC evaluated MCO compliance with Section 5.9 of their KanCare 2.0 contract, "Quality Assessment and Performance Improvement."

- Aetna *2019 QAPI Assessment; May 11, 2020*

- Sunflower *2017 QAPI Assessment; May 12, 2020*

- UnitedHealthcare *2017 QAPI Assessment; May 12,2020*

Appendix B

KanCare Program Annual External Quality Review Technical Report

(2019 – 2020 Reporting Cycle)

Aggregated KanCare HEDIS
Performance Measures – Adult and Child



KanCare Program Annual External Quality Review Technical Report
2019–2020 Reporting Cycle
Appendix B – Aggregated KanCare HEDIS Performance Measures – Adult

Table B1. Aggregated KanCare HEDIS Performance Measures (by measure year) – Adult											
Measure*	Measure Name & Indicator	2018		2017		2016		2015		2014	
		Rate	QC	Rate	QC	Rate	QC	Rate	QC	Rate	QC
ABA H	Adult BMI Assessment	↑90.39	≥50 th	↑86.45	<50 th	↑80.90	<33.33 rd	↑77.61	<33.33 rd	72.23	<25 th
AMM A	Antidepressant Medication Management – Effective Acute Phase Treatment	50.33	<50 th	50.71	<50 th	↓48.99	<33.33 rd	52.53	<50 th	52.81	≥50 th
	Antidepressant Medication Management – Effective Continuation Phase Treatment	33.35	<25 th	33.82	<33.33 rd	↓33.02	<33.33 rd	36.81	<50 th	37.20	≥50 th
AMR A	Asthma Medication Ratio (19–50)	54.88	≥50 th	53.99	≥50 th	↑51.27	≥50 th	46.44	<50 th	46.79	<50 th
BCS A	Breast Cancer Screening	48.05	<25 th	47.03	<10 th						
CBP H	Controlling High Blood Pressure (Total)	58.63	<50 th								
CCS H	Cervical Cancer Screening	59.10	<50 th	58.29	<50 th	54.81	<33.33 rd	51.57	<33.33 rd	53.22	<25 th
CDC H	Comprehensive Diabetes Care – HbA1c Testing	87.66	<50 th	86.22	<50 th	85.81	<50 th	84.86	<50 th	84.79	<50 th
	Comprehensive Diabetes Care – Poor HbA1c Control (lower is better)	36.79	≥50 th	↓35.33	≥50 th	↓41.14	<50 th	↓45.44	<50 th	52.87	<25 th
CHL A	Chlamydia Screening in Women (21–24)	54.87	<25 th	54.51	<25 th	52.76	<25 th	53.51	<25 th	54.47	<33.33 rd
FUA A	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 days (18+)	16.58	>66.67 th	15.40	>66.67 th						
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 days (18+)	23.76	>66.67 th	22.34	>66.67 th						
FUH A	Follow Up After Hospitalization For Mental Illness – 7 days (18–64)	49.02	>75 th								
	Follow Up After Hospitalization For Mental Illness – 30 days (18–64)	67.20	>75 th								
FUM A	Follow-Up After Emergency Department Visit for Mental Illness – 7 days (18–64)	59.61	>90 th								
	Follow-Up After Emergency Department Visit for Mental Illness – 30 days (18–64)	72.16	>90 th								
FVA C	Flu Vaccinations for Adults Age 18–64	53.37	>90 th	50.51	>90 th	↑48.80	>90 th	43.66	>75 th	46.51	>75 th

Arrows (↑↓) indicate a significant increase or decrease compared to prior year's rate ($p < .05$); green indicates significant improvement and purple indicates worsening of rates. Quality Compass (QC) ranks above the 90th percentile are also green, while those below the 10th percentile are also purple.

* A denotes an administrative method of data collection was used; H denotes a hybrid method of data collection was used; C denotes indicators which arise from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.

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Appendix B – Aggregated KanCare HEDIS Performance Measures – Adult

Table B1. Aggregated KanCare HEDIS Performance Measures (by measure year) – Adult (Continued)											
Measure*	Measure Name & Indicator	2018		2017		2016		2015		2014	
		Rate	QC	Rate	QC	Rate	QC	Rate	QC	Rate	QC
IET A	Initiation of AOD – Alcohol abuse or dependence (18+ Years)	40.49	<50 th	37.91	<33.33 rd						
	Initiation of AOD – Opioid abuse or dependence (18+ Years)	34.69	<25 th	36.06	<25 th						
	Initiation of AOD – Other drug abuse or dependence (18+ Years)	34.56	<25 th	34.37	<25 th						
	Initiation of AOD – Total (18+ Years)	35.29	<25 th	34.70	<25 th						
	Engagement of AOD – Alcohol abuse or dependence (18+ Years)	9.68	<50 th	8.77	<50 th						
	Engagement of AOD – Opioid abuse or dependence (18+ Years)	9.31	<25 th	10.54	<25 th						
	Engagement of AOD – Other drug abuse or dependence (18+ Years)	↑10.73	<50 th	7.66	<33.33 rd						
	Engagement of AOD – Total (18+ Years)	10.34	<33.33 rd	10.38	<33.33 rd						
MPM A	Annual Monitoring for Patients on Persistent Medications (Total)	90.40	>66.67 th	90.01	>66.67 th						
MSC C	Medical Assistance with Smoking and Tobacco Use Cessation – Total % Current Smokers (lower is better)	31.76	≥50 th	31.87	≥50 th	33.18	≥50 th	32.21	≥50 th	↓33.45	<50 th
	Medical Assistance with Smoking and Tobacco Use Cessation – Advising Smokers to Quit	76.09	<50 th	78.76	≥50 th	79.97	>66.67 th	79.54	>75 th	76.18	<50 th
	Medical Assistance with Smoking and Tobacco Use Cessation – Discussing Cessation Medications	53.42	<50 th	52.18	≥50 th	51.25	≥50 th	46.05	<50 th	43.22	<33.33 rd
	Medical Assistance with Smoking and Tobacco Use Cessation – Discussing Cessation Strategies	46.05	<50 th	46.02	≥50 th	48.38	>66.67 th	↑44.38	≥50 th	37.52	<25 th
PPC H	Prenatal and Postpartum Care – Postpartum Care	58.23	<25 th	61.13	<33.33 rd	57.96	<25 th	57.46	<50 th	55.79	<33.33 rd

Arrows (↑↓) indicate a significant increase or decrease compared to prior year's rate ($p < .05$); green indicates significant improvement and purple indicates worsening of rates. Quality Compass (QC) ranks above the 90th percentile are also green, while those below the 10th percentile are also purple.

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Table B1. Aggregated KanCare HEDIS Performance Measures (by measure year) – Adult (Continued)											
Measure*	Measure Name & Indicator	2018		2017		2016		2015		2014	
		Rate	QC	Rate	QC	Rate	QC	Rate	QC	Rate	QC
SAA A	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	54.58	<33.33 rd	54.21	<33.33 rd	55.58	<33.33 rd	↓54.07	<33.33 rd	58.49	<50 th
SSD A	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	79.49	<50 th	↑80.00	<50 th	76.56	<25 th	75.75	<25 th	74.05	<25 th

Arrows (↑↓) indicate a significant increase or decrease compared to prior year's rate ($p < .05$); **green** indicates significant improvement and **purple** indicates worsening of rates. Quality Compass (QC) ranks above the 90th percentile are also **green**, while those below the 10th percentile are also **purple**.

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Appendix B – Aggregated KanCare HEDIS Performance Measures – Child

Table B2. Aggregated KanCare HEDIS Performance Measures (by measure year) – Child											
Measure*	Measure Name & Indicator	2018		2017		2016		2015		2014	
		Rate	QC	Rate	QC	Rate	QC	Rate	QC	Rate	QC
ADD A	Follow Up Care for Children Prescribed ADHD Medication – Initiation Phase	48.68	>66.67 th	↓49.53	>66.67 th	52.15	>75 th	↑50.73	>75 th	48.04	>66.67 th
	Follow Up Care for Children Prescribed ADHD Medication – Continuation & Maintenance Phase	56.11	≥50 th	57.54	≥50 th	61.38	≥50 th	↑61.17	>66.67 th	54.82	≥50 th
ADV A	Annual Dental Visit (Total)	↑65.40	>75 th	↑64.82	>75 th	↑63.73	>75 th	↑60.91	>75 th	59.98	>66.67 th
AMB A	Ambulatory Care – Emergency Dept Visits/1000 MM (Total) <i>(lower is better)</i>	↓58.58	≥50 th	↑62.42	≥50 th	↓59.53	<50 th	↑66.31	≥50 th	64.19	≥50 th
AMR A	Asthma Medication Ratio (5–11)	↑79.00	>66.67 th	73.93	≥50 th	↑74.25	≥50 th	70.86	<50 th	69.55	<50 th
	Asthma Medication Ratio (12–18)	↑68.66	≥50 th	63.49	<50 th	↑62.56	<50 th	57.48	<50 th	55.05	<50 th
APC A	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (6–11) <i>(lower is better)</i>	2.55	<25 th	3.33	<25 th	4.12	<10 th	4.43	<10 th		
	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (12–17) <i>(lower is better)</i>	4.78	<25 th	5.02	<25 th	5.34	<25 th	5.74	<25 th		
	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Total) <i>(lower is better)</i>	3.91	<25 th	4.19	<25 th	4.78	<10 th	5.13	<25 th		
APP A	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	74.09	>75 th	71.94	>75 th	74.59	>90 th	72.18	>75 th		
AWC H	Adolescent Well-Care Visits	50.67	<50 th	↑53.30	<50 th	47.71	<50 th	46.81	<50 th	46.67	<50 th
CAP A	Children and Adolescents' Access To PCP (12–24 Months)	↓92.57	<25 th	93.29	<25 th	↓93.64	<33.33 rd	↓94.19	<33.33 rd	94.93	<33.33 rd
	Children and Adolescents' Access To PCP (25 Months–6 Years)	↓86.70	<50 th	↑87.46	<50 th	85.94	<50 th	86.09	<50 th	85.97	<33.33 rd
	Children and Adolescents' Access To PCP (7–11 Years)	91.08	≥50 th	↑91.26	≥50 th	↑90.22	<50 th	89.55	<50 th	89.46	<33.33 rd
	Children and Adolescents' Access To PCP (12–19 Years)	↓90.66	≥50 th	↑91.26	>66.67 th	↑89.42	<50 th	88.90	<50 th	88.66	<50 th
CHL A	Chlamydia Screening in Women (16–20)	↓37.53	<10 th	39.62	<10 th	41.04	<10 th	41.29	<25 th	41.00	<25 th

Arrows (↑↓) indicate a significant increase or decrease compared to prior year's rate ($p < .05$); green indicates significant improvement and purple indicates worsening of rates. Quality Compass (QC) ranks above the 90th percentile are also green, while those below the 10th percentile are also purple.

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Table B2. Aggregated KanCare HEDIS Performance Measures (by measure year) – Child (Continued)

Measure*	Measure Name & Indicator	2018		2017		2016		2015		2014	
		Rate	QC	Rate	QC	Rate	QC	Rate	QC	Rate	QC
CIS H	Childhood Immunization Status – Diphtheria-Tetanus-Acellular Pertussis (DTaP)	74.72	<50 th	75.09	<50 th	↓75.31	<50 th	↑80.79	>66.67 th	74.48	<33.33 rd
	Childhood Immunization Status – Haemophilus Influenzae B (HiB)	85.04	<25 th	85.23	<25 th	86.16	<33.33 rd	87.67	<50 th	86.34	<25 th
	Childhood Immunization Status – Hepatitis A	86.24	≥50 th	87.55	>66.67 th	86.90	≥50 th	88.10	>66.67 th	87.74	>66.67 th
	Childhood Immunization Status – Hepatitis B	91.40	≥50 th	90.29	≥50 th	91.69	>66.67 th	↑93.24	>75 th	90.98	<50 th
	Childhood Immunization Status – Inactivated Poliovirus Vaccine (IPV)	89.09	<50 th	86.96	<33.33 rd	88.34	<50 th	89.42	<50 th	87.38	<33.33 rd
	Childhood Immunization Status – Influenza	45.83	<50 th	↑45.11	<50 th	↓38.16	<33.33 rd	42.95	<50 th	41.70	<25 th
	Childhood Immunization Status – Measles-Mumps-Rubella (MMR)	86.89	<33.33 rd	87.71	<33.33 rd	88.63	<50 th	89.03	<50 th	88.81	<33.33 rd
	Childhood Immunization Status – Pneumococcal Conjugate	↑75.62	<50 th	↓70.53	<25 th	76.94	<50 th	75.95	<50 th	72.68	<25 th
	Childhood Immunization Status – Rotavirus	68.86	<50 th	70.76	<50 th	71.24	≥50 th	↑73.55	>66.67 th	66.78	<50 th
	Childhood Immunization Status – Varicella-Zoster Virus (VZV)	86.40	<33.33 rd	87.55	<33.33 rd	87.73	<33.33 rd	88.23	<50 th	88.57	<33.33 rd
	Childhood Immunization Status – Combination 10 (all 10 antigens)	34.52	<50 th	↑33.36	<50 th	↓28.51	<50 th	32.58	<50 th	29.91	<33.33 rd
FUH A	Follow Up After Hospitalization For Mental Illness – 7 days (6–17)	60.09	>75 th								
	Follow Up After Hospitalization For Mental Illness – 30 days (6–17)	80.10	>75 th								
IMA H	Immunizations for Adolescents – Human Papillomavirus (HPV)	33.25	<33.33 rd	31.70	<50 th						
	Immunizations for Adolescents – Meningococcal	75.64	<25 th	↑74.68	<25 th	↑67.81	<25 th	63.31	<25 th	60.98	<25 th
	Immunizations for Adolescents – Tetanus-Diphtheria-Pertussis (Tdap)	85.42	<33.33 rd	84.20	<25 th	82.43	<25 th	82.33	<33.33 rd	83.00	<33.33 rd

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Table B2. Aggregated KanCare HEDIS Performance Measures (by measure year) – Child (Continued)											
Measure*	Measure Name & Indicator	2018		2017		2016		2015		2014	
		Rate	QC	Rate	QC	Rate	QC	Rate	QC	Rate	QC
IMA H	Immunizations for Adolescents – Combination 1 (Meningococcal, Tdap)	74.63	<25 th	↑73.39	<33.33 rd	↑66.31	<25 th	61.81	<25 th	60.10	<25 th
	Immunizations for Adolescents – Combination 2 (Meningococcal, Tdap, HPV)	31.74	<50 th	30.88	<50 th						
PPC H	Prenatal and Postpartum Care – Timeliness of Prenatal Care [^]	↑75.46	<25 th	69.34	<10 th	68.44	<10 th	67.39	<25 th	70.38	<25 th
W15 H	Well-Child Visits in the first 15 Months of Life (6 or more visits)	↓54.84	<25 th	60.69	<33.33 rd	58.63	<50 th	↑58.73	<50 th	49.26	<25 th
W34 H	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	70.12	<50 th	71.01	<50 th	67.30	<33.33 rd	64.77	<33.33 rd	65.87	<33.33 rd
WCC H	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI percentile (Total)	63.81	<25 th	↑64.74	<25 th	↑56.01	<25 th	48.59	<25 th	↑45.28	<25 th
<p>Arrows (↑↓) indicate a significant increase or decrease compared to prior year's rate ($p < .05$); green indicates significant improvement and purple indicates worsening of rates. Quality Compass (QC) ranks above the 90th percentile are also green, while those below the 10th percentile are also purple.</p> <p>* A denotes an <i>administrative</i> method of data collection was used; H denotes a <i>hybrid</i> method of data collection was used.</p> <p>[^] 2017 to 2018 increases for PPC Timeliness of Prenatal Care for UHC and All MCO scores are attributable to methodology changes.</p>											

Appendix C

KanCare Program Annual External Quality Review Technical Report

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2018 Compliance Review Recommendations



Recommendations – Sunflower Health Plan

Quality, Timeliness, and/or Access to Health Care Services

1. §438.206(b)(1)(iv) Availability of Services – Delivery Network (Providers not accepting new patients):
For the SHP Network Adequacy report:
 - a. Continue to review how providers are classified and make corrections as necessary.
 - b. SHP incorporate corrections in the Network Adequacy Report into the GeoAccess Report to ensure mapping of access correctly reflects network adequacy
2. §438.206(b)(1)(v) Availability of Services – Delivery Network (Geographic location of providers and Medicaid enrollees):
 - a. Continue, at the State’s request, to make changes to the Network Adequacy Report to detail whether SED Waiver providers treat adults, pediatric, or both.
 - b. Continue to make efforts to identify providers who are serving KanCare members in other MCO networks, contact those providers to reach agreements to bring them in-network to provide services to SHP members, and, if an agreement cannot be reached, ensure timely access of members to providers in other MCO networks through a single case agreement.
 - c. Continue to review and correct Network Adequacy and GeoAccess reports to ensure physician extenders are reported correctly (SHP lists “*physician extenders – Advanced Practice Registered Nurses and Physician Assistants [PAs]*” in the Network Adequacy reports as physician specialists).
 - d. For the SHP GeoAccess document “*GEOQS073018*”:
 - i. Continue to recruit providers in counties that do not currently meet the access standards, focusing recruiting efforts on specialties of particular need for SHP members in these counties.
 - ii. Provide the most current two reports of the bi-monthly audit of the data in the Network Adequacy Report completed by the Data Management team.
3. §438.206(c)(1)(iii) Furnishing of Services – Timely Access (24 hours/7 days per week): Submit the Provider Manual with the identified language change that SHP expects PCPs to be available 24/7, and a recorded message afterhours is not acceptable.
4. §438.214(b)(2) Provider Selection (MCO must follow documented process for credentialing/recredentialing) [provider credentialing case review]: Ensure timeliness of written communication to the provider.

Areas to add to the 2019 Full Compliance Review

In the 2019 full review, the EQRO should review:

1. §438.206(b)(1)(v) Availability of Services – Delivery Network (Geographic location of providers and Medicaid enrollees):
 - a. Review the Network Adequacy report and any other applicable reports (e.g., GeoAccess) to verify the MCOs have implemented the State’s reporting requirements of identifying whether SED Waiver services are classified as available for adults, pediatric, or both (requirement beginning with the October 2018 report submitted for Quarter 3 [July – September 2018]).
 - b. Review the revised Network Adequacy Quarterly Report for the newly added county level information (beginning October 2018) and assess whether the State should consider requiring MCOs to include in GeoAccess mapping the availability of each HCBS service. At a minimum, a list of counties with limited access to specific HCBS services (reported, as of 2018, by counts and not by county names).

2. §438.208(b)(1) Coordination and Continuity of Care (Ongoing source of primary care): Review the SHP quarterly provider meetings, orientations, workshops, and physical and behavioral health cases to ensure:
 - a. The following topics continue to be addressed: Providers have developed processes to ensure effective follow-up required when labs are ordered, tests are run, results are documented and acknowledged in the chart, the patient is informed of the results, and abnormal results are addressed.
 - b. That providers continue to be made aware and that they continue to develop processes to ensure effective follow-up required when referrals are ordered, to ensure the referral is made, and documentation occurs of communication with the specialist regarding the results of the referral and changes in the treatment plan.
3. §438.214(b)(1) Provider Selection – Credentialing and Recredentialing Requirements: Review credentialing/recredentialing applications to verify SHP is using the most current State identified *“Kansas Organizational Provider Credentialing/Recredentialing Application”* and all HCBS provider credentialing/recredentialing applications include the HCBS Supplemental Form.
4. §438.230(b)(3) Sub-contractual Relationships and Delegation – Specific Conditions (MCO monitors subcontractor’s performance):
 - a. Review DVO Meeting Minutes to verify they detail the changes made to capture an update on the status of a requested line/category to be added to the scorecard and, if it could not be added, the minutes detail the reason.
 - b. Review SHP scorecards for the following:
 - i. Asterisks were placed within individual data points with corresponding footnotes providing descriptions of and/or reasons for the following:
 - 1) A category name changed/added,
 - 2) When no data are included,
 - 3) When data for the same timeframe change between quarterly reports,
 - 4) When there is a large variation in data from one quarter to another, and
 - 5) Include in the scorecard the identified method for year-to-date calculation (summed vs. averaged; duplicated vs. non-duplicated, etc.).
 - ii. Detail has been provided in the scorecard on how the year-to-date eligibility statistics are calculated.

Recommendations – UnitedHealthcare Community Plan of Kansas

Quality, Timeliness, and/or Access to Health Care Services

1. §438.206(b)(1)(iv) Availability of Services – Delivery Network (Network adequacy): For the “PVRLST” data source that was implemented, UHC:
 - a. Continue monitoring to ensure network adequacy reporting does not have classifications errors and ensure consistency in how providers are classified continues to improve.
 - b. Report any identified issues or enhancements.
 - c. Incorporate corrections in the Network Adequacy Report into the GeoAccess Report to ensure mapping of access correctly reflects network adequacy.
2. §438.206(b)(1)(v) Availability of Services – Delivery Network:
 - a. Continue to recruit providers in counties that do not currently meet the access standards, focusing recruitment efforts on specialties of particular need for UHC members in these counties and on specialties where distance to access is now greatest.
 - b. Continue to make efforts to identify providers who are serving KanCare members in other MCO networks; contact those providers to reach agreements to bring them in-network to provide services to UHC members; and, if a network agreement cannot be reached, ensure timely access of members to providers in other MCO networks through a single case agreement.

Technical

1. §438.214(e) Provider Selection: In the 2019 full review, if the State has issued its “Final Form Policy,” submit to the EQRO the revised UHC “Home & Community Based Service Provider Verification & Credentialing Policy” that details the language to support State requirement 2.2.4.1.5 (conflict free case management); or, if the State “Final Form Policy” has not been issued and UHC has updated the policy to incorporate the provision, it should be submitted to the EQRO for review.

Area to add to the 2019 Full Compliance Review

In the 2019 full review, the EQRO should review:

1. §438.208(b)(1) Coordination and Continuity of Care (Ongoing source of primary care):
 - a. Review UHCs results for the most recent two quarters of the “National PCP MRR Scoring Tool” (sections “Problem Evaluation and Management,” numbers 6 and 9, and “Problem Evaluation and Management-cont’d,” numbers 2 and 10).
 - b. Review physical and behavioral health files to verify:
 - i. Referrals are ordered and made, and documentation occurs of communication with the specialist regarding the results of the referral and changes in the treatment plan.
 - ii. Labs are ordered, tests are run, results are documented and acknowledged in the chart, the patient is informed of the results, and abnormal results are addressed;
 - iii. There is evidence of providers assisting members with referrals and coordination of care;
 - iv. There is detailed documentation of follow-up from previous concerns, and documentation in progress notes of all appointments/services members have received from their provider since the last visit; and
 - v. If there is no documentation of the aforementioned, there is evidence of UHC educating (e.g., site visit and/or letters) or taking corrective action with the provider for the lack of documentation in the record.

2. §438.206(b)(1)(v) Availability of Services – Delivery Network:
 - a. Review the revised Network Adequacy Quarterly Report for the newly added county level information (beginning October 2018) and assess whether the State should consider requiring MCOs to include in GeoAccess mapping the availability of each Home and Community Based Service (HCBS) service. At a minimum, a list of counties with limited access to specific HCBS services (reported, as of 2018, by counts and not by county names).
 - b. Review the Network Adequacy report and any other applicable reports (e.g., GeoAccess) to verify the MCOs have implemented the State’s reporting requirements of identifying whether the provider services (psychiatry availability) are for adults, pediatric, or both. Also, that SED services are classified as available for adults, pediatric, or both (requirements beginning with the October 2018 report submitted for Quarter 3 [July – September 2018]).
3. §438.214(b)(1) Provider Selection – Credentialing and Recredentialing Requirements: Review provider credentialing/recredentialing cases for the most current version of the “*Kansas Joint Credentialing Application*.”
4. §438.214(b)(2) Provider Selection (MCO must follow documented process for credentialing/recredentialing): Review the following:
 - a. Disclosure of alternate names has been requested.
 - b. Alternate names have been checked against the OIG LEIE Exclusions Database.
 - c. OIG LEIE checks are completed on names identified with ownership/control interest.
 - d. Full DOO and Controlling Interest statements are included.
 - e. DOO and Control Interest statements have been requested and submitted prior to credentialing decisions being completed.
 - f. All files include OIG LEIE checks of managing employees.
 - g. Alternate names are checked.
 - h. All names provided on the DOO and Control Interest statements are checked.
5. §438.214(e) Provider Selection: State Requirements (MCO must comply with additional State requirements) for State Contract Section 2.2.4.1.6 (Recredentialing to occur every three years and 2.2.4.1.7 (Timeframe requirements for credentialing of all service providers applying for network provider status): To ensure credentialing and recredentialing is being completed in the required timeframe:
 - a. Review provider credentialing and recredentialing files.
 - b. Review the “*Community Plan 2018 NCC ScoreCard*,” months August – December 2018.
6. §438.408(e)(2)(i–iii) Resolution and Notification: Grievances and Appeals – Content of Notice of Appeal Resolution (Right to State Fair Hearing): For appeal case review, the EQRO should ensure the appeal disposition (resolution) letters include the “*Member Grievance and Appeals Process*” document (when appropriate).

Appendix D

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**Degree to which the Previous Year's EQRO
Recommendations Have Been Addressed**



Degree to which Previous Year’s EQRO Recommendations Have Been Addressed

ISCA and PMV

Aetna (ISCA only)

Aetna began serving as an MCO for Kansas in 2019, so no previous ISCA has been performed.

Sunflower

There were no recommendations as a result of the most recent performance measure validation review. Sunflower is proactive in evaluating and applying quality improvement strategies throughout the year and is currently evaluating their HEDIS Auditor’s recommendations from HEDIS 2019.

UnitedHealthcare

UnitedHealthcare took action as a result of the recommendations from the prior year. For HEDIS 2018 Cervical Cancer Screening (CCS) and Comprehensive Diabetes Care (CDC) Hemoglobin A1c Control (<8.0 percent) measures, it had been discovered that not all Medicare/Medicaid dual eligible members were included in the initial population. Although this issue ultimately did not impact rates negatively, the recommendation was made to include the appropriate populations prior to hybrid sampling to ensure compliance with State reporting requirements. Since that time, UnitedHealthcare’s Medical Quality Application team configured the population for HEDIS 2019 to include all members, regardless of any dual coverage. In addition, the MCO also conducted double checks on the sample data produced to further instill confidence in its accuracy.

Amerigroup (Performance Measure only)

Through collaboration between KFMC and Amerigroup, all recommendations made during the previous year’s validation process were incorporated prior to the PMV report submission.

PIP

Sunflower

- Sunflower should document, in the 2018 annual report, what efforts were made to obtain feedback from enrollees with special health needs, specific to diabetes screenings.
Follow-up Response: Sunflower did not provide any new information regarding efforts to obtain feedback from enrollees with special health needs.
- In the 2018 annual report, each intervention related measurement should be defined as a study indicator with the description, numerator, and denominator.
Follow-up Response: Sunflower included the numerator and denominator for all of their PIP intervention measures in the 2018 annual report.
- A current and complete data analysis plan should be included with the 2018 annual PIP report that describes Sunflower’s quantitative and statistical analyses; and review opportunities for improvement for additional analyses.

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Follow-up Response: Sunflower did not provide a current and detailed analysis plan; one should be included with the 2019 annual progress report, with any changes from the original proposed plan identified.

- Sunflower should provide, in the 2018 annual report, copies of their intervention outreach materials used to date and any new materials with subsequent annual reports. When applicable, provide verification of the State’s approval of the materials.

Follow-up Response: Sunflower provided copies of their member and provider intervention materials in the 2018 annual report.

UnitedHealthcare

Methodology/Analysis/Reporting:

- Further develop the qualitative analysis of feedback gained from members, providers, care managers and clinical practice consultants. Report findings, patterns and lessons learned.

Follow-up Response: UnitedHealthcare provided a qualitative analysis section in the annual report that included feedback from Care Managers regarding barriers to members obtaining diabetes screenings.

Waiver Member Outreach:

- Provide additional information regarding Waiver Care Managers’ processes for outreach to members who remain on the MINs list regardless of initial successful outreach.

Follow-up Response: UnitedHealthcare reported “Gaps in care, including diabetic screening are reviewed at each member touchpoint.”

Whole Person Care:

- Provide information regarding the intensity/frequency of contact with the members identified in the PIP, if initial outreach has been successful.

Follow-up Response: Care Managers, who are the single point of contact for the member, develop a relationship with members and provide consistent and ongoing engagement both telephonically and face-to-face to assist with the closure of these gaps in care. Members who participate in the program work with their Care Managers to facilitate health care access and to assist them with decisions that can have an impact on the quality and affordability of their health care.

Written Communications to Members and Providers:

- Since UnitedHealthcare anticipated pairing member and prescriber mailings would enhance the improvement, the mailings should be sent the same month and preferably within the same week to evaluate the effectiveness of this approach. Otherwise, separate the interventions and track resulting screening accordingly.

Follow-up Response: In 2019, the prescriber mailing was sent three days after the member mailing. However, the mailings did not occur until September, with remeasurement using November C2 MLD. This may not be enough time to fully evaluate the paired intervention. Although, the screening rates for individuals receiving the July 2018 member mailing were also a little over 40%, suggesting mailings are not effective at increasing screening rates.

- Consider measuring SSD diabetes screening rates for members assigned to primary care providers (PCPs) receiving Gap-in-Care reports and/or visits from Clinical Practice Consultants (CPCs). Another option would be to count the number of Gap-in-Care reports per provider over time.

Follow-up Response: UnitedHealthcare responded: It is currently not possible to identify PCPs who might receive this report throughout the year since CPCs focus on clinic TIN, rather than provider

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NPI. New providers may join facilities mid-year, retire and/or specialize in a non-SSD area while working in a clinic with other providers who may have SSD gaps. These are the same barriers in attempting to monitor individual practitioner use of the provider portal as the office TIN is captured rather than a specific provider identifier.

Clinical Practice Consultant Outreach:

- Explore methods of evaluating the effectiveness of this intervention as it relates to the SSD PIP. Minimally, report feedback from the CPCs, similar to the insights provided from the care managers in the Waiver and WPC interventions.
Follow-up Response: It is currently not possible to identify PCPs who might receive this report throughout the year since CPCs focus on clinic TIN, rather than provider NPI. New providers may join facilities mid-year, retire and/or specialize in a non-SSD area while working in a clinic with other providers who may have SSD gaps. These are the same barriers in attempting to monitor individual practitioner use of the provider portal as the office TIN is captured rather than a specific provider identifier. UnitedHealthcare noted CPC information from providers regarding concerns and barriers around the SSD measure. An example was provided of a provider implementing new office policies after reviewing the SSD gaps-in-care list.

Collaborative HPV

Telephone Outreach:

- To reflect the MCOs’ intention of increasing the HPV vaccination rate through successful and effective outreach calls and the measurement, an additional goal should be documented regarding the effectiveness of successful outreach (i.e., percentage of eligible members who receive a HPV vaccination within 90 days of the successful call).
Follow-up Response: The MCOs addressed the recommendation with a goal of increasing the effectiveness of successful outreach.
- An additional measure for the study should be added: “The percent of eligible members successfully reached” (numerator - number of eligible members successfully reached; denominator – number of eligible members).
Follow-up Response: The additional measure was added.
- Provide further detail regarding analysis plan, including:
 - HEDIS-like county level rates, with numerators and denominators, should be provided for the treatment and control counties during the same time-period as the intervention, to provide context when evaluating the results.
Follow-up Response: Rate comparisons were completed between the treatment and control group. The control group is identified as the non-targeted counties plus the “unable to successfully reach” members from the targeted counties.
 - Limit the control group to the same criteria used in the treatment group (it appears to be males and females with 13th birthdays in October through December, that are not up-to-date as of July, August, or September.) This will help control for potential influencing factors, such as seasonal variation and increased difficulties in completing vaccine catch-up within a three to six-month timeframe.
Follow-up Response: Sunflower completed this recommendation.
 - Comparisons between urban and rural treatment/control groups and male and female treatment/control groups.
Follow-up Response: This level of comparison has not been reported.

Telephone Outreach – Unable to Contact by Telephone Written Communication/Mailer:

- To more fully assess the intervention, review the success and barriers of the various stages of the intervention. Provide denominators for the number of members not successfully reached by phone; number of members receiving a “Did not Reach” letter (and the percent of members not reached by phone who received a Did not Reach letter); number of return calls to the MCO (and percent of members receiving a “Did not Reach” letter who returned a call to the MCO); and number/percent of members with a return call that received a vaccination within 90 days of the return call; number of undeliverable letters.
Follow-up Response: Sunflower provided additional data pertaining to the various stages of the intervention.

Mailing HPV Specific Informational Materials:

- Since the goal is for 100% of the study population to receive the mailings, the MCOs need to identify the percent (including numerator/denominator) of the study population who received the PIP-specific mailing. If 100% did not receive mailings, provide a rationale in the report.
Follow-up Response: The MCOs stated, “Data collection sources include the HPV HEDIS® denominator to determine who should receive HPV-specific mailings. The number of members eligible to receive mailings is identified by the number of non-compliant members (those who have not completed the HPV series by their 13th birthday) in the MCO population denominator for the HPV measure.” They noted, “This number represents 100% of the HPV non-compliant population. MCOs can send mailers to this larger group or send to only the 12-year-old non-compliant members who have not yet turned 13 years of age.” There is no longer a stated goal for 100% of the study population to receive mailings.
- Revise the effectiveness measure to capture those who received a dose of the HPV vaccine “within 90 days after the mailing date” and ensure reported vaccination data is tied to a mailing time-period. If there is a spring and fall mailing, there would be two time-period where three months of vaccination data is captured after each mailing. If the MCO continues to capture vaccinations at any point in time for those that received a mailing, ensure the measurement rate only captures those within 90 days after the mailing date.
Follow-up Response: In a couple of sentences the MCOs note “within the 90 days following the date of mailing.” However, the phrase most frequently used continues to be “within 90 days of the date of the mailing.” The specific clarity is important since it appeared immunizations in the 90 days prior to the mailing date were previously included.

Gap in Care Report/Profiles to Providers:

- Provide further information regarding the number of providers who have members not up-to-date on the HPV vaccination. If the number does not generally match the number of Gaps in Care reports sent, provide further detail. If the number sent is lower than the number who have members not up-to-date, clarify how the MCO determines who receives a report. If the number sent is higher than the number of targeted providers, clarify whether these are multiples sent to the same provider and identify the unique number of providers receiving at least one Gap in Care report.
Follow-up Response: The number of provider clinics who have members not up-to-date on the HPV vaccination can be determined, although that is not currently documented. Gaps in care reports produced and delivered are directed at provider clinics with a high number of non-compliant HPV members where the most HPV immunization gaps can be closed. Various reasons were provided regarding why they could not identify what triggers a visit or sending a report, including their own internal processes, staffing, and availability to conduct these activities. Also, they noted an MCO

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may alter their process at different times of the year, such as when there is a decrease in the number of providers at the end of the year with gaps in care as member vaccinations increase.

Detailed Reports Informing Providers of Their Overall Performance:

- Identify a method(s) to evaluate the effectiveness of the Provider Profile reports and determine a goal.
Follow-up Response: In 2019, Sunflower added the number and percent of previously non-compliant members who received a dose of the HPV vaccine within 90 days of the provider profile date. UnitedHealthcare cannot use the same measure since they do not include member level detail in their provider profile reports.

CAHPS Survey Validation

1. For the child surveys, each MCO should comply with NCQA CCC survey protocols to ensure adequate numbers of surveys are completed in each subgroup to obtain generalizable results that meet NCQA requirements.

- **SHP 2019 Update Response:**
SPH Analytics is the NCQA approved survey vendor utilized by Sunflower Health Plan. Sunflower utilizes the Child with Chronic Condition survey protocol for both the Title XIX and Title XXI surveys and requests over samples for these populations in an effort to ensure responses that are adequate to optimize on CAHPS reporting.
- **UHC 2019 Update Response:** No response was received as of the report date.

KFMC 2019 Update: Sunflower and UnitedHealthcare appeared to be compliant with NCQA protocols. The SHP TXIX and TXXI CCC populations and the UHC TXIX CCC population each returned over 411 completed surveys, the NCQA-specified goal. The UHC TXXI CCC population returned fewer than 411 surveys, but this may be attributed to a lower than expected response rate rather to the sampling methodology. The numbers of returned surveys for the UHC and SHP TXXI CCC populations in 2019 were much higher than 2018 and 2017 counts but were lower than the numbers returned in 2015 and 2016. The UHC TXXI CCC completed 348 surveys in 2019 compared to 169 (2018), 263 (2017), 563 (2016) and 433 (2015). The completed surveys for the UHC TXIX GC and TXXI CCC survey populations did not meet the NCQA requirements. In 2019, the TXXI CCC population had nine questions and two composites scores that were unable to be ranked (QC NA rank), compared to two for each of the other three CCC populations. Sunflower’s TXXI CCC population completed 471 surveys in 2019 compared to 452 in 2018. Sunflower’s sample sizes required for child surveys met NCQA sample requirements in 2018. In 2019, SHP had only five questions and two composite scores that received QC NA rank.

2. All MCOs should continue and expand their care coordination efforts, particularly for children with chronic conditions, to promote improvement of the MCO and provider assistance in coordinating the child’s care among different providers and services. Consider obtaining feedback from members (e.g., through supplemental CAHPS questions, patient and family advisory committees, focus groups) to better understand their expectations regarding CCC coordination of care, the type of assistance, if any, they want, and how the MCO and providers can improve.

- **SHP 2019 Update Response:**
Sunflower continues to increase care coordination efforts utilizing member feedback from the Member Advisory Committee and LTSS Advisory Committee. Member Feedback is also elicited,

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not only from CAHPS, but, in the LTSS CM Survey, PHM CM Survey, and Behavioral Health Survey. The annual Provider Satisfaction Survey asks providers their view of continued care coordination. Communication between primary care providers and other health care providers is included in the provider workshop trainings (local, face to face meetings in local communities like Topeka) and the provider online quarterly orientations (webinars offered each quarter for new providers or providers who like a refresher). Sunflower increased provider trainings to monthly via workshops, webinars, and All-MCO trainings.

- **UHC 2019 Update Response:** No response was received as of the report date.

KFMC 2019 Update: The 2019 Coordination of Care for Children with Chronic Conditions composite score was 77 (<50th QC). No statistically significant increase in the score was seen compared to 2018; however, the ranking was higher than in 2018 (<25th QC). The primary driver of the low scores continues to be low rates for 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?” For both MCOs’ TXIX and TXXI CCC populations, percentages for Q29 ranged from 58% to 63%.

3. MCOs should encourage providers to improve and expand communications between providers and members regarding illness prevention. SHP should continue their provider trainings and member education as implemented in 2018 and planned in 2019. UHC should continue to implement their 2019 improvement efforts as planned. Both MCOs should consider methods to evaluate the effectiveness of provider communications, trainings and education to help determine whether changes to the improvement efforts are needed prior to 2020.

- **SHP 2019 Update Response:**

Sunflower has increased provider trainings in 2019 to monthly and has continued the monthly trainings in 2020. The trainings capture education for communication between providers and members. In addition to the trainings, Sunflower provides an annual mailer providing suggestions for best communication practices between providers and members, this is also found in the handbooks for each, respectively. Sunflower sends monthly lists to selected providers via email that include members who are not compliant for preventive screenings such as well child visits or immunizations. A survey is provided to providers after Sunflower trainings to help provide Sunflower best practices and provider understanding.

- **UHC 2019 Update Response:** No response was received as of the report date.

KFMC 2019 Update: Overall, scores and rankings for KanCare adult and child populations (Adult: 73, <50th QC; GC: 73, ≥50th QC; CCC: 75, <25th QC) did not show any improvement in 2019. No statistically significant trends over five years (2015–2019) were seen for the composite scores for KanCare adult and child populations.

4. MCOs should continue to increase efforts to ensure members receive a flu shot annually. Consider obtaining feedback from members and providers (e.g., additional survey questions, focus groups, patient and family advisory councils, provider advisory groups) regarding barriers to annual flu vaccinations. Assess whether more targeted interventions are needed; consider analyzing data to determine variation in rates by certain demographics.

- **SHP 2019 Update Response:**

Sunflower Health Plan implements the following initiatives to Plan members to encourage the flu shot vaccination: postcards, public service announcements, webinars to OB/GYN providers, brochures, inter-active voice recording (IVR), Start Smart for Babies (SSFB) text, Sunflower

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webpage posting, social media alerts, Proactive Outreach Manager (POM) calls to members, and other educational flu material (such as KRAMES) sent to members. Sunflower hosts the Member Advisory Committee to elicit feedback from members to include access to services. Sunflower continues to increase health plan ratings year over year, this includes pregnant women, youth under 5, and members with Chronic Conditions. CAHPS Flu data results is further segmented by regions to further assist in analysis.

- **UHC 2019 Update Response:** No response was received as of the report date.

KFMC 2019 Update: The KanCare rate for 2019 was 53% (54% for Sunflower and 52% for UnitedHealthcare), which indicates there is still opportunity for improvement. No statistically significant difference was seen compared to 2018, however the average rate of increase from 2014 to 2018 for the KanCare rates was 2.1 percentage points per year. The steady increase in rates and high QC rankings (>90th QC for 2017 to 2019) may be considered strengths for KanCare and the MCOs.

5. MCOs should continue to increase efforts and options to promote smoking cessation. Consider coordinated efforts/communications between MCOs to encourage providers to routinely give advice to quit smoking, and to discuss medications and other methods to assist with quitting smoking.

- **SHP 2019 Update Response**

Sunflower continues utilizing Nurtur Disease Management, now named Envolve People Care (EPC), to facilitate the smoking cessation initiative. EPC utilizes health coaching and member education to assist members. Of those members referred to the EPC smoking cessation program, 94% enrolled in services to assist with cessation. Member education materials related to smoking cessation are listed on the Sunflower Health Plan website, in the Member Handbook, and in the member newsletters. Sunflower continues to ask all three questions related to smoking cessation on the 2019 Adult CAHPS survey with the member self-reported results remaining about the same with some variances. Additionally, Sunflower provides KRAMES educational materials to members on smoking cessation. Sunflower provides information for providers in the CAHPS resources to include smoking cessation into their communications with members. Efforts at the health plan will continue in 2020.

- **UHC 2019 Update Response:** No response was received as of the report date.

KFMC 2019 Update: About one-third of the KanCare adult respondents reported they were currently cigarette smokers or tobacco users. No statistically significant difference was seen compared to 2018. The 2019 results showed only 76% of current smokers and tobacco users received advice on quitting from their health providers. Health providers of only about half of these members discussed or recommended medications to assist with quitting; these percentages were not statistically different from 2018 percentages. The 2019 ranking (<50th QC) was lower than in 2018 for SHP and the same as in 2018 for UHC (≥50th QC). Sunflower’s Discussing Cessation Strategies percentage dropped from 51% (>75th QC) in 2018 to 44% (n = 131, <33.33rd QC) in 2019. In contrast, UnitedHealthcare’s 2019 percentage 48% (n = 134, ≥50th QC) was higher than the 2018 percentage (41%, <33.33rd QC). Although statistical testing did not show the changes to be significant, they may prove to be so if the trend continues.

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6. MCOs should further review their processes for encouraging providers to assess and respond to members’ ratings of their mental health and emotional status, and for encouraging members to access mental health or substance use disorder services.

- **SHP 2019 Update Response**

Sunflower reviews and analyzes data annually relating to continuity and coordination of medical and behavioral health care. In 2019, Sunflower identified opportunities and initiated actions to conduct targeted education with provider’s on using the online provider portal to gather information about other providers members are seeing to help physicians know other physicians their patients are seeing. To help facilitate physician knowledge, Sunflower continued to provide behavior health discharge summaries to physicians, with member release of information. The care management (CM) team also continued to utilize CM contact to encourage release of information to help coordinate care. Provider profiles continued to be utilized in 2019 to assist with provider awareness of medication adherence. A significantly impacting and ongoing barrier is members being reluctant to engage with providers or the health plan representatives regarding behavior healthcare. Sunflower continues to develop partnerships with CMHC’s to reach out to members who they have relationships with to assist with members care. Sunflower sends out a provider newsletter that serves as a tool for sharing CAHPS results, strengths, opportunities, and serves as an opportunity to encourage feedback and partnerships with stakeholders. Results are shared in various Sunflower committees, which provides additional opportunities for network providers to provide their input and feedback on initiatives and opportunities for continued improvement. The Sunflower Provider Resources web page is utilized to share with providers a variety of added benefits for members to assist physicians with achieving best outcomes. MyStrength, a value-added program, is a digital behavioral health program contains online tools to help members overcome depression and anxiety; members and providers are able to access the program. Providers are provided the value-added benefit information at Sunflower trainings. Project ECHO is a resource available for providers found on the Sunflower Provider web page, also. Project ECHO connects work to bridge health gaps using ongoing case-based learning and tele-mentoring; it is a virtual immersion training. Sunflower continues efforts of robust trainings for providers in 2020 to address the behavioral and emotional wellness of members and provider support.

- **UHC 2019 Update Response:** No response was received as of the report date.

KFMC 2019 Update: In 2019, only one-third of the KanCare adult respondents rated their overall mental and emotional health as *excellent* or *very good* (32%). For KanCare GC respondents, two-thirds rated their child’s mental and emotional health as *excellent* or *very good* (68%), whereas for KanCare CCC, one-third of the respondents rated their child’s mental and emotional health as *excellent* or *very good* (38%). The 2019 and 2018 percentages for the adult population were similar, whereas the 2019 percentages for both child populations were significantly lower than in 2018.

7. MCOs should continue efforts implemented in 2018 to address barriers to accessing services during and after hours. Review results from implemented efforts in conjunction with other MCO Access Monitoring to identify specific opportunities for improvement in 2019.

- **SHP 2019 Update Response:**

Sunflower continues efforts implemented in 2018 through 2019 to address barriers to accessing provider services during after-hours time frames. The Sunflower internal goal was met as denoted in the 2019 CAHPS survey questions 56 (Adult) and 85 (Child), stating that members were able to get the advice needed after regular office hours, and zero member complaints

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regarding primary care after-hours access in 2019, meeting the Sunflower goal. In addition to the CAHPS survey, Sunflower conducts an additional after-hours survey annually, to discern provider access after business hours—just under two-thirds were compliant. In 2018, the Sunflower Provider Relations team held 6 training sessions for providers including the topics of after-hours access and appointment availability standard. These trainings continued for 2019. Sunflower conducts the annual survey to assess after-hours and appointment availability, then provides follow up outreach to providers identified as not meeting the standards for appointment availability and after-hours and addressed, as appropriate. The barrier continues to be lack of provider knowledge regarding the appointment standards. This is addressed through the provider handbook, member handbook, trainings and follow-up outreach after the annual health plan access survey for non-compliant practices.

- **UHC 2019 Update Response:** No response was received as of the report date.

KFMC 2019 Update: For the adult populations of both MCOs, composite scores for getting care quickly and getting needed care were less than 90, but progress is being made. In 2019, there was a statistically significant improvement in the UHC adult composite score for getting needed care. Both MCOs had non-significant increases in their scores for getting care quickly. For all GC and CCC respondents of both MCOs, composite scores for getting care quickly were greater than 90. The 2019 composite scores for getting needed care for the SHP TXIX, for both MCOs’ TXXI GC populations and TXIX and TXXI CCC populations were 90 or greater, whereas the score for the UHC TXIX GC population (85) and was significantly lower than 2018. The KanCare scores for the *getting needed specialist appointments quickly* component of the composite for the adult (84), GC (82), and CCC populations (88) continued to show a potential for improvement.

HCBS CAHPS Survey

There were no previous quality improvement recommendations to address for the HCBS CAHPS survey, as this was the first year of the survey.

Mental Health Survey

KFMC reviewed the previous recommendations from KFMC’s 2018 report (four Quality, Timeliness, and Access to Health Care Services; one Technical). The State provided an update on the extent to which the 2018 recommendations were addressed.

- The Behavioral Health Services Commission (BHS) continues to work with Community Mental Health Centers (CMHCs) to maintain and improve quality of care. Through the use of telehealth services, access to a psychiatrist and other mental health professionals continues to improve, especially in rural and frontier areas of the state. The Commission is working to encourage and expand evidence-based practices including the Individualized Placement and Support for Supported Employment throughout the state to provide more access to paid employment for consumers. In addition, the Commission is expanding Peer Support and connection to Consumer Run Organizations throughout the state with the Certified Peer Support Specialist training.
- The BHS also continues to work on improving the quality of health care services for Youth through the Systems of Care initiative (SOC). SOC initially partnered with four CMHCs in both rural and urban areas of the state. Continued positive outcomes of the collaboration include the expansion of parent peer support services and continued training for both families and the workforce to better support

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youth with mental health needs. BHS is also engaged in expanding the initiative beyond the original partners.

- BHS is also engaged in a more in-depth review of youth waiting for services in a PRTF to ensure that children are receiving the appropriate services in the community first so that higher levels of care may not be necessary. Ensuring the right care in the community will improve family life and enable youth to cope better when things go wrong.

Provider Survey Validation

ABH of Kansas conducted the Provider Satisfaction Survey for the first time in 2019, so there were no prior recommendations.

There were no previous recommendations for Sunflower and UnitedHealthcare, as the MCO Provider Satisfaction Surveys were not included in the EQRO contract last year.

Review of Compliance with Medicaid and CHIP Managed Care Regulation

Sunflower responded to and submitted documentation for the 2018 follow-up review. Of the 19 recommendations requiring follow-up from the previous review (2017), there were 46 individual items identified for improvement. Of the 46 individual items, 1 item was still in progress and 29 were fully met or not applicable in 2018. Of the 29 full met items, Sunflower brought 19 into full compliance; 2 items were fully met in the 2017 review but opportunity for improvement was identified and the recommendations were completed (fully met) in 2018; and 8 were no longer applicable (see Appendix C). The 16 items that were not brought into full compliance and the 1 item that is still in progress that continue to have opportunity for improvement are:

- §438.206(b)(1)(iv-v) Availability of Services – Delivery Network (Providers not accepting new patients and geographic location of providers and Medicaid enrollees): **Partially Met** (7 items) and **Still in Progress** (1 item)
- §438.206(c)(1)(iii) Furnishing of Services – Timely Access (24 hours/7 days per week): **Partially Met** (1 item)
- §438.214(b)(2) Provider Selection [provider credentialing case review]: **Partially Met** (1 item)
- §438.230(b)(3) Sub-contractual Relationships and Delegation – Specific Conditions (MCO monitors subcontractor’s performance): **Substantially Met** (7 items)

UnitedHealthcare responded to and submitted documentation for the 2018 follow-up review. Of the 15 recommendations requiring follow-up from the previous reviews (2016 and 2017), there were 48 individual items identified for improvement. Of the 48 individual items, 2 items were still in progress and 40 were fully met or not applicable in 2018. Of the 40 fully met items, UnitedHealthcare brought 29 into full compliance; 8 were fully met or had no rating in the 2016 and/or 2017 review but opportunity for improvement was identified and the recommendations were completed (fully met) in 2018; and 3 were no longer applicable (see Appendix C). The 6 items that were not brought into full compliance and the 2 items that were still in progress that continue to have opportunity for improvement are:

- §438.214(b)(2) Provider Selection [provider credentialing case review]: **Substantially Met** (2 items)

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- §438.206(b)(1)(iv–v) Availability of Services – Delivery Network (Network adequacy): **Partially Met** (4 items) and **Still in Progress** (1 item)
- §438.214(e) Provider Selection – Additional State Requirements: **Still in Progress** (1 item)

QAPI Assessment

Because this is the first year for KFMC’s MCO QAPI review, there are no prior recommendations.

Appendix E

KanCare Program Annual External Quality Review Technical Report

2019 – 2020 Reporting Cycle

List of Related Acronyms



List of Related Acronyms	
Acronym	Description
ABH	Aetna Better Health of Kansas (Aetna)
AGP	Amerigroup Kansas, Inc. (Amerigroup)
APC	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS measure)
BH	Behavioral Health
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CCC	Children with Chronic Conditions
CCS	Cervical Cancer Screening (HEDIS measure)
CDC	Comprehensive Diabetes Care
CHIP	Children’s Health Insurance Program (Title XXI)
CHIPRA	Children's Health Insurance Program Reauthorization Act
CMHC	Community Mental Health Center
CMR	Comprehensive Medication Reviews
CMS	Centers for Medicare & Medicaid Services
CPC	Clinical Practice Consultants
CY	Calendar Year
DOO	Disclosure of Ownership
DSS	DSS Research (UnitedHealthcare subcontractor)
DTaP	Diphtheria, Tetanus, and Acellular Pertussis Vaccine
DVO	Delegated Vendor Oversight
EQR	External Quality Review
EQRO	External Quality Review Organization
FA	Fiscal Agent
GC	General Child CAHPS survey population
HbA1c	Hemoglobin A1c
HCBS	Home and Community Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HiB	Haemophilus Influenzae Type B Vaccine
HPV	Human Papillomavirus
I/DD	Intellectual/Developmental Disability
IMA	Immunizations for Adolescents (HEDIS measure)
IPV	Inactivated Polio Vaccine
ISC	Integrated Service Coordination
ISCA	Information Systems Capabilities Assessment
KDADS	Kansas Department for Aging and Disability Services
KDHE	Kansas Department of Health and Environment
KDHE-DHCF	Kansas Department of Health and Environment, Division of Health Care Finance
KFMC	Kansas Foundation for Medical Care, Inc. (the EQRO)
KKMAR	KanCare Key Management Activities Reports
LEIE	List of Excluded Individuals and Entities
LTC	Long-term Care
MCO	Managed Care Organization
MHSIP	Mental Health Statistics Improvement Program

List of Related Acronyms	
Acronym	Description
MIP	Member Incentive Program
MMIS	Medicaid Management Information Systems
MMR	Measles, Mumps, and Rubella Vaccine
MTM	Medication Therapy Management
MY	Measurement Year
NA	Not Available
NCC	National Call Center
NCQA	National Committee for Quality Assurance
NOA	Notice of Action
OIG	Office of the Inspector General
P4P	Pay-for-Performance
PCP	Primary Care Provider
PH	Physical Health
PIP	Performance Improvement Project
PMV	Performance Measure Validation
PRTF	Psychiatric Residential Treatment Facility
Q	Question
QAPI	Quality Assessment and Performance Improvement
QC	Quality Compass (NCQA)
SED	Serious Emotional Disturbance
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (HEDIS measure)
SHP	Sunflower Health Plan of Kansas (Sunflower)
SSI	Supplemental Security Income
Tdap	Tetanus, Diphtheria toxoids, and Pertussis Vaccine
Title XIX	Title XIX Grants to States for medical assistance programs (Medicaid)
Title XXI	Title XXI State Child Health Insurance Programs (CHIP)
TMR	Targeted Medication Review
TXIX	Title XIX Grants to States for medical assistance programs (Medicaid)
TXXI	Title XXI State Child Health Insurance Programs (CHIP)
UHC	UnitedHealthcare Community Plan of Kansas (UnitedHealthcare)
VZV	Varicella Zoster Vaccine (Chicken Pox Vaccine)
W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (HEDIS measure)