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April 27, 2022

Laura Leistra
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, 2021–2022 Reporting Cycle

Dear Ms. Leistra:

Enclosed is the KanCare Annual External Quality Review technical report for the 2021–2022 reporting cycle of Aetna Better Health of Kansas, Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas.

This report includes summaries of reports for the following activities: Performance Measure Validation (PMV) and follow-up to Information Systems Capabilities Assessment (ISCA) recommendations, Performance Improvement Project (PIP) Validation, CAHPS 5.1H Survey Validation, Mental Health Consumer Perception Survey, Provider Survey Validation, Review of Compliance with Medicaid and CHIP Managed Care Regulations, Quality Assessment Performance Improvement (QAPI) Review, and Network Adequacy Validation.

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, bnech@kfmc.org, if you have any questions regarding this report.

Sincerely,

Beth Nech, MA

Beth Nech, MA
EQRO Manager

Electronic Version: Shirley Norris, Director of Managed Care

Enclosures

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HEALTH IMPROVEMENT PARTNERS

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ACCREDITED
Independent Review Organization: External Review Expires 06/01/2024

KanCare Program Annual External Quality Review Technical Report

2021–2022 Reporting Cycle

Contract Number: 46100

Submission Date: April 27, 2022

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TABLE OF CONTENTS

Appendices

Tables

Report:

KanCare Program Annual External Quality Review Technical Report Aetna Better Health of Kansas, Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas 2021–2022 Reporting Cycle Submission Date: April 27, 2022

Introduction

KFMC Health Improvement Partners (KFMC), under contract with the Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF), serves as the External Quality Review Organization (EQRO) for KanCare, 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 (BH) 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, UHC, or UHCCP) have provided KanCare managed care services since January 2013.

As the EQRO, KFMC evaluated services provided in 2020/2021 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 May 2021 through April 2022) 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) Review
- Performance Improvement Project (PIP) Validation
- Consumer Assessment of Health Care Providers and Systems (CAHPS®) Survey Validation[1]
- Provider Survey Validation
- Network Adequacy Validation

KFMC also conducted a Mental Health (MH) Consumer Perception Survey to evaluate the KanCare program, reflecting combined MCO performance.

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 these activities, including objectives;

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

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 primarily focus on those related directly to improving health care quality, access, and timeliness; additional technical, methodological, and general recommendations to the MCOs are included in the individual reports submitted to the State. The Quality Management Strategy section contains suggestions, based on the EQR findings, for how the State can target goals and objectives in the KanCare Quality Management Strategy (QMS).

KFMC used and referenced the following CMS EQR Protocol worksheets and narratives in the completion of these activities[2]:

- EQR Protocol 1: Validation of Performance Improvement Projects
- EQR Protocol 2: Validation of Performance Measures
- EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations
- EQR Protocol 6: Administration or Validation of Quality of Care Surveys
- EQR Protocol A: Information Systems Capabilities Assessment

The Coronavirus Disease 2019 (COVID-19) pandemic has affected the health and well-being of individuals, has disrupted social systems, and has presented barriers to economic opportunities. On March 11, 2020, the World Health Organization declared COVID-19 a global pandemic. The State of Kansas and Kansas counties responded to the pandemic with a variety of executive orders and disease containment measures such as stay-at-home orders and expansion of telemedicine. In the days and weeks following the executive orders, health care providers took steps to adapt their facilities and procedures to protect the health of staff and patients. During this time, access to care (such as for non-urgent or elective procedures) may have been reduced. During 2020, COVID-19 pandemic impacted MCO operations including service delivery, survey administration, data collection, and performance improvement interventions.

Vaccinations against COVID-19 began in December 2020, bringing some relief to the health care systems. However, in May 2021 Kansas reported its first case of the Delta variant, which created a surge in cases that began in October 2021 and peaked in January 2022. Member utilization of service, provider resources for care delivery and quality improvement projects, and in-person activities continued to be impacted by the pandemic. More details regarding the potential impact of COVID-19 are described throughout this report.

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[2] Centers for Medicare and Medicaid Services. *CMS External Quality Review Protocols*. October 2019. OMB Control No. 0938-0786.

Summary of Individual EQR Components

1. ISCA and PMV

Background/Objectives

KanCare MCOs are required to register with the National Committee for Quality Assurance (NCQA) and undergo an annual NCQA Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit™, which conveys sufficient integrity to HEDIS data used by consumers and purchasers to compare healthcare organization performance.[3] The State required Aetna, Sunflower, and UnitedHealthcare to report HEDIS Measurement Year (MY) 2020 data through the NCQA data submission portal and undergo an ISCA. Baseline ISCAs were conducted with Sunflower and UnitedHealthcare in 2013 and with Aetna in 2019; all MCOs provided biennial updates in 2021. KFMC also evaluated the MCOs' performance of the Adult and Child Core Set measures to provide an understanding of the strengths and opportunities for improvement related to quality, timeliness, and access to care.

The ISCA/PMV process had five main objectives:

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

The evaluation of performance focused on CMS Adult and Child Core Set HEDIS measures and included

- Calculating state-wide aggregate (KanCare) rates,
- Comparing the current year's KanCare and MCO rates to prior year's rates,
- Ranking rates according to Quality Compass® national percentiles, and
- Analyzing the most recent data (three to five years, depending on the measure) for trends.[4]

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

Technical methods for the performance measure validation and evaluation activities are detailed in Appendix B, Performance Measure Validation and Evaluation Methodology.

Performance Measure Validation

In addition to the HEDIS Compliance Audit that NCQA requires of the MCOs, the State requires the EQRO to use a NCQA-Certified HEDIS Compliance Auditor to conduct its PMV. KFMC contracted with MetaStar, Inc. (MetaStar), an NCQA-Certified HEDIS Compliance Auditor that is independent of the HEDIS Compliance Auditors contracted by the KanCare MCOs. KFMC worked closely with MetaStar and the MCOs throughout the validation process.

[3] HEDIS® and NCQA HEDIS Compliance Audit™ are registered trademarks of the National Committee for Quality Assurance (NCQA).
[4] Quality Compass® is a registered trademark of the National Committee for Quality Assurance.

Performance Measure Evaluation

MCO data were aggregated for KanCare-level results. This report contains KanCare and MCO results for CMS 2021 (MY 2020) Adult and Child Core Set measures that include rates, rankings, and indicators for notable changes in rates.[5]

- Adult Core Set (Table 1.1): 17 HEDIS measures, including 2 measures derived from the CAHPS surveys. The Plan All-Cause Readmission (PCR) measure is risk-adjusted and reported according to observed versus expected hospital readmissions.
- Child Core Set (Table 1.2): 13 HEDIS measures.

Ranks are denoted, in order of worst to best performance: <5th, <10th, <25th, <33.33rd, <50th, ≥50th, >66.67th, >75th, >90th, and >95th. For example, a rate ranked <10th will be less than the Quality Compass national 10th percentile but not less than the 5th percentile. Note that, as percentiles are based on HEDIS rates from across the nation, some measures with high scores in Kansas may rank very low due to high scores nationwide.

An objective of the KanCare Quality Management Strategy is to improve HEDIS rates that are below the national 75th percentile by at least 10% of the difference between that rate and the performance goal (the goal is 100% or 0%, depending on the measure).[6] In alignment with this objective, Table 1.1 and Table 1.2 indicate measures that had a "gap-to-goal" percentage change of at least 10%. The tables also indicate changes of at least 3.0 percentage points per year (pp/yr) averaged across three to five years and, for hybrid and survey measures, statistically significant changes from the prior year and statistically significant trendlines (see Appendix B for additional information).

Due to the COVID-19 pandemic, NCQA advised caution when evaluating health plan performance with MY 2020 Quality Compass data.

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[5] Data were available for trending KanCare rates from Sunflower and UnitedHealthcare for measurement years 2016 to 2020, from Aetna for 2019 and 2020, and from Amerigroup Kansas, Inc. (Amerigroup) for 2016 to 2018.

[6] *KanCare Quality Management Strategy*. State of Kansas, December 9, 2021, www.kancare.ks.gov/quality-measurement/QMS. Accessed March 14, 2022.

Table 1.1. HEDIS Performance Measures (Measurement Year 2020) – Adult Core Set

Indicators of strength or improving rates, shown with green font or letters "a," "b," "c," and "d":
Quality Compass ranks >90th or >95th (i.e., rates above the 90th percentile)
"a" Statistically significant improvement from the prior year (hybrid or survey only)
"b" At least 10.00% gap-to-goal improvement in rate from prior year based on a goal of 100% or 0%, depending on the measure
"c" Average improving trend of at least 3.0 percentage points per year (pp/yr) in rates over 3 to 5 years, depending on the measure
"d" Statistically significantly improving trend over 3 to 5 years, depending on the measure (hybrid or survey only)

Indicators of opportunities for improvement or worsening rates, shown in purple font or letters "w," "x," "y," and "z":
Quality Compass ranks <10th or <5th (i.e., rates below the 10th percentile)
"w" Statistically significant worsening from prior year (hybrid or survey only)
"x" At least 10.00% gap-to-goal worsening in rate from prior year based on a performance goal of 100% or 0%, depending on the measure
"y" Average worsening trend of at least 3.0 pp/yr in rates over 3 to 5 years, depending on the measure
"z" Statistically significant worsening trend over 3 to 5 years, depending on the measure (hybrid or survey only)

Other Indicators:
"n" Prior years' rates not available (measure was new or had a break in trend due to changes to the measure's technical specifications)
"NA" Quality Compass ranking was not available.

Measures & Indicators*		KanCare^		Aetna		Sunflower		UnitedHealthcare	
		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
AMM *A*	**Antidepressant Medication Management**								
	– Effective Acute Phase Treatment	**53.66**	<50th	51.63	<25th	53.30	<33.33rd	**55.58** b	<50th
	– Effective Continuation Phase Treatment	**38.30**	<33.33rd	38.24	<33.33rd	37.36	<33.33rd	**39.34**	<50th
AMR *A*	**Asthma Medication Ratio**								
	– 19–50 Years	56.47	≥50th	52.27 n	<33.33rd	61.21 c	>75th	54.70 b	<50th
	– 51–64 Years	54.30 b	<50th	50.70 n	<25th	52.33 b	<25th	57.46 b	≥50th
	– 19–50 and 51–64 Years	56.06	NA	51.99 n	NA	59.82 c	NA	55.33 b	NA
BCS *A*	**Breast Cancer Screening**	**48.66**	<33.33rd			**49.49**	<33.33rd	47.74	<25th
CBP *H*	**Controlling High Blood Pressure**	60.33 n	>66.67th	57.42 n	≥50th	57.42 n	≥50th	65.21 n	>75th
CCS *H*	**Cervical Cancer Screening**	59.77	≥50th	**49.88** b	<25th	62.04 c d	>66.67th	64.48	>75th
CDC *H*	**Comprehensive Diabetes Care**								
	– Poor HbA1c Control *(lower is better)*	36.64	>75th	41.36	≥50th	**38.20** a b	>75th	31.63 c d	**>90th**
CHL *A*	**Chlamydia Screening in Women**								
	– 21–24 Years	**51.17** x	<25th	**49.96** x	<25th	**52.03**	<25th	**51.05** x	<25th
FUA *A*	**Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (18+ years)**								
	– 7-Day Follow-Up	15.87	≥50th	19.46	>75th	14.49	≥50th	13.73	≥50th
	– 30-Day Follow-Up	21.81	≥50th	24.57	≥50th	19.60	<50th	21.03	<50th
FUH *A*	**Follow Up After Hospitalization For Mental Illness (18–64 years)**								
	– 7-Day Follow-Up	45.16	>75th	**41.17** x	>66.67th	46.67	>75th	46.64	>75th
	– 30-Day Follow-Up	65.25	>75th	61.67	>66.67th	66.26 x	>75th	66.90	>75th
FUM *A*	**Follow-Up After Emergency Department Visit for Mental Illness (18–64 years)**								
	– 7-Day Follow-Up	**64.29**	**>90th**	64.80 b	**>90th**	63.13 c	**>90th**	65.01 b	**>90th**
	– 30-Day Follow-Up	**76.65** b	**>95th**	**77.30** b	**>95th**	76.06 b	**>90th**	76.73 b c	**>95th**

* "A" denotes an administrative method of data collection was used; "H" denotes a hybrid method.
^ The KanCare rate is the average of the MCO adult population rates, weighted by administrative denominator.

Table 1.1. HEDIS Performance Measures (Measurement Year 2020) – Adult Core Set (Continued)

Indicators of strength or improving rates, shown with green font or letters "a," "b," "c," and "d":
Quality Compass ranks >90th or >95th (i.e., rates above the 90th percentile)
"a" Statistically significant improvement from the prior year (hybrid or survey only)
"b" At least 10.00% gap-to-goal improvement in rate from prior year based on a goal of 100% or 0%, depending on the measure
"c" Average improving trend of at least 3.0 percentage points per year (pp/yr) in rates over 3 to 5 years, depending on the measure
"d" Statistically significantly improving trend over 3 to 5 years, depending on the measure (hybrid or survey only)

Indicators of opportunities for improvement or worsening rates, shown in purple font or letters "w," "x," "y," and "z":
Quality Compass ranks <10th or <5th (i.e., rates below the 10th percentile)
"w" Statistically significant worsening from prior year (hybrid or survey only)
"x" At least 10.00% gap-to-goal worsening in rate from prior year based on a performance goal of 100% or 0%, depending on the measure
"y" Average worsening trend of at least 3.0 pp/yr in rates over 3 to 5 years, depending on the measure
"z" Statistically significant worsening trend over 3 to 5 years, depending on the measure (hybrid or survey only)

Measures & Indicators*		KanCare^		Aetna		Sunflower		UnitedHealthcare	
		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
FVA *C*	**Flu Vaccinations for Adults Ages 18–64**	47.13	>75th	47.67	>75th	50.77	**>90th**	**43.39** w x	>66.67th
IET *A*	**Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**								
	Initiation of AOD (18+ years)								
	– Alcohol Abuse or Dependence	44.09	≥50th	45.97	>66.67th	43.06	≥50th	43.33	≥50th
	– Opioid Abuse or Dependence	41.43	<25th	**45.17** b	<25th	45.00 c	<25th	36.20	**<10th**
	– Other Drug Abuse or Dependence	**44.69** c	≥50th	45.15	≥50th	45.92 c	>66.67th	**43.15** c	≥50th
	– Total	**43.37** c	<50th	44.59	≥50th	44.33 c	≥50th	**41.51** c	<33.33rd
	Engagement of AOD (18+ years)								
	– Alcohol Abuse or Dependence	10.56	<50th	10.41	<50th	9.29	<50th	11.88	≥50th
	– Opioid Abuse or Dependence	11.97	<25th	12.07	<25th	12.78	<25th	11.26	<25th
	– Other Drug Abuse or Dependence	12.53	≥50th	11.87	≥50th	13.44	>66.67th	12.20	≥50th
	– Total	11.72	<50th	10.97	<33.33rd	12.13	<50th	11.95	<50th
MSC *C*	**Medical Assistance with Smoking and Tobacco Use Cessation**								
	– Total % Current Smokers *(lower rate and ranking are better)*	30.28	≥50th	31.01	≥50th	25.49 d	<50th	34.20	>75th
	– Advising Smokers to Quit	**71.97** w x z	<33.33rd	70.00 x	<25th	75.86 x	≥50th	69.77 x	<25th
	– Discussing Cessation Medications	52.54	<50th	45.45	<25th	63.22 c d	**>90th**	47.66 x	<25th
	– Discussing Cessation Strategies	44.09	<33.33rd	44.95	<33.33rd	47.67	≥50th	40.16 x	<25th
PPC *H*	**Prenatal and Postpartum Care**								
	– Postpartum Care	**75.96** a b c	<50th	**76.64** a b	≥50th	68.37 b c	<25th	**83.21** a b c	>75th
SAA *A*	**Adherence to Antipsychotic Medications for Individuals With Schizophrenia**	58.65	<33.33rd	54.93	<25th	56.08	<33.33rd	**63.65** x	≥50th
SSD *A*	**Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications**	**76.17** x	<50th	73.89 x	<33.33rd	**75.69** x	<50th	**78.12** x	≥50th

Risk Adjusted Measure Name & Indicator†		KanCare			Aetna			Sunflower			UnitedHealthcare		
		O	E	O/E	O	E	O/E	O	E	O/E	O	E	O/E
PCR *A*	**Plan All-Cause Readmissions** – Total (18–64 years)	10.46	11.11	0.94	9.72	10.60	0.92	11.19	11.35	0.99	9.84	11.08	0.89

* "A" denotes an administrative method of data collection was used; "H" denotes a hybrid method.
^ The KanCare rate is the average of the MCO adult population rates, weighted by administrative denominator.
† "O" means "observed," "E" means "expected," and ratios O/E less than 1.00 indicates better than expected performance.

Table 1.2. HEDIS Performance Measures (Measurement Year 2020) – Child Core Set

Indicators of strength or improving rates, shown with green font or letters "a," "b," "c," and "d":
Quality Compass ranks >90th or >95th (i.e., rates above the 90th percentile)
"a" Statistically significant improvement from the prior year (hybrid or survey only)
"b" At least 10.00% gap-to-goal improvement in rate from prior year based on a goal of 100% or 0%, depending on the measure
"c" Average improving trend of at least 3.0 percentage points per year (pp/yr) in rates over 3 to 5 years, depending on the measure
"d" Statistically significantly improving trend over 3 to 5 years, depending on the measure (hybrid or survey only)

Indicators of opportunities for improvement or worsening rates, shown in purple font or letters "w," "x," "y," and "z":
Quality Compass ranks <10th or <5th (i.e., rates below the 10th percentile)
"w" Statistically significant worsening from prior year (hybrid or survey only)
"x" At least 10.00% gap-to-goal worsening in rate from prior year based on a performance goal of 100% or 0%, depending on the measure
"y" Average worsening trend of at least 3.0 pp/yr in rates over 3 to 5 years, depending on the measure
"z" Statistically significant worsening trend over 3 to 5 years, depending on the measure (hybrid or survey only)

Other Indicators:
"n" Prior years' rates not available (measure was new or had a break in trend due to changes to the measure's technical specifications)
"NA" Quality Compass ranking was not available.

Measure Name & Indicator*		KanCare^		Aetna		Sunflower		UnitedHealthcare	
		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
ADD *A*	**Follow Up Care for Children Prescribed ADHD Medication**								
	– Initiation Phase	54.17	>75th	49.40 n	>75th	56.34	>90th	55.17	>75th
	– Continuation & Maintenance Phase	61.43	>66.67th	54.88 n	<50th	63.55	>75th	63.47 b	>75th
AMB *A*	**Ambulatory Care** – Emergency Dept Visits/1000 MM (Total) *(lower is better)*								
	– Ages Less Than 1 Year	59.92 n	NA	57.04 n	NA	60.60 n	NA	61.45 n	NA
	– Ages 1–9 Years	29.23 n	NA	27.46 n	NA	29.73 n	NA	30.02 n	NA
	– Ages 10–19 Years	27.21 n	NA	26.67 n	NA	27.40 n	NA	27.43 n	NA
	– Ages 19 Years and Less	30.05 n	NA	28.79 n	NA	30.44 n	NA	30.61 n	NA
AMR *A*	**Asthma Medication Ratio**								
	– Ages 5–11 Years	81.88 b	>66.67th	81.61 n	>66.67th	83.62 b c	>75th	80.15 b	≥50th
	– Ages 12–18 Years	72.85 b	>66.67th	73.12 n	>66.67th	72.88 b c	>66.67th	72.61 b	>66.67th
	– Ages 5–18 Years	77.24 b	NA	77.32 n	NA	77.94 b c	NA	76.34 b	NA
APM *A*	**Metabolic Monitoring for Children and Adolescents on Antipsychotics**	40.40 x y	>75th	37.57 x	>75th	38.97 x y	>75th	44.12 x	>75th
APP *A*	**Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)**	75.08 x	>75th	76.29 x	>75th	75.68	>75th	73.42 x	>75th
CIS *H*	**Childhood Immunization Status**								
	– Diphtheria-Tetanus-Acellular Pertussis (DTaP)	74.67	≥50th	69.10 x	<25th	78.35	>66.67th	74.94	≥50th
	– Haemophilus Influenzae B (HiB)	86.89	<50th	85.40	<50th	88.56	≥50th	86.13	<50th
	– Hepatitis A	88.00	>66.67th	86.13 x	≥50th	90.27 b	>75th	86.86	≥50th
	– Hepatitis B	91.00 x	>66.67th	89.78 x	≥50th	91.24 x	>66.67th	91.73	>75th
	– Inactivated Poliovirus Vaccine (IPV)	89.36	≥50th	88.81 x	≥50th	91.24 b	>66.67th	87.59	<50th
	– Influenza	50.04 a b d	<50th	46.23	<50th	53.04 a b d	≥50th	49.64 d	<50th
	– Measles-Mumps-Rubella (MMR)	87.92 x	<50th	85.89 x	<33.33rd	90.02	>66.67th	87.10 x	<50th
	– Pneumococcal Conjugate	78.09 d	≥50th	72.99 x	<50th	81.02	>75th	78.83 b	≥50th
	– Rotavirus	73.21	≥50th	72.26	≥50th	75.91	>66.67th	70.80	<50th
	– Varicella-Zoster Virus (VZV)	87.28 x	<50th	85.40	<50th	89.78	>66.67th	85.89 x	<50th
	– Combination 10 (all 10 antigens)	39.98 c d	≥50th	35.04	<50th	43.31 d	>66.67th	40.15 d	≥50th

* "A" denotes an administrative method of data collection was used; "H" denotes a hybrid method.
^ The KanCare rate is the average of the MCO adult population rates, weighted by administrative denominator.

Table 1.2. HEDIS Performance Measures (Measurement Year 2020) – Child Core Set (Continued)

Indicators of strength or improving rates, shown with green font or letters "a," "b," "c," and "d":
Quality Compass ranks >90th or >95th (i.e., rates above the 90th percentile)
"a" Statistically significant improvement from the prior year (hybrid or survey only)
"b" At least 10.00% gap-to-goal improvement in rate from prior year based on a goal of 100% or 0%, depending on the measure
"c" Average improving trend of at least 3.0 percentage points per year (pp/yr) in rates over 3 to 5 years, depending on the measure
"d" Statistically significantly improving trend over 3 to 5 years, depending on the measure (hybrid or survey only)

Indicators of opportunities for improvement or worsening rates, shown in purple font or letters "w," "x," "y," and "z":
Quality Compass ranks <10th or <5th (i.e., rates below the 10th percentile)
"w" Statistically significant worsening from prior year (hybrid or survey only)
"x" At least 10.00% gap-to-goal worsening in rate from prior year based on a performance goal of 100% or 0%, depending on the measure
"y" Average worsening trend of at least 3.0 pp/yr in rates over 3 to 5 years, depending on the measure
"z" Statistically significant worsening trend over 3 to 5 years, depending on the measure (hybrid or survey only)

Other Indicators:
"n" Prior years' rates not available (measure was new or had a break in trend due to changes to the measure's technical specifications)

	Measure Name & Indicator*	KanCare^		Aetna		Sunflower		UnitedHealthcare	
		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
CHL *A*	**Chlamydia Screening in Women (16–20 Years)**	**37.86**	<25th	36.54	**<10th**	**38.41**	<25th	38.28	<25th
FUH *A*	**Follow Up After Hospitalization For Mental Illness (6–17 Years)**								
	– 7 Days	59.74	>75th	56.52	>66.67th	62.87	>75th	59.07	>75th
	– 30 Days	78.51	>75th	75.90	≥50th	80.77 x	>75th	78.24 b	>66.67th
IMA *H*	**Immunizations for Adolescents**								
	– Human Papillomavirus (HPV)	34.73 d	<33.33rd	31.87	<25th	37.71	<50th	33.82	<33.33rd
	– Meningococcal	83.28 b c d	<50th	83.70 x	<50th	83.70 c d	<50th	82.48 b c d	<50th
	– Tetanus-Diphtheria-Pertussis (Tdap)	**83.52** w x	<33.33rd	82.73 x	<25th	84.18 x	<33.33rd	83.45	<33.33rd
	– Combination 1 (Meningococcal, Tdap)	81.58 b c d	<50th	81.02 x	<50th	82.73 c d	≥50th	80.78 b d	<50th
	– Combination 2 (Meningococcal, Tdap, HPV)	33.95 d	<50th	30.66	<25th	36.98	≥50th	33.33	<33.33rd
PPC *H*	**Prenatal and Postpartum Care**								
	– Timeliness of Prenatal Care	**80.06** w x y	<33.33rd	77.37 x	<25th	**69.34** w x y	**<10th**	92.70 b	**>90th**
W30 *A*	**Well-Child Visits in the first 30 Months of Life**								
	– First 15 Months	55.10 n	≥50th	49.51 n	<50th	56.97 n	≥50th	57.11 n	≥50th
	– 15 Months–30 Months	65.27 n	<25th	63.43 n	<25th	67.41 n	<50th	64.19 n	<25th
WCC *H*	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents**								
	– BMI Percentile (Total)	**65.06** a b d	<25th	**65.21** a b	<25th	62.53	<25th	67.64 d	<25th
	– Counseling for Nutrition (Total)	58.16	<25th	54.74 b	<25th	61.07	<33.33rd	**57.66** w x	<25th
	– Counseling for Physical Activity (Total)	55.74 d	<25th	52.07 b	<25th	58.15	<33.33rd	55.96 d	<33.33rd
WCV *A*	**Child and Adolescent Well-Care Visits**								
	– 3–11 Years	48.41 n	<50th	46.40 n	<33.33rd	50.60 n	<50th	47.64 n	<50th
	– 12–17 years	46.14 n	≥50th	43.13 n	<50th	48.88 n	≥50th	45.67 n	≥50th
	– 18–21 years	23.90 n	<50th	21.53 n	<50th	26.07 n	≥50th	23.49 n	<50th
	– 3–21 years	45.19 n	<50th	42.77 n	<50th	47.57 n	≥50th	44.58 n	<50th

* "A" denotes an administrative method of data collection was used; "H" denotes a hybrid method.
^ The KanCare rate is the average of the MCO adult population rates, weighted by administrative denominator.

Conclusions Drawn from the Data

The MCOs calculated and submitted HEDIS rates for the 2020 measurement year. The performance measure rates were found to be valid, and no issues were found with the information systems review performed as part of the evaluation. COVID-19 adversely impacted the MCOs' access to certain medical records, but not to the extent that it had a substantial impact on measure reporting. Administrative rates were not affected.

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

KanCare

Performance Measures

The following were considered when determining key strengths (refer to Table 1.1 and Table 1.2): measurement year 2020 rates above the 90th percentile; statistically significant improvements from 2019 (hybrid or survey methods only); at least 10% gap-to-goal improvement in rates from 2019; improvements averaging at least 3 pp/yr since 2016 or 2017 (depending on the measure); and statistically significant improving trends (hybrid or survey methods only) since 2016 or 2017 (depending on the measure).

Generally, the MCOs improved their HEDIS performance rates over the past three to five years. KanCare rates were above the 75th percentile for four Adult and five Child Core Set measure indicators (see Table 1.1 and Table 1.2). The Follow-Up After Hospitalization for Mental Illness (18–64 years) 7-Day Follow-Up indicator ranked >90th, and the 30-Day Follow-Up indicator ranked >95th.

The following KanCare rates for Adult and Child Core Set measure indicators had improvements noted in Tables 1.1 and 1.2; percentage point (pp) changes from 2019 to 2020 and average (pp/yr) improvements over the last three to five years, depending on the type of improvement, are shown below.

- Adult
  - Asthma Medication Ratio, 51–64 years, 5.1 pp
  - Follow-Up After Emergency Department Visit for Mental Illness, 18–64 years, 30-Day Follow-Up, 4.9 pp
  - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependent Treatment
    - Initiation – Other Drug Abuse or Dependence (18+), 3.8 pp, 3.7 pp/yr improving trend from 2017 to 2020
    - Initiation – Total (18+), 3.1 pp, 3.1 pp/yr improving trend from 2017 to 2020
  - Prenatal and Postpartum Care, Postpartum Care, statistically significant 8.9 pp
- Child
  - Asthma Medication Ratio
    - Ages 5–11 Year, 3.5 pp
    - Ages 12–18 Years, 6.2 pp
    - Ages 5–18 Years, 4.7 pp
  - Child Immunization Status
    - Influenza, statistically significant 5.6 pp, statistically significantly improving trend of 2.3 pp/yr from 2016 to 2020
    - Pneumococcal Conjugate, statistically significantly improving trend of 1.0 pp/yr from 2016 to 2020
    - Combination 10 (all antigens), statistically significantly improving trend of 2.7 pp/yr from 2016 to 2020

- Immunizations for Adolescents
  - Human Papillomavirus (HPV), statistically significantly improving trend of 1.3 pp/yr from 2017 to 2020
  - Meningococcal, 2.8 pp, statistically significantly improving trend of 3.7 pp/yr from 2016 to 2020
  - Combination 1 (Meningococcal, Tdap), 2.4 pp, statistically significantly improving trend of 3.6 pp/yr from 2016 to 2020
  - Combination 2 (Meningococcal, Tdap, HPV), statistically significantly improving trend of 1.3 pp/yr from 2017 to 2020
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Total)
  - BMI Percentile, statistically significant 4.7 pp, statistically significantly improving trend of 1.4 pp/yr from 2016 to 2020
  - Counseling for Physical Activity, statistically significantly improving trend of 1.0 pp/yr from 2016 to 2020

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

The following were considered when determining key opportunities (refer to Table 1.1 and Table 1.2): measurement year 2020 rates below the 10th percentile; rates statistically significantly worse than in 2019 (hybrid and survey methods only); rates worse by at least 10% gap-to-goal from 2019; worsening trends of 3 pp/yr or more since 2016 or 2017 (depending on the measure); and statistically significant worsening trends (hybrid and survey methods only) since 2016 or 2017 (depending on the measure).

KanCare

For KanCare, no Adult or Child Core Set measure indicators were below the 10th percentile (three Adult and five Child indicators ranked <25th).

The following KanCare Adult and Child Core Set measure indicators had worsening performance noted in Table 1.1 or 1.2; percentage point (pp) changes from 2019 to 2020 and average (pp/yr) changes over the last three to five years, as applicable, are shown below.

- Adult
  - Chlamydia Screening in Women, 21–24 years, 4.7 pp
  - Medical Assistance with Smoking and Tobacco Use Cessation, Advising Smokers to Quit, statistically significant 6.8 pp, statistically significantly worsening trend of 1.6 pp/yr from 2016 to 2020
  - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications, 4.0 pp
- Child
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics, 7.7 pp, 4.8 pp/yr worsening trend from 2018 to 2020
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total), 3.2 pp
  - Childhood Immunization Status
    - Hepatitis B, 1.1 pp
    - Measles-Mumps-Rubella (MMR), 1.4 pp
    - Varicella-Zoster Virus (VZV), 1.4 pp
  - Immunizations for Adolescents – Tdap, statistically significant 3.0 pp
  - Prenatal and Postpartum Care, Timeliness of Prenatal Care, statistically significant 4.2 pp

Aetna

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

The following Adult and Child Core Set measures that worsened by 10% gap-to-goal or more from 2019 to 2020 (shown in pp) are noted in Tables 1.1 and 1.2:

- Adult
  - Chlamydia Screening in Women, 21–24 years, 4.7 pp
  - Follow Up After Hospitalization for Mental Illness (18–64 years), 7 days, 5.9 pp
  - Medical Assistance with Smoking and Tobacco Use Cessation, Advising Smokers to Quit, 6.2 pp
  - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications, 3.4 pp
- Child
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total), 8.4 pp
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total), 2.5 pp
  - Childhood Immunization Status
    - Diphtheria-Tetanus-Acellular Pertussis (DTap), 5.8 pp
    - Hepatitis A, 1.9 pp
    - Hepatitis B, 1.7 pp
    - Inactivated Poliovirus Vaccine (IPV), 2.1 pp
    - Measles-Mumps-Rubella (MMR), 1.6 pp
    - Pneumococcal Conjugate, 3.9 pp
  - Immunizations for Adolescents
    - Meningococcal, 4.9 pp
    - Tetanus-Diphtheria-Pertussis (Tdap), 5.1 pp
    - Combination 1 (Meningococcal, Tdap), 5.1 pp
    - Prenatal and Postpartum Care, Timeliness of Prenatal Care, 4.9 pp

Sunflower

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

The following Adult and Child Core Set measures worsened by 10% gap-to-goal or more or had worsening trends over three to five years (measured in pp/yr), depending on the measure, noted in Tables 1.1 and 1.2:

- Adult
  - Follow-up After Hospitalization for Mental Illness (18–64 years), 30 days, 4.4 pp
  - Medical Assistance with Smoking and Tobacco Use Cessation, Advising Smokers to Quit, 3.7 pp
  - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications, 4.9 pp
- Child
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total), 7.3 pp and worsening trend of 5.0 pp/yr from 2018 to 2020
  - Childhood Immunization Status, Hepatitis B, 1.0 pp

- Follow-up After Hospitalization for Mental Illness (6–17 Years), 30-Day Follow-Up, 2.8 pp
- Immunizations for Adolescents, Tetanus-Diphtheria-Pertussis (Tdap), 4.4 pp
- Prenatal and Postpartum Care, Timeliness of Prenatal Care, statistically significant 7.8 pp

UnitedHealthcare

One Adult Core Set measure indicator ranked <10th; seven more ranked <25th. No Child Core Set indicator rates were below the 10th percentile; four ranked <25th.

The following Adult and Child Core Set measures worsened by 10% gap-to-goal or more noted in Tables 1.1 and 1.2:

- Adult
  - Chlamydia Screening in Women, 21–24 Years, 5.3 pp
  - Flu Vaccinations for Adults Ages 18–64, statistically significant 8.8 pp
  - Medical Assistance with Smoking and Tobacco Use Cessation
    - Advising Smokers to Quit, 10.1 pp
    - Discussing Cessation Medications, 5.7 pp
    - Discussing Cessation Strategies, 10.7 pp
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia, 6.0 pp
  - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications, 4.0 pp
- Child
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics, 7.6 pp
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total), 5.2 pp
  - Childhood Immunization Status
    - Measles-Mumps-Rubella (MMR), 1.5 pp
    - Varicella-Zoster Virus (VZV), 1.9 pp
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Total), Counseling for Nutrition, statistically significant 9.2 pp

Technical Strengths

The following are areas of strength for HEDIS measure production and reporting.

Common Among the MCOs

- MCO information systems were configured to capture complete and accurate data. Comprehensive edits ensured fields were populated with valid and reasonable characters. Comprehensive methods existed to ensure data accuracy throughout the data integration processes for claims, encounters, eligibility and enrollment, provider, vendor, and ancillary systems.
- The MCOs utilized robust and automated processes to extract, transfer, and load data from source systems to their certified measure software.
- NCQA-certified vendors and compliance auditors were used by the MCOs to audit their processes and to calculate HEDIS rates.
- The MCOs calculated and submitted valid HEDIS MY 2020 rates.

Aetna

- Aetna continued to have excellent processes in place to ensure accurate and complete receipt and processing of claims, enrollment, and provider data. All organizational goals for accuracy and timeliness were met for the measurement period.

- Aetna maintained sufficient oversight of its claims processing vendors. A dedicated team ensures that vendor data were received and processed timely and completely.

Sunflower

- Sunflower's HEDIS team was knowledgeable and worked closely with Centene corporate to ensure data used to produce HEDIS rates were complete and accurate.
- Sunflower took appropriate action for each recommendation made during the prior year's review. This demonstrated the MCO's commitment to the PMV process.

UnitedHealthcare

- UnitedHealthcare continued to benefit from the support of its national plan for many aspects of HEDIS performance measure reporting, drawing on the extensive expertise of those within the corporate structure to achieve the goal of accurate and complete measure data.
- UnitedHealthcare utilized many supplemental data sources to enhance measure reporting, including leveraging data from other states' sources to use where applicable for Kansas members.

Technical Opportunities for Improvement

The following are opportunities for improving HEDIS measure production and reporting.

Aetna

- The required Kidney Health Evaluation for Patients with Diabetes measure was not reported by Aetna and also was not identified as a required measure in the HEDIS Roadmap Appendix 1; Aetna provided the measure data to the State on December 3, 2021.
- During the medical record review re-abstraction for the PMV, there were numerous issues with the initial chart documentation including incomplete information to support compliance, lack of chart annotation to demonstrate compliance, and incorrect member information. Aetna attributed the issues to recent staff turnover, internal miscommunication, and lack of the usual involvement from the national team.
- Although staffing changes were mitigated through Aetna's corporate structure for HEDIS MY 2020, Aetna should continue to build its HEDIS team for the Kansas Medicaid product.

Sunflower

- While Sunflower received supplemental data from several sources, there was no receipt of data files directly from provider electronic medical record systems in Kansas. Increasing the volume of supplemental data would potentially enhance data completeness and reduce the burden of medical record review.

UnitedHealthcare

- In response to last year's recommendation regarding communication issues, UnitedHealthcare reported that they added a new resource for tracking and follow-through of external audit requests and communications to facilitate timely responsiveness and coordination with internal constituents. It also noted that notification to KDHE, Kansas Department of Aging and Disability Services (KDADS) and KFMC to "cc" the UHC Kansas Compliance Mailbox was made. However, this email address was not used during the PMV-ISCA.
- UnitedHealthcare was unable to provide several of the follow-up items by the date requested.

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

Please see Appendix F for MCO responses to the recommendations made as a result of the ISCA and PMV process performed in 2020 (MY 2019).

Recommendations for Quality Improvement

Common Among the MCOs

1. The MCOs should prioritize improvement efforts towards the following HEDIS measures:
   - Metabolic Monitoring for Children and Adolescents on Antipsychotics
   - Child and Adolescent Well-Care Visits
   - Chlamydia Screening in Women
2. See the recommendation in the CAHPS Survey Validation regarding Medical Assistance with Smoking and Tobacco Use Cessation.

Aetna

Performance Measures

1. Aetna should prioritize improvement efforts towards the following additional HEDIS measures:

- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
  - Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
  - Initiation of Alcohol and Other Drug Abuse or Dependence Treatment
    - Opioid Abuse or Dependence
- Childhood Immunization Status and Immunizations for Adolescents, particularly HPV for adolescents; continue influenza vaccination performance improvement efforts.
- Well-Child Visits in the First 30 Months of Life, continue focus on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) PIP
- Medical Assistance with Smoking and Tobacco Use Cessation
- Cervical Cancer Screening

Technical

2. Aetna should thoroughly review all State reporting requirements to ensure that the HEDIS Roadmap Appendix 1 identifies all required measures, and to ensure that all required measures are produced and reported.

Sunflower

Performance Measures

1. Sunflower should prioritize improvement efforts towards the following additional HEDIS measures:
   - Antidepressant Medication Management – Effective Continuation Phase Treatment
   - Breast Cancer Screening
   - Follow-Up After Hospitalization for Mental Illness
   - Prenatal and Postpartum Care
   - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Technical

2. Sunflower should continue with its plans to develop a formal auditing program for supplemental data by auditing standard sources every two years and nonstandard sources every year.

Recommendations for Quality Improvement (Continued)

UnitedHealthcare

Performance Measures

1. UnitedHealthcare should prioritize improvement efforts towards the following HEDIS measures:
   - Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence
   - Breast Cancer Screening
   - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
   - Antidepressant Medication Management
   - Well-Child Visits in the First 30 Months of Life
   - Medical Assistance with Smoking and Tobacco Use Cessation

Technical

2. UnitedHealthcare should carefully review the Roadmap and ISCA responses prior to submission to ensure that where the questions are similar, the responses are consistent.

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3. Performance Improvement Project Validation

Background/Objectives

The purpose of a PIP is to assess and improve processes and, thereby, outcomes of care. The objectives of KFMC's review were to determine if the PIP design was methodologically sound, validate the annual PIP results, and evaluate the overall validity and reliability of the methods and findings.

Technical Methods of Data Collection and Analysis

In 2021, ten interagency meetings included focused PIP discussions among staff from KDHE, KDADS, KFMC, and each of the MCOs. KFMC provided feedback on initial and revised PIP methodologies, interventions, metric development, data analysis, and annual progress.

The PIP validations were conducted in accordance with the October 2019 Validation of Performance Improvement Projects Protocol worksheet and narrative provided by the CMS. Evaluation includes review of the MCOs' annual reports submitted for the current and prior years (where applicable), along with their originally submitted approved PIP methodology worksheets. The MCOs' monthly data submitted to KFMC for populating into PIP Action Reports (PARs) along with the corresponding PAR metric specifications were also reviewed.

Description of Data Obtained

Four of the fifteen PIPs validated during the 2021 to 2022 reporting cycle were based on HEDIS measures. As noted in the ISCA/PMV section of this report, KFMC and its NCQA-certified HEDIS Compliance Audit subcontractor, as well as the MCOs' NCQA-certified auditors, determined the MCOs' HEDIS rates were valid. For the various PIPs, sources of data included: claims, encounters, medical records, laboratory results, and immunizations identified through the Kansas Immunization Registry (KSWebIZ). The MCOs are each conducting a non-collaborative PIP on EPSDT, and two of the MCOs' PIP topics include Diabetes Monitoring of Members with Diabetes and Schizophrenia (SMD).

Overall Validity and Reliability of PIP

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. KFMC uses a numerical rating system for the evaluation of PIP Activities to determine a level of overall confidence; High Confidence: 95% to 100%, Confidence: 90% to <95%, Low Confidence: 80% to <90%, and Little Confidence: below 80%. Level of confidence ratings for each of the PIPs evaluated are included in Table 2.1 below.

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Table 2.1. MCOs' PIP Topics and Validation Ratings		
PIP Topic	**Validation Status**	**Validation Rating**
Aetna		
EPSDT	Yes	60.2% – Little
Pregnancy: Prenatal Care	Yes	81.4% – Low
Food Insecurity	Yes	92.6% – Confidence
LTSS ED Visits	Yes	85.4% – Low
Influenza Vaccination	Yes	88.7% – Low
Sunflower		
EPSDT	Yes	81.1% – Low
Cervical Cancer Screening	Yes	91.2% – Confidence
SMD	Yes	88.0% – Low
Waiver Employment	Yes	82.4% – Low
Mental Health Services for Foster Care	Yes	82.6% – Low
UnitedHealthcare		
EPSDT	Yes	91.3% – Confidence
Prenatal Care	Yes	84.8% – Low
SMD	Yes	88.7% – Low
Advanced Directives	Yes	92.0% – Confidence
Housing	Yes	97.1% – High
AMM*	No	NA
All MCOs (Collaborative)		
COVID-19 Vaccination^	No	NA

* PIP methodology was approved August 30, 2021, and the MCO was not required to submit annual report for the validation activity until February 13, 2023.
^ PIP methodology was approved July 29, 2021, and the MCOs were not required to submit annual report for the validation activity until January 31, 2023.

There are no previous EQRO recommendations for 14 of the 15 PIPs that were in their first year of validation during this annual reporting cycle.

Themes of Recommendations for Quality Improvement

In assessing the EQRO recommendations for the fifteen PIPs, the main themes involved the MCOs' analysis plans, presentations of their data, and accuracy of the results. The recommendations included to follow the analysis plan from the approved PIP methodology; ensure the described analysis results are accurate, clear; and that the interpretations are supported by the presented data. Another recommendation theme for future annual reports was to provide detailed documentation of intervention changes, lessons learned, and next steps.

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Aetna

EPSDT PIP

Background/Objectives

Aetna's stated aim for the PIP is to "*achieve an EPSDT participation rate of 85 percent for ages 0–20 years, over a five-year period.*" The first year of activity for this PIP was January 1, 2020, to December 31, 2020; however, two interventions were initiated prior to then. Aetna's original multifaceted intervention strategy included the five interventions listed in Table 2.2.

Table 2.2. Aetna's EPSDT PIP Interventions

PIP Interventions	Implementation	Outcome
Interactive Voice Response (IVR) system calling campaign to remind and educate parents/guardians of the importance of EPSDT visits and immunizations	Not implemented in 2020	NA
Text4Kids program ("Texting Campaign" or "Text Campaign") to provide educational messages to parents/guardians on health-related topics including EPSDT visits and immunizations	June 2019 through August 2020	Results provided for the initial campaign did not include calculation of the outcome measures or process measures for either the study or comparison groups
Member incentives for completing well-care visits and vaccinations	The campaign was effective January 1, 2019	Aetna's review of their internal reporting process, vendor communication, and available data identified the need for modifications to allow for evaluating the effectiveness of the intervention
Use of "Health Tag" reminders on prescriptions filled at CVS pharmacies ("CVS Health Tags")	Not implemented in 2020	NA
EPSDT-related webinars to educate providers/office staff on the EPSDT program and recommended screenings ("Provider Webinar")	Not implemented in 2020	NA

In Aetna's interpretation of their analysis they stated, "*Aetna expects that with full implementation of all interventions, adjustments and changes related to COVID-19, as well as corrections in data collection and analysis there will be notable change in outcomes as well as member results.*

Conclusions Drawn from the Data

- KFMC has concluded that there is little confidence in the overall validity and reliability of the described methods and findings.

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

- Modifications were made to the interventions that should improve analysis of the outcome and process measures, including changing vendors.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- There were many instances of insufficient detail to be able to fully evaluate the PIP (e.g., intervention process steps, targeted provider types, frequency of intervention, specific population inclusion).
- Rationale for many intervention changes was not adequately described (e.g., vendor changes, IVR scripts, and warm hand-offs).
- Several substantial changes to interventions indicated insufficient review and planning during intervention design and initial implementation (e.g., selected vendors not able to fulfill PIP data needs resulting in changes to vendors and additional delays, discovery of Health Insurance Portability and Accountability Act (HIPAA) concerns leading to change in text intervention, discovery of inability to simultaneously implement multiple CVS Health Tags, and national webinar not including Kansas providers).
- Some planned intervention components were eliminated when barriers were identified, with no apparent attempt to determine alternatives (e.g., not seeking an alternative method/platform to post or send recorded webinars for provider viewing after the live webinar and not seeking an alternative to communicate with the Foster Care population rather than simply excluding them from the phone and text interventions).
- The analysis provided was inconsistent with the analysis plan (e.g., participation rates, for the overall PIP population and the groups of special interest, were not provided as planned). Many data discrepancies existed that were not addressed (e.g., PIP population denominators were inconsistent between Activity 1 and Activity 9, age category data within tables were out of order, and results provided in the PIP measure for 2020 differed from data provided for the EPSDT PAR).

Recommendations for Quality Improvement

1. Work with Foster Care agencies to determine a method to ensure children and youth in Foster Care obtain their well-care, since Aetna has indicated phone calls and text campaigns are not feasible for this population.
2. Provide additional details so the rationale for each change in the intervention (IVR calling campaign) is clear, e.g., vendor change, IVR scripts, warm transfer option.
3. Ensure analysis results described in the report narrative are consistent with the data presented in tables.
4. The analysis should be conducted according to the analysis plan. Aetna did not report the total rates for ages 0 to 20 years, as defined in the PIP methodology.
5. The measurement period (anchor date) regarding age assignment in Activity 3 should be corrected, as it differs between baseline and remeasurement years.
6. Discuss wide variations in data between reporting periods (e.g., population numbers, response rates, etc.). Assess variation for potential data quality issues.
7. Ensure the PIP report references the correct documents and that PIP report content is consistent with actual methodology (i.e., EPSDT PIP Participation Rate Methodology [updated December 9, 2019] not reflected in PIP report).

Pregnancy: Prenatal Care PIP

Background/Objectives

Aetna identified the following two aims for the PIP:

- *"To use member- and provider-focused interventions to increase the average time between Aetna notification of the member's pregnancy to the date of delivery."*
- *"To use member- and provider-focused interventions to increase the percent of pregnant women with the initial prenatal visit occurring within the first trimester or within 42 days of enrollment from 42.00 percent (2019) to 75.5 percent by the end of the PIP. It is noted that this rate is based on modified, unaudited, HEDIS rates."*

Due to the COVID-19 pandemic and internal issues Aetna encountered, only one intervention was implemented during the first year of activity (from January 1, 2020, to December 31, 2020). Aetna's original plan included the five interventions shown in Table 2.3.

Table 2.3. Aetna's Pregnancy: Prenatal Care PIP Interventions

PIP Interventions	Implementation	Outcome
Texting campaign to female members aged 18–55 years	Not implemented in 2020	NA
IVR campaign to female members aged 18–55 years	Not implemented in 2020	NA
Telephonic care management outreach to newly enrolled pregnant members	August 2020	Staffing changes and how the data were captured may have impacted the outreach efforts and reduced accuracy of the results
Incentives for high-risk providers to notify Aetna of member pregnancy	Not implemented in 2020	NA
Incentives for Urgent Care providers to notify Aetna of member pregnancy	Not implemented in 2020	NA

Conclusions Drawn from the Data

- Although analytic results were provided, they were not as complete or accurate as they could have been.

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

- Aetna provided documentation of the Plan-Do-Study-Act (PDSA) cycles they completed for their five interventions.
- Aetna clearly documented plans for changes to the original interventions and opportunities for improvement.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Aetna did not follow the approved analytic plan for the PIP outcome measures.
- Invalid comparisons were made in the analysis of the PIP outcome measures.
- Aetna did not use appropriate statistical tests for the data being analyzed.

Recommendations for Quality Improvement

1. Report data as described in the approved analytic plan for Outcome Measure 1.
2. Set a specific goal for improvement in length of time (average number of days) from plan notification of pregnancy to delivery.
3. Follow the approved analytic plan for Outcome Measure 2.
4. Make valid comparisons between baseline and remeasurement years.
5. Use appropriate statistical tests for the data being analyzed.
6. Quality checks should be in place to ensure that data presented in annual reports are accurate.

Food Insecurity PIP

Background/Objectives

Aetna identified the following two aims for the PIP:

- "*Will member-, provider-, and community-facing interventions reduce food insecurity, reported in the annual Aetna health screening, for all members through the end of the PIP?*
- *Will provider engagement increase the use on claims of Z-codes that enhance identification of food insecure members?*"

Due to the COVID-19 pandemic and also as a result of internal project management issues, only two interventions were implemented during the first year of activity (from April 1, 2020, to March 31, 2021). Aetna's original plan included the five interventions listed in Table 2.4.

Table 2.4. Aetna's Food Insecurity PIP Interventions

PIP Interventions	Implementation	Outcome
Z-code project with outreach to select providers	Not implemented in first year of PIP	Analysis completed to select providers for intervention
Community Pharmacy Enhanced Service Network (CPESN) program with select pharmacies within the Aetna's network	July 2020	Aetna reported the CPESN program and partnership with community providers *"show promising results and potential positive impact on a full active year of the project."*
IVR welcome call with care management follow-up as indicated	Not implemented in first year of PIP	NA
Member webinar for members with diabetes to focus on education and options for healthy eating	Not implemented in first year of PIP	NA
Partnership with community providers to provide healthy food resources to communities identified as food deserts	Aetna participated in four food distribution events during first quarter 2020	Effectiveness of the intervention could not be determined because it was not targeted to Aetna's members

Conclusions Drawn from the Data

- The second year of activity will be important for assessing the progress of this PIP with the implementation of more interventions and available outcome measurement data.

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

- Aetna provided documentation of the PDSA cycles they completed for their five interventions.

- Aetna clearly documented plans for changes to the original interventions and opportunities for improvement.
- Aetna formed a cross-functional PIP Steering Committee for this PIP to assist with rapid cycle improvement and to eliminate barriers.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Some of Aetna's presented analysis results were not clear, did not appear accurate, or were not fully described in the narrative.
- It appears Aetna changed partnerships for the Z-code project; this change is not reflected in the annual report.
- An explanation was not provided for why the food-distribution events were the only aspect of the community providers intervention implemented.
- No interpretation was provided for the CPESN program intervention.
- It is unclear how many pharmacies are participating in the CPESN program.

Recommendations for Quality Improvement

1. In the annual progress reports, Aetna should provide an interpretation of the data and the extent to which they believe the intervention was or was not successful.
2. Develop an outcome measure, considering the provided example, for the second aim question.
3. The data, measure specifications, and programming used for the analysis of Z-codes in this activity should be reviewed to ensure they accurately reflect Z-code utilization.
4. Clarify if there was a change in the partnerships for providing education since the PIP methodology approval.
5. In future reports, include the number of pharmacies participating in the CPESN program.

Long-Term Services and Supports (LTSS) and Emergency Department Visits PIP

Background/Objectives

Aetna's stated aim for the PIP is to "*Decrease the use of emergency departments by HCBS members who are not in long-term care, are not subsequently admitted to higher-level care (i.e. inpatient, residential, etc.), and for selected primary diagnoses considered as non-emergent by 5 percentage points year over year, or approximately 2.5 visits per month, for the first year of the PIP.*" Aetna's strategy was to target members and caregivers with the interventions listed in Table 2.5. However, none of the interventions were implemented during the first activity period of this PIP (July 1, 2020, to June 30, 2021). Aetna cited project management issues, staff transitions, and the impact of the COVID-19 pandemic as contributing factors for the delay in implementation.

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Table 2.5. Aetna's LTSS ED Visits PIP Interventions		
PIP Interventions	**Implementation**	**Outcome**
Analyze and trend claims data for ED use to determine opportunities to decrease utilization of the ED for non-emergent conditions	Not implemented in first year of PIP	NA
Text campaign with education for members regarding appropriate use of ED and alternative sites of care	Not implemented in first year of PIP	NA
Member education and resources during face-to-face visits with distribution of refrigerator magnets including pertinent phone numbers and information	Not implemented in first year of PIP	NA
Provide education and outreach to primary caregivers for decision making regarding use of ED	Not implemented in first year of PIP	NA
Care Management outreach to members within 72 hours of notification to Aetna of discharge from ED for non-emergent condition	Not implemented in first year of PIP	NA

Conclusions Drawn from the Data

- Assessing the progress of this PIP will not occur until the second annual progress report since none of Aetna's interventions were implemented during the first year of activity.

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

- Aetna's use of CareUnify allows them to identify members with non-emergent ED visits in near real-time, instead of having to wait until a claim is received.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Aetna did not complete an analysis of HCBS ED utilization for non-emergent conditions according to the timeline in the approved PIP methodology.
- Counts of ED visits provided in two figures contradicted the outcome measure numerator, which was a count of members with at least one ED visit.
- Calculation of the PIP outcome measure rate for July 1, 2020, to June 30, 2021, did not allow the specified 90 days for claims runout; this deviation from the measure specifications was not discussed in the report.
- The goals for quantitative assessment of performance do not appear reasonable based on the reported data.

Recommendations for Quality Improvement

1. Initiate the analytic plan as outlined for the intervention since it was the first step to implementation of the interventions.
2. For each table and figure, clarify the specification for rates and counts presented. In particular, clarify whether the numerators for the presented ED utilization rates were deduplicated counts of members or counts of visits.
3. The amount of time specified for claims runout should be the same for the baseline PIP outcome measure rate and each remeasurement rate. Consider using an earlier remeasurement period to allow three months for claims to be processed. The analytic plan should specify the measurement periods to be compared in the annual reports.
4. Review the statements related to goals that were included in the analysis plan for quantitative assessment of performance.

Influenza Vaccination PIP

Background/Objectives

Aetna's stated aim for the PIP is to *"increase the influenza vaccination rate by 3 percentage points annually over the baseline year of 2019 for members age 6 months to 17 years. The longer-term goal is to meet the CDC goal of 80 percent."* Their second year of activity for this PIP was July 1, 2020, through June 30, 2021. Aetna's multifaceted education and outreach interventions, shown in Table 2.6, were developed to target providers and parents/guardians, as well as health departments. Due to multiple internal and external factors, several changes have occurred since the interventions were originally planned.

Table 2.6. Aetna's Influenza Vaccination PIP Interventions

PIP Interventions	Implementation	Outcome
Texting campaign to remind and educate parents/guardians on importance of influenza vaccination	Not conducted due to barriers encountered and multiple delays	NA
Outreach by an Aetna nurse at community-sponsored immunization events	Initially postponed, in the process of being replaced with a telephone outreach campaign	NA
HealthTag reminders affixed on prescriptions filled at CVS pharmacies	Discontinued, new intervention being developed	Did not impact outcome
Providing gaps in care (GIC) lists of members who have not received an influenza vaccination to providers	Provider reports delayed, planned to begin in January 2022	NA
Member incentives for receiving an influenza vaccine	Only intervention that occurred in both measurement years	Not able to tell from reported data whether intervention is having an impact on the outcome

Conclusions Drawn from the Data

Aetna's baseline influenza vaccination rate (2020) for the total PIP population was 25%, which was higher than the first remeasurement rate of 20%; see Table 2.7. In the stratified analysis of the 2021 rates by age group, children 6 months to 4 years had the highest rate (28%), children 5 to 12 years of age had the second highest rate (19%), and adolescents 13 to 17 years of age had the lowest rate (17%). The chi-square test for association found differences among the rates for the three age groups were statistically significant.

Table 2.7. 2021 Annual Influenza Vaccination Rates by Age Group

	6 Mo–4 Yrs	5–12 Yrs	13–17 Yrs	Total
Numerator	3,628	5,430	2,895	11,953
Denominator	13,047	28,982	16,963	58,992
Rate	27.8%	18.7%	17.1%	20.3%

Aetna reported the effectiveness of the PIP for the two measurement periods was unable to be illustrated. The third year of activity will be important for assessing progress of this PIP, with planned changes to the interventions in place and more outcome measurement data available.

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

- Aetna clearly documented their plans for changes to the original interventions and identified opportunities for improvement.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Data tables provided in Activities 8 and 9 had errors or were inconsistent with the discussions of the results.
- Some of Aetna's presented analysis results were not clear, did not appear accurate, or were not supported by the provided conclusions.
- Description of the second process measure for Intervention 5, Member Incentives, was not consistent with the numerator and denominator statements.
- Differences between the intervention measure data submitted to KFMC for the PARs and the annual report data were not discussed.

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

Of the 16 recommendations made in the 2020 PIP Evaluation, 15 were fully addressed and one was partially addressed. See Appendix F for more details.

Recommendations for Quality Improvement

1. Verify that the data provided in the annual report tables and narrative are correct. Also, the titles of the tables should be reflective of the displayed data.
2. Ensure that the reported analysis results are supported by the data (e.g., overall vaccination rate percentage point change).
3. Ensure that conclusions in the report narrative are supported by the presented data.
4. Report the Member Incentives process measures using the numerators and denominators defined in Activity 5.5.
5. Report corrected rates for both Member Incentives process measures for 2019–2020, taking claims lag into consideration, as stated in Aetna's prior year annual report.
6. Incorporate into the annual report the submission and monitoring of the PIP intervention data through the PAR system. Also, differences in the analysis results and data collection between the annual report and PARs should be explained when expected to match or be similar.

Sunflower

EPSDT PIP

Background/Objectives

Sunflower's PIP aim statement in their initially approved methodology was clearly written and included all required components. The following aim statement in their annual report did not specify the PIP population was KanCare members or state a measurable outcome goal. *"The question this project attempts to answer is: Will the use of multifaceted outreach interventions targeting providers and Sunflower member's (0–20 years of age) and their parents and/or guardians improve the overall rate of performed EPSDT visits?"* During the first year of activity for this PIP (January 1, 2020, to December 31, 2020), Sunflower implemented three of their five planned interventions described in Table 2.8 below.

Table 2.8. Sunflower's EPSDT PIP Interventions

PIP Interventions	Implementation	Outcome
mPulse text messaging campaign to members aged 6 to 20 years	Third quarter 2020	Statistically significant difference in EPSDT screening rates for members who received a text message vs. those that did not, with lower screening rates among members that received a mPulse text message
Warm outreach to members aged 6 to 20 years in the Severe Emotional Disturbance (SED) waiver	Second quarter 2020	Statistically significant difference in EPSDT screening rates for members in the SED waiver who received a warm call and those that did not, with EPSDT rates higher for members that received the warm call
One-on-one educational provider meetings with five targeted providers (selected from providers having 100 to 300 members 6 to 20 years of age)	Not implemented in first year of PIP (first quarter 2021)	NA
Partnership with foster care lead agencies	Second quarter 2020	Sunflower was unable to gather lead agency measurement data during the first phase of the intervention for the planned comparison.
Community initiative/event with community providers was replaced with staff education due to the COVID-19 pandemic	Not implemented in first year of PIP (completed April 2021)	NA

Conclusions Drawn from the Data

- Sunflower acknowledged the impact of the COVID-19 pandemic and state-wide stay-at-home recommendations could have impacted overall EPSDT screening rates in 2020 and threaten comparability of repeat measures.

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

- While there were barriers in data collection from the foster care lead agencies, communication was established between Sunflower and the agencies.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Interpretation of statistical analyses was incorrect and inadequate (e.g., outcome measure data in annual report different from the PAR data).
- Analyses deviated from the analytic plans without explanation.
- Ensure analyses for process and outcome measures are conducted according to the approved methodology's measure specifications and analytic plans or provide rationale and details of changes.
- In future analysis, Sunflower should avoid reporting redundant statistical test results and statistics not relevant to the PIP activity or the report's intended audience.

Recommendations for Quality Improvement

1. Ensure all data and statistical interpretations are verified for accuracy and clarity in future reports.
2. Provide next steps for all interventions in future reports.
3. Interpret baseline-to-remeasurement comparisons in Activity 9.1 in future reports.
4. In future reports, when including exploratory analyses, such as EPSDT screening rates based on demographics, interpret the results and explain how they will be used to advance the PIP.
5. When plans or procedures for interventions change during the PIP's activity period, ensure that the changes and rationale are documented in the report.

Cervical Cancer Screening PIP

Background/Objectives

Sunflower's stated aim for the PIP is to *"increase the HEDIS® CCS rate to 59.50% or higher in the first year of the PIP using a multifaceted intervention approach, targeting Sunflower members 24–64 years of age who meet HEDIS CCS criteria and targeting providers who serve this population."* Four of the five interventions listed in Table 2.9 were implemented during the first year of activity (January 1, 2020, through December 31, 2020).

Table 2.9. Sunflower's Cervical Cancer Screening PIP Interventions

PIP Interventions	Implementation	Outcome
Monthly non-compliant reports to providers	Fourth quarter 2020	Timing of implementation did not allow for full assessment of the intervention.
Interactive text messages to members through the mPulse platform	Second quarter 2020	1st campaign: More members who did not receive a text completed a CCS (7.6%) than those who received the text (5.6%) 2nd campaign: Slightly higher rate of completion of CCS for those who received a text (3.3%) vs. those that did not (2.9%)
Warm phone call outreach to members	Fourth quarter 2020	Timing of implementation did not allow for full assessment of the intervention.
Co-branded member mailers	Not implemented in first year of PIP	NA
Extension for Community Healthcare Outcomes (Sunflower Project ECHO) webinar for providers	Second quarter 2020	No quantitative data was reported due to the lack of targeted providers attending the webinar.

Conclusions Drawn from the Data

- There were large differences in the CCS rates for members receiving waiver case management (CM) (35.36%) compared to those in non-waiver CM (60.20%).
- Sunflower was unable to assess the impact of their interventions implemented in 2020 on the HEDIS MY 2020 hybrid CCS rate as data will not be available until 2021.
- Sunflower's regression analysis demonstrated statistical evidence that members between 31 and 64 years of age are less likely to obtain a CCS screening compared to younger members (24–30 years of age).

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

- Although the HEDIS MY 2020 administrative CCS rate was not available yet, Sunflower completed multiple analyses using "partial" MY 2020 data to assess the initial impact of their interventions.
- Sunflower was able to implement four of their five interventions despite the COVID-19 pandemic.
- The ECHO webinar, while not attended by targeted providers, did offer insight from other providers into why members on the Intellectual/Developmentally Disabled waiver do not complete CCS.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Annual progress reports should include all lessons learned regarding implementation of interventions.
- All data reported as "partial data" should be labeled as "partial data" in tables.

Recommendations for Quality Improvement

1. Set an annual percentage point increase as a target for improvement (e.g., increase HEDIS hybrid CCS rate for the total PIP population by 5 percentage points year-over-year).
2. Annual progress reports should include all lessons learned during implementation of the text messaging intervention and any planned steps to assess for less-than-optimal performance results.
3. Evaluate the success of process steps, in addition to process outcomes, when considering lessons learned. Consider conducting a PDSA cycle on the warm call process to identify whether improvements to the process could potentially increase the number of successful warm calls.
4. Race and ethnicity categories should be grouped in clearly distinct categories, and further defined (e.g., difference between "Caucasian" and "White [Non-Hispanic]").

Increasing the Rate of Diabetic Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SMD) PIP

Background/Objectives

The aim statement for this PIP in the annual report was modified from the initial approved methodology. While the revisions overall did not change the aim, it was worded as aim of interventions instead of the PIP, and reference to a provider-focused intervention was removed. The following was a suggestion for modifying the aim statement:

- The use of a multifaceted intervention approach, targeting Sunflower Health Plan members aged 18–64 years who have diagnoses of diabetes and schizophrenia or schizoaffective disorder and providers who serve this population will increase compliance with annual Low-density Lipoprotein Cholesterol (LDL-C) and Diabetes Glycated Hemoglobin (HbA1c) testing by 3 percentage points year over year.

Sunflower's interventions that they planned to implement during the first year of PIP activity (January 1, 2020, through December 31, 2020) are listed in Table 2.10.

Table 2.10. Sunflower's SMD PIP Interventions

PIP Interventions	Implementation	Outcome
Warm member phone outreach	November and December of 2020	Timing of implementation did not allow for full assessment of the intervention.
Gap-in-Care reports	Not implemented in first year of PIP (distributed February 2021)	NA
Co-branded letter campaign	November 2020	Timing of implementation did not allow for full assessment of the intervention.
Data deep dive – analysis of members who completed Health Risk Assessment in 2018 (completed HbA1c and LDL-C testing vs. those that did)	Completed in 2020	Analysis completed for ten demographic characteristics. From the results, Sunflower identified three possible avenues for interventions: understanding health conditions, taking medications without assistance, and facility-based care.

Conclusions Drawn from the Data

- The second year of activity will be important for assessing the progress of this PIP with further implementation of the interventions and more complete data available.

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

- Sunflower was able to begin implementation of the warm call and co-branded letter interventions during the first year of the PIP despite the COVID-19 pandemic.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Analytic results were not clearly described in the report narrative, and other data results displayed in the tables were misinterpreted.
  - Some of Sunflower's presented analytic results did not appear accurate.
  - Adjustments were made to interventions; however, no PDSA cycles were reported.
- Process measures included in the technical specifications for Intervention 1 (warm calls) and Intervention 3 (co-branded letter) were not reported.
- Several data tables contained denominators of 10 or less—too small for rate comparisons.

Recommendations for Quality Improvement

1. Before submitting future annual reports, verify the accuracy of the interpretations of the analysis. Also, conclusions should not be drawn based on data with small denominators.
2. Review the comparative analysis results (members completed HbA1c and LDL-C testing vs. those that did not) and their interpretation of the data for accuracy before drawing final conclusions.
3. Provide detailed documentation of adjustments made to the data analysis of 2018 members (Intervention 4). Elements of the PDSA cycle should be reported, as described in the Conducting PIP Worksheet Instructional Guide.
4. Provide analysis results for the process measures included with the intervention technical specifications, "members not completing testing for both LDL-C and HbA1c who successfully received a warm call reminding them to complete testing" and "the percent of members not completing testing for LDL-C and HbA1c who were sent the co-branded letter."

Waiver Employment PIP

Background/Objectives

The aim for this PIP is to "*increase employment for members on the IDD* [Intellectual/Developmental Disability]*, PD* [Physical Disability] *and BI* [Brain Injury] *waivers and those KanCare eligible members on the respective waiver and corresponding waiting lists by 2% year over year for the duration of the PIP by decreasing the barriers identified by providers and members."* Sunflower's planned interventions targeted members, providers, and CM staff. During the first year of PIP activity (April 1, 2020, through March 31, 2021)**,** not all of the interventions were implemented; see details in Table 2.11 below.

Table 2.11. Sunflower's Waiver Employment PIP Interventions		
PIP Interventions	**Implementation**	**Outcome**
Sunflower participation in Project Search, serve as Statewide Coordinator	2020 to 2021 school year	A clear description of the analysis results was not provided.
Send flyers to members offering support to link to community resources to meet employment goals	Planned mailer put on hold and replaced with mailer for how to stay safe during pandemic. A webinar was also offered but there was no member participation.	No data available
Case management team training to decrease myths (how employment affects benefits) and provide resources available to members to reach employment goals	Delayed until first quarter 2021	Intervention results for the process and outcome measurements were not presented in an easily understood manner
Member transportation to job fairs and interviews	September 2020 placed on hold	NA
Provide a value-based payment for providers to incentivize assisting members with disabilities to obtain and maintain employment	September 2020 placed on hold	NA

Conclusions Drawn from the Data

- Sunflower's analytic results were limited in the first year of this PIP and the data included were not presented clearly.

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

- Sunflower implemented three interventions during the first year of the PIP despite the COVID-19 pandemic.
- Sunflower was able to adapt to the challenges of the COVID-19 pandemic and successfully provide services to their Project SEARCH interns.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Sunflower did not conduct the analysis according to the analytic plan for the PIP outcome measure.
- Intervention analytic results for the case management team training and Project SEARCH were not presented clearly.
- The pre-test and post-test survey questions for the care coordinator training were not included in the annual report.

Recommendations for Quality Improvement

1. Follow the analysis plan in the approved methodology for the PIP outcome measure.
2. Fully describe the analysis results provided.
3. Describe the pre- and post-training survey questions and the response options that trigger inclusion in the counts for usefulness and increased knowledge.
4. Provide the average scores on the Likert scale questions for the care coordinator education intervention as movement in these scores could support analysis of the effectiveness of the intervention.

Mental Health Services for Foster Care PIP

Background/Objectives

The aim for this PIP is to "*increase the mental health access for out-of-home foster care youth ages 3 to 17 across the state over a three-year period. The effectiveness of the PIP will be measured by a 2% increase of foster care members with a behavioral health diagnosis using behavioral health services year over year for the duration of the PIP."* In the first year of PIP activity (August 1, 2020, through July 31, 2021), two of the planned interventions were discontinued due to internal and external challenges and barriers. Sunflower's intervention strategy was developed to target members, guardians, and providers, see details in Table 2.12 below.

Table 2.12. Sunflower's Mental Health Services for Foster Care PIP Interventions

PIP Interventions	Implementation	Outcome
Expedited access to behavioral health care services through the Federally Qualified Health Centers	Discontinued with State approval	NA
Qualitative analysis of foster care member data to identify possible causes for the lack of foster care members receiving SED Waiver services	Data collected and analyzed fourth quarter 2020	No analytic results provided
Expansion of the Parent Management Training, Oregon Model (PMTO) to two additional state contractors	Fourth quarter 2020	Intervention results were only partially provided and not presented clearly
Expansion of the behavioral health provider portal	Discontinued with State approval	NA
Extending the myStrength digital behavioral health platform to the foster care population	Fourth quarter 2020	A potential barrier was identified with use of the platform; only two members enrolled in the application.

Conclusions Drawn from the Data

- Sunflower's analysis results were limited in the first year of this PIP, and some of the data included were not presented clearly.

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

- Sunflower included PDSA cycles, with each intervention, documenting the barriers and challenges they encountered during the annual report period.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Sunflower did not provide analytic results for the SED intervention; for the PMTO and myStrength interventions data were only presented for some of the approved measures; and no reason was given for not providing the results.
- Sunflower did not define in the annual report what "successfully completed" means for the PMTO program.
- Analytic results were not clearly presented and contained misstatements.
- Intervention measure definitions did not match the definitions in the approved PIP methodology.

Recommendations for Quality Improvement

1. Verify that data provided in the annual report narrative and tables are correct and presented clearly. Also, table titles should be reflective of the displayed data. Ensure that the reported analysis results are supported by the presented data (e.g., percentage point change and relative difference).
2. In the next annual report, provide analysis results for Phase 1 and Phase 2 of the SED intervention as described in the intervention details and technical specifications.
3. Report data for all of the PMTO measures included in the technical specifications.
4. Descriptions of the PMTO analysis results in the report narrative should be presented clearly and consistent with data in the tables.
5. In the next annual report, the measures for the myStrength intervention should match the definitions in the approved PIP methodology or an explanation should be provided for why the technical specifications were changed.
6. In the next annual report, define "successfully completed" for the PMTO program.

UnitedHealthcare

EPSDT PIP

Background/Objectives

UnitedHealthcare did not include the aim statement from the approved methodology in the annual report; however, the initial aim was well written and included all the required components. *"Will the use of targeted interventions towards UHCCP KS members and providers improve the percentage of UHCCP KS members ages 0–20 who obtain at least one EPSDT screening during the measurement year? The aim for this PIP is to improve EPSDT screening compliance rates to at least 85% over a five-year period."* During the first year of activity (January 1, 2020, to December 31, 2020), UnitedHealthcare implemented all five planned interventions described in Table 2.13.

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Table 2.13. UnitedHealthcare's EPSDT PIP Interventions		
PIP Interventions	**Implementation**	**Outcome**
Live calls to members who were noncompliant for their EPSDT screening, with a warm-transfer option to schedule an appointment	Fourth quarter 2020	UHCCP reported 9.5% of members had an EPSDT claim within 90 days following the live call.
Mailers to members who did not receive a live call to notify them of the need to complete an annual EPSDT screening	Fourth quarter 2020	UHCCP reported 4.6% of members had an EPSDT claim within 90 days following mailer being sent.
GIC reports to UHCCP's Foster Care Coordinator to assist in EPSDT screening gap closure for members in the foster care system	Fourth quarter 2020	The percent of members who had a claim for an EPSDT screening submitted within 90 days following outreach was 22.7%.
GIC reports to providers and later survey them to gauge the usefulness and utilization of the reports by provider offices	Fourth quarter 2020	The percent of noncompliant members attributed to providers who received EPSDT GIC reports and whose EPSDT gap in care was closed within 90 days after report delivery was 9.8%.
Incentive payments to providers for closing EPSDT GIC	Fourth quarter 2020	The percent of noncompliant members attributed to providers who received an EPSDT GIC report and participated in the Community Plan Primary Care Incentive Program whose EPSDT GIC was closed within 90 days after report delivery was 29.7%.

Conclusions Drawn from the Data

- The COVID-19 pandemic, state-wide stay-at-home recommendations, and temporary cessation of outreach to members delayed interventions until 2020 quarter 4, which reduced the scope of the five interventions.
- UnitedHealthcare acknowledged the impact of the COVID-19 pandemic and state-wide stay-at-home recommendations could have impacted overall EPSDT screening rates in 2020 and threaten comparability of repeat measures; the EPSDT participation rate dropped 2.5 percentage points from the measurement year ending 2019 quarter 3 to the year ending 2020 quarter 3.

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

- UnitedHealthcare successfully implemented five interventions, despite the COVID-19 pandemic.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Interpretation of the assessment of each intervention's effectiveness, identification of causes or barriers that prevented success, lessons learned, and next steps was limited.
- A few measures and processes were unclearly stated.

Recommendations for Quality Improvement

1. In future reports, provide an assessment of each intervention's effectiveness, identify causes or barriers that prevented success, and offer lessons learned and next steps.
2. Provide next steps for all interventions in future reports.
3. Ensure measure specifications and tables reflect changes made during the activity period.
4. In future reports, use the interventions' outcome measures to assess their relative strengths.

Prenatal Care PIP

Background/Objectives

UnitedHealthcare's aim for this PIP included the following two statements:

- *"Improve rates for the Timeliness of Prenatal Care HEDIS® sub-measure to at least the 50th percentile of the QC* [Quality Compass] *(state's goal) by the completion of the PIP."*
- *"Increase the average time from notification of pregnancy to Estimated Day of Confinement (EDC) from 161 days to 176 days (first trimester timeframe) by completion of the PIP."*

Although the interventions were listed separately, as required, the improvement strategy was not mentioned in the aim statements that were revised since the approved PIP methodology. Their planned intervention approach included the five interventions listed below in Table 2.14. The first year of activity for this PIP was January 1, 2020, through December 31, 2020; UnitedHealthcare was approved on July 31, 2020, to conclude the PIP at the end of the first year.

Table 2.14. UnitedHealthcare's Prenatal Care PIP Interventions

PIP Interventions	Implementation	Outcome
Use of additional pregnancy-related codes to identify more pregnant women from claims data	Was not implemented due to challenges and decision to conclude the PIP on December 31, 2020	NA
Educating providers of a monetary incentive available to both members and providers upon receipt of an OB Risk Assessment Form from the provider office	2020	34.9% of eligible members received incentive ($200.00) 40.5% of eligible providers received incentive ($60.00)
Sending bi-annual mailers to female members of child-bearing age with education pertaining to the importance of early medical care when pregnant	September 2020	25,720 total mailers sent to eligible members No measurable positive outcome (free maternity T-shirt distributed following 1st trimester prenatal care visit)
Partnering with Community Mental Health Centers (CMHCs) to increase rates of early identification of pregnant women who are receiving BH services	2020	Pregnant members who received care at a CMHC and had BH-specific pregnancy notification form submitted – 0.65% CMHCs who received an incentive for submitting BH-specific pregnancy notification form – 3.85%
Partnering with Substance Use Disorder (SUD) Providers to increase rates of early identification of pregnant women who are receiving treatment for SUDs	Third and Fourth quarter 2020	Pregnant members who received care at a SUD Provider Group and had BH-specific pregnancy notification form submitted – 0.16% SUD provider groups who received incentive for submitting BH-specific pregnancy notification forms – 3.95%

Conclusions Drawn from the Data

- Some intervention process and outcome data had limited use due to the timing of the interventions.
- Unable to conclude success of the PIP outcome measures from the limited data due to the PIP ending after one year.

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

- The proposed interventions—with exception of Intervention 3 (mailers and maternity t-shirts)—seemed likely to lead to improvement in prenatal and postpartum care outcomes. In particular, Intervention 1 (identification via pregnancy-related CPT codes) seemed to have a high potential for early identification of pregnant members.
- Intervention 2 (member and provider incentives) has been in place for several years and appears to both benefit incentive recipients (members and providers) but also leads to favorable outcomes for the intervention and PIP outcome.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- UnitedHealthcare's intervention strategy was not fully realized, and there appeared to be minimal effort toward investigating impacts to the PIP or how improvements could be made.
  - UnitedHealthcare did not perform investigations into subpar performance of interventions and no course corrections to improve intervention outcomes were documented.
  - UnitedHealthcare did not detail opportunities for improvement following the PIP and did not provide sufficient detail for how improvements will be sustained, other than "*UHCCP KS will continue this intervention [#2] following the conclusion of the PIP*."
- Annual reports should have a higher level of detail, especially for Activities 8–10. Those activities describe the success or failure of interventions and then success or failure of the PIP following interventions. Sufficient detail is necessary to interpret whether data clearly evidence success of interventions and also for UnitedHealthcare to conclude that the PIP led to success against aims.
- PIP interpretations and conclusions did not include sufficient evidence nor rationale for the impact of interventions on PIP aims; stronger arguments are necessary to conclude PIP effectiveness.

Recommendations for Quality Improvement
There were no specific recommendations for UnitedHealthcare's Prenatal Care PIP as the activity ended December 31, 2020, and was replaced with their new PIP topic, "Antidepressant Medication Management." KFMC recommended UnitedHealthcare review and apply the noted opportunities for improvement to continuing and future PIPs.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (SMD) PIP

Background/Objectives

The aim for this PIP is to *"employ direct outreach to members and providers to bring rates of HbA1c and LDL-C testing back to, or exceeding, the 2015 rate of over 70% over the next 3 years with annual progress of at least 3%."* During the first activity period for this PIP (January 1, 2020, to June 30, 2021), UnitedHealthcare implemented the three interventions shown in Table 2.15.

Table 2.15. UnitedHealthcare's SMD PIP Interventions		
PIP Interventions	**Implementation**	**Outcome**
Direct outreach by Waiver Care Managers to members enrolled in a waiver program and in need of annual diabetic testing	Second quarter 2021	35% (25/72) of members received successful outreach (partial data through June 30, 2021).
Direct outreach by integrated care coordination team to assist members enrolled in the Whole Person Care (WPC) program with obtaining annual diabetic testing	Fourth quarter 2020 through second quarter 2021	1 of 7 members in WPC program received successful outreach. Other results had issues with documentation of outreach and timing of implementation did not allow for full assessment of the intervention
Distribution of GIC lists to primary care providers (PCPs) and CMHCs	PCPs: December 2020 and March 2021 CMHCs: March 2021	December 2020–May 2021: • 27.9% (50/179) of members received SMD testing within 90 days after inclusion in GIC report. • 40% (20/53) of members on a waiver or in WPC received SMD testing within 90 days after inclusion in GIC report. • 25.9% (30/116) of members not on a waiver or in WPC received SMD testing within 90 days after inclusion in GIC report.

Conclusions Drawn from the Data

- The intervention measurement data submitted routinely to KFMC for the PARs were consistent with results reported in the annual progress report.
- Although the COVID-19 pandemic caused delays in implementation of the gap in care lists to providers, initial reports were sent to primary care providers/physicians in December 2020.

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

- UnitedHealthcare provided additional analysis, beyond that required in the PIP analytic plan, to report trends in monthly HbA1c and LDL-C testing counts during the COVID-19 pandemic.
- UnitedHealthcare provided documentation of the PDSA cycles they completed for their three interventions.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- The analysis plan was very brief. Based on analysis presented in Activity 9.1, the plan was insufficient to properly guide the presentation of results from the PIP outcome measure.
- Tables in Activity 8.2 (intervention analysis results) incorrectly reported values that were not available as zero or 0%.
- In Activity 9.1 (analysis of PIP outcome measures), results of chi-square tests for independence of race/ethnicity on SMD rates were invalid due to small numbers.
- Statements made in Activity 9.3 that indicated PIP successes were not supported by the data presented, and many of the statistics presented did not lend support to the activity's objectives.

Recommendations for Quality Improvement

1. Before additional analysis is conducted, add the following details to the analysis plans:
   - Beginning and ending dates for measurement periods to be reported
   - Specify which measurement periods will be compared and the statistics used for comparison (e.g., percentage point change, relative change in rates, p values of statistical tests)
   - Details for stratification or rates, if applicable, and plan for displaying or suppressing rates for strata with small denominators
   - A clear statement of the intent of the regression analysis
2. In future reports, ensure the interpretation of the analytic results are supported by the presented data.
3. Review statistical tests and regression models to ensure they are appropriate for the data being analyzed.
4. In future reports, ensure data presented in Activity 9.3 supports the evaluation of the PIP and follow-up activities.
5. For counts and rates in future reports, a clear and accurate distinction should be made between "zero," "not available," and "not applicable."

Advanced Directives PIP

Background/Objectives

UnitedHealthcare's aim for this PIP is, "*The use of targeted, culturally competent education in members age 18 and older without a guardian with long term services and supports will lead to 50% of the identified population having an executed Advanced Directives* [AD] *on file with UHC by the end of the PIP measurement period. Year one will be the baseline year and a goal for year over year improvement will be set following year one performance*." The six interventions in Table 2.16 were implemented during the first activity period of this PIP (January 1, 2020, through December 31, 2020).

Table 2.16. UnitedHealthcare's Advanced Directives PIP Interventions

PIP Interventions	Implementation	Outcome
Develop an advanced directive (AD) educational form and process to: inform, document, store, track, and share	Developed by May 1, 2020	No data available
Develop and provide AD training for UHCCP's Community Health Workers and Care Coordinators	June and July 2020 for existing staff, August through November 2020 for new staff	100% of required UHCCP employees completed the training.
Educate providers on the AD Project	Updated provider manual in 2020. AD bulletin will be emailed to provider network during 2nd annual reporting cycle.	No data available
AD mailer and education for established members on the Frail Elderly waiver in Sedgwick County	Developed by June 1, 2020 Tracking of data October–December 2020	AD on file for established members within 90 days of visit (5%, 2/40)
AD mailer and education for new members on the Frail Elderly waiver in Sedgwick County	Developed by June 1, 2020 Tracking of data October–December 2020	AD on file for new members within 90 days of visit (0%, 0/30) AD on file for new members within 90 days of enrollment (43%, 13/30)
Store completed ADs in UHCCP's care management record and share with member permission	Fourth quarter 2020	19 additional members in Sedgwick County on Frail Elderly waiver had ADs on file during October–December 2020.

Conclusions Drawn from the Data

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

- Education regarding ADs targets members, providers, and UnitedHealthcare staff.
- The member facing interventions are being pilot tested.
- UnitedHealthcare was able to at least partially implement all six of their interventions despite the COVID-19 pandemic.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Target dates for intervention implementation and completion were not consistently provided.
- UnitedHealthcare did not address or discuss KFMC's recommendation regarding the denominator for Intervention 4 (AD mailer and education for Established Members on the Frail Elderly waiver in Sedgwick County).
- Analysis of the PIP outcome measure was not reported.
- The constant coefficients in regression analyses were not interpreted accurately.

Recommendations for Quality Improvement

1. Provide completion dates for specific interventions and ensure consistency of reporting.
2. Provide more specific target dates for implementation of Intervention 3 (Educate providers on the AD project) and strive to develop and email the bulletin to providers early in the reporting cycle.
3. To evaluate the success of Intervention 4, the denominator should exclude members that already have an AD on file. If members that already have an AD on file are included in the denominator, UnitedHealthcare should stratify the data by those with an AD already on file, and those without an AD on file.
4. The PIP outcome measure must be calculated and discussed separately from the intervention outcome and process measures. Demographic statistical analysis, similar to the analysis completed for the pilot group, should be conducted for the PIP outcome measure.
5. Revise the constant coefficient interpretation in future reports, as it was not interpreted accurately. The constant coefficient is not associated with specific members in this model, and the drop in the constant coefficient is not relevant without an interpretation.

Housing PIP

Background/Objectives

UnitedHealthcare stated their aim for this PIP, to improve identification and permanency of housing for members who are experiencing homelessness or at-risk of homelessness, in the form of two study questions.

- Question 1: *"Will member, staff, and provider interventions improve the identification of members who are experiencing homelessness or at-risk of homelessness?"*
- Question 2: *"Will the addition of member and community housing resources lead to permanent housing for members who are experiencing homelessness or at-risk of homelessness?"*

The first year of activity for this PIP was September 1, 2020, to August 31, 2021. However, some activity occurred following State approval of the PIP interventions and prior to full development of the methodology. Four of the five interventions described in Table 2.17 were implemented as planned.

Table 2.17. UnitedHealthcare's Housing PIP Interventions		
PIP Interventions	**Implementation**	**Outcome**
Staff training on homelessness and housing resources	First quarter 2020	Provided to 170 care coordinators and 30 community health workers as of July 31, 2021; 197 employees attended the annual training, and 3 attended a quarterly training for new employees.
Pilot of Housing Stabilization Funds	Second quarter 2020	18 members met the program requirements and were awarded funds.
Housing Bridge pilot to offer 10 units of transitional/permanent housing	Third quarter 2020	Data was not yet available due to the timing of the placements and annual report time frame.
Educate and engage a cohort of providers to use Z-codes for housing related issues	Not launched, with State approval, due to contract delays and impact of the COVID-19 pandemic	NA
Outreach by Housing Navigator to high-volume homeless shelters to increase member identification and housing referrals	October 2020	2 of 14 shelters (14%) agreed to identify and refer members to the Housing Navigator for the period October 2020 to July 2021.

Conclusions Drawn from the Data

- UnitedHealthcare implemented four of the five planned interventions during the first annual report year. However, the response of housing referrals from shelters remained low after multiple tactics were tried in an effort to increase the numbers.

Strengths Regarding Quality, Timeliness, and Access to Health Care Service

- All 18 members who received Housing Stabilization Funds successfully maintained housing for 60 or more days following receipt of the funds.
- UnitedHealthcare implemented new strategies while conducting the Bridge pilot to make the program more cost-effective and to meet the members' needs. They have incorporated what was learned in the first year of this PIP and are considering expanding the program to another location in year two.
- A new intervention is being developed to increase the number of Social Determinants of Health screenings, improve data collection, and identify more members with housing related needs.
- UnitedHealthcare provided and clearly described at least one PDSA cycle for each intervention with changes implemented in year one or planned for year two.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- UnitedHealthcare provided analytic results of the outcome measure for staff training that were not consistent with the measure's definition in the technical specifications.
- In the analytic results of the Bridge pilot, UnitedHealthcare reported the number of members that participated but did not provide the number of members identified by the algorithm or referred to the program.
- Some analytic results were not provided in the first annual report for the Bridge pilot because the data were incomplete; however, UnitedHealthcare did not include the average 12-month utilization of members in the pilot, prior to participation, which should have been available.

Recommendations for Quality Improvement

1. The analysis provided for the outcome measure is not consistent with the measure definition; revise the measure definition or provide the specified rate.
2. Provide in the next annual report data for the process measure, "the percent of individuals eligible for the Bridge Pilot Project who participated in the pilot.
3. In the next annual report, include all measures for the first year of the Bridge pilot intervention, as well as any interim data available for the second year.

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4. CAHPS Health Plan 5.1H Survey Validation

Background/Objectives

CAHPS is a nationally standardized survey tool sponsored by the Agency for Healthcare Research and Quality (AHRQ) 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 HEDIS measures and the CMS Child and Adult Core Set measures include CAHPS Health Plan Survey measures. The State contractually required 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 2021 CAHPS surveys (measurement year 2020) were conducted by Aetna, Sunflower, and UnitedHealthcare using the CAHPS 5.1H Adult Questionnaire (Medicaid) and CAHPS 5.1H Child Questionnaire (with CCC measure).[7]

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

For the 2021 survey, each MCO contracted with NCQA-certified CAHPS survey vendors to assist with scoring methodology, fielding the survey, and presenting the calculated results—Aetna contracted with the Center for the Study of Services; Sunflower and UnitedHealthcare contracted with SPH Analytics. NCQA-certified vendors have ongoing NCQA oversight to ensure adherence to survey requirements. Aetna chose the mixed-mode mail/telephone protocol and Sunflower and UnitedHealthcare chose the mixed-mode mail/telephone/internet protocol. Both protocols include an optional mailing of a prenotification postcard, an initial survey package mailing, mailing of a second survey package to non-respondents, reminder/thank-you postcard mailings after each survey mailing, and telephone follow-up to non-respondents. The survey packages include a cover letter, questionnaire, and postage-paid return envelope addressed to the survey vendor. The protocols specify three to six telephone follow-up attempts spaced at different times of the day and on different days of the week (within a survey, the maximum number of attempts must be the same for all members). For the internet methodology, a link to an online version of the survey is included in the cover letters. Aetna members who called to request a replacement survey were given the option to complete the survey online (two members completed the survey online). All surveys were fielded from February 2021 through May 2021.

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. Each MCO complied with the following NCQA requirements:

- Eligibility for each group required continuous enrollment in the MCO from July 1 to December 31, 2020,

[7] Aetna started its KanCare contract on January 1, 2019, and 2020 was the first year that fulfilled the survey eligibility requirements. Amerigroup was contracted by the KanCare program from 2013 through 2018 and conducted surveys from 2014 through 2018.

with no more than one gap of up to 45 days; enrollment on December 31, 2020; and enrollment on date of selection.

- Members eligible for each survey were
  - **Adults** – Age 18 years and older as of December 31, 2020;
  - **GC Populations** – Age 17 years and younger as of December 31, 2020; and
  - **CCC Populations** – A subset of the GC population identified as "CCC" using HEDIS criteria based on health criteria and specific survey answers.
- 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 adults;
  - **GC Sample** – 1,650 GC children; and
  - **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 onset of the COVID-19 pandemic was too late to have noticeably impacted 2020 CAHPS rates. The first round of survey mailing had been completed, and members who responded after March 11 may have completed their survey before personally experiencing any effects of the pandemic on their health care. The vendors adjusted their processes for following up with nonrespondents after the second survey mailing, and each MCO was able to obtain an adequate number of returned surveys for valid results (although the number of returned surveys was lower than ideal).

The pandemic had a greater effect on the 2021 rates, whose measurement period included the surge in new infection rates that began in October 2020. Although the vendors' administration of the CAHPS surveys in 2021 was not impeded, the pandemic was likely a factor in declining rates related to access to services and coordination of care.

Because different parts of the nation were not affected equally by the pandemic while the CAHPS survey was fielded in 2020, NCQA recommended against the use of 2020 data for improvement scoring and year-over-year trending. The vendors' CAHPS reports and this report display CAHPS percentile rankings for the current and prior years. The authors of these reports have used caution when comparing and interpreting 2020 and 2021 rates to prior years and advise their readers to do the same.

Conclusions Drawn from the Data Common Among the MCOs

With few exceptions, 2021 KanCare- and MCO-level survey results continued to demonstrate positive assessments by members of quality, timeliness, and access to healthcare. For the most part, global ratings, composite scores, and question percentages were at or above the 50th percentile, and many of these rates were above the 75th 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 2017–2021, 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 Quality Compass rankings by KanCare and MCO populations (adult, GC TXIX, GC TXXI, CCC TXIX, and CCC TXXI). The ratings are the percentage responding 8, 9, or 10 out of 10.

Table 3.1. Global Ratings by MCO and Program (Rating 8+9+10) – 2021

Global Rating		Adult		General Child				Children with Chronic Conditions			
				Title XIX		Title XXI		Title XIX		Title XXI	
	MCO	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank
Health Plan	ABH	76.7%	<50th	**90.2%**	>75th	87.8%	≥50th	85.1%	≥50th	87.6%	>75th
	SHP	83.2%	>75th	**90.0%**	>75th	**92.4%**	**>90th**	86.3%	≥50th	**90.9%**	**>95th**
	UHC	79.3%	≥50th	89.5%	>75th	89.9%	>75th	87.8%	>75th	**90.1%**	**>95th**
	KanCare	**80.0%**	**≥50th**	**89.9%**		**>75th**		**87.1%**		**>75th**	
Health Care	ABH	75.9%	<33.33rd	89.6%	≥50th	**90.3%**	>66.67th	86.0%	**<25th**	**↑90.1%**	>66.67th
	SHP	77.7%	<50th	89.8%	≥50th	**92.1%**	>75th	86.0%	**<25th**	**90.9%**	>75th
	UHC	76.9%	<50th	88.4%	<50th	89.4%	≥50th	87.8%	≥50th	**91.0%**	>75th
	KanCare	**76.9%**	**<50th**	**89.5%**		**≥50th**		**87.3%**		**<50th**	
Personal Doctor	ABH	80.8%	**<25th**	88.0%	**<25th**	**90.0%**	<50th	88.1%	<33.33rd	**90.6%**	≥50th
	SHP	89.3%	**>95th**	**93.4%**	>75th	**90.3%**	<50th	**91.8%**	>75th	88.5%	<50th
	UHC	85.1%	>66.67th	↓86.2%	**<5th**	**91.7%**	≥50th	87.2%	**<25th**	**91.9%**	>75th
	KanCare	**85.4%**	**>66.67th**	**89.5%**		**<33.33rd**		**89.3%**		**<50th**	
Specialist	ABH	85.0%	≥50th	88.5%		≥50th		87.6%	<50th	88.0%	≥50th
	SHP	86.0%	>75th	81.1%		**<10th**		81.9%	**<5th**	87.1%	<50th
	UHC	87.6%	>75th	86.1%		<50th		87.2%	<50th	84.9%	**<25th**
	KanCare	**86.4%**	**>75th**	**84.9%**		**>25th**		**↓85.6%**		**>75th**	

Note: The KanCare rate for the child surveys is the weighted average of the six subpopulations. The MCO-level General Child ratings of specialist are weighted averages of the Title XIX and Title XXI populations (denominators were too small to report separately).
Very High: percentages 90.0% or greater, KanCare Quality Compass rankings above the 75th percentile, and subpopulation rankings above the 90th percentile were considered "very high" and are shown in bold green font.
Relatively Low: KanCare rankings below the 50th percentile and subpopulation rankings below 25th percentile were "relatively low" and are shown in bold purple font.
↑↓Indicates a statistically significant increase or decrease compared to the prior year; $p<.05$.

Table 3.2 displays scores and rankings for composite measures Getting Care Quickly, Getting Needed Care, Coordination of Care, How Well Doctors Communicate, and Customer Service for KanCare and MCO populations. A composite score is the average of its component questions' percentages.

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Table 3.2. Composite Scores by MCO and Program – 2021

Composite		Adult		General Child				Children with Chronic Conditions			
				Title XIX		Title XXI		Title XIX		Title XXI	
	MCO	Score	Rank	Score	Rank	Score	Rank	Score	Rank	Score	Rank
Getting Care Quickly	ABH	83.8	>66.67th	**92.3**	>75th	88.8	≥50th	**93.1**	>75th	**92.8**	>75th
	SHP	87.5	**>90th**	↓89.9	>66.67th	88.4	≥50th	↓89.6	**<25th**	**93.7**	>75th
	UHC	83.8	≥50th	**92.4**	>75th	↓88.2	≥50th	**95.1**	**>90th**	↓**91.1**	≥50th
	KanCare	**85.1**	**>75th**	↓**91.0**		**>75th**		↓**92.6**		**>66.67th**	
Getting Needed Care	ABH	88.1	>75th	88.0	≥50th	88.0	≥50th	**91.3**	>75th	88.1	<50th
	SHP	89.0	**>90th**	87.2	≥50th	**92.4**	**>95th**	87.4	<50th	**93.7**	**>95th**
	UHC	88.4	>75th	**90.6**	>75th	**92.6**	**>95th**	88.8	≥50th	**91.5**	>75th
	KanCare	**88.5**	**>75th**	**89.1**		**>75th**		↓**89.3**		**≥50th**	
Coordination of Care	ABH	87.4	≥50th	82.1		**<25th**		86.8	≥50th	82.7	**<25th**
	SHP	**90.9**	>75th	84.1		<33.33rd		83.3	<33.33rd	↑**91.5**	**>95th**
	UHC	**90.8**	>75th	86.7		<50th		83.6	<33.33rd	84.7	<50th
	KanCare	**89.9**	**>75th**	**84.6**		**<33.33rd**		**84.7**		**<50th**	
How Well Doctors Communicate	ABH	**93.2**	≥50th	↓**95.5**	≥50th	**93.9**	<50th	**95.9**	>66.67th	**96.0**	>75th
	SHP	↑**95.3**	**>90th**	**97.5**	**>90th**	**96.3**	>75th	**98.1**	**>95th**	↓**96.0**	>75th
	UHC	↓**91.9**	<50th	**94.4**	≥50th	**95.6**	>66.67th	**95.8**	>66.67th	↓**95.7**	>66.67th
	KanCare	**93.4**	**>66.67th**	**95.7**		**>66.67th**		**96.5**		**>75th**	
Customer Service	ABH	89.1	<50th	↑**94.7**		**>95th**		**91.6**		≥50th	
	SHP	**92.0**	>75th	86.1		**<25th**		87.1		**<25th**	
	UHC	**93.3**	**>95th**	88.2		≥50th		**91.0**		≥50th	
	KanCare	**91.7**	**>75th**	**89.2**		**≥50th**		**89.7**		**>33.33rd**	

Note: The KanCare score for the child surveys is the weighted average of the six subpopulations. The general child Customer Service scores are weighted averages of the Title XIX and Title XXI populations (denominators were too small to report separately).
Very High: scores 90.0 or greater, KanCare Quality Compass rankings above the 75th percentile, and subpopulation rankings above the 90th percentile were considered "very high" and are shown in bold green font.
Relatively Low: KanCare rankings below the 50th percentile and subpopulation rankings below 25th percentile were "relatively low" and are shown in bold purple font.
↑↓Indicates a statistically significant increase or decrease compared to the prior year; $p<.05$.
* The denominator was less than 100; therefore, a Quality Compass ranking was not assigned (NA).

Table 3.3 provides scores and 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.

CAHPS questions related to access, timeliness, or quality of care that are not global ratings or composite questions (shown in Table 3.4, Table 3.5, and Table 3.6) include measures of

- Mental or emotional health,
- Having a personal doctor,
- Smoking and tobacco use and cessation strategies (four questions), and
- Flu vaccinations for adults.

Table 3.3. CCC Composite Scores by MCO and Program – 2021

Composite	MCO	Children with Chronic Conditions			
		Title XIX		Title XXI	
		Score	Rank	Score	Rank
Access to Prescription Medicines	ABH	93.0	>75th	95.6	>90th
	SHP	94.4	>75th	92.5	>50th
	UHC	96.7	>95th	↓92.6	>66.67th
KanCare		94.9		>75th	
Access to Specialized Services	ABH	↓77.8		>66.67th	
	SHP	79.8		>75th	
	UHC	81.7		>75th	
KanCare		↓79.9		>75th	
Coordination of Care for Children with Chronic Conditions	ABH	75.3		<25th	
	SHP	72.8		<25th	
	UHC	69.2		<5th	
KanCare		72.2		<25th	
Family-Centered Care: Getting Needed Information	ABH	91.0	<50th	93.5	>75th
	SHP	↓89.9	<50th	94.4	>90th
	UHC	92.9	>75th	95.4	>90th
KanCare		↓91.8		<66.67th	
Family-Centered Care: Personal Doctor Who Knows Child	ABH	91.1	≥50th	91.1	≥50th
	SHP	91.4	>66.67th	92.5	>75th
	UHC	90.5	<50th	92.5	>75th
KanCare		91.2		≥50th	

Note: The KanCare score is the weighted average of the six subpopulation scores. The Access to Specialized Services and Coordination of Care for Children with Chronic Conditions scores are weighted averages of the Title XIX and Title XXI populations (denominators were too small to report separately).
Very High: scores 90.0 or greater, KanCare Quality Compass rankings above the 75th percentile, and subpopulation rankings above the 90th percentile were considered "very high" and are shown in bold green font.
Relatively Low: KanCare Quality Compass rankings below the 50th percentile and subpopulation rankings below 25th percentile were "relatively low" and are shown in bold purple font.
↓Indicates a statistically significant decrease compared to the prior year; $p<.05$.

Table 3.4. Non-Composite Question Related to Mental or Emotional Health – 2017 to 2021

CAHPS Question		Population	2021	2020	2019	2018*	2017*
Q30/Q54.	In general, how would you rate your [your child's] overall mental or emotional health? *("Excellent" or "Very Good")*	Adult	30.7%	31.5%	32.0%	34.9%	↓32.3%
		GC	68.9%	68.1%	↓68.2%	72.7%	74.5%
		CCC	37.1%	38.1%	↓38.0%	↓41.2%	46.2%

Note: Percentages are reported at the KanCare-level (the combined percentages weighted by MCO and program populations) because of the number of MCO-level scores based on fewer than 100 responses.
* KanCare rates include Amerigroup's survey results for 2017 and 2018.
↓Indicates a statistically significant decrease compared to the prior year; $p<.05$.

Table 3.5. Non-Composite Question Related to Having a Personal Doctor – 2017 to 2021

CAHPS Question		Population	2021	2020	2019	2018*	2017*
Q10/Q25.	A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you [Does your child] have a personal doctor?	Adult	87.2%	86.7%	↑89.1%	83.6%	84.3%
		GC	86.8%	87.5%	↑88.7%	86.9%	87.4%
		CCC	93.2%	94.3%	↑94.7%	93.3%	94.5%

Note: Adult, GC and CCC percentages are combined percentages of MCO populations, weighted by MCO and program population size.
* KanCare rates include Amerigroup's survey results for 2017 and 2018.
Very High: scores 90.0 or greater were considered "very high" and are shown in bold green font.
↑Indicates a statistically significant increase compared to the prior year; $p<.05$.

Table 3.6. Adult HEDIS Measures Related to Flu Vaccination and Smoking and Tobacco Usage – 2021

Measure	KanCare		Aetna		Sunflower		UnitedHealthcare	
	Percent	Rank	Percent	Rank	Percent	Rank	Percent	Rank
Flu Vaccination for Adults 18–64 (FVA)	**47.1%**	**>75th**	47.7%	>75th	50.8%	**>90th**	↓43.4%	>66.67th
Medical Assistance with Smoking and Tobacco Use Cessation (MSC)								
– Total % Current Smokers *(lower is better)*	**30.3%**	**≥50th**	31.0%	≥50th	25.5%	<50th	34.2%	**>75th**
– Advising Smokers to Quit	**↓72.0%**	**<33.33rd**	70.0%	**<25th**	76%*	NA*	69.8%	**<25th**
– Discussing Cessation Medications	**52.5%**	**<50th**	45.5%	**<25th**	63%*	NA*	47.7%	**<25th**
– Discussing Cessation Strategies	**44.1%**	**<33.33rd**	45.0%	<33.33rd	48%*	NA*	40.2%	**<25th**

Note: Adult, GC and CCC percentages are combined percentages of MCO populations, weighted by MCO and program population size.
Very High: scores 90.0 or greater, KanCare Quality Compass rankings above the 75th percentile, and subpopulation rankings above the 90th percentile were considered "very high" and are shown in bold green font.
Relatively Low: KanCare rankings below the 50th percentile and subpopulation rankings below 25th percentile were "relatively low" and are shown in bold purple font (KanCare rank ≥50th and subpopulation rank >75th are in purple if lower is better).
↓Indicates a statistically significant decrease compared to the prior year; $p<.05$.
* Indicates the number of responses was less than 100; therefore, a Quality Compass ranking was not assigned (NA).

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

The following are areas of strength for KanCare identified by measures having very high KanCare rates (at least 90% or 90) or rankings (>75th or better). Also listed are demonstrations of improvement and MCO rates that were very high or ranked >90th or >95th.

Common Among the MCOs

Global Ratings

- **Rating of Health Plan** – The KanCare GC rate (90%, >75th) and the KanCare CCC rank (>75th) were very high. The following rates or ranks were also very high:
  - GC – ABH TXIX (90%), SHP TXIX (90%), SHP TXXI (92%, >90th), and UHC TXXI (90%)
  - CCC – SHP TXXI (91%, >95th) and UHC TXXI (90%, >95th)

  Increasing 5-year trends were obtained for KanCare adult (1.1 pp/yr), SHP adult (1.5 pp/yr), KanCare GC (0.6 pp/yr), and SHP TXXI CCC (1.3 pp/yr) rates.
- **Rating of All Health Care** – The following rates were very high:
  - GC – ABH TXXI (90%), SHP TXXI (92%)
  - CCC – ABH TXXI (90%, a statistically significant improvement), SHP TXXI (91%) and UHC TXXI (91%)

  An increasing 5-year trend was obtained for SHP TXXI CCC (1.1 pp/yr) rates.
- **Rating of Personal Doctor** – The SHP adult rank was >95th. The following rates were very high:
  - GC – SHP TXIX (93%), ABH TXXI (90%), SHP TXXI (90%), and UHC TXXI (92%)
  - CCC – SHP TXIX (92%), ABH TXXI (91%), and UHC TXXI (92%)

  Increasing 5-year trends were obtained for KanCare adult (0.8 pp/yr) and UHC adult (1.7 pp/yr).
- **Rating of Specialist Seen Most Often** – The KanCare adult rank was >75th. Increasing 5-year trends were observed for KanCare adult (1.1 pp/yr) and UHC adult (2.4 pp/yr) rates.

Composites

- **Getting Care Quickly** – The KanCare adult rank (>75th), KanCare GC rate and rank (91, >75th), and the KanCare CCC rate (93) were very high. The following rates or ranks were also very high:
  - Adult – SHP (>90th)
  - GC – ABH TXIX (92), SHP TXIX (90), and UHC TXIX (92)
  - CCC – ABH TXIX (93), SHP TXIX (90), UHC TXIX (95, >90th), ABH TXXI (93), SHP TXXI (94), and UHC TXXI (91)

- **Getting Needed Care** – The KanCare adult rank (>75th) and the KanCare GC rate and rank (90, >75th) were very high. The following rates or ranks were also very high:
  - Adult – SHP (>90th)
  - GC – UHC TXIX (91), SHP TXXI (92, >95th), and UHC TXXI (93, >95th)
  - CCC – ABH TXIX (91), SHP TXXI (94, >95th), and UHC TXXI (92, >75th)
- **Coordination of Care** – The KanCare adult rate and rank (90, >75th) were very high. The following rates or ranks were also very high:
  - Adult – SHP (91) and UHC (91)
  - CCC – SHP TXXI (92, statistically significant increase)
- **How Well Doctors Communicate** – The KanCare adult rate (93), KanCare GC rate (96), and the KanCare CCC rate and rank (97, >75th) were very high. The following rates or ranks were also very high:
  - Adult – ABH (93), SHP (95, >90th), and UHC (92)
  - GC – ABH TXIX (95), SHP TXIX (97, >90th), UHC TXIX (94), ABH TXXI (94), SHP TXXI (96), and UHC TXXI (96)
  - CCC – ABH TXIX (96), SHP TXIX (98, >95th), UHC TXIX (96), ABH TXXI (96), SHP TXXI (96), and UHC TXXI (96)

  Increasing 5-year trends were obtained for SHP TXIX GC (0.4 p/yr) and SHP TXXI GC (0.4 p/yr) rates.
- **Customer Service** – The KanCare adult rate and rank (92, >75th) and the KanCare CCC rate (90) were very high. The following rates or ranks were also very high:
  - Adult – SHP (92) and UHC (93, >95th)
  - TXIX and TXXI GC – ABH (95, >95th)
  - TXIX and TXXI CCC – ABH (92) and UHC (91)

  An increasing 5-year trend was obtained for KanCare adult (0.8 p/yr) rates.

<u>CCC Composites</u>

- **Access to Prescription Medicines** – The KanCare CCC rate and rank (95, >75th) were very high. The following rates or ranks were also very high:
  - TXIX CCC – ABH (93), SHP (94), and UHC (97, >95th)
  - TXXI CCC – ABH (96, >90th), SHP (93), and UHC (93)

  Rates from 2017 to 2021 were all 91 or greater.
- **Access to Specialized Services** – The KanCare CCC rank was very high (>75th).
- **Family-Centered Care: Getting Needed information** – The KanCare CCC rate (92) was very high. The following rates or ranks were also very high:
  - TXIX CCC – ABH (91), SHP (90), and UHC (93)
  - TXXI CCC – ABH (93), SHP (94, >90th), and UHC (95, >90th)

  Rates from 2017 to 2021 were all 90 or greater.
- **Family-Centered Care: Personal Doctor Who Knows Child** – The KanCare CCC rate (91) was very high. The following rates were also very high:
  - TXIX CCC – ABH (91), SHP (91), and UHC (91)
  - TXXI CCC – ABH (91), SHP (92), and UHC (92)

  Rates from 2020 to 2021 were all 90 or greater. Increasing 5-year trends were obtained for KanCare (0.6 p/yr), SHP TXIX (1.0 p/yr) and SHP TXXI (1.2 p/yr) rates.

<u>Non-Composite Questions</u>

- **Having a Personal Doctor** – KanCare CCC had a very high rate (93%).
- **Flu Vaccinations for Adults 18–64** – KanCare (47%, >75th) and SHP (>90th) rates are very high based on percentile rankings.

Technical

Common Among the MCOs

- The Center for the Study of Services (Aetna's vendor) and SPH Analytics (Sunflower's and UnitedHealthcare's vendor) are both NCQA-certified survey vendors, with NCQA oversight to ensure survey protocols followed recognized standards.
- The survey process was clearly defined by NCQA and provided comparative information across health plans.
- Each MCO's survey process included an initial mailing of the survey questionnaire, two reminder post card mailings, and a second mailing of the questionnaire to non-respondents. After the second postcard mailing, telephone outreach to non-respondents was conducted.
- The survey process was clearly defined by NCQA and provided comparative information across health plans.
- Vendor reports included the timeline for survey implementation.
- Analyses of survey results were clearly presented.
- Each MCO's vendor report included an analysis of key drivers for the Rating of Health Plan and recommendations or resources for improving the rating.

Aetna

- Aetna's vendor mailed an optional postcard notification prior to the first survey mailing.
- Aetna made up to six phone attempts to contact non-responding members (the maximum allowed).

Sunflower

- Sunflower sent postcard notification to selected adult and child TXIX members.
- Sunflower included an internet response option in addition to mail and phone response options.

UnitedHealthcare

- UnitedHealthcare included an internet response option in addition to mail and phone options.

Notable Improvements

- **Medical Assistance with Smoking and Tobacco Use Cessation**
  - **Smoking and Tobacco Usage** – SHP rates showed an improving trend (1.6 pp/yr).
  - **Discussing Cessation Medications** – SHP rates showed an improving trend (3.1 pp/yr).

Opportunities for Improvement

Outcomes

Several measures for the KanCare adult and child populations, as well as for each MCO, indicated a need for some improvement. Relatively low rates, that is, below the 50th percentile (for KanCare rates) or the 25th percentile (for subpopulation rates) and below 90 or 90%, were considered opportunities for improvement. Rates statistically significantly decreased from 2020 or with decreasing 2017–2021 trendlines were also considered opportunities for improvement.

Global Ratings

- **Rating of All Health Care** – The 2021 KanCare adult and KanCare CCC rates ranked <50th. Rates were also relatively low for ABH TXIX CCC and SHP TXIX CCC; both ranked <25th.
- **Rating of Personal Doctor** – Ratings were relatively low for KanCare GC (<33.33rd) and KanCare CCC (<50th). The following rates or ranks were also relatively low:
  - Adult – ABH (<25th)

  - GC – ABH TXIX (<25th) and UHC TXIX (<5th, statistically significant decrease)
  - CCC – UHC TXIX (<25th)
- **Rating of Specialist Seen Most Often** – The KanCare GC and KanCare CCC rates ranks were <25th. The following rates or ranks were also relatively low:
  - TXIX and TXXI GC – SHP (<10th)
  - CCC – SHP TXIX (<5th) and UHC TXXI (<25th)

  The KanCare CCC rate had decreased significantly from 2020 and had a decreasing 5-year trend (1.0 pp/yr).

Composites

- **Getting Care Quickly** – Although rates remained very high, KanCare GC and KanCare CCC rates declined significantly from 2020. Rates also declined significantly for four subpopulations:
  - GC – SHP TXIX and UHC TXXI
  - CCC – SHP TXIX (<25th) and UHC TXXI.

  Decreasing 5-year trends were observed for SHP TXXI GC (0.8 p/yr), UHC TXXI GC (1.0 p/yr), KanCare CCC (0.4 p/yr), SHP TXIX CCC (0.6 p/yr), and UHC TXXI CCC (0.7 p/yr) rates.
- **Getting Needed Care** – The KanCare CCC rate declined significantly from 2020 (five of six subpopulations declined non-significantly) but remained ranked ≥50th.
- **Coordination of Care** – The 2021 scores for KanCare GC (<33.33rd) and KanCare CCC (<50th) were relatively low. The following rates were also relatively low:
  - TXIX and TXXI GC – ABH (<25th)
  - CCC – ABH TXXI (<25th)
- **How Well Doctors Communicate** – Four populations had rates decrease significantly from 2020 but retained very high rates: UHC adults, ABH TXIX GC, SHP TXXI CCC, and UHC TXXI CCC.
- **Customer Service** – Two rates with TXIX and TXXI combined ranked <25th: SHP GC and SHP CCC. The SHP GC rates have a declining 5-year trendline (1.0 p/yr).

CCC Composites

- **Coordination of Care for Children with Chronic Conditions** – The KanCare CCC rate (72, <25th) was the lowest score from 2017 to 2021. Rates were also relatively low for each MCO:
  - TXIX and TXXI CCC – ABH (<25th), SHP (<25th), and UHC (<5th)
  - Declining 5-year trendlines were observed for KanCare CCC (0.9 p/yr) and UHC TXIX and TXXI CCC (2.0 p/yr) rates.
- **Access to Prescription Medicines** – The UHC TXIX CCC rate declined significantly but remained very high.
- **Access to Specialized Services** – The KanCare CCC rate and the ABH TXIX and TXXI CCC rate declined significantly.
- **Family-Centered Care: Getting Needed information** – The KanCare CCC and SHP TXIX CCC rates declined significantly but remained very high.

Non-Composite Questions

- **Rating of Mental or Emotional Health** – This continues to be an area with opportunities for improvement. Only 31% of KanCare adult, 69% of KanCare GC, and 37% of KanCare CCC respondents rated their [their child's] overall mental or emotional health as *excellent* or *very good.* The 2017–2021 trendlines are declining for KanCare adult (1.7 pp/yr), KanCare GC (1.6 pp/yr), and KanCare CCC (2.2 pp/yr) rates.

- **Medical Assistance with Smoking and Tobacco Use Cessation**
  - **Smoking and Tobacco Usage** – The KanCare rate (30%) was above (worse than) the 50th percentile. The UHC rate (34%) was worse than the 75th percentile.
  - **Advising Smokers and Tobacco Users to Quit** – The KanCare rate declined significantly and was ranked <33.33rd. ABH and UHC rates ranked <25th. A decreasing 5-year trend was observed for the KanCare rate (1.6 pp/yr).
  - **Discussing Cessation Medications** – The KanCare rank remained <50th. ABH and UHC rates ranked <25th.
  - **Discussing Cessation Strategies** – The KanCare rank decreased to <33.33rd. The UHC rate ranked <25th.
- **Flu Vaccinations for Adults 18–64** – The UHC rate decreased significantly.

Technical Opportunities for Improvement

The following are opportunities for improving survey administration and reporting.

Common Among the MCOs

- Fewer than 411 surveys, the targeted number of responses, were completed for 12 of the 14 survey populations.

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

Of the four recommendations made in the 2020 CAHPS Health Plan 5.0H Survey Validation report, one was addressed and three were in progress. Please see Appendix F for more details.

Recommendations for Quality Improvement

Common Among the MCOs

1. All MCOs should continue to expand their care coordination efforts, particularly for children with chronic conditions, including primary care physicians being informed and up to date about the care children receive from other doctors and health providers. Consider encouraging providers to discuss with the parents and guardians (or the youth themselves) whether their children receive care or services elsewhere, request releases of information, and establish bi-directional ongoing communication with the other providers. Consider whether the MCOs could assist providers in identifying members' other sources of care, for the provider to use in flagging medical records as prompts for initiation of coordination of care discussions (e.g., similar to gap-in-care communications).
2. 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.
3. MCOs should continue efforts to reduce smoking and tobacco use and to promote cessation. Consider methods to address providers' missed opportunities to discuss cessation medications and other strategies while advising smoking cessation (e.g., MCO supplying communication materials and identifying resources for providers to use, or for referrals).
4. MCOs should continue efforts to increase the number of people receiving flu vaccinations yearly.

5. 2021 KanCare Mental Health Consumer Perception Survey

Background/Objectives

Since 2010, KFMC Health Improvement Partners (KFMC) has administered a mental health consumer perception survey to KanCare beneficiaries receiving services, as per the External Quality Review contract with the Kansas Department of Health and Environment (KDHE) and the Kansas Department of Aging and Disability Services (KDADS). In 2021, KFMC contracted with SPH Analytics to administer the survey. KFMC provided operational oversight; SPH Analytics analyzed survey data and produced the analysis included in this report.

The survey objectives were to assess the quality of behavioral health services by focusing on the patient's experiences with care.[8] Specific objectives of the survey include the following for adult and child populations.

Adult:

- Determination of member ratings of
  - Counseling and Treatment Overall
- Assessment of member perceptions related to
  - Getting Treatment Quickly
  - How Well Clinicians Communicate
  - Getting Treatment and Information from the Plan
  - Being Informed about Treatment Options

Child:

- Determination of member ratings of
  - Child's Health Plan
  - Counseling and Treatment Overall
- Assessment of member perceptions related to
  - Getting Treatment Quickly
  - How Well Clinicians Communicate
  - Perceived Improvement
  - Getting Treatment and Information from Health Plan
  - Being Informed about Treatment Options

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

For 2021, the survey tool used was a modified version of the Experience of Care and Health Outcomes (ECHO) Survey. A total of 15,200 KanCare members (7,600 adults and 7,600 children) were included in the sample. KFMC created the sample frame from which SHP Analytics selected the sample. The survey was administered using a one-wave, mail-only protocol. Adult members and parents or guardians of child members were mailed a survey and cover letter that included an internet option for the survey. A total of 579 adult surveys and 392 child surveys were returned or completed online. Because 2021 was the first year the ECHO Survey was used, comparisons to prior years are not available. Additional details are provided in Appendix C.

Conclusions Drawn from the Data Common Among the MCOs

Adult Survey Results

Table 4.1 displays the summary rates of key measures and associated domains. In their reports, SPH Analytics includes a key driver analysis regarding counseling and treatment that identifies certain measures as Power (relatively large impact and high performance), Retain (relatively small impact but above average performance), Opportunity (relatively large impact but below average performance), or Wait (relatively small impact and low performance). These are indicated in Table 4.1.

[8] *Development of the CAHPS ECHO Survey*. Content last reviewed May 2018. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/cahps/surveys-guidance/echo/about/Development-ECHO-Survey.html.

Table 4.1. Summary Rates of Key Measures – Adult	
Categories identified by SPH Analytics as key drivers of the Rating of Counseling and Treatment were Power (*), Retain (^), Opportunity (†), and Wait (‡).	
Domain or Question	**2021 Rate**
Rating of Counseling and Treatment (Q25) (% 8, 9 or 10)	**69.7%**
Getting Treatment Quickly (% Always or Usually)	**67.6%**
Q3. Got professional counseling on the phone when needed	55.9%‡
Q5. Saw someone as soon as wanted (when needed right away)	67.5%‡
Q8. Got appointment as soon as wanted (not counting times needed care right away)	79.4%‡
How Well Clinicians Communicate (% Always or Usually)	**87.7%**
Q13. Clinicians listened carefully to you	87.4%*
Q14. Clinicians explained things	89.3%*
Q15. Clinicians showed respect for what you had to say	89.8%*
Q16. Clinicians spent enough time with you	87.1%
Q19. Involved as much as you wanted in treatment	84.7%†
Getting Treatment and Information from the Plan (% Not a problem)	**65.7%**
Q27. Problem with delays in counseling or treatment while waiting for approval	89.0%^
Q29. Problem getting the help needed when calling customer service	42.4%
Prescription Medicines (% Yes)	
Q17. Took prescription medicines as part of treatment	92.0%
Q18. Told about side effects of medications	76.1%
Q24. Felt you could refuse a specific type of medicine or treatment	78.3%
Informed about Treatment Options (% Yes)	
Q20. Told about self-help or support groups	47.8%
Q21. Given information about different kinds of counseling or treatment options	60.8%
Q22. Given information about what you could do to manage your condition	79.3%
Q23. Given information about rights as a patient	85.7%
Reasons for Counseling or Treatment (% Yes)	
Q30. Counseling was for personal problems, family problems, emotion, or mental illness	88.1%
Q31. Counseling was for alcohol or drug use	7.7%
Non-Domain Question from SPH Key Driver Analysis (% Always or Usually)	
Q12. Seen within 15 minutes of your appointment	76.5%‡
Supplemental Questions (% Strongly Agree or Agree)	
Q41. I am happy with the friendships I have.	85.7%
Q42. I have people with whom I can do enjoyable things.	85.6%

Strengths Regarding Quality, Timeliness, and Access to Health Care Services – Adult

The five questions with the highest rates were considered strengths, as well as the questions identified as Power or Retain in the key driver analysis.

- Q13. Clinicians listened carefully to you (Highest 5, Power)
- Q14. Clinicians explained things (Highest 5, Power)
- Q15. Clinicians showed respect for what you had to say (Highest 5, Power)
- Q16. Clinicians spent enough time with you (Highest 5)
- Q27. Problem with delays in counseling or treatment while waiting for approval (% Not a problem) (Highest 5, Retain)

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services – Adult

The five questions with the lowest rates were considered opportunities for improvement, as well as the questions identified as Opportunity or Wait in the key driver analysis.

- Q3. Got professional counseling on the phone when needed (Lowest 5, Wait)
- Q5. Saw someone as soon as wanted (when needed right away) (Lowest 5, Wait)
- Q8. Got appointment as soon as wanted (not counting times needed care right away) (Wait)
- Q12. Seen within 15 minutes of your appointment (Wait)
- Q19. Involved as much as you wanted in treatment (Opportunity)
- Q20. Told about self-help or support groups (Lowest 5)
- Q21. Given information about different kinds of counseling or treatment options (Lowest 5)
- Q29. Problem getting the help needed when calling customer service (% Not a problem) (Lowest 5)

Child Survey Results

Table 4.2 displays the summary rates of key measures and associated domains. In their reports, SPH Analytics includes a key driver analysis that identifies certain measures as Power, Retain, Opportunity, or Wait. These are indicated in Table 4.2.

Table 4.2. Summary Rates of Key Measures – Child

Categories identified by SPH Analytics as key drivers of the Rating of Counseling and Treatment were Power (*), Retain (^), Opportunity (†), and Wait (‡).

Domain or Question	2021 Rate
Rating of Counseling and Treatment (Q29) (% 8, 9 or 10)	**66.5%**
Rating of Child's Health Plan (Q54) (% 8, 9 or 10)	**81.6%**
Getting Treatment Quickly (% Always or Usually)	**63.7%**
Q3. Got professional counseling on the phone when needed	37.4%
Q5. Saw someone as soon as wanted (when needed right away)	74.5%
Q7. Got appointment as soon as wanted (not counting times needed care right away)	79.4%†
Q11. Seen within 15 minutes of appointment	90.5%^
How Well Clinicians Communicate (% Always or Usually)	**90.0%**
Q12. Clinicians listened carefully to you	92.4%*
Q13. Clinicians explained things	91.2%*
Q14. Clinicians showed respect for what you had to say	92.4%*
Q15. Clinicians spent enough time with you	85.0%†
Q18. Involved as much as you wanted in treatment	88.9%^
Getting Treatment and Information from the Plan (% Not a problem)	**72.5%**
Q46. Problem with delays in counseling or treatment while waiting for approval	95.0%^
Q47. Problem with getting counseling or treatment child needed	72.9%‡
Q51. Problem getting the help needed when calling customer service	50.0%
Perceived Improvement (% Much better or A little better)	**69.1%**
Q30. Helped by the counseling or treatment received (% A lot or Somewhat)	81.3%†
Q32. Child's ability to deal with daily problems, compared to one year ago	73.3%
Q33. Child's ability to deal with social situations, compared to one year ago	65.2%
Q34. Child's ability to accomplish things he/she want to do, compared to one year ago	68.2%
Q35. Rating of your child's problems or symptoms, compared to one year ago	69.7%

Table 4.2. Summary Rates of Key Measures – Child (Continued)	
Categories identified by SPH Analytics as key drivers of the Rating of Counseling and Treatment were Power (*), Retain (^), Opportunity (†), and Wait (‡).	
Domain or Question	**2021 Rate**
Non-Domain Question from SPH Key Driver Analysis	
Q20. Family got the professional help you wanted for your child (% Always or Usually)	85.8%^
Q21. Child had someone to talk to for counseling or treatment when he or she was troubled (% Always or Usually)	79.1%‡
Q44. Problem with getting someone for your child you are happy with (% Not a problem)	54.9%‡
Supplemental Questions (% Strongly Agree or Agree)	
Q71. I know people who will listen and understand me when I need to talk	96.6%
Q72. I have people with whom I can do enjoyable things	96.3%

Strengths Regarding Quality, Timeliness, and Access to Health Care Services – Child

The five questions with the highest rates were considered strengths, as well as the questions identified as Power or Retain in the key driver analysis.

- Q11. Seen within 15 minutes of appointment (Retain)
- Q12. Clinicians listened carefully to you (Highest 5, Power)
- Q13. Clinicians explained things (Power)
- Q14. Clinicians showed respect for what you had to say (Highest 5, Power)
- Q18. Involved as much as you wanted in treatment (Retain)
- Q20. Family got the professional help you wanted for your child (Retain)
- Q46. Problem with delays in counseling or treatment while waiting for approval (% Not a problem) (Highest 5, Power)
- Q71. I know people who will listen and understand me when I need to talk (Highest 5)
- Q72. I have people with whom I can do enjoyable things (Highest 5)

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services – Child

The five questions with the lowest rates were considered opportunities for improvement, as well as the questions identified as Opportunity or Wait in the key driver analysis.

- Q3. Got professional counseling on the phone when needed (Lowest 5)
- Q7. Got appointment as soon as wanted (not counting times needed care right away) (Wait)
- Q15. Clinicians spent enough time with you (Opportunity)
- Q29. Rating of Counseling and Treatment (% 8, 9 or 10) (Lowest 5)
- Q33. Child's ability to deal with social situations, compared to one year ago (% Much better or A little better) (Lowest 5)
- Q44. Problem with getting someone for your child you are happy with (Lowest 5, Wait)
- Q51. Problem getting the help needed when calling customer service (% Not a problem) (Lowest 5)

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

Four recommendations were made in 2020; three were related to quality, timeliness, and access to health care services, and one was a technical recommendation. The State provided an update on the extent to which the 2020 recommendations were addressed. Please see Appendix F for more details.

Recommendations for Quality Improvement

1. For adult members, monitor and explore methods to improve or continue improvement regarding
   a. Timeliness of treatment, including appointment wait times;
   b. Members getting information about treatment options, including information about self-help or support groups;
   c. Members feeling involved in treatment; and
   d. Getting the help needed when calling customer service.
2. For child members, monitor and explore methods to improve or continue improvement regarding
   a. Overall quality and timeliness of treatment;
   b. Child's perceived improvement of ability to deal with social situations;
   c. Getting a provider the child is happy with; and
   d. Getting the help needed when calling customer service.

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6. Provider Satisfaction Survey Validation

Background/Objectives

Aetna, Sunflower, and UnitedHealthcare conducted provider satisfaction surveys in 2021 to assess how well each plan was meeting its providers' expectations and needs and to identify strengths and opportunities for improvement. The objective of KFMC's review was to validate the methodological soundness of the completed surveys.

In 2021, KDHE executed MCO Contract Amendment 5.9.11, specifying more detailed requirements for the MCO provider satisfaction surveys, in efforts to improve survey quality and increase consistency across the MCOs. The MCOs must be in compliance with these requirements for their 2022 survey. In preparation, the State reviewed the MCOs' work plans for the 2021 survey and noted they did not meet these requirements, and did not allow for the generalization to the KanCare provider types listed in the contract (PCP, BH, HCBS, specialists).

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

KFMC used and/or referenced the Validating Surveys Protocol worksheet and narrative provided by CMS, revised October 2019.

The protocol is comprised of eight validating activities listed below:

1. Review survey purpose, objectives, and audience.
2. Review the work plan (approved by the State before survey implementation).
3. Review the reliability and validity of the survey instrument.
4. Review the sampling plan.
5. Review the adequacy of the response rate (strategy to maximize response).
6. Review the quality assurance plan.
7. Review the survey implementation.
8. Review the survey data analysis and final report.

Each MCO submitted survey documents, including the survey reports prepared by their survey vendors describing very brief survey methodologies and analytic results presenting the survey findings. Aetna and Sunflower also provided their vendor's Survey Quality Management Program document.

SPH Analytics conducted Aetna and Sunflower Surveys; Escalent conducted the UnitedHealthcare Survey. Each conducted their survey over three to four months. See Table 5.1 for dates the surveys were fielded, sample sizes, and response rates.

Table 5.1 Information on Fielding the Provider Satisfaction Surveys

MCO	Dates Fielded	Sample Size	Completed Surveys	Response Rate
Aetna	August–October	1,894	207	10.9%
Sunflower	May–August	2,500	315	12.6%
UnitedHealthcare	September–November	1,982	35	1.0%

KDHE requires four provider types (PCPs, specialists, BH, and HCBS) to be surveyed. Aetna indicated their sample included KanCare network PCPs, specialists, BH clinicians, and LTSS providers. Sunflower's sample included KanCare network PCPs, specialists, BH clinicians, and HCBS providers. UnitedHealthcare

noted the KanCare specialties eligible to be included were Family Practice, Internal Medicine, Cardiology, Endocrinology, Gastroenterology, Internal Medicine, Obstetrics/Gynecology, Oncology, Orthopedic, Pediatric Specialist, Pediatrician, Pulmonology, Radiology, and Rheumatology.

Conclusions Drawn from the Data

Common Among the MCOs

- The 2020 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 non-representativeness of their samples to their provider networks due to differences in their sample and study population compositions, low response rates, and low numbers of completed surveys providing data for analysis.
- The information from the MCOs' survey findings could not be compared to each other due to incomplete methodology information, issues with generalizability of findings, and differences in sample compositions and survey questionnaires.

Aetna and Sunflower

Analysis of the survey questions was problematic due to the nature of the wording of the questions. In Aetna's and Sunflower's survey instruments, the majority of the questions instructed providers to rate the MCO's plan in specific service areas compared to their experience with other health plans. Since the provider's satisfaction with the other appropriate health plans' services was unknown, responses to such relative questions could not be adequately assessed.

Aetna

The *Overall satisfaction rate of 56.1%* could potentially be generalized to Aetna's KanCare PCPs, specialists, BH clinicians and LTSS providers. However, a strong caution had to be applied to make this conclusion due to the low response rate, the low number of completed surveys, definition of a complete and valid survey, only one respondent indicating they were an LTSS provider, and the application of unweighted data analysis techniques.

Sunflower

The *Overall Satisfaction Rate of 69.5%* could potentially be generalized to Sunflower's KanCare PCPs, specialists, BH clinicians and HCBS providers. However, a strong caution had to be applied to make this conclusion due to a low response rate, lack of information whether 38 surveys completed by the HCBS providers were included in the analysis, low number of completed surveys by each provider type, and application of unweighted data analyses techniques.

UnitedHealthcare

The National UnitedHealthcare Overall Satisfaction Rate was 38%, with a Kansas rate of 26%. With the Kansas rate, results could not be representative of and generalizable to the study population, due to a very low response rate and a very low number of complete surveys. Also, not all types of provider categories, such as BH clinicians and HCBS providers, were included in the study population.

Technical Strengths

Common Among the MCOs

- Question categories seem to be organized appropriately and in accordance with different service areas.

- Multi-mode survey methodology including a mailed questionnaire with an internet option was used by the three MCOs.
- The statement for using caution while interpreting results due to insufficient sample size was included in the MCOs' survey reports.
- The survey vendors for the three MCOs had survey quality assurance procedures in place.

Aetna

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

- The multi-mode methodology of the Aetna survey also included a follow-up telephone component for the non-respondents of the mail and internet survey.
- Aetna compared the 2021 survey results to 2019 and 2020 results, as well as to benchmark scores.

Sunflower

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

- To increase the response rate, Sunflower used the National Change of Address and Phone Append Process to help ensure accurate addresses and phone numbers, sent an initial postcard, sent two mail questionnaires, and conducted follow-up phone calls.
- The stratified random sampling method was used to draw the survey samples of the four provider types.
- The total number of valid surveys was reported for each survey component (mail, internet, and telephone follow-up), and by provider type.
- Detailed and varied analyses using statistical procedures were completed with graphical presentations.
- Sunflower compared the 2021 survey results to 2019 and 2020 results, as well as to the 2020 SPH Analytics Medicaid Book of Business benchmarks.

UnitedHealthcare

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

- The survey instrument included well-formulated questions organized in seventeen categories covering different aspects of UnitedHealthcare's services.
- United Healthcare compared the 2021 survey results to 2020 results, and also reported national survey results.

Opportunities for Improvement

Common Among the MCOs

- The survey samples of the three MCOs were not in alignment with their KanCare provider network compositions, thus limiting the samples' representation of their KanCare provider network.
- The survey findings for the three MCOs were not generalizable to their overall KanCare provider networks or to the specific network provider types due to inadequate representations of the overall study populations, low response rates, low number of completed surveys with even lower numbers of individual question responses, and use of unweighted analysis technique.
- The overall response rates were low (10.9% for Aetna, 12.6% for Sunflower, and 1% for UnitedHealthcare. The number of completed surveys was low for Aetna (207) and Sunflower (315), and considerably low for UnitedHealthcare (35).
- There was missing or inadequate information in the MCOs' survey reports, such as reliability and validity testing of the survey instrument, sample size calculation and description, corrective action plan for responding to low response rates during survey implementation, application of quality

management processes, table footnotes related to the statistical test significance level and limitations due to insufficient sample size, non-response analysis, and discussion of the similarities and differences between the 2021 respondents and the survey respondents for the comparison surveys.

- There was no required response rate or required number of returned surveys established for the Aetna and Sunflower. It was not clear whether the possibility of a low response rate was considered in the sample size calculation to help ensure a sufficient sample size for collection of an adequate number of completed surveys. UnitedHealthcare's Survey Work Plan noted the required number of completed surveys (384 surveys) was based on an estimated response rate (2%); however, the survey was implemented with the goal to achieve a minimum of 30 completed surveys.
- The Aetna and Sunflower results included the percentages and denominators, whereas numerators were not shown. UnitedHealthcare only showed an overall number of returned surveys and percentages, without including their numerators and denominators. The percentages based on a small number of responses could be inaccurately interpreted if denominators are not shown.

Aetna

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

- A majority of the survey questions on Aetna's survey instrument were relative questions (out of 64 questions, 51 were relative questions).
- The low overall response rate (10.9%) and low number of completed surveys (207) indicated the sample size of 1,894 providers was not sufficient.
- A considerably small number of PCPs, specialists, BH clinicians and LTSS providers completed the survey (52 PCPs, 73 specialists, 103 BH clinicians, and one LTSS provider), thus the survey results could not be generalizable to these provider types.
- Aetna allowed surveys with responses for only one attribute/key question to be included in the total count of 207 complete survey and in the calculation of the overall response rate of 10.9%.
- There was no plan for follow-up by Aetna to provide correct/updated contact information to SPH Analytics to reach providers with bad addresses and phone numbers. Corrective steps were not applied by Aetna during the course of the survey administration to improve the response rate and number of completed surveys.
- Demographic segmental analyses were conducted; however, the numerator and denominator counts were not included in the Survey Report. Due to unavailability of these data, assessment of the generalizability of these results was not feasible.

Sunflower

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

- A majority of the survey questions on Sunflower's survey instrument were relative questions (out of 54 questions, 37 were relative questions).
- The total number of completed surveys for the individual provider categories were low (101 PCPs, 80 Specialists, 96 BH Clinicians and 38 HCBS providers).
- For the mail component, a survey was counted as a complete and valid survey if the respondent answered at least one question, whereas for the internet and phone components, a survey was counted as a complete survey if a respondent answered all survey questions.
- Demographic segmental analyses were conducted; however, the numerator and denominator counts were not included in the Survey Report.

UnitedHealthcare

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

- Telephone follow-up with the non-respondents of the mail and internet survey was not conducted and other steps were not planned to ensure collection of a sufficient number of completed surveys and an adequate response rate. Corrective actions weren't implemented during the course of survey administration to improve the low response rate and number of completed surveys.
- The reason for implementing the survey with a very low goal of achieving a minimum of 30 completed surveys using a sample of 1,982 providers, instead of achieving 384 completed surveys calculated as the required number of completed surveys based on 5% margin of error with a 95% confidence level was not mentioned.
- UnitedHealthcare results were not stratified by practice specialty.

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

The majority of the EQRO's provider survey recommendations have been repeated for multiple years with minimal improvement. Out of the 15 previous year's recommendations common among the MCOs, Aetna partially addressed three recommendations and did not address twelve recommendations; Sunflower fully addressed one recommendation, partially addressed seven recommendations and did not address seven recommendations; and UnitedHealthcare partially addressed five recommendations, and did not address ten recommendations. In addition to common recommendations among the MCOs, additional recommendations were made to each MCO. Out of two additional Aetna recommendations, they partially addressed one recommendation and did not address one recommendation. Out of two additional Sunflower recommendations, they partially addressed one recommendation, and did not address one recommendation. Out of two additional UnitedHealthcare recommendations, they fully addressed one recommendation and partially addressed one recommendation. Please see Appendix F for more details.

Recommendations for Quality Improvement

Common Among the MCOs

1. Describe in detail the survey methodology and analysis plan in the Survey Work Plan (Please Note: MCOs are required to submit the Survey Work Plan to the State and get it approved before survey implementation. The following items are recommended to be included in the Survey Work Plan document):
    - The survey methodology described in the Work Plan should include a clearly defined intended study population and its size; a clearly defined appropriate sampling frame and its size; detailed information on sampling methodology procedures; and clearly described parameters used in the sample size calculation (population size of the sampling strata by provider type, margin of error, confidence level, standard deviation, response rate).
    - The survey administration tasks should be described in detail. The timeline for all the tasks should be included.
    - The Analysis Plan should be described in detail.
    - Any deviation made from the approved Work Plan (sampling methodology, survey implementation tasks and data analysis) needs to be described in the Survey Report, with rationale provided.

Recommendations for Quality Improvement (Continued)

- The survey quality procedures for all steps of survey implementation should be included in the Work Plan; if a quality assurance plan provided by the Survey Vendor showed any deficiencies in quality management steps, then a plan to address these deficiencies should be included in the Work Plan.

2. Ensure data analysis results are appropriately interpreted:
   - Interpret the results within the context of the study population represented by the survey sample.
   - Ensure tables presenting survey results include numerator and denominator counts for each survey question.
   - Conduct non-response analysis.
3. Include a detailed description of the content of the survey design and administration in the Final Survey Report and accompanying documents submitted to the State after completion of the survey:
   - 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 defined parameters (population size, margin of error, confidence level, standard deviation, response rate) used in the sample size calculation.
   - Include the survey quality procedures for all steps of survey implementation; if a quality assurance plan is provided by the vendor, the Survey Report needs to address whether the plan was implemented in full.
   - Any changes made to the study design during the implementation of the survey, along with the reasons, should be described.
4. Consider using several of the same questions across MCOs:
   - Consider including several questions in the survey instrument that are the same across the three MCOs to provide comparative results, and to identify common and unique strengths and opportunities for improvement across the MCOs.

Aetna

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

1. Revise the survey tool to remove the phrasing that makes the provider answer relative to the other health plans they work with.
2. Increase the sample size to account for the previous low response rates.
3. Only HCBS providers are required to be surveyed among LTSS providers; therefore, exclude nursing facility providers from the study population.
4. Steps should be taken to improve the response rate or number of returned surveys, such as updating and correcting contact information of the providers (mail, phone, and email); using multiple methods to inform and encourage participation; ensuring appropriate timings for fielding the data; collecting data over an adequate duration; sending frequent reminder notices to the providers; and determining the reason for a large number of ineligible surveys.
5. Revise the criterium to count a survey as a "valid survey". The criterium to count a survey as a "valid survey" with one beyond demographic questions is not appropriate. Such criterium should be based on responses available to an adequate number of the survey questions. Document statistical testing performed to clearly indicate validity of the results.
6. Describe in detail the survey administration tasks in the Final Survey Report.

Recommendations for Quality Improvement (Continued)

Sunflower

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

1. Revise the survey tool to remove the phrasing that makes the provider answer relative to the other health plans they work with.
2. Determine the reason for such a large number of ineligible surveys and take steps to address identified issues.
3. Revise the criterium to count a survey as a "valid survey". The criterium to count a survey as a "valid survey" with one or very few questions answered is not appropriate. Such criterium should be based on responses available to an adequate number of the survey questions.
4. Apply the same criteria to count a survey as a "valid survey" for all the components of the multi-mode survey strategy (mail, internet, telephone follow-up).

UnitedHealthcare

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

1. Include a phone follow-up component for the non-respondents of the mal and internet survey components to the multi-mode methodology.
2. Steps should be taken to improve the provider response rate, such as ensuring frequent reminder notices and phone calls, verifying the contact information of the providers selected in the sample at the time of survey implementation, researching bad mail and email addresses to resend undeliverable surveys or complete further outreach, reminder postcards /phone calls, determining the reason for ineligible surveys, and appropriate timings for fielding the survey (data collection over an adequate duration).
3. Document statistical testing performed to clearly indicate validity of the results.
4. Ensure the analytic result for each question is based on a valid numerator and denominator. Findings based on inadequate numerators and denominators are not valid.
5. Describe in detail the survey administration tasks in the Final Survey Report.

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

Background/Objectives

The Medicaid and CHIP Managed Care Regulations require performance of independent, external reviews of the quality, timeliness of, and access to care and services provided to Medicaid and CHIP beneficiaries by MCOs.[9] The objective of KFMC's compliance review is to assess MCO compliance with federal standards. A full review is required every three years and may be completed over the course of the three years. Sunflower and UnitedHealthcare have provided KanCare managed care services since January 2013. KFMC completed full Sunflower and UnitedHealthcare regulatory compliance reviews in 2013 and 2016, with follow-up in the interim years. KFMC reviewed MCOs' compliance with the Medicaid and CHIP Managed Care regulations updated May 6, 2016, and November 13, 2020.

The process was updated in 2019 to spread the review of regulations over the three-year period (2019–2021), with KFMC conducting approximately one-third of the review each year for Sunflower and UnitedHealthcare, along with needed follow-up. Since Aetna's MCO contract went into effect January 1, 2019, KFMC completed most of the full regulatory compliance review for Aetna in 2019. KFMC's compliance review reports for the 2020 and 2021 reviews were submitted in February and March 2021 and January through March 2022, respectively, and are included in this *2021-2022 Annual EQR Technical Report*.

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

KFMC used Protocol 3, *Review of Compliance with Medicaid and CHIP Managed Care Regulations* from the *CMS EQR Protocols*, dated October 2019, to complete the reviews, which covered the 2020 and 2021 calendar years. In addition, KFMC compiled findings in a worksheet based on the EQR Protocol 3 documentation and reporting tool template developed by CMS.

The protocol involves completion of the following five activities:

- Activity 1: Establish Compliance Thresholds
- Activity 2: Perform Preliminary Review
- Activity 3: Conduct Managed Care Organization Onsite Visit
- Activity 4: Compile and Analyze Findings
- Activity 5: Report Results to the State

KFMC requested documentation from each MCO related to the federal regulations under review. Documentation provided included policies, procedures, and other materials related to the federal regulations, and case files for grievances and appeals.

The following Medicaid Managed Care Regulatory Provisions were reviewed in Years 2 and 3:

- Subpart B – State Responsibilities
- Subpart C – Enrollee Rights and Protections
- Subpart D – MCO, PIHP and PAHP Standards (requires compliance with Subpart F – Grievance and Appeal System)
- Subpart E – Quality Measurement and Improvement; External Quality Review

[9] Managed Care, 42 C.F.R. §438 (2016). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438?toc=1.

The regulatory areas were divided and categorized by year reviewed per MCO within the three-year review period (2019–2021), as displayed in Table 6.1.

Table 6.1. Standards Reviewed Timeframe

Regulatory Standard	Reporting Cycle in Which Last Reviewed by the EQRO								
	2019-2020			2020-2021			2021-2022		
	ABH	SHP	UHC	ABH	SHP	UHC	ABH	SHP	UHC
Subpart C – Enrollee Rights and Protections									
§438.56 Disenrollment: Requirements and Limitations	X							X	X
§438.100 Enrollee Rights	X							X	X
§438.114 Emergency and Poststabilization Services	X							X	X
Subpart D – MCO, PIHP, and PAHP Standards									
§438.206 Availability of Services	X	X	X						
§438.207: Assurances of Adequate Capacity and Services	X				X	X			
§438.208 Coordination and Continuity of Care	X	X	X						
§438.210 Coverage and Authorization of Services	X				X	X			
§438.214 Provider Selection	X	X	X						
§438.224 Confidentiality	X	X	X						
§438.228 Grievance and Appeal Systems (Requires compliance with Subpart F Grievance and Appeal System [§438.402–§438.424])	X				X	X			
§438.402 General Requirements	X	X	X						
§438.404 Notice of Adverse Benefit Determination	X				X	X			
§438.406 Handling of Grievances and Appeals	X				X	X			
§438.408 Resolution and Notification	X				X	X			
§438.410 Expedited Resolution of Appeals	X				X	X			
§438.414 Information about the Grievance and Appeal System to Providers and Subcontractors	X				X	X			
§438.416 Recordkeeping Requirements	X				X	X			
§438.420 Continuation of Benefits While Appeal and State Fair Hearing are Pending	X				X	X			
§438.424 Effectuation of Reversed Appeal Resolutions	X				X	X			
§438.230 Sub-contractual Relationships and Delegation	X	X	X						
§438.236 Practice Guidelines	X	X	X						
§438.242 Health Information Systems	X							X	X
Subpart E – Quality Measurement and Improvement									
§438.330 Quality Assessment and Performance Improvement Program	X	X	X						

KFMC utilized the five-point rating compliance scoring (Fully Met, Substantially Met, Partially Met, Minimally Met, and Not Met) as defined in the EQR Protocol 3 and results were compiled into a tabular format for reporting on each regulatory category. Please refer to the individual MCO 2020 and 2021 *Review of Compliance with Medicaid and CHIP Managed Care Regulations* reports for more detail.

A change in reporting schedules for submission of Years 2 and 3 Compliance Review reports ahead of submission of the Annual Technical Review means that Years 2 and 3 review findings are both covered in this Annual Technical Report, as opposed to the 2020 Annual Technical Report that included only findings from Year 1.

In 2021, rather than reporting only the percentage of components rated Fully Met, KFMC applied a point system to calculate the overall compliance score for each regulatory component, Subpart, and overall MCO compliance. For consistency and comparability across review years, KFMC applied the Year 3-point system to Years 1 and 2 regulatory components, Subpart, and overall MCO compliance. Each regulation potentially has multiple components. Each component earns a compliance score in the following way: Fully Met receives four points; Substantially Met receives three points; Partially Met receives two points; Minimally Met receives one point; and Not Met receives zero points. The Compliance Score for each regulation is a percentage found by dividing the numerator (the total number of points earned by the components within that regulation) by the denominator (the total number of points possible for components within that regulation).

Conclusions Drawn from the Data

Compliance

Common Among the MCOs, Year 2 Review – 2020

Each of the MCOs had opportunity for improvement in §438.207 Adequate Capacity and Services (Subpart D – MCO, PIHP and PAHP Standards).

Aetna, Year 2 Review – 2020

KFMC reviewed all regulatory areas in Subpart D – MCO, PIHP and PAHP Standards in Year 1 except for §438.207 Adequate Capacity and Services, which was reviewed in Year 2. Overall, Aetna was 81% compliant with §438.207, the only regulatory area KFMC reviewed in Year 2. Table 6.2 summarizes the compliance scores for those regulatory areas reviewed for Aetna in Year 2.

Table 6.2. Summary of Compliance Review – Aetna Year 2 (2020)

Federal Regulations	Component Compliance						
	Components	FM (4 Points)	SM (3 Points)	PM (2 Points)	MM (1 Point)	NM (0 Points)	Compliance Score*
Subpart D – MCO, PIHP and PAHP Standards							
§438.207 Adequate Capacity and Services	4	(2/4)	(1/4)	(1/4)	(0/4)	(0/4)	**81%** (13/16)
Subpart D – Overall Compliance	**4**	**(2/4)**	**(1/4)**	**(1/4)**	**(0/4)**	**(0/4)**	**81% (13/16)**

FM = Fully Met (96%–100%), SM = Substantially Met (75%–95%), PM = Partially Met (50%–74%), MM = Minimally Met (25%–49%), and NM = Not Met (0%–24%).
* Percent of available points awarded

Of the four components applicable to Aetna within §438.207 Adequate Capacity and Services, Aetna had the greatest opportunity for improvement in §438.207(a-b) Adequate Capacity and Services: Network Standards and Monitoring, and Nature of Supporting Documentation.

Aetna, Year 3 Review – 2021

Aetna's full three-year compliance review was completed in Years 1 and 2. There were no additional regulatory areas remaining for review in Year 3.

Sunflower, Year 2 Review – 2020

Overall, Sunflower was 92% compliant with the federal regulatory requirements reviewed in Year 2. Sunflower was 97% compliant with the two regulatory areas reviewed in Subpart D – MCO, PIHP and PAHP Standards and 89% compliant with the seven regulatory areas reviewed in Subpart F – Grievance System. Table 6.3 summarizes the compliance scores for those regulatory areas reviewed for Sunflower in Year 2.

Table 6.3. Summary of Compliance Review – Sunflower Year 2 (2020)

Federal Regulations	Component Compliance						
	Components	FM (4 Points)	SM (3 Points)	PM (2 Points)	MM (1 Point)	NM (0 Points)	Compliance Score*
Subpart D – MCO, PIHP and PAHP Standards							
§438.207 Adequate Capacity and Services	4	(2/4)	(2/4)	(0/4)	(0/4)	(0/4)	**88%** (14/16)
§438.210 Coverage and Authorization of Services	12	(12/12)	(0/12)	(0/12)	(0/12)	(0/12)	**100%** (48/48)
Subpart D Total^	**16**	**14/16)**	**(2/16)**	**(0/16)**	**(0/16)**	**(0/16)**	**97% (62/64)**
Subpart F – Grievance and Appeal System							
§438.404 Notice of Adverse Benefit Determination	8	(7/8)	(0/8)	(1/8)	(0/8)	(0/8)	**94%** (30/32)
§438.406 Handling of Grievances and Appeals	2	(0/2)	(1/2)	(1/2)	(0/2)	(0/2)	**63%** (5/8)
§438.408 Resolution and Notification	13	(10/13)	(2/13)	(1/13)	(0/13)	(0/13)	**92%** (48/52)
§438.410 Expedited Resolution of Appeals	3	(2/3)	(0/3)	(1/3)	(0/3)	(0/3)	**83%** (10/12)
§438.416 Recordkeeping Requirements	1	(0/1)	(1/1)	(0/1)	(0/1)	(0/1)	**75%** (3/4)
§438.420 Continuation of Benefits While Appeal and State Fair Hearing are Pending	4	(3/4)	(1/4)	(0/4)	(0/4)	(0/4)	**94%** (15/16)
§438.424 Effectuation of Reversed Appeal Resolutions	2	(1/2)	(1/2)	(0/2)	(0/2)	(0/2)	**88%** (7/8)
Subpart F Total	**33**	**23/33)**	**(6/33)**	**(4/33)**	**(0/33)**	**(0/33)**	**89% (118/132)**
Overall Compliance	**49**	**37/49)**	**(8/49)**	**(4/49)**	**(0/49)**	**(0/49)**	**92% (180/196)**

FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 959%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%).
* Percent of available points awarded

Of the individual regulatory areas within Subparts D and F, Sunflower had the greatest opportunity for improvement in the following:

- §438.207 Adequate Capacity and Services (Subpart D – MCO, PIHP and PAHP Standards)
- §438.424 Effectuation of Reversed Appeal Resolutions (Subpart F – Grievance System)

Sunflower, Year 3 Review – 2021

Overall, Sunflower was 95% compliant with federal regulatory requirements reviewed in Year 3. Sunflower was 97% compliant in Subpart C – Enrollee Rights and Protections and 91% compliant in Subpart D – MCO, PIHP and PAHP. Table 6.4 summarizes the compliance scores for those regulatory areas reviewed for Sunflower in Year 3.

Table 6.4. Summary of Compliance Review – Sunflower Year 3 (2021)

Federal Regulations	Component Compliance						
	Components	FM (4 Points)	SM (3 Points)	PM (2 Points)	MM (1 Point)	NM (0 Points)	Compliance Score*
Subpart C – Enrollee Rights and Protections							
§438.100 Enrollee Rights^ §438.10 Information Requirements §438.3(j) Standard Contract Requirements: Advance Directives	24	(21/24)	(3/24)	(0/24)	(0/24)	(0/24)	97% (93/96)
§438.114 Emergency and Post-stabilization Services	5	(5/5)	(0/5)	(0/5)	(0/5)	(0/5)	100% (20/20)
Subpart C Total	**29**	**(26/29)**	**(3/29)**	**(0/29)**	**(0/29)**	**(0/29)**	**97% (113/116)**
Subpart D – MCO, PIHP and PAHP Standards							
§438.210(c) Coverage and Authorization of Services†	1	(0/1)	(0/1)	(1/1)	(0/1)	(0/1)	50% (2/4)
§438.228(a-b) Grievance Systems† (Requires compliance with Subpart F Grievance and Appeal System [§438.402 - §438.424])	1	(0/1)	(1/1)	(0/1)	(0/1)	(0/1)	75% (3/4)
§438.404(a) Timely and Adequate Notice of Adverse Benefit Determination†	1	(0/1)	(0/1)	(1/1)	(0/1)	(0/1)	50% (2/4)
§438.408(d) Resolution and Notification†	2	(0/2)	(2/2)	(0/2)	(0/2)	(0/2)	75% (6/8)
438.414 Information about Grievance and Appeal System to Providers and Subcontractors^† §438.10(g)(2)(xi) Information for Enrollees of MCOs, PIHPs, PAHPs, and PCCM Entities: Enrollee Handbook	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)
§438.242 Health Information Systems	13	(13/13)	(0/13)	(0/13)	(0/13)	(0/13)	100% (52/52)
Subpart D Total	**19**	**(14/19)**	**(3/19)**	**(2/19)**	**(0/19)**	**(0/19)**	**91% (69/76)**
Overall Compliance	**48**	**(40/48)**	**(6/48)**	**(2/48)**	**(0/48)**	**(0/48)**	**95% (182/192)**

FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%).
* Percent of available points awarded
^ And related provision(s).
† Regulatory area reviewed in CY2020 – Year 2.

Of the individual regulatory areas within Subparts C and D, Sunflower had the greatest opportunities for improvement in §438.404(a) Timely and Adequate Notice of Adverse Benefit Determination and elements within §438.10 Information Requirements (Subpart C – Enrollee Rights and Protections), as this regulatory area is a sub-related requirement to regulations within Subpart D and had an impact on compliance.

UnitedHealthcare, Year 2 Review – 2020

Overall, UnitedHealthcare was 94% compliant with federal regulatory requirements in Year 2. UnitedHealthcare was 97% compliant in Subpart F – Grievance System and 88% compliant in Subpart D – MCO, PIHP and PAHP Standards. Table 6.5 summarizes the compliance scores for those regulatory areas reviewed for UnitedHealthcare in Year 2.

Table 6.5. Summary of Compliance Review – UnitedHealthcare Year 2 (2020)

Federal Regulations	Component Compliance						
	Components	FM (4 Points)	SM (3 Points)	PM (2 Points)	MM (1 Point)	NM (0 Points)	Compliance Score*
Subpart D – MCO, PIHP and PAHP Standards							
§438.207 Adequate Capacity and Services	4	(2/4)	(1/4)	(1/4)	(0/1)	(0/1)	**81%** (13/16)
§438.210 Coverage and Authorization of Services	12	(12/12)	(0/12)	(0/12)	(0/12)	(0/12)	**100%** (48/48)
Subpart D Total	**16**	**(14/16)**	**(1/16)**	**(1/16)**	**(0/16)**	**(0/16)**	**95% (61/64)**
Subpart F – Grievance System							
§438.404 Notice of Adverse Benefit Determination	8	(8/8)	(0/8)	(0/8)	(0/8)	(0/8)	**100%** (32/32)
§438.406 Handling of Grievances and Appeals	2	(1/2)	(1/2)	(0/2)	(0/2)	(0/2)	**88%** (7/8)
§438.408 Resolution and Notification	13	(13/13)	(0/13)	(0/13)	(0/13)	(0/13)	**100%** (52/52)
§438.410 Expedited Resolution of Appeals	3	(3/3)	(0/3)	(0/3)	(0/3)	(0/3)	**100%** (12/12)
§438.416 Recordkeeping Requirements	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	**100%** (4/4)
§438.420 Continuation of Benefits While Appeal and State Fair Hearing are Pending	4	(4/4)	(0/4)	(0/4)	(0/4)	(0/4)	**100%** (16/16)
§438.424 Effectuation of Reversed Appeal Resolutions	2	(2/2)	(0/2)	(0/2)	(0/2)	(0/2)	**100%** (8/8)
Subpart F Total	**33**	**(32/33)**	**(1/33)**	**(0/33)**	**(0/33)**	**(0/33)**	**99% (131/132)**
OVERALL COMPLIANCE	**49**	**(46/49)**	**(2/49)**	**(1/49)**	**(0/49)**	**(0/49)**	**98% (192/196)**

FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%).
* Percent of available points awarded

Of the individual regulatory areas within Subparts D and F, UnitedHealthcare had the greatest opportunity for improvement in the following:

- §438.207 Adequate Capacity and Services (Subpart D – MCO, PIHP and PAHP Standards)
- §438.406 Handling of Grievances and Appeals [Subpart F – Grievance System]

UnitedHealthcare, Year 3 Review – 2021

Overall, UnitedHealthcare was 91% compliant with the federal regulatory requirements reviewed in Year 3. UniteHealthcare was 93% compliant in Subpart C – Enrollee Rights and Protections and 88% compliant in Subpart D – MCO, PIHP and PAHP Standards. Table 6.6 summarizes the compliance scores for those regulatory areas.

Table 6.6. Summary of Compliance Review – UnitedHealthcare Year 3 (2021)

Federal Regulations	Component Compliance						
	Components	FM (4 Points)	SM (3 Points)	PM (2 Points)	MM (1 Point)	NM (0 Points)	Compliance Score*
Subpart C – Enrollee Rights and Protections							
§438.100 Enrollee Rights^ §438.10 Information Requirements §438.3(j) Standard Contract Requirements: Advance Directives	24	(19/24)	(2/24)	(3/24)	(0/24)	(0/24)	92% (88/96)
§438.114 Emergency and Post-stabilization Services	5	(5/5)	(0/5)	(0/5)	(0/5)	(0/5)	100% (20/20)
Subpart C Total	**29**	**(24/29)**	**(2/29)**	**(3/29)**	**(0/29)**	**(0/29)**	**93% (108/116)**
Subpart D – MCO, PIHP and PAHP Standards							
§438.210(c) Coverage and Authorization of Services†	1	(0/1)	(0/1)	(1/1)	(0/1)	(0/1)	50% (2/4)
§438.228(a-b) Grievance Systems† (Requires compliance with Subpart F Grievance and Appeal System [§438.402 - §438.424])	1	(0/1)	(1/1)	(0/1)	(0/1)	(0/1)	75% (3/4)
§438.404(a) Timely and Adequate Notice of Adverse Benefit Determination†	1	(0/1)	(0/1)	(1/1)	(0/1)	(0/1)	50% (2/4)
§438.408(d) Resolution and Notification†	2	(1/2)	(0/2)	(1/2)	(0/2)	(0/2)	75% (6/8)
438.414 Information about Grievance and Appeal System To Providers and Subcontractors^† §438.10(g)(2)(xi) Information for Enrollees of MCOs, PIHPs, PAHPs, and PCCM Entities: Enrollee Handbook	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)
§438.242 Health Information Systems	13	(11/13)	(2/13)	(0/13)	(0/13)	(0/13)	96% (50/52)
Subpart D Total	**19**	**(13/19)**	**(3/19)**	**(3/19)**	**(0/19)**	**(0/19)**	**88% (67/76)**
Overall Compliance	**48**	**(37/48)**	**(5/48)**	**(6/48)**	**(0/48)**	**(0/48)**	**91% (175/192)**

FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%).
* Percent of available points awarded
^ And related provision(s).
† Regulatory area reviewed in CY2020 – Year 2.

Of the individual regulatory areas within Subparts C and D, UnitedHealthcare had the greatest opportunity for improvement for elements within §438.10 Information Requirements (Subpart C – Enrollee Rights and Protections), as this regulatory area is a sub-related requirement to regulations within Subpart D and had an impact on compliance.

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

Common Among the MCOs

- Each MCO took a proactive role in responding to needs associated with the COVID-19 pandemic in 2020, from member support including telehealth care coordination and intensified case management, to collaboration and partnership with external organizations including outreach to providers. The MCOs continued their response to the COVID-19 pandemic in 2021.
- Each MCO had staff who are knowledgeable and committed to serving their members and providers, even beyond meeting minimum contract requirements, such as improving services, satisfaction outcomes, and considering the services members need.

Aetna

- Aetna continued to focus on quality assessment and improvement, including building efficiencies into workflows and task management.
- Aetna partnered with other organizations and outreach to providers in response to COVID-19.
- Aetna intensified case management for members in response to COVID-19, including home delivered meals for HCBS members.
- Aetna continued to support staff training and oversight to improve processes.

Sunflower

- SHP embedded staff in two hospitals and conducted discharge planning rounds with providers.
- SHP partnered with CMHCs and other community organizations to provide assistance for members with food access needs.
- SHP supported members in response to COVID-19, including conducting a telehealth care coordination survey.
- SHP had innovative technological approaches (e.g., members can complete health risk online; providers can make online referrals to case management).
- SHP tracked reasons for appeals to identify patterns and implement process improvement.
- SHP specifically designed their leadership team to reflect and meet the needs of the populations they serve.
- A majority (eight of 15) of SHP's board of advisors are active clinicians within Kansas.
- SHP staff have adapted to the need for monitoring consistency of message presented to providers since the start of the pandemic by continuing discussions through virtual touch-bases, and by even expanding their discussion points for 2022.
- SHP's Care Management team has individual conversations with members to encourage them to contact a self-advocacy group if members feel their guardians are not making decisions in their best interests.
- SHP indicated they have a new strong search tool, the Knowledge Management System, for real-time searching and answers for members.
- SHP has a commitment to self-disclose any hint of noncompliance they discover, even before they begin an investigation into the noncompliance issue.
- SHP worked with the community in meeting the needs of patients and facilities during the emergency stages of the pandemic.

UnitedHealthcare

- UHC continued its innovative approach to address member social determinants of health and implement pilot projects.
- UHC continued its collaboration with diverse partners and participation in community workgroups.
- UHC collaborated with health departments in response to COVID-19.
- UHC possesses experience and has a strong approach to cultural competency.
- UHC demonstrated innovative ways of reaching members and the general public during the pandemic. This was evident in the "Stop COVID" initiative, Health and safety kits provided, education on COVID testing and vaccinations, transportation to testing and vaccinations, food boxes, Surgical Mask Initiative (providing Personal Protective Equipment), Food Access Initiatives, Food Pantry Delivery Pilot, distribution of COVID kits, and partnering with the State for the CARES [Coronavirus Aid, Relief, and Economic Security] Act Provider Relief Fund. Additionally, a staff member assisted in outdoor COVID-19 vaccination events and provided translation of information and requirements with special sensitivity to immigrant and refugee communities' concerns with providing self-identifying information.
- It is clear what UHC's core values are and that UHC cares about their members and follows their mission statement.
- Staff are very knowledgeable.
- UHC has a warm handoff system of a member from Member Services to a Member Advocate if Member Services is unable to satisfactorily resolve a complex matter.
- UHC uses their internal instant messaging system to connect between Member Services and contacting the provider in question to be able to either get answers directly from the provider to the calling member in real-time, or member being referred to a member advocate if the member's issue cannot be resolved immediately this way.
- UHC demonstrated its dedication to trainings and town halls for UHC staff on topics of inclusion, diversity, and equity.
- UHC strives to consider what services members need, whether such services should be automatically approved, and what services require prior authorization.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

Common Among the MCOs

- Each of the three MCOs needed to clarify access monitoring for Availability, Access, and Coverage of Services and needed to follow up with KFMC's case review findings related to Coordination and Continuity of Care.

Aetna

- Related to Grievance, Appeal, and Notice of Adverse Benefit Determination, follow-up was needed on KFMC's case review findings.

Sunflower

- Related to Grievance, Appeal, and Notice of Adverse Benefit Determination:
  - Updates were needed to the *Member Handbook* and
  - Information was needed for members.
- Related to Grievance, Appeal, and Notice of Adverse Benefit Determination, follow-up was needed on KFMC's case review findings.

- Update Sunflower policies and procedures to include the following:
  - Required regulatory language related to disenrollment.
  - Add regulatory language related to the MCOs financial responsibility for post-stabilization care services.
- Update the *Member Handbook* with the following:
  - Add language related to services are free of charge, information can be obtained within five business days, members have the right to file grievances and appeals, and that the telephone number listed is toll-free.
  - Add a link to the Advance Directive page on the Sunflower website.
- The *Provider Directory* needs to be moved to a more prominent area of the Sunflower website.
- Update the SHP *Provider Manual* to include regulatory language related to member's free exercise of rights.

UnitedHealthcare

- Related to Grievance, Appeal, and Notice of Adverse Benefit Determination:
  - Updates to *Member Handbook* and
  - Information for members.
- Update UnitedHealthcare policies and procedures to include the following:
  - Required regulatory language related to timely determination to disenrollment
  - Definition for poststabilization care services
  - Regulatory language to policies and procedures related to Advance Directives
- Update the *HCBS Provider Directory* to include information on the following:
  - Whether the provider will accept new patients
  - The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office
  - Whether the provider has completed Cultural Competency training
- In the *Member Handbook*, consistently:
  - State services are free of charge
  - Information can be obtained within five business days
  - Use the same language name when describing the language
  - Include language indicating the telephone number listed is toll-free
- Update the UHC *Provider Manual* to include additional regulatory language related to member rights.

Technical Strengths

Aetna

Aetna had a technical strength in its coordination of informatics and reporting and in the creation of an encounter dashboard.

Sunflower

- SHP has multiple stringent information technology firewalls that limit access to information and only allows access with permissions and on a need-to-know basis (e.g., clinical and customer service systems).
- SHP staff were prompt in providing KFMC with additional documentation upon request.
- SHP demonstrated a commitment to data security with different systems in place to prevent unintentional or unauthorized access to sensitive information.

UnitedHealthcare

- UnitedHealthcare financially invested directly into Kansas communities to help keep services operating during the COVID-19 pandemic.
- UHC achieved NCQA High Performance Accreditation.
- UHC has an additional level of security on emails to ensure protected health information and personal identifiable information is not sent out. Also, upper management is notified.
- UHC demonstrated a commitment to data security with different systems in place to prevent unintentional or unauthorized access to sensitive information.

Technical Opportunities for Improvement

Common Among the MCOs

Each of the three MCOs needed to update their provider network policies and reports relating to Availability, Access, and Coverage of Services.

Aetna

Related to Availability, Access, and Coverage of Services, updates were needed to Aetna's GeoAccess reports.

Sunflower

- Related to Grievance, Appeal, and Notice of Adverse Benefit Determination, updates were needed to Sunflower's policies.
- Included language on the Anti-Fraud, Waste, and Abuse Program in the *Member Handbook* should be moved to a different location within the *Member Handbook.*

UnitedHealthcare

- Related to Grievance, Appeal, and Notice of Adverse Benefit Determination, updates were needed to UnitedHealthcare's policies.
- Make updates to UnitedHealthcare policies and procedures to include reference to the correct regulatory requirement and add missing language to policies and procedures.
- Review the history of policies and procedures prior to being discontinued.

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

Between August 2021 and January 2022, KFMC obtained from each MCO a series of updates to the progress tracking document that included KFMC's EQRO recommendations from 2019 and 2020 that were still in progress or less than fully addressed. KFMC provided each MCO with suggestions on how to bring outstanding recommendations into full compliance and each MCO was given the opportunity to respond on their progress. The following summaries include both Year 2 and Year 3 reviews.

Aetna

There is a total of 87 recommendations (79 in 2019 and eight in 2020) included in Appendix F, *Degree to Which the Previous Years' EQRO Recommendations Have Been Addressed:*

- 54 moved from either minimally, partially, or substantially addressed to fully addressed in 2020
- 26 moved from either in progress, partially or substantially addressed to fully addressed in 2021
- 6 are in progress
- 1 is not addressed

Sunflower

There is a total of 41 recommendations included in Appendix F. Because one recommendation

(§438.230(b)(3)) was a carryover from the previous three-year review (2016–2018), it is not included in the current three-year review period calculation, reducing the number of total active recommendations to 40 (16 in 2019 and 24 in 2020).

- 7 moved from either partially or substantially addressed to fully addressed in 2020
- 32 moved from either in progress, minimally, partially, or substantially addressed to fully addressed in 2021
- 1 is not addressed

UnitedHealthcare

There is a total of 39 recommendations included in Appendix F:

- 8 moved from either minimally, partially, or substantially addressed to fully addressed in 2020
- 16 moved from either in progress, minimally, partially, or substantially addressed to fully addressed in 2021
- 2 are substantially addressed
- 10 are in progress
- 2 are not addressed
- 1 was fully met in 2019 and rescinded by KFMC

Recommendations for Quality Improvement

A recommendation indicates where an MCO change is needed to be in full compliance with the stated regulation. See Appendix D for details.

Aetna

Year 2 Review – 2020

Based on the areas identified for improvement, KFMC made eight recommendations:

- Five related to Availability, Access, and Coverage of Services
- Three related to Coordination and Continuity of Care

Sunflower

Year 2 Review – 2020

Based on the areas identified for improvement, KFMC made 24 recommendations:

- 15 related to Grievance, Appeal, and Notice of Adverse Benefit Determination
- 5 related to Availability, Access, and Coverage of Services
- 4 related to Coordination and Continuity of Care

Year 3 Review – 2021

Based on the areas identified for improvement, KFMC made two recommendations related to Enrollee Rights and Protections.

UnitedHealthcare

Year 2 Review – 2020

Based on the areas identified for improvement, KFMC made 25 recommendations:

- 15 related to Availability, Access, and Coverage of Services
- 6 related to Grievance, Appeal, and Notice of Adverse Benefit Determination
- 4 related to Coordination and Continuity of Care

Recommendations for Quality Improvement (Continued)

UnitedHealthcare (Continued)

Year 3 Review – 2021

Based on the areas identified for improvement, KFMC made five recommendations:

- 4 related to Enrollee Rights and Protections
- 1 related to State Responsibilities described in current MCO policy

Summary of Three-Year Compliance Review

Table 6.7 details a summary of the MCOs' overall three-year Compliance Review results for Subparts C, D, and E. Subpart B – Disenrollment: Requirements and Limitations is not included because for regulation §438.56 Disenrollment: Requirements and Limitations, the State, through its fiscal agent, is responsible for disenrollment, and the MCOs are not able to disenroll members. Therefore, these requirements are not applicable to the health plans.

Table 6.7. Summary of Three-Year Compliance Review Results

Federal Regulation	Compliance Score		
	ABH	SHP	UHC
Subpart C – Enrollee Rights and Protections			
§438.100 Enrollee Rights	86%	97%	92%
§438.114 Emergency and Poststabilization Services	90%	100%	100%
Subpart C Total	**87%**	**97%**	**93%**
Subpart D – MCO, PIHP and PAHP Standards			
§438.206 Availability of Services	88%	94%	94%
§438.207 Assurances of Adequate Capacity and Services	81%	88%	81%
§438.208 Coordination and Continuity of Care	89%	89%	91%
§438.210 Coverage and Authorization of Services	92%	96%	96%
§438.214 Provider Selection	70%	75%	80%
§438.224 Confidentiality	50%	75%	75%
§438.228 Grievance and Appeal Systems (Requires compliance with Subpart F Grievance and Appeal System [§438.402 - §438.424])	50%	75%	75%
§438.402 General Requirements	80%	85%	85%
§438.404 Notice of Adverse Benefit Determination	81%	89%	94%
§438.406 Handling of Grievances and Appeals	75%	63%	88%
§438.408 Resolution and Notification	72%	90%	97%
§438.410 Expedited Resolution of Appeals	100%	83%	100%
§438.414 Information about the Grievance and Appeal System to Providers and Subcontractors	75%	100%	100%
§438.416 Recordkeeping Requirements	100%	75%	100%
§438.420 Continuation of Benefits While Appeal and State Fair Hearing are Pending	88%	94%	100%
§438.424 Effectuation of Reversed Appeal Resolutions	100%	88%	100%
§438.230 Sub-contractual Relationships and Delegation	100%	100%	100%
§438.236 Practice Guidelines	100%	94%	100%
§438.242 Health Information Systems	100%	100%	96%
Subpart D Total	**87%**	**91%**	**94%**
Subpart E – Quality Measurement and Improvement; External Quality Review			
§438.330 Quality Assessment and Performance Improvement Program	93%	100%	100%
Subpart E Total	**93%**	**100%**	**100%**
OVERALL COMPLIANCE	**87%**	**93%**	**94%**

8. Quality Assessment and Performance Improvement Review

Background/Objectives

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. KFMC's objectives were to review completeness of each MCO's 2021 QAPI design, examine strengths, identify opportunities for improvement, and provide recommendations for improvement. The KanCare MCO contracts for both Sunflower and UnitedHealthcare went into effect January 1, 2013, and were re-awarded January 1, 2019. Aetna's KanCare MCO contract went into effect January 1, 2019.

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

For this review, KFMC assessed the following:

- The *2020 QAPI Program Description* and *2020 QAPI Work Plan* activities evaluated against the *2020 QAPI Evaluation*
- The *2021 QAPI Program Description* and *2021 QAPI Work Plan* evaluated against the *2020 QAPI Evaluation*
- MCO trending of Quality Improvement (QI) results, trending, and outcomes for PIPs over time, comparison against performance objectives defined in the QAPI program description, and assessment of performance measures
- MCO compliance with State contract sections 5.2.2 Disenrollment – Tracking Reasons for Disenrollment and 5.16.1 Reports and Audits – Review of Reports
- Follow-up to previous recommendations (2019 and 2020)

Table 7.1 details the subsections that comprise Section 5.9. Quality Assessment and Performance Improvement within the State's KanCare 2.0 contract. State contract Section 5.9.1, letter N, number 6, stipulates the following:

- MCOs must complete an annual evaluation within the first quarter of each new year.
- Findings and recommendations from the annual QAPI evaluation must shape the annual QAPI program description and annual QAPI work plan.
- The QAPI evaluation should assess the extent to which goals and objectives are met and include recommendations for continuous quality and service improvement.

Table 7.1. KanCare 2.0 Contract, Section 5.9., Quality Assessment and Performance Improvement

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

KFMC also considered federal requirements (42 CFR §438.330, Quality Assessment and Performance Improvement Program) and NCQA requirements related to annual QAPI evaluations. See Table 7.2, 2021 QAPI Review – Summary of Compliance, for a comprehensive list of annual QAPI evaluation requirements from all three sources (the state, the federal government, and NCQA).

In addition to KFMC's 2020 QAPI review findings, the following items were reviewed for this report:

- Aetna:
  - *Aetna Better Health of Kansas Quality Assessment Performance Improvement 2020 Program Description* (hereafter referred to as *Aetna 2020 QAPI Program Description*)
  - *2020 Aetna Better Health of Kansas QAPI Work Plan* (hereafter referred to as *Aetna 2020 QAPI Work Plan*)
  - *Aetna Better Health of Kansas Quality Assessment and Performance Improvement Program Evaluation January – December 2020* (hereafter referred to as *Aetna 2020 QAPI Evaluation*)
  - *Aetna Better Health of Kansas Quality Assessment Performance Improvement 2021 Program Description* (hereafter referred to as *Aetna 2021 QAPI Program Description*)
  - *2021 Aetna QAPI Work Plans* dated June 1 and November 30, 2021 (hereafter referred to as *Aetna 2021 QAPI Work Plans*)
- Sunflower:
  - *Sunflower Health Plan 2020 Quality Program Description* (hereafter referred to as *Sunflower 2020 QAPI Program Description*)
  - *2020 Work Plan Sunflower Health Plan* (dated May 21, 2020; hereafter referred to as *Sunflower 2020 QAPI Work Plan*)
  - *Sunflower Health Plan Annual 2020 Quality Program Evaluation Medicaid* (hereafter referred to as *Sunflower 2020 QAPI Evaluation*)
  - *Sunflower Health Plan 2021 Quality Program Description Medicaid* (hereafter referred to as *Sunflower 2021 QAPI Program Description*)
  - *2021 Work Plan Sunflower Health Plan* dated June 1 and November 30, 2021 (hereafter referred to as *Sunflower 2021 QAPI Work Plans*)
- UnitedHealthcare:
  - *UnitedHealthcare of the Midwest, Inc. dba UnitedHealthcare Community Plan of (KS) Community & State UnitedHealthcare Community Plan KS 2020 Quality Improvement Program Description, March 2020* (hereafter referred to as *UnitedHealthcare 2020 QAPI Program Description*)
  - *UnitedHealthcare Community Plan, KS United Clinical Services Accreditation and Clinical Quality 2020 National Quality Work Plan Activities* (hereafter referred to as *UnitedHealthcare 2020 QAPI Work Plan*)
  - *UnitedHealthcare Plan of Midwest, Inc. DBA UnitedHealthcare Community Plan (KS) Community & State 2020 Quality Improvement Evaluation [March 2021]* (hereafter referred to as *UnitedHealthcare 2020 QAPI Evaluation*)
  - *UnitedHealthcare of the Midwest, Inc. dba UnitedHealthcare Community Plan (KS) Community & State (UnitedHealthcare Community Plan of Kansas) 2021 Quality Improvement Program Description [March 2021]* (hereafter referred to as *UnitedHealthcare 2021 QAPI Program Description*)
  - *UnitedHealthcare Plan of Midwest, Inc. dba UnitedHealthcare Community Plan of Kansas (UnitedHealthcare Community Plan of KS) United Clinical Services Accreditation and Clinical Quality 2021 National Quality Work Plan Activities* dated June 1 and November 30, 2021 (hereafter referred to as *UnitedHealthcare 2021 QAPI Work Plans*)

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Conclusions Drawn from the Data

State Contract QAPI Requirements

Common Among the MCOs

KFMC reviewed State Contract Sections 5.2.2(B)(2) Disenrollment – Tracking Reasons for Disenrollment and 5.16.1(B) Reports and Audits – Review of Reports related to the QAPI and the findings are detailed below.

Section 5.2.2 Disenrollment

Section 5.2.2(B)(2): The CONTRACTOR(S) is also required to track the reason for the disenrollments for the CONTRACTOR(S)' Quality Assessment and Performance Improvement (QAPI) process.

- Aetna:
  - 2021 – Not Met
  - In the *2020 QAPI Program Description*, Aetna stated they review, monitor, track, and trend member disenrollment patterns. However, it was not included in the *2020 QAPI Work Plan* or *2020 QAPI Evaluation.* In future QAPI work plans and QAPI evaluations, Aetna should include information related to the review, monitoring, tracking, and trending of member disenrollment patterns.
- Sunflower:
  - 2021 – Partially Met
  - In the *2020 QAPI Program Evaluation*, Sunflower detailed they monitor member disenrollment. However, tracking the reason for disenrollment was not included. Also, it was not included in the *2020 QAPI Work Plan* or *2020 QAPI Program Description.* In future QAPI work plans, program descriptions, and evaluations, Sunflower should include information related to the review, monitoring, tracking, and trending of member disenrollment patterns.
- UnitedHealthcare:
  - 2021 – Partially Met
  - In the *2020 QAPI Work Plan,* UnitedHealthcare detailed they review and discuss enrollment and disenrollment reports, and enrollment disenrollment data was discussed at the Service Quality Improvement Subcommittee. It is unclear whether this includes tracking the reason for disenrollment. It was not included in the *2020 QAPI Program Description* or *2020 QAPI Evaluation.* In future QAPI work plans, program descriptions, and evaluations, UnitedHealthcare should include information related to the review, monitoring, tracking, and trending of member disenrollment patterns.

Section 5.16.1 Reports and Audits

Section 5.16.1(B): As part of its QAPI program, the CONTRACTOR(S) shall review all reports submitted to the State to identify instances and/or patterns of non-compliance, determine and analyze the reasons for non-compliance, identify and implement actions to correct instances of non-compliance and to address patterns of non-compliance, and identify and implement quality improvement activities to improve performance and ensure compliance going forward.

- Aetna:
  - 2021 – Not Met
  - Aetna's *2020 QAPI Program Description*, *2020 QAPI Work Plan*, and *2020 QAPI Evaluation* do not include language related to review of all reports submitted to the State. In future QAPI work plans, program descriptions, and evaluations, Aetna should include information related to the MCO's review of all reports submitted to the State.

- Sunflower:
  - 2021 – Not Met
  - Sunflower's *2020 QAPI Program Description*, *2020 QAPI Work Plan*, and *2020 QAPI Evaluation* do not include language related to review of all reports submitted to the State. In future QAPI work plans, program descriptions, and evaluations, Sunflower should include information related to the MCO's review of all reports submitted to the State.
- UnitedHealthcare:
  - 2021 – Partially Met
  - UnitedHealthcare's *2020 QAPI Program Description* includes information on developing and maintaining reporting systems and reports being reviewed; however, there is no information related to review of reports submitted to the State for non-compliance and associated follow-up steps to resolve the non-compliance. The *2020 QAPI Work Plan* and *2020 QAPI Evaluation* do not include language related to review of all reports submitted to the State. In future QAPI work plans, program descriptions, and evaluations, UnitedHealthcare should include information related to the MCO's review of all reports submitted to the State.

Annual QAPI Evaluation

Common Among the MCOs

Table 7.2 provides an overall summary of MCO compliance with required elements of the annual QAPI evaluation.

Table 7.2. 2021 QAPI Review – Summary of Compliance

		Compliance Rating		
		ABH	**SHP**	**UHC**
General Requirements	Process in place to evaluate impact and effectiveness of QAPI program	Fully Met	Fully Met	Fully Met
	Annual evaluation completed in the first quarter	Fully Met	Fully Met	Fully Met
	Recommendations/findings from the *2020 QAPI Evaluation* were used to shape the *2021 QAPI Program Description* and *2021 Work Plan*	Substantially Met	Minimally Met	Minimally Met
Annual Evaluation (2020)	Completed and ongoing QI activities outlined in the *2020 Program Description* and *2020 QAPI Work Plan*	Substantially Met	Partially Met	Partially Met
	Trending of QI results over time, including trending and outcomes for Performance Improvement Projects	Fully Met	Substantially Met	Substantially Met
	Comparison against performance objectives defined in the program description	Fully Met	Substantially Met	Fully Met
	Assessment of performance measures	Fully Met	Substantially Met	Substantially Met
	Recommendations for continuous quality and service improvement	Fully Met	Fully Met	Partially Met
	Determination of overall effectiveness of QI program	Fully Met	Fully Met	Fully Met
Summary of Overall Effectiveness	Assessment of adequacy of QI program resources	Fully Met	Fully Met	Fully Met
	Description of QI Committee structure	Fully Met	Fully Met	Fully Met
	Description of practitioner participation in QI program	Fully Met	Fully Met	Fully Met
	Description of leadership involvement in QI program	Fully Met	Fully Met	Fully Met
	Assessment of the need to restructure or change QI program for subsequent years	Fully Met	Fully Met	Fully Met

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

Common Among the MCOs

- Continued collaboration across departments to maximize quality assessment and coordination of quality improvement

Aetna

- Continued effort and improvement for the practitioner profile interface to improve provider quality of care
- Demonstrated improvement with recommendations/findings from the annual QAPI evaluation being used to shape the subsequent QAPI program description and QAPI work plan

Sunflower

- Identified their plan strengths and accomplishments, including receiving a "Commendable with Long-Term Services and Supports (LTSS) distinction first survey (Medicaid)" status during the annual 2020 NCQA reassessment

UnitedHealthcare

- Identified their plan strengths and accomplishments, including being converted by NCQA to an "Accredited" status beginning July 1, 2020
- Continued innovative ways to improve service to members and providers

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

Common Among the MCOs

KFMC identified the following opportunities for improvement for the MCOs' QAPI programs:

- The MCOs' *2020 QAPI Evaluation* did not address all of the activities identified by the MCO in the *2020 QAPI Program Description* and *2020 QAPI Work Plan.* Examples for each MCO are detailed below. For the comprehensive list, see Appendix E, *QAPI Program Opportunities for Improvement*.
  - Aetna: The *2020 QAPI Evaluation* addressed most of the activities identified by ABH in the *2020 QAPI Program Description* and *2020 QAPI Work Plan.* There were 21 ABH-identified activities that were not addressed. Examples are detailed below.
    - Maintain systems for monitoring and tracking practitioner and provider medical recordkeeping practices
    - Provide communications to practitioners and providers on the status and success of Quality Management activities
    - "Reporting abuse, neglect, or exploitation/extortion"
    - "Analyses from NET1 and NET2 to determine gaps, implement interventions, and measure of effectiveness"
    - "Conduct Activities and Evaluate CCOC" [Continuity and Coordination of Care]
  - Sunflower: The *2020 QAPI Evaluation* addressed a little over two-thirds of the activities identified by SHP in the *2020 QAPI Program Description* and *2020 QAPI Work Plan.* There were 14 SHP-identified activities that were not addressed. Examples are detailed below.
    - Five interventions that were scheduled for launch in 2020 or results of the PIP for the evaluation year
    - 2019 Pay for Performance Incentives
    - Evaluation of physician and hospital directories
    - Reports: *Directory Accuracy*, *Denial Systems Control*, *Population Health Management (PHM) Stratification/Segmentation, PHM Impact/Effectiveness*, *My Health Pays Utilization*, *Quality*

& Accuracy of Customer Service Process Benefit & Pharmacy Information, *Website Quality Monitoring*, *Email Response and Accuracy of Email Inquiries Analysis*, *New Member Understanding*, *LTSS Case Management - Experience*, *LTSS Case Management Effectiveness Measure*, *Active Participation*, and *Reducing Unplanned Transition*
    - Activities and outcomes for the EPSDT program
  - UnitedHealthcare: The *2020 QAPI Evaluation* addressed a little over two-thirds of the activities identified by UHC in the *2020 QAPI Program Description* and *2020 QAPI Work Plan.* There were 20 UHC-identified activities that were not addressed. Examples are detailed below.
    - Confirming member notification of Primary Care Physician (PCP) terminations within 30 calendar days of termination[10]
    - Member notification of continuity of care for specialty care physician (SPC)/PCP termination
    - Review and update of the *National Utilization Management (UM) Program Description*
    - Annual UM evaluation and inclusion of analysis of provider and member experience with the UM process
    - Confirming the member and provider websites contain Preferred Drug List (PDL) updates[10]
- There were opportunities for improvement identified by each MCO in the *2020 QAPI Evaluation* that were not addressed in either the *2021 QAPI Program Description* or *2021 QAPI Work Plan*. Examples for each MCO are provided below. For the comprehensive list, see Appendix E, *QAPI Program Opportunities for Improvement.*
  - Aetna: The opportunities for improvement identified in the *2020 QAPI Evaluation* generally connect to the *2021 QAPI Program Description* and *2021 QAPI Work Plan*. However, there were 11 opportunities for improvement identified by ABH that were not addressed. Examples are detailed below.
    - Intervention to improve performance: HEDIS Manager hired/assigned to Plan; provide further targeted approach to HEDIS measures/activities
    - How monitoring and addressing potential quality of care gaps and/or failures immediately will occur
    - *Behavioral Health Satisfaction Survey*: Include detail on plans to encourage BH providers to include member support in treatment planning
    - Planned activities/interventions to improve CAHPS outcomes for areas previously not met
    - *Practitioner Appointment Accessibility Study* increase the number of provider types surveyed for better identification of appointment accessibility rates and increase awareness of appointment availability standards
  - Sunflower: There were 36 opportunities for improvement identified by SHP that were not addressed. Examples are detailed below.
    - Efforts to promote provider and specialist communication to improve coordination of care
    - PIPs and actions for improvement
    - Sunflower will target the rural counties for further investigation and outreach to improve access for rural members based on the network adequacy report
    - Utilize the newly developed report that compares the Kansas Medical Assistance Program (KMAP) listing to the Sunflower Network to identify providers who are non-participating for recruitment/contracting
    - Education on the expectations of 24-hour access to contracted practitioners in 2021
    - Communication and education around the accessibility expectations that will be revisited with targeted practitioners and practices

[10] Opportunity for improvement was also identified in the 2020 QAPI Review.

- UnitedHealthcare: The following six opportunities for improvement identified by UHC were not addressed*:*
  - Reinforcing/reeducating other departments on the Quality of Care internal referral mechanism
  - Nineteen identified opportunities for PIPs
  - Medical Record Review improvement for providers failing the audit to be reaudited within six months
  - Evaluating the effectiveness of a member incentive program or measures included in Member Rewards
  - Evaluating the education process regarding notification of specific drug criteria and preferred agents to encourage appropriate prescribing
  - Kansas Long-term Care/LTSS and Group/Residential Home Task Force to have ongoing collaboration due to the increase in quality of care issues involving group homes

Aetna

KFMC identified the following related to Aetna's QAPI program:

- The *2021 QAPI Program Description* outlines responsibilities for the Quality Management Department, and one of these is to monitor performance rates for performance measures. Additionally, the Quality Management/Utilization Management Committee will "review and evaluate the results of QAPI activities (such as HEDIS® results, reports, data sets, study results, member and provider satisfaction survey findings and general information related to programs, systems, and processes)." The *2020 QAPI Work Plan* does include general activities related to HEDIS (annual HEDIS training to staff and compare findings to previous year and performance against other health plans), but the *2021 QAPI Work Plan* lacks detail on the interventions identified to address unmet goals regarding performance measures.

UnitedHealthcare

Related to UnitedHealthcare's QAPI program, KFMC was unable to assess whether all recommendations and findings from the *2020* QAPI *Evaluation* were used to shape the *2021 QAPI Program Description* or *2021 QAPI Work Plan,* as not all findings were reported in the QAPI evaluation. Some findings were reported in documentation separate from the QAPI evaluation. See the following:

- *2019 Continuity and Coordination of Care* report[10]
- *2019 Continuity and Coordination of Behavioral Health and Medical Care* report[10]
- *2019 NET 1-2* report[10]
- Annual practitioner satisfactions survey results[10]

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

KFMC obtained from the MCOs (Aetna – August and October 2021; Sunflower – October 2021 and January 2022; UnitedHealthcare – September and December 2021) a series of updates to the progress tracking document that included KFMC's EQRO recommendations from 2019 and 2020 that were still in progress or less than fully addressed. KFMC provided the MCOs suggestions on how to bring outstanding recommendations into full compliance, and the MCOs were given the opportunity to respond on their progress. The findings are detailed below and are also detailed in Appendix F, *Degree to Which the Previous Years' EQRO Recommendations Have Been Addressed.*

[10] Opportunity for improvement was also identified in the 2020 QAPI Review.

Aetna

Section 5.9.1 General Requirements

5.9.1(F): 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.

- 2019 – Partially Met; 2020 – In Progress; 2021 – Substantially Addressed
- In the 2019 review, KFMC identified this area as an opportunity for improvement and made a recommendation. In the 2020 review, in follow-up to the prior year recommendation, this element was determined to be In Progress. In 2021, KFMC reviewed the Aetna *2021 QAPI Program Description* and the exact requirement was cited. However, a detailed response for how Aetna monitors to ensure services and supports received are those identified in the member's treatment/service plan (Letter F) was not provided as indicated. Aetna advised KFMC the detailed response is included in the *Integrated Service Coordination (ISC) Program Description*. KFMC reviewed the program description and verified the required information was detailed. However, the *2021 QAPI Program Description* does not include a footnote detailing this information is found in the *Integrated Service Coordination (ISC) Program Description*. This recommendation is Substantially Addressed, and from the documentation submitted, the previous recommendation was modified to a new recommendation: Aetna should include a footnote in the next version of the QAPI program description.

There is a total of 13 recommendations (10 from 2019 and three from 2020). From KFMC's review of Aetna's updates to prior recommendations, KFMC determined:

- 9 moved to fully addressed
- 2 are still in progress
- 1 was substantially addressed
- 1 was not addressed

Sunflower

There is a total of nine recommendations (seven from 2019 and two from 2020). From KFMC's review of Sunflower's updates to prior recommendations, KFMC determined:

- 6 moved to fully addressed
- 3 are still in progress

UnitedHealthcare

There is a total of 15 recommendations (12 from 2019 and three from 2020). From KFMC's review of UnitedHealthcare's updates to prior recommendations, KFMC determined:

- 7 moved to fully addressed
- 1 was not addressed
- 7 are still in progress

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Recommendations for Quality Improvement

Common Among the MCOs

1. In future QAPI work plans, program descriptions, and evaluations, include information related to the review, monitoring, tracking, and trending of member disenrollment patterns.
2. In future QAPI work plans, program descriptions, and evaluations, include information related to MCO's review of all reports submitted to the State.
3. Include assessment of all interventions outlined in the QAPI program description and/or QAPI work plan in the annual QAPI evaluation.
4. Address all opportunities for improvement and proposed interventions identified by the MCO in the QAPI evaluation in the subsequent year's QAPI program description and/or QAPI work plan. Specific to ABH, language in those areas should not be an exact or near exact repeat of the previous year.

Aetna

1. In the *2022 QAPI Work Plan* and *2022 QAPI Program Description*, include interventions to address unmet performance measurement goals.
2. In the *2022 QAPI Program Description,* include information on the *Substance Use Disorder Survey* that is completed annually.
3. In the *2022 QAPI Program Description*, section "QAPI General Requirements," letters F and G, should include a footnote indicating the information can be found in the Aetna *Integrated Service Coordination (ISC) Program Description*.

Sunflower

1. Detail all areas assessed as part of the QAPI program in the QAPI evaluation, QAPI work plan, and/or QAPI program description.
2. For a more comprehensive and thorough QAPI work plan, include individual objectives and activities the MCO completes related to the QAPI program (e.g., refer to Sunflower's *2020 QAPI Work Plan*)
3. When graphs are included in the QAPI evaluation,
   a. Narrative should be included to explain the results, and
   b. The entirety of a graph should be included (e.g., the bottom of several graphs were not included in the *2020 QAPI Evaluation*).
4. Detail all areas assessed as part of the QAPI program in the QAPI evaluation, QAPI work plan, and/or QAPI program description.

UnitedHealthcare

1. For all areas evaluated as part of the QAPI program, report findings in the annual QAPI evaluation. For example, include value-based programs, cultural competency plan, and HCBS provider credentialing.
2. Detail all areas assessed as part of the QAPI program in the QAPI work plan and QAPI program description. For example, include the cultural competency plan and *Substance Use Disorder Survey.*
3. In the *2022 QAPI Work Plan*, include the *Provider Satisfaction Survey* and HCBS provider credentialing.

9. Network Adequacy Validation

Background/Objectives

MCOs contracted with the State of Kansas for the KanCare program must maintain sufficient provider networks to provide adequate access to covered services for all KanCare members. KanCare offers services to members covered by Medicaid and the Children's Health Insurance Program (CHIP). Contracts between the State of Kansas and MCOs specify certain requirements for provider access and availability, including after-hours access. Periodic monitoring of the KanCare provider network is necessary to assess and enhance the access and availability of that network.

Objectives for Primary Care Provider After-Hours Access Monitoring

The study had a primary objective to assess after-hours availability of a stratified random sample of adult and pediatric PCPs presumed to be active in fall 2021 for each MCO. The goal for each call placed was to determine, from a member's perspective, the after-hours availability of each provider and accuracy of provider information available from MCOs. For each provider in the study contacted after hours by phone, the caller aimed to address specific objectives:

- Confirm the accuracy of the provider phone number sourced from MCO provider directory.
- Categorize the call by respondent type (*intended/on-call provider*, *triage/nurse line*, *answering service*, *answering machine*, *other respondent*, or *no answer).*
- Determine whether the provider was practicing and contracted by the MCO at that location at the time the call was placed.
- Determine whether the provider may be available after hours or whether another appropriate provider may be available (e.g., on-call provider).
- Provide details on quality aspects of the call (e.g., incomplete answering machine instructions, received fax machine line).

Technical Methods of Data Collection and Analysis

Technical Methods for Primary Care Provider After-Hours Access Monitoring

Sample frames were created from unique records resulting from the validation of provider directories and network files described above. Unique PCP records were obtained from the cleaned second quarter 2021 provider network files, deduplicated by multiple methods, and merged with matching records in the second quarter 2021 provider directory that included phone number. These sets of unique PCPs created sample frames for each MCO. Sample sizes for each MCO were then calculated according to a sampling formula and samples of providers were randomly selected from those sample sizes. The samples from each MCO were then combined and deduplicated, resulting in a total of 1,318 PCP records.

Each distinct provider in the sample was represented by a "record." Each record contained information on the provider's identifying and contact information as listed in the provider network and directory files, combined with the results from the call(s) placed to the provider. KFMC's callers tracked findings from each call within an information system, including specific elements from the objectives, requirements, and standards described above. Calls were categorized according to the result of the call (e.g., reached intended provider, reached answering machine, no answer). Multiple staff made calls. To reduce overall call time and prevent unnecessary additional calls to the same phone number, callers batched some provider records that had the same phone number and assigned the results of a call for

all selected providers with that phone number. Callers used an inter-rater reliability system to settle any conflicting dispositions between caller and quality reviewer.

Results for each record were assessed according to the study's standards. Records clearly not possessing access issues or quality concerns were considered to have requirements and standards "Fully Met." Records with minor issues were considered "Substantially Met." Records with clear issues not determined to be critical were considered "Partially Met." Lastly, records with major issues were considered "Not Met."

After calls for all 1,318 sampled records were completed, KFMC deemed 107 records (8.1% of all records) ineligible to be included in this analysis and removed them from analysis. Records were deemed ineligible due to one or more of the following: the provider was not listed in an MCO online provider directory, the provider was not indicated as a PCP in the MCO online provider directory, or the caller was told that the PCP was not practicing at the location indicated on the record (but confirmed to be a PCP with the MCO online provider directory).

Description of Data Obtained

Data Obtained for Primary Care Provider After-Hours Access Monitoring

The sample datasets for each MCO, and subsequent merged records, contained provider details from the provider network files (e.g., name and address, KMAP ID, MCO, provider type, and county type) and phone number from provider directory files. After calling was completed, each record included additional fields describing call placement (e.g., caller name, date) and outcomes of call, including contact type (e.g., intended provider, answering machine); specific findings (e.g., provider after-hours availability, missing answering machine recording elements); disposition of inter-rater review; and categorization by the level study requirements and standards were met. Summary tables were created that included counts of records and at what levels they met evaluation criteria, as well as other specific findings with descriptive statistics such as percentages of grand total (all records) and percentages of contact type (e.g., all records leading to answering machine recordings) to provide context.

Conclusions Drawn from the Data Common Among the MCOs

Conclusions from Primary Care Provider After-Hours Access Monitoring

The 2021 After-Hours Access Monitoring study held a primary objective to assess after-hours availability of PCPs presumed to be active in fall 2021 among KanCare MCOs. Secondary objectives were to assess the accuracy of provider data from MCO databases and to characterize the quality of calls. Although findings were not always conclusive for after-hours access availability, the study found that many contracted providers may not offer sufficient after-hours availability to members and many issues exist with respect to the quality of responses available to members.

Records deemed Fully Met clearly satisfied the critical standards of the study. The results of calls within this level of perceived achievement are believed to fully meet reasonable after-hours availability. Of the eligible records, 159 records (13.1%) were Fully Met, with the caller reaching the intended provider, the on-call provider, or a person who indicated the provider could return a call within one hour. Calls for 21 records (1.7% of eligible records) resulted in the caller reaching the intended provider or the on-call provider. In addition, calls for 138 records (11.4% of eligible records) resulted in the caller reaching a person who indicated that the provider could return a call within one hour.

Records deemed Not Met clearly failed to satisfy the study's standards for PCP after-hours availability. Of the eligible records, 298 records (24.6%) were Not Met and clearly failed meeting study standards for PCP access. Calls covering 105 provider records (8.7% of eligible records) resulted in the caller reaching an answering machine recording with no or unclear instructions. Calls covering 90 provider records (7.4% of eligible records) resulted in the caller reaching a person who indicated that the provider could not be made available after hours. For calls covering 36 provider records (3.0% of eligible records), the caller reached a person who indicated that the provider was not practicing at that location and no provider could be made available after hours. Calls covering 67 provider records (5.5% of eligible records) were not answered, connected to a non-working number, were disconnected, had a busy signal, or otherwise did not lead to reaching a person or answering machine recording on behalf of the provider.

Data quality issues were found in all data files provided by MCOs that presents challenges to understanding the KanCare provider network. Clear issues were also observed regarding KanCare members' potential experiences attempting to access after-hours care for urgent and non-emergent services, indicating a need for improvement within PCPs' operations and infrastructures. To better serve members in times of need, KanCare MCOs should take steps to address the issues related to the after-hours availability of providers.

In lieu of a contractual requirement from the State that obligates MCOs to include specific availability terms or conditions in their PCP contracts, a written definition for after-hours non-emergent service availability is needed to objectively evaluate after-hours availability.

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

- The State and MCOs continued to improve network data in 2021 and the State remains committed to continuing to work with the MCOs on improving data quality and reporting.
- Findings from the 2021 study indicated that over half of sampled eligible PCP records fully or substantially met KanCare requirements and the study's performance standards (637 records, 52.6% of eligible records). Of the sampled eligible PCP records, 159 providers (13.1% of eligible records) were categorized as fully meeting requirements and standards, that a KanCare Member could contact the provider or an on-call provider after hours. A plurality of records was categorized as substantially meeting requirements and standards (478 records, 39.5% of eligible records).
- The sample frame of provider records compared reasonably well to counts in the MCOs' quarterly Mapped Provider Count reports. Although the sample of provider records was deduplicated on multiple fields, multiple sampled records had the same phone number. The sample frame was known to contain multiple records for providers practicing at more than one location or with multiple phone numbers available for those locations. Each of these instances was considered acceptable in the study to include the experiences of members who would access the provider in different geographic areas. Additionally, the sample frame was not substantially higher than the PCP counts detailed in mapped provider counts submitted to KDHE. Thus, the sample frame was expected to be a reasonable representation of KanCare PCPs, and the study was expected to have reasonable external validity for generalizability.
- While the MCOs were not directly the subjects of the study and no inferential statistics, such as for independence of MCO, were performed, a cursory review of the data did not reveal any noticeable differences in call outcomes associated with MCO contracting.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Additional details in certain contractual provisions and State policies are warranted for performance evaluation and clearer MCO and provider responsibilities for network adequacy. For example, there is no commonly agreed upon definition of "after-hours availability" for medical providers available for objective evaluation.
- Objective study of PCP after-hours availability and call quality was also impeded by the absence of an external quality review protocol by CMS.
- Just under half of PCP records displayed minor or major issues (572 records, 47.2% of eligible records) leading to Partially Met or Not Met categorizations.
- Almost one-third of contacts led to answering machine recordings (390 records, or 32.2% of eligible records), which suggests that a common system for PCPs to handle after-hours calls is offering a pre-recorded message for members who call when the provider is not present. For this reason, such pre-recorded messages must be high-quality, informative, and provide callers with directions for emergency and non-emergency situations, such as including the name and contact details for a local hospital or other care option. Ideally, a member should, at minimum, have a means for leaving a message and should be told when to expect to be in contact with a PCP, though this was not a requirement or standard for MCOs nor an evaluation component in the present study.
- Data quality issues with data supplied by MCOs prevented construction of an accurate PCP sample frame and sample (e.g., duplicate records). To address this, a less conservative sampling strategy was applied to prevent excluding eligible PCPs but led to some duplication within the sample frame and sample.
- Following completion of call outcomes for the 1,318 records in the 2021 study's sample, KFMC deemed 107 records (8.1% of all records) ineligible to be included in this year's analysis because the outcomes did not conclusively meet the study's requirements or standards, reducing the total number of completed records eligible to be analyzed to 1,211. Of the 107 ineligible provider records, 64% were not indicated to be PCPs in the MCOs' online provider directories, 26% were not found in the MCOs' online provider directories, and 10% had inconsistent locations of practice between the provider record in the MCOs' Network Adequacy reports and the MCOs' online provider directories.

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

KFMC's seven overall recommendations from 2020 are detailed in Appendix F, *Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed.* Based on the 2020 study, five recommendations were related to MCO quality improvement and two recommendations involved proposed policy changes for the State and providers. KFMC obtained in March and April 2022 the State's and MCOs' progress updates on KFMC's recommendations from the 2020 study. A general assessment of progress on the 2020 recommendations follow below.

Aetna

Of the five recommendations related to MCO quality improvement, KFMC determined all five were fully addressed.

Sunflower

Of the five recommendations related to MCO quality improvement, KFMC determined all five were fully addressed.

UnitedHealthcare

Of the five recommendations related to MCO quality improvement, KFMC determined

- 3 were fully addressed,
- 1 was partially addressed, and
- 1 was not addressed.

State

KFMC determined the State fully addressed this recommendation related to proposed policy changes.

PCPs

KFMC determined PCPs in the 2021 study partially addressed this recommendation related to proposed policy changes.

Recommendations for Quality Improvement

Recommendations for the State

1. The State should use KFMC's annual Primary Care Provider After-Hours Access Monitoring report to review findings directly with MCOs to ensure each MCO has adopted and operationalized the after-hours availability definition and policy requirements.
2. The State should continue to review and work with the MCOs on accuracy and comparability among the various databases.

Recommendations for the KanCare MCOs

3. KanCare MCOs should review data from this study provided by the State that highlights specific provider issues and follow up with the State on any internal policy changes or any actions taken with providers.
4. KanCare MCOs should establish internal processes to review provider information available through multiple data streams to provide the most up-to-date provider information to the members (e.g., correct phone, currently practicing providers). MCOs should also work to standardize data fields shared between databases (e.g., provider name and address fields) so providers may be uniquely distinguished.
5. KanCare MCOs should provide training and technical assistance to providers on how to adequately implement standards on after-hours availability requirements.
6. KanCare MCOs should use findings from KFMC's annual Primary Care Provider After-Hours Access Monitoring report and post-facto discussion with the State to directly review those providers indicated as having after-hours availability issues and provide best practices, solutions, and consequences.
7. KanCare MCOs should review their information systems to ensure that providers are accurately classified by provider type and specialty.

Recommendations for Quality Improvement with Respect to Policy

Recommendations for the State

1. The State should consider amendments or addendums to MCO contracts that better define "after-hours availability" and detail requirements and standards, or that the MCOs better define these standards in their provider contracts, which would improve the State's ability to measure and evaluate after-hours availability.

Recommendations for Quality Improvement with Respect to Policy (Continued)

Recommendations for the KanCare MCOs

2. KanCare MCOs should include a refined definition of "after-hours availability" in agreements with their providers.
3. KanCare MCOs should adopt internal systems of consequences to after-hours availability definition/policy violations by their providers.

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10. Quality Management Strategy

The KanCare Quality Management Strategy (QMS), submitted to CMS on December 9, 2021, includes goals and objectives to improve "performance of our managed care partners and improving the quality of care our KanCare members receive."[11] The EQRO activities KFMC completed in the last year that were related to goals and objectives in the QMS are described below in Table 9.1. Additionally, and in accordance with the Code of Federal Regulations §438.364(a)(4), suggestions for how the State can improve the quality strategy to better support improvement of the quality, timeliness, and access to health care services provided through the KanCare program are listed below.

Table 9.1. KanCare Quality Management Strategy and EQRO Activities
Goal #1: Improve the delivery of holistic, integrated, person centered, and culturally appropriate care to all members
Objective 1.2: MCOs will annually submit a cultural competency plan which includes robust elements of a health equity strategy along with all elements required in the contract (5.5.4.B.)
As part of the Compliance Review, KFMC assessed whether MCO provider directories included the provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed Cultural Competency training. KFMC made a recommendation for the MCO to add these items to their provider directory if either was missing from the provider directory. Please see the Review of Compliance with Medicaid and CHIP Managed Care Regulations section of this report for more details. As part of the QAPI review, KFMC assessed whether the MCOs included the cultural competency plan in the MCO QAPI documentation. If it was not included, KFMC made a recommendation for the MCO to include this in their QAPI materials. For more information, please see the QAPI Review section of this report.
Goal #2: Increasing employment and independent living supports to increase independence and health outcomes
Objective 2.5: Each MCO will implement a Performance Improvement Project (PIP) that addresses SDOH [social determinants of health]

KFMC validated the following PIPs related to the social determinants of health:
• Aetna Food Insecurity, 92.6% (Confidence)
  ○ Two of five interventions were implemented, with an outcome reported for only one intervention.
• UnitedHealthcare Housing, 97.1% (High Confidence)
  ○ Four of five interventions were implemented as planned.
• Sunflower Waiver Employment
  ○ The validation rating was 82.4% (Low Confidence).
  ○ Two of five interventions were implemented (without clear outcome data presented), and three were put on hold.
  ○ For more details, see the Performance Improvement Project Validation section of this report.
For more details, see the Performance Improvement Project Validation section of this report.

Objective 2.6: Increase the rate of completed health screens
As part of the Compliance Review, KFMC reviewed MCO care coordination records. Across all MCOs, the number of members with a completed health screen needed to increase. The State, KFMC, and MCOs also identified the need for a revised health screen tool and formed a workgroup to develop the new tool with representation from the State, EQRO, and MCOs. The MCOs are currently in the process of implementing the revised tool.
Objective 2.9 Increase the rate of claims that use of Z codes by 1% on claims year over year to better identify members with employment, housing, legal, food or health access needs
Aetna's Food Insecurity PIP included an intervention regarding Z-code outreach to providers. • This intervention was not yet implemented. • See Goal #2, Objective 2.5, and the Performance Improvement Project Validation section of this report for more details.

[11] *KanCare Quality Management Strategy*. State of Kansas, December 9, 2021, www.kancare.ks.gov/quality-measurement/QMS. Accessed April 6, 2022.

Table 9.1. KanCare Quality Management Strategy and EQRO Activities (Continued)
Goal #4: Removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members will result in improved beneficiary access to Substance Use Disorder (SUD) treatment service specialists
Objective 4.3: Increase peer support utilization for BH services by 10% year over year
In 2021, KFMC administered the ECHO Survey to KanCare adults and children who had utilized mental health services. Of the adult respondents to the survey, 47.8% were told about self-help or support groups (Q20). For more details, please refer to the 2021 KanCare Mental Health Consumer Perception Survey section of this report.
Objective 4.5: Achieve the National HEDIS 75th percentile for Opioid abuse or dependence: Age 13+, Initiation of AOD Treatment (IET)
The ISCA and PMV section of this report addresses the KanCare Quality Management Strategy objectives regarding HEDIS rates. Please see Table 1.1. HEDIS Performance Measures (Measurement Year 2020) – Adult Core Set.
Objective 4.6: Develop and implement direct testing or secret shopping activities for provider network validation
KFMC conducted the Primary Care Provider After-Hours Access Monitoring study. For more detail within this report, please see the Network Adequacy Validation section.
Goal #5: Improve overall health and safety for KanCare members
Strategy: All MCOs are expected to achieve the Quality Compass national 75th percentile for all reported HEDIS data. For HEDIS measures falling below the 75th percentile, the State strategy is aimed at reducing annually, by 10%, the gap between the baseline rate and 100%. Each measure that shows improvement equal to or greater than the performance target is considered achieved. For those measures which have exceeded the 90th percentile, plans are expected to maintain or improve their outcomes. MCOs are to assess and report their annual progress and goals for each measure below the 75th percentile in their QAPI. **Objective 5.1:** HbA1c good control (<8.0%) for members with diabetes **Objective 5.2a:** Well-Child Visits first 15 months (effective 2020 W15 became an indicator of W30) **Objective 5.2b:** Well-Child Visits 15–30 months (15-30-month period & name change in 2020) **Objective 5.3a:** Child and Adolescent Well-Care Visits (WCV) ages 3–11 **Objective 5.3b:** Child and Adolescent Well-Care Visits (WCV) ages 12–17 **Objective 5.3c:** Child and Adolescent Well-Care Visits (WCV) ages 18–21 **Objective 5.7:** Increase rates of selected Adult and Child Core measures by 5% annually: • Breast Cancer Screening (BCS-AD) • Chlamydia Screening in Women (CHL) ages 16 to 24
The ISCA and PMV section of this report addresses the KanCare Quality Management Strategy objectives regarding HEDIS rates. Please see Table 1.1. HEDIS Performance Measures (Measurement Year 2020) – Adult Core Set and Table 1.2. HEDIS Performance Measures (Measurement Year 2020) – Child Core Set.

EQRO Suggestions for the State

1. Continue to include a focus on culturally appropriate care, health equity, and the requirement of the MCOs to address the social determinants of health by implementing PIPs.
2. Continue to support the MCOs towards increasing the number of members with a completed annual health screen.
3. Continue the assessment and improvement of member access to providers.
4. For HEDIS Measures below the 75th Quality Compass percentile, continue to include these metrics as priority metrics in the quality strategy and require plans to implement performance targets that align with those in the quality strategy.
5. The State should include the following in its quality management strategy.
   a. The consistent use of SMART objectives (Specific, Measurable, Attainable/Achievable, Relevant, and Time-bound)
   b. Performance targets for each objective

End of written report

Appendix A

KanCare Program Annual External Quality Review Technical Report

2021–2022 Reporting Cycle

List of KFMC EQR Submitted 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 Kansas Department of Health and Environment during the 2021 – 2022 reporting cycle. However, due to Compliance Review reporting cycle changes, reports for this deliverable from both the 2020 –2021 and 2021 –2022 reporting cycles are included.

PMV and ISCA

- Aetna — *2021 Validation and Evaluation of HEDIS MY 2020 Performance Measures of Aetna,* December 20, 2021
- Sunflower — *2021 Validation and Evaluation of HEDIS MY 2020 Performance Measures of Sunflower,* December 21, 2021
- UnitedHealthcare — *2021 Validation and Evaluation of HEDIS MY 2020 Performance Measures of UnitedHealthcare,* December 21, 2021

Performance Improvement Project Validation

- Aetna
  - *2021 PIP Annual Evaluation of Aetna,* ***EPSDT*** *(*January 1, 2020, to December 31, 2020), July 12, 2021; Year 1 PIP evaluation
  - *2021 PIP Annual Evaluation of Aetna,* ***Pregnancy: Prenatal Care*** *(*January 1, 2020, to December 31, 2020), August 19, 2021; Year 1 PIP evaluation
  - *2021 PIP Annual Evaluation of Aetna,* ***Food Insecurity*** *(*April 1, 2020, to March 31, 2021), September 27, 2021; Year 1 PIP evaluation
  - *2021 PIP Annual Evaluation of Aetna,* ***LTSS-Emergency Department Visits*** *(*July 1, 2020, to June 30, 2021), December 7, 2021; Year 1 PIP evaluation
  - *2021 PIP Annual Evaluation of Aetna,* ***Influenza Vaccination*** *(*July 1, 2020, to June 30, 2021), February 3, 2022; Year 2 PIP evaluation
- Sunflower
  - *Evaluation of 2021 Sunflower,* ***EPSDT*** PIP *(January 1, 2020, to December 31, 2020),* July 13, 2021; Year 1 PIP evaluation
  - *Evaluation of 2021 Sunflower,* ***Cervical Cancer Screening*** PIP *(January 1, 2020, to December 31, 2020),* May 19, 2021; Year 1 PIP evaluation
  - *Evaluation of 2021 Sunflower,* ***Diabetics Monitoring for People with Diabetes and Schizophrenia (SMD) PIP*** *(January 1, 2020, to December 31, 2020),* February 1, 2022; Year 1 PIP evaluation
  - *Evaluation of 2021 Sunflower,* ***Waiver Employment*** PIP *(April 1, 2020, to March 31, 2021),* August 19, 2021; Year 1 PIP evaluation
  - *Evaluation of 2021 Sunflower,* ***Mental Health for Foster Care*** PIP *(August 1, 2020, to July 31, 2021),* February 16, 2022; Year 1 PIP evaluation

- UnitedHealthcare
  - *Evaluation of 2021 UnitedHealthcare,* ***EPSDT*** PIP *(January 1, 2020, to December 31, 2020),* July 14, 2021**;** Year 1 PIP evaluation
  - *Evaluation of 2021 UnitedHealthcare,* ***Timeliness of Prenatal Care and Improving Early Detection Strategies of Pregnant Moms (Prenatal Care)*** PIP *(January 1, 2020, to December 31, 2020),* July 17, 2021**;** Year 1 PIP evaluation
  - *Evaluation of 2021 UnitedHealthcare,* ***Diabetes Monitoring for Members with Diabetes and Schizophrenia (SMD) PIP,*** *(January 1, 2020, to June 30, 2021),* October 11, 2021**;** Year 1 PIP evaluation
  - *Evaluation of 2021 UnitedHealthcare,* ***Advanced Directives*** PIP *(January 1, 2020, to December 31, 2020),* May 20, 2021**;** Year 1 PIP evaluation

    2021 Addendum, September 3, 2021
  - *Evaluation of 2021 UnitedHealthcare,* ***Housing*** PIP *(September 1, 2020, to August 31, 2021),* January 6, 2022**;** Year 1 PIP evaluation

CAHPS Health Plan 5.1H Survey Validation

- Aetna, Sunflower, UnitedHealthcare — *2021 CAHPS Health Plan 5.1H Survey Validation – Aetna Better Health of Kansas, Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas,* March 29, 2022. The 2021 CAHPS surveys were conducted by each MCO from February through May 2021.

Mental Health Consumer Perception Survey

- KanCare — *2021 Kansas Medicaid Mental Health Consumer Perception Survey,* April 21, 2022.

Provider Survey Validation

- Aetna — *2021 Provider Survey Validaton*, February 21, 2022. Aetna's survey was conducted from August 2021 through October 2021 by the vendor, SPH Analytics.
- Sunflower — *2021 Provider Survey Validaton*, February 28, 2022. The Sunflower survey was conducted from May 2021 through August 2021 by the vendor SPH Analytics.
- UnitedHealthcare — *2021 Provider Survey Validaton,* March 30, 2022. The UnitedHealthcare survey was conducted from September 2021 through November 2021. UnitedHealthcare partnered with Escalent to conduct this survey.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

- Aetna
  - *2021 Review of Compliance with Medicaid and CHIP Managed Care Regulations of Aetna,* January 26, 2022.
  - *2020 Review of Compliance with Medicaid and CHIP Managed Care Regulations of Aetna,* February 24, 2021.
- Sunflower
  - *2021 Review of Compliance with Medicaid and CHIP Managed Care Regulations of Sunflower,* March 9, 2022.
  - *2020 Review of Compliance with Medicaid and CHIP Managed Care Regulations of Sunflower*, March 9, 2021.
- UnitedHealthcare
  - *2021 Review of Compliance with Medicaid and CHIP Managed Care Regulations of UnitedHealthcare,* February 9, 2022.
  - *2020 Review of Compliance with Medicaid and CHIP Managed Care Regulations of UnitedHealthcare,* February 11, 2021.

Quality Assessment and Performance Improvement Review

- Aetna — *2021 QAPI Review*, March 7, 2022.
- Sunflower — *2021 QAPI Review*, March 21, 2022.
- UnitedHealthcare — *2021 QAPI Review*, March 14, 2022.

Network Adequacy Validation

- *Primary Care Provider After-Hours Access Monitoring,* April 5, 2022.

Appendix B

KanCare Program Annual External Quality Review Technical Report

2021–2022 Reporting Cycle

ISCA and PMV Methodology

Technical Methods of Data Collection and Analysis/Description of Data Obtained – Performance Measure Validation and Evaluation

Performance Measure Validation Methods

MetaStar performed validation of the HEDIS Measurement Year (MY) 2020 performance measures according to the 2019 Centers for Medicare & Medicaid Services (CMS) protocol, "*External Quality Review (EQR) Protocol 2: Validation of Performance Measures Reported by the MCO*," (the Protocol).

Common Among the MCOs

The CMS protocol identified key types of data that should be reviewed as part of the validation process. MetaStar's review included the following types of data:

- 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 (prepared for the MCO-contracted audit that was concurrent with measure production), 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 virtual onsite interviews, provided documentation, system demonstrations and data output files, primary source verification, 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, the Timeliness of Prenatal Care and Postpartum Care indicators of the Prenatal and Postpartum Care measure were reabstracted by MetaStar (30 records per measure for each MCO). KFMC provided a randomly selected list of cases to the MCOs, and the MCOs provided the medical records for the reabstraction. MetaStar performed the reabstractions prior to the on-site interviews.

Prior to the virtual onsite, KFMC requested member-level files for 20 measures in order to conduct validations, such as comparing figures in the MCO's IDSS to what resided in the State's Medicaid Management Information System (MMIS). The measures requested are used by the State and KFMC for evaluation of the KanCare 2.0 and Substance Use Disorder 1500 Demonstration projects and for the pay-for-performance incentive program. The validations serve three purposes:

- Test the accuracy of the reported HEDIS measures
- Check that provider data and member demographic and enrollment data sent by the State are accurately stored in the MCO's systems
- Assess the completeness of the encounter data sent by the MCO and test for discrepancies between the submitted encounters and the encounter records in the MMIS reporting database

From the set of all member-level tables, the uniqueness of the Medicaid ID was tested (that is, verifying a Medicaid ID appeared only once per denominator). Within each MCO's records, the relationship between the Medicaid ID and MCO-defined identifiers was examined by checking for Medicaid IDs associated with multiple MCO-defined identifiers, and vice versa. For records showing the members' names and dates of birth, comparison to the names and dates of birth in MMIS were made.

Many HEDIS measures require that the member be enrolled with the MCO on a specific date, the "anchor date," to be included in the denominator. KFMC checked that the members in the administrative denominator for the following measures were enrolled on the anchor date:

- Measures with December 31, 2020, anchor date
  - Adults' Access to Preventive/Ambulatory Health Services (AAP)
  - Annual Dental Visit (ADV)
  - Cervical Cancer Screening (CCS)
  - Comprehensive Diabetes Care (CDC)
  - Chlamydia Screening in Women (CHL)
  - Use of Opioids From Multiple Providers (UOP)
  - Well Child and Adolescent Visits (WCV)
- Measures anchored on the second birthday
  - Childhood Immunization Status (CIS)
  - Lead Screening in Children (LSC)

The denominator inclusion criteria for CIS and LSC are the same. KFMC verified that the two measures had the same denominator populations for each MCO. CIS denominator criteria were then applied to MMIS demographic and MCO-assignment tables to estimate the denominators. Discrepancies between the member-level tables' denominators and the MMIS-derived denominators were investigated.

For the Total Membership (TLM) measure, MCOs report a deduplicated count of members, including all products and product lines. Per HEDIS technical specifications, members in CHIP are included in the Medicaid count, and dual Medicaid/Medicare members are part of the Medicare count. These counts were compared to the number of members enrolled with each MCO on December 31, 2020, calculated from MMIS. No concerns were raised.

The denominator for the Mental Health Utilization Measure (MPT) is the total of member-months, which is a count that includes members once for each month they are enrolled. Members with dual Medicaid/Medicare enrollment are included in the MPT denominator. The total of member-months was compared to a corresponding count from MMIS. No concerns were raised.

The denominators for Prenatal and Postpartum Care (PPC) indicators were also estimated using MMIS data. The technical specifications for the PPC denominator include claims-based criteria (e.g., procedure codes indicating delivery and office visits, and diagnosis codes indicating non-live birth). The PPC denominator and estimated denominator were reasonably close.

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

Findings Specific to Aetna

Counts of membership and member-months confirmed that Aetna appropriately included members with dual Medicaid/Medicare enrollment and segments of retroactive eligibility when identifying the denominator populations.

No discrepancies were identified in the analysis for Aetna that warranted concern or further investigation.

Findings Specific to Sunflower

Counts of membership and member-months confirmed that Sunflower appropriately included members with dual Medicaid/Medicare enrollment and segments of retroactive eligibility when identifying the denominator populations.

Three types of discrepancies were investigated and satisfactorily resolved.

KFMC was unable to establish that 11 members met continuous eligibility requirements for one or more measures. MMIS did show that each was a Sunflower member on the December 31 anchor date. Sunflower provided enrollment records from their system that showed the members were enrolled in another Sunflower health plan (Ambetter) during part of the year. HEDIS technical specifications allow health plans to combine enrollment segments from multiple products to determine continuous enrollment.

Two members had dates of birth in the member-level files that did not match dates from MMIS. The dates differed by only one digit. The discrepancies were attributed to differences in birthdates stored for the members in MMIS compared to demographic records loaded into the HEDIS system for another of Sunflower's health plans. The volume is too low to affect HEDIS rates; KanCare claims processing and care management are not impacted.

One Medicaid ID identified a different person in the member-level tables than in MMIS. The mismatch of members was only within the HEDIS system and not Sunflower's KanCare claims processing or care management systems.

Findings Specific to UnitedHealthcare

Counts of membership and member-months confirmed that UnitedHealthcare appropriately included members with dual Medicaid/Medicare enrollment and excluding segments of retroactive eligibility when identifying the denominator populations.

Four types of discrepancies were investigated and satisfactorily resolved:

- Fifteen records had dates of birth different from the dates found in MMIS for the members
- Six records had invalid Medicaid ID
- One Medicaid ID in the member-level tables was used for two different people
- Two additional member-level records had Medicaid IDs that matched to a different person in MMIS

The source of the discrepancies was determined to be a limitation of the processes within the HEDIS system that identify person's records from multiple health plans. If a person had records loaded into the HEDIS system from multiple plans, the HEDIS system uses the demographic information from one record, and that information may be different from MMIS data. The number of discrepancies is too small to affect HEDIS rates. The discrepancies are within the HEDIS system and not within UnitedHealthcare's claims processing and case management systems used for KanCare.

Performance Measure Evaluation Methods

KFMC analyzed data for all HEDIS measures that are CMS Adult or Child Core Set measures, plus some non-core set measures reported to the State, to identify strengths and opportunities for improving access, timelines, and quality of healthcare.

Common Among the MCOs

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 Measurement Year 2020 & Measurement Year 2021, 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 were averages weighted by the administrative denominators (from which the hybrid sample was drawn).
- Mixed Hybrid and Administrative – Where the MCOs did not report rates using the same method, KanCare rates were also averages weighted by the administrative denominators. For statistical testing of mixed KanCare rates, the administrative rates were treated as rates with denominator 411.
- CAHPS Survey – KanCare rates for CAHPS survey measures were 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 Compass®. MCO and KanCare rates were ranked using the Quality Compass percentiles. The ranks are denoted, in order of worst to best performance: $<5^{th}$, $<10^{th}$, $<25^{th}$, $<33.33^{rd}$, $<50^{th}$, $\geq 50^{th}$, $>66.67^{th}$, $>75^{th}$, $>90^{th}$, and $>95^{th}$. Note that, as rankings are based on national percentiles, some measures with high scores in Kansas may have very low rankings due to high scores nationwide. For example, a rate of 87 for one metric may rank <10th, while the same rate for another metric may rank >90th.

Changes in MCO and KanCare rates and rankings across years 2016 to 2020 were assessed. Amerigroup was included in KanCare aggregations from 2016 to 2018. Aetna data was included in KanCare rates for 2019, where available (for some measures, Aetna had few or no members meeting continuous eligibility criteria).

For hybrid and CAHPS measures, annual changes between rates and the prior year's rates were tested for statistical significance using Fisher's exact for MCO rates or Pearson chi square for KanCare rates. 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.

Changes in rates between 2019 and 2020 were also assessed using a "gap-to-goal" percentage change, which measures the change in rates relative to the potential for change. Identification of strengths and opportunities for improvement used gap-to-goal percentage changes of 10% or more as a threshold. The formula for the gap-to-goal percentage change is

(2020 Rate – 2019 Rate)/(Goal Rate – 2019 Rate), where Goal Rate is 100% or 0%.

Slopes of trend lines were calculated using the ordinary least-squares method. Depending on data availability, three to five years were trended for KanCare, Sunflower, and UnitedHealthcare; only two years of data existed for Aetna. The slopes provide the "average rate of change" across the trending period in percentage points per year (pp/yr). The slopes were tested to see if they were statistically significantly different from horizontal (i.e., significantly different from 0 pp/yr) using Mantel-Haenszel chi-square (*p* less than 0.05 considered significant).

Appendix C

KanCare Program Annual External Quality Review Technical Report

2021–2022 Reporting Cycle

2021 Mental Health Consumer Perception Survey Methodology

Technical Methods of Data Collection and Analysis/Description of Data Obtained – Mental Health Consumer Perception Survey

Survey Instruments

From 2010 to 2020, an adapted version of the Mental Health Statistics Improvement Program (MHSIP) Survey instrument was used to gauge consumer perception of KanCare members. In 2021, the State made the decision to use the ECHO Survey tool. The ECHO Survey is the result of the merging of two surveys: MHSIP Survey, and the Consumer Assessment of Behavioral Health Services (CABHS) Survey.[1] Additional questions were added to both the adult and child ECHO tools (Q41 and Q42 for adults, Q71 and Q72 for children) in order to satisfy KDADS' block grant reporting requirements to the Substance Abuse and Mental Health Service Administration (SAMHSA). As a result, Kansas ECHO survey results may not be directly comparable to results from similar surveys conducted in other states.

KFMC contracted with SPH Analytics to administer the Kansas ECHO Survey. SPH Analytics is a certified CAHPS® vendor with experience administering the ECHO Survey since its development .[2] SPH Analytics also processed and analyzed the data and provided the final reports upon which this summary report is based. The SPH Analytics reports were provided with the full 2021 KanCare Mental Health Consumer Perception Survey report. KFMC created the sample frames and provided them to SPH Analytics.

Survey Population and Sampling Process

Members eligible to receive the survey were adult (ages 18 or older) and child (ages 17 or younger, family responding) populations enrolled in KanCare and residing in Kansas on the date of sample selection (October 29, 2021), continuously enrolled during the measurement period (September 1, 2020, through August 31, 2021), and who had received one or more mental health or substance use disorder services through one of the three MCOs during the measurement period.[3] See Table C-1 for the method of identifying mental health and substance use disorder services. A total of 48,226 adult members and 47,386 child members met the criteria. The sample frames were pulled from the October 2021 Medicaid Enrollment file, which included enrollment and demographic data (such as member name, age, phone number, and mailing address).

After receiving the sample frame files from KFMC, SPH Analytics implemented a process of deduplication of the sample frames. The sample frames were deduplicated to one record per household. To improve response rates, members whose household received Sunflower Health Plan's ECHO Survey (also administered by SPH Analytics) were then removed. The resulting files included 34,573 eligible adult and 31,371 eligible child members.

The minimum number of survey responses required to obtain a 95% confidence level with a 5% margin of error was calculated for the adult (396) and child (379) populations. Because of time constraints with survey implementation in 2021, the survey methodology used a one-wave survey mailing protocol instead of two, as done in prior years. An initial number of surveys to be mailed (based on 2020 response rates) was doubled to offset the reduction in survey mailings. Samples were selected for the

[1] https://www.ahrq.gov/cahps/surveys-guidance/echo/about/Development-ECHO-Survey.html
[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)
[3] Age is calculated as of August 31, 2021. "Continuous enrollment" allows one gap of up to 45 days during the measurement period but requires enrollment on August 31, 2021.

adult and child populations using simple random sampling. Surveys were mailed to 15,200 KanCare members, representing 7,600 adult and 7,600 child members.

Table C-1. Codes for Identifying Mental Health and Substance Use Disorder Services

Value Set	Type of Service	Steps
Identification of Mental Health Services		
Mental Health Diagnosis	Institutional and professional encounters with mental health related primary diagnosis code	Step 1 inclusion criteria
MPT IOP/PH Group 1 MPT Stand Alone Outpatient Group 2 Partial Hospitalization or Intensive Outpatient Transcranial Magnetic Stimulation	Outpatient and professional encounters with procedure codes indicating outpatient, intensive outpatient, or partial hospitalization settings	Step 2 inclusion criteria
Visit Setting Unspecified Outpatient Place of Service (POS) Community Mental Health Center POS Partial Hospitalization POS Telehealth POS	Professional encounters for listed procedure and POS codes indicating an outpatient, Community Mental Health Center, partial hospitalization, or telehealth	Step 2 inclusion criteria
Notes: Value sets are from the HEDIS MY 2020 & MY 2021 technical specifications for the Mental Health Utilization (MPT) measure. Identification was based on encounters meeting the Step1 inclusion criteria and one or more of the Step 2 inclusion criteria.		
Identification of Substance Use Disorder (SUD) Services		
Alcohol Abuse and Dependence Opioid Abuse and Dependence Other Drug Abuse and Dependence	Services on institutional and professional encounters with diagnosis code indicating SUD.	Step 1 inclusion criteria.
Detoxification	Institutional and professional encounters with procedure or revenue codes indicating detoxification	Step 2 exclusion criteria
IAD Stand-Alone Outpatient Observation	Institutional and professional encounters with procedure code indicating outpatient service	Step 3 inclusion criteria
Visit Setting Unspecified Outpatient POS Non-residential Substance Abuse Treatment Facility POS Community Mental Health Center POS Partial Hospitalization POS	Professional encounters for listed procedure and POS codes indicating an outpatient, Community Mental Health Center, or partial hospitalization	Step 3 inclusion criteria
IAD Stand-Alone IOP/PH	Institutional and professional encounters with procedure code indicating intensive outpatient setting	Step 3 inclusion criteria
AOD Medication Treatment	Professional encounters with procedure code indicating medication assisted treatment	Step 3 inclusion criteria
Notes: Value sets are from the HEDIS MY 2020 & MY 2021 technical specifications for the Identification of Alcohol and Other Drug Services (IAD) measure. Identification was based on encounters meeting the Step1 inclusion criteria and one or more of the Step 3 inclusion criteria. Encounters meeting the Step 2 criteria were excluded from analysis.		
Identification Pharmacy Claims for Medication Assisted Treatment for SUD		
Medication Treatment for Alcohol Abuse or Dependence Medications Medication Treatment for Opioid Abuse or Dependence Medications Alcohol Use Disorder Treatment Medications Opioid Use Disorder Treatment Medications	Pharmacy encounters with National Drug Code (NDC) indicating medication assisted treatment	Step 1 inclusion criteria
Notes: Value sets are from the HEDIS MY 2020 & MY 2021 technical specifications for the Identification of Alcohol and Other Drug Services (IAD) measure. Identification was based on encounters meeting the Step1 inclusion criteria.		

Survey Protocol

The survey methodology employed a mail-only distribution process consisting of a one-wave mail protocol. A survey with a cover letter and postage-paid return envelope was mailed to each adult in the sample, and to the parent or guardian of each child in the sample. The cover letter provided an internet Uniform Resource Locator (URL), username, and password, so the member (or parent/guardian) could take the survey online, if desired. The tasks and timeframes employed were based on the standard NCQA protocol for administering surveys. Surveys were mailed November 22, 2021.

The 2021 Adult and Child ECHO Surveys were also made available in Spanish. A flag was added to each sample file indicating Spanish as the preferred language. Spanish surveys were mailed to the members with a Spanish flag in the sample files, and the internet URL option was also available for those wishing to take the survey online and in Spanish. Of the 7,600 adult surveys mailed, 82 were in Spanish. Of the 7,600 child surveys mailed, 159 were in Spanish.

Survey Response Rates

A total of 971 valid surveys were returned: 579 adult surveys and 392 child surveys. Of the 579 adult surveys received, 538 were completed by mail (533 English and 5 Spanish), and 41 were completed via the URL provided (all English). For the child surveys, 342 were received by mail (337 English and 5 Spanish), and 50 surveys were completed online (all English). No surveys completed via URL were in Spanish. The adjusted response rates for the adult and child populations were 8.04% and 5.45%, respectively. A total of 799 surveys were undeliverable (395 adult and 404 child).

Data Processing and Analysis

SPH Analytics processed all completed surveys and analyzed the results. Their methodology and results were provided with the submission of the 2021 KanCare Medicaid Consumer Perception Survey report.

There are data limitations regarding the comparison of the KanCare adult and child ECHO survey results to SPH Analytics' book of business. The ECHO Survey does not have national specifications, such as criteria for identifying members receiving mental health services, for identifying the sample frames. Therefore, care must be used in interpreting the results of statistical testing between the KanCare rates and rates from the SPH Analytics Book of Business. States with Medicaid expansion may be included in the SPH Analytics book of business, which may also explain the significantly lower rates for the adult KanCare population in comparison to the SPH Analytics book of business.

Impact of the COVID-19 Pandemic

Without a baseline, there is not a way to assess the impact of the pandemic on this survey.

Appendix D

KanCare Program Annual External Quality Review Technical Report

2021–2022 Reporting Cycle

2020 and 2021 Compliance Review Recommendations

Compliance Review

Regulatory Area	2020 and 2021 Compliance Review Recommendations
Common Among the MCOs	
2020 Review Recommendations	
Subpart D – MCO, PIHP and PAHP Standards: Coordination and Continuity of Care	
Case Review Related to §438.208 Coordination and Continuity of Care: Follow-up to case review	**Aetna:** 1. For future case review requests, ensure all outreach attempts to members for health screenings are included with submitted documentation. KFMC will ensure this is an included element of the request. 2. For future case review requests, ensure submitted documentation includes dates of completion (on assessments, for example). 3. In the service plan, KFMC recommends documenting the member's preferred method of receiving a copy of their service plan (paper or electronic).
	Sunflower: 1. Develop a way to assess for incomplete assessments or force (e.g., programming in hard edits) certain questions to be answered before the assessment can be marked as complete. 2. Include medication lists in the Service Plan and not just in TruCare. 3. Add a "date completed" field to the health screen to make clear when the assessment was completed (even if it is not documented immediately). 4. Develop a process to make outreach letters more accessible in the care coordination system.
	UnitedHealthcare: 1. Clearly identify in the documentation of Health Risk Assessments conducted with pediatric members which questions, if any, were answered pertaining to the parent's or guardian's circumstances/condition rather than the child's condition. 2. Explore working with the State regarding the potential for adapting the HRA to allow for some questions to be answered for both the parent and member, as appropriate. 3. With future record requests, include member services' documentation of all outreach attempts for health screenings for members in the request; KFMC will ensure this is included as a request element. 4. Identify and implement strategies to increase health screens of members in the behavioral and physical health populations.
Subpart F – Grievance and Appeal System: Grievance, Appeal, and Notice of Adverse Benefit Determination	
§438.406(b)(5-6): Handling of Grievances and Appeals – Special Requirements: Member's request of case file during appeal	**Aetna:** Aetna's full three-year compliance review was completed in Years 1 and 2; therefore, no recommendations were made.
	Sunflower: In the Sunflower *Member Handbook*, include information for members regarding how to request their case file during the appeal, and encourage a timely request to allow Sunflower to provide the file in advance of the appeal resolution.
	UnitedHealthcare: 1. In the UnitedHealthcare *Member Handbook,* page 74, clarify that members may request their case file free of charge. 2. In member materials that include how to request their case file, make clear the need for members to make a timely request in order for UHC to send the case file sufficiently in advance of the resolution timeframe for appeals.

Compliance Review

Regulatory Area	2020 and 2021 Compliance Review Recommendations
Common Among the MCOs	
2021 Review Recommendations	
Subpart C – Enrollee Rights and Protections	
Sunflower: §438.10(c)(6)(v) Information Requirements – Basic Rules: Receipt of the Provider Directory and Privacy Rights	**Aetna:** Aetna's full three-year compliance review was completed in Years 1 and 2. KFMC made a recommendation in this area in the Year 1 (2019) review and it was reported in the 2020–2021 Annual EQR Technical Report.
	Sunflower: 1. In the *Member Handbook*: a. In chapter "Welcome & Resources," subsection "Provider Directory" (page 7), add the language "within five business days." It would read, "Call Customer Service toll free at 1-877-644- 4623 to help you find a provider in your area or to get a free copy of our provider directory within five business days. Customer Service can also give you information about the provider's medical school and residency." b. In chapter "Notice of Privacy Rights," section "Individual Rights," last bullet (page 51), add the language, "free of charge" and "we will mail it within five business days." It would read, "Right to Receive a Copy of this Notice – You may request a copy of our Notice free of charge at any time by using the contact information list at the end of the Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice and we will mail it within five business days."
UnitedHealthcare: §438.10(c)(6): Information Requirements – Basic Rules (§438.10[c][6][iv] requires compliance with the content and language requirements in §438.10[a-j] Information Requirements)	**UnitedHealthcare:** 1. Add the following language to the Member Handbook, chapter "Other plan details': a. Subsection "Finding a network provider," add the words "free of charge" and "within five business days." It would read, "Call Member Services 1-877-542-9238, TTY 711. We can look up network providers for you. Or, if you'd like, we can send you a Provider Directory in the mail within five business days free of charge." b. Subsection "Provider Directory," add the words "free of charge" and "within five business days." It would read, "If you would like a printed copy of our directory, please call Customer Service at 1-877-542-9238, TTY 711, and we will mail one to you free of charge within five business days." c. Subsection "Your Rights," sixth bullet, add the words "free of charge" and "we will mail it within five business days." It would read, "You have the following rights: To get a paper copy of this notice. You may ask for a paper copy at any time free of charge and we will mail it within five business days." You may also get a copy at our website (www.uhccommunityplan.com)." Compliance with §438.10 Information Requirements also applies to §438.228(a-b) Grievance and Appeal Systems (Subpart D) and §438.404(a) Timely and Adequate Notice of Adverse Benefit Determination – Notice (Subpart F), and §438.408(d)(1-2) Resolution and Notification: Grievances and Appeals – Format of Notice: Grievances and Appeals (Subpart F).

Compliance Review

Regulatory Area	2020 and 2021 Compliance Review Recommendations
Aetna	
2020 Review Recommendations	
	Subpart D – MCO, PIHP and PAHP Standards: Availability, Access, and Coverage of Services
§438.207(a): Assurances of Adequate Capacity and Services – Basic Rule (§438.68[b][1-2] Provider-Specific Network Adequacy Standards and LTSS): Time and distance standards; appointment timeframe standards	1. Policy documents should better define specific specialties currently grouped together (e.g., "high-volume specialists," "high-impact specialists") so that it is clear that all specialty providers are covered by a policy and differences are noted (e.g., psychiatrists have a shorter time/distance range than other behavioral health providers). Specifically, Aetna policy *6400.06 Practitioner and Provider Availability: Network Composition and Contracting Plan* should list time and distance standards by provider type or define providers within the specialist groups for which the standards apply.
§438.207(a) Assurances of Adequate Capacity and Services – Basic Rule (§438.206[c][1][v] Availability of Services – Furnishing of Services): Monitoring	2. Provide more detailed methodology for access and availability studies to give a clear understanding of the stratified sample frame; sampling strategy; decision criteria (e.g., numerator or denominator compositions); and any other necessary components for an external evaluation. Include all provider types called for in network adequacy standards. 3. In 2021 follow-up review, please provide the summary report referenced in Aetna policy *6300.26 Primary Care Practitioner (PCP) After-Hours Accessibility Study.*
§438.207(b)(1) Assurances of Adequate Capacity and Services – Nature of Supporting Documentation: Appropriate range of services	4. Ensure that all policies and other official documents submitted are completed and approved with appropriate signatures from leadership and effective dates.
§438.207(b)(2) Assurances of Adequate Capacity and Services – Nature of Supporting Documentation: Sufficient number/mix/distribution of providers	5. Ensure that explanation fields are completed in GeoAccess reports that call for explanations, justifications, or remedies (e.g., *Unmapped Specialties* sub-report). Finally, ensure that submitted reports are comprehensively reviewed for accuracy and attestations/certifications accompany those reports.
2021 Review Recommendations	
Aetna's full three-year compliance review was completed in Years 1 and 2. There were no additional regulatory areas remaining for review in Year 3, and therefore no recommendations.	

Compliance Review

Regulatory Area	2020 and 2021 Compliance Review Recommendations
Sunflower	
2020 Review Recommendations	
Subpart D – MCO, PIHP and PAHP Standards: Availability, Access, and Coverage of Services	
§438.206(c)(1)(v) Availability of Services – Furnishing of Services-Timely Access (Monitor network providers regularly to determine compliance): During and after-hours monitoring	1. Provide more detailed methodology for access and availability studies to give a clear understanding of the stratified sample frame; sampling strategy; decision criteria (e.g., numerator or denominator compositions); and any other necessary components for an external evaluation.
	2. Assess and report reasons for after-hours non-compliance and follow-up efforts with non-compliant providers.
	3. Assess and report the effectiveness of individual provider communication regarding non-compliance and overall provider education.
	4. Consider additional interventions (noted in Sunflower policy *CC.PRVR.48*) to help providers improve access to appointments for urgent needs (e.g., assisting providers in improving their scheduling systems).
§438.207(b) Assurances of Adequate Capacity and Services – Nature of supporting documentation	5. Though the GeoAccess issues noted above were corrected for Q3 2020, MCO analytic directors and leaders should follow State guidelines for reporting.
Subpart F – Grievance and Appeal System: Grievance, Appeal, and Notice of Adverse Benefit Determination	
§438.404(c)(2): Timely and Adequate Notice of Adverse Benefit Determination – Timing of Notice	6. In the 2021 follow-up review, provide documentation of compliance with the State contract (Attachment D, Section 5.3.3.1) requirement, "The Contractor(s) shall send written Notice of an Action to the Provider within one (1) business day following the date of Action affecting the claim."
§438.406(a): Handling of Grievances and Appeals – General Requirements: Member assistance for grievances or appeals	7. Regarding the Sunflower *Member Appeal Rights Attachment for NABD – KDHE approved 1/8/2020*, clarify that Sunflower will provide reasonable assistance in completing forms and other steps for grievances or appeals.
§438.406(b)(5): Handling of Grievances and Appeals – Special Requirements: Member's request of case file during appeal	8. In Sunflower policy *KS.QI.11 Appeal and Grievance System Description*, section *Member Requests for Appeal Documents,* specify that if members make a request for documentation the information must be supplied sufficiently in advance of the appeal resolution.
§438.406(b)(6): Handling of Grievances and Appeals – Special Requirements: Member representation in an appeal	9. In Sunflower policy *KS.QI.11 Appeal and Grievance System Description,* section *Notification of Member Appeal Rights,* clarify that "the enrollee and his or her representative, or the legal representative of a deceased enrollee's estate" are parties to the appeal.

Compliance Review

Regulatory Area	2020 and 2021 Compliance Review Recommendations
Sunflower (Continued)	
2020 Review Recommendations (Continued)	
Subpart F – Grievance and Appeal System: Grievance, Appeal, and Notice of Adverse Benefit Determination (Continued)	
§438.408(c)(2): Resolution and Notification: Grievances and Appeals – Extension of Timeframes (Requirements Following Extension)	10. In Sunflower policy *KS.QI.11 Appeal and Grievance System Description,* clarify that prompt oral notice of the delay for a standard appeal will be given, and written notice of the delay must be provided within 2 calendar days for both standard and expedited appeals.
	11. In Sunflower policy *KS.QI.11 Appeal and Grievance System Description,* address the member's right to file a grievance if they disagree with the decision to extend the timeframe of either a standard or expedited appeal.
	12. Update language in the *Member Handbook, Appeals Basics* section, to include verbal notification of the delayed appeal. Recommendations 11-13 also apply to §438.410(c)(2).
§438.408(c)(3): Resolution and Notification: Grievances and Appeals – Extension of Timeframes (Deemed Exhaustion of Appeals Processes)	13. In the Sunflower *Member Handbook,* clarify that if Sunflower does not meet the notice and timing requirements for appeals, the Member will be considered to have completed the internal Sunflower appeal process and may request a State Fair Hearing. This also applies to §438.408(f)(1)(i).
§438.416(c) Recordkeeping Requirements: Grievance and appeal records	14. In Sunflower policy *KS.QI.11 Appeal and Grievance System Description*, clarify that grievance and appeal records will be made available to CMS upon request.
§438.420(c) Continuation of Benefits While the MCO Appeal and State Fair Hearing are Pending – Duration of Continued or Reinstated Benefits: Continuation of non-HCBS benefits	15. In Sunflower policy *KS.QI.11 Appeal and Grievance System Description*, include a statement clarifying that benefits will continue unless "The Member withdraws the Appeal or State Fair Hearing request." The statement could be added to either of the following policy sections: "Continuation of Benefits during the Appeal/SFH Process" or "Non-Home and Community Based Services (Non-HCBS) Appeal."
§438.424(a) Effectuation of Reversed Appeal Resolutions – Services Not Furnished While the Appeal is Pending): Timing of service authorization	16. In Sunflower policy *KS.QI.11 Appeal and Grievance System Description*, section *Resolving an Appeal*, include language specifying the authorization or provision of services within 72 hours from the date of reversal of the determination.
Case Review Related to §438.210 and Subpart F Grievance and Appeal System	17. Develop a process to either eliminate the need for the manual entry of appeals data into TruCare or develop a process to ensure accurateness of data.
	18. Work with subcontractors to ensure timeliness of Appeal Acknowledgement letters.
	19. In the 2021 follow-up review, submit the Notice of Appeal Resolution for Member 16.

Compliance Review

Regulatory Area	2020 and 2021 Compliance Review Recommendations
Sunflower (Continued)	
2021 Review Recommendations	
Subpart C – Enrollee Rights and Protections	
§438.10(g)(2)(xi) Information for Enrollees of MCOs, PIHPs, PAHPs, and PCCM Entities – Enrollee Handbook: Right to File Grievances and Appeals	1. To the *Member Handbook*, add language that clearly states members have "the right to file grievances and appeals."
UnitedHealthcare	
2020 Review Recommendations	
Subpart D – MCO, PIHP and PAHP Standards: Availability, Access, and Coverage of Services	
§438.207(a): Assurances of Adequate Capacity and Services: Basic Rule (§438.68(b)(1-2) Provider-Specific Network Adequacy Standards and LTSS): Time and distance standards	1. Include time and distance standards for physical health providers in United's policy *UHN Network Development and Retention* or similar policy.
	2. Include time and distance standards for LTSS providers in United's policy *UHN Network Development and Retention* or similar policy.
§438.207(a): Assurances of Adequate Capacity and Services – Basic Rule (§438.68[c][1] Development of Network Adequacy Standards – Provider Supply and Capacity and Accessibility): Network Assessments	3. Include a more detailed description of how network assessments are performed and how those findings are analyzed or evaluated, as mentioned within the *UHN Network Development and Retention* policy (Procedure Detail #3). If a separate documented policy or procedure details this, please attach in future documentation requests.
	4. Describe findings from the assessments mentioned within the *UHN Network Development and Retention* policy (Procedure Detail #3) in quarterly Access and Availability Analysis reports (sub-report of geo-access reports), described in the April 2019 GeoAccess Reporting Requirements (VIII.F.2.).
§438.207(a) Assurances of Adequate Capacity and Services – Basic Rule (§438.206[c][1][iv] and [vi] Compliance and Corrective Action): Monitoring and corrective action	5. Include details in policies and procedures regarding processes for follow-up with providers that are non-compliant with access requirements.
	6. Review performance formulas and calculations within certain GeoAccess reports (e.g., specialty care, Non-Emergent Medical Transportation [NEMT]) for accuracy.
	7. Access and Availability Analysis Reports are an opportunity to address strengths and limitations for the entire network but also to detail specific issues and remedies identified by other network reporting. Consider using the Access and Availability Analysis Reports to monitor progress toward improving deficiencies from those reports.
	8. Ensure that required report fields are completed for each quarterly submission file and that only unique providers are present.

Compliance Review

Regulatory Area	2020 and 2021 Compliance Review Recommendations
UnitedHealthcare (Continued)	
2020 Review Recommendations (Continued)	
Subpart D – MCO, PIHP and PAHP Standards: Availability, Access, and Coverage of Services (Continued)	
Assurances of Adequate Capacity and Services – Basic Rule (§438.206[c][1][v]: Monitor Network Providers Regularly to Determine Compliance): During and after-hours monitoring	9. In the 2021 follow-up review, provide KFMC with the results from UHC's follow-up with providers that were not able to be reached.
	10. In the 2021 follow-up review, provide KFMC the number of providers that were not reachable due to non-compliance versus those not reachable due to provider network data quality issues.
	11. Continue to work to improve provider network data quality.
	12. Develop and implement strategies to improve after-hours access.
Assurances of Adequate Capacity and Services – Basic Rule (§438.206[c][1][v]: Monitor Network Providers Regularly to Determine Compliance): During and after-hours monitoring	13. Recommend revision of analysis methods for the DialAmerica study in the following ways: a. Analysis strictly on those providers able to be contacted and then surveyed should be consistently described and interpreted as arising from the subset able to be contacted. b. Ensure that data shared between tables includes the same values or totals (e.g., Table 5 does not match data from Tables 1, 3A, or 3B). c. Revisit calculations to ensure that totals and percentages arise from values within the table. d. Further quantify reasons providers are not able to be contacted and/or don't complete the survey, using DialAmerica Outcome Codes.
§438.207(b) Assurances of Adequate Capacity and Services – Nature of Supporting Documentation	14. Review data analytics for Specialty Care Standards Report and Call Center measures.
	15. Discuss the following in the quarterly Access and Availability Analysis Report: NEMT potential count issues with Call Center measures; explanations for less than full coverage in the Unmapped Specialties Report.
Subpart F – Grievance and Appeal System: Grievance, Appeal, and Notice of Adverse Benefit Determination	
§438.406(b)(1): Handling of Grievances and Appeals – Special Requirements: Grievance acknowledgement process and timeframes	16. In the UnitedHealthcare *Member Handbook* where the grievance process is explained, add language to inform members of the grievance acknowledgement process and timeframe.
§438.406(b)(2): Handling of Grievances and Appeals – Special Requirements: Individuals making appeal decisions	17. In all related documentation, explain how State contract Section 4.5.1 "*Member Expedited Appeal System,"* subsection 4.5.1.1.3 through 4.5.1.1.5, regarding individuals who make appeal decisions, will be addressed.
§438.406(b)(4): Handling of Grievances and Appeals – Special Requirements: Evidence to support member appeals	18. In the UnitedHealthcare *Member Handbook* where the appeal process is explained, include language explaining members may present evidence to support their appeal.

Compliance Review

Regulatory Area	2020 and 2021 Compliance Review Recommendations
UnitedHealthcare (Continued)	
2020 Review Recommendations (Continued)	
Subpart F – Grievance and Appeal System: Grievance, Appeal, and Notice of Adverse Benefit Determination (Continued)	
§438.408(d)(2)(ii): Format of notice (Appeals): Informing members of delay in expedited appeals process	19. In both the *Member Grievance, Appeal, and State Fair Hearing* letter insert and *Member Handbook,* add language to clarify the MCO will "make reasonable efforts to provide oral notice of the delay" if the expedited appeal timeframe is extended by the MCO.
2021 Review Recommendations	
Subpart B – State Responsibilities	
§438.56(e)(2) Disenrollment: Requirements and Limitations – Timeframe for Disenrollment Determinations: Timeframe for Determination	1. In UHC policy *KSMS-0012 Member Disenrollment*, section "Procedure: Member Disenrollment," second bullet (page 2), add an additional sentence (see bold underlined) stating, "If the state or its fiscal agent fails to make the determination within the timeframes specified herein, the disenrollment is considered approved." The revised language would read, "UnitedHealthcare explains to members who wish to dis-enroll that they must do so verbally or in writing to the State or the State's Fiscal Agent. And that the disenrollment will be effective on the first day of the second month in which the member or UnitedHealthcare requests the disenrollment. **If the state or its fiscal agent fails to make the determination within the timeframes specified herein, the disenrollment is considered approved**."
Subpart C – Enrollee Rights and Protections	
§438.114(a) Emergency and Poststabilization Services – Definitions (related provision to §438.10[g][2][v] Information Requirements – Information for Enrollees of MCOs, PIHPs, PAHPs, and PCCM Entities: Enrollee Handbook) and §422.113(c)(1) Special rules for ambulance services, emergency and urgently needed services, and maintenance and post-stabilization care services: Maintenance Care and Post-stabilization care services – Definition Post-stabilization Care Services: Defining Poststabilization Care	2. In the UHC *Clinical Services Medical Management Operational Policy UCSMM.04.11 Consumer Safety*, add the regulatory definition of "Poststabilization care services" following the definitions for "Emergency Medical Condition" and "Emergency Services" to the table in the column "State/Federal Medicaid Rules."

Compliance Review

Regulatory Area	2020 and 2021 Compliance Review Recommendations
UnitedHealthcare (Continued)	
2021 Review Recommendations (Continued)	
Subpart C – Enrollee Rights and Protections (Continued)	
§438.10(g)(2)(xii) Information Requirements – Information for Enrollees of MCOs, PIHPs, PAHPs, and PCCM Entities (Enrollee Handbook); §438.3(j)(1) Advance Directives; and §422.128 Information on Advance Directives	3. Incorporate into procedure for discontinuing a policy, to review the history related to the reason it was created, and review policies and procedures that will remain to ensure all the regulatory requirements are included from the policy that is being discontinued. Compliance with §438.10 Information Requirements also applies to §438.404(a) Timely and Adequate Notice of Adverse Benefit Determination – Notice (Subpart F) and §438.408(d)(1) Resolution and Notification: Grievances and Appeals – Format of Notice: Grievances and Appeals (Subpart F)
§438.10(h)(1)(i-viii) Information Requirements – Information for Enrollees of MCOs, PIHPs, PAHPs, and PCCM Entities (Provider Directory): Network Providers	4. Add to the UHC *Kansas HCBS Provider Directory* language detailing: a. Whether the provider will accept new patients. For example, in other UHC Provider Directories (Eastern, Western, Northern, Southern, and Statewide), every other page included the notation, "Unless noted, all providers accept new patients." b. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office. For example, in other UHC Provider Directories (Eastern, Western, Northern, Southern, and Statewide), after the phone number listed, the provider description includes "Languages Spoken" Languages "Staff" speak and this includes, when applicable, a notation of "Sign Language." c. Whether the provider has completed Cultural Competency training. Compliance with §438.10 Information Requirements also applies to §438.242(b)(6) Health Information Systems – Basic Elements of a Health Information System (Subpart D), §438.242(d) Health Information Systems – State Review and Validation of Encounter Data (Subpart D), and §438.404(a) Timely and Adequate Notice of Adverse Benefit Determination – Notice (Subpart F) , and §438.408(d)(1-2) Resolution and Notification: Grievances and Appeals – Format of Notice: Grievances and Appeals (Subpart F)

Appendix E

KanCare Program Annual External Quality Review Technical Report

2021 – 2022 Reporting Cycle

QAPI Program Opportunities for Improvement

QAPI Program Opportunities for Improvement	
Activities not addressed by the MCO in their *2020 QAPI Evaluation* that were identified by the MCO in the *2020 QAPI Program Description* and *2020 QAPI Work Plan*	
Common Among the MCOs	
The activities detailed are specific to each MCO's QAPI Program; therefore, there are no common activities.	
Aetna	
1.	Meeting frequency of the Member Advisory Committee and each Quality Management Committee
2.	Maintain systems for monitoring and tracking practitioner and provider medical recordkeeping practices
3.	Provide communications to practitioners and providers on the status and success of Quality Management activities
4.	Implement rapid response process and Rapid Response Team meetings
5.	Standards Establishment and audits for medical records documentation
6.	"Reporting abuse, neglect, or exploitation/extortion"
7.	Language line utilization, specifically, the percent of the member population utilizing the service and the most frequent languages
8.	"Number of plan staff with a second language"
9.	Grievance and Appeal biennial assessment and the formal report that was to be created and reported to the Quality Management Oversight Committee
10.	Health Risk Questionnaire quarterly reports
11.	Health Plan Member Services Annual Summary (reporting only detailed Pharmacy Benefit Information Call Center Performance)
12.	Review of health services contracts and annual review of practitioner/provider contract templates
13.	Annual review and update of the *Integrated Care Management (ICM) and ISC Program Description*
14.	Semiannual evaluation of maintaining the committee calendar
15.	Guidelines specific to disease management programs
16.	Data on member appeal turnaround time (< 30 days)
17.	Monthly appeal and case management/service coordination file audits
18.	"Analyses from NET1 and NET2 to determine gaps, implement interventions, and measure of effectiveness"
19.	Assessment of Physician Directory Accuracy and usability Testing of the Physician and Hospital Directory
20.	"Conduct Activities and Evaluate CCoC"
21.	Review of state meeting minutes, providing monthly updates, and communicating the meeting agenda to appropriate health plan staff

QAPI Program Opportunities for Improvement	
Activities not addressed by the MCO in their *2020 QAPI Evaluation* that were identified by the MCO in the *2020 QAPI Program Description* and *2020 QAPI Work Plan* (Continued)	
Sunflower	
1.	Five interventions that were scheduled for launch in 2020 or results of the PIP for the evaluation year
2.	Diabetic testing rates annual and monthly PAR submission to State
3.	Provider incentive models being sent to the Quality Committee for review
4.	Annual demonstration of value-based payment arrangement(s) and reporting the percentages of total payments tied to VBP
5.	2019 Pay for Performance Incentives
6.	Annual review and update of the Grievance System policy
7.	Member and Provider NCQA Communication Plan
8.	Evaluation of physician and hospital directories
9.	Reports: *Directory Accuracy*, *Denial Systems Control*, *PHM Stratification/Segmentation*, *PHM Impact/Effectiveness*, *My Health Pays Utilization*, *Quality & Accuracy of Customer Service Process Benefit & Pharmacy Information*, *Website Quality Monitoring*, *Email Response and Accuracy of Email Inquiries Analysis, New Member Understanding*, *LTSS Case Management - Experience*, *LTSS Case Management Effectiveness Measure*, *Active Participation*, and *Reducing Unplanned Transition*
10.	PHM Strategy and Program Description
11.	Activities and outcomes for the EPSDT program
12.	LTSS Program Descriptions
13.	Conduct regularly scheduled LTSS Quality Assurance Committee meetings
14.	KanCare Meaningful Measures Collaborative Meetings
UnitedHealthcare	
1.	Annual segmentation worksheet that is completed
2.	Annual review and update of case management policies on case management systems, case identification, assessments and management process
3.	Identification of members for case management using multiple data and referrals sources

QAPI Program Opportunities for Improvement	
Activities not addressed by the MCO in their *2020 QAPI Evaluation* that were identified by the MCO in the *2020 QAPI Program Description* and *2020 QAPI Work Plan* (Continued)	
UnitedHealthcare (Continued)	
4.	Confirming member notification of PCP terminations within 30 calendar days of termination[1]
5.	Member notification of continuity of care for SPC/PCP termination
6.	Review and update of the National UM Program Description
7.	Annual UM evaluation and inclusion of analysis of provider and member experience with the UM process
8.	Confirming the availability of UM communications includes TDD/TTY (Telecommunications Device for the Deaf/TeleTYpewriter) services and language assistance via member handbook or other medium
9.	Confirming distribution of affirmation statement (no rewards/financial incentives given for UM decisions) to members and providers at least every two years via the member and practitioner newsletters[1]
10.	Confirming the Member and Provider Websites contain PDL updates[1]
11.	Oversight of local UM delegates as applicable
12.	Confirming member and provider handbooks contain required rights and responsibilities, and confirm annual distribution of member rights and responsibilities to members and practitioners via newsletters[1]
13.	Confirming annual distribution of subscriber notice via newsletter or other medium[1]
14.	Communication with prospective members correctly and thoroughly representing the benefits and operating procedures of the health plan
15.	Assessment of new member understanding of policies and procedures, implementation of procedures to maintain accuracy of marketing communication, and acting on identified opportunities for improvement for all members not just those in relation to the PIP involving pregnant members

[1] Opportunity for improvement was also identified in the 2020 QAPI Review.

QAPI Program Opportunities for Improvement	
Opportunities for improvement identified by the MCO in the *2020 QAPI Evaluation* that were not addressed in either the *2021 QAPI Program Description* or *2021 QAPI Work Plan*	
Common Among the MCOs	
The opportunities for improvement detailed are specific to each MCO's QAPI Program.	
Aetna	
1.	Intervention to improve performance: HEDIS Manager hired/assigned to Plan; provide further targeted approach to HEDIS measures/activities
2.	Healthier Outcomes Program and that results will be validated with payment to participating providers in the second quarter of 2022
3.	How monitoring and addressing potential quality of care gaps and/or failures immediately will occur
4.	The plan to identify structures and incentives to effectively capture and enhance the use of Screening, Brief Intervention and Referral to Treatment screens for Aetna members
5.	*Behavioral Health Satisfaction Survey*: Include detail on plans to encourage behavioral health providers to include member support in treatment planning
6.	Improving member appeals: Include detail on oversight meetings to address transportation issues
7.	Improvements/actions for claims that will be taken based on recommendations from the EQRO
8.	Planned activities/interventions to improve CAHPS outcomes for areas previously not met
9.	*Practitioner Appointment Accessibility Study* for increasing the number of provider types surveyed for better identification of appointment accessibility rates and increase awareness of appointment availability standards
10.	Grievance and appeal outcomes for Attitude and Service, Benefit Coverage and Provider/Service Provided, and Transportation
11.	Value-based Service Arrangement contract with Children's Mercy Integrated Care Solution/Pediatric Care Network
Sunflower	
1.	Efforts to promote provider and specialist communication to improve coordination of care
2.	Strategic alignment across the Enterprise
3.	Improving Corporate and Plan coordination
4.	Performance Improvement Projects and actions for improvement

QAPI Program Opportunities for Improvement	
Opportunities for improvement identified by the MCO in the *2020 QAPI Evaluation* that were not addressed in either the *2021 QAPI Program Description* or *2021 QAPI Work Plan* (Continued)	
Sunflower (Continued)	
5.	Work that is done with the other Kansas Medicaid Managed Care Organizations
6.	Refinement and alignment of strategies to improve overall Sunflower performance
7.	Provider education and encouragement to submit required documentation with the initial request for services/authorizations that will help in making decisions in a more timely and efficient fashion to potentially avoid an appeal
8.	Focus on Provider Relations
9.	Implementation of customer service training to improve member experience and perception
10.	Empathy training and video for health plan staff
11.	Increasing member engagement in provided materials
12.	Educating Members regarding the transportation benefit via the member newsletter
13.	Increasing member knowledge of standard/expected timeframes to obtain an appointment
14.	Monitoring and reporting telephone access monthly to allow for tracking, trending, and identifying any opportunities while striving to continue to meet or exceed the requirements
15.	Targeting the rural counties for further investigation and outreach to improve access for rural members the report that compares the KMAP listing to the Sunflower Network to identify non-participating providers for recruitment/contracting
16.	Identification of potential providers through other sources
17.	Utilization of listings of newly licensed providers and state reports of providers issued new National Provider Identifier (NPI) numbers, which may include identifying providers through sources such as Kansas Board of Healing Arts and local Medical Societies
18.	Review of non-par claim reports
19.	Approaching PCPs and other providers with limited or closed panels, and request that they open their panels to new members or existing members
20.	Identification of out-of-network providers utilized by Sunflower members in the past
21.	Maintaining relationships with providers who have declined to join the network
22.	Education on the expectations of 24-hour access to contracted practitioners in 2021

QAPI Program Opportunities for Improvement	
Opportunities for improvement identified by the MCO in the *2020 QAPI Evaluation* that were not addressed in either the *2021 QAPI Program Description* or *2021 QAPI Work Plan* (Continued)	
Sunflower (Continued)	
23.	Communication and education around the accessibility expectations that will be revisited with targeted practitioners and practices
24.	Member grievances around accessibility to be targeted for further education on the expectations
25.	Care Coordination Monitor 1[1]: The four opportunities for improvement identified by the plan related to the number of newborns having a follow-up visit with an outpatient provider within 30 days of discharge after delivery.
26.	Care Coordination Monitor 2[1]: The four opportunities for improvement identified by the plan related to the total number of inpatient discharges that resulted in a follow-up visit with an outpatient practitioner within 30 days.
27.	Care Coordination Monitor 3[1]: The three opportunities for improvement identified by the plan related to the number of members discharged from an inpatient setting following a live birth who had a postpartum visit with a PCP or Obstetrics and Gynecology within 21 to 56 days following discharge.
28.	Care Coordination Monitor 4[1]: The five opportunities for improvement identified by the plan related to practitioner satisfaction with the communication between primary care providers and specialists.
29.	Continuity of Care between Medical and Behavioral Healthcare: i. Exchange of Information Monitor 1[1]: The six opportunities for improvement identified by the plan related to the rate of practitioner satisfaction with behavioral health practitioner communication as reported through the annual provider satisfaction survey. ii. Appropriate diagnosis, treatment, and referral of BH disorders commonly seen in primary care Monitor 2[1]: The four opportunities for improvement identified by the plan related to the AMM HEDIS Measure: Acute Phase & Continuation Phase. iii. Appropriate use of psychotropic medications Monitor 3[1]: The opportunity for improvement identified by the plan related to the Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication-Initiation Phase (ADD). iv. Management of treatment access and follow-up for member with coexisting medical and BH disorders Monitor 4[1]: The two opportunities for improvement identified by the plan related to Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD). v. Primary or secondary preventive BH program Monitor 5[1]: The four opportunities for improvement identified by the plan related to Risk of Continued Opioid Use.
30.	Research on technological solutions
31.	Implementation of medication-specific forms

[1] Opportunity for improvement was also identified in the 2020 QAPI Review.

QAPI Program Opportunities for Improvement	
Opportunities for improvement identified by the MCO in the *2020 QAPI Evaluation* that were not addressed in either the *2021 QAPI Program Description* or *2021 QAPI Work Plan* (Continued)	
Sunflower (Continued)	
32.	Educating providers on: i. The UM process, request forms, medical necessity criteria, and how to contact UM staff enhancing the provider portal to increase usability ii. Minimum data elements needed for clinical review prior to submitting a prior authorization iii. The need for complete clinical information to make a timely decision iv. The new appeal and reconsideration link on the website
33.	Continued review of the prior authorization list and processes at least biannually
34.	Member and provider education regarding the PDL and medication prior authorization requirements
35.	Focus on provider satisfaction
36.	Related to Inter-Rater Reliability: i. Member engagement in care management ii. Efficiency and communication of documentation HCBS iii. Efficiencies in prior authorization and concurrent review processes iv. Enhanced training of UM staff, new staff, and integrated behavioral health staff, on these processes (Inter-Rater Reliability) v. Maintain and improve on the gains achieved in 2020 and take necessary steps to improve on the areas noted with priority opportunities for improvement in 2021.
UnitedHealthcare	
1.	Review and discussion of Disenrollment Reports[1]
2.	Review and discussion of the updated Healthy First Steps National Program Description
3.	Member Services Call Volume Update[1]
4.	State Fair Hearing information
5.	Quality of Service – National Advisory Board

[1] Opportunity for improvement was also identified in the 2020 QAPI Review.

Appendix F

KanCare Program Annual External Quality Review Technical Report

2021–2022 Reporting Cycle

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

ISCA and PMV

The scoring scale for the degree to which previous recommendations were addressed is Fully Addressed, Partially Addressed, Not Addressed, In Progress, and Substantial Progress.

	Follow-Up to Previous Recommendations (2020)	Status
Common Among the MCOs		
Performance Recommendations		

1.	The MCOs should continue efforts to further improve assistance with smoking and tobacco use cessation. Consider focusing on reducing providers' missed opportunities to discuss medications and other cessation strategies while advising members to quit smoking or using other tobacco products.
	
	KFMC Update: MCO efforts may have been offset by increased barriers due to the pandemic. Changes in reported rates for the Medical Assistance with Smoking and Tobacco Use Cessation measure between 2019 and 2020 measurement years were:
	• Total % of Current Smokers
	  ○ Aetna 1.3 pp decrease
	  ○ Sunflower 0.6 pp decrease
	  ○ UnitedHealthcare 2.0 pp increase
	• Advising Smokers to Quit – greater than 10% gap-to-goal worsening
	  ○ Aetna 6.2 pp decrease
	  ○ Sunflower 3.7 pp decrease
	  ○ UnitedHealthcare 10.1 pp decrease
	• Discussing Cessation Medications
	  ○ Aetna 2.6 pp decrease
	  ○ Sunflower 3.9 pp increase
	  ○ UnitedHealthcare 5.7 pp decrease – greater than 10% gap-to-goal worsening
	• Discussing Cessation Strategies
	  ○ Aetna 2.2 pp increase
	  ○ Sunflower 2.9 decrease
	  ○ UnitedHealthcare 10.7 pp decrease – greater than 10% gap-to-goal worsening
		In Progress

2.	The MCOs should explore and implement improvement efforts regarding Initiation and Engagement of Treatment for Opioid Abuse or Dependence. For example, consider ways to partner with physical health providers for early identification of opioid dependence and referral to treatment.	Substantial Progress

ISCA and PMV

Follow-Up to Previous Recommendations (2020)		Status
Common Among the MCOs (Continued)		
Performance Recommendations (Continued)		

	KFMC Update: Changes in reported rates for the Initiation and Engagement of Treatment for Opioid Abuse or Dependence indicators between 2019 and 2020 measurement years were:
	• Initiation of Treatment for Opioid Abuse or Dependence
	  ○ Aetna 6.6 pp increase – 10.8% gap-to-goal improvementSunflower 5.4 pp increase
	  ○ UnitedHealthcare 2.4 pp increase
	• Engagement of Treatment for Opioid Abuse or Dependence
	  ○ Aetna 3.8 pp increase
	  ○ Sunflower 3.6 pp increase
	  ○ UnitedHealthcare 0.9 pp increase	

3.	The MCOs should work with providers to improve Chlamydia screening in young women. **KFMC Update:** Changes in reported rates for the Chlamydia Screening in Women (16–20) between 2019 and 2020 measurement years were: • Aetna 2.3 pp decrease • Sunflower 2.7 pp decrease • UnitedHealthcare 2.2 pp decrease	In Progress
4.	For all measures, the MCOs should work to improve indicator rates that are below the Quality Compass national 75th percentile, pursuant to the State's Quality Management Strategy. **KFMC Update:** For the 2019 measurement year, Aetna had four Adult Core Set and three Child Core Set measure indicators that ranked above the 75th percentile; in 2020, those counts were unchanged. Ten Adult and five Child Core Set measure indicators, ranked below the 75th percentile in MY 2019, improved their ranking in MY 2020. For MY 2019, Sunflower had six Adult Core Set and seven Child Core Set measure indicators that ranked above the 75th percentile; for MY 2020, eight Adult and nine Child Core Set measure indicators ranked above the 75th percentile. Nine Adult and 12 Child Core Set measure indicators, ranked below the 75th percentile in MY 2019, improved their ranking for MY 2020. UnitedHealthcare had seven Adult and four Child Core Set measure indicators in MY 2019 that ranked above the 75th percentile; for MY 2020, those counts were eight Adult and seven Child Core Set measure indicators. Rates that ranked below the 75th percentile in MY 2019 increased their ranking for 11 Adult and 11 Child Core Set measure indicators.	Substantial Progress

ISCA and PMV

Follow-Up to Previous Recommendations (2020)		Status
Aetna		
Technical Recommendations		
1.	Aetna should do a thorough inventory of the Roadmap documentation including attachments for completeness and applicability prior to submission for PMV. This would help to eliminate follow-up items requested. **Response:** In 2021, as part of an organizational restructure, Aetna added staff to its national team overseeing performance measure reporting. This included the addition of a project manager to develop a project plan and monitor Roadmap submission for the performance measure validation, which reduced the number of follow-up items requested.	Fully Addressed
2.	Because of the challenges in interpreting the supplemental data impact report output, Aetna should continue to work with its corporate and vendor teams to ensure the impact report accurately reflects the specific population under the scope of the audit. **Response:** Aetna appropriately identified its reporting populations in the supplemental impact report. This enabled the review team to identify Kansas-specific counts for each data source. For MY 2021 reporting, supplemental data impact reports will be pulled by Aetna's corporate staff for each plan as part of a hybrid review project.	Fully Addressed
Performance Recommendations		
3.	Aetna should prioritize improvement efforts toward the following HEDIS measures: • Controlling High Blood Pressure • Cervical Cancer Screening • Antidepressant Medication Management • Adolescent Well-Care Visits • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents **KFMC Response:** The Controlling High Blood Pressure measure definition changed between MYs 2019 and 2020, resulting in a break in trending; the MY 2020 rate was 57.4 and ranked above or equal to the 50th percentile. The Cervical Cancer Screening rate improved 5.6 pp from MY 2019; the ranking increased from below the 10th percentile to below the 25th percentile and was a 10.1% gap-to-goal improvement. The Antidepressant Medication Management, Effective Acute Phase Treatment indicator, improved 4.6 pp for MY 2020; the Effective Continuation Phase Treatment rate improved 4.1 pp. Both indicators ranked below the 25th percentile in MY 2019; the ranking improved to below the 33.33rd percentile for Effective Continuation Phase Treatment. Adolescent Well-Care Visits is no longer a core set measure; it was replaced by Child and Adolescent Well-Care Visits, with indicators for ages 3–11, 12–17, and 18–21 years. For MY 2020, Aetna's rates for ages 12–21 ranked below the 50th percentile. Rates improved for all three Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents indicators in MY 2020. The BMI Percentile (Total) had a 26.3% gap-to-goal improvement; Counseling for Nutrition (Total) had an 11.0% gap-to-goal improvement. Both indicators increased their ranking from below the 10th percentile to below the 25th percentile in MY 2020; although the ranking for Counseling for Physical Activity remained unchanged at below the 25th percentile, it had a 10% gap-to-goal improvement. Aetna has been conducting a performance improvement project for Early and Periodic Screening, Diagnostic, and Treatment which may positively impact the Child and Adolescent Well-Care Visits and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure rates.	Substantial Progress

ISCA and PMV

Follow-Up to Previous Recommendations (2020)		Status
Sunflower		
Technical Recommendations		
1.	Sunflower should continue to develop documentation to support supplemental data sources used for reporting electronic clinical data system (ECDS) measures, specifically quality data element classification (QDE) in their master data management plan as required by NCQA's ECDS guidelines. **Response:** Centene centrally manages all supplemental data utilized in quality measurements. QDEs are identified through validating Industry Standard Codes provided from the submitter's source system of record and mapping text descriptions to industry standard codes. In addition, all records utilized and stored in Centene's supplemental database are required to have member information, date of service, and event/QDE. Centene is continuing to develop their ECDS master data management plan as ECDS measures become more prevalent.	Fully Addressed
2.	Sunflower should explore periodically comparing outputted provider data from Portico with the State's provider data file to ensure consistency between the two sources. **Response:** Sunflower has several processes that are currently live or are in development by the end of the calendar year to reconcile the provider database to the State provider network verification files, including validating new provider enrollments via the portal, validating provider information from group enrollment files, billing and mailing address reconciliation, service location reconciliation, and specialty reconciliation.	Fully Addressed
3.	Sunflower should resubmit denied dental encounters that were incorrectly submitted to the State. **Response:** Sunflower resubmitted all improperly submitted dental encounters to the State in 2020 that had 2019 dates of denial.	Fully Addressed
Performance Recommendations		
4.	Sunflower should prioritize improvement efforts toward the following: • Antidepressant Medication Management – Effective Continuation Phase Treatment • Breast Cancer Screening • Comprehensive Diabetes Care – Poor HbA1c Control • Prenatal and Postpartum Care • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile (Total) **KFMC Update:** Comprehensive Diabetes Care – Poor HbA2c Control had a statistically significant increase of 10.2 pp and a 21.1% gap-to-goal improvement in MY 2020. In MY 2019, the rate was below the 25th percentile; in MY 2020, it was above the 75th percentile. The rate for the Postpartum Care indicator increased 6.3 pp in MY 2020, had a 16.7% gap-to-goal improvement, and the ranking improved from below	Substantial Progress

ISCA and PMV

Follow-Up to Previous Recommendations (2020)		Status
Sunflower (Continued)		
Performance Recommendations (Continued)		
	the 10th percentile to below the 25th percentile. The BMI Percentile (Total) indicator improved 1.2 pp between MYs 2019 and 2020 and was unchanged at below the 25th percentile. Two rates decreased from MY 2019 to MY 2020 but improved their Quality Compass percentile rankings from <25th to <33.33rd: the Antidepressant Medication Management – Effective Continuation Phase Treatment rate decreased 0.1 pp and the Breast Cancer Screening rate statistically significant decreased by 3.0 pp. The Timeliness of Prenatal Care indicator had a statistically significant decrease of 7.8 pp, had a 34.1% gap-to-goal worsening, and dropped from below the 25th percentile to below the 10th percentile. Sunflower has been conducting a performance improvement project for Early and Periodic Screening, Diagnostic, and Treatment that may positively impact the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents indicators.	
UnitedHealthcare		
Technical Recommendations		
1.	Because UnitedHealthcare submitted multiple Roadmap Section 4 versions related to Medical Record Review, one for each entity involved in the process, it was observed that sometimes the information in these sections conflicted with the other. It is recommended that UnitedHealthcare consider consolidating responses from each entity into a single Section 4 and use different font colors to differentiate the entities providing the response. **Response:** UnitedHealthcare Section 4 was consolidated, and responses differed by color depending on the entity.	Fully Addressed
2.	UnitedHealthcare should also work to expand documentation for Roadmap Section 5, Attachment 5.6, for electronic clinical data system (ECDS) reporting and how these sources are accessible to the care team, to more specifically address verification procedures across multiple data systems and to ensure consistent identification and classification of quality data elements (QDE) and standardized data reconciliation procedures. **Response:** UnitedHealthcare expanded the explanation of reporting and sharing of ECDS data in the "Rec_4_HEDISMY2020_Att_5.6_Master_Data_Management_Plan" document. It addresses data validation and the downstream processes to share data with providers and the care teams.	Fully Addressed
3.	Due to continued challenges with State reporting requirements, it is strongly recommended that UnitedHealthcare reach out to subject matter experts if clarifications are needed early in the measure production process, and proactively work with all internal stakeholders to ensure the HEDIS software set-up, including benefit flags and populations for inclusion, are accurate. **Response:** UnitedHealthcare engaged internal stakeholders from the market in late summer to validate benefit flags and populations for inclusion.	Fully Addressed

ISCA and PMV

Follow-Up to Previous Recommendations (2020)		Status
UnitedHealthcare (Continued)		
Technical Recommendations (Continued)		
4.	As a result of challenges in obtaining responses to requested items during the review process, for example, obtaining the correct response from the appropriate team member for a requested item, UnitedHealthcare should also work to improve its procedures for internal communication related to audit requests and provision of responses. **Response:** UHC added a new resource for tracking and follow-through of external audit requests and communications that helps facilitate timely responsiveness and coordination with internal constituents. UHC stated that notification to KDHE, KDADS and KFMC to "CC" the UHC Kansas Compliance Mailbox@UHC.com was made. Adding this address to and from UHC is monitored by the UHC RAM team to assure timely responses. However, this email address was not used during this PMV-ISCA.	Fully Addressed
5.	Because it was unclear where formal reconciliation procedures were done to ensure provider data from the State file matched the data in the MCO's provider data system, UnitedHealthcare should develop documentation and processes for comparing these data to ensure they are uniform. **Response:** UnitedHealthcare developed an internal process to compare the State provider (PRN) files with its provider database (NDB) to identify and address differences between those systems. UHC's initial focus was on issues that arise during encounter submission that required manual review (provider not found). UHC is working to automate more of the process to enable validation of additional provider demographic data fields. Several steps were described.	Fully Addressed
6.	UnitedHealthcare should carefully review all Medicaid identification number (ID) changes to ensure consistency with MMIS. **Response:** UnitedHealthcare implemented a process to review all Medicaid ID changes to ensure consistency with MMIS. UHC verified that the integration of its Electronic Eligibility Management System (EEMS) into the Kansas enrollment data process occurred in June 2019 (contrary to the information contained in Section 2.2A of the HEDIS Roadmap).	Fully Addressed
7.	UnitedHealthcare should ensure the planned update of eligibility processing requirements, to be completed within 24 hours, is implemented. **Response:** UnitedHealthcare developed processes to ensure the planned update of eligibility processing requirements, to be completed within 24 hours, was implemented.	Fully Addressed

ISCA and PMV

Follow-Up to Previous Recommendations (2020)		Status
UnitedHealthcare (Continued)		
Performance Recommendations		
8.	UnitedHealthcare should prioritize improvements efforts for the following: • Controlling High Blood Pressure • Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase • Adolescent Well-Care Visits • Follow-Up After Hospitalization for Mental Illness (6-17 years) **KFMC Update:** The Continuation and Maintenance Phase indicator for Follow-Up Care for Children Prescribed ADHD Medication had a 7.0 pp (16.0% gap-to-goal) improvement between MYs 2019 and 2020, and its ranking increased from <50th percentile to >75th. The Controlling High Blood Pressure measure ranked >75th for MY 2020 (a change in specifications broke trending of rates between years). UnitedHealthcare has been conducting a performance improvement project for Early and Periodic Screening, Diagnostic, and Treatment which may positively impact the Child and Adolescent Well-Care Visits measure rates—Adolescent Well-Care Visits was replaced in HEDIS by Child and Adolescent Well-Care Visits, which has indicators for ages 3–11, 12–17, and 18–21 years. For MY 2020, UnitedHealthcare's rate for ages 12–17 ranked ≥50th and the rate for ages 18–21 ranked <50th.	Substantial Progress

Performance Improvement Projects (PIPs)

The scoring scale for the degree to which previous recommendations were addressed is Fully Addressed, Partially Addressed and Not Addressed.

	Follow-Up to Previous Recommendations (2020)	Status
Aetna PIP – Influenza Vaccination		
1.	For report clarity purposes, the word significant should not be used unless statistical testing has been completed. ("Because data from WEBIZ were manually extracted and reported to the Kansas Informatics team, this allowed for significant under-reporting of vaccinations through this database.") **Aetna Response:** The word significant was not used outside of statistical analyses. **KFMC Response:** In discussing data limitations for interventions, Aetna stated *"Data limitations may be significant to this measure…"* Figure 2 is described as showing *"the significant and dramatic increase in coronavirus cases."* Activity 9.3 states Aetna expects once all interventions are implemented, there will be a *"significant change in outcomes."*	Partially Addressed
2.	Aetna should move the table with the total PIP population counts and the table of population counts stratified by gender and age from Activity 1.1 (Topic Selection Process) to Activity 3.1, where the PIP population is described. **Aetna Response:** This was corrected per recommendations. **KFMC Response:** Aetna moved the tables as recommended.	Fully Addressed
3.	Aetna should revise the verbiage in Activity 7.1 of their annual report to reflect there is only one outcome measure for the PIP aim. **Aetna Response:** This was corrected per recommendations. **KFMC Response:** Aetna made this correction.	Fully Addressed
Recommendations from Activity 5, Intervention 3		
4.	In their second annual progress report, Aetna should include the approved HealthTag intervention materials which reflect the current verbiage. **Aetna Response:** The language used on the HealthTag is included in the Appendix. **KFMC Response:** Aetna included the HealthTag materials in Appendix A.	Fully Addressed
5.	For timely implementation of the intervention in subsequent measurement periods, time needed for the HealthTag setup at CVS pharmacies and other logistics should be taken into account. **Aetna Response:** This recommendation is noted. This intervention is in process of being changed as it did not drive vaccination rates. However, implementation lead time will be factored into future interventions. **KFMC Response:** No longer applicable to this intervention.	Fully Addressed

Performance Improvement Projects (PIPs)

Follow-Up to Previous Recommendations (2020)		Status
Aetna PIP – Influenza Vaccination		
Recommendations from Activity 5, Intervention 4		
6.	Aetna should revise the text in their second annual report to reflect one of the process measures was delayed until 2021. **Aetna Response:** This has been addressed in the update to this intervention. **KFMC Response:** This was revised in the report.	Fully Addressed
7.	In the second annual report, Aetna should provide the updated time for the survey being administered to providers after they have received the Gap in Care report. **Aetna Response:** This has been addressed in the update to this intervention. **KFMC Response:** The updated time for the survey being administered was included in the report.	Fully Addressed
8.	Aetna should update the sample Gap in Care report cover letter in their second annual progress report to reflect the correct PIP member age range, 6 months to 17 years of age. **Aetna Response:** This has been completed per recommendations. **KFMC Response:** Sample Gaps in Care reports were included in Appendix A.	Fully Addressed
9.	In the description of data collection methods and data sources, Aetna has included that claims with CPT codes for any office visit (not limited to well-child checks) will be used for the identification of member office visits. Aetna should clarify whether this is still applicable since the intervention measure was simplified to accessing influenza vaccination rates regardless of an office visit. **Aetna Response:** This has been addressed in the update to the intervention. **KFMC Response:** Aetna stated the Gaps in Care reports are independent of the reason for the office visit. They further stated this data collection method is null for the measurement year 2021–2022 as they will be using a different platform to identify gaps in care.	Fully Addressed
Recommendations from Activity 5, Intervention 5		
10.	Aetna should clarify how the limitation regarding management of the incentive on a calendar year basis could impact the intervention results and outline the steps to minimize the impact of this limitation. **Aetna Response:** This has been addressed in the update to the intervention. **KFMC Response:** Aetna removed this from the data limitations.	Fully Addressed

Performance Improvement Projects (PIPs)

Follow-Up to Previous Recommendations (2020)		Status
Aetna PIP – Influenza Vaccination		
Recommendations from Activity 5, Intervention 5 (Continued)		
11.	In the second annual report, Aetna should explain how the one process measure for the member incentives intervention is different from the measurable outcome goal of the aim statement. If the two measures are the same, the measure should be removed as a process measure for the member incentives intervention. **Aetna Response:** This process measure has been removed from the annual report. **KFMC Response:** The measure that was the same as the outcome goal of the aim statement was removed from the report.	Fully Addressed
Recommendations from Activity 8, Intervention 1		
12.	Include information on the number of the subscribers submitted to the vendor, number of subscribers to whom the texts were sent, number of subscribers who actually received texts, and response rate for the intervention. This information will help in making interpretation of the results obtained for the first process measure, as well as will assist in determining whether the analysis results are indicating the extent of the success of the intervention. **Aetna Response:** This will be completed going forward. This information was not available from Aetna's previous vendor and the text messages were not sent out in the 2020–2021 measurement year. **KFMC Response:** Not applicable for this annual report because the intervention did not occur in 2020–2021 measurement year.	Fully Addressed
13.	Include analysis results and interpretation for the second process measure to give the complete picture of the intervention's successful implementation and to describe the extent of its impact on the PIP outcome. **Aetna Response:** This will be completed going forward. This information was not available from Aetna's previous vendor and the text messages were not sent out in the 2020–2021 measurement year. **KFMC Response:** Not applicable for this annual report because the intervention did not occur in 2020–2021 measurement year.	Fully Addressed
14.	Include numbers with the percentages to provide sufficient information to assess whether information was obtained from an adequate number of respondents. **Aetna Response:** This will be completed going forward. This information was not available from Aetna's previous vendor and the text messages were not sent out in the 2020–2021 measurement year. **KFMC Response:** Not applicable for this annual report because the intervention did not occur in 2020–2021 measurement year.	Fully Addressed

Performance Improvement Projects (PIPs)

	Follow-Up to Previous Recommendations (2020)	Status
Aetna PIP – Influenza Vaccination		
Recommendations from Activity 8, Intervention 5		
15.	In the next annual report, Aetna should modify the table title to more clearly describe the displayed data. **Aetna Response:** This has been corrected per recommendation. **KFMC Response:** Aetna's Table 10 was labeled "Members Vaccinated and Earned a Member Incentive (annual 2021);" Table 11 was labeled "Administrative Codes matching KSWebIZ Immunization Record (annual 2021);" Table 12 was labeled "Z-Codes Describing Reason for No Immunization (annual 2021)." The labels were descriptive of the table contents.	Fully Addressed
16.	Aetna should revise their measure calculation to be consistent with the measure denominator description, those identified through KSWebIZ as obtaining the influenza vaccination. **Aetna Response:** This has been corrected per recommendation. **KFMC Response:** The measure from the 2019–2020 annual report was corrected in Activity 8 of the current report. Although the recommendation was fully addressed, the denominator definition in 5.5.c also needs to be corrected to be only those members identified through KSWebIZ (no claim).	Fully Addressed

CAHPS Health Plan 5.1H Validation

The scoring scale for the degree to which previous recommendations were addressed is Fully Addressed, Partially Addressed, Not Addressed, and In Progress.

	Follow-Up to Previous Recommendations (2020)	Status
Common Among All MCOs		
1.	All MCOs should continue to expand their care coordination efforts, particularly for children with chronic conditions, including primary care physicians being informed and up to date about the care children receive from other doctors and health providers. Consider encouraging providers to discuss with the parent/guardian or youth whether the child/youth receives care or services elsewhere, request releases of information, and establish bi-directional ongoing communication with the other providers. Consider whether the MCOs could assist providers in identifying members' other sources of care, for the provider to use in flagging medical records as prompts for initiation of coordination of care discussions (e.g., similar to gap-in-care communications). **KFMC 2021 Update:** The KanCare composite scores for Coordination of Care improved from 2020 to 2021 for all three populations. However, the KanCare GC and KanCare CCC scores continue to be below the national 50th percentile. The score for the Coordination of Care for Children with Chronic Conditions composite decreased and was ranked <25th in 2021.	In Progress
2.	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. **KFMC 2021 Update**: The KanCare adult and CCC percentages of respondents indicating their [their child's] mental or emotional health was excellent or very good did not improve for 2021. The KanCare CCC percentages declined, on average, by more than two percentage points per year over the last five years. Relationships between declining mental and emotional health and the pandemic has been reported.[1]	In Progress
3.	MCOs should continue efforts to reduce smoking and tobacco use and to promote cessation. Consider methods to address providers' missed opportunities to discuss cessation medications and other strategies while advising smoking cessation (e.g., MCO supplying communication materials and identifying resources for providers to use, or for referrals). **KFMC 2021 Update**: MCO efforts may have been offset by increased barriers due to the pandemic. KanCare rates worsened for all four indicators (significantly for Advising Smokers and Tobacco Users to Quit).	In Progress
Common Among Sunflower and UnitedHealthcare		
4.	Sunflower and UnitedHealthcare should monitor NCQA updates regarding SPH Analytics' probationary status. **KFMC 2021 Update:** SPH Analytics no longer has probationary status.	Fully Addressed

[1] *Interim Guidance on Supporting the Emotional and Behavioral Health Needs of Children, Adolescents, and Families During the COVID-10 Pandemic*. American Academy of Pediatrics, December 9, 2021. www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance. Accessed March 8, 2022.

KanCare Mental Health Consumer Perception Survey

The scoring scale for the degree to which previous recommendations were addressed is Fully Addressed, Partially Addressed, Not Addressed, In Progress, and No Longer Applicable.

	Follow-Up to Previous Recommendations (2020)	Status
Common Among the MCOs		
Recommendations for Quality Improvement		
1.	For Adult members, continue monitoring and explore methods to improve or continue improvement regarding: a. Identification of needed services for members, and access to the identified needed services (Service Access). b. Members' engagement in treatment planning and goal setting (Participation in Treatment Planning). c. Increasing promotion of consumer-run programs and monitor member engagement to prevent further decline of peer participation activities (Service Quality and Appropriateness). d. Members being better able to deal with crisis and handle things going wrong (Outcomes and Improved Functioning). e. Members doing better in social situations (Outcomes). f. Member's symptoms not bothering them as much (Outcomes and Improved Functioning). g. Social connectedness for members, especially ways to foster a sense of community belonging (Social Connectedness). h. Helping members who want a paid job to obtain paid employment (Employment non-domain question). **KDADS Response:** See below	In Progress
2.	For Youth members, continue monitoring and explore methods to improve or continue improvement regarding: a. Youth members doing better in school and/or work (Outcomes and Improved Functioning). b. Youth members being better able to cope when things go wrong (Outcomes and Improved Functioning) **KDADS Response:** See below	In Progress
3.	Continue to monitor the availability of crisis services for Adult and Youth members to ensure services are available when needed. **KDADS Response:** See below	Fully Addressed
Technical Recommendations		
4.	For future survey administration, explore alternative data sources to determine if better quality contact data exist for the survey populations. **KFMC Response:** Alternative data sources are not feasible.	No Longer Applicable

KanCare Mental Health Consumer Perception Survey

Follow-Up to Previous Recommendations (2020)	Status
KDADS Update:	
In 2021, the Kansas Department for Aging and Disability Services (KDADS) focused on continuing to expand crisis services throughout Kansas, including creating a 988 implementation plan to ensure the smooth and appropriate transition to the use of 988 which becomes effective July 16, 2022. KDADS continues to improve and expand crisis response by increasing capacity for crisis call service, planning for development of mobile crisis response services and expanding the number of crisis receiving and stabilization facilities. The Kansans Together initiative helped to establish a new awareness across Kansas of how systems of care allow providers to integrate, collaborate, and work together to support the mental health needs of children, youth, and families. The recognized collaborative, Kansans Together, utilizing formal outreach efforts to develop systems of care in communities, ended in 2019. However, the working relationships and integration of guiding core principles which place the needs of people first, will live on, and be fostered by the multitude of behavioral health agencies, organizations, and communities which adopted these philosophies and still practice them today. KDADS has seen a remarkable growth in the number of local Youth Leaders in Kansas (YLINK) programs: currently at 29 groups in various communities across the state of Kansas and counting. YLINK offers the groups opportunities for interactions with supportive adults and parents who have a commitment towards supporting the well-being and skill development of future leaders. YLINK provides financial support, technical assistance, and opportunities to network with other Kansas youth. Community service projects and enhanced leadership skills are a common outcome. Youth have opportunities to participate in state advocacy initiatives and bring important youth voice to issues facing young adults. Thousands of Kansas youth in middle school and high school have benefited from participation in their local YLINK groups.	

Provider Satisfaction Survey Validation

The scoring scale for the degree to which previous recommendations were addressed is Fully Addressed, Partially Addressed, and Not Addressed.

	Follow-Up to Previous Recommendations (2020)	Status
Common Among the MCOs		
1.	**Ensure generalizability of the survey findings to the intended study population**	
•	Apply a robust probability sampling method such as stratified random sampling to help ensure generalizability of the survey results to the intended KanCare study population described in the purpose of the survey, align the sampling frame and selected sample with the composition of the study population, select a sufficient sample size, and achieve an adequate response rate and number of completed surveys. **KFMC Response:** Aetna provided ambiguous information regarding the probability sampling method applied to draw the 2021 survey sample and it was not clear whether simple random sampling or stratified random sampling was used. The issues were seen with the compositions of the study population, sample frame and selected sample for Aetna's survey. Very limited information regarding the sample frame was provided by Aetna, and several key aspects need further clarity to understand what constitutes the survey's sample frame. It was not feasible to assess the appropriateness of the sample size for the survey as Aetna did not provide any information on the parameters used to calculate the sample size (population size, margin of error, confidence level, standard deviation, response rate). The response rate for Aetna survey was low (10.9%), and a low number of completed surveys were achieved (207 completed surveys) along with even fewer numbers of respondents in various provider categories limited the ability of the survey findings to be generalizable to the Aetna Better Health of Kansas Provider Network and its demographic categories. Sunflower applied stratified random sampling, however, the procedure to select sampling strata sizes by provider types was not clearly described. The sampling frame and sample was in alignment with the composition of the study population of the Sunflower survey. It was not feasible to assess the appropriateness of the sample size for the Sunflower survey due to incomplete information on the parameters used to calculate the survey sample size. The response rate for Sunflower survey was low (12.6%). A total of 315 providers completed the 2021 survey. The valid surveys completed by each provider type were considerably low, therefore survey results could not be generalizable to each of these provider categories within the Sunflower KanCare Provider Network. UnitedHealthcare applied random sampling for the 2021 Survey, however the study population included providers from only certain specialties, and excluded others such as BH clinicians and HCBS providers; therefore, the survey results could not be generalizable to the intended KanCare study population described in the purpose of the survey. The compositions of the sample frame and selected sample were same as that of study population, however these included providers from only certain specialties and excluded others such as BH clinicians and HCBS providers. It was not feasible to assess the appropriateness of the sample size calculation procedure due to unavailability of complete information on all the parameters used to calculate the sample size (standard deviation), and non-clarity regarding the decision to achieve a minimum of 30 complete surveys instead of achieving the calculated required number of 384 complete surveys. The response rate for UnitedHealthcare survey was very low (1%), and a very low number of completed surveys were achieved (35 completed surveys); therefore, survey results could not be generalizable to the UnitedHealthcare KanCare Provider Network.	**Partially Addressed:** Aetna, Sunflower, UnitedHealthcare.

Provider Satisfaction Survey Validation

Follow-Up to Previous Recommendations (2020)		Status
Common Among the MCOs (Continued)		
•	Establish a minimum accepted response rate and number of complete surveys, and consider them in the sample size calculation to help ensure a sufficient sample size for achieving an adequate number of valid surveys. **KFMC Response:** Aetna and Sunflower did not establish a specified required response rate or required number of returned surveys; and it was not clear whether the possibility of a low response rate was considered in the sample size calculation to help ensure a sufficient sample size for collection of an adequate number of completed surveys. UnitedHealthcare's Survey Work Plan noted the required number of completed surveys (384 surveys) based on an estimated response rate (2%), however, the survey was implemented with the goal to achieve a minimum of 30 completed surveys without specifying the minimum required response rate.	**Not Addressed:** Aetna, Sunflower, and UnitedHealthcare.
•	Include an adequate number of KanCare providers by provider type (PCPs, specialists, BH clinicians, and HCBS providers) in the survey sample. **KFMC Response:** Aetna's 2021 survey sample was comprised of 1,894 providers including PCPs, specialists, BH clinicians, and LTSS providers, however, the number of providers in the sample by these provider types was not noted. Also, Aetna did not describe how many of the LTSS providers included in the sample were HCBS providers. Sunflower's survey sample was comprised of 2,500 providers including 1,200 PCPs, 600 Specialists, 500 BH Clinicians, and 200 HCBS providers; however, it was not clear how the stratified random sampling procedure was applied to achieve these sampling strata sizes. UnitedHealthcare Survey included providers from only certain specialties, and excluded others such as BH clinicians and HCBS providers. In addition, Aetna did not provide any information, and the other two MCOs, Sunflower and UnitedHealthcare, provided incomplete information on the parameters used to calculate the sample size of their survey.	**Partially Addressed:** Sunflower. **Not Addressed:** Aetna, and UnitedHealthcare.
•	Weight the analysis by provider type. **KFMC Response:** The three MCOs did not use sampling weights in the analyses of the 2021 Survey data.	**Not Addressed:** Aetna, Sunflower, and UnitedHealthcare.
2.	**Apply steps to improve response rate of the survey:**	
•	Use a multi-mode survey methodology including a two-wave mail survey accompanied with an internet option component and a phone follow-up component; apply steps such as using multiple methods to inform and encourage participation, ensuring appropriate timing for fielding the data, data collection over an adequate duration, frequent reminder notices/follow- up, determine the reason for a large number of ineligible surveys, and updated/correct contact information for tracking and contacting the providers. **KFMC Response:** Aetna used multi-mode survey methodology including mail, internet, and phone follow-up components, and sent an additional email to the providers. The response rate for the Aetna Survey increased from 8.1% in 2020 to 10.9% in 2021. No other steps were taken to improving the response rate and there continues to be limitations to generalizability of the results due to the number of responses.	**Partially Addressed:** Aetna, Sunflower, and UnitedHealthcare.

Provider Satisfaction Survey Validation

Follow-Up to Previous Recommendations (2020)		Status
Common Among the MCOs (Continued)		
	Sunflower used multi-mode survey methodology including mail, internet, and phone follow-up components, and increased the sample size to 2,500 providers for the 2021 Survey to improve the number of returned surveys. Sunflower applied most of these steps for the 2021 Survey, such as mailing of an initial postcard to the providers, mailing a second questionnaire to all providers in the sample, and running the sample through the National Change of Address and Phone Append Process prior to fielding to ensure the most accurate addresses and phone number were used. Sunflower monitored the response rates and took action steps throughout fielding phase. These included provider bulletins (before the survey is fielded and during the fielding), discussed at all provider meetings and included on provider communications, and provided incentives to the providers to complete the survey. The response rate increased from 8.6% in 2020 to 12.6% in 2021. While there was improvement in the response rate, a higher number of completed surveys is needed for the generalizability of the survey findings to the Sunflower Health Plan Provider Network and its provider categories. In addition, an internal team, Provider Satisfaction Survey Taskforce developed an Action Plan to improve overall survey scores, and these action steps were applied throughout the year in effort to improve the upcoming 2022 Provider Satisfaction Survey. UnitedHealthcare applied a few steps, such as implementation of a dual-mode strategy with mail and internet modalities, sending of multiple reminders after an initial invitation to the providers to complete the survey, updating of the providers' contact information twice a year, and a plan to use provider advocates to encourage providers to complete the survey (it was not clear whether this step was implemented), were applied to achieve an adequate response rate and an adequate total number of completed surveys. However, the response rate was 1% and the number of completed surveys was very low.	
•	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. **KFMC Response:** Aetna and UnitedHealthcare did not apply corrective steps during the course of the survey, and did not have a documented plan for corrective actions if goals were not met. Sunflower applied several steps to improve the response rate, however, there was no stated goal for the number of completed surveys or a response rate, and no documented plan for corrective actions if goals were not met.	**Partially Addressed**: Sunflower. **Not Addressed:** Aetna, and UnitedHealthcare.
3.	**Ensure data analysis results are appropriately interpreted:**	
•	Document statistical testing performed to clearly indicate validity of the results. **KFMC Response**: Sunflower's Survey Report described the statistical tests applied for data analysis. Aetna and UnitedHealthcare did not describe the statistical tests applied for the data analysis in their Survey Reports.	**Fully Addressed**: Sunflower. **Not Addressed:** Aetna, and UnitedHealthcare.

Provider Satisfaction Survey Validation

Follow-Up to Previous Recommendations (2020)		Status
Common Among the MCOs (Continued)		
•	Ensure the analytic result for each question is based on a valid numerator and denominator. Findings based on inadequate numerators and denominators are not valid. **KFMC Response:** All three MCOs had considerably low overall number of completed surveys (Aetna: 207; Sunflower: 315; and UnitedHealthcare: 35) and low overall response rates (Aetna: 10.9%; Sunflower 12.6%; and UnitedHealthcare: 1%) for their 2021 Survey. The results presented in the survey reports of three MCOs did not include numerator and denominator counts for the rates calculated for the individual survey questions. Therefore it was not feasible to assess whether the percentages calculated for the individual questions were valid.	**Not Addressed:** Aetna, Sunflower, and UnitedHealthcare.
•	Interpret the results within the context of the study population represented by the survey sample. **KFMC Response:** Aetna's Survey Report did not include the narrative interpretations of results. Sunflower's Survey Report provided the interpretations for a few results, which were not based on the provider population included in the survey sample. The UnitedHealthcare Survey Report provided the interpretations for only three items, which were stated in general terms and were not specifically based on the provider population included in the survey sample.	**Not Addressed:** Aetna, Sunflower, and UnitedHealthcare.
•	Conduct non-response analysis. **KFMC Response:** The three MCOs did not apply non-response analyses of the 2021 Survey data.	**Not Addressed:** Aetna, Sunflower, and UnitedHealthcare.
4. •	**Include a 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 defined parameters (population size, margin of error, confidence level, standard deviation, response rate) used in the sample size calculation. **KFMC Response:** The three MCOs did not include the sampling methodology description in their 2021 Survey Reports. Sunflower and UnitedHealthcare provided some information upon follow-up regarding different aspects of the sampling plan. The study population, sample frame, sampling method and sample size was described in the Work Plan and provided in response to KFMC's request for additional information; however, several crucial pieces were lacking or not clear. A few discrepancies in these descriptions were also seen. Aetna's follow-up did not address KFMC's questions.	**Partially Addressed**: Sunflower, and UnitedHealthcare. **Not Addressed:** Aetna

Provider Satisfaction Survey Validation

	Follow-Up to Previous Recommendations (2020)	Status
Common Among the MCOs (Continued)		
•	Describe the survey administration tasks in detail. **KFMC Response:** The Aetna 2021 Survey Report and accompanying documents did not describe detailed survey administration tasks. The Sunflower 2021 Survey Report provided a brief description of the steps for the multi-mode strategy and a timeline for implementation of these steps; however other tasks including quality assurance steps were not described. The UnitedHealthcare 2021 Survey Report included only a brief description of the dual-mode strategy. Sunflower and UnitedHealthcare provided some information on the survey administration tasks along with the timelines for some of the tasks in the accompanying documents, however some crucial pieces were lacking or not clear. In addition, a few discrepancies in these descriptions were also seen for both MCOs.	**Partially Addressed**: Sunflower, and UnitedHealthcare. **Not Addressed** Aetna.
•	Describe the quality procedures applied during each step of the survey implementation and data analysis with reference to the vendor's quality management plan. **KFMC Response:** Aetna and Sunflower provided their survey vendor's Quality Management Plan (QMP) document, which described the quality management protocol and mentioned audits were conducted; however, the Aetna and Sunflower 2021 Survey Reports did not reference the vendor's QMP document or mention whether the quality procedures were applied. In response to KFMC's request for additional information, UnitedHealthcare noted the third-party vendor was responsible for the quality of data as specified in the vendor contract, however, the vendor's Quality Assurance Plan document was not provided, and no information related to the application of the quality management procedures while conducting the survey was mentioned in the Survey Report.	**Partially Addressed**: Aetna, Sunflower, and UnitedHealthcare.
•	Describe any changes made to the study design during the survey implementation and their reasons. **KFMC Response:** The three MCOs did not provide this information in their 2021 Survey Reports. A few discrepancies were seen between the descriptions for certain aspects of the study design provided in three MCOs' Work Plans and in their response to KFMC's request for additional information. However, no explanations or reasons for those discrepancies and deviations were provided by the MCOs.	**Not Addressed:** Aetna, Sunflower, and UnitedHealthcare.
5.	**Consider using several of the same questions across MCOs:**	
•	Consider including several questions in the survey instrument that are the same across the three MCOs to provide comparative results, and to identify common and unique strengths and opportunities for improvement across the MCOs. **KFMC Response:** The survey instruments of three MCOs included questions with different wordings, therefore the results obtained from the three surveys were not comparable.	**Not Addressed:** Aetna, Sunflower, and UnitedHealthcare.

Provider Satisfaction Survey Validation

Follow-Up to Previous Recommendations (2020)		Status
Aetna		
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. **KFMC Response:** The 2021 Survey instrument included nine sections with twenty-one items comprised of a total of sixty-four questions. Out of these sixty-four questions, fifty-one questions were relative questions and included the following instruction: "When compared to your experience with other health plans you work with." The differences in the providers' understanding and application of the instructions, as well as the differences in the characteristics of the "other health plans," could impact the results. As such, there cannot be a true assessment of Aetna's actual performance or the provider satisfaction for those questions.	**Not Addressed**
•	An increased sample size should be used to account for the previous low response rates. **KFMC Response:** The sample size of 1,894 providers for the 2021 Survey was higher than the sample size of 1,500 providers for the 2020 survey, and there were 85 more returned surveys, with an increase in response rates from 8.1% in 2020 to 10.9% in 2021. However, there were continued limitations to generalizability and the parameters regarding sample size calculation were not provided to indicate they were based on previous response rates.	**Partially Addressed**
Sunflower		
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. **KFMC Response:** The survey instrument included a majority of questions (thirty-seven out of fifty-four questions) that 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." The differences in providers' understanding of the questions and instructions for responding to the questions, as well the differences in the characteristics of the "other health plans," could impact the results. As such, there cannot be a true assessment of Sunflower's actual performance or the provider satisfaction for those questions.	**Not Addressed**
•	Apply steps to ensure an adequate number of surveys completed by the BH providers. . **KFMC Response:** A higher number of BH providers were selected in 2021 Survey sample as compared to the 2020 Survey (500 vs. 46 providers). The number of valid surveys completed by BH Providers was also higher than the 2020 Survey (96 vs. 5 providers). While there was improvement, it was not clear how it was decided to select a sample of 500 BH providers for the 2021 Survey. The information on the size of the sample frame for BH providers and the parameters for the overall sample size calculation was not provided. In addition, a required response rate for the survey and number of valid surveys was also not specified.	**Partially Addressed**

Provider Satisfaction Survey Validation

Follow-Up to Previous Recommendations (2020)		Status
UnitedHealthcare		
The recommendations below are in addition to the "Common Among the MCOs" recommendations.		
•	Include the information in the Survey Report regarding reliability and validity testing of the survey instrument for the target study population (UHC eligible providers) and more specifically, UHC KanCare providers. **KFMC Response:** The information regarding testing of the instrument for its reliability and validity was not provided in the Survey Report or the Work Plan for the 2021 Survey. UHC provided this information in their response to KFMC's request for additional information. UHC noted the formal reliability and validity testing of the survey instrument was not conducted; questions were developed by UHC and have been in use for more than a decade. This information needs to be included in the 2022 survey work plan and report.	**Partially Addressed**
•	Address whether the survey sample and respondents completing the survey represent UnitedHealthcare's KanCare providers when interpreting analytic results. **KFMC Response:** UHC reported all the providers selected in the survey sample were UnitedHealthcare Community and State Providers with an active contract.	**Fully Addressed.**

Compliance Review

The scoring scale for the degree to which previous recommendations were addressed is Fully Addressed, Substantially Addressed, Partially Addressed, Minimally Addressed, Not Addressed, and In Progress.

	Follow-Up to Previous Recommendations	2019 Status	2020 Status	2021 Status
Common Among the MCOs				
2019 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards				
1.	**Aetna:** §438.206(b)(3) Availability of Services: Delivery Network (Second opinion): The *Provider Manual* does not indicate that a second opinion is at no cost to the member whether in- or out-of-network. • Add language to the *Provider Manual* on page 26, in the section *"Self-Referrals/Direct Access,"* detailing the second opinion is at no cost to the member whether in- or out-of-network. **KFMC Update:** 2020 Review – ABH provided the *Provider Manual* with updated language indicating that a second opinion is at no cost to the member whether in- or out-of-network.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
	Sunflower: §438.206(b)(3) Availability of Services: Delivery Network (Second opinion): The *Member Handbook* describes how members may obtain a second opinion, in the section "Second Medical Opinion" on page 26. This section does not indicate an out-of-network second opinion is at no cost to the member. • Add language to the *Member Handbook* on page 26, in the section "Second Medical Opinion," detailing an out-of-network second opinion is at no cost to the member. **KFMC Update**: • 2020 Review: SHP provided a written progress update that they would submit to the State the proposed addendum to the Member Handbook for approval by February 12, 2021, after the timeframe for the 2020 compliance review. • 2021 Review: SHP provided the *Member Handbook* with updated language detailing that an out-of-network second opinion is at no cost to the member.	New Recommendation	In Progress	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations	2019 Status	2020 Status	2021 Status
Common Among the MCOs (Continued)			
2019 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
UnitedHealthcare: §438.206(b)(3) Availability of Services: Delivery Network (Second opinion): The UnitedHealthcare *Member Handbook* describes how members may obtain a second opinion, in the section "*Getting a Second Opinion*" on page 23. This section indicates an out-of-network second opinion is "at no more cost to you than if the service was provided in-network." • Revise the last sentence on page 23 of the *Member Handbook*, in the section *"Getting a Second Opinion,"* detailing an out-of-network second opinion is at *no cost* to the member. For example, the sentence could be: "If the type of doctor needed is not available in-network for a second opinion, we will arrange for a second opinion out-of-network at no cost to you." **KFMC Update:** • 2020 Review: UHC revised the *Member Handbook* to include language that states "A second opinion is when you want to see a second doctor for the same health concern. You can get a second opinion from a network provider or non-network provider for any of your covered benefits. This is your choice. You are not required to get a second opinion. If the type of doctor needed is not available in-network for a second opinion, we will arrange for a second opinion out-of-network at no more cost to you than if the service was provided in-network." However, the language should state "at no cost to you" not "at no more cost to you than if the service was provided in-network." • 2021 Review: UHC provided the 2021 *Member Handbook* that included the recommended revised language about out-of-network second opinions at no more cost than that provided in-network.	New Recommendation	Substantially Addressed	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations	2019 Status	2020 Status	2021 Status
Common Among the MCOs (Continued)			
2019 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
2. **Aetna:** §438.224: Confidentiality (Medical records and other identifying information): Information was not provided regarding the retention time periods or how this will be implemented and monitored. • Provide details regarding the retention time periods and how this will be implemented and monitored in all documentation that includes information on medical records retention (contracts and policies). Details need to include: "*Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of such litigation, if the litigation is not terminated within the normal retention period. Electronic copies of documents contemplated herein may be substituted for the originals with the prior written consent of the State, provided that the microfilming procedures are approved by the State as reliable and are supported by an effective retrieval system. Upon expiration of the ten (10) year retention period, unless the subject of the records is under litigation, the subject records may be destroyed or otherwise disposed of without the prior written consent of the State.*" (Recommendation also made in KFMC's 2019 QAPI Review for State contract Section 5.9.12[C]: *Records Retention requirements*.) **KFMC Update:** • 2020 Review: ABH provided policy *3000.55 Documentation and Records Retention*, but it only related to the compliance department. Policy *CRCMGT-002 Corporate Records Management Program* mentioned the Aetna Records Retention Schedule, but KFMC needed a copy of the retention schedule and this policy did not contain retention time periods. KFMC requested the *Aetna Records Retention Schedule* This policy addresses implementation and monitoring but does not contain retention time periods. (Policy *KS 3000.55* included timeframes for the compliance department, only.) • 2021 Review: ABH provided policy *8000.30 Review of Practitioner Office Medical Records* that included the required information on records retention.	New Recommendation	Substantially Addressed	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations	2019 Status	2020 Status	2021 Status
Common Among the MCOs (Continued)			
2019 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
Sunflower: §438.224: Confidentiality (Medical records retention): The *Provider Manual* contains an incorrect timeframe for record retention after litigation. • In the *Provider Manual*, update the timeframe for retention of records after litigation (not less than 10 years). This recommendation is also in KFMC's 2019 QAPI Review for State contract Section 5.9.12(C): *Records Retention Requirements*. (In response to the 2019 QAPI Review, Sunflower indicated they will update the *Provider Manual*.) **KFMC Update**: 2020 Review – SHP updated the *Provider Manual* to include the recommended language: "Sunflower requires providers to maintain all records for members for at least 10 years for adult members and 13 years for minors; however, when an audit, litigation or other action involving records is initiated prior to the end of such period, records shall be maintained for not less than 10 years following the resolution of such action."	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
UnitedHealthcare: §438.224: Confidentiality (Medical records retention): The documentation provided addresses confidentiality of members' personal information and clinical and medical records requirements. However, more detail is needed regarding clinical and medical records retention timeframes. • For the 2020 follow up review, provide documentation regarding clinical and medical record retention, as detailed in State contract section 5.9.12 *Clinical and Medical Records*, letters A, B, and C, including documentation of retention time periods and how this will be implemented and monitored. This recommendation is also in KFMC's 2019 QAPI Review for State contract Section 5.9.12[C]: Records Retention Requirements. **KFMC Update:** • 2020 Review: UHC advised they provided the policy *UHC Records Retention*; however, KFMC did not receive this policy. In the 2021 review, UHC is to submit the *UHC Records Retention Policy*. • 2021 Review: UHC provided updated policy *UHC Records Retention Schedule UHG* that addressed clinical and medical record retention time periods, implementation, and monitoring.	New Recommendation	In Progress	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations	2019 Status	2020 Status	2021 Status
Aetna			
2019 Follow-Up Recommendations: Subpart C – Enrollee Rights and Protections			
1. §438.10(c)(6)(v): Information Requirements: Basic rules (Information provided electronically): Member enrollment materials available online, including the *Member Handbook* and *Provider Directory*, do not include a statement that the materials will be provided to the member in a printed format, upon request, "within five (5) business days." • Under the "Member Handbook" and "Provider Directory" tab on the Aetna Better Health of Kansas website's "For Members" page, include "within five (5) business days" where stated that members may request a hard copy *Member Handbook* or *Provider Directory* at no cost to them. **KFMC Update:** • 2020 Review: ABH updated the language on the Provider Directory tab of the ABH website to read, "If you would like a printed copy of the *Provider Directory* sent to you..." ABH incorrectly updated the language on the Member Handbook tab of the ABH website to read, "If you would like a printed copy of the *Provider Manual* sent to you..." instead of required language around requesting the *Member Handbook*. • 2021 Review: ABH updated the required language on the Member Handbook tab of the ABH website to read, "If you would like a printed copy of the *Member Handbook* sent to you within five (5) business days, you may request one at no cost to you..."	New Recommendation	In Progress	Fully Addressed
2. §438.10(e)(2): Information Requirements: Information for potential enrollees: Both KFMC and Aetna identified a gap related to education for potential members regarding rights, benefits, and plan features, related to State contract Section 5.2.1, Enrollment, letter J. • Develop a policy for implementation regarding education for potential members addressing member rights, member benefits, and plan features. **KFMC Update:** • 2020 Review: ABH indicated they were in the process of updating policy *4600.05 Member Communications* and had not yet updated the website. • 2021 Review: Aetna updated the required language and it now appears in the *Become a member* tab of the ABH website, covering "enrolling and choosing Aetna Better Health of Kansas."	New Recommendation	In Progress	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart C – Enrollee Rights and Protections (Continued)				
3.	§438.10(e)(2)(vi): Information Requirements: Information for potential enrollees (Formulary): The *Member Handbook*, as well as the website, does not convey the formulary is available in a printed format. • Although the formulary is provided by the State, clarify in the *Member Handbook* that it is available in a printed format upon request. Determine whether the MCO will send a printed version or whether the MCO will request it from the State for the member, or whether the MCO will provide the appropriate State phone number in the *Member Handbook* for the member to request a printed formulary. **KFMC Update:** 2020 Review – ABH updated the *2021 Member Handbook*, with a link for the State website and instructs the member that a printed option will be made available via reaching out to member services.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
4.	§438.10(e)(2)(viii) and related provision §438.68(a–e) Network Adequacy Standards (as it relates to Information Requirements for potential enrollees): In Aetna policy *4500.15 New, Existing and Reinstated Member Information,* it is unclear how Aetna meets the Network Adequacy standards required by the State. • Provide more information to members regarding how Aetna meets the network adequacy standards required by the State in Aetna policy *4500.15 New, Existing and Reinstated Member Information*. Explain how members are assured Aetna is meeting the required Network Adequacy standards. **KFMC Update:** • 2020 Review: ABH indicated they were in the process of updating policy *A-KS 4500.15 New, Existing and Reinstated Member Information*. • 2021 Review: ABH updated policy *A-KS 4500.15 New, Existing and Reinstated Member Information* to include how they meet the network adequacy standards.	New Recommendation	In Progress	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart C – Enrollee Rights and Protections (Continued)				
5.	§438.10(e)(2)(x): Information Requirements: Information for potential enrollees (Quality and performance indicators): The QAPI program description does not provide information on how members are informed of Subcontractor and Provider quality improvement information. • Describe how members are informed of quality and performance indicators, including results of member satisfaction surveys. (Recommendation also made in KFMC's 2019 QAPI Review for State contract Section 5.9.1[N]: *Provider quality improvement information)* **KFMC Update:** • 2020 Review: KFMC opted to wait until ABH submitted the updated QAPI program description through the normal QAPI timeframe before reviewing ABH's action to address this recommendation. • 2021 Review: ABH provided policy *2019 438_10_e_2_x*, mentioning how ABH shares quality improvement information, including with members, but provided no evidence of sharing such information with members. KFMC was unable to locate evidence of sharing of member survey and performance measure results through ABH's quarterly member newsletters from spring 2019 through fall 2021 available on the ABH website.	New Recommendation	In Progress	Not Addressed
6.	§438.10(f)(2): Information Requirements: General requirement (Member disenrollment): Updated language from State contract Amendment 3 (III) regarding member disenrollment needs to be added to Aetna policy *4500.86 Member Disenrollment/Disruptive Member Transfer.* • In Aetna policy *4500.86 Member Disenrollment/Disruptive Member Transfer*, page 3, in the section "*Member Voluntary Disenrollment*" under "*Without Cause*," include language from KanCare 2.0 Amendment 3: "after automatic re-enrollment, when the State imposes intermediate sanctions on a CONTRACTOR in accordance with 42 CFR § 438.702(a)(3), and when the State terminates the CONTRACT in accordance with 42 CFR § 438.722(b)." **KFMC Update:** • 2020 Review: ABH indicated they were in the process of updating policy *4500.86 Member Disenrollment/Disruptive Member Transfer.* • 2021 Review: ABH updated language in policy *4500.86 Member Disenrollment/Disruptive Member Transfer* to meet request, though referencing KanCare 2.0 Amendment 3 rather than 42 CFR §438.702 and §438.722.	New Recommendation	In Progress	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations	2019 Status	2020 Status	2021 Status
Aetna (Continued)			
2019 Follow-Up Recommendations: Subpart C – Enrollee Rights and Protections (Continued)			
7. §438.10(g)(2)(i) and (ii)(A–B): Information Requirements: Information for enrollees of MCOs [– Enrollee Handbook (Provided benefits): Clarification is needed in Aetna policy *4500.15 New, Existing and Reinstated Member Information* and the *Member Handbook* regarding coverage of authorized services. • Add to policy *4500.15 New, Existing and Reinstated Member Information* and the *Member Handbook* clarification that the MCO will be liable only for those services authorized by the MCO. **KFMC Update:** • 2020 Review: ABH provided policy *4500.15 New, Existing and Reinstated Member Information*, which included the required language regarding coverage of authorized services, but ABH did not also update the same language in the *Member Handbook*. • 2021 Review: ABH provided policy *4500.15 New, Existing and Reinstated Member Information* and the *Member Handbook*, which included the language, "...a notice stating that Aetna Better Health is liable only for those services authorized by Aetna Better Health." ABH also provided updated language in the *Member Handbook*: "If you receive health care services which are not medically necessary or if you receive care from doctors who are out of the Aetna Better Health of Kansas network, you may be responsible for payment."	New Recommendation	Substantially Addressed	Fully Addressed
8. §438.10(g)(2)(v-vi): Information Requirements: Information for enrollees of MCOs – Enrollee Handbook (Provided benefits): The *Member Handbook* does not explicitly state that Aetna offers pregnant members a choice to be assigned to a PCP that provides obstetrical care. • In the *Member Handbook*, add to page 21, under "*How do I pick my PCP?"* the statement that Aetna offers "pregnant members a choice to be assigned a PCP that provides obstetrical care." **KFMC Update:** 2020 Review – ABH updated the *Member Handbook* to include the required language around offering pregnant members a choice to be assigned a PCP that provides obstetrical care.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart C – Enrollee Rights and Protections (Continued)				
9.	§438.10(g)(2)(xii) and related provisions §438.3(j) Advance Directives, §422.128 Information on Advance Directives, and §417.436(d) Advance Directives: State contract, Section 5.1.12 *Advance Directives,* states the contractor policy must "Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians," "Identify the State legal authority (K.S.A. 65–28,107 or K.S.A. 58–625) permitting such objection," and "Describe the range of medical conditions or procedures affected by the conscientious objection." Aetna policy *4500.70 Advance Directives*, page 4, states "Participating practitioners and providers are not required to implement an advance directive if, as a matter of conscience, the practitioner or provider cannot implement an advance directive and state law allows any practitioner or provider, or any agent of such to conscientiously object." • In policy *4500.70 Advance Directives,* include the elements of the referenced State contract as well as reference the State legal authority. **KFMC Update:** • 2020 Review: ABH indicated they were in the process of updating policy *4500.70 Advance Directives* with the required elements of the referenced State contract and legal authority. • 2021 Review: ABH provided policy *4500.70 Advance Directives* that includes the elements of the referenced State contract as well as reference the State legal authority.	New Recommendation	In Progress	Fully Addressed
10.	§438.10(g)(2)(xii) and related provisions §438.3(j) Advance Directives, §422.128 Information on Advance Directives, and §417.436(d) Advance Directives: Aetna policy *4500.70 Advance Directives*, page 7, states "Aetna Better Health contracts or agreements with hospitals, nursing facilities, home health agencies, hospices or other organizational providers that deliver personal care to Aetna Better Health members require the provider to comply with federal and state laws about advance directives for members…" KFMC was unable to locate this specific language in the provider contract agreements. • In the 2020 follow-up review, provide the contract agreements with the advance directive language. **KFMC Update:** 2020 Review – ABH provided a written progress update indicating they adequately addressed advance directives in the *Provider Manual*. KFMC verified this is addressed in section 1.3 in the Simplicity Agreement template.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart C – Enrollee Rights and Protections (Continued)				
11.	§438.10(g)(2)(xii) and related provisions §438.3(j) Advance Directives, §422.128 Information on Advance Directives, and §417.436(d) Advance Directives: In follow-up to a site visit question about tracking whether members have advance directives, Aetna noted they identify and track this through the Health Risk Assessment. If the member indicates they have an advance directive, they remind the member to make sure their physician has a copy. Aetna asks for a copy in the event the member has a durable power of attorney. • Address how all members are informed about the purpose of advance directives and how to obtain more information if they want to create an advance directive. **KFMC Update:** 2020 Review – ABH updated the *Member Handbook* to include the required language around informing members of the purpose of advance directives and how to obtain more information if they want to create an advance directive.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
12.	§438.10(h)(3–4): Information Requirements: Information for all enrollees of MCOs – Provider Directory: During desk review, the Provider Directory access through Aetna's website was dated December 2018. • Maintain a Provider Directory online that is up to date. **KFMC Update:** 2020 Review – In December 2020, ABH updated and deployed the six provider directories through their website.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
13.	§438.10(h)(3–4): Information Requirements: Information for all enrollees of MCOs – Provider Directory: No documentation was found in submitted policies addressing the State contract requirement: "The online version of the Provider Directory shall be updated no later than thirty (30) calendar days after the Contractors(s) receives updated Provider information. All updates shall by implemented by the fifth (5th) calendar day of each month." • Add the following to relevant policy: "The online and paper version of the Provider Directory shall be updated no later than thirty (30) calendar days after Aetna receives updated Provider information. All updates shall by implemented by the fifth (5th) calendar day of each month." **KFMC Update:** 2020 Review – ABH verified that when changes are made, the online Provider Directory is updated every morning at 3:00 AM; therefore, changes are real time. The hard copy is updated monthly and kept electronically so they can print the current version when requested.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart C – Enrollee Rights and Protections (Continued)				
14.	§438.100(b)(2)(iv–vi): Enrollee Rights: Specific Rights (Basic requirement): The right to request and receive a copy of medical records, and to request they be amended, is not included in Aetna policy *4500.35 Member Rights and Responsibilities.* • Add to Aetna policy *4500.35 Member Rights and Responsibilities*, page 3, second bullet: "Copy of medical records. Each member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended." **KFMC Update:** • 2020 Review: ABH indicated they were in the process of updating policy *4500.35 Member Rights and Responsibilities*. • 2021 Review: ABH provided updated policy *4500.35 Member Rights and Responsibilities* that includes the additional language around the guarantee that members have the right to request and receive a copy of medical records and request amendment to them.	New Recommendation	In Progress	Fully Addressed
15.	§438.114(d)(1-3): Emergency and Postabilization Services: Additional rules for emergency services (payment): Aetna policy *7000.64 Emergency Services* is missing relevant language regarding coverage and payment for post-stabilization services. • Add the bold text to policy *7000.64 Emergency Services: The attending emergency physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge,* ***and that determination is binding on Aetna as responsible for coverage and payment."*** (State contract, Section 5.8.3.4 *Emergency and Post-Stabilization Services)* **KFMC Update:** 2020 Review – ABH provided policy *7000.64 Emergency Services*, containing the required language around coverage and payment for post-stabilization services. While the reader may be able to infer from the policy that this requirement is met, it is not clearly stated. KFMC suggested adding clarifying language (such as what is in bold in the original recommendation above).	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart C – Enrollee Rights and Protections (Continued)				
16.	§438.114(e): Emergency and Poststabilization Services: Additional rules for emergency services (Pre-approval): Aetna policy *7000.64 Emergency Services* is missing relevant language regarding pre-approval of post-stabilization services. • Add the bold text to policy *7000.64 Emergency Services: Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR § 422.113(c).* ***Contractor(s) is financially responsible for post-stabilization services obtained within or outside the entity that are pre-approved by Aetna's Participating Provider or other entity representative.*** (State contract, Section 5.8.3.4 *Emergency and Post-Stabilization Services)* **KFMC Update:** 2020 Review – ABH provided policy *7000.64 Emergency Services*, containing the required language around pre-approval of post-stabilization services.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
2019 Follow-Up Recommendations (Continued): Subpart D – MCO, PIHP and PAHP Standards				
17.	§438.206(b)(2) Availability of Services: Delivery Network (Maintains and monitors a network of appropriate providers): The *Provider Manual* is missing language regarding direct access to women's health specialists for female members. • Add language to the *Provider Manual* in the section "*Self-Referrals/Direct Access*" on page 26, to include "Aetna Better Health provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist." **KFMC Update**: 2020 Review – ABH provided the *Provider Manual* with updated language regarding direct access to women's health specialists for female members.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
18.	§438.206(b)(2) Availability of Services: Delivery Network (Maintains and monitors a network of appropriate providers): The *Provider Manual* is missing clarifying language regarding non-network providers and well-woman services. • Revise the sentence in the *Provider Manual,* page 76, in the section "*Exceptions to Prior Authorizations*" to include the language "or non-network provider" to be consistent with policy and procedure. The bullet would state, "Well-woman services by a non-network or in-network provider." **KFMC Update**: 2020 Review – ABH provided the *Provider Manual* with updated language regarding non-network providers and well-woman services.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
19.	§438.206(b)(2) Availability of Services: Delivery Network (Maintains and monitors a network of appropriate providers): The *Member Handbook* is missing clarifying language regarding authorization of well-woman services. • Add language to the *Member Handbook* in the section "Getting specialist care" that well-woman services do not require authorization, whether furnished by a network or non-network provider or practitioner. **KFMC Update:** 2020 Review – ABH provided the *Member Handbook* with updated clarifying language regarding authorization of well-woman services.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
20.	§438.206(c)(1)(iii) Furnishing of Services: Timely Access (Evening and weekend appointment availability): Evening and weekend appointment availability is missing in descriptions of access to care in *Provider Manual* and related documentation. • In the *Provider Manual* and related documentation, describe how evening and weekend appointment access standards are met. **KFMC Update:** 2020 Review – ABH provided the *Provider Manual* with updated language describing how evening and weekend appointment access standards are met.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
21.	§438.206(c)(2) Access and Cultural Considerations: The *Provider Manual* needs to address responsiveness to member health literacy needs. • In the *Provider Manual,* add responsiveness to health literacy needs and its definition to the first paragraph in "*Cultural Competency*" on page 34. The recommended language is: "Aetna Better Health is responsive to members' health literacy needs. Health literacy is the degree to which individuals have the capacity to obtain, understand and repeat back health information and services needed to make appropriate health decisions." **KFMC Update:** 2020 Review – ABH provided the *Provider Manual* with updated language on responsiveness to member health literacy needs.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
22.	§438.206(c)(2) Access and Cultural Considerations: The *Provider Manual* needs to address responsiveness to member health literacy needs. • In the *Provider Manual,* page 35 lists what "Providers and their office staff are responsible for." Add a fourth bullet to this list stating "Responding to member's health literacy needs." **KFMC Update:** 2020 Review – ABH provided the *Provider Manual* with updated language stating that providers and office staff are responsible for responding to member's health literacy needs.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
23.	§438.206(c)(2) Access and Cultural Considerations: The *Member Handbook* needs to include language regarding member choice of their PCP based on cultural preference. • In the *Member Handbook*, include language that indicates members may choose their PCP based on cultural preference. **KFMC Update:** 2020 Review – ABH provided the *Member Handbook* with updated language indicating members may choose their PCPs based on cultural preferences.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
24.	§438.210(d)(3): Coverage and Authorization of Services: Timeframe for decisions (Covered outpatient drug decisions): The *Provider Manual* and *Member Handbook* do not specify timeframes for prior authorization decisions and filling qualifying prescriptions. • Aetna should add the timeframes for pharmacy prior authorization decisions and filling qualifying prescriptions to the *Provider Manual* and *Member Handbook* as noted in Aetna policy *7600.07 Pharmacy Prior Authorization.* **KFMC Update:** 2020 Review – ABH provided the *Provider Manual* and *Member Handbook* with updated language on timeframes for pharmacy prior authorization decisions and filling qualifying prescriptions.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
25.	§438.224: Confidentiality (Medical records and other identifying information): Letters iii. and iv. of State contract Section 5.9.12(B) are not addressed in documentation provided. • Provide details regarding the release of clinical and medical records [State contract Section 5.9.12(B)(iii)] and include the acknowledgment of compliance with Federal guidelines at 42 CFR § Part 2 regarding releases of information for SUD specific clinical or medical records. **KFMC Update:** 2020 Review – ABH provided document *CHIP-0006 Authorization for Use and Disclosure of Protected Health Information*, which was updated to reflect 5.9.12(B)(1)(c-d).	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart E – Quality Measurement and Improvement; External Quality Review				
26.	§438.330(b)(5)(i-ii): Quality Assessment and Performance Improvement Program: Basic elements (Assess quality and appropriateness for LTSS [Long-Term Support Services]): Detail is needed regarding how Aetna monitors to ensure services and supports received are those in the member's treatment/service plan. • In the *ISC* [Information System Capability] *Program Description*, describe how Aetna monitors to ensure services and supports received are those identified in the member's treatment/service plan. (Recommendation also made in KFMC's 2019 QAPI Review for State contract Section 5.9.1[F]: *General requirements*.) **KFMC Update:** • 2020 Review: ABH indicated LTSS was in the process of developing a process for reviewing the *Utilization Report* each month and once the process has been initiated, the team will update ISC Program Description. • 2021 Review: ABH provided the *ICM Program Description* that describes how Aetna monitors to ensure services and supports received are those identified in the member's treatment/service plan.	New Recommendation	In Progress	Fully Addressed
2019 Follow-up Recommendations: Subpart D – MCO, PIHP and PAHP Standards				
27.	§438.208(a)(1): Coordination and Continuity of Care: Basic requirement: Further review is needed regarding Aetna's care coordination process related to case review documentation for §438.208 (KFMC will review in 2020). • In the 2020 follow-up, provide KFMC demonstration of the HSTs (Health Screening Tool), HRAs, Person-Centered Service Plan and Plans of Service for specific cases by displaying all relevant documentation directly from their electronic database, to ensure KFMC's review is based on all available data. **KFMC Update:** 2020 Review – ABH provided a demonstration of their case management system in October 2020 and walked KFMC through specific cases during the November 2020 site visit.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
28.	§438.208(a)(3): Coordination and Continuity of Care: Basic requirement (Dually eligible enrollees): Description is needed regarding dually eligible members included in care coordination processes. • Aetna should clarify how dually eligible members are included in care coordination processes, including in the desktop "Outreach and Enrollment" document and define "Medicaid-only members." **KFMC Update:** • 2020 Review: ABH indicated they were in the process of updating their desktop *Outreach and Enrollment* regarding dually eligible members being included in care coordination processes and in defining "Medicaid-only members." • 2021 Review: ABH did not provide sufficient evidence on dually-eligible members included in care coordination processes in the Outreach and Enrollment document, and mistakenly removed the definition of "Medicaid only" from the "Attempting to Outreach the Member for the HST (CMA)" table.	New Recommendation	In Progress	In Progress
29.	§438.208(b)(2): Coordination and Continuity of Care: Care and coordination of services (Care Transition): Staff education is needed regarding member transitions. • Ensure all appropriate Kansas staff are familiar with Aetna policy *7000.40 Member Transition* and that processes are being followed. **KFMC Update:** 2020 Review – ABH provided the LTSS desktop processes to support *7000.40 Member Transition Policy* and provided trainings documents of the trainings they provided to Long-term Care, ICM, and LTSS team staff in fall 2020.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
30.	Case Review Related to §438.208 Coordination and Continuity of Care: • Aetna should reference the various documents by title in their Desktop document that represent compliance with the Health Screening, HRA, Needs Assessments, Person-Centered Service Plan and Plan, and Plan of Service requirements and provide links or report templates in the policy and procedure documents. **KFMC Update:** 2020 Review – ABH provided four examples of updated desktops related to service plans and assessments to ensure appropriate documents were referenced, links were added, and names were spelled out.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
31.	Case Review Related to §438.208 Coordination and Continuity of Care: • For the 2020 follow-up review, Aetna should review the Health Screen scoring algorithm to determine needed improvements and provide KFMC with the algorithm for further review. Aetna should review the detail regarding the individual case reviews (provided by KFMC) and follow-up as needed. **KFMC Update:** 2020 Review – ABH provided health screening tools, a demonstration of their case management system in October 2020, and walked KFMC through specific cases during the November 2020 site visit.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
32.	Case Review Related to §438.208 Coordination and Continuity of Care: • Aetna should review the cases identified for potential follow-up and address as appropriate (KFMC will separately provide Aetna with more detailed review findings regarding these specific cases). **KFMC Update:** 2020 Review – ABH provided a demonstration of their case management system in October 2020 and walked KFMC through specific cases during the November 2020 site visit.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
33.	Case Review Related to §438.208 Coordination and Continuity of Care: • Aetna should encourage providers to assess whether the member is receiving services elsewhere. Education and expectations should be provided on how to approach the member and other providers for collaboration. **KFMC Update:** • 2020 Review: ABH indicated they planned to develop a provider bulletin following feedback obtained in their upcoming Q1 Provider Advisory Committee. • 2021 Review: ABH provided three documents, *Assessing and Evaluating LTSS Program Members*, the *Care Plan Development and Updating Desktop*, and *Outreach and Enrollment*, each of which included the required information about service coordinators ensuring collaboration and coordination and continuity of care for members between providers.	New Recommendation	In Progress	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
34.	§438.214(c) Provider selection: Nondiscrimination and Related Provision §438.12(a-b): Provider discrimination prohibited: General rules and Construction: Language is needed in the *Provider Manual* regarding non-discrimination against providers. • Add language to the *Provider Manual* in section "*Initial Credentialing Individual Practitioners*" regarding non-discrimination against providers that serve high-risk populations or specialize in conditions that require costly treatment. **KFMC Update:** 2020 Review – ABH updated the *Provider Manual* to include the required language around non-discrimination against providers that serve high-risk populations or specialize in conditions that require costly treatment. ABH also added to the ABH website on the Provider Portal under Network the statement "Aetna Better Health of Kansas doesn't discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatments."	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
35.	§438.214(c) Provider selection: Nondiscrimination and Related Provision §438.12(a-b): Provider discrimination prohibited: General rules and Construction: Language is needed in relevant documentation, other than the *Provider Manual*, regarding non-discrimination against providers. • Address how providers serving high-risk populations or who specialize in conditions that require costly treatment are not discriminated against in relevant documentation (other than *Provider Manual)*. **KFMC Update:** 2020 Review – ABH provided policy *A-KS QM 53 Credentialing Allied Health Practitioners* that was updated with the requested language. ABH also added to the ABHKS website on the Provider Portal under Network the statement, "Aetna Better Health of Kansas doesn't discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatments." ABH specified that the required language already existed in *A-KS QM 54 Practitioner Credentialing Recredentialing Amendment* and *A-KS 8100.32A Non-Traditional Provider Credentialing Amendment*.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
36.	Credentialing/Recredentialing Case Review Related to §438.214 Provider Selection: • In the 2020 follow-up review, Aetna include a database screen shot or other evidence that details the date a complete application was received and a copy of a dated written communication to the provider notifying them of the credentialing decision for Individual Health Care Providers 1, 2, 4, 6, 10, 11, and 13. Aetna should review and provide evidence of National Practitioner Data Bank check results beyond the checklist noting completion for providers 1, 2, 4,and 13). Skygen should provide documentation indicating the reason for the State's Board of Healing Art's sanction was reviewed for Provider 5. **KFMC Update:** • 2020 Review: ABH provided evidence to demonstrate the application was received, copies of provider approval letters, and Aetna Enterprise Credentials Verification Organization is NCQA certified and Utilization Review Accreditation Commission accredited. Starting January 1, 2021, Aetna CVO will begin including screenshot copies of verification results from NPDB in the ABH practitioner credentialing files to support the checklist noting completion. Also, documentation needed to be provided for Provider 5 and was not available at the time. • 2021 Review: ABH provided the necessary documentation indicating the reason for the State's Board of Healing Art's sanction was reviewed for Provider 5.	New Recommendation	In Progress	Fully Addressed
37.	Credentialing/Recredentialing Case Review Related to §438.214 Provider Selection: • In the 2020 follow-up review, Aetna should provide evidence of the date of submission of the complete application, date of the credentialing decision, and the dated communication notifying the provider of the communication. **KFMC Update:** 2020 Review – In March 2020, ABH's local team's contracting and credentialing workflow database underwent a series of enhancements. Improvements were based on operational audit findings, recommendations, and lessons learned from the first year of operations. Improvements include additional fields for more detailed tracking of the end-to-end workflow to incorporate the Kansas Modular Medicaid System portal and receipt of enrollment applications.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
38.	Credentialing/Recredentialing Case Review Related to §438.214 Provider Selection: • In the 2020 follow-up review, Aetna should provide credentialing documentation for cases 12, 13, and 15, or rationale for credentialing not needed. **KFMC Update:** • 2020 Review: KFMC sought clarification from the State on what is required of the MCOs regarding these types of providers, since there is variation between the MCOs on credentialing of hospitals, radiology centers, pharmacy/infusion therapy centers. • 2021 Review: ABH provided rationale for why credentialing was not required for cases 12, 13, and 15.	New Recommendation	In Progress	Fully Addressed
2019 Follow-Up Recommendations: Subpart F: Grievance and Appeal System				
39.	§438.402(c)(1)(i): General Requirements: Filing requirements (Authority to file): The *Member Handbook* needs additional clarity regarding the State Fair Hearing process. • In the *Member Handbook* on page 69, in the section "*State Fair Hearing Process,*" add "A member may request a State Fair Hearing after receiving notice that the adverse benefit determination is upheld." **KFMC Update:** 2020 Review – ABH added the language to the Member Handbook that states, "If you disagree with our decision on your appeal request, you can appeal directly to the Office of Administrative Hearings. This process is known as a State Fair Hearing."	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
40.	§438.402(c)(1)(i): General Requirements: Filing requirements (Authority to file): The *Member Handbook* needs additional clarity regarding the State Fair Hearing process. • In the *Member Handbook,* include an explanation that the MCO "cannot require a written form from the Member for a request for a State Fair Hearing or use the lack of a written or signed form from the Member as a basis for refusal to process the request" to page 69 and all associated documentation. **KFMC Update:** 2020 Review – KFMC determined this language does not need to be added to the Member Handbook, as the MCO would not process the request. Rather, the MCO should let the member know how to submit a State Fair Hearing request. ABH provided policy *3100.70 Member Appeals,* and *w*hile the language regarding this recommendation is sufficient, KFMC suggests ABH add language to clarify that members do not have to submit a written form for a State Fair Hearing to be processed.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart F: Grievance and Appeal System (Continued)				
41.	§438.402(c)(1)(i): General Requirements: Filing requirements (Authority to file): In documentation that includes member appeal information, more detail is needed regarding requirements of members regarding written forms. In all documentation that includes member appeal information: • Include language explaining the MCO "cannot require a written form from the member or member's authorized representative for an appeal." • Additionally, include in documentation that the MCO "must process an oral request for an appeal if the written appeal is not received." Also applies to §438.402(c)(1)(ii); §438.402(c)(3)(ii); and §438.406(b)(3) **KFMC Update:** 2020 Review – ABH provided policy *3100.70 Member Appeals* and the language in the policy includes the requirements of members regarding written forms.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
42.	§438.402(c)(1)(ii): General Requirements: Filing requirements (Authority to file): Clarification is needed regarding member appeals and requests for continuation of benefits. Although providers may be an authorized representative for a member in an appeal, they may not request continuation of benefits for a member. • In the *Provider Manual* and Aetna policy *3100.70 Member Appeals* and associated documentation, include a statement explaining that providers cannot request continuation of benefits for a member, even though they may be an authorized representative for a member in an appeal. **KFMC Update:** • 2020 Review: ABH provided the *Provider Manual* and policy *3100.70 Member Appeals.* The *Provider Manual* was updated to include the recommended clarification. However, the policy does not include the recommended language. In the 2021 review, ABH needs to indicate where this recommendation has been addressed in the policy *3100.70 Member Appeals.* • 2021 Review: ABH provided updated policy *3100.70 Member Appeals* stating, "Providers cannot request continuation of benefits for an enrollee, even though they may be an authorized representative for an enrollee in an appeal."	New Recommendation	Substantially Addressed	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart F: Grievance and Appeal System (Continued)				
43.	§438.402(c)(3)(ii): General Requirements: Filing requirements (Procedures - Appeal): Clarity is needed in the *Member Handbook* related to how appeals are submitted. • On page 67 of the *Member Handbook*, include "The Member or Member's Authorized Representative may submit an Appeal either orally or in writing." **KFMC Update:** • 2020 Review: ABH provided the *Member Handbook*; however, it did not include language detailing the Member or Member's Authorized Representative may submit an Appeal either orally or in writing. ABH needs to add this language to the *Member Handbook*. It is not clear the member has both options under the section *How to Submit Your Appeal*. • 2021 Review: ABH planned to include the clarifying language on submitting appeals in the 2022 Member Handbook, which was not complete by the time of this status update.	New Recommendation	Partially Addressed	In Progress
44.	§438.404(a): Timely and Adequate Notice of Adverse Benefit Determination: Notice: More detail is needed in Aetna policy *7100.05 Prior Authorization* regarding Notice of Adverse Determination communication requirements. • In policy *7100.05 Prior Authorization*, replace "at or below a sixth (6th) grade reading level" with "at or below a 5.9 grade reading level" on page 22 in the first full paragraph. **KFMC Update:** 2020 Review – ABH provided policy *7100.05 Prior Authorization* that included the recommended revised language.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
45.	§438.404(a): Timely and Adequate Notice of Adverse Benefit Determination: Notice: More detail is needed in Aetna policy *7100.05 Prior Authorization* regarding Notice of Adverse Determination communication requirements. • In policy *7100.05 Prior Authorization*, add the following to the first full paragraph on page 22 after the sentence beginning "A Notice of Action sent to a member must be…": "The Notice of Action must also be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. The Notice of Adverse Benefit Determination shall be available in the State-established prevalent non-English languages. All Members shall be informed that information is available in alternative formats and how to access those formats." **KFMC Update:** 2020 Review – ABH provided policy *7100.05 Prior Authorization* that was revised to address the recommendation.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart F: Grievance and Appeal System (Continued)				
46.	§438.404(b)(2): Timely and Adequate Notice of Adverse Benefit Determination: Content of notice (Reasons for the adverse benefit determination): State contract, Attachment D, Section 4.3.2.1.5, regarding reasons for Adverse Benefit Determination, needs clarified in Aetna policy. • Add the following to Aetna policy *7200.05 Concurrent Review/Observation Care,* page 14, in the section "*Notice of Action Requirements*," after bullet two: "The right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits." **KFMC Update:** • 2020 Review: ABH provided policy *7200.05 Concurrent Review/Observation Care* that included the language, "Notification that, upon request, the practitioner/provider or member, if applicable, may obtain a copy of the benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based." However, this did not fully address the recommendation. For the 2021 review, ABH was to add the language, "The right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's Adverse Benefit Determination." • 2021 Review: ABH provided updated policy *7200.05 Concurrent Review/Observation Care*, which includes the required language around the member's right to be provided reasonable access to and copies of all information relevant to the Member's Adverse Benefit Determination.	New Recommendation	Partially Addressed	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart F: Grievance and Appeal System (Continued)				
47.	§438.404(b)(2): Timely and Adequate Notice of Adverse Benefit Determination: Content of notice (Reasons for the adverse benefit determination): State contract, Attachment D, Section 4.3.2.1.5, regarding reasons for Adverse Benefit Determination, needs clarified in Aetna policy. • Add the following to Aetna policy *7100.05 Prior Authorization,* page 22, in section "*Notice of Action Requirements*," after bullet two: "The right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits." **KFMC Update**: • 2020 Review: ABH indicated the verbiage was added but the policy must be approved by the policy committee. Approval will be provided in Q1 2021. • 2021 Review: ABH provided updated policy *7100.05 Prior Authorization* that included the required language around the member's right to be provided reasonable access to and copies of all information relevant to the Member's Adverse Benefit Determination.	New Recommendation	In Progress	Fully Addressed
48.	§438.404(b)(2): Timely and Adequate Notice of Adverse Benefit Determination: Content of notice (Reasons for the adverse benefit determination): State contract, Attachment D, Section 4.3.2.1.5, regarding reasons for Adverse Benefit Determination, needs clarified in the *Member Handbook.* • Add this requirement to the "*Member Rights*" section in the *Member Handbook*, and all other documentation that includes the list of member rights. **KFMC Update**: 2020 Review – ABH provided the *Member Handbook* and reasons for Adverse Benefit Determination was detailed in the *Appeals* section; therefore, it does not need to be included in the *Member Rights* section.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
49.	§438.404(c)(1): Timely and Adequate Notice of Adverse Benefit Determination: Timing of notice: KFMC did not find evidence for §431.214(a-b) or State contract Attachment D, Section 4.3.4.2, *Timeframe for Notice of Adverse Benefit Determination for Termination, Suspension, or Reduction of Services,* Subsection 4.3.4.2.1.1, detailing Adverse Benefit Determination timeframes for instances of probable fraud and abuse by the member. • Include these specific timeframes in Aetna policy *3100.70 Member Appeals.* **KFMC Update**: 2020 Review – ABH provided policy *3100.70 Member Appeals* that was revised to include the timeframe for notice of adverse benefit determination for termination, suspension, or reduction of services.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart F: Grievance and Appeal System (Continued)				
50.	§438.404(c)(2): Timely and Adequate Notice of Adverse Benefit Determination: Timing of notice (Denial of payment): Aetna policy *2000.10 Claims Adjudication* needs clarification regarding timing requirements on page 3. • In Aetna policy *2000.10 Claims Adjudication,* include timing requirements as stated in State contract, Attachment D, Section 5.3.3.1: "The Contractor(s) shall send written Notice of an Action to the Provider within one (1) business day following the date of Action affecting the claim." **KFMC Update:** • 2020 Review: ABH indicated verbiage was in the process of being added and approved. • 2021 Review: ABH provided updated policy *2000.10 Claims Adjudication*, which includes the required language around timing requirements for Notice of an Action.	New Recommendation	In Progress	Fully Addressed
51.	§438.406(b)(1): Handling of Grievances and Appeals: Special Requirements (Acknowledge receipt): Aetna policy *6300.38 Provider Appeals and Reconsiderations* needs more detail regarding grievances resolved the same day of receipt. • Include the following language in Aetna policy *6300.38 Provider Appeals and Reconsiderations* and related documentation: "For Grievances resolved the same day of receipt, the Contractor(s) is not required to issue an acknowledgement, but shall acknowledge receipt of the Grievance in the Notice of Provider Grievance Resolution." **KFMC Update:** 2020 Review – ABH provided policy *6300.38 Provider Appeals and Reconsiderations* that was revised to include the recommended language.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
52.	§438.406(b)(2): Handling of Grievances and Appeals: Special Requirements (Grievances and appeals decisions): Aetna policy *3100.70 Member Appeals* needs additional detail regarding documentation submitted for appeal. • In Aetna policy *3100.70 Member Appeals,* on page 13, section *"Appeal Review – Same or Similar Specialty,"* as a sub-bullet of the first bullet, add: "take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination." **KFMC Update:** 2020 Review **–** ABH provided policy *3100.70 Member Appeals* that was revised to include the recommended language.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart F: Grievance and Appeal System (Continued)				
53.	§438.406(b)(2): Handling of Grievances and Appeals: Special Requirements (Grievances and appeals decisions): Aetna policy *3100.90 Member Complaint/Grievance* needs additional detail regarding documentation submitted for appeal. • In Aetna policy *3100.90 Member Complaint/Grievance,* in the third paragraph in section "*Scope,*" on pages 5-6, add the following language in bold: "Aetna Better Health will verify that the individuals who determine a decision about grievances are individuals who were not involved in any previous level of review or decision-making**, are individuals who take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination**, and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the state agency, in treating the member's condition." **KFMC Update:** • 2020 Review: ABH provided policy *3100.90 Member Complaint/Grievance* and it was not revised to include the recommended language. For the 2021 review, ABH is to address the recommendation. • 2021 Review: ABH provided updated policy *3100.90 Member Complaint/Grievance* that contains the required additional detail on documentation submitted for appeal.	New Recommendation	Partially Addressed	Fully Addressed
54.	§438.406(b)(2): Handling of Grievances and Appeals: Special Requirements (Grievances and appeals decisions): In relevant policy and procedure, description is needed regarding State contract Section 4.5.1 "Member Expedited Appeal System," subsection 4.5.1.1.3 through 4.5.1.1.5 pertaining to individuals who make decisions on appeals. • In all related documentation, explain how State contract Section 4.5.1 "Member Expedited Appeal System," subsection 4.5.1.1.3 through 4.5.1.1.5, regarding individuals who make appeal decisions, will be addressed. **KFMC Update:** • 2020 Review: ABH indicated they are reviewing the pertinent sections of the contract to address the recommendation. • 2021 Review: ABH provided draft updates to policy *A-KS 3100.70* that met KFMC's recommendation to addressing individuals who make appeal decisions, but the policy was not yet finalized and signed.	New Recommendation	In Progress	In Progress

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart F: Grievance and Appeal System (Continued)				
55.	§438.408(d)(1): Resolution and Notification: Grievances and Appeals (Format of notice: Grievances): Aetna policy *3100.90 Member Grievance* needs more detail regarding the format and content of Notice of Appeal Resolution letters. • In Aetna policy *3100.90 Member Grievance*, add the following to section "Grievance Resolution and Notification" on page 13 at the end of the first paragraph: "All notices containing the Member Grievance Resolution shall be in writing, use easily understood language of no more than a 5.9 grade level and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. The Notice of Member Grievance Resolution shall be available in the State-established prevalent non-English languages. All Members shall be informed that information is available in alternative formats and how to access those formats." **KFMC Update:** • 2020 Review: ABH provided policy *3100.90 Member Grievance*; however, it was not revised to add the recommended language. For the 2021 review, KFMC advised that ABH indicate where this recommendation has been addressed. • 2021 Review: ABH provided updated policy *3100.90 Member Grievance* that includes the required additional language.	New Recommendation	Partially Addressed	Fully Addressed
56.	§438.408(d)(2)(i): Resolution and Notification: Grievances and Appeals (Format of notice: Appeals): Aetna policy *3100.70 Member Appeals* lacks clarity regarding required reading level for member materials. • In Aetna policy *3100.70 Member Appeals,* page 6, section "*Scope*," sub-section "*Appeal Summary,*" add "and shall be at no more than a 5.9 grade reading level" to the first sentence in section. Revised language will read: "All written documents relating to an appeal, including but not limited to the policies, acknowledgment letter, notice of extension for resolution and appeal resolution letter, will be written in English and available in Spanish and other languages upon request, and shall be at no more than a 5.9 grade reading level." **KFMC Update:** • 2020 Review: ABH provided policy *3100.70 Member Appeals*; however, it was not revised to include the recommended language "and shall be at no more than a 5.9 grade reading level." In the 2021 review, KFMC advised that ABH indicate where this recommendation has been addressed in the policy. • 2021 Review: ABH provided updated policy *3100.70 Member Appeals* that includes the required revised language.	New Recommendation	Partially Addressed	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart F: Grievance and Appeal System (Continued)				
57.	§438.408(f)(3): Resolution and Notification: Grievances and Appeals (Requirements for State Fair Hearings): Aetna policy *3100.70 Member Appeals* needs more detail regarding the State Fair Hearing process. • Add the following to Aetna policy *3100.70 Member Appeals: "*The grievance process is not a substitute for the State Fair Hearing or State Appeal Committee (SAC) process. The parties to the State Fair Hearing include Aetna Better Health, the member, and his or her representative or the representative of a deceased member's estate." **KFMC Update:** • 2020 Review: ABH provided policy *3100.70 Member Appeals*; however, it was not revised to include the recommended language. In the 2021 review, KFMC advised that ABH indicate where this recommendation has been addressed in the policy. • 2021 Review: ABH provided updated policy *3100.70 Member Appeals* that includes the required additional language.	New Recommendation	Partially Addressed	Fully Addressed
58.	§438.420(c)(1-3): Continuation of Benefits while the MCO Appeal and the State Fair Hearing are Pending (Duration of continued or reinstated benefits): Aetna policy *3100.70 Member Appeals* needs more detail regarding the Appeals process and State Fair Hearing process. Add the following to Aetna policy *3100.70 Member Appeals:* • A reference to 42 CFR §438.420(c)(1–3) in footnote #25 (page 11). • In section *"Request for Continued Benefits During Appeals Process"* (page 12), the language *"or request for State fair hearing"* to the first paragraph, first bullet. It would read: *"The health plan will continue the member's benefits until the following occurs: The member withdraws the appeal or request for State fair hearing."* **KFMC Update:** • 2020 Review: ABH provided policy *3100.70 Member Appeals*; however, it was not revised to include the reference to the footnote or the recommended language. In the 2021 review, KFMC advised that ABH indicate where this recommendation has been addressed in the policy. • 2021 Review: ABH provided updated policy *3100.70 Member Appeals* that includes the required additional language.	New Recommendation	Partially Addressed	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Subpart F: Grievance and Appeal System (Continued)				
59.	§438.420(c)(1-3): Continuation of Benefits while the MCO Appeal and the State Fair Hearing are Pending (Duration of continued or reinstated benefits): The Aetna *Provider Manual* needs more detail regarding the Appeals process and State Fair Hearing process. Add the following to the *Provider Manual* in section "I" on page 80: • The language "or request for State fair hearing" to the second paragraph, first bullet. It would read: "Aetna Better Health continues the member's benefits until one of the following occurs: The member withdraws the appeal or request for State fair hearing." • In the second paragraph add the statement, "The member or member's authorized representative requests previously authorized waiver services or benefits to end and be replaced with another waiver service or benefit" to be consistent with Aetna policy *3100.70 Member Appeals*. **KFMC Update**: 2020 Review – ABH provided the *Provider Manual* and both recommendations were addressed. Also, there are separate sections explaining continuation of benefits for appeals and State Fair Hearings.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
2019 Follow-Up Recommendations: Case Review for Subpart D: MCO, PIHP and PAHP Standards and Subpart F: Grievance and Appeal System				
60.	Grievance Case Review Related to §438.210(b-e) Coverage and Authorization of Services**:** For the 2020 follow-up review: Aetna should review 12 cases to ensure the date of grievance resolution was documented (Members 10, 13, 14, 17, 19, 21, 23, 24, 25, 26, 28 and 29). **KFMC Update:** 2020 Review – ABH provided screenshots of member grievance cases and their dates of resolution, as well as demonstration of the ABH appeal and grievance system during the 2020 onsite visit.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
61.	Grievance Case Review Related to §438.210(b-e) Coverage and Authorization of Services: Aetna should follow up regarding Member 29 to ensure the grievance was resolved and communicated in the member's parent/guardian language preference. **KFMC Update:** 2020 Review – ABH provided a written progress update that contact was made with Member 29 in February 2019, a letter was sent on March 1, 2019, and the Member's carrier was updated and supplies were shipped.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Case Review for Subpart D: MCO, PIHP and PAHP Standards and Subpart F: Grievance and Appeal System (Continued)				
62.	Grievance Case Review Related to §438.210(b-e) Coverage and Authorization of Services: Re-educate staff on the grievance documentation process including: • Capturing grievances using correct grievance forms. • Documenting the correct information in the activity log. • Ensuring the documentation of accurate member information in the activity log, acknowledgement letter, and grievance resolution letter. • Aetna should review procedures for using the identified language preference for communications. • Using correct form letters in member communications. **KFMC Update:** 2020 Review – ABH implemented review and audit processes and have automated most of the elements of the letter, such as ensuring that letters can only be sent with dates filled out. At the 2020 onsite visit, ABH also informed KFMC that every letter gets reviewed.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
63.	Appeal Case Review Related to §438.210(b-e) Coverage and Authorization of Services: Re-educate staff to capture who filed the appeal and whether the appeal was written or verbal. **KFMC Update:** 2020 Review – ABH implemented review and audit processes, meeting the KFMC recommendation.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
64.	Appeal Case Review Related to §438.210(b-e) Coverage and Authorization of Services: In the tracking system, include receipt of verbal or written appeal and note who made the appeal. **KFMC Update:** 2020 Review – ABH provided screenshots of the notification method and requester for each appeal, meeting the KFMC recommendation.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
65.	Appeal Case Review Related to §438.210(b-e) Coverage and Authorization of Services: In the Acknowledgement Letter, note who made the appeal. **KFMC Update:** 2020 Review – ABH implemented review and audit processes, meeting the KFMC recommendation.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Case Review for Subpart D: MCO, PIHP and PAHP Standards and Subpart F: Grievance and Appeal System (Continued)				
66.	Appeal Case Review Related to §438.210(b-e) Coverage and Authorization of Services: In the Appeal Decision Letter: Note who made the appeal and include date of appeal resolution. **KFMC Update:** 2020 Review – ABH provided a recent appeal resolution letter following the 2020 onsite visit, meeting the KFMC recommendation.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
67.	Appeal Case Review Related to §438.210(b-e) Coverage and Authorization of Services: Include documentation of the Appointment of Representative Form (whether it was received or not). Also applies to **Appeal Case Review related to §438.402(c)(1)(ii)** **KFMC Update:** 2020 Review – ABH demonstrated where this information is documented during the 2020 onsite visit, meeting the KFMC recommendation.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
68.	Appeal Case Review Related to §438.210(b-e) Coverage and Authorization of Services: In the 2020 follow-up review, clarify the appeal decision in the appeal decision letter and include date of appeal resolution in the appeal decision letter (Member 13). **KFMC Update:** 2020 Review – ABH provided a recent appeal resolution letter following the 2020 onsite visit, meeting the KFMC recommendation.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
69.	Appeal Case Review related to §438.402(c)(1)(ii): KFMC recommends Aetna Better Health provide re-education to staff to capture who filed the appeal and the relationship to the member (including "member" if the member is filing the appeal). **KFMC Update:** 2020 Review – ABH implemented review and audit processes, meeting the KFMC recommendation.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
70.	Grievance Case Review related to §438.402(c)(1)(ii): Ensure the name of the person filing the grievance, and relationship to the member (including "member" as the relationship if the member is filing the appeal) is documented. **KFMC Update:** 2020 Review – ABH provided a demonstration of their appeal and grievance system during the 2020 onsite visit, showing KFMC where this information is captured and meeting the recommendation.	New Recommendation[1]	Fully Addressed	Fully Addressed (in 2020)

[1] Although this case review element is fully met, KFMC recommends Aetna address this item.

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations: Case Review for Subpart D: MCO, PIHP and PAHP Standards and Subpart F: Grievance and Appeal System (Continued)				
71.	Grievance Case Review related to §438.402(c)(3)(i): For the 2020 Follow-Up Review, provide screenshots showing whether the grievances were filed in orally or in writing. **KFMC Update:** 2020 Review – ABH provided a demonstration of their appeal and grievance system during the 2020 onsite visit, showing KFMC where this information is captured and meeting the recommendation.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
72.	Appeal Case Review related to §438.408(b)(3): Resolve expedited appeals within required timeframe. **KFMC Update:** 2020 Review – ABH implemented review and audit processes, meeting the KFMC recommendation.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
73.	Appeal Case Review related to §438.408(b)(3): Send appeal acknowledgement letters for all appeals received and appeal decision letters for all resolved appeals. Also applies to **Appeal Case Review related to §438.408(d)(2)(i-ii)** **KFMC Update:** 2020 Review – ABH implemented review and audit processes, meeting the KFMC recommendation.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
74.	Appeal Case Review related to §438.408(e)(1): Re-educate staff to capture date of appeal resolution in the notice of appeal resolution. **KFMC Update**: 2020 Review – ABH implemented review and audit processes, meeting the KFMC recommendation.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
75.	Appeal Case Review related to §438.408(e)(1): Re-educate staff to capture results of resolution process in notice of appeal resolution. **KFMC Update:** 2020 Review – ABH implemented review and audit processes, meeting the KFMC recommendation.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
76.	Appeal Case Review related to §438.408(e)(1): Review Members 13, 24, 25, and 29 to verify resolution of appeal and whether resolution letters were sent. **KFMC Update:** 2020 Review – ABH provided the appeal resolution letters for Members 24, 25, and 29.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2020 Follow-Up Recommendations: Subpart D: MCO, PIHP and PAHP Standards				
77.	Appeal Case Review related to §438.408(e)(2)(i-iii): For the 2020 follow-up review, provide letter of disposition. **KFMC Update:** 2020 Review – ABH provided a recent appeal resolution letter, meeting the KFMC recommendation.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
78.	§438.207(a): Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.68[b][1-2] Provider-Specific Network Adequacy Standards Provider types and LTSS): Time and distance standards; appointment timeframe standards • Policy documents should better define specific specialties currently grouped together (e.g., "high-volume specialists," "high-impact specialists") so that it is clear that all specialty providers are covered by a policy and differences are noted (e.g., psychiatrists have a shorter time/distance range than other behavioral health providers). Specifically, Aetna policy *6400.06 Practitioner and Provider Availability: Network Composition and Contracting Plan* should list time and distance standards by provider type or define providers within the specialist groups for which the standards apply. **KFMC Update:** 2021 Review – ABH provided updated policy *6400.06 Practitioner and Provider Availability: Network Composition and Contracting Plan* that includes the required clarifying language.	Not Yet Reviewed	New Recommendation	Fully Addressed
79.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.206[c][1][v] Availability of Services: Furnishing of Services): Monitoring • Provide more detailed methodology for access and availability studies to give a clear understanding of the stratified sample frame; sampling strategy; decision criteria (e.g., numerator or denominator compositions); and any other necessary components for an external evaluation. Include all provider types called for in network adequacy standards. **KFMC Update**: 2021 Review – ABH had not yet produced the annual timeliness report which KFMC will need to review as to whether ABH included the required detailed methodology for access and availability studies regarding the stratified sample frame, sampling strategy, decision criteria, and any other necessary components for external evaluation. In 2021, KDHE approved the MCOs methodology; however, the State advised the MCOs in 2022 the methodology must comply with MCO contract Amendment 14.	Not Yet Reviewed	New Recommendation	In Progress

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2020 Follow-Up Recommendations: Subpart D: MCO, PIHP and PAHP Standards (Continued)				
80.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.206[c][1][v] Availability of Services: Furnishing of Services – Timely access (Monitoring): • In 2021 follow-up review, please provide the summary report referenced in Aetna policy *6300.26 Primary Care Practitioner (PCP) After-Hours Accessibility Study*. **KFMC Update:** 2021 Review – ABH provided the documents *Analysis of Network Appointment1* and *Analysis of Network Appointment2* that demonstrated the summary report requested.	Not Yet Reviewed	New Recommendation	Fully Addressed
81.	§438.207(b)(1) Assurances of Adequate Capacity and Services (Nature of supporting documentation): Appropriate range of services • Ensure that all policies and other official documents submitted are completed and approved with appropriate signatures from leadership and effective dates. **KFMC Update:** 2021 Review – ABH provided explanation of their internal systems to ensure all policies and other official documents submitted are completed and approved with appropriate signatures from leadership and have effective dates.	Not Yet Reviewed	New Recommendation	Fully Addressed
82.	§438.207(b)(2) Assurances of Adequate Capacity and Services (Nature of supporting documentation): Sufficient number/mix/distribution of providers • Ensure that explanation fields are completed in GeoAccess reports that call for explanations, justifications, or remedies (e.g., *Unmapped Specialties* sub-report). Finally, ensure that submitted reports are comprehensively reviewed for accuracy and attestations/certifications accompany those reports. **KFMC Update:** 2021 Review – ABH provided the *Desktop_Kansas Informatics Process* and *Standard Report Process* documents that each address that attestations accompany standard reports.	Not Yet Reviewed	New Recommendation	Fully Addressed
83.	Case Review Related to §438.208 Coordination and Continuity of Care: For future case review requests, ensure all outreach attempts to members for health screenings are included with submitted documentation. KFMC will ensure this is an included element of the request. **KFMC Update:** 2021 Review – KFMC will assess ABH's compliance with ensuring all outreach attempts to members are included with submitted documentation during the Coordination of Care case review during the next review cycle and this recommendation will remain rated In Progress until reviewed again.	Not Yet Reviewed	New Recommendation	In Progress

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2020 Follow-Up Recommendations: Subpart D: MCO, PIHP and PAHP Standards (Continued)				
84.	Case Review Related to §438.208 Coordination and Continuity of Care: For future case review requests, ensure submitted documentation includes dates of completion (on assessments, for example). **KFMC Update:** 2021 Review – ABH verified that the date of completion is included on all assessments and that they ensure all required documents are included in requested submissions.	Not Yet Reviewed	New Recommendation	Fully Addressed
85.	Case Review Related to §438.208 Coordination and Continuity of Care: In the service plan, KFMC recommends documenting the member's preferred method of receiving a copy of their service plan (paper or electronic). **KFMC Update:** 2021 Review – ABH planned to incorporate the documenting of the member's preferred method of receiving a copy of their service plan in a new "Preferences" section of the Service Plan in their Case Management System (Dynamo), but this action was due to be completed after the KFMC deadline to review and assign final ratings for progress on prior recommendations for 2021.	Not Yet Reviewed	New Recommendation	In Progress
Sunflower				
2018 Follow-Up Recommendations/Areas Added to the 2020 Review: Subpart D – MCO, PIHP and PAHP Standards				
1.	§438.230(b)(3) Sub-contractual Relationships and Delegation – Specific Conditions (MCO monitors subcontractor's performance): DVO Meeting Minutes and Scorecards: In the 2018 follow-up review, provide documentation of completion of the following for the scorecards: • Asterisks be placed within individual data points with corresponding footnotes providing descriptions of and/or reasons for the following: ○ A category name changed/added, ○ When no data are included, ○ When data for the same timeframe change between quarterly reports, ○ When there is a large variation in data from one quarter to another, and ○ Include in the scorecard the identified method for year-to-date calculation (summed vs. averaged; duplicated vs. non-duplicated, etc.).	Carry Over from 2018 Substantially Met	In Progress	In Progress

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Sunflower (Continued)				
2018 Follow-Up Recommendations/Areas Added to the 2020 Review Subpart D – MCO, PIHP and PAHP Standards (Continued)				
	KFMC Update: • 2020 Review: SHP provided in a written progress update that during the quarterly DVO meetings, the dashboards are presented and during discussion any variances, changes, or updates are noted within the meeting and captured in the minutes, as well as reasoning if or when an SLA or metric is missed. Legends are available within the current DVO dashboards. KFMC determined that this update was not enough to give a rating other than In Progress and would seek updated documentation to review in 2021. • 2021 Review: SHP was in discussion and planning stages with vendors for creation of dashboards for the quarterly DVO Joint Oversight Committee meetings and was unable to provide evidence of this recommendation having been incorporated.			
2.	§438.236(c): Practice Guidelines (Dissemination of guidelines): Sunflower policy and procedure *KS.UM.01 Utilization Management Program Description*, page 24, section *Practitioner Access to Criteria,* states, "The Plan shall disseminate the Kansas medical necessity definition, ASAM [American Society of Addiction Medicine] criteria as contained in the KCPC [Kansas Client Placement Criteria] system (for Substance Use Disorder), authorization policies, procedures, and any applicable practice guidelines to all affected providers as requested." State contract Section 5.8.3 *Utilization Management Activities*, letter D, states, "The Contractor(s) shall disseminate the Kansas medical necessity definition, medical necessity criteria, authorization policies, procedures, and any applicable practice guidelines to all affected Providers and, upon request, to Members and potential Members." • In the Sunflower policy and procedure *KS.UM.01 Utilization Management Program Description*, page 24, section *Practitioner Access to Criteria,* remove "as requested" in the last sentence of the section; also add "and upon request, to members and potential members." **KFMC Update**: 2020 Review – SHP updated policy *KS.UM.01 Utilization Management Program Description* to remove and add the recommended language for removal or addition, respectively.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
3.	§438.206(c)(2) Availability of Services: Furnishing of Services (Access and Cultural Considerations): The first line on page 9 of Sunflower policy and procedure *KS.QI.26 Cultural, Linguistic, and Disability Competency Plan* states, "Sunflower will increase access to care as needed through the use of telemedicine per KS.CONT.11." • In the Sunflower policy and procedure *KS.QI.26 Cultural, Linguistic, and Disability Competency Plan,* expand the above statement to explain how care and services will be delivered in a culturally competent manner via telemedicine strategies.	New Recommendation	In Progress	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Sunflower (Continued)				
2018 Follow-Up Recommendations/Areas Added to the 2020 Review Subpart D – MCO, PIHP and PAHP Standards (Continued)				
	• Additionally, include the expanded language in Sunflower policy and procedure *KS.CONT.11: Telemedicine-Telehealth.* **KFMC Update**: • 2020 Review: SHP provided a written progress update that they had added the recommended language to policies *KS.QI.26 Cultural, Linguistic, and Disability Competency Plan* and *KS.CONT.11: Telemedicine-Telehealth*. KFMC determined that this update was not enough to give a rating other than In Progress and would seek the updated documentation for review in 2021. • 2021 Review: SHP provided the updated policy *KS.CONT.11: Telemedicine-Telehealth* that includes the expanded language around care and service delivery in a culturally competent manner via telemedicine strategies.			
4.	§438.208(a)(3): Coordination and Continuity of Care: Basic requirement (Dually eligible enrollees): Sunflower identifies members with other insurance and ensures coordination of benefits (through the provider submitting the Explanation of Benefits during claims submission). Also, for non-dual new members, they contact the previous insurer for the current plan of service. Sunflower's KanCare care coordinator is able to identify and work with the AllWell (SHP Medicare Plan) coordinator; however, Sunflower reported around 92% of the members with dual eligibility are with non-SHP plans. It is not clear how ongoing care is coordinated with other insurances' care coordinators for dually eligible members in care management. • In relevant Sunflower policies and procedures (e.g., Care Coordination Case Management Services, Continuity and Coordination of Care), add descriptions of how ongoing care is coordinated with other health plans for dually eligible members in care management. **KFMC Update**: • 2020 Review: SHP provided a written progress update that they had added the recommended language to policies *KS.CM.16 Continuity and Coordination of Care* and the *Kansas Addendum to CC.CM.02 Care Coordination Care Management*. KFMC determined that this update was not enough to give a rating other than In Progress and would seek the updated documentation for review in 2021. • 2021 Review: SHP provided the policy *KS_CM_16* as well as *Addendum CC.COM.02* that addressed ongoing care coordination with other health plans for dually eligible members in the member's care plan and services.	New Recommendation	In Progress	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Sunflower (Continued)				
2018 Follow-Up Recommendations/Areas Added to the 2020 Review Subpart D – MCO, PIHP and PAHP Standards (Continued)				
5.	Case Review Related to §438.208 Coordination and Continuity of Care: Sunflower should review the specific cases and more current information to determine whether follow-up with the members and/or providers are needed. **KFMC Update**: 2020 Review – SHP provided a written progress update that cases were reviewed in preparation for 2020 compliance review and that if outreach was needed for health risk screenings or other gaps in case, outreach had begun.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
2019 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards				
6.	Case Review Related to §438.208 Coordination and Continuity of Care: To sustain and continue improvements with providers regarding follow-up for laboratory or other tests and referrals, Sunflower should continue to embed these topics in their provider trainings and communications. Sunflower should continue to encourage providers to document whether members are receiving any services elsewhere, as well as encourage communication including the member and other providers. Education and expectations could be provided on how to approach the member and other providers for collaboration. [Combined with similar recommendation from 2018 for §438.208(b)(1)] • 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. **KFMC Update**: • 2020 Review: SHP provided a written progress update that the recommendations had been incorporated into monthly new provider training and bi-annual CEO forums for providers. KFMC determined that this update was not enough to give a rating other than In Progress and would seek the updated documentation for review in 2021. • 2021 Review: SHP provided the *2021 Provider Manual* noting PCP responsibility to maintain complete medical records for members, including services and referrals provided. SHP also provided slides from the SHP Semiannual CEO Provider Forum, mentioning facilitating care coordination and documenting communication of services provided by other providers in the medical record. Finally, KFMC confirmed that the SHP Medical Records webpage noted medical record documentation requirements.	New Recommendation	In Progress	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Sunflower (Continued)				
2019 Follow-up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
7.	§438.214(e) Provider Selection and Related Provision §438.12(a-b): Provider discrimination prohibited: General rules and Construction (including State requirements): State contract Section 5.5.1 *Credentialing and Re-credentialing*, letter D, states the MCO shall "Demonstrate that its Providers are credentialed and reviewed through the Contractor(s)' Credentialing Committee that is chaired by the Contractor(s)' local Medical Director." The *QAPI Program Description*, page 9, *Credentialing Committee,* indicates "The Committee is initially chaired by the Medical Director, although as committee member leadership develops, the Committee may be chaired by a network physician at the discretion of the CMD [Chief Medical Director]." • In the *QAPI Program Description*, revise the *Credentialing Committee* section to reflect the Committee will continue to be chaired by Sunflower's Medical Director. **KFMC Update**: • 2020 Review: SHP provided a written progress update that the *2021 QAPI Program Description* would reflect the Chief Medical Director as the Chair of the Credentialing Committee. KFMC determined that this update was not enough to give a rating other than In Progress and would seek the updated documentation for review in 2021. • 2021 Review: SHP provided the draft *2022 QAPI Program Description* that states the Chief Medical Director "as committee member leadership develops, a committee network provider may chair at the discretion of the Credentialing Committee."	New Recommendation	In Progress	Fully Addressed
8.	Credentialing/Recredentialing Case Review Related to §438.214 Provider Selection: In the 2020 follow-up review, provide evidence that written communication to the provider regarding the initial credentialing decision was provided, as well as documentation for the date of the communication (for Individual Health Care Providers 2, 4, 5, 11, and 14). **KFMC Update**: • 2020 Review: SHP provided a written progress update that the documentation evidence of letters to providers were provided to KFMC in August 21, 2020, and that File 14 was an instance of recredentialing and not applicable. KFMC determined that this documentation evidence was not included in documentation received, that that this update was not enough to give a rating other than In Progress, and that KFMC would seek the necessary documentation for review in 2021. • 2021 Review: SHP provided the credentialing approval letters for Providers 2, 4, 5, and 11, including dates of written notification. KFMC determined that an approval letter for Provider 14 was unnecessary as there was no approval letter for Provider 14 as this provider type does not apply for recredentialing.	New Recommendation	In Progress	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Sunflower (Continued)				
2019 Follow-up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
9.	Credentialing/Recredentialing Case Review Related to §438.214 Provider Selection: Sunflower should recheck the list of OIG [Office of Inspector General] Excluded Individuals/Entities using the provider's current name (Provider 20) and ensure all alternative names are checked going forward. **KFMC Update**: • 2020 Review: SHP provided a written progress update that they had a robust Credentialing Quality Monitoring program which include audits for alternative names to ensure all names are reviewed against OIG. KFMC determined that this update was not enough to give a rating other than In Progress and would seek the documentation for verification in 2021. • 2021 Review: SHP provided verification of Provider 20 (also Provider 4).	New Recommendation	In Progress	Fully Addressed
10.	Credentialing/Recredentialing Case Review Related to §438.214 Provider Selection: In the 2020 follow-up review, Sunflower should provide evidence of the date of written notification to the provider regarding the credentialing decision. **KFMC Update**: • 2020 Review: SHP provided a written progress update that their credentialing department provided decision letters for those files noted as missing. KFMC determined that although SHP sent the *SHP Cred 20200821* document, the necessary decision letters are still missing. KFMC determined that this update was not enough to give a rating other than In Progress and would seek the documentation for verification in 2021. • 2021 Review: SHP provided the credentialing approval letters for Providers 2, 4, 5, and 11, including dates of written notification. KFMC determined that an approval letter for Provider 14 was unnecessary as there was no approval letter for Provider 14 as this provider type does not apply for recredentialing.	New Recommendation	In Progress	Fully Addressed
11.	Credentialing/Recredentialing Case Review Related to §438.214 Provider Selection: Sunflower should ensure the names/alternate names of all owners, managers, and Board members are checked against the exclusion databases/lists. **KFMC Update**: 2020 Review – SHP indicated the process to validate owners, managers and board members provided on the Disclosure of Ownership forms had been "owned" previously by the Corporate Compliance area. Effective January 2021, the Corporate Credentialing Department is assisting by providing listings found during the recredentialing process to Corporate Compliance for monthly review.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Sunflower (Continued)				
2019 Follow-up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
12.	Credentialing/Recredentialing Case Review Related to §438.214 Provider Selection: Sunflower should clarify or revise policies *CC.CRED.10 Competence and Board Certification Criteria* and *CC.CRED.01 Practitioner Credentialing & Recredentialing* for consistency regarding whether board certification is required for physicians. **KFMC Update**: • 2020 Review: SHP indicated they will attempt to provide additional clarification on this element in the policies as requested. For the 2021 review, SHP needs to submit policies *CC.CRED.10 Competence and Board Certification Criteria* and *CC.CRED.01 Practitioner Credentialing & Recredentialing* for review. • 2021 Review: SHP provided updated policies *CC.CRED.10 Competence and Board Certification Criteria* and *CC.CRED.01 Practitioner Credentialing & Recredentialing*, which demonstrated consistency on board certification for physicians.	New Recommendation	In Progress	Fully Addressed
2019 Follow-up Recommendations: Subpart F – Grievance and Appeal System				
13.	§438.402(c)(1)(i): General Requirements: Filing requirements (Authority to file): In documentation that includes member grievance information, clarity is needed regarding the member's ability to file a grievance "at any time." • In the *Member Handbook* and Sunflower policy and procedure *KS.QI.11 Appeal and Grievance System Description,* include clarification that members may file a grievance "at any time." Also applies to §438.402(c)(2)(i) **KFMC Update**: 2020 Review – SHP provided *KS.QI.11 Appeal and Grievance System Description* and the 2021 Member Handbook that were updated to include clarification that members may file a grievance "at any time."	New Recommendation	Fully Addressed	Fully Addressed (in 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Sunflower (Continued)				
2019 Follow-up Recommendations: Subpart F – Grievance and Appeal System				
14.	§438.402(c)(1)(ii): General Requirements: Filing requirements (Authority to file): Sunflower policy and procedure *KS.QI.11 Appeal and Grievance System Description*, page 10, letter I, states "a provider may not request continuation of benefits on behalf of a member, even if the provider is an authorized representative." A similar statement is needed in the *Provider Manual.* • In the *Provider Manual*, include a statement explaining that providers cannot request continuation of benefits for a member, even though they may be an authorized representative for a member in an appeal. **KFMC Update**: 2020 Review – SHP provided the *Provider Manual* that was updated to include the statement explaining that providers cannot request continuation of benefits for a member, even though they may be an authorized representative for a member in an appeal.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
15.	§438.402(c)(3)(i): General Requirements: Filing requirements (Procedures): Sunflower meets the requirements for this regulation. However, it is unclear that members may file a grievance verbally or in writing in Sunflower policy and procedure *KS. QI.11 Appeal and Grievance System Description.* • To be consistent with other policies and procedures, add clarification to Sunflower policy and procedure *KS. QI.11 Appeal and Grievance System Description* regarding the right of members to file a grievance verbally or in writing. **KFMC Update**: 2020 Review – SHP provided *KS. QI.11 Appeal and Grievance System Description* that was revised to include clarifying language regarding the right of members to file a grievance verbally or in writing.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
2020 Follow-up Recommendations: Subpart D – MCO, PIHP and PAHP Standards				
16.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.206(c)(1)(v) Availability of Services: Furnishing of Services – Timely access (Monitor network providers regularly to determine compliance: During and after-hours monitoring): Provide more detailed methodology for access and availability studies to give a clear understanding of the stratified sample frame; sampling strategy; decision criteria (e.g., numerator or denominator compositions); and any other necessary components for an external evaluation. **KFMC Update**: 2021 Review – SHP provided the *Sunflower Health Plan Provider Directory and Appointment Availability Survey (September 2019)*, which does not cover stratified sample frame, sampling strategy, decision criteria, nor other necessary components for external evaluation.	Not Yet Reviewed	New Recommendation	Not Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Sunflower (Continued)				
2020 Follow-up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
17.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.206(c)(1)(v) Availability of Services: Furnishing of Services – Timely access (Monitor network providers regularly to determine compliance: During and after-hours monitoring): Assess and report reasons for after-hours non-compliance and follow-up efforts with non-compliant providers. **KFMC Update**: 2021 Review – SHP detailed after-hours noncompliance and follow-up efforts with noncompliant providers in written progress updates and in the documents *SHP Provider Access Follow up plan 8.15.2021* and *S. Tag 23406-PNTWKQS073021 – SHP*.	Not Yet Reviewed	New Recommendation	Fully Addressed
18.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.206(c)(1)(v) Availability of Services: Furnishing of Services – Timely access (Monitor network providers regularly to determine compliance: During and after-hours monitoring): Assess and report the effectiveness of individual provider communication regarding non-compliance and overall provider education. **KFMC Update**: 2021 Review – SHP provided a written explanation in their progress updates on how they worked to meet the KFMC recommendation on assessing and reporting the effectiveness of individual provider communication on noncompliance and overall provider education.	Not Yet Reviewed	New Recommendation	Fully Addressed
19.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.206(c)(1)(v) Availability of Services: Furnishing of Services – Timely access: (Monitor network providers regularly to determine compliance: During and after-hours monitoring): Consider additional interventions (noted in Sunflower policy *CC.PRVR.48*) to help providers improve access to appointments for urgent needs (e.g., assisting providers in improving their scheduling systems). **KFMC Update**: 2021 Review – SHP provided a written explanation in their progress updates on how they met the recommendation by considering additional interventions for providers to improve access to appointments for urgent needs, even though in practice the reality of the Covid-19 pandemic meant that the recommendation could mostly not be adopted at the provider level.	Not Yet Reviewed	New Recommendation	Fully Addressed
20.	§438.207(b) Assurances of Adequate Capacity and Services: Nature of supporting documentation: Though the GeoAccess issues noted above were corrected for Q3 2020, MCO analytic directors and leaders should follow State guidelines for reporting. **KFMC Update**: 2021 Review – SHP provided the document *Assurances of Adequate Capacity and Services*, demonstrating discussion of GeoAccess/GeoMap issues with the State and Sunflower's actions to resolve or follow up on specified issues by following State guidelines.	Not Yet Reviewed	New Recommendation	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Sunflower (Continued)				
2020 Follow-up Recommendations: Subpart F – Grievance and Appeal System				
21.	§438.404(c)(2): Timely and Adequate Notice of Adverse Benefit Determination (Timing of notice): In the 2021 follow-up review, provide documentation of compliance with the State contract (Attachment D, Section 5.3.3.1) requirement, "The Contractor(s) shall send written Notice of an Action to the Provider within one (1) business day following the date of Action affecting the claim." **KFMC Update**: 2021 Review – SHP provided the *2021 YTD GAR Report*, demonstrating a 99.7% or better compliance with the requirement of State Contract Attachment D, Section 5.3.3.1.	Not Yet Reviewed	New Recommendation	Fully Addressed
22.	§438.406(a): Handling of Grievances and Appeals (General requirements): Member assistance for grievances or appeals: Regarding the Sunflower *Member Appeal Rights Attachment for NABD* [Notice of Adverse Benefit Determination] – *KDHE approved 1/8/2020*, clarify that Sunflower will provide reasonable assistance in completing forms and other steps for grievances or appeals. **KFMC Update**: 2021 Review – SHP provided the document *Member Appeal Rights for NABD*, stating, "Sunflower will provide assistance in filling out any forms needed for the process by contacting Sunflower at 1-877-644-4623."	Not Yet Reviewed	New Recommendation	Fully Addressed
23.	§438.406(b)(5): Handling of Grievances and Appeals (Special requirements): Member's request of case file during appeal: In Sunflower policy *KS.QI.11 Appeal and Grievance System Description*, section Member Requests for Appeal Documents, specify that if members make a request for documentation the information must be supplied sufficiently in advance of the appeal resolution. **KFMC Update**: 2021 Review – SHP provided the updated policy *KS.QI.11_Appeal_and_Grievance_System_Description_10.2021*, stating, "If the member requests documents and/or records prior to appeal resolution, the Plan will provide requested documents in advance of appeal resolution."	Not Yet Reviewed	New Recommendation	Fully Addressed
24.	§438.406(b)(5): Handling of Grievances and Appeals (Special requirements): Member's request of case file during appeal: In the Sunflower *Member Handbook*, include information for members regarding how to request their case file during the appeal, and encourage a timely request to allow Sunflower to provide the file in advance of the appeal resolution. **KFMC Update**: 2021 Review – SHP provided the *2022 Sunflower MCD Mbr Handbook Addendum KDHE-Appd 1-12-2022* and the *2022 Member Handbook*, containing the required language.	Not Yet Reviewed	New Recommendation	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Sunflower (Continued)				
2020 Follow-up Recommendations: Subpart F – Grievance and Appeal System (Continued)				
25.	§438.406(b)(6): Handling of Grievances and Appeals (Special requirements): Member representation in an appeal: In Sunflower policy *KS.QI.11 Appeal and Grievance System Description*, section Notification of Member Appeal Rights, clarify that "the enrollee and his or her representative, or the legal representative of a deceased enrollee's estate" are parties to the appeal. **KFMC Update**: 2021 Review – SHP provided the updated policy *KS.QI.11_Appeal_and_Grievance_System_Description_10.2021*, clarifying the enrollee and representative, or legal representative of a deceased enrollee's estate, are parties to an appeal.	Not Yet Reviewed	New Recommendation	Fully Addressed
26.	§438.408(c)(2): Resolution and Notification: Grievances and Appeals (Extension of timeframes: Requirements following extension): In Sunflower policy *KS.QI.11 Appeal and Grievance System Description*, clarify that prompt oral notice of the delay for a standard appeal will be given, and written notice of the delay must be provided within 2 calendar days for both standard and expedited appeals. **KFMC Update**: 2021 Review – SHP provided the updated policy *KS.QI.11_Appeal_and_Grievance_System_Description_10.2021*, clarifying written and oral notice of the delay provided within 2 calendar days for both standard and expedited appeals.	Not Yet Reviewed	New Recommendation	Fully Addressed
27.	§438.408(c)(2): Resolution and Notification: Grievances and Appeals (Extension of timeframes: Requirements following extension): In Sunflower policy *KS.QI.11 Appeal and Grievance System Description*, address the member's right to file a grievance if they disagree with the decision to extend the timeframe of either a standard or expedited appeal. **KFMC Update**: 2021 Review – SHP provided the updated policy *KS.QI.11_Appeal_and_Grievance_System_Description_10.2021*, stating, "the member or authorized representative may request a grievance if they disagree with the decision to extend the timeframe of either standard or expedited appeal."	Not Yet Reviewed	New Recommendation	Fully Addressed
28.	§438.408(c)(2): Resolution and Notification: Grievances and Appeals (Extension of timeframes: Requirements following extension): Update language in the *Member Handbook*, Appeals Basics section, to include verbal notification of the delayed appeal. Recommendations 11-13 also apply to §438.410(c)(2). **KFMC Update**: 2021 Review – SHP provided the *2022 Sunflower MCD Mbr Handbook Addendum KDHE-Appd 1-12-2022* as well as the *2022 Member Handbook*, containing the required language.	Not Yet Reviewed	New Recommendation	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Sunflower (Continued)				
2020 Follow-up Recommendations: Subpart F – Grievance and Appeal System (Continued)				
29.	§438.408(c)(3): Resolution and Notification: Grievances and Appeals (Extension of timeframes: Deemed exhaustion of appeals processes): In the Sunflower *Member Handbook*, clarify that if Sunflower does not meet the notice and timing requirements for appeals, the Member will be considered to have completed the internal Sunflower appeal process and may request a State Fair Hearing. This also applies to §438.408(f)(1)(i). **KFMC Update**: 2021 Review – SHP provided the *2022 Sunflower MCD Mbr Handbook Addendum KDHE-Appd 1-12-2022* as well as the *2022 Member Handbook*, containing the required language.	Not Yet Reviewed	New Recommendation	Fully Addressed
30.	§438.416(c) Recordkeeping Requirements: Grievance and appeal records: In Sunflower policy *KS.QI.11 Appeal and Grievance System Description*, clarify that grievance and appeal records will be made available to CMS upon request. **KFMC Update**: 2021 Review – SHP provided the updated policy *KS.QI.11_Appeal_and_Grievance_System_Description_10.2021*, stating, "all records accessible to the member/authorized representative will be made available to CMS upon request."	Not Yet Reviewed	New Recommendation	Fully Addressed
31.	§438.420(c) Continuation of Benefits While the MCO Appeal and State Fair Hearing are Pending (Duration of continued or reinstated benefits): Continuation of non-HCBS benefits: In Sunflower policy *KS.QI.11 Appeal and Grievance System Description*, include a statement clarifying that benefits will continue unless "The Member withdraws the Appeal or State Fair Hearing request." The statement could be added to either of the following policy sections: "Continuation of Benefits during the Appeal/SFH Process" or "Non-Home and Community Based Services (Non-HCBS) Appeal." **KFMC Update**: 2021 Review – SHP provided the updated policy *KS.QI.11_Appeal_and_Grievance_System_Description_10.2021*, clarifying that benefits will continue unless the member withdraws the appeal or state fair hearing request.	Not Yet Reviewed	New Recommendation	Fully Addressed
32.	§438.424(a) Effectuation of Reversed Appeal Resolutions (Services not furnished while the appeal is pending): Timing of service authorization: In Sunflower policy *KS.QI.11 Appeal and Grievance System Description*, section Resolving an Appeal, include language specifying the authorization or provision of services within 72 hours from the date of reversal of the determination. **KFMC Update**: 2021 Review – SHP provided the updated policy *KS.QI.11_Appeal_and_Grievance_System_Description_10.2021*, specifying the authorization of provision of services within 72 hours from the date of reversal of the determination.	Not Yet Reviewed	New Recommendation	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Sunflower (Continued)				
2020 Follow-up Recommendations: Case Review for Subpart D MCO, PIHP and PAHP and Subpart F – Grievance and Appeal System				
33.	Case Review Related to §438.210 and Subpart F Grievance System: Develop a process to either eliminate the need for the manual entry of appeals data into TruCare or develop a process to ensure accurateness of data. **KFMC Update**: 2021 Review – SHP provided the *Weekly TAT* [Turn-Around-Time] *Report* that outlines controls to ensure accuracy, even though it does not eliminate manual data entry. However, KFMC recommended that SHP incorporated the information and processes detailed in the *Weekly TAT Report* into the applicable SOP.	Not Yet Reviewed	New Recommendation	Fully Addressed
34.	Case Review Related to §438.210 and Subpart F Grievance System: Work with subcontractors to ensure timeliness of Appeal Acknowledgement letters. **KFMC Update**: 2021 Review – SHP provided meeting minutes from quarterly meetings between SHP and National Imaging Associates, SHP and Envolve Pharmacy Solutions, and SHP and Envolve that demonstrate operational meeting discussion of appeals and timeliness.	Not Yet Reviewed	New Recommendation	Fully Addressed
35.	Case Review Related to §438.210 and Subpart F Grievance System: In the 2021 follow-up review, submit the Notice of Appeal Resolution for Member 16. **KFMC Update**: 2021 Review – SHP provided the document *Member 16 Appeal Details*, demonstrating the appeal review process leading to its denial, including multiple attempts to acquire a completed Authorized Representative Designation form that were eventually deemed unsuccessful. SHP also provided the document *Member 16 Resolution*, demonstrating the Notice of Adverse Benefit Determination in this case.	Not Yet Reviewed	New Recommendation	Fully Addressed
36.	Case Review Related to §438.208 Coordination and Continuity of Care: Develop a way to assess for incomplete assessments or force (e.g., programming in hard edits) certain questions to be answered before the assessment can be marked as complete. **KFMC Update**: 2021 Review – SHP provided the document *HRST Required Questions*, demonstrating with yes/no language whether each question in each section of the adult and pediatric versions of the Health Information Form require an answer before the assessment can be marked as complete. SHP also provided a written progress update that a "prefer not to answer" response in both versions of the Health Information Form will allow SHP to pull data as needed for any unanswered questions.	Not Yet Reviewed	New Recommendation	Fully Addressed
37.	Case Review Related to §438.208 Coordination and Continuity of Care: Include medication lists in the Service Plan and not just in TruCare. **KFMC Update**: 2021 Review – SHP provided the example *Support Plan pages 9-13- redacted*, demonstrating a completed Person-Centered Support Plan with examples of Medical Support and medication needs.	Not Yet Reviewed	New Recommendation	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Sunflower (Continued)				
2020 Follow-up Recommendations: Case Review for Subpart D MCO, PIHP and PAHP and Subpart F – Grievance and Appeal System				
38.	Case Review Related to §438.208 Coordination and Continuity of Care: Add a "date completed" field to the health screen to make clear when the assessment was completed (even if it is not documented immediately). **KFMC Update**: 2021 Review – SHP provided the image *HRST DATE COMPLETION FIELD*, demonstrating that the health screen contains a field called "Date of Completion."	Not Yet Reviewed	New Recommendation	Fully Addressed
39.	Case Review Related to §438.208 Coordination and Continuity of Care: Develop a process to make outreach letters more accessible in the care coordination system. **KFMC Update**: 2021 Review – SHP provided the documents *Master Checklist Handout 07.16.21* and *Trucare Letter Job Aid*, which meet the KFMC recommendation.	Not Yet Reviewed	New Recommendation	Fully Addressed
UnitedHealthcare				
2019 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards				
1.	§438.206(c)(1)(vi) Furnishing of Services (Timely Access): More clarity is needed to understand how Kansas subcontractors, including small and emerging businesses or small entrepreneurships, are considered in UnitedHealthcare's vendor selection, as outlined in State contract Section 5.5.14 "*Minimum Subcontract Provisions*," letter A. • In UnitedHealthcare's policy *Vendor Replacement* and other relevant documentation, clarify how Kansas subcontractors, including small and emerging businesses or small entrepreneurships are considered during vendor selection. **KFMC Update:** • 2020 Review: UHC indicated the following language would be added to the Q1 *2021 Kansas Credentialing Addendum*: "Provider selection requirements must comply with 42 CFR § 438.12. Contractor Provider selection policies and procedures must not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment." For the 2021 review, UHC is to submit the *Q1 2021 Kansas Credentialing Addendum*. • 2021 Review: UHC provided examples of their search for local and emerging businesses to contract and perform certain services. KFMC will keep this item rated In Progress until a proper rating can be assigned following future UHC submission of documentation evidence.	New Recommendation	Substantially Addressed	In Progress

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
UnitedHealthcare (Continued)				
2019 Follow-Up Recommendations: Case Review for Subpart D – MCO, PIHP and PAHP Standards				
2.	Case Review Related to §438.208 Coordination and Continuity of Care: Encourage providers to document whether members are receiving any services elsewhere, as well as encourage communication including the member and other providers. Education and expectations could be provided on how to approach the member and other providers for collaboration. **KFMC Update:** 2020 Review – UHC indicated they communicate with providers routinely through a biannual provider newsletter, at quarterly provider/MCO meetings/virtual, and through UHC's MMR audit annually. At the direction of the State and KFMC, UHC added new questions to the MMR Audit Questions. UHC reviews the results of the MMR audit at the Quality Management Committee and takes action to contact and resolve/educate issues with providers. UHC can issue provider failure letters, educate directly, reaudit after 6 months, etc.	New Recommendation	Fully Addressed	Fully Addressed (In 2020)
3.	Case Review Related to §438.208 Coordination and Continuity of Care: Encourage and remind providers to follow-up and document test/procedure results and member notification, as well as follow-up regarding referrals and consultations. [Combined with 2018 recommendation for §438.208(b)(1) Coordination and Continuity of Care (Ongoing source of primary care)] **KFMC Update:** 2020 Review – UHC indicated they communicate with providers routinely through a biannual provider newsletter, at quarterly provider/MCO meetings/virtual, and through UHC's MMR audit annually. At the direction of the State and KFMC, UHC added new questions to the MMR Audit Questions. UHC included results from that audit such as: a. 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. b. 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; c. There is evidence of providers assisting members with referrals and coordination of care. d. 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. UHC reviews the results of the MMR audit at the Quality Management Committee and takes action to contact and resolve/educate issues with providers. UHC can issue provider failure letters, educate directly, reaudit after 6 months, etc.	New Recommendation	Fully Addressed	Fully Addressed (In 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
UnitedHealthcare (Continued)				
2019 Follow-Up Recommendations: Case Review for Subpart D – MCO, PIHP and PAHP Standards (Continued)				
4.	Case Review Related to §438.208 Coordination and Continuity of Care: UnitedHealthcare should review the specific cases and more current information to determine whether follow-up with the members and/or providers is needed. **KFMC Update:** 2020 Review – UHC indicated they reviewed the cases submitted for Coordination and Continuity of Care for 438.208 and identified several opportunities to connect with providers and members.	New Recommendation	Fully Addressed	Fully Addressed (In 2020)
5.	Credentialing/Recredentialing Case Review Related to §438.214 Provider Selection: KFMC recommends UnitedHealthcare review files or obtain an attestation to correctness of the submitted information from Provider 1. **KFMC Update:** 2020 and 2021 Reviews – KFMC found this to be not applicable due to being fully met in 2019; therefore, KFMC rescinded the recommendation.	New Recommendation	Not Applicable[2]	Not Applicable[2]
6.	Credentialing/Recredentialing Case Review Related to §438.214 Provider Selection: In the 2020 follow-up review, UnitedHealthcare should provide the full credentialing files for Providers 6 and 15, evidence of the date of written notification to the provider regarding the credentialing decision for Provider 14, evidence of signed attestations to correctness for Providers 9 and 15, and evidence of receipt of the Corrective Action Plan and CMS letter regarding compliance for Provider 1. **KFMC Update:** 2020 Review – UHC provided documentation evidence for the following: for Provider 1, evidence of receipt of the Corrective Action Plan and an explanation that the UHC National Credentialing Committee is not required to obtain an actual copy of the CMS letter regarding compliance, but instead only verification the CMS certification is active, proof of which was also included; for Provider 6, the full credentialing file; for Provider 9, evidence of signed attestation to correctness; for Provider 14, evidence of the date of written notification to the provider regarding the credentialing decision; for Provider 15, an explanation that this pharmacy's contract through the Pharmacy Services Administration Organization called Arete conducts its own full credentialing process and through a contract that UHC holds with Arete, they are able to pass on such credentialing decisions to UHC, negating the need to provide the full credentialing file or evidence of signed attestation to correctness.	New Recommendation	Fully Addressed	Fully Addressed (In 2020)

[2] Not applicable due to being fully met in 2019; KFMC rescinded the recommendation

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
UnitedHealthcare (Continued)				
2019 Follow-Up Recommendations: Case Review for Subpart D – MCO, PIHP and PAHP Standards (Continued)				
7.	Credentialing/Recredentialing Case Review Related to §438.214 Provider Selection: UnitedHealthcare should ensure the names/alternate names of all owners, managers, and Board members are checked against the exclusion databases/lists. **KFMC Update:** 2020 Review – UHC indicated they check all names including alias against the OIG LEIE Exclusions Database during the credentialing/recredentialing process as well as during ongoing sanctions monitoring. UHC does not require Disclosure of Ownership (DOO) forms from providers who are KMAP enrolled and In-Network (UHN), however all submitted claims continue to be processed through their system edits against sanctioned providers. Beginning April 2019, all out-of-network provider claims are held pending single case agreement and receipt of DOO. Prior to paying any ONN claims, sanction checking is completed from the received DOO form.	New Recommendation	Fully Addressed	Fully Addressed (In 2020)
8.	Credentialing/Recredentialing Case Review Related to §438.214 Provider Selection: UnitedHealthcare should provide the credentialing file for Provider 1, with rationale for denying the credentialing in Missouri and approving in Kansas. **KFMC Update:** 2020 Review: UHC provided the credentialing file that detailed the requested rationale.	New Recommendation	Fully Addressed	Fully Addressed (In 2020)
9.	Credentialing/Recredentialing Case Review Related to §438.214 Provider Selection: In the *UnitedHealthcare Credentialing Plan 2019-2021*, include specific language indicating "Providers that service high-risk populations or specialize in conditions that require costly treatment" are not discriminated against. **KFMC Update:** 2020 Review: UHC indicated the following will be added to the *Q1 2021 Kansas Addendum* to the UHC Credentialing Plan: "UHC Kansas C&S does not discriminate in making credentialing decisions for providers that service high-risk populations or providers who specialize in conditions that require costly treatment."	New Recommendation	Fully Addressed	Fully Addressed (In 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
UnitedHealthcare (Continued)				
2019 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
10.	§438.214(e) and Related Provision §438.12(a-b): Provider Selection: (State requirements): For the 2019 review, UnitedHealthcare submitted the following: "UnitedHealthcare awaits formal and final State guidance regarding steps we are allowed to take, to prevent or remediate conflict, that are congruent with CMS expectations. After receiving State policy guidance, UnitedHealthcare will update the *HCBS Provider Verification and Credentialing Policy* in support of 2.2.4.1.5.i." The referenced policy was not updated for the 2019 review. • In the 2020 review, if the State has issued its *Final Form Policy,* submit the revised UnitedHealthcare *Home & Community Based Service Provider Verification & Credentialing Policy* that details the language to support State contract Section 5.4.1 "*Service Coordination Program Overview*," letter B, number 9. [Combined with 2018 recommendation for §438.214(e) related to *Final Form Policy*] **KFMC Update:** • 2020 Review: UHC indicated after receiving State policy guidance, they updated the *HCBS Provider Verification and Credentialing Policy* in support of 2.2.4.1.5.i. KFMC did not receive the *HCBS Provider Verification and Credentialing Policy* to review. For the 2021 review, UHC is to submit the *HCBS Provider Verification and Credentialing Policy*. • 2021 Review: UHC provided *UHC_HCBS Provider Verification Credentialing Policy*, which is still missing required language approximating State Contract Section 5.4.1.B.9.	New Recommendation	In Progress	Not Addressed
2019 Follow-Up Recommendations: Subpart F: Grievance and Appeal System				
11.	§438.402(c)(1)(i): General Requirements: Filing requirements (Authority to file): The *Member Handbook* explains the grievance process on page 65 but does not state members can file a grievance "at any time." • In the *Member Handbook*, on page 65, include language that clarifies members may submit a grievance "at any time." Also applies to §438.402(c)(2)(i) **KFMC Update:** 2020 Review: UHC provided the *Member Handbook* and *Member Welcome letter* that was revised to include the language "at any time."	New Recommendation	Fully Addressed	Fully Addressed (In 2020)

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
UnitedHealthcare (Continued)				
2019 Follow-Up Recommendations: Subpart F: Grievance and Appeal System (Continued)				
12.	§438.402(c)(1)(ii): General Requirements: Filing requirements (Authority to file): The *Provider Manual*, Chapter 5 "*Member Grievances & Appeals*" covers member appeals and grievances, and that members may request continuation of benefits. Federal regulation §438.402(c)(1)(ii) details a provider may serve as a member's authorized representative in an appeal, but "providers cannot request continuation of benefits." • In Chapter 5 of the *Provider Manual*, include language stating "providers cannot request continuation of benefits" if they are the member's authorized representative in an appeal. **KFMC Update:** • 2020 Review: UHC indicated they updated the *Provider Manual* to include language that a provider (if a member's authorized representative) cannot request continuation of benefits for an appeal. KFMC did not receive the *2020 Provider Manual* and the UHC website has the *2019 Provider Manual*. For the 2021 review, UHC is to submit the *2020 Provider Manual*. • 2021 Review: UHC provided *2021 Care Provider Manual Physician, Health Care Professional, Facility and Ancillary*, that was revised to include language stating, "A care provider may serve as a member's representative in an appeal, but the care provider cannot request continuation of benefits."	New Recommendation	In Progress	Fully Addressed
2020 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards				
13.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.68[b][1-2] Provider-Specific Network Adequacy Standards: Provider types and LTSS [Time and distance standards]): Specific time and distance standards for access to behavioral health providers were clearly present but specific time and distance standards for access to physical health providers were not clearly present in the policies submitted. • Include time and distance standards for physical health providers in United's policy *UHN Network Development and Retention* or similar policy. **KFMC Update:** 2021 Review – UHC provided policies *KSPN-0036*, referencing "UHC KS KanCare final-geoaccess standards – effective 5-31-19 with hcbs standards v2," and *UHC_KS_KanCare_ final-geoaccess-standards*, stating geo access standards and time and distance standards for physical health providers (20 miles/40 minutes for Urban and Semi-Urban and 30 miles/45 minutes for Densely-Settled Rural, Rural, and Frontier).	Not Yet Reviewed	New Recommendation	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
UnitedHealthcare (Continued)				
2020 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
14.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.68[b][1-2] Provider-Specific Network Adequacy Standards: Provider types and LTSS [Time and distance standards]): Time and distance standards for access to Long Term Services and Supports were not clearly present within UnitedHealthcare's 2019 policy documents. • Include time and distance standards for LTSS providers in United's policy *UHN Network Development and Retention* or similar policy. **KFMC Update:** 2021 Review – UHC provided policies *KSPN-0036*, referencing "UHC KS KanCare final-geoaccess standards – effective 5-31-19 with hcbs standards v2," and *UHC_KS_KanCare_final-geoaccess-standards*, stating geo access standards and time and distance standards for physical health providers (20 miles/40 minutes for Urban and Semi-Urban and 30 miles/45 minutes for Densely-Settled Rural, Rural, and Frontier).	Not Yet Reviewed	New Recommendation	Fully Addressed
15.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.68[c][1] Development of Network Adequacy Standards: "Provider Supply and Capacity" and "Accessibility"): Network Assessments: Policy documents detail some required elements and generally discuss criteria for evaluating their provider network capacity and access. DialAmerica provides their Access and Availability Program Guidelines. • Include a more detailed description of how network assessments are performed and how those findings are analyzed or evaluated, as mentioned within the *UHN Network Development and Retention* policy (Procedure Detail #3). If a separate documented policy or procedure details this, please attach in future documentation requests. **KFMC Update:** 2021 Review – UHC was in the process of revising their policy and procedures to incorporate the KFMC recommendation.	Not Yet Reviewed	New Recommendation	In Progress

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
UnitedHealthcare (Continued)				
2020 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
16.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.68[c][1] Development of Network Adequacy Standards: "Provider Supply and Capacity" and "Accessibility"): Network Assessments: Policy documents detail some required elements and generally discuss criteria for evaluating their provider network capacity and access. DialAmerica provides their Access and Availability Program Guidelines. • Describe findings from the assessments mentioned within the *UHN Network Development and Retention* policy (Procedure Detail #3) in quarterly *Access and Availability Analysis* reports (sub-report of geo-access reports), described in the April 2019 GeoAccess Reporting Requirements (VIII.F.2.). **KFMC Update:** 2021 Review – UHC was in the process of revising their policy and procedures to incorporate the KFMC recommendation.	Not Yet Reviewed	New Recommendation	In Progress
17.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.206(c)(1)(iv) and (vi) Availability of services: Furnishing of services – Timely Access (Compliance and Corrective Action: Monitoring and corrective action): Policy documents discuss monitoring but do not provide detailed procedures or plans for monitoring. Policy documents do not explicitly detail corrective actions but describe general processes. The Provider Manual offers some insight for providers. • Include details in policies and procedures regarding processes for follow-up with providers that are non-compliant with access requirements. **KFMC Update:** 2021 Review – UHC was in the process of revising their policy and procedures to incorporate the KFMC recommendation.	Not Yet Reviewed	New Recommendation	In Progress
18.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.206(c)(1)(iv) and (vi) Availability of services: Furnishing of services – Timely Access (Compliance and Corrective Action: Monitoring and corrective action): Policy documents discuss monitoring but do not provide detailed procedures or plans for monitoring. Policy documents do not explicitly detail corrective actions but describe general processes. The Provider Manual offers some insight for providers. • Review performance formulas and calculations within certain GeoAccess reports (e.g., specialty care, NEMT) for accuracy. **KFMC Update:** 2021 Review – UHC was in the process of revising their Standard Operating Procedure to incorporate the KFMC recommendation.	Not Yet Reviewed	New Recommendation	In Progress

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
UnitedHealthcare (Continued)				
2020 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
19.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.206(c)(1)(iv) and (vi) Availability of services: Furnishing of services – Timely Access (Compliance and Corrective Action: Monitoring and corrective action): Policy documents discuss monitoring but do not provide detailed procedures or plans for monitoring. Policy documents do not explicitly detail corrective actions but describe general processes. The Provider Manual offers some insight for providers. • *Access and Availability Analysis* reports are an opportunity to address strengths and limitations for the entire network but also to detail specific issues and remedies identified by other network reporting. Consider using the *Access and Availability Analysis* reports to monitor progress toward improving deficiencies from those reports. **KFMC Update:** 2021 Review – UHC provided the document *UHC_HP_Monthly Network Meetings Overview*, outlining UHC's Monthly Network Development and Gap (SCA) [single case agreements] Meetings and offering an example of a dashboard reviewed and policy drafted as a result of these meetings and improving deficiencies from reports provided.	Not Yet Reviewed	New Recommendation	Fully Addressed
20.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.206(c)(1)(iv) and (vi) Availability of services: Furnishing of services – Timely Access (Compliance and Corrective Action: Monitoring and corrective action): Policy documents discuss monitoring but do not provide detailed procedures or plans for monitoring. Policy documents do not explicitly detail corrective actions but describe general processes. The Provider Manual offers some insight for providers. • Ensure that required report fields are completed for each quarterly submission file and that only unique providers are present. **KFMC Update:** 2021 Review – UHC provided policy *UHC_KS_GeoCheckList* that meets the KFMC recommendation to "ensure that required report fields are completed for each quarterly submission file." For the second piece of the KFMC recommendation "that only unique providers are present," UHC provided a written progress update stating "per the network adequacy report unique providers are listed as unique based on NPI and address. UHC does attempt to remove duplicates, however, due to the review/validation volume, individual review is not possible. It is machine review and there are some limits and providers with similar addresses do sometimes get included in the network adequacy." It appears they are doing machine reading for verifying unique providers. KFMC rates this item as substantially complete and will continue to monitor it. Through the Quarterly Feedback Reports the state completes, KFMC will be able to see duplicates identified by the state.	Not Yet Reviewed	New Recommendation	Substantially Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
UnitedHealthcare (Continued)				
2020 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
21.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.206(c)(1)(v) Availability of services: Furnishing of services – Timely Access (Monitor network providers regularly to determine compliance: During and after-hours monitoring): In review of UnitedHealthcare's 2019 annual report of DialAmerica findings for appointment waiting times and after-hours access, KFMC identified concerns with methodologies for survey administration, data analysis and reporting. As such, KFMC was unable to be confident in the findings and interpretations of the report. The report detailed key observations regarding results reported by UnitedHealthcare. • In the 2021 follow-up review, provide KFMC with the results from UHC's follow-up with providers that were not able to be reached. **KFMC Update:** 2021 Review – UHC provided the document *Access Monitoring Provider Issues_UHC and UHC_Medical Groups Needing After Hours*, covering UHC's follow up with providers not able to be reached in the Access Monitoring review.	Not Yet Reviewed	New Recommendation	Fully Addressed
22.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.206(c)(1)(v) Availability of services: Furnishing of services – Timely Access (Monitor network providers regularly to determine compliance: During and after-hours monitoring): In review of UnitedHealthcare's 2019 annual report of DialAmerica findings for appointment waiting times and after-hours access, KFMC identified concerns with methodologies for survey administration, data analysis and reporting. As such, KFMC was unable to be confident in the findings and interpretations of the report. The report detailed key observations regarding results reported by UnitedHealthcare. • In the 2021 follow-up review, provide KFMC the number of providers that were not reachable due to non-compliance versus those not reachable due to provider network data quality issues. **KFMC Update:** 2021 Review – UHC provided the document *Access Monitoring Provider Issues_UHC*, which meets the KFMC recommendation on the numbers of providers not reached due to noncompliance versus those not reached due to provider network data quality issues.	Not Yet Reviewed	New Recommendation	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
UnitedHealthcare (Continued)				
2020 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
23.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.206(c)(1)(v) Availability of services: Furnishing of services – Timely Access (Monitor network providers regularly to determine compliance: During and after-hours monitoring): In review of UnitedHealthcare's 2019 annual report of DialAmerica findings for appointment waiting times and after-hours access, KFMC identified concerns with methodologies for survey administration, data analysis and reporting. As such, KFMC was unable to be confident in the findings and interpretations of the report. The report detailed key observations regarding results reported by UnitedHealthcare. • Continue to work to improve provider network data quality. **KFMC Update:** 2021 Review – UHC provided a written progress update indicating incorporation of the KFMC recommendation to continue improving provider network data quality.	Not Yet Reviewed	New Recommendation	Fully Addressed
24.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.206(c)(1)(v) Availability of services: Furnishing of services – Timely Access (Monitor network providers regularly to determine compliance: During and after-hours monitoring): In review of UnitedHealthcare's 2019 annual report of DialAmerica findings for appointment waiting times and after-hours access, KFMC identified concerns with methodologies for survey administration, data analysis and reporting. As such, KFMC was unable to be confident in the findings and interpretations of the report. The report detailed key observations regarding results reported by UnitedHealthcare. • Develop and implement strategies to improve after-hours access. **KFMC Update:** 2021 Review – UHC provided the document *UHC_2021 Dial America Sample COWEN v*, evidencing a list of providers needing after-hours data quality education including some examples of follow up with providers, such as timestamps and discussion items. However, this item will continue to be rated In Progress until submission of the requested meeting minutes from the quarterly Medicaid Provider Meetings and/or submission of minutes from the planned upcoming semi-annual training that will include this as an agenda item.	Not Yet Reviewed	New Recommendation	In Progress

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
UnitedHealthcare (Continued)				
2020 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
25.	§438.207(a) Assurances of Adequate Capacity and Services: Basic Rule (requires compliance with §438.206(c)(1)(v) Availability of services: Furnishing of services – Timely Access (Monitor network providers regularly to determine compliance: During and after-hours monitoring): In review of UnitedHealthcare's 2019 annual report of DialAmerica findings for appointment waiting times and after-hours access, KFMC identified concerns with methodologies for survey administration, data analysis and reporting. As such, KFMC was unable to be confident in the findings and interpretations of the report. The report detailed key observations regarding results reported by UnitedHealthcare. • Recommend revision of analysis methods for the DialAmerica study in the following ways: ○ Analysis strictly on those providers able to be contacted and then surveyed should be consistently described and interpreted as arising from the subset able to be contacted. ○ Ensure that data shared between tables includes the same values or totals (e.g., Table 5 does not match data from Tables 1, 3A, or 3B). ○ Revisit calculations to ensure that totals and percentages arise from values within the table. Further quantify reasons providers are not able to be contacted and/or don't complete the survey, using DialAmerica Outcome Codes. **KFMC Update:** 2021 Review – UHC provided the *UHC Timeliness Report*, indicating that the *2021 Annual Timeliness Survey* was completed at the local plan level rather than using DialAmerica as was done in 2020 due to the health plan having to do extensive follow-up after DialAmerica's audit in 2020. The UHC *2021 Timeliness Report* demonstrates comprehensiveness and consistency regarding sampled providers, those who were contacted, matching data values between tables, accurate calculations and percentages, and quantified/qualified reasons providers were not able to be contacted and/or did not complete the survey.	Not Yet Reviewed	New Recommendation	Fully Addressed
26.	§438.207(b) Assurances of Adequate Capacity and Services (Nature of supporting documentation): *GeoAccess Reporting (Q3-Q4 2019, Q1-Q2 2020): Specialty Care Standards Report (Home Health Agencies)* – Counts may be inflated or calculated differently than the other MCOs. A discussion may be needed to understand how analysis of appointments against standards is being performed. • Review data analytics for *Specialty Care Standards Report* and Call Center measures. **KFMC Update:** 2021 Review – UHC was in the process of revising their policy and procedures to incorporate the KFMC recommendation.	Not Yet Reviewed	New Recommendation	In Progress

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
UnitedHealthcare (Continued)				
2020 Follow-Up Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
27.	§438.207(b) Assurances of Adequate Capacity and Services (Nature of supporting documentation): *Access and Availability Analysis Report: Q3-Q4 2019* reports contained excellent detail for network strength, opportunities, and interpretation of network with additional discussion on strategies for improvement. However, Q [Quarter]1-Q2 2020 reports focused only on Optum BH (Q1) and other vendors (Q2) with substantially less detail. • Discuss the following in the quarterly *Access and Availability Analysis Report: NEMT* [Non-Emergency Medical Transportation] potential count issues with Call Center measures; explanations for less than full coverage in the *Unmapped Specialties Report*. **KFMC Update:** 2021 Review – Within UHC's 2021 Q2 report, there are, at minimum, missing explanations or remedies called for within the Unmapped Specialties report (for HCBS) and NEMT Access report (for claims-based measures). There is no evidence that UHC noted any network issues in the *Access and Availability Analysis* reports.	Not Yet Reviewed	New Recommendation	Not Addressed
2020 Follow-Up Recommendations: Subpart F: Grievance and Appeal System				
28.	§438.406(b)(1): Handling of Grievances and Appeals (Special requirements): Grievance acknowledgement process and timeframes: The UnitedHealthcare Member Handbook, pages 72-73, covers the grievance process but did not explicitly state UnitedHealthcare will acknowledge receipt of the grievance. It mentions they will send the decision within 30 days, but there is no mention of acknowledgement. • In the UnitedHealthcare *Member Handbook* where the grievance process is explained, add language to inform members of the grievance acknowledgement process and timeframe. **KFMC Update:** 2021 Review – UHC provided an Addendum to the *Member Handbook*, stating, "If you file a grievance, we will send you a letter within 10 calendar days telling you that we got your grievance. We will review your grievance. We will send our decision within 30 calendar days of getting your grievance. We will send you a letter with the decision."	Not Yet Reviewed	New Recommendation	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
UnitedHealthcare (Continued)				
2020 Follow-Up Recommendations: Subpart F: Grievance and Appeal System (Continued)				
29.	§438.406(b)(2): Handling of Grievances and Appeals (Special requirements): Individuals making appeal decisions: UnitedHealthcare policy *POL2015-01 Provider Appeal and Grievance Policy* addresses that reviewers are not individuals involved in previous levels of review, etc., but does not address they are "health care professionals who have the appropriate clinical expertise for any Grievance involving clinical issues." • In all related documentation, explain how State contract Section 4.5.1 "Member Expedited Appeal System," subsection 4.5.1.1.3 through 4.5.1.1.5, regarding individuals who make appeal decisions, will be addressed. **KFMC Update:** 2021 Review – UHC provided an Addendum to the *Member Handbook*, stating, "The person who reviews your appeal will be a new person who has not previously reviewed it and will have the right level of clinical expertise." This met the requirements of State contract Section 4.5.1, Member Expedited Appeal System, subsection 4.5.1.1.3 through 4.5.1.1.5.	Not Yet Reviewed	New Recommendation	Fully Addressed
30.	§438.406(b)(4): Handling of Grievances and Appeals (Special requirements): Evidence to support member appeals: In the UnitedHealthcare *Member Handbook* where the appeal process is explained, more detail is needed regarding how members may present evidence to support their appeal. • In the UnitedHealthcare *Member Handbook* where the appeal process is explained, include language explaining members may present evidence to support their appeal. **KFMC Update:** 2021 Review – UHC provided an Addendum to the *Member Handbook*, stating, "You can present evidence to support your appeal in writing."	Not Yet Reviewed	New Recommendation	Fully Addressed
31.	§438.406(b)(5-6): Handling of Grievances and Appeals (Special requirements): Member's request of case file during appeal: The UnitedHealthcare *Member Handbook*, page 74, states, "If you would like to look at your case file before or during your appeal, call Member Services at 1-877-542-9238, TTY [TeleTypewriter] 711 to request a case file review. If your appeal is ruled in your favor, we will pay for those services." The underlined text makes it seem like there is a cost associated with the member requesting their case file. The federal and state requirements outline the member can request their case file free of charge. • In the UnitedHealthcare *Member Handbook*, page 74, clarify that members may request their case file free of charge. **KFMC Update:** 2021 Review – UHC provided an Addendum to the *Member Handbook*, stating, "You may request a copy of your case file free of charge. You can also ask for and be given reasonable access to all documents, records, and other information relevant to your Adverse Benefit Determination. This is all free of charge."	Not Yet Reviewed	New Recommendation	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
UnitedHealthcare (Continued)				
2020 Follow-Up Recommendations: Subpart F: Grievance and Appeal System (Continued)				
32.	§438.406(b)(5-6): Handling of Grievances and Appeals (Special requirements): Member's request of case file during appeal: The federal and state requirements detail that the members case file and supporting documents must also be provided "Sufficiently in advance of the resolution timeframe for appeals." • In member materials that include how to request their case file, make clear the need for members to make a timely request in order for UHC to send the case file sufficiently in advance of the resolution timeframe for appeals. **KFMC Update:** 2021 Review – UHC provided an Addendum to the *Member Handbook*, stating, "It will take time for UnitedHealthcare to send your case files once you have requested them. Please make your request as soon as possible. A timely request will help you have the time you need to review before the resolution of your appeal."	Not Yet Reviewed	New Recommendation	Fully Addressed
33.	§438.408(d)(2)(ii): Format of notice (Appeals): Informing members of delay in expedited appeals process: The State contract, Attachment D in Section 4.5.2 "Member Expedited Appeal Process," subsection 4.5.2.7.1 details, "Make reasonable efforts to provide oral notice of the delay." The Member Grievance, Appeal, and State Fair Hearing letter insert and Member Handbook do not explain the MCO will "make reasonable efforts to provide oral notice of the delay" upon extension of an expedited appeal. The documents state the member will get a letter or notice of the reason for extension. • In both the *Member Grievance, Appeal, and State Fair Hearing* letter insert and Member Handbook, add language to clarify the MCO will "make reasonable efforts to provide oral notice of the delay" if the expedited appeal timeframe is extended by the MCO. **KFMC Update:** 2021 Review – UHC provided an Addendum to the *Member Handbook*, stating, "UnitedHealthcare will make reasonable efforts to provide oral notice of the delay."	Not Yet Reviewed	New Recommendation	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
UnitedHealthcare (Continued)				
2020 Follow-Up Recommendations: Case Review for Subpart D: MCO, PIHP and PAHP Standards				
34.	Case Review Related to §438.208 Coordination and Continuity of Care: Case review that included review of HRAs. • Clearly identify in the documentation of HRAs conducted with pediatric members which questions, if any, were answered pertaining to the parent's or guardian's circumstances/condition rather than the child's condition. **KFMC Update:** 2021 Review – UHC provided document *UHC_HST Pediatric_08042021* with the written progress update that the call script was no longer modified, the HARC (Hospitality Assessment Reminder Center [the UHC outreach call team]) followed the assessment, and the HST 2.0 was in production, though there was a delay due to a defect not allowing automatic referrals.	Not Yet Reviewed	New Recommendation	In Progress
35.	Case Review Related to §438.208 Coordination and Continuity of Care: Case review that included review of HRAs. • Explore working with the State regarding the potential for adapting the HRA to allow for some questions to be answered for both the parent and member, as appropriate. **KFMC Update:** 2021 Review – UHC provided written progress update stating that assessments with referral were anticipated to go live as of March 1, 2022, outside the timeframe of the 2021 review period.	Not Yet Reviewed	New Recommendation	In Progress
36.	Case Review Related to §438.208 Coordination and Continuity of Care: Findings from case review conducted. • With future record requests, include member services' documentation of all outreach attempts for health screenings for members in the request; KFMC will ensure this is included as a request element. **KFMC Update:** 2021 Review – UHC provided the documents *UHC_KS_Welcome Script_12092021* and *VHARC_KS Campaign Results 7.19.21*. The first document demonstrated that UHC staff ask about/explain member annual wellness exam screenings during welcome calls, although the second document does not address the request around the questions 1-10 documented as yes/no-type questions.	Not Yet Reviewed	New Recommendation	Substantially Addressed
37.	Case Review Related to §438.208 Coordination and Continuity of Care: Case review that included review of health screens. • Identify and implement strategies to increase health screens of members in the behavioral health and physical health populations. **KFMC Update:** 2021 Review – UHC provided written progress update stating that assessments with referral were anticipated to go live as of March 1, 2022, outside the timeframe of the 2021 review period.	Not Yet Reviewed	New Recommendation	In Progress

Quality Assessment and Performance Improvement Review (QAPI)

The scoring scale for the degree to which previous recommendations were addressed is Fully Addressed, Substantially Addressed, Partially Addressed, Minimally Addressed, Not Addressed, and In Progress.

	Follow-Up to Previous Recommendations	*2019 Status*	*2020 Status*	*2021 Status*
Common Among the MCOs				
2019 Follow-Up Recommendations				
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. **KFMC Update:** • ABH provided the updated *ISC Program Description* and UHC provided documentation of their internal process. Both documents addressed the recommendation for the MCO. • SHP: 2020 Review: SHP indicated this update will be made to the 2021 QAPI documentation. 2021 Review: SHP submitted the draft *2022 QAPI Program Description* that included language that addressed the recommendation.	New Recommendation	ABH Fully Addressed	ABH Fully Addressed (in 2020)
			SHP In Progress	SHP Fully Addressed
			UHC Fully Addressed	UHC Fully Addressed (in 2020)
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 (All). • Include references to how SHP is expanding access to quality care using telehealth in QAPI documentation (Sunflower). **KFMC Update:** • ABH updated the *2020 QAPI Program Description* to include the Plan's strategy for telehealth and e-Visits. UHC provided documentation related to their work with the other MCOs on a collaboration with Central Kansas Foundation and the UHC Care Coordinators are conducting visits through televideo (Zoom) when the Member agrees to this option. This addressed the recommendation for both ABH and UHC. • SHP: 2020 Review: SHP indicated this update will be made to the 2021 QAPI documentation. 2021 Review: SHP provided the *2020 QAPI Program Description* and *2021 QAPI Program Description* that details information on telehealth and e-visits.	New Recommendation	ABH Fully Addressed	ABH Fully Addressed (in 2020)
			SHP In Progress	SHP Fully Addressed
			UHC Fully Addressed	UHC Fully Addressed (in 2020)

Quality Assessment and Performance Improvement Review (QAPI)

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Common Among the MCOs (Continued)				
2019 Follow-Up Recommendations (Continued)				
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 (All) • 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 (Sunflower) **KFMC Update:** • ABH updated the *2020 QAPI Program Description* to include the process for communicating the Peer Review process to ABH staff, members, and providers. SHP provided documentation of their internal process. This addressed the recommendation for both ABH and SHP. • UHC: 2020 Review: UHC indicated updates to the *Member Handbook* and Member web Portal will be made to address this recommendation. 2021 Review: Documentation UHC provided did not adequately explain how members, member advocates, QM, and other MCO staff are educated on the peer review process. In the next review (2022), KFMC requested UHC submit policy *UHC Quality of Care, Investigation, Improvement of Action and Disciplinary Actions Policy and Procedure*, that is identified to address the actions of the organization and management of the Peer Review Process.	New Recommendation	ABH Fully Addressed SHP Fully Addressed UHC In Progress	ABH Fully Addressed (in 2020) SHP Fully Addressed (in 2020) UHC In Progress

Quality Assessment and Performance Improvement Review (QAPI)

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Common Among the MCOs (Continued)				
2019 Follow-Up Recommendations (Continued)				
4.	5.9.11(D) *Provider Satisfaction Survey* sampling methodology: • Address achieving statistically valid samples for HCBS and BH provider populations (Aetna and UnitedHealthcare). • Include a reference for the sampling methodology for HCBS and BH provider populations in QAPI documentation (Sunflower). **KFMC Update:** • ABH: 2020 Review: ABH did not provide an update on this recommendation. 2021 Review: The 2021 *Provider Satisfaction Survey* contains 12 HCBS providers, but there is no indication that this is a statistically valid sample size. There is a plan to include a sample of HCBS providers in the 2022 *Provider Satisfaction Survey*. • SHP: 2020 Review: SHP indicated this update will be made to the 2021 QAPI documentation. 2021 Review: SHP provided the draft *2022 QAPI Program Description* that detailed sampling methodology for HCBS (as well as PCPs and Specialists) but does not account for the same for the BH provider population. • UHC: 2020 Review: UHC is developing a policy and procedure to address this recommendation. 2021 Review: The statement included in the methodology indicates BH and HCBS were not sampled with a methodology that would allow generalization to HCBS or BH providers, which would meet the definition of statistically significant sample. The State advised the MCOs that the 2022 *Provider Satisfaction Survey* must meet State Contract Section 5.9.11 requirements.	New Recommendation	ABH In Progress	ABH Not Addressed
			SHP In Progress	SHP In Progress
			UHC In Progress	UHC Not Addressed

Quality Assessment and Performance Improvement Review (QAPI)

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Common Among the MCOs (Continued)				
2019 Follow-Up Recommendations (Continued)				
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). **KFMC Update**: • ABH: 2020 Review: ABH provided policy *CRCMGT-002 Corporate Records Management Program,* which mentions the *Aetna Records Retention Schedule*. KFMC requested a copy of the retention schedule, as the aforementioned policy does not contain retention time periods. 2021 Review: ABH provided policy *8000.30 Review of Practitioner Office Medical Records* that includes the timeframe for record retention that addresses the recommendation. • SHP: 2020 Review: SHP indicated this update will be made to the 2021 QAPI documentation. 2021 Review: SHP updated the *Provider Manual* with the timeframe for record retention that addresses the recommendation. • UHC: 2020 Review: UHC indicated policy *Record and Retention* was submitted to address this recommendation; KFMC had not received the policy at the time of reporting. 2021 Review: UHC submitted policy *UHC KSCO 0011 Records Retention Policy* that includes language that meets the intent of the recommendation.	New Recommendation	ABH Substantially Addressed SHP In Progress UHC Substantially Addressed	ABH Fully Addressed SHP Fully Addressed UHC Fully Addressed
2020 Follow-Up Recommendations				
6.	Include assessment of all interventions outlined in the QAPI program description and/or QAPI work plan in the annual QAPI evaluation. **KFMC Update:** 2021 Review – ABH, SHP, and UHC: Assessment of all interventions outlined in the program description and/or QAPI work plan were not included in the annual evaluation.	Not Yet Reviewed	New Recommendation	ABH/SHP/UHC In Progress

Quality Assessment and Performance Improvement Review (QAPI)

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Common Among the MCOs (Continued)				
2020 Follow-Up Recommendations (Continued)				
7.	Address all opportunities for improvement and proposed interventions identified in the QAPI evaluation in the subsequent year's QAPI program description and/or QAPI work plan. **KFMC Update:** 2021 Review – ABH, SHP, and UHC: All opportunities for improvement and proposed interventions identified in the evaluations were not included in the subsequent year QAPI program description and/or QAPI work plan.	Not Yet Reviewed	New Recommendation	ABH/SHP/UHC In Progress
Aetna				
2019 Follow-Up Recommendations				
1.	QAPI General Recommendation: • Within each section of the program description, include references to all associated supplemental documents. **KFMC Update:** 2020 Review – ABH addressed this recommendation by updating the *2020 QAPI Program Description* to include footnotes to reference supplemental documents associated with the content in the QAPI program description.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
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. **KFMC Update:** • 2020 Review: ABH indicated they were in the process of updating the *ISC Program Description*, which includes this information. • 2021 Review: Aetna provided the document *ICM Program Description* that was updated to include this information.	New Recommendation	In Progress	Fully Addressed

Quality Assessment and Performance Improvement Review (QAPI)

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Aetna (Continued)				
2019 Follow-Up Recommendations (Continued)				
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. **KFMC Update:** 2020 Review – ABH updated the *2020 QAPI Work Plan* to include a section titled *Communications* that outlines all required communication activities, including "Notification of QI Information" which describes how ABHKS will disseminate QI information related to subcontractors/providers.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
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. **KFMC Update:** 2020 Review – ABH provided policy *8200.05 HEDIS* that describes the process for ensuring complete and accurate data reporting related to member and provider services.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
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. **KFMC Update:** 2020 Review – ABH provided policy *8200.07 Inter-Rater Reliability and Quality Assurance HEDIS Chart Abstraction* that describes the process for ensuring and maintaining a staff with the capacity and capability to abstract and provide accurate collection of data for performance reporting.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
2020 Follow-Up Recommendations				
6.	In the 2020 QAPI work plan, include interventions to address unmet performance measurement goals. **KFMC Update:** 2021 Review – Not all interventions to address unmet performance measure goals were included in the *2021 QAPI Work Plan*.	Not Yet Reviewed	New Recommendation	Substantially Addressed

Quality Assessment and Performance Improvement Review (QAPI)

Follow-Up to Previous Recommendations		2019 Status	2020 Status	2021 Status
Sunflower				
2019 Follow-Up 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 overturned. **KFMC Update:** 2020 Review – SHP provided documentation to address this recommendation.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
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. **KFMC Update**: • 2020 Review: SHP indicated this update will be made to the 2021 QAPI documentation. • 2021 Review: SHP provided the draft 2022 QAPI Program Description that includes information on NCI and NCI-AD results incorporated in the QAPI program.	New Recommendation	In Progress	Fully Addressed
2020 Follow-up Recommendations				
In 2020, there were no recommendations for Sunflower that were not common to all MCOs.				
UnitedHealthcare				
2019 Follow-Up Recommendations				
1.	QAPI General Recommendation: • Include references to all associated supplemental documents within each section of the Program Description. **KFMC Update:** • 2020 Review: UHC indicated this update will be made to the 2021 QAPI documentation. • 2021 Review: UHC provided policy *KSCO-0029 KS Audit Procedures* that details a process is in place.	New Recommendation	In Progress	In Progress

Quality Assessment and Performance Improvement Review (QAPI)

	Follow-Up to Previous Recommendations	2019 Status	2020 Status	2021 Status
UnitedHealthcare (Continued)				
2019 Follow-Up Recommendations (Continued)				
2.	5.9.3(A)(2): Staff training and development: • Expand on the descriptions of staff training and development. **KFMC Update:** 2020 Review – UHC provided the Care Coordination Staff Training Schedule that detailed the training process for new hires and existing staff.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
3.	5.9.3(B)(1): Promotion of member employment: • Describe how member employment is promoted. **KFMC Update**: 2020 Review – UHC provided documentation of their internal process that addressed this recommendation.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
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). **KFMC Update:** • 2020 Review: UHC indicated an update will be made to policy *KSAD-0004 Provider Data Accuracy* to include a reference to QAPI documentation. • 2021 Review: UHC provided policy *KSAD-0004 Provider Data Accuracy* and it is specific to provider demographic data and does not meet the intent of the recommendation. UHC advised they continue to work with Optum IT; therefore, this is still in progress.	New Recommendation	In Progress	In Progress
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. **KFMC Update:** • 2020 Review: UHC indicated an update will be made to policy to include requested language. • 2021 Review: UHC provided *UHC 5.4 Critical Incident Policy Addendum v2* that was revised to include language that addresses the recommendation.	New Recommendation	In Progress	Fully Addressed

Quality Assessment and Performance Improvement Review (QAPI)

	Follow-Up to Previous Recommendations	2019 Status	2020 Status	2021 Status
UnitedHealthcare (Continued)				
2019 Follow-Up Recommendations (Continued)				
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. **KFMC Update:** 2020 Review – UHC provided documentation of their internal process that addressed this recommendation.	New Recommendation	Fully Addressed	Fully Addressed (in 2020)
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. **KFMC Update:** • 2020 Review: UHC is developing a policy and procedure to address this recommendation. • 2021 Review: UHC provided documentation that adequately addressed the timeline; however, it did not include barrier analysis, nor intervention(s) to address results as recommended.	New Recommendation	In Progress	In Progress
2020 Follow-Up Recommendations				
8.	For all areas evaluated as part of the QAPI program, report findings in the annual QAPI evaluation. For example, include high level results from the Continuity and Coordination of care report in the annual QAPI evaluation. **KFMC Update:** 2021 Review – Not all areas evaluated as part of the QAPI program were reported in the annual QAPI evaluation.	Not Yet Reviewed	New Recommendation	In Progress

Provider Network Adequacy

The scoring scale for the degree to which previous recommendations were addressed is Fully Addressed, Partially Addressed, Not Addressed, In Progress, and Not Assessed.

	Follow-Up to Previous Recommendations (2020)	Status
Common Among the MCOs		
Recommendations for Quality Improvement		
1.	Review after-hours access study data provided by KFMC, through the State, that highlights specific provider issues, follow-up with the providers and report to the State on any internal policy changes and actions taken with providers. **KFMC Update:** For Quarter 2 of 2021, each MCO reported to the State their follow-up with individual providers, including actions taken to resolve outstanding issues noted in *2020 Primary Care Provider After-Hours Access Monitoring Report*.	ABH-Fully Addressed SHP-Fully Addressed UHC-Fully Addressed
2.	Review all provider network data to be reported to the State for accuracy and completeness, especially for fields such as unique identifiers (e.g., National Program Identifier (NPI), KMAP ID), address, panel capacity and count, termination dates, and other critical data fields, as specified in network reporting standards. **KFMC Update:** • ABH noted that 1) they review their provider network data quarterly for accuracy and completeness; 2) their provider network data matches the existing State provider file since the implementation of the State PRN file as the basis of provider network data since late 2019; and 3) they only make changes to provider demographic data after having received the data from the external contractor Gainwell, through the State's PRN file, and these are changes other than key fields extracted (such as provider name, address, NPI, federal ID, affiliation, and specialty) or validation errors (such as with federal ID number, address, ZIP code, or NPI). • SHP noted that they 1) analyze their provider network data for inconsistencies and scrub that data before reporting it to the State; and 2) corrected their provider count reports and GEOMaps to ensure they matched and checks for reliability on provider counts and the GEOMaps to ensure accurate matching occurs before submitting their reports to the State. • UHC noted that their provider directory generation process includes more than 10 data checks by multiple staff and departments to ensure accuracy.	ABH-Fully Addressed SHP-Fully Addressed UHC-Fully Addressed

Provider Network Adequacy

Follow-Up to Previous Recommendations (2020)		Status
Common Among the MCOs (Continued)		
Recommendations for Quality Improvement (Continued)		
3.	Ensure that the MCO's provider directory is regularly compared with its provider network databases, at a minimum with the quarterly network adequacy reporting, as specified within State network adequacy reporting standards. **KFMC Update:** • ABH noted that they update their Provider Directory nightly with additions, changes, or deletions when any are received from the State PRN file provided by the external contractor Gainwell. • SHP noted that they use the quarterly feedback report to improve completeness and accuracy of the provider network data. • UHC's progress update noted their provider data systems are amalgamated to ensure that provider information appearing in the provider directory is identical whether in online or printed format. However, UHC did not specify the frequency of comparison between the provider directory and their provider network databases.	ABH-Fully Addressed SHP-Fully Addressed UHC-Partially Addressed
4.	Maintain standardization of data fields that may be shared between databases, such as name, address, and provider specialty fields. Consider also including unique identifier fields (e.g., NPI, KMAP ID, MCO-created unique identifier) within all different provider databases. **KFMC Update:** • ABH noted that 1) they only make changes to provider demographic data after having received the data from the external contractor Gainwell, through the State's PRN file; and 2) they therefore do not need to do crosswalks or establish unique identifier fields across their databases, including the Provider Directory. • SHP noted that they utilize practitioners' NPIs when reporting practitioner information and maintain the standardization of data fields that are shared by their databases and the KMAP data. • UHC did not provide a progress update specifying whether they maintain standardization of data fields that may be shared between databases.	ABH-Fully Addressed SHP-Fully Addressed UHC-Not Addressed
5.	Establish internal processes to review provider information available through multiple data streams in order to provide the most up-to-date provider information to the members (e.g., correct phone, currently practicing providers). Then, standardize data fields shared between databases (e.g., provider name and address fields) so providers may be uniquely distinguished. **KFMC Update:** • ABH noted that 1) they possess a desktop procedure that establishes its internal process for reviewing the accuracy of data in the Provider Directory; and 2) the accuracy rate for March 2022 was 99.43%. • SHP noted that their providers submit their data through a roster, provider credentialing documents, and the KMAP Online Provider Enrollment System, after which SHP staff perform quality checks following a four-step system • UHC noted that they have established an internal process to validate provider data and ensure that data flows from one source system accurately into any reports.	ABH-Fully Addressed SHP-Fully Addressed UHC-Fully Addressed

Provider Network Adequacy

Follow-Up to Previous Recommendations (2020)		Status
Common Among the MCOs (Continued)		
Policy Recommendations		
6.	The State should consider targeting one or more objectives in the QMS toward 1) enhancement of MCO provider data quality and 2) improvement of after-hours primary care availability. This may include additional contractual or policy-related activities and collaboration with Kansas providers to support improvement in quality, timeliness, and access. **KFMC Update:** KDHE did not include an objective related to "enhancement of MCO provider data quality" in the current QMS, as this was an old objective in the previous QMS. KDHE did include "improvement of after-hours primary care availability" in objective 4.6 of the QMS, which states "Develop and implement direct testing or secret shopping activities for provider network validation."	Fully Addressed
7.	Kansas primary care practitioners should review their after-hours contact systems against best practices to ensure availability for KanCare members. This should include both assessing the quality of answering machine recordings and updating communication protocols for automated roll-overs to secondary lines (e.g., hospital operators). Additionally, hospital operators, answering services, and other respondents that receive calls rolled over from primary care practices should be knowledgeable of the providers within those provider practices and be able to respond to member questions. **KFMC Update**: The following are comparisons of the results for the 2020 and 2021 Primary Care Provider After-Hours Access Monitoring studies. Results for "Calls in which the caller reached a provider's answering machine recording that offered no instructions or was unclear" in the 2020 study included 155 records representing 11.6% of eligible records, while in the 2021 study, this included 105 records representing 8.7% of eligible records. Results for "Calls in which a person or recording indicated that a provider could not be made available after hours" in the 2020 study included 103 records representing 7.7% of eligible records, while in the 2021 study, this subcategory included 90 records representing 7.4% of eligible records. The "provider not practicing at that location" call results in the 2020 study included 92 records representing 6.9% of eligible records (7 of which were rated Partially met, 61 rated Not Met, and 24 were found to be inconclusive), while in the 2021 study, this included 36 records representing 3.0% of eligible records (all rated Not Met). The "Calls regarded as 'no answer'" results in the 2020 study included 106 records representing 7.9% of eligible records (all found to be inconclusive), while in the 2021 study, this subcategory included 67 records representing 5.5% of eligible records (all rated Not Met).	Partially Addressed

Appendix G

KanCare Program Annual External Quality Review Technical Report

2021 – 2022 Reporting Cycle

List of Abbreviations and Acronyms

List of Abbreviations and Acronyms	
Abbreviation/Acronym	**Description**
AD	Advanced Directives
ADHD	Attention Deficit Hyperactivity Disorder
Aetna or ABH	Aetna Better Health of Kansas
AHRQ	Agency for Healthcare Research and Quality
Amerigroup	Amerigroup Kansas, Inc. (Amerigroup)
AMM	Antidepressant Medication Management
BH	Behavioral Health
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCC	Children with Chronic Conditions
CCS	Cervical Cancer Screening (HEDIS measure)
CHIP	Children's Health Insurance Program (Title XXI)
CHIPRA	Children's Health Insurance Program Reauthorization Act
CM	Case Management
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CPESN	Community Pharmacy Enhanced Service Network
DHCF	Division of Health Care Finance
DOO	Disclosure of Ownership
DTaP	Diptheria, Tetanus, and Acellular Pertussis Vaccine
ECHO	Experience of Care and Health Outcomes
ED	Emergency Department
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FVA	Flu Vaccination for Adults
GC	General Child CAHPS survey population
GIC	Gaps in Care
HbA1c	Diabetes Glycated Hemoglobin
HCBS	Home and Community Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HPV	Human Papillomavirus
HST	Health Screening Tool
ICM	Integrated Care Management
ISCA	Information Systems Capabilities Assessment
IVR	Interactive Voice Response
KDADS	Kansas Department for Aging and Disability Services
KDHE	Kansas Department of Health and Environment
KMAP	Kansas Medical Assistance Program
KSWebIZ	Kansas Immunization Registry
KFMC	KFMC Health Improvement Partners

List of Abbreviations and Acronyms	
Abbreviation/Acronym	**Description**
LDL-C	Low-density Lipoprotein Cholesterol
LTSS	Long-term Services and Supports
MCO	Managed Care Organization
MetaStar	MetaStar, Inc.
MH	Mental Health
MMIS	Medicaid Management Information Systems
MMR	Measles-Mumps-Rubella
MY	Measurement Year
NA	Not Available
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergency Medical Transportation
NPI	National Program Identifier
OIG	Office of the Inspector General
PAR	PIP Action Report
PCP	Primary Care Physician/Provider
PCR	Plan All-Cause Readmission
PDSA	Plan-Do-Study-Act
PIP	Performance Improvement Project
PMTO	Parent Management Training, Oregon Model
PMV	Performance Measure Validation
POS	Place of Service
pp	Percentage Points
pp/yr	Percentage Points Per Year
QAPI	Quality Assessment and Performance Improvement
QC	Quality Compass (NCQA)
QI	Quality Improvement
QMS	Quality Management Strategy
SED	Severe Emotional Disturbance
SMD	Diabetes Monitoring of Members with Diabetes and Schizophrenia
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (HEDIS measure)
SUD	Substance Use Disorder
Sunflower or SHP	Sunflower Health Plan
Tdap	Tetanus, Diptheria toxoids, and Pertussis Vaccine
TXIX	Title XIX Grants to States for medical assistance programs (Medicaid)
TXXI	Title XXI State Child Health Insurance Programs (CHIP)
UnitedHealthcare, UHC, UHCCP	UnitedHealthcare Community Plan of Kansas
UM	Utilization Management
URL	Uniform Resource Locator
WPC	Whole Person Care Program