EVALUATION OF THE KANCARE QUALITY MANAGEMENT STRATEGY

JULY 6, 2018

CONTENTS

INTRODUCTION AND PURPOSE

The State of Kansas (State) maintains that, when developed and implemented deliberately, the Quality Management Strategy (QMS) can advance the State's focus on performance improvement (PI) activities by: building a culture that is focused on outcomes, efficiently deploying resources, setting realistic and attainable goals, and providing a pathway of progressive discipline to hold managed care organizations (MCOs) responsible. Because the KanCare program offers a comprehensive benefit package which includes physical health (PH) and behavioral health (BH) services, as well as long-term services and supports (LTSS), each component plays a critical part in the development of the State's QMS.

The Kansas Department of Health & Environment (KDHE), the single State Medicaid Agency, in partnership with the Kansas Department for Aging and Disability Services (KDADS), is revising its QMS in accordance with the Code of Federal Regulations (CFR) at 42 CFR 438.340 and submitted to Centers for Medicare & Medicaid Services (CMS) in July 2018. The QMS will be updated as needed based on performance, feedback from stakeholders and/or changes in policy resulting from legislative, State or federal authorities. In order to demonstrate compliance with CMS's quality strategy evaluation requirements set forth in 42 CFR 438.340(c)(i), the State has evaluated its previous QMS to measure the effectiveness and usefulness to help shape health care delivery and policy for the KanCare program going forward.

The State believes its QMS acts as a roadmap outlining the performance measures and PI strategies to maximize health outcomes and the quality of life for all members to achieve the highest level of dignity, independence and choice through the delivery of holistic person-centered and coordinated care and promote employment and independent living supports.

Kansas routinely monitors and evaluates its KanCare MCOs through several mechanisms, which include, but are not limited to:

- The annual External Quality Review (EQR) annual technical report
- The annual KanCare 1115 waiver evaluation
- Ongoing MCO monitoring, achieved through day-to-day monitoring and regular meetings with the MCOs

KDHE and KDADS work together to develop State Operating Agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The State agencies work in partnership with participants, advocacy organizations, provider groups and other interested stakeholders to monitor the State's quality strategy and performance standards, and discuss priorities for remediation and improvement. The State's quality improvement strategy includes

protocols to review cross-service system data to identify trends and opportunities for improvement related to all State waivers, policy and procedure development, and systems change initiatives. KDHE and KDADS maintain the authority and responsibility for the updating and annual evaluation of the QMS.

Data gathered by KDADS regional staff during the quality survey process is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion, identified areas of improvement are compiled into reports and shared both internally and externally, including with KDHE. Staff from all three MCOs engages with State staff to ensure a strong understanding of Kansas' waiver programs and the quality measures associated with each. The MCOs have begun to collect data regarding the waiver performance measures and reporting options. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a State interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the State Medicaid Agency and the State Operating Agency.

State staff and/or KanCare MCO staff request, approve and assure implementation of provider corrective action planning and/or technical assistance to address non-compliance with waiver and performance standards, as detected through onsite monitoring, survey results and other performance monitoring. These processes are monitored by both program managers and other relevant State and MCO staff, depending upon the type of issue involved, and results are tracked consistent with the statewide quality improvement strategy and the operating protocols of the Interagency Collaboration Team.

Monitoring and survey results are compiled, trended, reviewed and disseminated consistent with protocols identified in the statewide quality improvement strategy. Each provider receives annual data trending, which identifies provider specific performance levels related to statewide performance standards and statewide averages. Corrective action plan requests, technical assistance and/or follow-up to remediate negative trending are included in annual provider reports where negative trending is evidenced.

In addition, both KDHE and KDADS have defined quality units within each of their respective organizations responsible for the day-to-day oversight and monitoring activities. KDADS's 1915(c) waiver quality monitoring is defined within the parameters of the seven (7) individual home and community based 1915(c) waivers. Provider qualifications and waiver assurance metrics have been harmonized, to the extent possible, across each waiver to allow for consistency in review and evaluation of the data. MCOs are required to submit reports through the State's Report Administration Database, which are then reviewed and analyzed by State staff.

The goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence, in addition to traditional Medicaid benefits. The State seeks a five-year Section 1115 demonstration renewal from CMS to further improve health outcomes, coordinate care and social services, address social determinants of health, facilitate achievement of member independence and advance fiscal responsibility. Specific to BH and LTSS services, the goal of KanCare 2.0 will be to ensure the right services are provided to participants at the right time and right place. The fundamental goal of both KanCare 2.0 and the State's QMS is to ensure that each individual receives the right services, in the right place and at the right time. The goals for KanCare 2.0 serve as the foundation to the revised QMS and our commitment for ensuring Kansans receive the quality health care they rightly deserve.

EXTERNAL QUALITY REVIEW (EQR)

CMS defines EQR as the analysis and evaluation by an independent, external quality review organization (EQRO) of aggregated information on the quality of, access to and timeliness of the health care services that the State's MCOs furnish to Medicaid recipients (KanCare enrollees). While KDHE and KDADS perform ongoing monitoring and oversight activities that act as an early alert system, EQR activities retrospectively evaluate MCO activities. EQR activities include validation of performance measures, validation of PI projects (PIPs), information systems capabilities assessment (ISCA) and a Balanced Budget Act (BBA) audit that assesses each contracted MCOs' compliance with quality, access and timeliness standards. Those quality, access and timeliness standards are part of the federal Medicaid managed care regulatory provisions which are grouped into three (3) categories:

- Subpart C — Enrollee Rights and Protections
- Subpart D — Quality Assessment (QA) and PI
- Subpart F — Grievance System

At the conclusion of each annual EQR cycle the EQRO produces an annual technical report that provides details on the methodology, data collection process, tools used, information reviewed, compliance findings and recommendations for improvement; the strengths and opportunities for improvement for each MCO are identified. This information allows the State to take action to improve each MCOs performance under the KanCare contract. The ISCA and the BBA audits occur on a three-year cycle. For Kansas, this means that 2015 was the last year of a three-year cycle, and the focus was corrective actions placed by the MCOs as a result of previous audits; 2016 acted as a full compliance review, addressing all the elements and requirements under the federal regulations for quality, access and timeliness, as noted above; and 2017 is the first follow up year, or second year of three-year cycle. For the purposes of the evaluation of the quality strategy, primary attention is given to the full review conducted in 2016, as that serves as the baseline for all compliance.

2016 Recommendations for Improving the Quality of Healthcare Services

- Overall recommendation for all KanCare MCOs:
  - *Availability of Services: Delivery Network*, improve the accuracy and completeness of the provider data that feeds the network adequacy reports and provider directories
- Specific recommendations by MCO:
  - **Amerigroup —** Cleared three (3) of the fifteen (15) areas identified for improvement from the prior year review; one (1) review area was determined as no longer applicable, bringing the total to three (3) out of fourteen (14) areas:
    - *Coordination and Continuity of Care* — Take advantage of opportunities to help train/coach members to follow up with their provider

    - › *Resolution and Notification: Grievances and Appeals* — Add appropriate regulatory language to the Member Handbook
  - **Sunflower —** Cleared six (6) of the twenty-four (24) areas identified for improvement from the prior year review:
    - › *Coordination and Continuity of Care* — Stronger PH and BH integration, improve primary care provider engagement, encourage coordination of care across providers
    - › *Availability of Services: Delivery Network* — Revisions to the Provider Manual to address language pertaining to women's preventive health services and whether referrals are required for in- or out-of-network providers
  - **United HealthCare —** Cleared three (3) of the ten (10) areas identified for improvement from the prior year audit:
    - › *Updates to Internal Policy* — Add specific regulatory language to internal policy to ensure consistency with specific requirements

During the course of the year, EQRO and State staff met quarterly with the MCOs, and technical assistance was provided to address areas of ongoing concern. At the conclusion of the 2017 EQR cycle, the three contracted MCOs achieved at or above 76% compliance on all federal regulatory requirements. Each MCO achieved 100% compliance on the requirements of Subpart D — Measurement and Improvement Standards. The Subpart D — QA and PI: Structure and Operation Standards demonstrated the lowest compliance score, with each MCO achieving at or below 50%.

As a result of the 2017 review activities, the EQR identified the following three strengths across all three MCOs:

- Collaboration on training for providers — This is a provider-centric model to streamline the amount of time providers spent reviewing information and to ensure consistency in information received
- Demonstrated commitment to caring — Based on shared examples, success stories and interview responses during MCO site visits
- Each MCO's efforts to clear areas that were found to be less than compliant in prior review periods

2017 Recommendations for Improving the Quality of Healthcare Services

- Overall Recommendations for all three MCOs:
  - *Availability of Services: Delivery Network* — Improve the accuracy and completeness of the provider data that feeds the network adequacy reports and provider directories
  - *Coordination and Continuity of Care: BH and PH* — When case specific issues are found, the MCOs should take steps to review internal processes and procedures and make the necessary adjustments to facilitate improved outcomes

Analysis and Recommendations for EQR Activities

The EQRO plays an important role in the State's quality strategy by providing a detailed analysis of the strengths, weaknesses and opportunities of each contracted MCO as they relate to the quality, access and timeliness of service delivery. Ongoing technical assistance provided to the MCOs by the EQRO has helped to close compliance gaps, disseminate best practices and build synergies not just within the MCO, but across the MCOs, as evidenced by their collaboration in coordinating provider training and education. Because of the depth and scope of EQR services, there may be opportunities for the State to leverage the available enhanced match funding by the federal government for EQR activities. This could serve to build synergies between KDHE and KDADS quality improvement activities, as well as harmonize efforts between the State and its contracted MCOs. The State is exploring the development of a Quality Improvement Initiatives Task Force (QII-TF) that would include representation from KDHE, KDADS, the EQRO and the contracted MCOs to help drive these efforts. The QII-TF would provide support for the development and implementation of the KanCare QMS, identification and implementation of quality improvement strategies, and build synergies across the KanCare program. Additionally, there are other EQR activities, such as focused studies and PIPs that can be conducted by the EQRO, which can serve to extend the State's capacity to conduct continuous quality improvement activities. Because these services are eligible for enhanced funding, they are viewed as both economical and effective.

PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

PIPs rely on data analytic systems that focus on integration of data sources, can quickly and easily unlock data, enable effective sharing of data and result in significant and sustained improvement over time. PIPs require input from interdisciplinary teams to analyze the data and discover patterns that lead to insights, including identification of barriers and selection of meaningful interventions. The most successful PIPs are agile, interactive and iterative processes that produce meaningful and sustained results.

CMS requires each State to conduct PIPs, and the KanCare program requires each MCO to participate in at least two PIP activities: one that is self-selected by the MCO and the other a mandated topic by the State. Annually, CMS requires state EQROs to validate PIPs according to a pre-defined PIP validation protocol they publish (https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf). This protocol includes the assessment of the study methodology, verifies the study findings, and evaluates the overall validity and reliability of the study results. PIPs can address topics related to clinical care, as well as address service-related aspects of care delivery.

State-mandated PIP

The State-mandated PIP topic was a collaborative effort between the State and it's contracted MCOs. The topic selected was focused on improving the rate of vaccinations for the Human Papilloma Virus (HPV), as Kansas appeared to lag behind other states in the rate of adolescent HPV immunizations. The final study question was, "Do multifaceted education and outreach interventions, targeting both providers and parents/guardians, improve HPV immunization rate for adolescent female Kansas Medicaid members?" Technical specifications for the Immunization for Adolescents (IMA) Healthcare Effectiveness Data and Information Set (HEDIS) measure were used to define the measurement of the study question. One limitation of this measure for the baseline and first remeasurement timeframes is that it only captures data for female members. The HEDIS 2017 technical specifications update expanded the IMA measure to include HPV vaccination for both males and females. Both administrative and hybrid rates were provided, although hybrid rates, based on a statistically valid sample of the overall population, are being used for the PIP evaluation due to the increased accuracy of the hybrid data, which includes information collected through medical record review. The table below is excerpted from the KanCare Program Annual External Quality Review Technical Report, 2017–2018 Reporting Cycle.

Table 3.4. Female HPV Vaccine Rates by MCO, 2014–2016							
MCO	Measure	2014	2015	2016	2014 to 2015	2015 to 2016	2014 to 2016
AGP	Admin	10.2%	11.9%	15.7% ↑	1.7%	3.8%	5.5%
	Hybrid	14.6%	13.7%	15.2%	-0.9%	1.5%	0.6%
SSHP	Admin	16.6%	17.0%	22.2% ↑	0.4%	5.2%	5.6%
	Hybrid	21.7%	18.8%	21.7%	-2.9%	2.9%	0.0%
UHC	Admin	15.9%	18.0%	19.7% ^	2.1%	1.7%	3.8%
	Hybrid	17.0%	22.6%	19.4%	5.6%	-3.2%	2.4%
Total	Admin	14.3%	15.7% †	19.3% ↑	1.4%	3.6%	5.0%
	Hybrid	17.7%	18.3%	18.8%	0.6%	0.5%	1.1%

↑ Indicates percentage was statistically significantly higher in 2016 than in 2015 and in 2016 compared to 2014.

^ Indicates percentage was statistically significantly higher in 2016 than in 2014.

† Indicates percentage was statistically significantly higher in 2015 than in 2014.

One of the strengths of the MCOs during this conduct of this PIP was their ability to modify their interventions and analysis to be consistent with changes in the HEDIS technical specifications for the HPV vaccine measurements. Their modifications are consistent with the Centers for Disease Control and Prevention guidelines for HPV vaccination. The majority of the identified opportunities for improvement addressed the process by which the MCOs analyzed the results, performed barrier analysis, and identified and selected interventions for improvement.

MCO-specific PIPs

In addition to the State-required collaborative PIP, each MCO selected its own study topic. An overview of the results is presented below.

Amerigroup

Amerigroup's PIP topic was focused on the study question, “Does the implementation of targeted interventions improve well-child visit rates in the third, fourth, fifth, and sixth years of life?” The PIP uses the annual HEDIS measure technical specifications for “Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life” (W34) as its primary measure of success. The MCO’s PIP stratified results by Title XIX and Title XXI recipients, and presented an aggregate report of rates. In 2016, Amerigroup took a more in-depth review of the results, further stratifying and comparing results by age, program (Title XIX and Title XXI), and whether the child was enrolled in the Health Rewards Incentive Program. Amerigroup also studied whether rates improved after successfully contacting parents about overdue well-child visits. The following table is excerpted from the KanCare Program

Annual External Quality Review Technical Report, 2017–2018 Reporting Cycle. This table demonstrates that Amerigroup has not been able to achieve pre-KanCare rates. Additional actions by Amerigroup are focused on expanding the Healthy Rewards Incentive Program, streamlining the enrollment process into the program, expanding telephonic outreach efforts to improve the rate of contact, and working with providers on gaps-in-care information.

Table 3.1. Annual Well-Child Visit Rates

Year	Title XIX (Medicaid)	Title XXI (CHIP)	Overall
2016	**62.90%**	**65.84%**	**63.23%**
2015	62.60%	62.76%	62.62%
2014	63.92%	63.29%	63.84%
2013	65.97%	63.24%	65.59%
2012*	68.17%	61.58%	67.20%

*Baseline (Pre-KanCare)

Sunflower

Sunflower's PIP topic was focused on the study question, “Will provision of care coordination to members diagnosed as needing alcohol and other drug (AOD) treatment result in a statistically significant improvement in member initiation and engagement in AOD services?” as its primary measure of success. Sunflower’s PIP topic is a modified HEDIS measure — Initiation and Engagement of AOD Dependence Treatment (IET). The HEDIS criteria were modified for the PIP to include children age 12, expand the time frame through the calendar year, and remove the new episode criterion. The major focus of the Sunflower PIP is to provide care coordination to eligible members and to assess whether rates of initiation and engagement improve through provision of care coordination, compared to members who are not receiving care coordination.

The primary PIP indicators are the rates of initiation and engagement for members receiving care coordination, compared to members who are not receiving care coordination. In addition to assessing overall rates of initiation and engagement in treatment, Sunflower’s methodology includes reporting and analyzing rates for the following: Title XIX and Title XXI, age group (ages 12–17, age 18 and older), members in need of urgent services (pregnant/using and intravenous drug users within the previous six months), MyStrength tool (an interactive web and mobile application), and whether the member was already in care coordination for other PH or BH needs or was enrolled in care coordination based on IET PIP eligibility.

Service data used to calculate the study outcomes are claims-based and reported in the Sunflower Enterprise Data Warehouse, the central repository for all Sunflower claims data. Sunflower developed custom HEDIS-like measurements to support measurement of the PIP indicators.

Of the 3,151 members eligible for the PIP in 2016, 1,231 members (39.1%) completed initiation and 426 members (13.5%) completed engagement. For members who participated in care coordination, Sunflower reported significantly higher initiation and engagement rates in 2016 in total, in all strata for initiation and in many of the strata for engagement. The following table is excerpted from the KanCare Program Annual External Quality Review Technical Report, 2017–2018 Reporting Cycle.

Table 3.3. Initiation and Engagement Rates by Care Coordination, 2014–2016

	Initiation			Engagement		
	Ages 12 to 17					
	2014	2015	2016	2014	2015	2016
Care Coordination	62.3%	54.6%	54.5%	40.6%	35.4%	21.6%
Not in Care Coordination	41.2%	26.0%	42.1%	28.0%	12.4%	24.0%
	Age 18 and Older					
	2014	2015	2016	2014	2015	2016
Care Coordination	50.4%	49.2%	48.9%	19.6%	19.6%	18.7%
Not in Care Coordination	35.3%	31.2%	34.9%	9.7%	4.2%	10.0%
	Total					
	2014	2015	2016	2014	2015	2016
Care Coordination	52.3%	50.1%	49.6%	23.0%	22.4%	19.0%
Not in Care Coordination	36.1%	30.7%	35.8%	12.1%	5.0%	11.8%

As a proof of concept, the Sunflower PIP was successful in demonstrating that members participating in care coordination activities had generally better rates of initiation and engagement of treatment. However, there was marked decrease in the initiation and engagement of 12–17 year old members, which could not be adequately explained and bears further analysis. There is also an opportunity to improve identification of pregnant members for inclusion, as well as the potential to expand the use of the MyStrength program to include individuals who are in need of AOD services, but who declined care coordination services.

United Healthcare

United's PIP topic was focused on the study question, “Do the MCO’s targeted interventions to members and providers improve the percentage of members with schizophrenia or bipolar disorder

at risk of having undiagnosed diabetes obtaining a glucose or HbA1c screening test?" was primarily selected to increase outcomes measured by the HEDIS indicator Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD). The SSD rate for calendar year 2016 (baseline) was 76%, which was below the Quality Compass (QC) 25th percentile. United Healthcare's PIP topic is a modified HEDIS measure — IET. The HEDIS criteria were modified for the PIP to include children age 12, expand the time frame through the calendar year, and remove the new episode criterion. This PIP activity included the 2016 baseline year and the 2017 re-measurement year.

United Healthcare implemented four member-targeted and four provider-targeted interventions to increase the percentage of members in the study population who received a glucose test or HbA1c test during the measurement year. The general conclusions of this new PIP activity indicate a promising outcome, including improving the overall baseline rate from 73.0% in 2016 to 93.9% in 2017, which indicates confidence in overall validity and reliability of the PIP's findings.

Analysis and Recommendations for PIP Activities

To help improve the uptake of continuous quality improvement strategies, the State and its EQRO meet quarterly with the MCOs. These quarterly business meetings focus primarily on PIP activities. Progress toward outcomes is discussed and best practices are presented in a collaborative fashion. To facilitate ongoing monitoring, the State developed and implemented the KanCare Key Management Activities Report (KKMAR). The KKMAR is a template used by the MCOs to submit quarterly activities and progress updates related to PIP barrier analysis and implementation of interventions. Additionally, the EQRO developed a more streamlined PIP documentation tool that allows for PIP activity to be captured and reported in a consistent fashion across the MCOs. The PIP template is designed to require the use of objective quality indicators, support in-depth barrier analysis, and support ongoing evaluation of the effectiveness of interventions in driving systemic and sustainable improvements. In early 2015, the State and its EQRO introduced rapid-cycle process improvement methodologies incorporating lead and lag measures as a mechanism for the MCOs to quickly identify activities that were successful in achieving results, versus those that did not produce results. The intent is to decrease non-value add "busy" work and emphasize more meaningful and impactful interventions.

Under the new KanCare 2019 program, there is an even greater emphasis placed on the adoption of rapid-cycle processes and continuous quality improvement principles. As a result, the State is requiring that each MCO conduct a minimum of five PIPs. The five PIPs include at least three clinical and two non-clinical topics, of which one of the non-clinical PIPs must be targeted at an area of long-term care; all PIP topics must be approved by the State. A sixth PIP, focused on the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Screening and Community outreach plans, may be required when overall CMS-416 (Annual EPSDT Participation Report) rates drop below 85%.

PERFORMANCE MEASURES

The State has identified quality of care, access to care and timeliness of care measures for the KanCare program using a mix of quantitative and qualitative measures. The State prefers to use nationally recognized measure sets whenever possible, including the National Committee for Quality Assurance's (NCQA) HEDIS, and the Medicaid Adult and Child Core Measurement sets. The KanCare QMS has historically included many performance measures that are attributed to either a contractual compliance focus or producing true outcome measures.

In 2015, 2016 and 2017, Kansas conducted a validation of their pay-for-performance measures for the three MCOs. The State's EQRO completed evaluations of these measures in accordance with CMS protocol for performance measure validation, found at (https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf), to ensure accuracy of the reported performance measure, determine the extent to which the health plans calculated the measures based on the specifications established by the State, and to ensure annual rates are produced with valid methods and source data.[1]

In the 2015–2016 reporting cycle, Kansas selected both administrative and hybrid HEDIS measures for inclusion in their pay-for-performance measures for the MCOs. The measures included:

- Annual Dental Visit
- Annual Monitoring for Patients on Persistent Medications
- Follow-up After Hospitalization for Mental Illness
- Childhood Immunization Status
- Immunization for Adolescents
- Human Papillomavirus Vaccine for Female Adolescents
- Prenatal and Postpartum Care
- Ambulatory Care

For the reported HEDIS measures, results above the 50th percentile were achieved by all MCOs regarding quality, timeliness and access to health care services. Results included:

- Annual Dental Visits — Above 75.00th percentile
- Annual Monitoring for Patients on Persistent Medications, Follow-up after Hospitalization for Mental Illness, and Childhood Immunization Status: Hepatitis A — Above 66.66th percentile

[1] KanCare Program Annual EQR Technical Report, 2015-2016 and 2016-2017. Kansas Foundation for Medical Care, Inc. April 27, 2017 and April 26, 2018.

The results from 2015–2016 also identified areas of improvement regarding quality, timeliness and access to health care services for all MCOs. Areas of improvement included:

- Comprehensive Diabetes Care: HbA1c Testing, Childhood Immunization Status: MMR and VZV, and Ambulatory Care: Emergency Department (ED) Visits — Below 50.00th percentile
- Immunizations for Adolescents: Tdap/Td — Below 33.33rd percentile
- Prenatal and Postpartum Care: Timeliness of Prenatal Care and Immunizations for Adolescents: Meningococcal — Below 25.00th percentile

In the 2016–2017 reporting cycle, Kansas selected similar measures to the previous reporting cycle for inclusion in their pay-for-performance measures for MCOs. The measures included:

- Annual Dental Visit
- Annual Monitoring for Patients on Persistent Medications
- Ambulatory Care
- Comprehensive Diabetes Care
- Childhood Immunization Status
- Immunization for Adolescents
- Human Papillomavirus Vaccine for Female Adolescents
- Prenatal and Postpartum Care

Common areas of strengths regarding quality, timeliness and access to care for all MCOs included:

- Annual Dental Visits — At or above 66.66th percentile
- Annual Monitoring for Patients on Persistent Medications, Childhood Immunization Status: Hepatitis B, and Comprehensive Diabetes Care: Eye Exams — At or above 50.00th percentile

In the evaluation of performance measures, it was noted that the MCOs' performance for Ambulatory Care: ED Visits improved by 5% each compared to their 2015 rating. This was identified as another strength in the performance of the MCOs during this reporting cycle.

Common areas of improvement regarding quality, timeliness and access to care for all MCOs included:

- Childhood Immunization Status: DTaP, HiB, Influenza, MMR, VZV, Combination 10, Combination 2 and Well-Child Visits in the 3rd–6th Years of Life — Below 50.00th percentile
- Immunizations for Adolescents: Tdap — At or below 33.33rd percentile
- Comprehensive Diabetes Care: Medical Attention for Nephropathy and Immunizations for Adolescents: Meningococcal — At or below 25.00th percentile
- Prenatal and Postpartum Care: Timeliness of Prenatal Care — At or below 10.00th percentile

In addition to HEDIS performance measures, the State requires comprehensive quality reporting through their 1915(c) Home and Community Based waiver assurances. The current quality assurance system requires that states develop and measure performance indicators in 14 areas, including waiver administrative authority, health and welfare of participants and financial integrity, levels of care, provider qualifications and service planning and delivery. Each waiver must have its own quality assurance system. Approximately 10 months prior to the waiver renewal date, the State submits an evidentiary report that includes the remediation taken for each systemic and individual instance when a performance measure has less than 100% compliance.[2] Ongoing monitoring and performance monitoring is a regular and consistent form of our oversight of the health plans.

The State has been making strides towards improving its CMS-372 (Annual Report on Home and Community Based Services (HCBS) Waivers) reporting based on findings from CMS's review of the KanCare program. CMS issued a corrective action plan on [insert date] based on their review, and the State has completed implementation on all but three elements. Changes that have been made include timely completion of quality reports, assurances that providers are meeting required licensure and/or certification standards timely, increased monitoring of performance measures and implementation activities for an Adverse Incident Reporting System.

The State has since further refined and streamlined its subset of measures to support the overall goals of the KanCare program and the populations it serves. The measures per each goal are prioritized for continuous quality improvement and are based on identified areas of opportunity and designed to achieve favorable outcomes in health status and experience of care. Annually, the State will publish a report evaluating progress towards the following goals and the comparative achievement of each objective by MCO. Additionally, the State will post to the KanCare website, at a minimum, the HCBS data and all CMS-required Medicaid Adult and Child Core Measurement sets for each MCO. The State will also work to harmonize these measures with those identified in the 1115 Demonstration waiver as they become finalized during the waiver renewal process. The State believes improvements in member health, well-being and satisfaction will help drive improved costs and long-term sustainability of the KanCare program.

[2] Centers for Medicare and Medicaid Services. Modifications of Quality Measures and Reporting in Section 1915(c) Home and Community-Based Waivers. March 12, 2014.

ACCESS TO COVERED SERVICES

Kansas conducts several different activities used to assess the access to covered services, including geo-spatial analysis, provider file validation and the EQRO's assessment of availability of services under Subpart D — QA and PI: Access Standard, found at 42 CFR 438.206. Member grievance data and member experience of care survey results are also used to gauge potential issues with network access and adequacy.

KanCare relies on geo-spatial analysis to evaluate the time and distance a member must travel to see a provider. Under the new Managed Care Final Rule, states were asked to develop additional standards for specific provider types and for services in which the provider drives to see the member; the latter services are more common in Home and Community Based waiver programs. In addition to the geo-spatial analysis, the State also evaluates the underlying provider data that is used to develop the geo-spatial reports as well as, used to populate each MCO's Provider Directory. The Managed Care Final Rule placed additional requirements on the State and its MCOs to ensure that Provider Directory information was accurate and complete, and included specific information such as languages spoken, whether the provider is accepting new patients, the location and office hours, whether the provider had participated in cultural competency training and if the provider's office complies with the American's with Disabilities Act for access, including access and accommodations for individuals with BH issues.

The EQRO evaluates access to care on an annual basis, following up on noted deficiencies and activities implemented by each MCO to close identified gaps. Throughout the three-year period of this analysis, general feedback from the EQRO for all of the MCOs has focused on the accuracy and completeness of the data used to support network adequacy reporting. In the most recent EQRO review, the following table outlines the result of the assessment of Subpart D — QA and PI: Access Standards, as excerpted from the KanCare Program Annual External Quality Review Technical Report, 2017–2018 Reporting Cycle.

Table 2.1. Summary of BBA Compliance Results - Amerigroup

Federal Regulations	Component Compliance*					
	FM	SM	PM	MM	NM	Components
Subpart D – Quality Assessment and Performance Improvement						
Access Standards						
§438.206 Availability of Services	54% (7/13)	31% (4/13)	15% (2/13)	0%	0%	13
§438.208 Coordination and Continuity of Care	83% (5/6)	0%	17% (1/6)	0%	0%	6
§438.210 Coverage and Authorization of Services	92% (11/12)	8% (1/12)	0%	0%	0%	12
Access Standards Total	**74%** (23/31)	**16%** (5/31)	**10%** (3/31)	**0%**	**0%**	**31**

Table 2.2. Summary of BBA Compliance Results - Sunflower						
Federal Regulations	Component Compliance*					
	FM	SM	PM	MM	NM	Components
Subpart D – Quality Assessment and Performance Improvement						
Access Standards						
§438.206 Availability of Services	15% (2/13)	54% (7/13)	31% (4/13)	0%	0%	13
§438.208 Coordination and Continuity of Care	83% (5/6)	0%	17% (1/6)	0%	0%	6
§438.210 Coverage and Authorization of Services	75% (9/12)	17% (2/12)	8% (1/12)	0%	0%	12
Access Standards Total	**52% (16/31)**	**29% (9/31)**	**19% (6/31)**	**0%**	**0%**	**31**

Table 2.3. Summary of BBA Compliance Results – UnitedHealthcare						
Federal Regulations	Component Compliance*					
	FM	SM	PM	MM	NM	Components
Subpart D – Quality Assessment and Performance Improvement						
Access Standards						
§438.206 Availability of Services	85% (11/13)	0%	15% (2/13)	0%	0%	13
§438.208 Coordination and Continuity of Care	83% (5/6)	0%	17% (1/6)	0%	0%	6
§438.210 Coverage and Authorization of Services	75% (9/12)	0%	25% (3/12)	0%	0%	12
Access Standards Total	**81% (25/31)**	**0%**	**19% (6/31)**	**0%**	**0%**	**31**

The rating scale used in these tables is based off a five-point scoring system as follows:

- Fully Met (FM) = 100% compliance
- Substantially Met (SM) = 75%–99% compliance
- Partially Met (PM) = 50%–74% compliance
- Minimally Met (MM) = 25%–49% compliance
- Not Met (NM) = 0%–24% compliance

As demonstrated by these tables, each MCO has attained a PM designation or higher for each of the elements under the standards.

Analyis and Recommendations for Access to Covered Services

In response to these new requirements, the State has hired additional staff and has bolstered efforts to monitor and evaluate each MCO's provider network adequacy. An assessment of each MCO's data was completed and a root cause analysis was performed. Root cause analysis determined that the MCOs lacked standardized technical specifications and clear direction on how to populate the provider file. A training program was developed, the MCOs received technical assistance and a standardized reporting format was implemented. Internal training for KanCare staff was conducted

to support consistent evaluation of the submitted provider files. As a result, the MCOs are now given a “report card” that summarizes the accuracy of their submission and identifies the specific lines within the provider file that must be corrected.

In addition to the provider files, the MCOs submit quarterly geo-spatial reports. These reports are developed based on the network time/distance standards determined by the State, which vary by geography. Given the variation in Kansas’ geography, ranging from urban to frontier, the State has maintained a flexible approach to network adequacy. As the State has amended its provider network adequacy standards, new requirements will become effective on January 1, 2019. Additional monitoring and oversight activities being explored by the State include validating the provider file against the geo-spatial reports, validating the provider file against the provider directory and performing primary source verification through secret shopper or other outreach calls.

MEMBER'S EXPERIENCE AND SATISFACTION

The KanCare program includes a number of different surveys. Surveys help identify member experience of care and provider experience working with the MCOs. The most common survey is the NCQA's Consumer Assessment of Healthcare Providers and Systems (CAHPS). The CAHPS survey is tailored to adult and child populations, including special supplements for Children with Chronic Conditions. MCOs that are NCQA accredited are required to perform the CAHPS survey; the State requires all of its MCOs to be NCQA accredited.

For the 2017 survey, each of the three MCOs contracted with NCQA-certified survey vendors to assist with scoring methodology, fielding the survey and presenting the calculated results: Amerigroup and UnitedHealthcare contracted with DSS Research (DSS) and Sunflower contracted with Morpace. As NCQA-certified vendors, DSS and Morpace are required to adhere to NCQA survey specifications. The State further directs each MCO to stratify its CAHPS sample to ensure a representative sample of adult and child populations. The child population is further stratified into those with and without chronic conditions; within each of those levels, they are stratified into those that are Title XIX (Medicaid) and those that are Title XXI (Children's Health Insurance Program (CHIP)). Surveys are conducted using a mixed-mode approach that includes mail, telephone and/or online. Annually, NCQA publishes regional and national benchmarks for HEDIS and CAHPS results in a database referred to as the QC. The QC data allows for specific benchmarking of progress to national and regional averages. The 2017 CAHPS results demonstrated that, in general, the MCOs earn positive assessments by members for measures related to quality, timeliness and access to healthcare for most ratings, questions and composites. Responses were, for the most part, at or above the 50th QC percentile, with many of the ratings, composites and questions on the child surveys above the 75th QC percentile.

The following table is excerpted from the KanCare Program Annual External Quality Review Technical Report, 2017–2018 Reporting Cycle and provides the most recent snapshot of members' experience of care across the adult and child populations, with additional stratification of the child population by those with chronic conditions, and Medicaid and CHIP.

Table 4.2. Composite Scores by MCO and by Program - 2017

Composite	MCO	Adults		General Child				Children with Chronic Conditions			
				Title XIX		Title XXI		Title XIX		Title XXI	
		Score	QC	Score	QC	Score	QC	Score	QC	Score	QC
Getting Care Quickly	AGP	84.2	>66.67th	**91.3**	**>66.67th**	**92.7**	**>75th**	**94.6**	**>75th**	**96.1**	**>95th**
	SSHP	**87.9**	**>90th**	**92.9**	>75th	**91.9**	**>66.67th**	**93.8**	>66.67th	**94.6**	>75th
	UHC	**87.7**	**>90th**	**93.6**	**>75th**	**93.7**	**>75th**	**97.1**	**>95th**	**95.1**	**>90th**
Getting Needed Care	AGP	85.1	>75th	**90.6**	**>75th**	85.6	>50th	89.2	**>66.67th**	88.0	>50th
	SSHP	86.2	>75th	**88.5**	**>66.67th**	**90.5**	>75th	89.2	>66.67th	**91.1**	**>90th**
	UHC	84.7	**>75th**	**92.0**	**>95th**	**92.8**	**>95th**	**92.1**	**>95th**	**94.2**	**>95th**
How Well Doctors Communicate	AGP	**91.3**	<50th	**94.2**	>50th	**95.0**	>66.67th	**95.6**	**>75th**	**95.2**	>66.67th
	SSHP	**93.7**	>75th	**95.9**	**>90th**	**94.9**	>66.67th	**93.9**	**<50th**	**95.2**	>66.67th
	UHC	**92.4**	**>66.67th**	**96.7**	**>95th**	**96.8**	**>95th**	**97.9**	**>95th**	**97.8**	**>95th**
Shared Decision Making	AGP	77.7	<25th	82.4	>75th	**82.6**	**>90th**	86.9	>75th	84.5	<50th
	SSHP	79.3	<50th	79.1	<50th	80.4	>50th	82.6	**<25th**	85.3	>50th
	UHC	81.6	>75th	81.0	NA^	**82.0**	**>75th**	86.6	**>75th**	**86.6**	**>75th**
Customer Service	AGP	87.2	<33.33rd	87.1	<33.33rd	**89.3**	**>66.67th**	85.8	**≤10th**	87.7	NA^
	SSHP	**90.5**	>75th	89.0	>50th	89.7	>75th	87.4	<25th	90.7	>50th
	UHC	88.2	<50th	89.6	>66.67th	91.6	**>90th**	**92.3**	NA^	90.4	NA^
Coordination of Care	AGP	82.4	<50th	82.9	<50th	81.4	<50th	80.1	<25th	79.8	<25th
	SSHP	**90.0**	**>95th**	**84.7**	**>50th**	**82.8**	**<50th**	83.0	>50th	**81.2**	<33.33rd
	UHC	79.9	<25th	88.1	>75th	**81.7**	**<50th**	80.3	<25th	**78.7**	NA^
Health Promotion and Education	AGP	68.4	**<10th**	**71.6**	**<50th**	**68.5**	<25th	**75.2**	<25th	75.5	<25th
	SSHP	**73.5**	**<50th**	**70.7**	**<50th**	**68.0**	<25th	70.4	**<5th**	73.7	**<5th**
	UHC	70.1	<25th	69.7	**<33.33rd**	63.9	**<5th**	**78.5**	**>50th**	69.2	**<5th**

^Indicates number of responses <100; NCQA assigns "NA" rather than a QC percentile ranking.
Bold Scores: those 90.0 or above and those that increased by 2 or more points from 2016 to 2017
Bold Quality Compass (QC) rankings: those >90th QC and those that increased in QC ranking from 2016 to 2017
Rankings above the 90th QC are in green; rankings below the 10th QC are in purple.

In addition to the CAHPS survey, the State's EQRO conducts the Kansas Medicaid Mental Health Consumer Perception Survey (MH Survey) to all Medicaid members receiving MH services. The objectives of the MH Survey include:

- Determining the strengths and weaknesses in consumer perception of access to care, quality and appropriateness of services, and effectiveness of services
- Describing consumer perception of their participation in planning their treatment
- Describing the healthcare access, quality and outcomes for KanCare adult and youth members who have received MH services
- Describing the access, quality and outcomes for youth and young adult members receiving services through the Serious Emotional Disturbance (SED) waiver
- Comparing 2017 MH Survey results to prior years (2011–2016)

The Mental Health Statistics Improvement Program (MHSIP) survey tools (Youth Services Survey, Youth Services Survey for Families and Adult Consumer Survey) were adapted for use in the project. The MHSIP survey is a nationally standardized survey, having been tested and determined to be valid and reliable. Surveys were distributed to adult and youth members enrolled in KanCare on the date of sample selection who received one or more MH services through one of the three MCOs between October 1, 2016, and March 31, 2017. Four subgroups were stratified within the domain composite categories:

- General Adults — Members age 18 or older who received MH services, excluding members of the SED waiver Young Adult subgroup (ages 18–21)
- General Youth — Members age 17 or younger who received MH services, excluding members of the SED waiver Youth subgroup)
- SED Waiver Youth — Members age 17 or younger who received MH services through the SED waiver
- SED Waiver Young Adults — Members age 18–21 who received MH services through the SED waiver

For most questions, responses were generally positive and did not change significantly from pre-KanCare (2011–2012) to KanCare (2013–2017).

Analysis and Recommendations for Member Experience Activities

The CAHPS and the MH Survey data are essential to understanding how the KanCare program is operating. Survey data can provide necessary benchmarks, uncover the "why" behind perceptions and give a voice to consumers. However, it should be balanced against the potential for survey fatigue. Survey fatigue is often described as when survey respondents become bored, tired or uninterested, resulting in the survey becoming less valuable. MCOs also conduct surveys of their members and there is a new State requirement for MCOs to obtain NCQA LTSS distinction, which requires the CAHPS — Home and Community Based Survey. Additional surveys, such as the National Core Indicators (NCI) and the NCI — Aging and Disabilities, are also being explored for use with some of the Home and Community Based waiver populations. As a result, the use of surveys has become a point of focus for the modernization of the KanCare QMS. The State will be evaluating all surveys and sampling methodologies to make determinations about the types of surveys to be used, as well as making decisions about how data from surveys should be integrated into quality improvement activities.

CONCLUSION

The State's approach to its QMS is continuing to evolve, with a revised QMS submitted to CMS in July 2018. The revised strategy separates compliance related monitoring and oversight activities from targeted performance improvement actions. The new QMS incorporates a mix of quantitative and qualitative measures that form the foundation of the State's ongoing continuous QI efforts. The new QMS is intentionally focused on the following five goals:

- Goal 1: Improve the delivery of holistic, integrated, person-centered, and culturally appropriate care to all members.
- Goal 2: Improve member experience and quality of life.
- Goal 3: Improve provider experience and network relationships.
- Goal 4: Increase access to and availability of services.
- Goal 5: Increase the use of evidence based practices for members with behavioral health (mental health and substance use disorder) and chronic physical health conditions.

It is the State's belief that by focusing performance improvement activities on drivers of health inequities, addressing gaps in network adequacy and promoting the use of evidence based practices all under a member and provider centric model will result in meaningful and sustained improvements. As the State continues to systemize the quality improvement activities throughout the year, new measures will be added, as needed, to effectuate improvement and to ensure that high quality of care is achieved through an iterative quality improvement process.

The State remains committed to a dynamic evolving process for quality improvement as a critical element to the success of the KanCare program. The State has begun a more intense and methodological process for ensuring quality of care is being delivered to Kansans. The KanCare 2.0 program embodies change for the better health and independence for Medicaid members. Steps have been taken to reduce the number of reports required by the MCOs, while ensuring that required reports will be reviewed for completeness and timeliness of submission through the use of a reporting database. Efforts are also being made to use the data submitted by the MCOs in a more meaningful way to influence the quality of services in the KanCare program.

KanCare leadership, in collaboration with Quality Management Integrated Model structure that will oversee the ongoing review and evaluation of the KanCare QMS, will work throughout the year to support, oversee and monitor the quality activities of the KanCare program to ensure its goals and objectives are achieved. With additional technical support provided by the EQRO and the KanCare Quality Improvement Committee, the State is committed to working with the MCOs to ensure the PIPs and performance measures continue to support the overall QMS and health of the program. All of these efforts work to strengthen the KanCare program to ensure the delivery of quality care and

services to KanCare members. The State believes that the alignment of goals and objectives as well as, the collaborative approach to continuous quality improvement will act as an incentive or “carrot” to achieve goals. However, in this approach it firmly believes that MCOs must also be held accountable. The establishment of new benchmarks for improvement set a high bar for which the State’s managed care contractors will be held accountable. The State has streamlined its system of progressive accountability which may include non-financial as well as, financial penalties or sanctions for non-compliance.

APPENDIX A: ACRONYMS

AOD	Alcohol and Other Drug
BBA	Balanced Budget Act
BH	Behavioral Health
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
DSS	DSS Research
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
HCBS	Home and Community Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HPV	Human Papilloma Virus
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
IMA	Immunizations for Adolescents
ISCA	Information Systems Capabilities Assessment
KDADS	Kansas Department for Aging and Disability Services
KDHE	Kansas Department of Health and Environment
KKMAR	KanCare Key Management Activity Report
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MHSIP	Mental Health Statistics Improvement Program
NCI	National Core Indicators
NCQA	National Committee for Quality Assurance
PH	Physical Health
PI	Performance Improvement
PIP	Performance Improvement Project
QC	Quality Compass
QII-TF	Quality Improvement Initiative Task Force
QMS	Quality Management Strategy
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications


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